PAIN AND THE HUMAN EQUATION

J. Braeckman[1], H. Van den Enden[1], W. Distelmans[2]

[1] Vakgroep Wijsbegeerte en Moraalwetenschap,
Universiteit Gent, Blandijnberg 2, B-9000 Gent (Belgium)
[2] Afdeling Radiotherapie en Palliatieve Zorg,
Vrije Universiteit Brussel, Laarbeeklaan 101, B-1090 Brussel (Belgium)
johan.braeckman@rug.ac.be

ABSTRACT

As pain is a sensation generated in the brain, the validity of the distinction that is often made between physical and psychic pain can be questioned. We postulate that the distinction is irrelevant for the person experiencing pain or grief. Both physical and psychic pain, as well as other causes, can lead to mental suffering. The medical profession, and society in general, take psychic pain and mental suffering much less seriously than physical pain. We discuss existential depression, which affects the stability and integrity of the entire personality, and argue for a more prominent place of psychic pain and mental suffering in medical and bio-ethical discourses.

Key words: Pain - Suffering Existential depression - Subjective experiences

A MONISTIC VIEW OF PAIN

As evidenced by the papers assembled for the symposium, the notion 'pain' can be studied from many different angles (see also Rey, 1998). We wish to concentrate on the subjective, individual pain that is experienced by a human being. In particular, we wish to comment on the concept of 'psychic pain', i.e. that type of pain that cannot be associated with, or be reduced to, a somatic injury or wound. Our basic philosophical approach to pain is monistic. This means that, concerning the experience of pain by an individual, we do not make a fundamental distinction between physical and psychic pain. For the human subjective experience of pain and, if possible, for dealing with it, it does not matter where in the body pain is felt. The only meaningful distinction that can be made is based on the intensity and duration of the pain-sensation as experienced by the subject. This can vary from intense and unendurable to mild and bearable. It is possible for physical pain to be experienced by the human subject as worse than psychic pain, but the reverse can equally be true. In the end, every sensation of pain is generated by the brain. This holds not only for mental grief but also for physical pain. This is clearly illustrated by what is called phantom-pain: feeling pain in limbs that no longer exist. The experience of still having an arm that in reality has been amputated is impressive in itself. But the numerous testimonies of patients who complain of nails being painfully pressed into the palm of the phantomhand by convulsive and sustained clenching fists, illustrate even more convincingly that the brain is ultimately responsible for the experience of pain. The Indian-American neurobiologist V.S. Ramachandran gives many dramatic examples of the brain's capability of causing pain and illusory locating this sensation in the body on the basis of visual stimuli only. Ramachandran has a knack of designing simple experiments from which far-reaching conclusions can be drawn. We give one example of such an experiment. The testee sits at a table on which a small cardboard 'wall' is positioned. The testee hides his/her hand behind the wall. Before the wall is an artificial hand. The experimenter simultaneously strokes the same spots of the artificial hand and the hand of the testee. Soon the testee appears to feel the artificial hand being caressed. What happened is the following. The testee's brain experienced certain stimuli which it interpreted as the stroking of the hand. The visual perception that is linked with this sensation, however, does not match with the location of the real hand. The brain 'solves' this discrepancy autonomously, i.e. without the influence of the autonomous 'I', by locating the sensation in the artificial hand. When a needle is then suddenly jabbed in the artificial hand, the brain will produce a pain-sensation even though the testee, aware of the fact that the needle was not inserted in his/her real hand, realises that he/she is not supposed to feel pain. Pain-sensations, however, are not generated in the way people generally assume. According to Ramachandran and Blakeslee (1998: p. 54): "Pain is an opinion on the orga-

nism's state of health rather than a mere reflexive response to an injury. There is no direct hotline from pain receptors to 'pain centres' in the brain".

We quote this statement in order to illustrate that there is no fundamental distinction between physical and psychic pain. Even so, society has a different attitude towards physical and psychic pain: the latter is ignored and minimised in comparison with the former. The following factors are responsible for this:

- The problem of psychic suffering is underrated because people are less inclined to talk about this type of suffering than about physical suffering.
- Whoever expresses psychic pain risks an indifferent reaction. What is even worse, people tend to allocate the responsibility for mental suffering to the patient him-/herself. As a consequence, mental suffering is condemned which increases the patient's misery even further.
- Many people hold the opinion that the relief of psychic pain is a matter of character and will power. However, just as is the case with pain caused by physical injury, it is impossible to suppress mental suffering by means of so-called free will.
- People associate psychic pain with 'psychiatric', 'deviant' and 'mental instability'. Whereas people are often eager to help someone suffering from physical pain, patients of psychic pain are ignored and avoided.
- This tendency is worsened because there's no clear or efficient therapy for the majority of mental illnesses.
- People often erroneously associate psychic pain with temporary problems which are solvable or which will, in time, sort themselves out.
- People often repressively deny what they cannot understand. This is also the case with psychic suffering. Cheap remarks such as 'you shouldn't allow such thoughts in your head' are frequently heard in this context.

This difference in attitude towards mental versus somatic pain is apparent in several medical-ethical debates. In the euthanasia-debate, for example, there is much greater resistance against the notion of 'unbearable psychic pain' than against the notion of 'unbearable physical pain'. Many people sympathise with a physician's act of euthanasia in the latter case, but only a minority shows the same understanding in the former case.

PAIN AND SUFFERING

Pain is often the cause of suffering, but both terms are not identical. It is possible to suffer without feeling pain, and it is possible to feel pain without suffering from it. Important in the context of this essay is that people may suffer and call this suffering 'psychic pain', although no symptoms of pain can be medically discerned. Eric Cassell (1995), in his article 'pain and suffering' in the *Encyclopedia of Bioethics*, describes suffering as: "a specific state of severe distress induced by the loss of integrity, intactness, cohesiveness, or wholeness of the person, or by a threat that the person believes will result in the dissolution of his or her integrity" (op.cit.: p. 1899). Suffering is linked with the notion 'person', i.e. human beings – and perhaps certain animals such as chimpanzees and dolphins as well – with a history, a future, a sense of individuality, social context and autonomy to plan and act. Anybody experiencing the disintegration of his/her 'being-a-person', by definition, suffers. The person in this situation often describes this feeling, however, as 'psychic pain' (Cassell, 1999; Haythornthwaite *et al.*, 1991). Below we use the notion of 'psychic pain' in the meaning of 'suffering' without being able to go into further detail about the possible distinction between psychic and somatic pain on the one hand, and suffering on the other.

CAUSES OF PSYCHIC PAIN AND EXISTENTIAL DEPRESSION

There are many factors that may cause psychic suffering. Some of the most important ones are:

- a loss that is felt to be irretrievable (e.g. of a child or partner),
- the feeling of having failed to achieve a certain actively pursued goal,
- sudden or chronic unemployment,
- a fundamental desire that is unattainable,
- severe frustration or setback,
- with ageing and terminal illnesses: the feeling of having to part, of having to let go, and of weakening and humiliation,
- experiencing pain that is chronic or that is considered to be very severe,
- more generally: incidents, situations or emotions which compromise an individual's subjective perception of the future.

In this paper we do not discuss classical psychiatric syndromes, but instead focus on what we wish to call 'existential depression'. Diagnostically the following characteristics can be discerned:
(a) The motivations, engagements and interests are reduced or completely lost in the 'existentially depressed' person. He/she feels burnt out, listless and worn out.

The cause of existential depression can partly be ascribed to present society with its emphasis on performance, competition, and the pursuit of power and status. Nearly everybody is caught in this whirligig for at least a part of his/her life, and whoever drops out becomes 'existentially exposed'. The zest for living fades away, the lust and courage to enter the arena grow dim. People whose personality reflects their place in society appear to be most susceptible to existential depression. Once they lose their function in society, their personality disintegrates as well.

(b) This demotivation brings along a negative mood which the depressed person experiences as a pessimistic attitude towards life. He/she sees everything as grey or black, as uninteresting or redundant. He/she responds to stimuli with irritation or boredom. The inability to attribute meaning to his/her daily existence leads to chronic discomfort, lethargy and despondency.

(c) The patient is trapped in a downward spiral. Consequently, his/her attention is drawn towards everything that has to do with finiteness, decay, failure, and death. This process confirms and aggravates the melancholy and results in relativism and nihilism. Everything appears futile, pointless, worthless, annoying and déjà vu. Reflecting on his/her own past and achievements gives no satisfaction. To the contrary, one considers him/herself as a failure.

(d) In addition, we wish to note that physical pain coupled to psychic pain can lead to 'total pain', a concept introduced by dame Cicely Saunders (Saunders and Sykes, 1993), who founded the palliative care system that was provided in the British hospice-movement for decades. The sensations associated with physical pain originate in the cortex, that part of the brain responsible for our more complex cognitive capabilities. This implies that somatic pain can be aggravated by psychic pain. This is an important observation considering that physical pain can by itself induce psychic pain. Consequently, a cancer-patient who experiences mild physical discomfort may become depressed because of his illness. The psychic pain caused by the depression aggravates the physical pain which, in turn, aggravates the depression, and so on (Haley *et al.*, 1985; Ingham and Portenoy, 1998).

SOLITUDE AND ABSURDITY

The 'existentially depressed' person as circumscribed above, can, because of his/her condition, become socially isolated. Even more important, however, is his/her state of existential solitude. Social solitude concerns the absence of a relevant social entourage, while existential solitude concerns the introvert and subjective experience of isolation from life itself. His/her existence, all personal achievements and prospects, appear absurd. The protagonist in Jean Paul Sartre's novel *Nausea*, on a specific moment, sits on a bench in the park when the essence of the concept 'existence' suddenly imposes itself upon him. He understands that there is no reason why he exists; there is no reason why anything at all exists. Everything that is, is superfluous and redundant, and so is his life and are his thoughts, actions and achievements.

Finding oneself in such a state, one becomes absorbed in ones own introvert displeasure, and becomes completely dysfunctional and passive. Some patients truly do not leave their beds anymore. They try to flee from themselves, but they can't succeed. Whatever they try, they are forever confronted with the feeling that their personal existence, as well as life in general, is redundant and absurd. Contrary to what is often asserted, the sedatives, anti-depressants and anxiolytics that are available at present are ineffective against the pain and misery of existentially depressed people. Severe psychic pain affects the personality in its entirety, because all mental attention becomes exclusively focussed on this pain. Consequently, the personality becomes totally destabilised. They lose the ability to focus on objects, problems or activities in the external world, which in turn induces an increased absorption into their own discomfort, and so on. It is not surprising, therefore, that the vicious circle in which the existentially depressed patient is trapped, may be the underlying cause of suicide attempts or appeals for euthanasia. We think it exasperating that in the consideration of cases that qualify for euthanasia or assistance with suicide, in Oregon, Belgium as well as the Netherlands, (existential) depression is repeatedly excluded because of the ill-founded assumption that it can be treated. In our opinion, this attitude exposes the arrogant attitude of part of the medical world and the overexaggerated expectations from the palliative care sector. The false impression is created that the present medical-therapeutic advances can successfully treat all forms of depression, and vague terms such as 'spiritual support' are proposed as remedies against all sort of trouble. It is important in this context to recall the difference between pain and suffering. Medical treatment might ease physical pain, but not suffering unless this suffering is a direct consequence of the physical pain. Unfortunately, many other factors apart from physical pain can cause suffering (Melzack, 1990).

THERAPEUTIC CONSIDERATIONS

Introvert reflection by the patient does not suffice to break free from the downward spiral. Only enforced situation-therapy can be a solution, although pure

luck is always needed as well. A new job or relationship can turn the tide, but the illness itself often prevents the occurrence of such changes. Trying to involve the patient in new activities or challenges, which can be therapeutically useful, will evoke considerable resistance from the patient. In fact, such resistance is characteristic of this condition. Yet, all indications are that the help offered by the patient's social circle, rather than that offered by the medical profession, has the greatest chance of success. The feeling of solitude is often a crucial factor in the development and confirmation of mental suffering. Overcoming this sometimes purely subjective feeling may be crucial in order to help the patient. This has been poignantly illustrated in Tolstoy's *The death of Ivan Illych*. Everybody, apart from his servant Gerasim, runs out on Illych when he is ill. The servant cannot take away the illness of his master, but certainly reduces his suffering.

All psychotherapies available at present are, with regard to their treatment of existential depression, some form or other of pseudo-science. Anyone perceiving him/herself and the world as fundamentally negative is so demotivated that the skill to cure this person remains a mystery until present. Patients who claim to be cured often allocate this to chance, such as finding a new interest in something or an encounter with somebody who evokes attention and empathy. We suspect, however, that these factors are the effect rather than the cause of the healing process. The real cause for the renewed interest in things and people remains obscure. This does not imply that conventional medical treatment will necessarily remain ineffective in the future. Apart from the above-mentioned socio-cultural factors that may be co-responsible for the occurrence of existential depression, other factors, for example genetic or neuronal ones, may be involved as well. More effective treatments may be developed as further research enhances our knowledge of the causative agents. It is in any case obvious from the concept of 'total pain', as has been described above, that it is necessary to take into account psychic factors, even for what concerns physical pain. Painkillers may alleviate somatic pain, but ignoring the psychic factors might annul the effect. Consideration for the psychic factors may even help with, for example, stabilising the dosage of morphine needed to control or reduce the amount of physical pain. The prognosis for taking away the physical pain of a patient is clearly negative when failing to get grip on the psychic pain (Ingham and Portenoy, 1998; Wall, 1999).

CONCLUSION

The pain and suffering discussed in this paper are underrated by society and the medical profession because they are not forms of physical pain. The suffering by an existentially depressed person is, nevertheless, as real and unbearable as is severe and chronic physical pain. According to many patients it is even worse than somatic pain. We plead for a proper ethical consideration for this form of pain. Although this type of pain cannot be healed by conventional medicine, taking seriously psychic pain and mental suffering in general and existential depression specifically, may make a real difference in bio-medical/ethical debates. People who know what existential depression is think differently, and have a different attitude towards, for example, euthanasia and palliative care, in comparison with people who are not familiar with this syndrome.

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