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The Mind and Body in Pain: Psychoanalytic Work and the Phenomenology of Suffering

The Phenomenology of Suffering: Treating the Mind and Body in Pain

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In this paper, I will discuss the idea of using psychoanalytic theory and practice to treat physical pain. I will also make reference to the mental pain which accompanies physical pain. I will define the concept of physical pain as it is currently scientifically understood and I will make a case for the value of psychoanalytic approaches for treating pain. I will further describe some of the challenges faced by psychoanalysts in becoming involved in pain psychology. To contextualize the discussion, I will present a brief history of how psychoanalytic thinking has been applied to the problem of pain. Finally, I will suggest future directions for psychoanalysts to develop a role in this area of clinical practice.

The *International Association for the Study of Pain (IASP)* defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. The definition is further elaborated: “Pain is always subjective. Each

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individual learns the application of the word through experiences related to injury in early life ... It is unquestionably a sensation in a part or parts of the body, but it is also always unpleasant and therefore also an emotional experience ... Many people report pain in the absence of tissue damage or any likely pathophysiological cause; usually this happens for psychological reasons. There is usually no way to distinguish their experience from that due to tissue damage if we take the subjective report. If they regard their experience as pain and if they report it in the same ways as pain caused by tissues damage, it should be accepted as pain. This definition avoids tying pain to the stimulus. Activity induced in the nociceptor and nociceptive pathways by a noxious stimulus are not pain which is always a psychological state, even though we may well appreciate that pain most often has approximate physical cause". (IASP, 2015).

This definition clearly ties the pain experience to a person's subjectivity and developmental history. Yet, the approaches used to understand and treat pain in the Western world are dominated by the ideas of conscious control and stress management. The orientations are based upon behavioral and cognitive constructs. With a few exceptions, psychoanalytic thinking is absent in pain psychology.

This reality is largely due to the domination of the evidence-based practice (EBPP) trend in Western medicine. Best practice guidelines rely upon scientific validation of treatment methods for payers to authorize care and for scholarship to be accepted by the peer reviewed journals in medicine – and in much of psychology. Within American psychology, “health psychology”, an empiricist domain, is the foundation for the mental health services provided

within medical pain management. Yet, EBPP is illusory and flawed (Westen, 2003). Studies tend to investigate simple phenomena with outcomes based upon efficacy of interventions and not comparison of treatment approaches. And pain patients often demonstrate highly complex presentations which may not be measurable in the research designs used.

This EBPP trend was concretized in 2014 with the entire issue of *American Psychologist* devoted to pain psychology (Jensen & Turk, 2014). “Contributions of Psychology to the Understanding and Treatment of People with Chronic pain: Why it Matters to ALL Psychologists” defined the psychological approaches to the treatment of pain as: 1) the operant model (decreasing pain behaviors and reinforcements); 2) the peripheral psychophysiological model (muscle relaxation); 3) the cognitive and coping model (coping skills training); and 4) the central neurophysiological model (neurofeedback). There was no mention whatsoever of psychoanalytic approaches and not one reference to the literature of psychoanalysis. This type of omission reflects the dire seriousness of how psychoanalysis is ignored in the literature of pain psychology. Psychoanalytic treatments for pain may only be valued in limited instances as a last resort for patients who have failed other psychotherapies (Grzesiak et al, 1996).

Yet, psychoanalytic treatment of pain is vibrant in some areas of Europe, particularly Germany and France (e.g., Fischer-Kern, et al, 2010; Sollner & Schussler, 2001; de Lantsheere, 2000). However, in the U.S. this approach was valued for only a short time during the mid-20th century. Currently, there is no formal recognition of the psychoanalytic treatment of pain either in American health care, psychoanalytic institutions or the psychoanalytic community.

This situation is striking as psychoanalysis emanated from a quest to understand pain. Following the zeitgeist of physicians in the 19th century, Freud's early works considered the problem of what was known as "lesionless pain" (Hodgkiss, 2000). Both the "Project for a Scientific Psychology" (Freud, 1895, published in 1950) and "Studies in Hysteria" (Breuer & Freud, 1895, published in 1955) were outcomes of this effort.

"Studies" may be most relevant to this clinical work. Freud described a psychotherapeutic clinical method that resulted from his failure to reduce the suffering of his pain patients with the objectivist methods of 19th century physicians (electrotherapy, massage, rest cures and hypnosis). These patients suffered with physical symptoms (including pain) accompanied by mental distress. Freud described his clinical method: *"The fact is that local diagnosis and electrical reactions lead nowhere in the study of hysteria, whereas a detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me, with the use of a few psychological formulas, to obtain at least some kind of insight into the course of that affliction"* (Breuer & Freud, 1955, p. 160 – 161).

The case of Fraulein Elisabeth von R. was *"... one of the hardest that I had ever undertaken, and the difficulty of giving a report upon it is comparable, moreover, with the difficulties that I had then to overcome"* (Breuer & Freud, 1955, p. 139). He observed that emotional states were involved in the neurophysiological processes of pain and that underlying conflicts influenced suffering.

After this initial work, Freud never again took up physical problems nor did he discuss "psychosomatic" phenomena (or ever use the term). He explained why: *"This implied, of*

course, that I abandoned the treatment of organic nervous diseases; but that was of little importance. ... the prospects in the treatment of such disorders were in any case never promising, while, on the other hand, in the private practice of a physician working in a large town, the quantity of such patients was nothing compared to the crowds of neurotics, whose number seemed further multiplied by the way in which they hurried, with their troubles unsolved from one physician to another” (Freud, 1925).

Freud was only focused on the somatic consequences of the abnormal mind, which he described as *“a change in the action of their minds upon their bodies”* (Freud, 1905b), and *“the puzzling leap from the mental to the physical”* (Freud, 1917a). Today, most of American psychoanalysis is similarly organized. The focus has been to clarify unconscious processes and their bodily effects not to understand the effects on the mind of the patient with a medical illness.

Psychoanalysis as a method to understand organic disease evolved under Ernst Simmel at the Schloss Tegel in Berlin in the late 1920’s (Danto, 2005). Franz Alexander established a similar American movement in the 1930’s (Alexander, 1936). This movement was a humanistic reaction against the “excesses and cold impersonality of the 19th century somatic style” (Hale, 1995). Using the case-study method, psychoanalysts, including Groddeck (1925), Dunbar (1947), Ruesch (1948), Grinker (1953) and Engel (1959), regarded that the primacy of emotion and the conversion of unconscious conflict into physical symptoms and defenses were causative factors to physical illness. The journal *Psychosomatic Medicine* defined the psychoanalytic psychosomatic movement as being concerned with *“the psychic component in the disease process and the emotional relationship between the physician and patient”* (Dunbar, 1939).

The American psychoanalytic psychosomatic movement was respected within internal medicine for the next 25 years. Alexander reflected on the value of understanding emotional factors in disease: “... *the patient as a human being with his worries, fears, hopes and despairs, ... not only as the bearer of organs – is becoming the legitimate object of medical interest*” (Alexander, 1950, p. 17). He also was aware of questions about the scientific legitimacy of psychoanalytic psychosomatics: “*Some sound and conservative clinicians deem this a threat to the so arduously acquired scientific foundations of medicine, and authoritative voices warn the profession against this new “psychologism” as incompatible with medicine as a natural science*” (Alexander, 1950, p. 17). The view that psychoanalysis was effective with physical illness was not challenged during this period of time.

By the mid-20th century, empiricism emerged as a dominating force within American health care and psychoanalysis was seen as irrelevant. This trend was a consequence of the lack of evidence for psychoanalytic psychosomatics. The U.S. government and private foundations (such as Rockefeller) redirected its research grants away from psychoanalytic projects. The cognitive revolution, medical specialization and the non-dynamic DSM (1952) further damaged the value of psychoanalysis (Burnham, 2012; Paris, 2005). By the late 1960’s, psychological treatments, including those related to the psychological effects of physical illness were considered insignificant unless empirically validated. Unconscious processes were improvable and thus regarded as speculative. Psychoanalytic hubris also contributed to this decline. Hale (1995), concluded that “*the rhetoric of psychoanalytic psychosomatic medicine moved from*

diffidence to dogmatism ... the first papers of the 1930's were cautious ... the first texts were confident ... popularization attained certainty”.

The American psychoanalytic psychosomatic movement essentially disappeared. This area of inquiry continued on a limited basis – for example, at the Paris School of Psychosomatics with its drive-based work and at the University College London with the attachment-based work of Fonagy and Target (Gubb, 2013). A few psychoanalytic scholars from North American, including Taylor (2008, 1987) continued to reflect upon psychoanalytic psychosomatics and pain. It is unusual to see a psychoanalyst specializing in medical psychoanalysis or pain management (Rickles, 1986). Yet there are psychoanalysts, such as those on this panel, who consider medical conditions from a psychoanalytic perspective.

American psychoanalysis currently is mostly concerned with those similar to Freud – the influence of somatic processes on mental disorders. There is less of a focus on the psychological aspects of physical disease. Psychoanalytic psychosomatics may have become too complicated and challenging to American psychoanalysis given the assaults on it as a legitimate mental health treatment.

As well, contemporary psychoanalysis does not often consider the experience of the body (Bronheim, 1996). Psychoanalytic training programs do not include courses on psychoanalytic psychosomatics or pain (Taylor, 1992). Formulations by psychoanalysts about physical pain may not be relevant to the language of current medical practice (Gendrault, 2001). It can be difficult for the psychoanalytically oriented to work with medical professionals who have not been trained in reflective thinking (Goldie, 1985). Medical practitioners who work with

physical illness and death may have anxieties about suffering and may defensively avoid experiential patient interactions (Skogstad, 1997).

Work with the medically ill has been left to those in consultation liaison psychiatry, health psychology and behavioral medicine. In the US, psychosomatic medicine as it is practiced today is focused upon the negative impact of mediating stimuli on physical response. This field lacks a unified theory/practice; subsuming a range of factors such as health anxiety, disease phobia, fear of death, denial of illness, and somatization disorders (Fava, 2012). These psychological interventions objectify experience. Treatments are directed at conscious control and symptom reduction.

A psychoanalytic pain practice would best follow the clinical method and wisdom of Freud as espoused in “Studies in Hysteria”. Psychoanalytic therapies possess characteristics that are distinctive and set them apart from other treatments (Shedler, 2010). There is limited evidence for psychoanalytic therapies for pain (Roy, 2008) yet outcome studies will not solve the problem; psychoanalysis is a hermeneutic practice that ought not to try to emulate objectivist medical science. The absence of evidence is not absence of effectiveness. The benefit of psychoanalysis is not dependent upon empirical verification. We cannot wait for or rely upon scientific validation to apply psychoanalysis in the treatment of pain. There are far too suffering patients who would benefit. We must promote our work as a viable option in health care now, substantiating its efficacy.

While there is no one specific orientation for an effective psychoanalytic pain psychology; there are many useful perspectives. Our goal as clinicians should be to bridge the

gap between the experience of the mind and the experience of the body of the patient with pain. As Grubb (2013) suggests, such methods could address the “speechless mind” (an undeveloped mind which cannot function due to faulty development) and/or the “speaking body” (the body which functions for the mind which cannot).

Several promising short-term models for the psychoanalytic treatment of pain have been developed in European centers (e.g., Luyten, et al, 2013; Nickel, et al, 2010; Beutel, et al 2008; Ventegodt, et al, 2007). Many of these therapies are multi-modal - they include practices such as meditation, body work and art therapy. There are actually empirical studies with good evidence in this area - a recent RCT meta-analysis of short-term psychodynamic psychotherapy for somatic disorders showed effectiveness. It was concluded that these treatments may be a preferred first-line alternative to invasive medical procedures as reduced health care utilization was obtained with these therapies (Abass, et al, 2009).

Psychological trauma is often found in the patient population. Many patients with pain have had prior psychological trauma (Fischer-Kern et. al, 2010; Roy, 2008; Taylor, 2008; de Lantsheere, 2000; Aron & Anderson, 1998; Krystal, 1997; Grzesiak, et. al, 1996; Grzesiak & Ciccone 1994; Engel, 1959; Szasz, 1955) which cannot be adequately managed with behavioral and cognitive therapies. The trauma can be repressed in the unconscious until injuries precipitate the deferred action of physical expression (Grzesiak, 2003). Thus, pain can be a signifier for previous trauma. And, psychological trauma may also result from chronic pain in and of itself, even in patients with stable backgrounds. The insult to self-integration and the catastrophic losses and debilitation that physical pain creates is traumatizing (Bullington, et al, 2009).

Existential issues are critical to the psychology of pain. Chronic pain ruptures the relationship of the person's body to their psyche, and thus their mind to the world. The patient is left with being-in-pain, negotiating-with-pain, explaining-pain and identifying-with-pain (Bullington, 2013). Optimal treatment reduces the pain experience by reconnecting the patient in their relationship to the world (Bullington, et al, 2009). Psychological treatments that are focused upon the alteration of mental mechanisms alone do not resolve the alienation that is central to the reality of the patient in pain and may create new symptoms.

When we speak of pain, we must also speak of suffering. Suffering is a process which threatens personal integrity. It is "the increasing awareness of the impact of the physical state on the person, not the physical impairments per se that causes the suffering" (Cassell, 1999). An inadvertent cause of worsened suffering is the failure to relieve it (Cassell, 1983). Perhaps the reason for the exclusion of psychoanalysis from American health care is an intrinsic aspect of the health care system. Suffering is a subjective state and hence it may be devalued as it cannot be removed. The use of methods to address suffering – such as empathic listening and non-discursive reflection – may not be esteemed as these cannot effect change, they can only share the experience. Physicians now are directed at the body and not the person, hence suffering is missed (Cassell, 1999).

As psychoanalysts, we are trained to understand the meaning of both pain and suffering. The communication of both experiences and the symbolization of the unbearable emotions attached to these can promote mental re-integration and resilience. The psychoanalytic approach can be provided to patients alongside the objectivist, technologically oriented

interventions which dominate medical practice. As well, patients may find that they need less of the latter and more of the former after a psychoanalytic assessment.

Some of the ways in which psychoanalytic clinicians can develop a role in the practice of pain include: 1) Participation in collaborative care medical teams (which is supported by provisions of the Affordable Care Act; 2) Education of medical trainees and professionals about the value of psychoanalysis; 3) Development of short-term and long-term treatment models and 4) Outcome research with these models.

In summary, it is evident that contextual factors influence the value given to professional knowledge and what ideas are acceptable at any given time period. These issues affect the construction of professional roles. For psychoanalysis to become significant, the socio-cultural situation needs to be approached with this understanding. On a personal note, 25 years of medical psychoanalysis with patients who have chronic pain has validated this approach as having excellent outcomes for well-selected patients. It is my fervent hope that psychoanalytic practitioners will be able to embrace the care of this patient population where so much can be achieved. And so much good can be gained.

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