THE PSYCHOLOGY OF PAIN†

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INTRODUCTION

After all the information you have already received this morning it would seem unnecessary, perhaps even superfluous to add anything else at all, and seeing that I am painfully aware of the fact that I will not be forgiven if I just reiterate what was said, very eloquently, by previous speakers, I must immediately declare my interests in this matter.

I am participating as a human scientist and as such I think that I represent a certain perspective which may complement what was already given to you, in that way contributing towards a fuller understanding of the vexing problems surrounding the pain phenomenon. As a human scientist, a psychologist in my case, I hold certain views which may differ in certain respects from those already given to you; not in any way diametrically opposed, perhaps only certain accents will be placed on different aspects.

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THE IMPORTANCE OF THE UNITY OF A PERSON'S EXISTENCE

Although it is factually so that a human being can be described in terms of body, mind, or person language as Prof. Degenaar in his excellent paper expounded, this introduces to my way of thinking a threat to the full understanding of the unity of a person's existence not as a final product of all the separate approaches but as a starting point. Some protagonist of the same point of view I hold, once

facetiously said that if we separate body and soul (as psyche and soma, or whatever other terms we may use), then, on the one hand we end up with a soulless body and on the other hand with a bodyless soul, in other words with a corpse and a ghost!! "And all the king's horses and all the king's men, will not be able . . . .!" etc.

I must stress the unity of individual experience in an immediacy that precedes the scientific need for greater specialization and abstraction.

I think that we must have it quite clear in our minds that no individual experiences his pain as being either neurological, physiological or psychological but just as pain, his pain. Perhaps it is also important to note that pain as a generality exists only in the minds of people talking about it or studying it; real pain, in *contrast*, is always specific, is always the pain of a specific human being; a person with a name and a surname; with a history and perhaps with a perceived future. It is this suffering person, also being aware of the fact that he suffers, that we are concerned with.

THREE MODES OF BEING-IN-THE WORLD

To understand this sufferer we must analyse and try to understand the background against which this individual becomes visible to us. For this background I would like to use the term 'world'; a term that Rollo May (1961): defines as: "The structure of meaningful relationships in which a person exists and in the design of which he participates".

We cannot understand the behaviour of any person fully by describing his environment, important as it may be, as environment constitutes only one mode of world to him — the "world — around" that we share with all other "organisms". This is the world of biological determination of birth, ageing, dying, the world of objects around us, the world of natural laws and natural cycles, of sleep and wakefulness of desire and relief; the 'world' into which we are catapulted at birth and to which each of us must adjust in some way or other.

Apart from this or rather interwoven through this, man creates other worlds for himself. Binswanger (1942) mentioned two of these:

The world of our being with others: This world is constituted by our interrelationships with other human beings and the structure of meanings designed by the interrelationships of the persons in it. In the environment we talk of *adaptation* and *adjustment*, but in this world-with-others the more appropriate terms is 'relationship': the essence of a relationship being that in the encounter both persons are changed.

The own-world or private-world: My world of consciousness of my self-awareness, of self relatedness, the result of the most intimate and most meaningful of all dialogues, my dialogue with myself. This is the realm of my self-image, self-esteem and my self-confidence. These modes of world are in their most creative and productive forms unique webs of interrelationships, intimately bound up with my ego, as the centre of identity and continuity that guarantees my conscious being.

TEMPORALITY

Temporality is one of the most important coordinates of the worlds we create; *coordinates* which assist us in determining our position physically and spiritually as we travel through life.

Although we of the West have formally chopped time up into equal blocks of seconds, hours, or days, we, as a matter of fact do not experience time in this way; for two people in love time flies, for two people awaiting news about a son declared lost on the Border, time drags.

For the euphoric, happy individual the passing of time is hardly noticeable, for the depressed individual time stands still, becomes a quagmire. Patients in a hospital experience time differently because all, or most, of the usual milestones have fallen away and they create new ones that usually become extremely important. We cannot but be struck by the fact that the most profound and central human experiences like anger, joy, depression and anxiety always occur in the dimension of time. We must therefore understand what the meaning of time is for the suffering patient; how he relates himself to the temporal structure of past, present and future where the *past* is constituted as that which lie behind one, closed, unchangeable, history, open only to man's frail and counterfeiting memory; the realm of the obsolete, accompanied by guilt remorse.

The *future* on the other hand is constituted by that which is still to happen, is therefore completely open, to the point of unreality. The future is also the realm of hope, expectations and ethical action — the horizon of our expectations. When the future is perceived in any way as closed or foreshortened, the flow of time is turned round and flows back into the past, invariably followed by feelings of remorse or shame and guilt and eventually a severe depression. The *present*, that illusive point where future passes into past if we do not succeed in stopping it. This is only possible through consciously acting upon it.

To assist and help a patient in pain one must have an understanding of these worlds of the patient, one must be able to grasp how this particular person gives meaning to whatever happens around him. It is not only important, it is imperative.

There are many problems surrounding the phenomenon of pain that would, I think, remain unanswered. if we do not accept the lived world as our point of departure, e.g. is pain the opposite of pleasure? or does the existence of the masochist who seems to derive pleasure from painful experiences put a lie to that? How is the thesis of a direct relationship between a so-called pain stimulus and pain experience altered by phenomena like "glove anaesthesia" exhibited by a hysterical patient and hypnotically induced anaesthesia, that in some cases worked so well that people could be operated upon.

How do we explain Bakan's (1968) experiment where he induced pain in the phantom limb of a patient by referring to some cause of anxiety in the patient's private social world?

Is it not perhaps possible to explain it, in the light of what we have said so far, as follows: This experience caused the patient to restructure his lived-world so that he could meaningfully integrate this new information, but being unable to do so successfully constrict his existence to the *limb* (which is not there in any case!)?

COPING WITH PAIN

Pain as perceived by the sufferer is determined, not only, and perhaps not even primarily, by the quality and the quantity of the pain stimulus, but by determinants of behaviour, like background, education, culture etc., and, by the ability or inability of the patient to meaningfully integrate this experience into his world.

In the coping of the patient with his pain one could see this as a two-pronged approach that one could call a hygiene approach and a growth approach.

Hygiene approach as suggested by Melzack (1973):

"gate-control theory . . . suggests that pain control may be achieved by the enhancement of normal physiological activities rather than their disruption by destructive, irreversible lesions. In particular it has led to attempts to control pain by activation of inhibitory mechanisms."

This not only refers to aspects like pharmacological control of pain, or sensory control of pain by using anaesthetic blocking agents but also to the psychological control of pain by means of methods or techniques like

Progressive Relaxation (Jacobsen)
Autogenic Training (Schultz) or Concentrative self Relaxation
Hypnotic suggestion techniques
Desensitization techniques
Psychotherapeutic relief of anxiety or depression
All these I refer to as hygiene methods.

Growth methods: There is enough evidence that in terms of personality growth better results can sometimes be obtained by freeing the patient to face up to the pain experience. As Maslow (1962: 97) puts it peak experiences like pain are usually acute identity experiences, i.e. experiences that could assist a person to face up, not only to pain, but ultimately to himself, to see him for what he really is, to try and live a really authentic existence. In such an existence pain would not necessarily be seen as an enemy, but as an opportunity for self development and self-enhancement. For after all, what would life be like if there was no pain left? No headaches when I have drunk too much, no tummy aches when I have eaten too much.

If pain as signal, symbol and significance disappeared, would not death be near at hand?

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