Citation: Gunton, G. (2001). The Experience of Chronic Pain: How Communicative Trigger Decoding Reveals New Insights into the Unconscious Experience of Pain. (Unpublished Doctoral thesis, City, University of London)

The Experience of Chronic Pain:

How Communicative Trigger Decoding Reveals New Insights into the Unconscious Experience of Pain.

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A Dissertation submitted

for the PhD Programme

Submitted to City University, London

Conducted at Regent's College

School of Psychotherapy and Counselling

Submitted August 2001

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2. Acknowledgements

I would like to thank the following people for their support:

Dr. David Smith for acting as my supervisor and encouraging disciplined thinking and for his generocity in allowing me to build upon his excellent bibliography of communicative writings.

Dr. Ron Smithers for his academic expertise and continued encouragement and friendship.

To Helena Gunton for her outstanding organisation and typing of the references.

To my friend, Sally Yandell for her support throughout and for her excellent typing skills.

To Anthony and Fiona Prior for having faith in this work and acting as my sponsors during one year of this study.

In particular I give tremendous thanks to my husband Andrew and my two daughters Helena and Sophie for their continued enthusiasm and support. Without them, offering their constant emotional and practical assistance, I would not have been able to complete this thesis. They have been quite wonderful. My husband's total dedication I would especially like to honour. Finally I thank Robert Langs, whose work I have found inspirational.

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3. Abstract

The Experience of Chronic Pain: How Communicative Trigger Decoding Reveals New Insights into the Unconscious Experience of Pain.

This dissertation explores the conscious and unconscious experience of chronic pain. The study undertaken by Vrancken (1989) is used as a basis for discussion upon the medical approach to chronic pain and five different schools of thought into which the many approaches and models for chronic pain can be placed are reviewed. Documented research shows that chronic pain has significant psychological and emotional impact upon the patient, the effect of which disrupts the patient's cognitive state and conscious functioning. However literature documenting the patient's experience of chronic pain is a poorly researched and neglected area. It is asserted that the experience of chronic pain and an unconscious perception of chronic pain might add further insight into the complex subject of chronic pain.

The communicative approach to psychotherapy claims a framework and methodology whereby unconscious mental functioning can be accessed and the work of Robert Langs and the theory and methodology of the communicative approach is detailed. The psychotherapy sessions of a patient suffering with chronic pain are used to test this claim and gain insight into the unconscious perception of chronic pain. The session material is examined in detail according to the communicative framework and all observations confined entirely to communicative principles. Conclusions are drawn which show that communicative adaptive listening, and trigger decoding in the light of therapist interventions and frame related issues offers insight into the unconscious perception of pain and is an area worthy of further research. These findings suggest that communicative psychotherapy may have a role in gaining greater insight into the unconscious perception of chronic pain but further evaluation of this approach is clearly necessary, involving larger numbers of patients, before a more definitive conclusion can be reached.

Although this is a very small particular study, there is a broader implication concerning the role that death anxiety plays in psychotherapy in general and in particular in the role that death anxiety plays in working therapeutically with patients who suffer from chronic pain. These areas are worthy of further research.

4. Introduction

The purpose of this dissertation is to explore from a patient's point of view both the conscious and unconscious experience of pain and to analyse from a communicative point of view how communicative trigger decoding reveals new insights into the unconscious experience of working therapeutically with pain patients.

Using communicative philosophy as a framework the following hypotheses are proposed:

- Intense chronic pain causes conscious cognitive disruption.
- Despite such conscious disruption cognitive functions may remain unconsciously intact.
- Communicative psychotherapy claims a framework and methodology whereby unconscious mental functioning can be accessed and utilised therapeutically.
- Communicative trigger decoding is the translation process required to understand the information contained in unconscious communication.
- Communicative trigger decoding of unconscious meaning can provide insight into the unconscious perception of pain.
- Information gained from communicative trigger decoding can be used to offer guidelines to therapists working with patients who suffer from chronic pain.

Using the Communicative Approach as the theoretical framework, a retrospective analysis of the psychotherapy of a patient suffering with chronic pain will be used to test the hypothesis.

4.1 Dissertation contribution

The dissertation contributes new knowledge to the field of communicative psychotherapy and chronic pain in the following ways:

- It contributes to the chronic pain and psychotherapeutic literature in that this is the first research to explore and document the communicative approach as a form of psychotherapy for chronic pain patients.
- It points out the lack of any major chronic pain research based on the experiences of the patient.
- It demonstrates that the majority of pain therapies are based upon medical, behavioural and cognitive behavioural programmes and that the use of patients' encoded narratives and unconscious experience as a means of working with pain is a new and unexplored area.
- It demonstrates that using communicative trigger decoding reveals new insights into the unconscious experience of pain patients.
- It postulates that such insights indicate that death anxiety plays a crucial role for the patient and the therapist within the therapy.
- It demonstrates that the communicative manner of adaptive listening in light of the therapist's interventions defines ground rules and confirms that deep unconscious intelligence as understood in the communicative approach is centred on frame issues.

- It demonstrates that communicative frame breaks become atypically mobilised by an acute situation such as Chronic Pain Syndrome.
- It demonstrates that such atypical frame breaks, and the death anxiety that is considered to induce them, become a major issue for the psychotherapy.
- It demonstrates how the therapist's pain issues influence how she does the therapy and how she maintains the therapeutic frame.
- It demonstrates that chronic pain promotes unconscious denial and the destruction of encoded communication.
- It demonstrates, through the use of patient encoded narrative, a form of unconscious denial not previously recorded in any depth in communicative literature.
- It extends the realms of communicative theory in regard to systems overload.
- It traces the effects of the therapist's interventions on the patient, and makes clear how the clinical consequences of such interventions add to communicative theory.

4.2 Intention of Study

Part one of the dissertation will investigate the conscious experience of chronic pain. The concept of chronic pain will be introduced and discussed. The study undertaken by Vrancken (1989) will be used as a basis for discussion upon the medical approach to pain and five different schools of thought into which the many approaches and models of pain can be placed will be reviewed. The work of Leder (1984; 1984-5; 1988; 1990a,b,c) and Scarry (1985) will be described in detail. It will be asserted that when a patient is unable to be cured of chronic pain the outcome for both the patient and the doctor is ambiguous and unresolved. It will be upheld that such a position confronts medicine with the limitations of it's own theory and practice and is a statement of medicine's reflection upon how it understands pain and its overall philosophy about pain. The debate over the last century regarding the role of psychological and emotional factors in respect to pain is noted and it is recognised in analysing the causal relationship between pain and emotion that the outcome remains unclear and further research is required. A theory of emotion that is pertinent to aspects of pain is discussed. It will be upheld that chronic pain is so overwhelming that it can cause psychological fragmentation into projections and denials, depersonalisation, disorientation and denial of reality, which is ultimately self-destructive. It is suggested that a greater understanding of the experience of the patient would be desirable and that an unconscious perception of chronic pain might add further insight into the complex and intriguing subject of pain.

The literature documenting the psychological and emotional effects of chronic pain will be reviewed and it will be demonstrated that chronic pain has significant psychological and emotional impact upon the patient, the effect of which disrupts the cognitive state and conscious functioning of that person.

It will be maintained that the recognition and understanding of chronic pain as experienced by the patient is vital in that patient pain experiences have something fundamental to reveal about the human condition with its universal suffering and death. It will be demonstrated that the literature connected with patient pain experience is a sparse and a relatively poorly researched area and that documented pain literature contains no systematic study of this issue. The question is posed as to why this should be and it is suggested that it is as if there is a ‘conspiracy of silence’ regarding the documentation of patient pain experience. The conscious and unconscious reasons for this are discussed and some radical and controversial points of view are considered. It is shown that patients in chronic pain raise death anxiety issues yet documentation in the literature of how such death anxiety issues could affect treatment still remains a relatively unexplored area. It will be suggested that chronic pain creates unconscious responses. Unconscious responces in connection with pain is a poorly researched area and further investigation is required. It will be proposed that communicative psychotherapy offers a framework in which unconscious responses to pain can be examined.

The thesis will explore the unconscious perception of chronic pain using the communicative approach as a theoretical model for the research. The historical and theoretical support for the communicative approach will be explored and a contemporary list of references supporting the communicative approach will be included as an appendix. It will be confirmed that historical study shows that there is evidence to suggest that a number of prominent analysts were to similar to defining an ideology very close to that propounded by Langs. It will be suggested also on the evidence of Smith’s research (1991a) that Freud was also close to adopting a form of unconscious perception similar to that eventually formulated by Langs. It will be affirmed that Langs' work although taking a different stance to traditional psychoanalysis has precedence and contributes systematic research within the psychoanalytic discipline.

The work of Robert Langs and the communicative approach to psychotherapy will be explored. It will be asserted that the communicative approach has a framework and methodology whereby unconscious mental functioning can be accessed. An account of communicative theory, including the evolutionary theoretical background and the theory of the frame is given and the way one a) decodes, b) intervenes, and c) evaluates interventions is described. Frame infringement and in particular the concept of death anxiety - considered to be pivotal concepts of the communicative approach - are discussed in detail.

It will be maintained that the communicative approach proposes a way of perceiving inter-personal relations that is adaptive in essence, evolutionary-based and rooted in the recognition of unconscious coping efforts in response to emotionally charged triggering events. In this instance chronic pain is taken as an emotionally charged triggering event.

The psychotherapy sessions of a patient suffering with chronic pain are used to test this claim and to gain insight into the unconscious perception of chronic pain. Information about the patient is given and the patient's chronic pain is summarised. The setting (frame) of the psychotherapy is described and the therapeutic issues regarding the psychotherapy are explored.

The therapy sessions are explored in retrospect and using the communicative model as a conceptual framework the patient's encoded narratives are examined in detail. A critique of the sessions is posed and the communicative manner of adaptive listening, trigger decoding in the light of therapist interventions and frame related issues, is upheld as a model. A discussion of the analysed session material is undertaken. It is noted that both therapist and patient deviated from the secure frame, which would normally be demanded by the communicative approach resulting in an extensive number of frame breaks. It is noted also that the therapist used non-valid communicative interventions throughout the therapy. It is conjectured that such frame breaks and inappropriate communicative interventions are linked to both therapist and patient death anxiety, stemming from intense chronic pain. It will be asserted that death anxiety as described in communicative philosophy is integral in the analysis of the patient session material. It will also be proposed that the analysis of the patient's psychotherapy sessions offers an insight into the unconscious perception of pain, that has not previously been demonstrated in the communicative approach.

General conclusions regarding the conscious experience of pain will be drawn and conclusions based on the communicative framework and regarding the unconscious outcomes from the therapy will be formulated. The outcome for the patient is seen to be positive despite therapist non-valid communicative interventions. The author speculates as to why this might be. From the communicative viewpoint a number of points regarding the client material are asserted and the outcomes regarding chronic pain, the patient and therapist, and death anxiety are discussed. General conclusions regarding working with pain patients from a communicative point of view are extrapolated and guidelines to other therapists faced with the same predicament are offered.

The thesis upholds that the insight gained through communicative adaptive listening, and trigger decoding in the light of therapist interventions and frame related issues could offer insight into the unconscious perception of pain and is an area worthy of further research. It is also determined that although this is a very small particular study, there is a broader implication concerning the role that death anxiety plays in psychotherapy in general and in particular in the role that death anxiety plays in working therapeutically with patients who suffer from chronic pain which is also worthy of further research.

It is also noted that although there is a huge amount of research already in existence documenting a variety of aspects to do with chronic pain, there is very little that takes the conscious and especially the unconscious experience of the patient as its focal point. There is also little literature that considers death anxiety as pivotal in respect to chronic pain and there is no research, which includes Communicative Psychotherapy as a means of gaining different insight into the chronic pain syndrome.

5. Issues in the Treatment of Chronic Pain: Five Schools of Thought.

Chronic pain is an excruciating and torturing disabler; it damages its victims, their families and society and the human suffering it causes is incalculable. But what is pain? It is something we all recognise but is difficult to define. Charlie Brown of Peanuts fame had his own definition: 'Pain is when it hurts'. Sternback (1968) defines pain as:

> ... an abstract concept, which refers to a) a personal, private sensation of hurt, b) a harmful stimulus, which signifies current or impending tissue damage, c) a pattern of impulses which operate to protect the organism from harm. (12)

Merskey and Spear (1967) define pain as follows: 'An unpleasant experience which we primarily associate with tissue damage or describe in terms of such damage, or both' (298). The recommended definition of pain as put out by the APA (1980) is 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.' (2)

Indeed Medvie (1949) in his introductory historical remarks spends much of his book defining pain but concludes '... there are many gaps left in our knowledge without factual or even hypothetical explanations' (55). Nearly 60 years on, pain still cannot be easily categorised nor is it fully understood (Melzack and Wall 1982).

From the beginning of time pain has intrigued us. The Book of Genesis stated how Eve was condemned to bear children in pain because of her sin of disobedience. From the time of the ancient Greeks, pain was considered an essential part of the human condition; the opposite composite to pleasure. Aristotle developed the concept of pain as a quality of experience like sadness. He considered the heart as the seat of pain yet Plato favoured the four elements; air, fire, water, earth, suggesting pain was caused from the result of their violent actions. Buddhist and Hindu philosophy similarly attached significance to the emotional experience of pain. Although the central nervous system was discovered about 300 BC, it was the 19th century pioneers who furthered our pain knowledge so that the mechanisms of pain were redefined into two main categories - the physiological (physical and chemical) and the psychological.

Yet pain is neither a purely physical phenomenon nor a psychological one. There is no predictable relationship between pain and injury (Melzack and Wall, 1982; Engle 1958) so that there can be huge injury with little or no pain and no injury but excruciating pain (Guthrie, 1827; Beecher, 1946, 1962; Marshall 1894).

There have been wide swings of scientific opinion and numerous vignettes illustrating such swings of opinion regarding the psychological relationship to pain. For example, the well-known case described by Tuke (1884) of the butcher and the meat hook is typical of such vignettes. Whilst working in his daily routine the butcher slipped and caught his arm in a meat hook whilst trying to hook up a heavy carcass of meat. As a chemist cut away the arm of the butcher's coat to examine the injury, the butcher screamed with the agony and pain caused by his damaged arm. The chemist however, found only the coat damaged for the butcher's arm had been untouched by the meat hook. It seemed that fear had been the cause of such excessive pain. In contrast the well-documented work of Beecher (1956) offers vignettes showing totally opposite scenarios, in which he reported that

68% of soldiers severely wounded in battle were observed as having total indifference to any pain caused by the lesions and damage to their body.

Various studies (Sofaer, 1984; Melzack & Wall, 1982; Engel, 1958; Sternbach, 1968) have documented that there is no predictable relationship between injury and pain. This is partly the reason why so many varied theories about pain have been recorded.

There are an inordinate number of factors which can be taken into account when considering pain, such as the neurological, physiological, behavioural and affective dimensions (Sofear, 1984). From such factors various pain theories have developed (Melzack & Wall, 1982) and a number of medical models devised (McCarty & Drake, 1956; Melzack and Wall, 1965). Ways to measure pain have been created (Melzack & Torgerson, 1971) and the physiological responses to pain recorded (Vander et al, 1986). Pain can be measured, assessments made, treatments given but still some pain remains unresponsive, untreatable and ragingly out of control. Such pain can continue over a lengthy period of time, often for years: this is the type of pain, which is referred to as chronic pain. Miller & Kraus (1990) provides a description of a typical evolution of chronic pain syndrome. I quote the description in full for it raises a number of issues pertinent to this study.

> The problem typically begins with some accident or injury which causes a degree of acute pain requiring medical treatment. In a certain proportion of these patients, the pain and disability never seem to get better, and in fact, are reported by the patient to worsen with time. Various medical strategies are tried by the inpatient treatment team, or by outpatient physicians, but nothing seems to work. Excessive physical disabilities related to sleep and appetite disturbance complicate the picture, and are often in turn exacerbated by the side effects of excessive medication.
>
> The patient's ongoing struggle with continual pain frequently results in depression, obsessive somatic pre-occupation, hypochondriacal concerns, death anxiety, and a tendency to increasingly conceptualise

> most life events, activities, and problems solely in terms of greater or lesser degrees of pain. This leads to a vicious cycle of hopelessness, helplessness, and despair. Each new treatment or physician briefly reignites hope, which is followed by disappointment when the procedure fails to 'cure' the pain. Resentment and bitterness grow toward the medical profession and this antipathy often become reciprocal, as doctors come to dread visits by the 'crock.' In fact, the majority of my own referrals are from physicians who can no longer 'handle' these difficult patients. Pain now becomes the central focus of the patient's life. External attachments and interests are abandoned, resulting in the patient's withdrawal from family and social activities. Interactions are fraught with tension and anger. Problems with medication and other drug and alcohol abuse may, progressively allow the patient to avoid any kind of stressful task or issue. This leads to further incapacitation, which aggravates the problem, compound the problem by producing toxicity and addiction. Pain becomes a major coping mechanism alienates friends and family, and leads to the further decline toward total invalidism. (435)

Chronic pain is intriguing and complex but when a patient ends up unable to be cured the outcome of such chronic pain is ambiguous and unresolved for both the patient and the doctor. Chronic pain confronts medicine with the limitations of it's own theory and practice and ultimately chronic pain becomes a statement of medicine's reflection upon how it understands pain and upon its overall philosophy about pain.

In order to explore medicine's relationship with pain I shall use the study undertaken by Vrancken (1989) as a basis for discussion. Vrancken (1989) undertook to study eight university hospitals in the Netherlands which specialised in the treatment of pain and which led the field in a wider approach to pain. They were some of the first to put into practice the theories of Bonica (1953) in incorporating different disciplines and philosophies in treating pain and in offering more than the nerve block clinic mainly run by anaesthetists and concentrating upon the symptomatic relief of pain through technological procedures. Vrancken's study outlines a range of schools of thought in the prevailing approaches to pain and deduces five major categories into which the many approaches towards pain can be placed.

The five major concepts of pain that Vrancken (1989) puts forward are as follows:

a) The somatic-technical approach
b) The dualistic, body-oriented approach
c) The behaviourist approach
d) The phenomenological approach
e) The consciousness approach

5.1 The Somatic-Technical Approach: Pain as a Symptom or a Disease and the Dualistic Body–Oriented Approach.

It is generally agreed that these two models for pain were originally based upon dualistic theory as proffered by Descartes (1991). Cartesian Dualism proposes a view in which the world ultimately consists of two different kinds of substance e.g. mind and matter, subject and object, observer and observed, etc. As such the Cartesian view of human beings is one which consists of bodies and minds. Descartes' basic premise as the body as machine empowered through components of the mind was the foundation for a new way of thinking that has culminated in the 19th and 20th century's expansion of medical scientific thinking.

It was Descartes' (1975) belief that all things in the physical world, including the human body operated according to the laws of mechanics.

> The body of man should be considered as a kind of machine, so made up and composed of bones, nerves, muscles, veins, blood, and skin, that although there were in it no mind, it would still exhibit the same

> motions which it at present manifests involuntarily, and therefore without the aid of the mind. (138)

His work L'Homme (1664) describes his anatomic studies. Here for example nerves are considered as hollow tubes through which a type of marrow is spread via fine threads originating from the brain and spreading through the body, skin and tissues. Through these threads sensory stimuli were transmitted to the brain. Descartes maintained that the integration of the mind and body occurred within the pineal gland, thus pain was considered a state of excessive sensory awareness modulated by the mind. Such origins opened the way for the development of a scientific approach to medicine, which has resulted in much of the thinking during the 19th century regarding organic causes as the major explanation for pain.

Wall (1999) describes such thinking in the following way:

> The commonest prevailing opinion, which comes from our intuition and is, expressed by the majority of philosophers, is dualistic: that is to say, we have a body and a separate entity, the mind. The body is generally seen as a wonderful, intricate machine operating on understandable principles that will be revealed by increasingly sophisticated scientific investigation. It includes a sensory nervous system whose function is to direct events in the world around us and within our own bodies. This sensory nervous system collects and collates all the available information and presents it in a form that generates pure sensation, according to the dualists. At this supposed frontier, the mind, which operates on entirely different principles, may inspect the sensory information and begin mental processes such as perception, affect, memory, self-awareness and planning of action. (18)

In effect dualistic models of human disease and illness have become firmly established in Western thought and a series of sensory models explaining pain have remained uppermost. Turk and Rudy (1986) document that this dualistic thinking about pain is retained in the Diagnostic and Statistical Manual of Mental Disorders (DSM III – American Psychiatric

Association, 1980) under the classification of Psychogenic Pain disorder. DSM III accepts a sensory-physiological model of pain and Cartesian dualism. They propose that pain is either physical or psychogenic.

Vrancken (1989) states that such concepts incorporate the pragmatic approaches to pain based upon the neurophysical model of pain, and which considers pain as basically organic in component i.e. pain has its origin in the body which can be traced. The factor, which turns it from acute pain to chronic pain, is time. Thus, in these approaches chronic pain syndromes are categorised in the same way as acute pain: neurological, musculoskeletal and vascular. Both approaches have this base for their model but effect different treatment for the patient.

In the somatic-technical approach Vrancken (1989) details that any pain that does not show immediate organic source is seen as psychological, having the psyche as its origin. As such, Vrancken suggests, patients are categorised into 3 main groups – real pain, psychiatric pain and malingerers. Treatment for the somatic-technical approach is mainly surgical to erase, block or ease the pain.

Leavitt & Garron (1979) note how difficult and challenging this approach becomes diagnostically. Patients in psychological distress are generally assumed to develop physical symptoms as a means of communicating and managing their difficulties. Often there is reluctance by patients to acknowledge a psychological cause for physical symptoms to the extent even that many patients have a powerful need to substantially deny psychological difficulties. Such diagnostic challenges are further compounded for practitioners (such as surgeons or GP's) whose limited experience in psychological matters hinder their assessment of such patients, many of whom are unlikely to volunteer the relevant psychological information.

In the dualistic-body approach treatment is often psychological in nature. Such psychological treatment is advised because although the practitioner considers the pain as still organic in basis, he determines it as pain in which psychological factors are dominating or have prevailed from the beginning. In this school the pain may be designated as psychogenic, irrational, psychosomatic or hysterical.

There has been lengthy debate, lasting over a century about the role of psychological and emotional factors in respect to pain, and much has been documented. (Wall, 1999; Melzack and Wall, 1982; Engle, 1958; Beecher, 1946, 1962; Miller and Kraus, 1990; Leavitt and Garron, 1979) Hodgkiss (1991) documents the historical origins during the 19th century of emotional factors in respect to pain and cites terms such as hysteria, hypochondria, spinal irritation and neuralgia as entering the pain language. More recently such psychological disorders as post-traumatic stress disorder have been shown to result from uncontrolled pain following physical injury (Schreiber and Galai-Gat ,1993) and other psychological traumas have also been shown to correlate with unsuccessful surgery and its resultant pain. (Schofferman *et al,* 1992; Shopper, 1995)

Swanson's (1984) historical study details a number of theoretical models regarding pain. Spinoza in the 17th century classified pain as a form of sorrow and therefore primarily of emotion (Parkinson 1985). Kolb (1954) provided a psychological interpretation for pain, linked with body image experience, loss, denial, and depression. Swanson (1984) also commented upon Szasz (1963, 1974, 1975) who argued that pain was a consequence of perceived threat to bodily integrity as recognised by the ego and that pain served as a communication - a request for help, a form of aggression or an expiation of guilt. He detailed Engel (1951, 1958, 1959, 1977) who emphasised that pain was a psychic phenomenon involving systems concerned with protecting the body from injury. Swanson's (1984) own theoretical model advocates pain as a threat to the person so that the integrity of the ego requires adjustment and such adjustment is more psychologically acceptable and more easily coped with if it is translated into an assumed tangible bodily problem.

In particular though, it is the papers by Szasz (1957) and Engel (1959) that were instrumental in influencing new psychoanalytic based theories of pain. Engel argued that for some patients unexplained pain could fulfil emotional needs and pain would therefore persist despite the best efforts of medical practitioners. Engel (1958) states in his summary:

> What is experienced and reported as pain is a psychological phenomenon. Pain does not come into being without the operations of the psychic mechanisms which give rise to its identifiable qualities and which permit its perception. (1495).

Engel (1959) one of the first proponents to such a school speaks of 'psychogenic' pain and the 'pain-prone' patient. He relates pain to having particular psychological meaning connected to concepts of good and bad, and success and failure. Pain becomes a psychological means of dealing with guilt. Weisenberg (1980) summarises Engel's position regarding the pain-prone patient in the following way:

1) Conscious or unconscious guilt with pain providing atonement.

2) A background pre-disposing to use pain as punishment.
3) A history of suffering, defeat, and intolerance of success, large numbers of painful injuries, operations and treatment.
4) Pain as a replacement for loss, or threat of loss of relationship
5) A tendency toward a sado-masochistic type of sexual development, with pain occurring over sexual conflict.
6) Pain location related to unconscious identification with a love object in which the pain either is the one suffered by the love object or is aroused by conflict with the love object.
7) Psychiatric diagnoses include conversion hysteria, depression, hypochondriasis, or, occasionally, paranoid schizophrenia. (87)

Szaz (1968) similarly links chronic pain with guilt. He proposes that chronic pain can become a form of aggression and a means thereby of atoning for guilt. He introduces the concept of the patient who makes a career out of pain which he refers to as, 'l'homme douloureux'.

Such a milestone in thinking created new schools of theoretical models in which the thorny problem of chronic pain, which did not have organic cause or respond to organic treatment was addressed. There still exists a strong faction of practitioners who debate that emotional and psychological disturbance creates the pain, (e.g. Carne, 1967; Divine and Merskey, 1965; Egbert *et al* , 1964; Friedman *et al* , 1962; Livingston, 1953; Merskey, 1994; Rangell, 1953; Sternbach, 1968; Walters, 1961; Wieder *et al*, 1944) Mersky (1994) subsequently retracts this belief in a later paper by stating that 'I now think that the frequency with which pain is primarily due to psychiatric illness is much lower than originally thought, but nevertheless it does occur' (71). Indeed, Dudley & Holm (1984) go so far as to suggest that nurses undertreat pain in a medical and pharmaceutical way in favour of psychological interpretation.

Such work however has been criticised, particularly by Merskey and Spear (1967) as being anecdotal and impressionistic and uncontrolled. Yet this pioneering work and the psychoanalytically informed theories which followed (Dorsell, 1989; Coen & Sarno, 1989; Benjamin *et al*,1988; Reich *et al*, 1983; Sternbach, 1974; Merskey & Buhrich, 1975; Ziegler *et al*, 1960) are important in calling attention to models that differ to the organic model that still remains upper most today.

Although there is a significant body of literature that supports the dualistic model (Schneider, 1959; Wolff, 1948; Livingston, 1966; Elkind, 1962; Wolff,1966; Brodie, 1941; Hart ,1947; Merskey & Spear, 1967) such dualistic models of pain are, however, now being considered inadequate by the profession for they expose a limited understanding of the pain experience.

As Miller (1991) states 'Chronic pain patients cannot easily be dichotomised into those with physical *vs.* psychological disorders; many patients have both and a few have neither.' (110) Therefore although pain is universally experienced and acknowledged it is not easy to define. It seems that pain is neither a purely physical phenomenon nor a totally psychologically one. Sternbach (1968) tries to address this difficulty by recommending the following definition of pain ' ... pain is an abstract concept which refers to 1) a personal, private sensation of hurt, 2) a harmful stimulus which signifies current or impending tissue damage, 3) a pattern of impulses which operate to protect the organism from harm'. (12)

Bond (1979) explores such concepts- the consequences of pain in physical illness, pain and psychosomatic disorders and pain without obvious physical causes -at some length. He suggests that pain, emotion and physical disorders are linked in three ways:

1. Painful physical diseases or injuries produce emotional changes (somatopsychic problems).
2. Pain occurs in physical diseases assumed to be initiated and maintained chiefly by psychological factors (psychosomatic disorders).
3. Pain occurs in mental disorders although physical disorders for it are absent. (127)

Many medical practitioners now consider that if no organic cause is present then the pain of which the patient complains will be caused or emphasised by a variety of reasons. These reasons could include the personality make-up of the patient, the pathology of the patient such as their proneness to anxiety or depression and whether they are considered to have hysterical, hypochondriac or obsessional traits. Such factors as the patient's belief system, their cultural background, environment, age, sex, socio-economic, moral-ethical and religious considerations, etc. are also considered relevant. Hayward (1979) proposes that pain is made up of a psychological, biological, social and cultural mix. *(See Figure 1).* The literature documenting similar reasoning is vast (e.g. Almay, 1987; Blazer 1980-1; Blumer & Heilbronn, 1982; Gentry *et al* ,1974; Mohammed, Weisz &

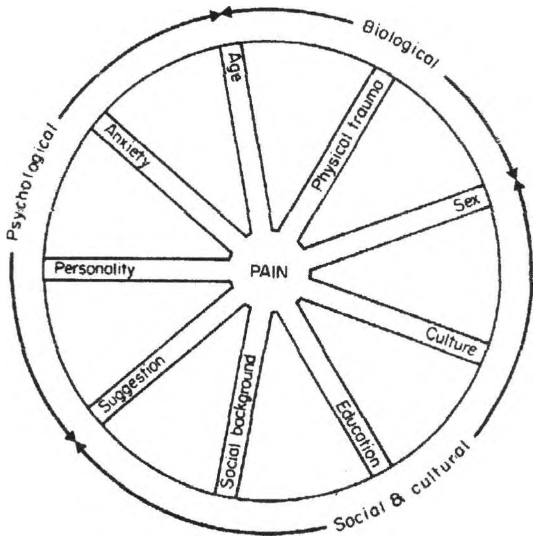

Figure 1. Hayward's (1979) proposal of the structure of pain.

Waring, 1978; Sternbach, 1974; Violon, 1982; Woodforde & Merskey, 1972). Mainly though the debate in the literature has often centred around the demise of whether psychological and emotional effect is a cause or consequence of chronic pain. For example, Gamsa (1990) poses this very argument in her paper, 'Is emotional disturbance a precipitator or consequence of chronic pain?'

In analysing the causal relationship between pain and emotion it becomes evident that the outcome remains unclear and much research still needs to be done. The emotional element however seems critical in understanding the patient's response to pain. Skevington (1995) cites Di Matteo & Friedman (1982) as identifying six main emotions; happiness, sadness, anger, disgust, surprise and fear of which all but happiness are part of the chronic pain experience. Blank (1982) however suggests that there could be as many as forty-seven distinct and representative emotions. The theories of emotions are varied and complex; feedback theories of emotion, combined appraisal-feedback theory, appraisal theory of emotion, systems theory of emotion, interacting cognitive subsystems model, socio-cultural functionalism etc. This is not an appropriate forum to discuss such theories in detail but it is relevant to include a brief outline of emotion theory that is pertinent to the aspects of pain within this thesis. Parkinson (1995) in his integrative overview of emotion theory cites Smith & Lazarus (1993)

> Each positive emotion is said to be produced by a particular kind of appraised benefit, and each negative emotion by a particular kind of appraised harm. The emotional response is hypothesised to prepare and mobilise the person to cope with the appraised harm or benefit in an adaptive manner, that is, to avoid, minimise or alleviate an appraised hurt, or to seek, maximise, or maintain an appraised benefit. (234)

According to appraisal theory Parkinson (1995) propounds that there are four components which play the following roles in emotional reactions:

1. *Appraisal*: Which detects adaptationally significant events, and evaluates the adaptive requirements of these events.
2. *Action tendencies*: Which arise as a direct consequence of appraisal in accordance with the adaptive requirements identified.
3. *Bodily changes*: Which serve to provide or conserve internal energy to support activated action tendencies.
4. *Facial expressions*: Which arise as part of action tendencies, or to communicate emotional state and behavioural intentions to others. (1)

Leventhal (1984) develops a similar theory in his systems theory of emotion. He argues that emotion is under the control of three separate levels of processing:

1. *Expressive-motor mechanisms:* Which react directly to stimulus features prior to any extensive cognitive analysis of the situation,

automatically producing the relevant facial expression and autonomic response pattern.

2. *Schematic processes*: Where emotional schemas are 'integrations of separate perceptual codes of the visual, auditory, somesthetic, expressive, and autonomic reactions that are reliably associated with emotional experience'

3. *Conceptual processes:* Which depend on cultural and individual knowledge and beliefs about how emotions work based on experience, education, and prejudice. (171)

According to this theory, emotion occurs when the output of expressive motor mechanisms and schematic processing is not anticipated by conceptual judgement. One of the more recent of the theories of emotion, the interacting cognitive subsystems (ICS) model (Teasdale & Barnard, 1993) takes as its central assumption that the cognitive system is modular, comprising a network of partially independent subsystems, each of which processes a particular kind of information. In this model it can be seen that emotion is considered a product of the processes occurring within the mental system and as such will have impact on cognitive functioning.

Melzach & Dennis (1978) have identified steps in the processing of emotions associated with the duration of pain:

> Brief phasic pain occurs at the time of injury and is commonly associated with fear and avoidance but may also be linked to emotions like guilt, pleasure or sexual excitement. High levels of anxiety and self-concern represent persisting acute pain, especially where distress continues. Normally healing would be completed at this stage but if pain goes beyond the point of healing then it becomes chronic. Although wide-ranging individual differences are seen in

> chronic pain patients the emotions of depression, fear, somatic preoccupation and intense distress characterise this step. (174)

However some modern day research dismisses that emotional aspects are significant as the theory swings back to a biological and genetic reasoning for pain. Recent research at Johns Hopkins Medical Institutions report that the varied response people have to pain is due to a genetic basis. Professor Uhl (1999) states that:

> Pain exists mainly in the brain. It occurs, in part, when something activates dedicated pain nerves in the body and spinal cord that relay impulses to the brain. But superimposed at strategic places on nerves in this system are the mu receptors. They respond to natural opiates in the body and, like mutes on so many trumpets, effectively damp down pain's intensity. Now people can think of pain as a genetically regulated problem. (7753)

Similar research goes as far as stating that biologically pain can cure itself. The latest research from the Journal of Neuroscience (1999) asserts that ‘pain itself elicits pain relief and does so through ‘reward pathway.’ (484) The researchers believe that bodily injury can sometimes trigger the release of the body’s natural opiate painkillers. These natural painkillers are found in the reward pathway, which is, located in the middle of the brain in the nucleus accumbens, the centre for reward systems.

Skevington (1995) questions the success of a ‘medical’ model, which is geared to identifying pathology to obtain diagnosis and then treating the symptoms by attacking that pathology. She cites the work of Fordyce (1976) who similarly argues that such a model is both inappropriate and ineffective when dealing with chronic pain.

Michel (1985) propounds that a dualistic or mechanistic theory of pain stems from an inadequate depth of understanding of what pain is or what mechanisms underlie the full pain experience. He links this with the limitations of professional groups, whom he sees as being locked into their own vocabulary of pain so that 'the ability to cross-fertilise experience or understanding may be limited by the language and concepts of the group.' (3) Thus many medical professionals still tend to interpret most pain to the rather limited model of acute pain which has a clear sensory component. It is likely that such responses have remained at this level for so long because such views have been reinforced within the medical literature. The main line scientific/medical literature has been interested mostly in the mechanisms of pain and the actualisation and management of pain within medical settings. Patient experience has tended to be shown as psychological traits of patients which could then be measured by clinically administered and interpreted personality inventories, and until recently the literature has not often viewed pain from a phenomenological, philosophical or experiential viewpoint or from the viewpoint of the patient.

Kelemen and London (1983) also note that the difficulty of the present day dualistic models of pain lie in the way that medicine has dichotomised the pain problem as being either organic or psychogenic in nature. They propose that such theoretical constraint can create an inability in the doctor to understand the patient as a psychobiosocial being and create within the patient feelings of alienation from the medical process. Whilst pain remains dichotomised in this way as being either 'organic' or 'psychogenic' in nature there will continue to be theoretical problems with the medical profession's understanding the full significance of the patient's experience of pain. Charmaz (1983) reinforces this view. She states:

> Physical pain, psychological distress and the deleterious effects of medical procedures all cause the chronically ill to suffer as they experience their illness. However, a narrow medicalised view of suffering solely defined as physical discomfort, ignores or minimises the broader significance of the suffering experienced by debilitated chronically ill adults. (172)

Bond (1979) in an earlier paper made a similar point. He considered it unwise to separate pain into the terms' organic' or 'psychogenic' for the latter was often interpreted as an indication that patients had deliberately exaggerated or falsified their symptoms, with patients being told that their pain was 'imaginary' or 'in their head'. He proposed that such terms as 'organic' and 'psychogenic' be discarded and in their place a broader description of the pain state be acknowledged.

Morris (1992) draws attention to how little the medical profession really knows about pain. He quotes Bonica (1983) - the first president of the International Association for the Study of Pain - who cautioned the medical profession about 'the great void in our knowledge of the mechanisms and physiology of pain' (2). Morris, too, recognises that for the doctor the approach to pain is a mechanistic challenge whereas for the patient, pain removes one from the normal ways of dealing with the world. Morris (1992) is quite clear, 'pain is always more than a bodily mechanism gone awry.' (5) and his message is that the old dualistic model of pain must be replaced with a new multi-dimensional model. He considered there to be four themes crucial for a broader understanding to pain:

a) Chronic pain constitutes an immense invisible crisis at the centre of contemporary life.

b) Traditional western medicine has consistently led us to misinterpret pain as no more than a sensation, a symptom, and a problem in biochemistry.

c) Our present crisis is in large part a dilemma created and sustained by the failures of this traditional medical reading of pain.

d) By taking back responsibility of how we understand pain we can recover sufficiently to begin to alleviate it. (64)

Sternbach (1968) states clearly: 'Our current approaches leave much to be desired with respect to patient care ... Such approaches based on the assumption that the duality exists in the process, so that the pain is either mental or physical, penalises the patient in pain.' (147)

Engel's (1977) position is more emphatic, 'I contend that all medicine is in crisis and further that medicine's crisis derives from...(an)... adherence to a model of disease no longer adequate for...(its)... scientific tasks and social responsibilities' (129). He is outspoken in his stance that medicine's crisis stems from the fact that physicians feel they need not be concerned with the psychosocial issues which lie outside medicine's responsibility and authority. He argues for a more inclusive medical model, maintaining that the biomedical model is insufficient, leaving no room for 'social, psychological and behavioural dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behaviour, it also demands that behavioural aberrations be somatic (biochemical or neurophysiological) processes' (130). Bury (1991) similarly concludes that a biomedical model for pain is inadequate on its own.

Engel (1977) puts forward the concept (developed further by the later work of Perry, 1984) that the attitude and belief systems of physicians regarding biomedical models are moulded long before they eventually practice medicine. As such this limited approach to pain often goes unrecognised within the medical profession. Engel concludes that a biopsychosocial model concerning pain and illness would go a long way to providing a framework for the real world of healthcare.

The work of Melzach and Wall (1965, 1982) a milestone in the field of pain has so developed in recent decades that Wall (1999) now considers pain as an awareness of a need state rather than a sensation. He suggests that pain has only a weak connection to injury but a strong connection to the body state. This is quite a shift in thinking from his early work in which he was involved in understanding the mechanistic and neurochemical aspect of pain (1965). Indeed he goes further and states that pain and anxiety are two aspects of the same phenomena and that both are related more to recovery processes than to the injury itself. He cites the 'orphaned' patient, the one for whom no doctor can do anything. He considers this an important area, for doctors are trained to see pain as a symptom rather than a problem in itself. The modern day medical model creates doctors who think that they must identify the cause of pain and eliminate it. This is their job, however the irony of this is that the treatment of pain is given very little attention in most medical schools. Professor Wall points out that many fully licensed doctors in the US will have had only a total of 2½ hours of formal training in treating pain as such. As a result, patients who have intractable pain are often abandoned by doctors and left to suffer in isolation. This situation is eminently illustrated by a posting on the Internet from a patient decrying such abandonment:

> I call the situation when doctors tell us to go away the 'hot potato syndrome.' So long as we consent to a (or another, and another, and another) surgery, we are their patients. But when we ultimately get failed back syndrome, with its continuous severe pain, decreased mobility, nerve damage, etc., we no longer can be their patients. I've had this happen more times than I want to remember. Not only by surgeons, either. I have a very complicated medical history (as most of us at ASCP do). I go to my doctors when I've tried every single trick in my bag but still am sick. About half of the doctors I've seen (of any speciality) have told me to go away within one year of becoming their patient. They get very frustrated when they can't find a quick fix. They also can't deal with the tears that sometimes flow when I'm really struggling. Most often, instead of coming right out and saying they won't be my doctor any longer, they refer me to some other 'specialist.' Then if I call back later, either a nurse or receptionist tells me that Dr. 'so-and-so' has referred me to someone else and I need to contact that doctor instead. The new specialist generally thinks s/he will be the one to solve my problems, but within a year I'm back to being the hot potato again. I have never done anything to deserve being 'kicked out.' (Not that I agree any patient deserves to be kicked out by a doctor, with the exception of a patient who poses a threat to the doctor or staff.) I comply with all of my doctors' orders unless I disagree with it, in which case I speak directly with the doctor and tell her/him, rationally and tactfully, why I don't agree. I do not harass, and I rarely cry in front of them. When I explain that I don't want to be referred to another doctor, they generally tell me that it will be like this for the rest of my life and I just need to learn to live with it. Some even go so far as to tell me that the problem lies with me and my coping skills, rather than my body!!! I hate going to doctors, yet I have to go all the time. Sound familiar anyone? (alt.support.chronic-pain, 2000)

Professor Wall's (1999) analysis of pain is that it is a complex response to stimulus and it is part of the healing process. He proposes that pain forces us to protect the injury and puts our bodies into a mode that promotes healing. This process often goes awry as in the case of chronic pain. He writes against the dualistic approach to pain and argues a case for a humanistic approach in that we have a duty to understand the things around our fellow humans and to communicate that understanding to the best of our ability. He suggests that there are aspects of pain that cannot be cured and that we must do the best we can with the resources available.

Waddell *et al* (1984) who emphasise the need to treat patients and their illness rather than concentrating exclusively on the physical disease voice a similar point of view. Swanson (1984) goes so far as to state that it is justifiable to consider a model of chronic pain as an emotion as 'one attempts to understand the patient whose peripheral complaint clearly eludes comprehension and successful treatment' (214).

Such viewpoints come as welcome relief to the patients suffering the chronic pain. Many patients engulfed in pain find humiliating and confusing the suggestion that if no organic cause can be found or if pain is not immediately cured by medical procedures, that the pain is all in their head.

I quote the views of two patients, chosen at random from many of similar such postings taken from a chronic pain support group on the Internet. (alt.support.chronic-pain)

> I am interested in how many of you have been told it is all in your head. I have been looking for a diagnosis and cannot find one. I tell the docs that I am in a better frame of mind than ever before (except for this %^&@ing pain all the time) but they still say that it's my anxiety. I told one of them, 'okay, lets say you are 100% correct and my anxiety (which is non-existent) amplifies a little bit of soreness into this ripping, burning tearing pain in the middle of my torso. What can we do about it?' There was a pregnant pause, then 'I don't know.' (Jenny, 1999)

> Telling me, insinuating, accusing and hinting, to me that it is all in my head does nothing but demean me, disregard me, alienate me, confuse me, make me defensive, make me angry, and make me more crazy than they already think I am. One thing is sure if I had no brain I would have no pain!! (King of Pain, 1999)

Kleinman (1988) sums up the limitations of these dualistic models of pain.' I have come to believe that this life in pain.... teaches us that our science as much as our clinical practice is at fault in the repeated failure to understand pain and its sources; we are unwilling to take the meaning of pain as seriously as we take its biology.' (73)

There are similar schools of thought now becoming prominent in the growing body of literature that is calling for a wider approach to pain. Bendelow and Williams (1995) argue for a sociological approach to pain. They propose that 'scientific medicine reduces the experience of pain to an elaborate broadcasting system of signals' (139). They consider that pain is effected and translated by the individual and their socio-cultural context and that a major impediment to a fuller understanding of pain stems from it's medicalisation and the Cartesian split between body and mind. Pain, they claim, is an everyday experience and a sociological approach would help reclaim pain from 'the dominant scientific paradigm' (139). They put forward a framework, which transcends the division between mind and body, but most significantly for this study they propose that the importance of studying narratives is fundamental in shaping responses to pain. They have no wish to caricature the biomedical model and they pay respect to pioneering work of many pain specialists, but they still maintain that 'whilst the medical voice is a valid one, other voices especially those of the subject are often lost in 'the neglected encounter between pain and meaning.' (141) They argue that the lack of attention to subjectivity brings about a limited approach to the patient in pain and a neglect of broader issues connected with components of pain. They suggest that a far more sophisticated understanding of pain is required. They call upon the work of Leder, 1984-5; Kotarba,1983; Turner, 1992; Denzin, 1987; Lynch, 1985; Morris, 1991; and others to illustrate the dichotomy between the clinical and the experiential, and the need to consider the human body as a structure of ongoing lived experience.

Michael Bury (1991) also calls for a sociology of chronic pain. He maintains interpretative sociology in particular has developed a view of people as agents, rather than being merely the products of the contents in which they live.

Such voices demanding a more complex and wider theoretical stance towards chronic pain are part of the growing body of literature that is developing within the medical field and making attempts to construct a theory on chronic pain. Such wider theoretical stances and approaches Vrancken categorises into the following three areas; the behaviourist approach, the phenomenological approach and the consciousness approach.

5.2 The Behavioural Approach.

Vrancken (1989) describes this school as dealing exclusively with chronic intractable pain. In this approach chronic pain is considered a behaviour which is observable and which differs from acute pain in that the persistence of the pain is, ‘Largely dependent on behavioural changes, which in their term are induced, maintained and reinforced by environment reward responses.’ (437)

The theory for this approach is based upon the assumption that pain, a negative stimulus, will compel the individual to react and that such reactions will be influenced by antecedent variables such as cognition, coping styles, environmental variables etc. Vrancken describes the typical pain patient as 'caught in the web of chronic pain' (437), having a long medical history, a complex history of analgesic medication and a preoccupation with somatic fixation.

Mikail, Henderson and Tasca (1994) describe this as 'behaviourism and chronic pain.' They propose that a behavioural perspective should focus on the environmental-contextual factors to explain the development and experience of chronic pain. They cite the work of Fordyce (1986) who characterises pain as 'a complex set of events composed of peripheral stimulation, cognitive and perceptual processes, neurochemical and neuropsychological changes and emotional expression'. (3) The significance of this is that everything that makes up the experience of pain has at its centre a set of behaviours that signal to others the existence of such pain. Chronic pain then becomes defined as pain, which continues beyond the normally expected healing time.

Behaviour treatment is therefore based upon altering and reinforcing the concept of well behaviour. The goal is to reduce learned pain behaviours; avoidance of exercise, excessive medication, pain complaints, grimacing, groaning, etc with different environmental factors so that the patients physical and social activities are positively reinforced and pain behaviours ignored.

The success of behavioural programs have been noted in the literature (Fordyce *et al*, 1968, 1973; Greenhoot and Sternbach, 1974; Sternbach, 1974; Fowler, 1975 ; Seres and Newman, 1976; Swanson *et al*, 1976; Anderson *et al*, 1977; Cairns and Pasino, 1977). However, Turner and

Chapman (1982) point out a number of limitations. They suggest that this approach is limited to a very strict definition of chronic pain, which creates an approach, which ignores the mental processes associated with persisting pain. The goal is in changing pain behaviours rather than the relief of the subjective state of suffering. Indeed, Slater et al (1977) state that the majority of subjects in their trials receiving behavioural treatment did not make clinically significant improvement when the perimeters were extended beyond pain behaviour to the patients dimension of pain, disability and depression. They state that only one of seventeen patients showed any evidence of making full improvement in those areas.

Those advocates of the behavioural school of pain are very much aware that change in behaviour is just a part of a variety of measures that are needed to help the patient suffering from chronic pain. Over the last fifteen years this school of thought has developed to offer multi-faceted packages within pain clinics or pain management centres. Pain management centres are now seen to be the way forward in managing untreatable pain and changing pain behaviour (Reagles, 1984; O'Brien et al, 1983; Sternbach, 1978; Wells & Miles, 1991; Pither & Nicholas, 1991). Pain management centres offer a wide variety of treatments including distraction techniques, behaviour and cognitive brief therapy, instruction and modelling, acupuncture, fitness programmes, massage, guided imagery, relaxation techniques and a variety of other procedures. Much is documented on these treatments (Mikail, Henderson and Tasca, 1994; Whale, 1992; Schafer, 1985; Reinking, Tempkin and Tempkin, 1995; Slater et al, 1977; Miller, 1993; Lakoff, 1983; Boersma and Houghton, 1990; Turner and Chapman, 1982 a,b,c) However there still there is significantly little documented evidence on pain as experienced by the patient and comparatively little time is given over in pain clinics to listening to the patients' pain experiences in this school of thought.

5.3 The Phenomenological Approach: Pain as a Mode of Being.

Vrancken (1989) describes the starting point for this school of thought upon pain as being the phenomenological experience of pain. This school proposes that pain is a mode of being in which the body becomes the centre of one's life-world (Lebenswelt.) The significance of this is that pain divides the body from its normal state of being unnoticed. Simply put, pain attacks by the breach it causes in the continuity of existence: so that the patient in pain experiences the body out of its context, and the experience of pain as an interpretation within the framework of existence. Vrancken (1989) suggests that from the phenomenological viewpoint the patient in pain is in existential need. They separate off their pain for the encounter with pain causes a chasm in the life-world.

Such existential thinking argues for an approach to pain as a lived embodied experience. The work of Dr. Drew Leder develops this line of thinking and it is his work especially that I will explore in detail for he raises pertinent issues regarding present day medical approaches.

The work of Dr. Drew Leder (1984, 1984-5, 1988, 1990a,b,c) offers the unusual blend of medicine and philosophy. As associate professor of Philosophy at Loyola College in Maryland, USA he has a MD in medicine and a PhD in Philosophy. His published work that is particularly relevant to this study (1984b, 1984c, 1988, 1990a, 1990b, 1990c) critiques conventional western medicine and draws attention to our bodily experience in sickness and health from a phenomenological and philosophical viewpoint.

In the face of pain Leder (1984-5) states that one's whole being is forcibly re-oriented. He suggests that pain reorganises our lived space and time, our relation with others and with ourselves so that pain creates a new world that is totally constricted. 'With chronic suffering there is nowhere to go, nothing to do, no escape. Space loses its normal directionality as the world ceases to be the locus of purposeful action.' (75) Most importantly pain exerts a power that alters and disrupts our relationship to the world and to ourselves

Leder (1990a) argues that the physiological diagnosis by the doctor is different to the world of the suffering patient. The doctor treats the physiological disease whilst the patient's suffering world contains symptoms and life transformations experienced by the pain as well as a disruption and reorganisation of the sense of time and space and of embodiment and sociality. Hence he suggests between doctor and patients there are two vastly differing experiences 'one defined in terms of physiological disease, the other defined through illness experiences.' (2)

Although Leder comments on the bridging between the two experiences, through the compassion of the doctor and the scientific awareness of the patient, he points out that however successful the therapeutic encounter, the two worlds never overlap and indeed one can even obscure the other. As medical knowledge and technological advances increase, the patient's experience becomes increasingly peripheral. Leder applauds the many beneficial results of the pathoanatomical approach but is concerned to address the illness experience.

In order to do this Leder (1984-5) examines the phenomenon of pain in detail and the way in which pain transforms ones relationship to the body and to the surrounding world. This is of particular significance to this study and so I will incorporate at some length Leder's construct on the phenomenology of pain. Leder focuses upon the spaciotemporal field that is altered by the pain experience, upon the meaning of pain as sensed and understood by the person in pain, and upon a reinterpretation of the dichotomies of the mind and body and self and world.

He describes two fundamental ways in which the experience of space and time are transformed by the suffering of pain. Firstly, he explores how our sensory experiences which are normally directed outwardly upon the world, in pain, become translated so that sensory experience is forced inward. As our sensory experience is forced inward the world is no longer experienced through our body but instead the body itself becomes what we feel. Our spatiality constricts and the objects of our experience are also constricted. We only exist as pain. Leder (1984-5) comments, 'The 'closedness' of the world of concern discussed by Heidegger is suddenly revealed in all its imminent horror.' (256)

Morris (1992) describes something similar. He details how pain takes us 'out of our normal modes of dealing with the world. It introduces us to a landscape where nothing looks entirely familiar and even the familiar takes on an uncanny strangeness (5). Leder (1990a) suggests that our motor possibilities are also constricted. Often in intense pain, one literally cannot move and all range of motion has a single axis point of pain. Similarly the temporal domain is reorganised. In pain there is only here and now and one remains trapped in the present. The past is forgotten and the future remains closed – a stance reinforced by Scarry (1985) and the many studies reported in the literature review in Chapter 6.

Leder (1990a) maintains that on a sensory level different possibilities of meaning arise which go beyond the sheer hurt of pain. 'Pain points toward injury, disease, the internal failure or external invasion of our being. We experience our essential possibilities constricted or breaking down, our integrity being violated. We come face to face with our own vulnerability and finitude and thus ultimately our death' (259). Although pain has positive revelations as in the Heideggerian sense of authentic recognition of our ownmost limitations and possibilities, Leder considers a most significant aspect of pain to be its paradoxical manner of obliterating meaning altogether. i.e. the deconstruction of our world as described by Scarry (1985) for the chronicity of pain defeats all interpretative modes.

Leder's view (1984) offers a direct challenge to the traditional dualistic theory of pain The existential viewpoint challenges the concept of the body being a machine driven by mechanical causality and it opposes the view that bodily acts are merely mechanical and cognition truly 'mental'. Through observing experience, it becomes apparent from the existential point of view that 'it is the body which first 'understands' the world, grasping its surroundings and moving to fulfil it's goals. In phenomenological terms, the body is not just a caused mechanism, but an 'intentional' entity always directed towards an object pole, a world.' (31). Merleau-Ponty (1962) describes this body intentionality as bodily intelligence and affectivity.

It is not relevant here to discuss in depth the details of existentialist philosophy, but to make Leder's (1984) point, which is, 'Contra Descartes we lead a unified existence'. (31). He maintains that the parameters of this unified existence are set by our physical body which from an existential view point have been re-envisioned not just as biological but as intentional structures also. Such implications, concerning possible medical applications, form the continuing focus of Leder's argument. He terms it 'a phenomenology of the clinical encounter'. (32)

In the medical encounter Leder (1984) suggests that the patient presents the 'lived-body' for treatment whereas the doctor treats the Cartesian or 'object-body'. An over-simplified way of explaining this is as follows: there are two differing agendas; one for the patient and one for the doctor. The patient's agenda is connected to the many transformations that pain has brought to his world. For the doctor the agenda is connected to examining the physical body to search for the 'mechanical precipitant of the disease, be it toxin, trauma or bug'. (33)

Leder explores how the objectification of the body is initially colluded with by the patient both by the alienation of the body that the illness brings and by experiencing the body as a scientific object during the physical examination by the doctor. Yet the patient in pain can never really escape the lived-body experience however much collusion is entered into.

In the conclusion of his paper Leder (1984) propounds that the recognition of the lived-body experience will create a reunification for the patient and that an overcoming of the mind-body split may be of great interest to medicine. He suggests that 'when disease is understood as arising out of bodily intentionality it can no longer be seen as a merely mechanical event.' (39). Leder (1984) applauds the newer therapies that have appeared such as bio-feedback and autogenic training, which seek to foster health through realigning the intentions and processes of the active body. He sees this as bringing into the treatment an expressiveness of bodily functioning rather than a dis-embodied consciousness of Cartesian dualism. Thus the lived-body is incorporated directly into treatment. Leder (1984) has no wish to replace the traditional view of medicine but to incorporate a new notion of embodiment, which will complement the traditional view and enhance new directions for medicine.

In place of a scientific model of medicine Leder (1990b) proposes a medical understanding that is hermeneutic in nature. By this he means the practice of the study of interpretation. With regard to medicine Leder (1990b) sees tremendous potential in medical practice becoming a hermeneutic enterprise in which the 'health care practitioner interprets the patient's signs and symptoms to ferret out their meaning; the underlying disease.' (10)

This is a view much accepted in the philosophy of modern pain clinics. Morris (1992) cites the work being undertaken at the Pain Management Center in Michigan USA. At such centres pain is treated as a diagnosis rather than a symptom; a significant shift from the dualistic viewpoint, and one which constitutes an entirely new way of thinking about pain. As such, pain is redefined and is no longer seen as a sensation but as a perception. This implicitly challenges the traditional medical thinking that treats the patient as divided into separate blocks of body and mind. Such thinking intrinsically acknowledges the importance of understanding body and mind as inseparably linked. Further this view of pain as diagnosis extends to our surrounding lifestyle and takes account of cultural and psychosocial influences upon the perception of pain.

Just as Langs (2000a, 2001a) has most recently developed drama as a special means of bringing attention to the communicative approach so Leder too has used the dramatic medium to represent his ideas. In critiquing Sophocles' Philoctetes' (1990c) Leder illustrates his point of view regarding pain and suffering and directly challenges the medical models of pain prevalent today. In interpreting the play Leder traces a phenomenology of illness in which he outlines and reflects pain as a transformation of one's experiential world and a transformation of one's being-in-the-world. Leder (1990c) uses Philoctetes situation as a metaphor for pain in its essence, and uses the textual images within the play to construct a phenomenology of illness. Leder in using this theme as a metaphor proposes that it is illness itself that is the exile; illness is banishment from the customary world.

The protagonist of the play, Philoctetes, in severe and agonising pain has been abandoned by his companions and exiled upon the island of Lemnos, where he has lived alone for 10 years. In Philoctetes, illness is seen as itself, not as a medical diagnosis. The illness that is shown is that of the suffering and disability of the patient which incorporates a transformation to the patient’s experiential world, not just a change in his physiological functioning. Leder argues that this transformation of Philoctetes' experiential world consists of a three-fold exile; an exile from the cosmos, the body and the social world. This is much in line with the points put forward by Kleinman (1988) for his experience of working with patients for over 30 years is that a patient's being-in-the-world is totally transformed.

Transformation of the Patient's World

The first of such transformations which Leder (1990c) traces is connected with the change in the patient's relationship with the cosmos. Philoctetes' illness is of God's sending. Having strayed too near Chryse's shrine Philoctetes has violated the divine order of things. This creates links with punishment and divine retribution and has considerable significance for the patient in pain. Engel (1951,1959) emphasises strongly the psychodynamic of pain as punishment. He goes so far as to propound that rejecting fathers and punishing mothers have a correlation with those patients who experience pain where no organic cause can be found. The very word pain arises from *poine*, the Greek word for punishment. As Leder (1990c) stated: 'Pain is the very immediate, bodily sense of something bad or wrong … to be ill is to feel oneself out of joint with the cosmos, an exile from the harmonious totality of the world.' (2)

Leder (1990c) develops this in contemplating a second sense of disharmony from the cosmos. In the play Philoctetes' violation of the shrine was an innocent misjudgement. He is known as a good and just man. He has wronged no one, killed no one and has lived a good life among goodly people. His illness is therefore unjust. The significance of this, Leder suggests, is that illness makes one a victim of chance and as such sickness and pain can destroy one's faith in an ordered universe. To suggest that pain can be responsible for destroying one's faith in an ordered universe is a somewhat extreme comment. Yet elements of such a viewpoint are borne out in the literature examining the psychological effects of pain (Henriksson, 1995; Charmaz, 1983) and in expositions from the patients themselves (Kodiath & Kodiath, 1995; Bowman 1994a, 1994b; Kleinman, 1988).

The second type of transformation that pain brings to Philoctetes' world, Leder proposes, is exile from the body. In health we are our body - in pain our body is 'other'. In health our body seems not to exist, in pain it is only the body, which exists. Leder (1990c) draws a paradox, 'here then is the paradox of illness; we are brought home to a heightened awareness of the body; but it is a body in which we are no longer at home' (4). This is the basis of Scarry's work (1985) and evident in the psychological effects of pain. (Kodiath & Kodiath, 1995; Donovan M.I., 1987; Manne *et al*, 1990; Strauss, 1985; Bond, 1978; Rose, 1994; Charmaz, 1983; Williams & Thorn, 1988).

The third transformation brought by pain, Leder (1990c) maintains, is exile from our social world, stemming not just from changes of physical routine but more significantly from a 'shift within our framework of meaning'. (4) When in pain, the patient cannot absorb the concerns that are meaningful to the outside world. Only pain is present. In the play, his injured foot and his rage bound Philoctetes' world. Although the person in pain will often purposely isolate themselves from others in the wish to remain alone, such aloneness relates wholly to the total isolation that becomes overwhelming to them. No other can fully understand or share the experience of the pain and suffering or the immediacy of pain that overpowers the person in pain. Leder (1990c) states: 'For pain is the consummately private sensation. While sight and hearing reach out to a common world, pain is largely enacted within the solitary theatres of the body. Pain is notoriously difficult to translate into speech. It is, in fact, actively speech destroying; Philoctetes is reduced to cries and shrieks by a severe attack.' (5) The irony of such isolation is that paradoxically the person in pain yearns for discourse and society.

Such inner isolation, Leder (1990c) suggests, is increased by the outer isolation caused by the response from others. Philoctetes was abandoned on Lemnos because his comrades could no longer bear his groans and screams and terrible cries. In a social world it is difficult for another to stand not just the cries of agony but the physical representations of a body in pain. The other fears for himself as awareness of his own vulnerability is raised. As Leder points out, it is natural to want to escape from sickness. 'We thus find ways to quarantine the sick. Hospitals, nursing homes, mental institutions can all serve such a function ... The world-disruptions affected by illness are hardened into place through the reactions of others. (6)

It would not be too far-fetched to consider Leder's radical interpretation of Sophocles play as somewhat outlandish. However the review of the literature which is presented in Chapter 6 on the impact and psychological effects of pain categorically reinforce that such interpretations are not outlandish but on the contrary they exemplify the way patients view themselves and their lives.

Suchman and Matthews (1988) point out that medicine initially arose out of the magic and ritual of religious healing, and that the interpretation of illness and response to suffering were originally religious matters. They note how cures were sought through direct appeal to a god (Apollo) or through divinely inspired healers such as Askelepios. In today's world they propose that illness and pain involve threats to connection and meaning to the patient. They cite Rabin (1982) who propounds that pain threatens a patient's sense of connection to others and the world. They cite also Booth (1967) who comments that pain interferes with the patient's security, challenges his sense of control over his destiny and thus produces feeling of alienation from himself, his family, his community and his God.

This is similarly evident in the research findings put forward in various studies connected with pain (Bond, 1979; Henriksson, 1995; Bowman, 1994a; Bowman, 1994b; Vlaeyan *et al* , 1987; Kodiath & Kodiath, 1995; Strauss, 1975; Donovan M. I., 1987; etc.)

The theme of repatriation that Leder proposes is significant because it offers a bridge to working in a therapeutic way with pain. Leder (1990c) suggests that it is 'compassion' that brings about change in Philoctetes. He defines what he means by compassion. 'Etymologically, the word derives from *pat*, 'to suffer' and *com* 'together with'. 'To feel compassion is to suffer together with the ill. We are capable of this; in fact it is almost unavoidable.' (8). Leder (1990c) states that we can respond on a pre-thematic basis, for we want to ease suffering, a suffering 'no longer clear perhaps to whom it belongs ... We thus echo one another. The space between two faces … a rich membrane ... Pain thus need not remain a fully private thing; it can be transformed into a band of communication. In this mutual echoing begins the repatriation of the ill.' (9) In order to be effective compassion must issue in proper action and right speech. Leder concludes his paper by summarising the many-dimensional exiles of the ill and recalls the power of others to compound or alleviate distress. He propounds that the real struggle in any project of healing lies in the dichotomy of the other to both withdraw and reach out to the person in pain.

This final part of the critique of 'Philoctetes' by Leder is highly relevant to this study for it reinforces the stand taken by Scarry (1985), the illustrations offered by Kleinman (1988); that is that the victory of pain is in its unshareability and in its isolating phenomenon. It is quite remarkable that all aspects within Leder's critique of the play fit into the discussion put forward in this study. In exposing the transformations that pain brings to the patient's various worlds and roles within those worlds, in witnessing the sense of isolation and abandonment that is the victory of pain and in exploring the very serious issues outlined by Kleinman's patients, Leder looks into the very demise which epitomises the world of pain for the patient.

This point is reinforced when Leder (1988) states,

> 'successful medical treatment in most cases rests upon a certain co-operation and mutual understanding between patient and staff. This is not possible unless they share a set of common presumptions about the nature of illness, the treatment and roles that patient and staff are to assume. When interpretative schemas diverge too far, the therapeutic alliance breaks down.' (374)

Leder reinforces that in portraying medicine as a hermeneutic enterprise it does not deny its scientific foundations but incorporates modes of interpreting the world, which involve values and pragmatic goals. Unless such hermeneutic stance can be addressed Leder states that the rapid growth of medical science cannot be put to best use.

Merskey (1994) makes an apposite point with respect to the importance of subjective experience, 'pain behaviour is not necessarily

> different according to its cause but it could be. … It appears that this issue has not been studied. The questionable feature … is that we cannot dissect the patient's experience in accordance with what we take to be its causes. (71)

In effect, the crux of the matter is that the patient's lived-body experience becomes a vital component in understanding and enhancing our vision regarding pain and thus the treatment of pain. Suchman and Matthews (1988) concur with Leder. They propound that a shift in emphasis of the medical model would lead to changes in medical education. They state, 'We must be prepared to examine our patients' subjective experiences, as well as our own. We must learn how to observe, characterise and verify theses experiences, to shape them using various interview techniques and to correlate them with clinical outcomes' (129). They conclude their paper by calling for a medical model which embodies the wholeness of a human being's experience so that clinicians and patients can be guided towards complete healing.

I have described Leder's work in detail yet it is only one example taken from a small cross-section of a much greater volume of research (see for example: Anderson & Bury *Eds.,* 1988; Annandale, 1989; Blackster, 1976; Bury, 1982, 1986; Charmaz, 1983; Jobling, 1990; Kelly, 1986; Young, 1981; Zola, 1982). Although conceptual consistency and methodological rigour might differ in the stances adopted by the researchers, there is no doubt that these are part of the increasing voice which call for increasingly different models for working with patients in pain.

5.4 The Consciousness Approach: Pain as Consciousness in Form and Content

Vrancken (1989) details this school as one which considers pain as a problem of consciousness; whether it be from the immediate here-and-now awareness of pain from a stubbed toe to the state of pain when a person is hurt to the core of his existence and his soul **becomes** pain. Vrancken asserts that in this school pain is seen to limit man's ability to be a free being because it takes away the ability to reflect upon 'self' and gain self-consciousness.

This school challenges the neurophysiological model of pain and resolves that thinking of pain in terms of pain–pathways is a mistake. This school's view is that pain is always the content of consciousness. The are no fixed guidelines for therapy but they do not aim to treat the pain. The aim is to regain a conscious state in which the psycho–physical unity is regained.

The work of Elaine Scarry develops this theory. Scarry's (1985) basic premise is that pain defines our reality in an absolute way so that for the person in pain there is no reality other than that pain. Scarry states that when one hears about another's pain the pain that exists within that person's body is quite remote to the other, it has no reality. It is vaguely alarming yet it is unreal. The pain occurring in other people's bodies flickers before our mind but then disappears. When one talks about 'one's own physical pain' and about 'another person's physical pain' it is as if one were speaking of two wholly distinctive orders of events. Even when within inches of someone in pain this distinction remains. For the person in pain the only reality is the pain itself, for the other there is no such awareness. As Ferrell & Dean (1995) succinctly state ‘pain is more than a symptom it is an all-consuming experience’. (21)

Scarry (1985) states that the victory of pain is in the split it achieves; that is the split between one’s essence of one’s own reality and the reality of other people. Thus pain, she maintains, is something which is undeniable by the one but which cannot be confirmed by the other. For the person in pain it is so incontestably and unnegotiably present that having pain becomes the most ‘vibrant example of what it is to ‘have certainty’ ‘. (4) Whatever pain achieves it achieves through unshareability. Scarry (1985) maintains that the difficulty of expressing physical pain is such a central issue that one person can be in the presence of another yet can be partially or wholly unaware of that person’s pain. In other words pain - ‘to the individual experiencing it is overwhelmingly present, more emphatically real than any other human experience - yet almost invisible to anyone else, unfelt, unknown. Even the sound of pain, screams etc. convey only a limited dimension of the sufferer’s experience.’ (51) The alienation for the person in pain and the failure to be able to express his pain can bring about serious consequences.

Sternbach (1968) reinforces this position. He takes the stance that the experience of pain is a subjective sensation, which we can only imperfectly communicate to one another. He maintains that pain defies logical analysis because the imperfect communications of subjective experience cannot be directly communicable. The philosophical point that he makes is that such uniqueness of mans’ experiences have to do with the validity of our knowledge of the world and our perception of it. How do we know that our perceptions are accurate or that others perceive things including pain as we do? A point of reference, he suggests, is initially through linguistics, his point being that a single event or state may be described in different but parallel 'languages'. He further proposes that in order to understand the essence of pain it is necessary to conceive of it as a set of responses; that is a person does something or responds in some way to a 'painful stimulus'. (5)

In the consciousness school of thought this is a vital concept for as Scarry (1985) propounds:

> 'Pain has no language; no voice, only cries. Pain has no thought. Pain is all there is. For the person in pain the body and its pain are overwhelmingly present and voice, world, self are absent. For the other the voice, world, self are present and the body and the pain are absent'. (46)

It is as if in pain one deconstructs. The route through which language has come into being has been reversed. As Scarry states pain 'uncreates'. 'Pain is an act of destruction and hence the opposite of creation' (21). She maintains that in chronic pain there is no language and that pain resists language, actively destroying it and bringing a reversion to a state anterior to language. Scarry affirms that such resistance to language, across cultures 'is not incidental or accidental but is essential to what pain is'. (5)

Scarry (1985) attributes this shattering of language to the exceptional character of pain when compared to all other interior states. Other 'emotional perceptual and somatic states take an object - hatred *for*, seeing *of*, being hungry *for*, ... Physical pain - unlike any other state of consciousness - has no referential content. It is not *of* or *for* anything. It is precisely because it takes no object that it, more than any other phenomena resists objectification in language.' (5)

Scarry (1985) argues that in pain, one witnesses not only the destruction of language but of one's conscious dimension as well. Her argument proposes that in pain we become utterly split off from one another and that with that comes a disintegration of the contents of consciousness. 'In its obliteration of the contents of consciousness pain annihilates the objects of complex thought and emotion and acts of perception' (54). Thus one becomes conscious of the body being a vehicle of excruciating torture invisible to others and the cause of self-abomination. As Scarry states 'if pain had a goal it would be to be felt and known exclusively in its intensity' (327).

It therefore becomes a basic assumption that the act of verbally expressing pain is a necessary prelude to the task of diminishing pain. The impediments to expressing pain need to be overcome. When physical pain is transformed into an objectified state, it (or at least some of its) aversiveness is eliminated. It is important to the individuals who have been in great pain and who have witnessed the destruction of language to the pre-language of cries and groans, to re-create the language of pain. Similarly it is important in medicine, for the success of physicians' work depends on how they can hear the fragmentary language of pain, gain clarity and interpret it. Often though physicians don't trust the human voice, finding the patient an 'unreliable narrator' of bodily events (this is eminently illustrated in Chapter 7*)* and the voice is bypassed to get to the physical events themselves. Scarry propounds that in doing this they bypass the person in pain.

One way this was taken on board medically was through the work of Ronald Melzack and his colleagues W. S. Torgerson and Patrick Wall in their celebrated 'Gate Control Theory of Pain' (1965) and 'McGill Pain

Questionnaire' (1975). By listening to the random words uttered by patients in pain they were able to arrange the words into coherent groups so that some visibility could be bestowed on the character of pain - *throbbing* pain, *burning* pain, *flickering*, *quivering*, etc. Words were divided into groups where the felt experience of pain could be given a temporal dimension. By uncovering the vocabulary originated by the patients themselves an external image can be provided of interior events. Melzach (1988) believes that the human voice is capable of accurately exposing even the most resistant aspects of material reality. Thus the human voice can:

1. Record the felt experience of pain.
2. Give signs of the accompanying disease.
3. Invite appropriate treatment.
4. Pick up secrets of the neurological and physiological pathways themselves.(5)

In support of this Scarry (1985) expounds that any action that restores the voice becomes a denunciation of the pain and a reversal of the process. Scarry proposes that the activity of re-creation has an identifiable structure and that when this private human interior is made visible pain, is no longer able to isolate and alienate in the same way and its victory is no longer complete

This is a vital concept and it is fundamental to this study to investigate a way in which the private human interior can be made visible, thus denying the total isolation, alienation and victory caused by pain. It is in what Scarry terms the making of the world, this restoration of the voice and the reversal of the obliteration of consciousness, that I make a link with communicative theory. It is the phenomenological concept of Scarry's (1985) work that stands out for me and which I wish to link to communicative theory. That is:

1. In pain our conscious state deconstructs.
2. With visibility comes recreation and denunciation of pain.

Communicative theory claims a method of communicating the unconscious perceptions of conscious events. On this basis it may be possible to shed a light on the design and operation of pain mechanism as perceived by the emotion-processing mind. It is also significant to explore further the emotional and psychological impact of chronic pain in order to ascertain the nature of cognitive dysfunction and deconstruction.

These last two schools of thought - the phenomological and the conscious – very much emphasise the importance of understanding the patient's experience of pain. In order to gain greater insight into the pain phenomenon this dissertation will explore this issue in Chapter 7.

6. The Impact, Psychological and Emotional Effects of Chronic Pain: A Review of the Literature.

This chapter will review the literature documenting the psychological and emotional effects of chronic pain. It is my intention to show that chronic pain can have significant psychological and emotional impact upon the patient, the effect of which can disrupt the cognitive state and conscious functioning of that person.

Addiction

The link between addiction and pain is not greatly focused upon within the literature. Bond (1979) warns that an increase in the consumption of alcohol, or even frank alcoholism, may develop as a result of chronic pain. Clarke (1980) sees addiction as a means of escape. He suggests that some people will attempt to escape the psychological distress of pain by taking alcohol or tranquillisers.

It was surprising to find so little in the literature regarding addiction and patients suffering from chronic pain. However addiction seems to be a greater problem for the patients in their response to pain than the literature shows. Styron (1992) writes at length about his relationship with alcohol as a result of his pain and depression. Sutherland (1976) in his autobiography, similarly discusses how alcohol and tranquillisers became a fundamental part of his life as he fought his battle against chronic pain. In many of the patients' narratives, quoted in Kleinman (1988), there is also significant mention of alcohol and tranquillisers. The Chronic Pain Support Group on the Internet (Newsgroup: alt.support.chronic-pain) frequently has postings from people suffering chronic pain who comment upon their addiction to alcohol and tranquillisers.

It is appropriate to question why there is such discrepancy between what is voiced by the people in pain regarding alcohol and tranquillisers and what appears in the medical literature. One can only surmise that patients withhold such information from their doctors and that their doctors do not ask them about it. It is also possible that the patient does not see that their increased consumption of alcohol and tranquillisers is a direct emotional effect of their pain. More work needs to be done in this area to clarify these issues.

Anger

There is a much greater response in the literature to the emotion of anger in connection with chronic pain. Kodiath and Kodiath (1995) report how many patients show anger regarding their pain process. They claim that patients felt they deserved to be angry about their situation and often stayed angry directing their anger towards the physician from whom they felt they were not receiving adequate medical advice or treatment. The work of Fernandez and Turk (1995), and Schwartz *et al* (1991) also acknowledges the high frequency with which chronic pain patients exhibit anger and hostility. They note that the anger felt by the chronic pain experience make difficulties for the patient when interacting with their spouses, friends, family, as well as healthcare providers. Schwartz *et al* (1991) propose that anger is linked to other salient emotions which then becomes a major complicating factor in trying to treat the chronic pain patient. They state that treatment requires mutual trust, acceptance and co-operation. When a patient is overtaken by anger, treatment becomes undermined and the patient in pain less able to function. Their research into pain and negative emotions indicate that anger is a salient feature of the chronic pain experience and that the prevalence of anger needs to be treated urgently and taken seriously for it has negative consequences for both the physical and psychosocial well-being of the patient.

Wade *et al* (1990) similarly found that anger and frustration were important components of the emotional unpleasantness caused by chronic pain. Craig (1984) states how a portion of his chronic pain patients became angry, demanding and manipulating in the course of their disorder.

The study under-taken by Gamsa and Vikis-Freibergs (1991) showed that pain patients were more likely to express their angry feelings and their awareness of emotional problems than a control group. They also noted that the greater the amounts of pain the patient suffered the more likely they were to express their angry emotions.

Such research backs up the work of Fenichel (1945) a milestone in psychoanalytic interpretation upon anger. Fenichel states that emotional qualities are often felt as anxiety and rage. Where urgent need is not fulfilled and available discharges are inadequate then the frustration felt is transposed to rage. It is not difficult to see how patients who undergo continual and enduring attacks of pain vent their frustrations in the emotion of rage.

Leder (1990a) and Kleinman (1988) show that it is common for patients in chronic pain to believe that their treatment at the hands of fate has been grossly unfair. Patients believe such pain should not have happened to them and they demand results from healthcare providers. Levels of anger and frustration are increased when this is not forthcoming and this complicates further the patient's adjustments to pain.

Sternbach (1968) has shown that in a variety of species, pain is an unconditional stimulus for aggressive behaviour. He speculates that this may well occur in man as well. Coyle *et al* (1994) notice with their patients that paroxysms of pain often became accompanied by marked agitation. Patients were noted to be irritable and inattentive when they were in their greatest pain. Anger is a predominant emotion that accompanies pain.

Anxiety

The emotion of anxiety is covered extensively within the literature. (I include also the emotions of fear and uncertainty.) Many researchers comment on the observable features of anxiety in pain patients. Vlaeyan *et al* (1987) in their study of observable behaviours of chronic pain noted the patient became tense, restless, and nervous, even in a panic. The patient became particularly nervous when having difficulties in doing something. Physical observations such as blushing, sweating and stuttering were also observed. Henriksson (1995) comments that such anxiety features are increased when patients undergo long periods of investigation and treatment. The anxiety increases even further when no new findings come to fruition.

Bowman (1994a) offers a similar opinion. She confirms that individuals with chronic pain often experience uncertainty most frequently about whether or not their pain will get better. Patients also show anxiety about a number of pain related conditions, such as whether their walking ability will improve, and whether their legs would give way without warning. An earlier study by Kaufman and Brown (1961) noted that when pain threatened an individual's ability to function in society, then the patient's sense of self worth and his concept of himself was damaged. Such damage brought a high degree of anxiety and frustration to the patient.

Paice (1991) noted that pain brought about many feelings connected with anxiety. Such feelings cover a variety of areas, from the fear of death, uncertainty about the future, to concerns about family and finances. Bond (1979) similarly recognised that pain was linked with anxiety. He detailed patients' fear and uncertainty about their fate, about their fear of prolonged disability and even death, their apprehension about further suffering and their worry about whether or not any relief might be possible. He noted that unsuccessful treatment increased a patient's sense of anxiety considerably. Several authors, Wade *et al* ,1990; Muse, 1986; Chapman and Cox, 1977; Classen *et al* ,1993; and Bury, 1991 all comment that frustration and anxiety are significant contributors to the overall emotional unpleasantness that is suffered by the patient in chronic pain. They have noted how the patient in chronic pain who is also suffering with anxiety is likely to have nightmares and feel a rapid onset of terror or intense anxiety as pain increases.

Uncertainty and anxiety appear to be key aspects of the disruptive experience of chronic pain. However, as Hayward (1987) maintains anxiety is quite an ambiguous concept and its relationship to pain is not yet clear. It is now understood that there are at least two types of commonly experienced anxiety; trait anxiety – anxiety which is considered to be a fairly permanent feature of an individual's personality and state or transitory anxiety when a patient tends to experience acute anxiety in response to specific situations. Peck (1986), points out that there is a linear relationship between pain and anxiety where increased pain is related to increased anxiety and where increased anxiety is related to increased pain. Peck (1986) cites Bobey and Davidson, 1970; Cohen and Lazarus, 1973; Johnson, Rice and Fuller, 1978; Sime, 1976; Wilson, 1981; and Wolfer and Davis, 1975 as reinforcing that anxiety is one of the psychological variables which has been most reliably related to high levels of pain.

Seligman (1975) defines anxiety as a chronic fear that occurs when a threatening event is in the offing, but is unpredictable. It is this unpredictability that leads the individual to lose their sense of power over a situation. Seligman calls this loss of power ‘learned helplessness’. He notes that this powerlessness or helplessness leads to further anxiety, particularly if the individual feels that his or her ability to control their life is low. Bowers (1968) further observes that powerlessness leads to anxiety and that anxiety is caused by the sense of powerlessness over the pain.

Skevington (1995) has completed one of the most detailed research projects undertaken about the psychological effects of pain. Skevington (1995) suggests that patients become particularly anxious when they are unable to find a meaning for their pain. The sense of that uncertainty she suggests adds to the patient's sense of vulnerability. Feelings of ambiguity, of not understanding what is going on and uncertainty of the future are strongly related to the stressful event of being in pain. Yet Skevington is quite clear that she thinks it a mistake to view anxiety as a personality characteristic of individual patients. Rather, she suggests, such anxious feelings are most likely to occur where symptoms of pain remain unexplained because a valid disease cannot be identified. As such Skevington suggests uncertainty, anxiety and ambiguity represent an absence of beliefs for the pain patient.

Cognitive disruption

By far the largest amount of research on the psychological and emotional impact of pain is centred upon the cognitive disruption that is experienced by the patient. Craig (1978) observes that the role of cognitive appraisal and other thought processes in connection with pain were initially established by Beecher's (1959) observations. Beecher's work of observing pain during wartime has provided dramatic evidence that cognitive appraisal affected both emotional responses during pain and the manner in which the individual responded to demands of injury and disease.

Classen, Koopman and Speigal (1993) report that the stress associated with physical pain can cause abrupt and marked alterations in the patient's mental state. They comment upon how traumatic pain experiences are well known triggers of intense emotions that can bring about a disintegrating effect on the mind. They call upon the psychiatric literature, which clearly demonstrates that traumatic events will most likely be followed by depressive and anxiety symptoms. They also observe that one of the features of intense physical pain is the development of dissociative symptoms. Such dissociation might well interfere with the patient's ability to be able to work through the traumatic pain symptoms. They recall Speigal's

(1986) earlier work which points out that pain can bring about a feeling of abject helplessness, which comes from a sense of having little or no control over the course of events that is happening to the patient. This in turn creates an experience for the patient of themselves as either damaged or fragmented.

Eigen (1985) is also interested in the dissociation that can come from chronic pain. He comments on the capacity that pain has to blank oneself out, i.e. to lose one's mind. He considers this to be a form of self-protection that is widespread within patients. Such form of protection can vary from a momentary lack of attention to a vast nulling of the self. He comments that spinning, paralysis, nulling, mesmerization, fading, obliviousness, going blank and dying out are among some of the varied states that self-anaesthetisation can take. He recalls Freud's views on hallucinatory wish-fulfilment and notes that the death wish is understood in the terms of the need to blur pain or to null it with insensibility. Eigen explains this as a form of decathexis, i.e. the way to numb or deaden oneself by attempting to return to a zero point. He propounds that the subject commits a kind of psychological suicide by emptying or getting rid of the experience of pain by becoming as if inanimate. Thus absolute decathexis is absolute painlessness.

Two studies (Flor & Turk, 1988; Keefe & Williams, 1990) comment on the negative distorted beliefs that come about when in intense pain. These distorted beliefs can create and influence the severity and maintenance of other emotions, such as depression. Flor & Turk (1988) categorised patients' distorted beliefs into 3 main areas: 1) catastrophising, which is the misinterpreting of an event as a catastrophe, 2) personalisation when the patient takes personal responsibility for negative events and 3) selective abstraction, when the distorted belief can bring about a means whereby the patient selectively attends to only the negative aspects of a situation.

Gill *et al* (1990) further categorise patients negative cognitive disruption into the following areas: negative self-statements, negative social cognition and negative self-blame. A significant factor of Gill *et al*'s (1990) work was the finding that the frequency with which patients have negative thoughts and the pervasiveness of these thoughts were significantly associated with the psychological distress brought about by pain. Philips (1989) also reported that cognitive responses for chronic pain patients represented negative automatic thoughts including the desire to withdraw, disappointment in themselves, helplessness and negative emotional reactions. Craig (1978) produced similar findings to Flor & Turk (1998). In his investigation he reported the main cognitive errors connected with chronic pain. The first error was that of catastrophising, which he defined as the anticipating or misinterpreting events as particularly severe. The second he categorised as over-generalisation, when the patient will assume that the outcome of any form of experience is likely to be the same as their pain experience. The third categorisation was selective abstraction, where the patient selectively refers to only the negative aspects of the experience.

Much work has been done on these areas of cognitive distortion of catastrophising, over-generalisation, personalising and selective abstraction. Miller (1991) found that patients who were prone to such cognitive distortion were often much more depressed than patients who did not. Smith *et al*

(1986) whose study claim that catastrophising and over-generalisation were related to excessive cognitive impairment through pain. Beck (1976) proposed that it was the uncertain and often changing course of pain that affected the cognitive processing and brought about such distortion. He found that for the patient the future impact of pain was so uncertain that the patient's expectations had a significant influence on their cognitive functioning. This links back to the early study by Festinger (1957) who postulated that individuals have a basic tendency toward having consistent cognition about themselves and their world. The effect of chronic pain is such that consistencies are threatened. Such threat leads to dissonance when the patient becomes aware that his pain behaviour is inconsistent with his beliefs, values or motives. Lefebvre (1981) notes that it is not just that the patient suffers cognitive distortion in general but that individual cognitive errors can be influenced by a specific context, such as the sudden impact of chronic pain attack.

Turk and Rudy (1986) have studied extensively the relationship between cognitive functioning and pain and they report that no single study is sufficient to demonstrate the importance of cognitive factors and the maladapted variables that come about through chronic pain and pain exacerbation. They cite a number of studies Turk and Genest, 1979; Turner, 1982; Bakal *et al*, 1981; Holroyd *et al* , 1977; Stam *et al*, 1984; Bradley *et al,* 1982; Flor *et al*, 1983; Holroyd *et al*, 1984; Follick *et al,* 1983; Tan, 1982; Turk *et al*, 1983; Turner and Chapman, 1982a as studies which all comment upon the cognitive maladaptions that are created from the experience of chronic pain.

By far the most radical point of view put forward about the relationship between chronic pain and cognitive distortion is that voiced by Ciccone and Grzesiak (1984). They argue that chronic pain is first and foremost an emotional, behavioural and psycho-physiologic problem. They suggest that pain itself is not the problem, but that all the major symptoms associated with chronic pain are the direct result of cognitive error. They recommend that rather than remediate the biological causes of pain that a total philosophic change needs to take place. They propose that it is important to convince clients that the cause of their pain may be under internal as opposed to external control. They advise that new thinking skills must be facilitated, that explicitly challenges the cognitive causes of chronic pain. They state that because as human organisms we draw inferences about our sensations, that we are limited in our capacity for reasoning and judgement and we may well then be prone to misinterpreting pain sensation. As a result, our cognitive schemata may contain faulty beliefs based on our faulty logic or improper inference in connection with the pain experience. They detail that much of reality in all our transactions with the environment are made on the basis of subjective inference. They propose that we are prone to both misinterpreting and misappraising the nature of reality and that mistaken inference is the primary if not the only cause of chronic pain. They maintain that there are certain symptoms that chronic pain patients exhibit with seeming regularity and that all these symptoms have cognitive origins. The symptoms include affective disorders, such as depression, anxiety, anger and behavioural disorders, such as inactivity, procrastination and avoidance. This is radical and contentious thinking, yet links with the consciousness approach to chronic pain discussed in chapter six.

Concern about themselves

A smaller body of the literature concentrates on the way in which pain alters a patient's concern about himself. Kodiath and Kodiath (1995) comment that patients in severe pain have trouble concentrating on anything else except themselves and their pain relief. This reinforces the earlier work of Donovan M.I. (1987) who observed that individuals became more self centred and started to spend more time with others who have the same problem, as they became more significantly affected by chronic pain. He also noted that much time was spent by the patient in trying to control the pain and in other feelings associated with pain. Strauss (1975) similarly comments that the greatest focus for individuals with chronic pain is the self. He adds that this focus can sometimes prevent a successful management of a pain treatment regime.

Bond (1979) gives greater analysis to this same feature. He proposes that pain leads to a greater level of introspection than is normally present. He confirms that neurotic behaviour including preoccupation with genuine symptoms may appear, as the person attempts to come to terms with the pain they have to face. He states that it seems to be natural to be absorbed by suffering when it is inescapable and almost constant. He further proposes that the preoccupation with the symptoms is a form of defence in which the sufferer's focus of interest is diverted from the worst emotional consequence of the threats posed by the pain.

Charmaz (1983) observes how pain becomes the focus of patients' lives and treatment regimes, periods of discomfort, medical appointments and a number of other problems and activities, structure and fill a patient's day. She comments that pain creates a restricted life and fosters an all-consuming retreat into illness. Under these conditions, pain structures the patient's world and shapes the patient's self-concept. She comments that friends and relatives also observe that the patient in pain has consuming thoughts about their pain and illness. Thus she state chronic pain evinces heightened self concern about the person they see themselves becoming and about valued self-images from a past which patients feel they have lost.

Rose (1994) takes a difference stance. She proposes that the overwhelming concern with the pain situation is because the patient enters an unrelenting search for answers. She suggests the patient wishes to know what is the cause of the pain, how it could be treated, would the treatment be successful, and how would it be possible to adapt to the situation. Many patients, she ascertains, make a virtual career of seeking answers to these questions and in doing the rounds of various doctors and therapists. Craig (1978) takes a similar stance to Rose. He maintains that the patients' increasing demands for care and concern about themselves is matched by the extraordinary efforts they also go to protect themselves from the anticipation of additional threatened pain.

Complaining

It has been noted by Bond (1979), in his study of overt observable pain behaviour that as the patient becomes more concerned with his own situation there is sometimes an increase of complaining behaviour. Bond (1979) mentions that patients complain of having more pain after treatment, say they cannot stand the pain any more, complain about pain attacks, complain about the pain saying that the pain has not diminished, cry, groan, moan, sigh, etc. He noted additional complaint about stiffness after therapy and a demand for further specialised treatment, for consultations with a psychologist, for a lighter therapy programme. He noted that the programme was considered too hard and often patients become querulous and demanding. Bond (1979) associates this increase in complaints about the physical discomforts and symptoms that the patients are suffering as a response to the unpleasant emotional feelings that are aroused by pain He proposes that at times of better health such symptoms would be ignored or played down by the patients.

Vlaeyan *et al* (1987) also note that patients in chronic pain frequently seek additional attention, often interrupting and disturbing other's activities, talking continuously, becoming obtrusive, or claiming the attention of nurses and other patients more frequently than those not in such pain. The knock-on effect of this causes additional difficulties for the patient in pain for they are frequently seen by those caring for them as ungrateful and difficult. A cycle of miscommunication occurs with both the carer and the patient ending up feeling frustrated and under-valued.

Denial or Stoicism

The literature also notes the opposite effect for patients, that of denial or stoicism. Craig (1978) comments that the apprehension of severe pain attacks can have a serious debilitating effect upon the patient, including substantial fear behaviour, behavioural disorganisation, denial and a refusal to seek care. Charmaz (1983) found in her study that some patients glossed over their symptoms and minimised their discomfort. Kodiath and Kodiath (1995) noted that several patients refused to participate in their study at all and said 'I just don't want to talk about that' 'I don't want to talk about pain'. (194)

Classen *et al* (1993) see such denial as a defence strategy that helps to boost a sense of control for the patient. They propose that strategies of denial and dissociation remove or filter the experience of pain from the conscious awareness of the patient and thereby offer the patient a measure of immediate relief and protection. They propose that such strategies also enable the patient in pain to discover that although they might have no direct control over their pain they have ways to control how such pain is experienced. Classen *et al* (1993) are concerned that the reasons for the use of such defensive strategies as these can become habitual for the patient and eventually even shape their way of being in the world. Clarke (1980) similarly determines that denial is one of the mental defence mechanisms employed by people in pain. However he notes that other defence mechanisms such as repression, displacement and intellectualisation are also used to deal with the stress of pain.

Stewart (1987) makes an interesting connection between patients in chronic pain and the symptoms stages described by Kubler-Ross (1970) in fatal disease. Kubler-Ross describes five stages. The stages of which are:

1. Denial and isolation: This is when the person withdraws emotionally from other people and it becomes very difficult for emotional contact to be established with them. A person in chronic pain who feels they have no hope of permanent relief from the unremitting pain is also in this first stage.
2. Anger: Anger is significantly felt by patients facing death as well as by patients who experience a life of chronic pain. Such anger is directed in a variety of directions, i.e. anger towards themselves, anger towards friends and family, anger towards life in general. The concern is that such anger is destructive and antagonises those who wish to help the person in pain.
3. Bargaining: Patients in chronic pain symbolically associate themselves with death and dying. This is especially so if the patient has to curtail activities or if the pain interferes with their various relationships.
4. Depression: This is considered to be a stage that causes significant difficulties for the sufferer of chronic pain. Depression has been shown to lead to inactivity, feelings of helplessness and of dependency. (The literature concerned with chronic pain and depression will be referred to at a later stage in this chapter.)
5. Acceptance: In Kubler-Ross (1970) acceptance is connected with the need to die with dignity and without despair. In chronic pain there is a similar process regarding cause and the limitations imposed on them by the pain condition. Only when sufferers have come to this stage of acceptance are they able to benefit from pain relieving measures.

Dependency, helplessness and despair

Bond (1979) states that chronic pain creates a tendency to become more dependent upon others than is really necessary. Charmaz (1983) gives insight into why this might be. She states that over time many debilitated chronic pain patients become dependent and immobilised. She suggests that as patients' experience diminished control over their lives and their futures, they become severely affected and lose both their self-esteem and their self-identity. This is particularly significant she states because ideologies are predicted on values of independence, hard work and individual responsibility. Not being able to achieve such ideologies, patients in chronic pain not only view any dependency as negative but also often blame themselves for it. Patients experience a sense of becoming a burden as their immobility and dependent needs increase. The fact that patients have little power over their situations or over the quality of their existences demeans their identity and often guilt and shame follow. She states that feelings of uselessness become apparent as a patient's dependency is affirmed. The circle is relentless as chronic pain fosters greater dependence on others and at the same time creates relationships, which become strained and problematic.

An earlier study by Fenichel (1945) states how patients sometimes develop an attitude of helplessness and passive dependence. Seligman (1975) definines such helplessness as a psychological state which may result when events are perceived as uncontrollable. Lefcourt (1973) reinforces that it is the perception rather than the reality of control that is important. Williams (1996) takes a slightly different tack and states that weakness and vulnerability caused by pain elicit a very real need for nurture and dependence in some patients rather than a state of self-sufficiency. He ascertains that such patients are not ready to take control of their own pain but self-sufficiency forces them to take control when really they have a desire for the support of others. Forcing self-sufficiency he suggests could introduce rather than relieve anxiety and distress.

Skevington's (1995) extensive study confirms that helplessness is widely discussed with reference to pain. Fitzpatrick *et al* (1990) show that the patients in greatest pain expressed the greatest helplessness, depression, internal control and the least self-esteem and psychosocial control. Rose (1994) details something similar in her research and reports that patients in chronic pain feel trapped in a vicious circle of trying to cope with their pain, of getting help and when such help fails of feeling more overwhelmed, isolated and helpless.

Clarke (1980) observed the physical responses of the patient in pain and explored how pain made the person seem slow, sluggish and damped down. He reported how the individual appeared inactive and often introverted.

One of the few studies that concentrate on patient perception of their pain is that undertaken by Jensen *et al* (1991). They claim that chronic pain patients believe that their pain impedes their normal function. They state that patients do not understand why they are experiencing pain and some believe that they are helpless and hopeless in the face of their pain. This extends into a belief that if there is a pain flare-up that it is their own fault. Kodiath and Kodiath (1995) cite a similar response from one of their patients who stated, ‘this pain is so cruel, it's like a dagger in the heart, I have lost all hope.’ (193)

Miller (1991) proposes that it is the type of personality of the person in pain that causes the emotional experiences of helplessness and hopelessness. Dorsel (1989) reports that pain patients tend to be unassertive, passive and martyr-like. He propounds that patients in pain are overly dependent on others and constantly fearful of both specific situations and life in general. He continues that such personality traits lead to withdrawal and further inaction. Helplessness he states is the hallmark of the chronic pain patient. He also maintains that the person in chronic pain uses a number of tactics including threatening, demanding, acting hurt, projecting guilt, failing, compliance and blaming others to induce other people to take care of them. Henriksson (1995) has a more compassionate view as he notes how his patients hope changes into despair and feelings of hopelessness as relentless pain continues.

Turk and Rudy's (1992) extensive study shows that such helplessness refers to the belief for patients that effective solutions are not available to them and that they are unable to eliminate or reduce the source of their stress. They quote a number of research programmes, Flor and Turk,1988; Nicassio *et al*, 1985; Smith, Peck and Ward, 1990 who demonstrate that the greater the feelings of helplessness to be significantly correlated with added psychological distress. This is backed up by the longitudinal study by Stein, Wallston, Nicassio and Castner (1988) who report that changes in helplessness over a period of six months were directly associated with changes in depression and pain severity. There is no doubt that people in chronic pain have negative expectations about their own ability, as to how they can exert any control over their pain. As such, such feelings leave them to view themselves as helpless. Whether it is cause or effect, such feelings of helplessness link significantly with depression.

Depression

The amount of literature studying chronic pain and depression is vast and next to cognitive disruption is the impact most reported upon in the literature. The study undertaken by Vlaeyan *et al* (1987) tracing the overt observable pain behaviour of patients gives clear guidelines to the behaviour shown by patients in pain suffering from depression. They observed behaviours which showed that the patient who is in pain and in depression behaved passively and might not take any initiative. Such a patient is likely only to do what is asked and will miss therapy sessions if not reminded. It is likely that such a patient will undertake nothing outside of what is demanded, can be quiet, withdrawn, isolated, show listlessness, become low, down, worried and talk about suicide or talk in a pessimistic way. They repeated that patients often commented that things were not working out well and mentioned not being interested in anything. Even when encouraged to undertake something, they appeared drowsy and sleepy and commented that they felt continually tired.

Kodiath and Kodiath (1995) reinforce such impressions, stating that they noted that some of their patients in pain, who were also depressed wanted to die or commented they were waiting for the end of life. Paice (1991) traced how the events that frequently accompany pain, such as the loss of one's job and the change in role within the family often lead to emotions such as helplessness and depression. Merskey (1994) asserts that the degree of depression increases with the severity of the pain that is felt. Craig (1980) confers with such a position and declares that the longer the pain persists the greater the probability that the patient will become depressed, fearful, irritable, somatically preoccupied and erratic in their search for relief. He continues that in extreme chronic pain it is likely that severe depression will develop as the patient may have lost hope for the prospect of any relief from the pain. This is especially so as the patient comes to realise that pain will create a disabling lifestyle that will change their world as they have known it.

Doan and Wadden (1989) cite a number of studies Fordyce, 1976; Klusman, 1975; Kraemlinger *et al,* 1983; Maruta *et al,* 1976; Melzach and Wall, 1982; Price and Blackwell, 1980; Stegar and Fordyce, 1982; Sternbach, 1974, which document that depression is a pervasive problem among chronic pain sufferers. They turn the argument round and suggest that depression is also an indicator of the level of pain that the patient suffers and that depression may be a predictor of poor response to treatment. Statistically Doan and Wadden (1989) found that 27% of their patients had scores suggesting moderate to severe depression, 39% had scores in the mildly depressed range and 34% had scores as non-depressed. A similar study by Kraemlinger *et al* (1983) showed that 25% of patients with chronic pain were definitely depressed, 39% were probably depressed and 36% were not depressed. Such findings support the repeated observation that depression may be the more important predictor of the degree to which patients in pain are impaired. Such impairment may well interfere with the patient's ability to cope with their continuous pain over the course of a day. As such depressed pain patients become more preoccupied with their physical problems, more irritable and more prone to negative cognition about their ability to cope.

Depression can also significantly alter the way patients with chronic pain perceive and report their pain. Gil *et al* (1990) showed that negative thinking in chronic pain patients is particularly frequent during a flare-up of their pain. They reported negative self-statements such as 'other people have to do everything for me' and negative social cognition, such as 'no-one cares about my pain'. Skevington (1995) confirms that depression is believed to be amongst the most common disturbance of emotion for chronic pain patients. She notes how depression in pain also links to symptoms of helplessness, passivity, low self-esteem, sadness, aggression and reduction in appetite. Central to this Skevington (1995) confirms is the notion that people in pain have lost control over the unpleasant event that has happened to them.

Miller (1991) details that the most common diagnostic association of chronic pain is that of depression. He cites the studies of Benjemin *et al*, 1988; Fishbain *et al*, 1986; Kraemlinger *et al*, 1983; Krishnan *et al*, 1985; to support this. He also relates that between 10% and 100% of patients in chronic pain report depression. There are a vast number of similar studies, Lefebvre (1981), cites Freeman, Calysan and Louks, 1976; Muruter *et al*, 1976; McCreary *et al*, 1977; Fordyce, 1976; Sternbach, 1974; all of whom show how depression is associated with chronic pain. Hammen,1978; Hammen and Krantz, 1976; Krantz and Hammen, 1979; comment that depressed patients show more cognitive distortions than non-depressed patients do.

Chapman *et al*, 1979; Merskey and Boyd, 1978; Sternbach and Timmermans, 1975 also present research that shows that patients become depressed as a reaction to their chronic pain. Such studies support the findings that pain plays a central role in the depression of patients. Sternbach and Timmermans (1975) compared two depressed groups of patients; one group of patients was suffering from chronic pain, the other was not. Their research found that the patients suffering from depression and chronic pain endorsed catastrophising, over-generalisation and selective abstraction significantly more strongly than the depressed patients who were not suffering from chronic pain. This upholds the work of Willner (1984) who maintains that there is little evidence to support the view that depression arises out of existing depressive attitudes. He puts forward a number of changes, which come about for a patient who suffers chronic pain and depression. The central change being that the patient has less ability to maintain concentration and effort, but an increase in connecting to the adverse and negative events in their life and a decrease in acknowledging anything pleasant. The extensive amount of literature relating to depression and chronic pain is indicative that depression is a pervasive problem among chronic pain sufferers.

Determination

The literature proposes that pain has made some patients more determined people and given them focus to their lives that was not there previously. Bowman (1994a) details that in her clinic some patients were determined that their pain would not control their lives. She notes how several of her patients spoke of fighting back against pain and that this fighting back enabled them to accept the pain. Such determined attitude influenced the way the patient was able to live with his pain. Craig (1978) supports this evidence and suggests that the pain disorder provides a focus in life for some patients that enable them to ignore stressful life challenges or crises. He sees this as a means of the patient having some control over their depression, anger or resentment.

Discredited

The literature also documents that the effect of chronic pain can create totally the opposite emotion so that many patients feel discredited and unable to cope. Henriksson (1995) comments on the inability of some of his patients to complete their normal activities, which made them feel clumsy and incomplete. Charmaz (1983) comments on how patients feel discredited once in chronic pain. She found her patients unable to face potentially difficult situations or encounters and stated that they felt unable to participate in the normal world.

Physiological alterations

Bond (1979) specifies the physiological changes that occur when emotion is suddenly provoked as in pain. There is alteration in heart rate, respiratory rate, sweating and gastro-intestinal function. He notes that there are also subtler and more extended physiological responses to emotional changes. These are exhibited in disorders of the skin, muscular, skeletal, respiratory, gastro-intestinal, cardio vascular and other symptoms of the body. Bond continues that such elements may be prolonged or recurrent, dependent on the nature and duration of the precipitating pain.

Vlaeyan *et al* (1987) observed that patients in pain often need help rising after sitting for a while, they need help when leaving bed, they might wear a brace or walk with crutches. Patients in pain can need a wheelchair or have problems with the activities of daily living. They are likely to move rigidly and stiffly with stretched limbs, stand in an unusual posture or walk with an abnormal gait. Vlaeyan *et al* (1987) noted that patients in pain have bad mobility, walk guardedly and carefully and often with dragging steps. Patients change from one buttock to the other while sitting, they grimace, and move rigidly and shyly. It is not surprising then that Jensen *et al* (1991) report that many chronic pain patients express a belief that they are disabled and no longer functioning as able-bodied.

Concept of time

A less researched but still significant aspect of chronic pain and emotion is the way in which the patient in chronic pain has a changed concept of time. Henriksson (1995) points out that the patient's time aspect changes and that everything slows. Williams and Thorn (1989) point out that for the patient there is a consistent belief that pain will be enduring and that this belief is associated with the patient's subjective experience regardless of the age or sex of the patient or the actual pain duration. In Skevington's (1995) analysis she showed that the most important patient belief was about the temporal stability of the pain they were feeling, in other words how long they felt their pain would last. Skevington found that for the patient his pain appeared constant and enduring and long-term.

However, Ciccone and Grzesiak (1984) see the patient's relationship with time as part of an over-generalisation. They propound that the patient's belief that their present pain and misfortune will continue indefinitely is a form of cognitive distortion. They refer to this distortion as the 'fortune teller's error' and suggest that it is a form of inference that is directly or indirectly responsible for depression in many patients with chronic pain. They detail that it has direct relationship with the patient's experience of undergoing medical treatment often with disappointing results. Many patients in chronic pain jump to the conclusion that their predicament is hopeless and thus enduring. Such inference Ciccone and Grzesiak (1984) suggest, along with sufficiently negative appraisal, causes patients to become depressed.

Changes in sleep

One of the more physical changes that the literature comments upon is that the patient in chronic pain undergoes changes in their sleep patterns so that the patient in chronic pain often suffers considerable fatigue and sleep disturbance. Paice (1991) propounds that fatigue and sleeplessness are strongly associated with pain. Shacham *et al* (1984) documented that there is a strong correlation between pain, fatigue and sleeplessness. Dorrepaal *et al* (1989) noted that pain was related to difficulty in falling asleep and staying asleep. In a similar study of fatigue, Blesch *et al* (1991) observed that there was a significant correlation between fatigue intensity and pain severity.

Henriksson (1995) notes that symptoms of fatigue and sleep disturbance are often accompanied by generalised muscle pain. Henriksson (1995) cites Bengtsson *et al*, 1994; and Felson and Goldenberg, 1986; whose studies show that such symptoms of sleep disturbance rarely disappear. They note that the symptoms of fatigue, sleep disturbance and muscle pain influence a patient's daily performance and cause profound impact on all activities of everyday life. They observed that for patients in chronic pain up to 90% of their daytime was spent in either pain or muscle fatigue; fatigue they suggest is more disabling than the pain itself. The effects of fatigue mirror the effects of pain; tiredness, lack of well being and difficulties in coping.

Vlaeyan *et al* (1987) discuss the observable features of fatigue, the patient falls asleep during the day, lies in bed during the weekend, lies down between therapy sessions, rests on the way to therapy session, asks for a resting pause and sleeps between therapy sessions. They also noted that the patient in pain often fell asleep very early in the morning, or had difficulty falling asleep, woke up at night or awoke very early in the morning. Such sleep disturbances are typical of a high majority of patients suffering chronic pain. Fenichel (1945) gives an explanation for this. He states that sleep presupposes a state of relaxation. An organism flooded with pain, he suggests, is unable to relax and therefore it is understandable that sleeplessness and fatigue become one of the main symptoms for patients in chronic pain.

Isolation

Although there is a smaller body of research connected with patient's perception of isolation, the literature is emphatic about the effects upon the patient. Hilbert (1984) maintains that the experience of chronic pain was so isolating that sufferers could find no social resources to help them organise their experiences. He terms this 'a cultural dimension of pain'; that is, extreme isolation. Rose (1994) agrees that the effect of pain upon the sufferer affects their ability to socialise and thus cuts people off from society. As an outsider she states that one can only appreciate what it feels like for the patient through metaphor and this of course in itself isolates the sufferer from the rest of the world. Scarry (1985) extends this dimension of isolation and I explore her premise at length in chapter five.

Bowman (1994b) noticed that patients suffering chronic pain felt that they no longer had real friends. Some individuals experiencing such pain wanted to avoid people when they were hurting but others felt alone because they believed their friends did not contact them. Thus social isolation Rose (1994) suggests is experienced either as a conscious choice or as a situation imposed by others. The longer the pain continues Donovan M.I. (1987) maintains, the more isolated the individual becomes. Charmaz (1983) in a lengthy study on the social isolation of patients suffering chronic pain confirms that social isolation is a major consequence of the restricted life that chronic pain brings about. She notes that the lack of participation in work alone can result in social isolation. She detailed how few patients had developed intimate relationships beyond those that they had through their work or their family. Those who had built earlier friendships found that such friendships waned as friends were no longer able to share the same world as the ill person. Equality in relationships Charmaz noted was difficult, for visitors must always come to the patient in pain and reciprocity became difficult, resulting in the chronic pain person being left behind within the relationship. She also noted how the inattentiveness of former friends and relatives often shocked the ill person and created angry and resentful feelings. Thus isolation of the patient in pain grew from experiences of feeling discredited, embarrassed, ignored or otherwise devalued within social relationships.

Charmaz (1983) comments how from the patient in pain's point of view that isolation grows. When in pain the patient does not have the time, the energy or the concentration to sustain relationships. Lengthy hospitalisation also adds towards the drift into isolation and such lengthy absence further weakens whatever bonds might have existed in the past. Isolation continues to grow as the patient begins to feel a burden and negatively identified within his family and by friends. Yet above all it is the experience of pain itself that is isolating she suggests; the experience alone sets the ill person apart from others. She confirms how the pain experience focuses the ill person's attention upon himself and how continuous immersion in illness takes its toll upon relationships with others. As such the ill person frequently remains unaware of the difficulties and strains that they put upon their loved ones.

Thus pain can be a catch 22 situation, for even though the patient may desire and need more intimate social contact they are less capable of maintaining such as they become all-consumed with pain. Sadly if patients openly reveal their suffering and show self-pity, guilt, anger or other emotions conventionally seen to be negative, Charmaz (1983) states, they are more than likely to further estrange themselves from those who originally took an interest in them. Subsequently loneliness becomes most obvious and a visit from an attentive neighbour or a call from a relative can assume tremendous significance for the person suffering in pain.

Locus of control

The literature seems to be in almost total agreement that where the patient places the locus of control concerning their pain relates significantly to whether their pain can be increased or decreased. Pellino and Oberst (1992) state that a patient's perception of internal control of pain impacted on the amount of pain that they described. They confirm that a perceived lack of emotional support led to the patient dealing with their pain negatively. This agrees with Merskey's (1994) study. He propounded that it was quite common to find that patients who reported more intractable pain placed the locus of control outside their own power. Merskey maintained that if patients thought that they could do nothing about their pain they were less cheerful and optimistic and held greater negativity towards pain. Skevington (1983) shows that the more patients attribute events to chance happenings and not to internal control, the more likely they are to be depressed and distressed. Strong *et al* (1990) confirm the inverse, that the more that patients endorsed a sense of control over their pain the less likely they were to report that pain interfered with their daily functioning.

Crisson and Keefe (1988) similarly observe that patients who believed that the severity of pain was due to chance often suffered greater psychological distress. Flor and Turk (1988) report similar findings and determine that those in chronic pain who perceive they are helpless report the greatest severity of pain, greater intensity of pain and greater interference with activities. They also noted that such patients had increased visits to their physicians.

Turk and Rudy (1992) bring an added dimension to this theory. They note that for patients in chronic pain, a perceived lack of personal control is likely to be related to many ongoing but unsuccessful efforts to control their pain. Peck (1986) offers an explanation for this. He states that if patients believe that they cannot have control or terminate their pain then a learned helplessness is created. Patients may then become helpless and give up trying. Taylor (1982) suggests that in hospitalised patients there may be created a state of anxious helplessness. Friedman and DiMatteo (1982) point out patients in chronic pain often yield to the healthcare system and concede their most basic human rights including the ability to make decisions regarding their own bodies.

Charmaz (1983) comments that as long as an individual feels that he or she can exercise some choice in their valued activities and be able to have some freedom of action to be able to pursue such choices then their suffering is reduced and their self-image maintained. As Craig (1980) reminds us, loss of control is undoubtedly important in chronic pain and the ability to control experienced or impending physical pain can influence its emotional impact. He continues that as the patient pursues the round of health practitioners, the inability to find relief will contribute to feelings of hopelessness, helplessness, despair and pessimism about his future. He concludes that it is exceedingly difficult for people to resign themselves to chronic pain. Chapman and Gavrin (1993) note, pain can challenge and exhilarate the person who feels he can cope masterfully with it but it can evoke anguish from the person who cannot cope and who has insufficient resources to draw upon. Such a patient will see himself as helpless. They state that this perception of helplessness where there is a lack of physical, psychological and social resources is the key element of a patient's suffering. Finally Skevington (1995) concludes that loss of control can contribute to our explanation about why people become distressed and further incapacitated by pain.

The Meaning of Pain

Paice (1991) observed that meaning associated with painful events contributed significantly to the experience of the pain so that for example labour pain is interpreted differently to pain associated with surgery for mastectomy. The work undertaken by Craig (1980) evidences how people in pain eagerly and sometimes desperately search for information that would give meaning to their pain experience. Such meaning would provide relief and enhance recovery. Criddle (1993) also enforces that patients seek meaning from their pain experience. In doing so patients often reviewed their past decisions and examined their lives and values.

Rose (1994) gives insight into this search for meaning. She proposes that whilst acute pain has the function of warning sufferers that something is wrong, chronic pain is totally different. Chronic pain is not a meaningful event, but rather it is a meaningless situation. She suggests that if people are to adjust to a life, which includes chronic pain, they have to be able to see it as having a meaningful component. In gaining some form of meaning, Rose suggests, patients can gain a new role and perception of themselves other than a perception of suffering. In finding some worth in their suffering some patients are able to use pain in a positive way and consequently they are able to see themselves as something other than just a pain- afflicted person. Charmaz (1983) makes the point that we live in a society, which emphasises doing rather than being and for those patients who cannot perform conventional tasks and take a positive social stance or position then they lose the very means with which to sustain a meaningful life. As such she suggests that there are particular events that clearly mark the point in time when individuals consider themselves useless and their existence meaningless.

New Feelings

There was a small focus in the literature that concentrated on the fact that chronic pain created a series of new feelings for the person experiencing that pain. Kodiath and Kodiath (1995) explain that the experience of pain can evoke feelings within the patients that they had never thought about before, much less discussed. Charmaz (1983) calculated that for some patients pain became the foundation of re-evaluation and change of the self. She connected it with having periods of time when they felt they were free from the bonds of ordinary routine existence. Such freedom she presupposes heightens the consciousness of the patient as to who they are and who they wish to become. She suggests that for patients such as these pain becomes a tool of self-discovery and a fundamental source of later self-development. She notes however that it is important to acknowledge that those who are very seriously debilitated by pain and still in the throws of the crisis were much less positive about their experience of pain.

Bowman (1994b) sees such new feelings as a form of empathy where the patient experiencing the pain has an increased awareness and understanding of others who have had pain, something which they might not have paid attention to in the past. She notes that previously when such a patient had seen someone experiencing pain they might not have believed that the individual was really hurting until they had experienced pain themselves. Thus Bowman states that the experience of pain makes one aware that other people are also able to hurt.

Pain as Punishment

A small amount of literature also noted the relationship between pain and punishment or self-blame. Kodiath and Kodiath (1995) pose that pain is often seen by the patient experiencing it as a form of punishment. Often the patient would consider that they had failed in some way. They quote one of their patients as saying ‘I guess there is some lesson I am supposed to learn from this but I wish I could have learned it another way.' (194) Bowman (1994b) also quotes from one of her patients 'I have wondered a lot about it, but I don't know what the reason is, I don't know what but I feel it is because of something I have done.' (93) The study undertaken by Kiecolt-Glasser and Williams (1987) detail that a sample of 49 patients hospitalised for acute burn injuries show that self blame for the injury was found to be significantly associated with increased pain and greater depression.

Fenichel (1945) offers insight into this seeming need for punishment and self blame. Fenichel suggests that associative connections are immediately established between the pain and infantile conflicts that become activated within the patient. He suggests that old infantile threats and anxieties suddenly reappear when in pain and assume a serious character. As such these feelings arouse old conflicts between ego and super-ego and the patient reflects this with feelings of, 'it serves me right because I must be guilty.'

Relationships with Others

The literature has a great deal to say about the way pain affects patients relationships with others and the emotional changes that come about from that. Several major studies in this area have been undertaken, one of which was completed by Henriksson (1995).

The main outcome of Henriksson's study pointed to the disbelief from others felt by those suffering from chronic pain. A number of areas of disbelief were highlighted. Within the healthcare profession, patients who received continual referrals without getting information from their healthcare practitioners often believed that doctors were questioning their perception of their pain, frequently considering them malingerers. Similar distrust and doubt, Henriksson states, came from workmates and within the family. Patients found that others had difficulties in understanding and accepting the limitations that chronic pain brought. They felt that others expected them to take hold of the situation and improve with time.

The change in habits and the roles that accompany the chronic pain patient often create a problem within the family situation and cause a lack of understanding and impossible role expectations. It was not uncommon for people in chronic pain to experience marriage break-ups. Patients noted that friends and acquaintances distanced themselves and showed a lack of empathy or rejection. Henriksson (1995) points out that friends became frightened and disturbed by being in the company of patients experiencing heightened pain. He noted that the patients in this study felt that their symptoms, pain and excessive fatigue, were not taken seriously. Patients showed concern that they had either imagined they had a serious disease or that they must be imagining the pain. To imagine the pain meant to the patients that they could not trust their own perception or that they might have psychiatric problems both of which explanations led to negative consequences to the quality of their lives.

Rose (1994) also commented on how many sufferers felt they were not believed when they described their pain, particularly when no organic cause could be found. She states how patients felt they could not tell their relatives how they felt because they believed the family must get fed up and think 'what's the matter now.' Such disbelief Rose states creates additional isolation. The idea that patients were not believed or taken seriously further isolates the person suffering the pain. She quotes one of her patients as stating 'my family and GP abandoned me altogether.' (26) Rose propounds that even being referred from one doctor to the next was sometimes interpreted by the patient as a doctor's desire to get rid of them, believing that the patient 'was putting it on.'

Rose notes that the intensity of the pain often made the individuals unable to continue their ordinary life both in terms of physical day to day activities and in terms of relationships. Bowman's (1994a) literature review upon the way in which chronic pain affects people's relationships showed that individuals did not respond as they would normally have if they were not experiencing pain. In pain, patients became short tempered even though they did not intend to respond in that way and the amount of pain she suggests made it difficult not to respond negatively towards others. Many patients in pain become grouchy and snap at others.

Bowman (1994a) similarly discovered that patients often feared others would not believe their pain was real or present. She cites Hudgen (1979) in showing that patients became dependent upon their spouse or a significant other person, yet communication with that other person was often indirect and social contacts limited by the patient. This is confirmed by Payne (1982) who comments that 68%-87% of patients in pain showed poor communication habits, withholding of feelings, avoidance of emotionally laden topics and a failure to resolve conflict.

Faucett and Levine (1991) noted that interactions with others were significantly affected if pain was characterised by a lack of organic cause.

Such lack of organic cause for the pain increased uncertainty for others about the reason and intensity of the pain. They also note that as chronic pain worsens and disability increases, patients may minimise their complaints in an attempt to reduce the strain on those they care about and to try and forestall the distress that may come about by the burden of long term family care giving. They too note, that pain like depression worsens in a non-supporting social environment and that the presence of chronic pain unquestionably affects social relationships.

Discredited and devalued

Charmaz (1983) notes that for the patient in chronic pain, the experience of being discredited, embarrassed, ignored or otherwise devalued by others contributes significantly to the growing isolation of individuals in pain. She states that the person in pain does not have the time, energy or concentration to be able to sustain prolonged relationships. The effect of this is that continuous emotion and pain wears out family and friends and takes its toll on involved others.

Often the person in pain, because of his total involvement with his pain symptoms, is unaware of the strain that he places upon his family and friends. She propounds that visibility of obvious suffering causes friends and acquaintances discomfort, since obvious suffering rips away a public and social presentation of the self. This affects the normal social interaction. Charmaz (1983) details that for many patients being discredited by others causes considerable distress and she states that a patient's activities will be restricted rather than face potential discrediting. The intensity of the distress caused by being discredited will depend upon the relative importance of who is doing the discrediting, the situation in which the discrediting takes place and the amount of repetition of discrediting events. Such distress intensifies even further when the individual either feels forced to accept the discredited definitions and/or feels that these definitions further weaken their relationships.

Embarrassment

Charmaz (1983) continues that embarrassment accompanies discreditness. The greater the potential embarrassment from chronic pain the more likely the individual's self-concept will suffer and that he or she will restrict his or her life voluntarily. Bowman (1994b) details that subjects felt embarrassed in telling others that they were in great pain or needed to lie down. She records that feeling embarrassed prevented patients from telling others how much pain they were experiencing.

Restriction of a patient's life-style

There is a significant body of literature, which documents how chronic pain restricts the patient's life. Gamsa and Vikis Freibergs (1991) comment on how as the duration of a patient's pain increases so the emotional distress that he suffers is also likely to increase. With increased emotional distress and the physiological and behavioural changes that go with that, pain becomes more exacerbated and is more likely to persist, they suggest. Such behavioural changes from this situation typically involve social withdrawal and reduction in activity, which in turn lead to increased depression and physical de-conditioning. A cycle is set up as the patient does less and less. Any activity becomes painful and any further heightened association with distress continues to amplify pain and decrease physical activity. They note that the patient becomes trapped in a vicious circle with intractable pain intensifying emotional distress, which in turn exacerbates and perpetuates the pain.

Henriksson's (1995) study complements these findings. He states that ordinary daily life becomes limited for the person in chronic pain and some activities impossible to manage. Ordinary motor tasks such as cooking and opening jars can be difficult to manage, walking can also become too strenuous an activity. He cites how patients in pain have limited endurance and quickly tire especially when performing repetitive tasks or slightly physical work. This in turn induces withdrawal from activities. The patient can become anxious that they will be unable to manage the activities or will wish to avoid further pain from completing them.

Sense of Loss

A sense of loss accompanies such restriction in life for lack of fitness, mobility, and stamina bring about a sense of loss of use and of youth (Henriksson, 1995). Not being able to complete tasks influences the perception one has of one's self as young, healthy and in physical well-being. This responds to Charmaz's (1983) work. Charmaz proposes that when one is in chronic pain one lives a narrow, restricted life, which contrasts sharply with the lives of other adults. Individuals become aware that they cannot do the things that they valued and enjoyed in the past. She suggests that participation in events is much diminished from that of the past and as such values of independence and individualism combine to intensify the immobilising effect. Henriksson (1995) submits that limitations imposed by pain affect one's whole life situation so that there is a sense of a lost future, of not being able to choose freely, of always having to consider the limitations that pain imposes upon life. Henriksson proposes that the person in pain cannot fulfil their aspirations, expectations, and previous goals. They have to accept a lower level of achievement.

Bowman (1994b) also recognises the sense of loss of future. She propounds that when patients don't know whether they can live and exist with their pain they often describe the presence of their pain as messing up their whole life. She states for some the most difficult aspect about living with pain is the fact that they are unable to do what they could in the past and patients sense that they have little future.

Charmaz (1983), suggests that a loss of the self is a profound form of suffering in people who suffer chronic pain. She proposes that chronic pain creates a crumbling away of a patient's former self-image and this happens without a simultaneous development of equally valid new concepts of themselves. She states the experiences and meanings upon which individuals had built their former positive self-images are no longer available to them.

Loss of self-worth

Bury (1991) maintains that the onset of chronic pain represents an assault not only the person's physical self but also on their sense of identity. He upholds that this attack on the person's sense of identity calls into doubt their self worth. The loss of confidence in the body leads to loss of confidence in social interaction. Bury (1991) terms this a biographical disruption.

Further insight comes from Ciccone and Grzesiak (1984). They proffer that many of us believe that our worth depends on how well we perform. They state that if we perform in a skilled and proficient manner, we rate as good or worthy, but when we perform badly or ineptly as one does with chronic pain then we are considered as bad or worthless. They regard that any sense of self-worth based on a single good or bad performance is a mistake yet they observe many clients with chronic pain do exactly that when they cannot perform as they previously did. As such this is a form of over generalisation in which any evidence of diminished role, status or performance is apt to be interpreted by the person suffering chronic pain as evidence of personal worthlessness.

Levels of Stress

Very little research is evident in connection with chronic pain and levels of stress. Jensen *et al* (1991) proffers that there is significant relationship between the experience of stress and the incidence and severity of painful conditions. Turner *et al* (1987) identified that 35% of people considered pain as being the most stressful aspect of their lives. The effects of chronic pain such as the loss of income and marital difficulties may also be viewed as significant stresses.

Suffering

The literature has pertinent comments to make about the nature of suffering with reference to chronic pain. Chapman and Gavrin (1993) observe severe pain alone is sufficient cause for sustained suffering. They define suffering as a 'complex negative, affective and cognitive state, characterised by perceived threat to the integrity of the self.' (11) In addition suffering involves a perceived helplessness in the face of such threat and the exhaustion of psycho, social and personal resources for coping. They maintain that pain pervades every aspect of life and permits no time out even for sleep. Thus relentlessness becomes a major feature of suffering.

Skevington (1995) comments at length about the relationship between suffering and chronic pain. Suffering she propounds is an exceptionally unpleasant emotional response that is frequently associated with pain and distress. She proposes that suffering integrates many socio emotional components associated with pain. Cassel (1982) observes that suffering occurs when an impending destruction of the person is perceived. Suffering continues until the threat of that perceived destruction has passed or until the person's integrity can otherwise be restored. The greater the pain Cassel states, the greater the suffering. He points out that suffering not only occurs in those with severe and chronic pain, but also in those with minor pain if the pain's cause is unknown. Cassel (1982) maintains that suffering is also more likely if pain is believed to be uncontrollable. He maintains that suffering occurs in a wide range of social conditions and can be affected by the individual's body image and their fulfilment of social roles. Suffering similarly affects a person's identity and their identification with social groups.

Craig (1983) details the way in which suffering embraces the uniquely human quality of being able to anticipate the consequences of events. This has the negative attribute of enabling people to ruminate over their diminished capacities and goals. It allows the anticipation of prolonged distress and the contemplation of the possibility of physical disability, disfigurement and death.

Suicide

It is not too great a leap to make when suffering is at its greatest for the patient to consider suicide. The literature is succinct in respect of chronic pain and suicide. Bond (1979) briefly mentions that there is significant association between suicide and chronic pain, especially in older men but he does not develop this theme. Rose (1994) describes how her patients tended to describe their pain in extreme language. Words such as excruciating and phrases like, 'it could make you suicidal' and 'I felt like cutting my leg off with the pain' (23) were not uncommon. Bowman (1994b) noted how individuals spoke of suicide. One of her patients speculated on why others committed suicide whilst another said that he had decided it was not really an answer.

It is possible that the literature upon suicide and chronic pain is not more forthcoming because suicide is generally considered to be related to a combination of emotional feelings and practical difficulties rather than one specific dilemma.

Trauma

Fairly new to the literature in relationship to chronic pain is the experience of trauma. Muse (1986) asserts that only recently has data been presented which indicates that there is a prevalence of post traumatic stress syndrome amongst the chronic pain population and that this has been significantly misdiagnosed previously. He states that the distress of patients suffering from this syndrome cannot be over-emphasised. Not only do they have to deal with the discomfort and functional restrictions of chronic pain, but they are also faced with a terrifying phobic reaction, which completely threatens the patient's self-confidence. Aghabegi, Feinmann and Harris (1992) state that a substantial proportion of patients seen in their pain clinic may suffer from post traumatic stress disorder, a diagnosis they believe is frequently missed.

Fenichel (1945) describes the symptoms of trauma. He states that there can be stimuli of such overwhelming intensity that it will have a traumatic effect on anyone. Symptoms will include a blocking off or decreasing in various ego functions, spells of uncontrollable emotions, especially of anxiety and frequently of rage and sleeplessness or severe disturbance. He details how the concentration of all the patient's mental energy is put to one task which is the building of counter energies to master the intruding overwhelming stimuli. The urgency of this task makes all other ego functions relatively unimportant and the emergency of the task completely governs the person.

Skevington (1995) maintains that phobia and depression often accompany post-traumatic stress disorder and she states that pain itself may represent sufficient trauma to be the cause of post traumatic stress disorder. Tracey (1991) in observing cases in a burns ward in Australia notes that an autistic deadened psychic space can result from the trauma of pain. He upholds that trauma is a psychic wound caused by violent intrusion. An excess of psychic pain floods the ego, the psychic pain becomes unbearable and there is fear of fragmentation and death. There is unthinkable fear he proposes, so there is no thinking and hence no symbolisation. This creates within the patient an autistic, deadening quality. Tracey (1991) outlines the case of David, a child traumatised through burning. He describes David as lying staring into space, as if he'd given up, or as continually crying. David was unresponsive, unaware; his eyes were open but he was not looking anywhere.

Tracey researched psychoanalytic theory to try to understand the relationship between chronic pain and trauma. Laplanche and Pontalis (1973) chronicle that in psychic trauma three explicit ideas exist; the idea of violent shock, the idea of wound and the idea of consequences affecting the organism.

Thus for the person consumed with chronic pain the trauma comes from the terrible intensity of the pain. As such, intense pain becomes more than a psyche can cope with and denial, detachment and despair become symptoms of the psychic wound from pain. In effect trauma results from pain too great to be borne.

Trauma from pain can bring unthinkable fear and a loss of the capacity to think and to symbolise and therefore an inability to process the pain.

Withdrawal, depersonalisation and avoidance

It is fitting then that the final contribution of the literature that I wish to discuss in relation to chronic pain and psychological and emotional effects is that of withdrawal, de-personalisation and avoidance. Classen *et al* (1993) describes withdrawal and dissociation as a unique form of consciousness. They suggest that events that would normally be connected become separate from each other. This dissociation enables the sufferer to detach from overwhelming fear and hopelessness engendered by their intense pain. Kodiath and Kodiath (1995) suggest that withdrawal can be such that the effect of pain can even replace the basic desire to eat, drink and sleep. Attig (1996) confirms withdrawal as a loss of wholeness and with that loss of wholeness comes distress, anguish and suffering. Asmundson *et al* (1997) propose that withdrawal arises from an innate drive to reduce discomfort and thoughts and beliefs that will actively produce pain and suffering. This however is characterised by decreased self-efficacy and fear and further avoidance and disability.

Rose (1994) offers a different insight. She specifies that the overwhelming nature of chronic pain cuts off the suffering patient emotionally from the world in which they existed prior to such pain. This she proposes leaves the patient in a kind of limbo where they find it hard to understand or make sense of what was happening to them.

I conclude that the outcome of this literature review leaves no doubt as to the cognitive disruption and emotional impact that chronic pain has upon the patient. However it is also crucial for this study to investigate chronic pain from the patient's point of view. The recognition and understanding of such an experience is vital in that the pain experience 'has something fundamental to teach each one of us about the human condition with its universal suffering and death… We can envision in chronic pain and its therapy a symbolic bridge that connects body, self and society.' (Kleinman 1988 xiii). Understanding the experience of chronic pain is also vital in that as this review of the literature has shown confrontation with pain can be so overwhelming that people psychologically fragment into projections and denials, into a sense of depersonalisation, disorientation and denial of reality that is harmful and destructive.

7. Patient Pain Experience – Theories on the Paucity of Recorded Literature and Interpretations on the Conscious and Unconscious Reasons for this.

> 'My pain is a screech against an open, black, ripped, upside down sky. And the sky is my head, jagged and tearing, tearing, tearing. Sometimes I think it's on backwards because my teeth are in the wrong place. How can your own teeth gnash your own temple otherwise? The same way your temple is a fist all doubled up to really smash you with those steel knuckles, first icy cold, then fire hot; then flashes out in tough, ragged mandarin nails to scrape that same spot over and over. And there's a bruise – blue and purple and blood red – in the back of your eye. Your ear is being ripped off and the blood isn't blood but fire, stabbing in centimeter by centimeter down the back of your neck.
>
> And your neck fights back. It wants to be the sky so it sends the lightning back boxerlike in stiff jabs and explosion punches. Your teeth erupt and pelt you in the face; your ear bursts open and pastes itself against your eye; your eye recoils and shoots out through your temple and the blades and the whistles and the symbols and the blackboard chalk and the bombs and the jets all go off at the same time in a piercing scream. Then the rocket attached to the electric drill attached to the razors zooms down exactly on target to the temple. And a minute has passed.'
>
> (Bresler, 1979: 1)

Such a description of a migraine is one of the few patient experiences documented in the pain literature. It shows the voracity, complexity and horror of the chronic pain situation as the patient experiences it. However the literature connected with patient pain experience is a sparse and a relatively poorly researched area. Current literature contains no systematic study of this issue. Instead, there seems to be a small number of personal vignettes that highlight various idiosyncratic reactions to pain and further vignettes to show the impact of such pain on the patient's relationships and life.

A full search of the Medline and Clin. Psych databases was undertaken, searching the years 1920 to 2001, in order to trace documented literature relating to patient pain experience. It was relatively straightforward finding documented evidence regarding the psychological effects of pain (see Chapter 6) and the methods of treating pain (e.g. Craig, 1983, 1984; Gamsa, 1994; Leavitt and Garrond, 1979 and see Chapter 5). The research in this area divided mainly into two groups: standardised trials of some length carried out under controlled conditions and reported findings from clinicians in the field.

Similarly, there was considerable research documenting the attributes of the use of psychotherapy in the field of pain (Herman & Baptiste, 1981; Reinking & Tempkin, 1995; Whale, 1992; Lakoff, 1983; Miller, 1991, 1993). Only a very small percentage of papers suggested that psychotherapy offered little or no benefits to pain control. There was frequent reference to the success of pain-clinics, cognitive-behavioural therapy and relaxation techniques throughout the world. (eg. Asmundson & Norton, 1995; Many & Berg, 1995; Criddle, 1993). Indeed, much of the literature recommends a psychotherapeutic input for those patients suffering chronic pain (Priel *et al*, 1991; Baldoni *et al,* 1995; Miller, 1991, 1993; Basler,1993; Saarijarvi, 1992; Whale, 1992; Frierson *et al*, 1987). Although psychotherapeutic input was shown to be of benefit to patients in pain the databases revealed no psychoanalytic research examining the unconscious mental functioning of states of intense pain. Nor was there any research using the communicative approach in relation to states of intense pain.

Not only was it difficult to locate documented evidence regarding patient pain experience it also proved difficult in locating documented evidence regarding the unconscious mental functioning of states of intense pain and patient pain experience. The nearest research areas were connected with cognitive disfunctioning, cognitive errors and cognitive dimensions in chronic pain (see Willner, 1984; Lefebvre, 1981; Smith *et al*, 1986; Turk & Rudy, 1986; Cicconi & Grzesiak, 1984 and Chapter 6). Most of these papers describe the cognitive changes brought about by chronic pain or show how cognition plays an important role in the development, maintenance and treatment of chronic pain. They do not however explore these mental states further.

There is research connected with the traumatic effects that pain brings (eg. Doerfler *et al* ,1994; Shopper, 1995; Chessick, 1995; Schreiber & Galia-Gat, 1993). Such papers propose that pain has been unrecognised as being a core-trauma in post traumatic stress disorder and hence requires similar pain management offered to survivors of traumatic injury. They suggest that the traumatic reactions of pain are highly correlated with emotional distress, including depression, generalised anxiety and anger. However they do not document the experience undergone by the patient.

Perhaps the paucity of comprehensive work describing the patient's experience of pain is connected with expressions of avoidance and denial that are some times invoked when faced with the anxiety and guilt and vulnerability that accompanies the incapacitating pain. Lasky (1990b) offers insight into this predicament. He accepts that the mechanism of denial is enforced but suggests it is more than that. He maintains that catastrophic pain is not a common experience and unless forced to do so we prefer not to contemplate the issue.

Those who have undergone and suffered catastrophic pain, Lasky suggests, are too traumatised by the event and its aftermath to write about it.

It requires a considerable passage of time before one feels sufficient distance from the experience to analyse one's function within it with any confidence about the conclusions. Often the psychic effects outlast the pain itself and cause the anxiety - for the psychic ramifications remain perpetually traumatic.

Of course not every person in pain feels capable of writing a professional paper and may have no wish to do so, for writing such a paper publicly exposes oneself emotionally. The patient reveals his inner-most feelings at a very vulnerable time and disclosing very private information could alter ones reputation, one's ability to gain employment, and one's relationships. It also stays as a constant reminder about a state of vulnerability. Yet it is as if the paucity of literature is a 'conspiracy of silence' (Dewald & Schwartz 1993) 'reflective of the wish to avoid recognising the ultimately quite human desire to deny one's mortality and helplessness.' (191)

Interestingly I could find no writing by Freud about the effects of his pain on his work, even though he was a prolific writer and had suffered cancer of the jaw for 17 years. He not only survived 17 years of the jaw cancer, but 33 operations, severe pain and discomfort, difficulty in being able to speak, yet he made no mention about the effect of his pain on his ability to work. (Halpert, 1982)

It is vital for this study to address the issue of patient pain experience, for as Leder (1988) states, 'Successful medical treatment in most cases rests upon a certain co-operation and mutual understanding ... This is not possible unless they share a set of common presumptions about the nature of illness.'

(374) The pain experience of the patient also gives greater insight into a conceptual understanding of the chronic pain syndrome. I therefore review in some detail the few papers offering a first-hand account of a patient's understanding of his/her pain. Papers reflecting pain experience, although sparse, give clear evidence that a significantly changed mental state is brought about and that death anxiety is continually prevalent. Chessick (1995) attempts to throw light on the inner mental processes that went on for him immediately following traumatic pain (open-heart surgery). In his self-reflective phenomenological study he propounds, as I do, that the combination of organic assault, medication, post-traumatic stress and psychological injury involved produces an abnormal mental state that can better be treated if it is understood from the point of view of the patient.

Chessick (1995) in his paper describes his increasing sense of paranoia, isolation, denial and death-anxiety, following open-heart surgery. In his changed mental state his paranoia saw his surgeon as an evil magician enacting *contra naturam* acts on the operating table. He feared his soul would be removed and put into the body of his newly born granddaughter. Drugs did not help his paranoia; instead he believed he had discovered a great truth regarding the essence of life and the transmigration of the soul. Yet it is not the paranoia but the sense of isolation and death anxiety that stand out in his paper.

> 'My wife became irritated. She did not understand what I was talking about. She could not penetrate this mystery, even though I tried to explain it to her ... she could not penetrate my 'explanation'. She offered me another 15 milligrams of Serax... Having come upon a discovery of magnitude is there no one and nobody that I can share it with? And the answer seemed to be no. No one wants to know this... Nobody wants to take a walk and discuss this... There is nobody.' (173-4)

Indeed on later reflection he attributed much of his pain experience and psychosis to his own death-anxiety. Chessick (1995) upholds that such confrontation is so overwhelming that people can psychologically fragment into projections and denials, into a sense of depersonalisation, disorientation and denial of reality. He looked towards Heidegger and his concept of being-towards-death, claiming that, in boundary situations we are forced to face the truth about our vulnerability and may become psychotic and do things, which are ultimately self-destructive. Significantly Chessick ends his paper with the remark that:

> 'The most dramatic thing about my dramatic 'discovery' is that I am all alone ... There is no one to talk with and no one wants to know this information. Everyone wants to deny it and we have knowledge, each of us privately to ourselves which we are born with and which we die with alone.' (178)

Bradley-Springer (1995) describes her personal experience of the overwhelming experience of pain in the following way:

> 'I wake slowly, dragging into consciousness. It is dark except for streetlight filtering through Venetian blinds. As I approach awareness I recognise that something is wrong, I should not be awake at this hour of the early morning. And then I feel the pain. My pulse is pounding and my respirations are irregular. I try to calm myself with deep breathing techniques. I breathe in through my nose, starting to count, but can barely make it to three when I learn that breathing is a mistake. That one, regulated effort to breathe sends my body into spasm. The pain is extraordinary. It starts at the base of my spine and rapidly moves up, down, and out in waves that shatter my composure. Instead of controlled breathing, I now hold my breath, afraid to inhale. At the same time my spine arches and I contort into a 'C' of rigidity. My face screws into a grimace.' (58)

At the end of Bradley-Springer's (1995) account, although recognising how pain has been analysed, recognised and explored by the scientists in a physical, social and psycho-social way, she maintains 'Pain is highly individualised and ultimately, pain is what the individual says it is.' (60) She raises pertinent questions such as, 'Is pain real only if it can be externally perceived?' (60) The question is pertinent because medical clinical judgements can be based on such external perceptions and objective perception of pain frequently takes precedence over the sufferer's analysis.

Using Schrag's work (1982), Bradley-Springer is able to identify the change in her mental state or 'field of consciousness', as she defines it. She notes (1995) her change in judgement and conceptual understanding when engulfed by pain. 'During the event I was intensely focused on pain, my concerns and myself. I could not have attended to less immediate concerns. When the pain was severe, I lived a body of pain'. (63) This essential component of the pain experience details how our experience of our own existence is transformed from one of control and self-preservation into a fear of death. It also offers a sense of 'how unfree, transitory and helpless we really are and how life is essentially capable of becoming an enemy to itself' (Buytendijk, 1962: 27). Bradley-Springer (1995) powerfully describes this changed mental state.

> 'Pain shattered my ability to maintain order and had consequences for the moment but also for the long range: how would pain change my life? Answers to that question would reveal a basis for my fear, my anger and the struggle to regain jurisdiction over my errant body. I experienced dependency and powerlessness and I raged against that helplessness. Pain meant loss of control and that loss threatened my definition of self, compounding my feelings of frustration, decreasing my ability to find relief and leading to a fear of my very existence.' (64)

Added to this, there is a changed sense of time that pain brings which can create an experience of the everlasting now. In pain there is only now, with every second distorted to feel like eternity in the sufferer's reality. Because pain occurs within a human body in a manner that is not shareable with others (Buytendijk 1962, Scarry 1985) isolation within a conscious state is complete and pain victorious. Benner and Wrubel (1989), Bollnow (1967) and Bakan (1968) also explore how this division of the self from others becomes a further destructive element for the sufferer in pain.

Significantly Bradley-Springer (1995) concludes her paper by suggesting that people in pain be allowed to tell their stories. Scarry (1985) concurs that an interchange of the pain experience allows the sufferer to 'externalise, objectify and make shareable what was originally an interior and unshareable experience.' (16)

For anyone other than the person in pain, such stories mean little, hence the sparse literature of personal pain-experience and often the blank perceptions of medical staff if pain does not fall within normal parameters. Leroux (1996) suffered with chronic pain for 10 years before a rare spinal condition called Syringomyelia was diagnosed. In the early days she tried to describe to her family how she felt. They wanted to believe her but found it difficult. Eventually she wrote about her pain in fictional terms and handed it to her brother:

> 'A pack of wild dogs has taken permanent residence inside me. They curl up in my muscles and scratch fleas off my nerve endings. Snapping and snarling, they never settle. Sharp claws rake my guts as they fight for position. Recruits are admitted to the pack grudgingly, but have to fight to the death for acceptance. Irritable and snappish, they sink sharp teeth into soft flesh upon awakening. I tire of them constantly yapping at the gates of my defences. The dogs become angry at my attempts to drug and ignore them. Codeine infuriates them. They snarl viciously and gnaw upon the bones of my resistance, grunting and mewling. I can feel their hot saliva. Their stinking breath.' My brother looked at me and passed back the paper. 'I would get a cat if I were you,' he said.' (51)

Leveaux (1996) too found her mental state altered. She was crippled with fear and indecision; fear of death, wishing for death as a cessation of the chronic pain, fear of pain, fear of everything. She became incapable of making the smallest decisions. 'Soup for lunch? A sandwich? No soup. No sandwich. Soup. Sandwich.' (51)

A leading psychiatrist writing in 'The Psychiatric Bulletin' (1996) does not disclose his name when describing his psychological experiences, after the prolonged pain of severe head injury. This may suggest his anxiety of a reaction of disapproval from his medical colleagues. However, his experience of being a patient in pain has altered his way of being with his own patients, for his experience of getting better was of essentially, 'regaining some cerebral abilities I had lost. I remember feeling perturbed that those around me did not know what I was thinking or what my preferred action in any situation would be.' (239) He ends his unsigned personal view with a plea to the medical profession for a little more patience and understanding and a request not to retreat into stereotypes when considering a patient's situation, but to listen.

The anxiety of humiliation or disbelief from those in authority could in part explain why by far the most revealing source of patient pain experience that is available is not found in textbooks or published papers but on the Internet. Within bulletin boards and support groups, written anecdotes and records of pain experiences are all charted within this new medium of communication.

Chapman (1997) has analysed such cyberspace pain sites. He puts forward that there are two main groups of sites. One group of sites formally represents national patient advocacy organisations, while the other consists of personal pages that pain patients have developed on their own. The former Chapman (1997) suggests, 'tells us something about the issues surrounding the social reality of pain in our society and the latter about the personal experiences and needs of people who suffer from chronic debilitating pain.' (1) Patient advocacy sites differ enormously in size and character. A few of them provide basic contact information and mission statements about the organization. Whereas others are much larger, artistic, and visually striking information resources which provide clearly articulated objectives. Various healthcare providers and experts endorse the objectives of the better developed sites, and in many cases, they contribute information or advice.

Why have such organisations sprung up? And what implications, if any, do they have for pain researchers and clinicians? Chapman (1997) has examined the sites and suggests that such web sites have six main criteria:

1. To publish information, educate, and conduct outreach efforts. All of the organisations call attention to the incidence and prevalence of a painful condition and strive to make the population as a whole aware of the suffering that the condition causes.
2. To lobby governments and influence funding.
3. To change awareness of the painful condition in society as a whole and particularly in the work place. Employers sometimes fail to recognise the nature of painful conditions and the special needs of afflicted employees. Patients with irritable bowel syndrome, headache, or interstitial cystitis may require special consideration in the

vocational setting. These organisations try to help their members with problems related to vocational adjustment by informing employers about the effects of their medical conditions.

4. To influence healthcare policy and medical practice. These organisations advocate for the rights of their members. For example, they address the problems pain patients have in getting access to opioid drugs. Naturally, this causes raised eyebrows. They express concerns that physicians know too little and often hesitate for the wrong reasons to prescribe opioids for patients who could benefit from such treatment.
5. To meet the informational and psychological needs of members-- Patients with headaches or other debilitating conditions typically want as much information as possible on the condition and how they can cope with it. These organizations work hard to collect and disseminate such information. In addition, many of them serve as 'science watchers' by providing progress updates on the understanding and treatment of the painful condition. They also actively watch for potential new treatments on the therapeutic horizon.
6. The organisations help people with debilitating pain to contact others who suffer from similar problems. In part, this meets a simple fellowship need, but there is a substantial sharing of coping skills through chat rooms or discussion forums at some of the WWW sites. For example, a migraine patient writes that putting her hands in ice water for 5 minutes aborts her attacks and hopes that this will help others. A fascinating feature of these sites is that they allow

> geographically separated patients with rare conditions, who would otherwise never meet, to find one another via a society in cyberspace.(3)

Exploring the shared advice and patient dialogue at several sites gave Chapman (1997) the strong impression that having a chronically painful condition without obvious accompanying physical pathology creates a sense of social alienation. To maintain jobs and normal family roles, the patients must minimise symptom presentation in their everyday lives by hiding their invisible handicaps. Intense pain may be a private experience, but its consequent disability is not.

One specific feature of these sites is that instead of expressing frustration and anger toward healthcare providers who fail to cure or control the painful condition, they advocate for constructive solutions such as more research and dissemination of knowledge. They are valuable windows on the experience of patients living with debilitating pain. Moreover, they reflect the culture of specific painful conditions; that is, what patients believe about themselves and their illness. Fibromyalgia for example is considered a medical diagnosis and a pain syndrome, but fibromyalgia patients have evolved an elaborate set of shared beliefs and attitudes that possibly affect their clinical presentation and response to intervention. Understanding the culture attached to a diagnosis might add to an enhanced understanding of chronic pain.

This journey into cyberspace suggests that patient advocacy groups can serve as important allies in endeavors to encourage shifting research funding to pain. More fundamentally, the very existence of these organizations demonstrates a need for further research in areas such as fibromyalgia and other pain conditions requiring better definition.

Uniquely, these 'web sites give immediate communications of the pain experience from the 'patients' themselves: they have not been intellectualised or medicalised. In fact, these communications have not been processed through any formal discipline at all. This is what Beverly Burton (1998) posted on the Internet:

> 'I have 3 distinct kinds of pain resulting from a high speed rear-end auto accident. I have been diagnosed with facet syndrome, severe myofascial pain dysfunction, herniated C4-5 disc, closed head injury (termed as mild although I have a documented loss of 20% of my IQ), and post-traumatic stress syndrome.
> After the 'acute' phase (which lasted about 4 months) where all I knew was that I was in excruciating pain every minute of every day, I began to notice different types of pain. One kind is that I feel achy and stiff all over from the moment I awake. My body is weak and sometimes I have trouble raising my arms or closing my hands. I have screamed in pain trying to open the refrigerator door (even using both hands.)
> If I'm in one position (say in a car) for 30 minutes or so, I stiffen up again and have trouble moving and standing up straight. I call this a 'good pain day.' I avoid going into the freezer section at the supermarket because cold temperatures immediately make me stiff (I keep the house at 80 degrees now and sleep with heating pads -- in Houston!). Some times I can't even stand a breeze blowing on my skin.
> I have trouble staying asleep (even with sleeping pills) because while I am asleep, I don't move and so the myofascia and muscles tighten up. I wake up when I turn over because of the pain and then it takes about 45 min. to an hour to get comfortable enough to fall back to sleep.
> The 'bad pain days' are like nothing I've ever experienced. I lie in bed not moving and still my body screams in pain. It is searing and feels like white heat coming from the core of my body. It radiates out to every inch of my body. This is not like a surface injury that you can rub or put a salve on -- it's like it comes from your soul. It can last from a few hours to a few days. Narcotics do little more than take the edge off. NOTHING helps this kind of pain; I just have to wait it out. Sometimes I feel like killing myself -- not because of depression -- but because it's the ONLY way I can figure out to stop the pain.
> The third kind of pain is electrical jolts that travel down my arms and legs. I refer to them as cattle prods from the inside. They come and go and usually only affect one limb at a time. They leave that limb

> paralysed for a few seconds and then the limb becomes weak for a short time. I consider these more of a nuisance because compared to the bad pain, everything else in the world seems inconsequential.
> Living through all of this leaves me constantly exhausted because I feel like I'm at war with my body. I try to pace myself and be careful how I move. I always worry about when the next bad pain day will be. I constantly dream I'm dying or being murdered. I dread the following day.
> I am lucky enough to have a team of doctors who are experts in their field. I should be getting facet and trigger point injections every 3 months, but haven't been able to get them lately because of the cost (they're done under anaesthesia in the hospital.) Until I start getting relief from the insurance company or qualify for SS disability, my doctors are trying to keep me 'comfortable' with narcotics, sleeping pills, anti-depressants and a lidocaine/ketoprophen topical cream.
> I used to think that these medications were making me stupid until we did testing and discovered the brain damage. The doctors console me by saying that I should be happy that I was a genius (member of Mensa) pre-morbid, and that I now have only a slightly higher than average IQ. They said if I had started out average, I'd be a vegetable now. Some consolation, huh?' (1)

Such accounts are overwhelming and disturbing for the listener and go some way further as to understanding why there is so little documented evidence in the medical literature on patient pain experience:

1) Such accounts overwhelm the listener psychically
2) They leave the listener feeling helpless, yet wanting to rescue the patient from and resolve the situation of such chronic pain.
3) Such rescue and resolution often prove impossible leaving the listener with unresolved guilt.

On the Internet chat-lines and support groups however, others in a similar situation, seem able to stay with the patient's pain in a way that is not available in normal day to day living. Being in a similar pain situation they appear not to be so overwhelmed or guilt ridden and can therefore offer a form of support that seems critical. Such e-support groups and chat lines attract hundreds of 'hits' each day.

The main text that documented patients' pain experiences was Kleinman's, 'The Illness Narrative' (1988). In this text Kleinman powerfully outlines the pain experiences of his patients during his medical career spanning three decades. Using the patients' experiences he explores their pain and uses their narratives to discover the effect of pain. He argues that the study of the experience of pain:

> 'has something fundamental to teach each one of us about the human condition with its universal suffering and death... We can envision in chronic pain and its therapy a symbolic bridge that connects body, self and society. This network interconnects physiological processes, meanings and relationships so that our social world is linked recursively to our inner experience. Here we are privileged to discover powers within and between us that can either amplify suffering and disability or dampen symptoms and therefore contribute to care.' (xiii)

He further argues that the interpreting of illness experience is a core task in understanding something fundamental about life generally and chronic pain in particular.

The main concepts of the book are divided into three areas. Firstly, Kleinman analyses the meaning of pain; secondly he details accounts of patients' particular pain experiences. He uses patients' pain narratives to highlight different aspects of pain meaning. Thirdly he offers a guide as to how such pain experiences can be used by the medical profession to improve care. The final emphasis of his book is the suggestion that if the meanings of the pain experiences are taken as a starting point then the very understanding of medicine is challenged.

Throughout the book extensive use of patients' quotations through direct transcripts bring an immediate and powerful presence of pain.

Descriptions of Kleinman's interactions with patients in pain show how the power of pain affects lives. I quote in full such a description:

> 'The first patient was a pathetic seven-year-old girl who had been badly burned over most of her body. She had to undergo a daily ordeal of a whirlpool bath during which the burnt flesh was tweezered away from her raw, open wounds. The experience was horribly painful to her. She screamed and moaned and begged the medical team, whose efforts she stubbornly fought off, not to hurt her anymore. My job as a neophyte clinical student was to hold her uninjured hand, as much to reassure and calm her as to enable the surgical resident to quickly pull away the dead, infected tissue in the pool of swirling water, which rapidly turned pinkish, then bloody red. Clumsily, with a beginner's uncertainty of how to proceed, I tried to distract this little patient from her traumatic daily confrontation with terrible pain. I tried talking to her about her home, her family, her school – almost anything that might draw her vigilant attention away from her suffering. I could barely tolerate the daily horror: her screams, dead tissue floating in the blood-stained water, the peeling flesh, the oozing wounds, the battles over cleaning and bandaging. Then one day, I made contact. At wit's end, angered at my own ignorance and impotence, uncertain what to do besides clutching the small hand, and in despair over her unrelenting anguish, I found myself asking her to tell me how she tolerated it, what the feeling was like of being so badly burned and having to experience the awful surgical ritual, day after day after day. She stopped, quite surprised, and looked at me from a face so disfigured it was difficult to read the expression; then, in terms direct and simple, she told me. While she spoke, she grasped my hand harder and neither screamed nor fought off the surgeon or the nurse. Each day from then on, her trust established, she tried to give me a feeling of what she was experiencing. By the time my training took me off this rehabilitation unit, the little burned patient seemed noticeably better able to tolerate the debridement. But whatever effect I had had on her, her effect on me was greater. She taught me a grand lesson in patient care: that it is possible to talk to patients, even those who are most distressed, about the actual experience of illness, and that witnessing and helping in order that that experience can be of therapeutic value.' (15)

From such accounts Kleinman (1998) argues that by examining how the person in pain views their world it is possible to break the viscous cycles that amplify distress. Interpretation of pain meaning, he suggests, can:

> 'liberate sufferers and practitioners from the oppressive iron cage imposed by a too intensely-morbid preoccupation with painful bodily

> processes and a too technically narrow and therefore dehumanising vision of treatment respectively.' (9)

Although working from a different perspective Kleinman incorporates part of the basic premise of communicative theory regarding unconscious communication and narratives. He quotes from Rycroft (1986) 'unscientific utterances can and indeed usually do, have double meanings, ... and may indeed mean the opposite of what they apparently mean...' (272) In recording accounts of patients' pain experiences he regards patients' narratives as particularly important. He states:

> 'the reader should be aware that the emphasis in each of these lives of pain patients is on their experiences as revealed by my interpretation of their narratives. I do not spend much time on their treatment nor do I recommend in this context a specific course of therapy'. (60)

In treating over 2000 pain patients he comments on three major aspects of pain particularly relevant to this study:

1. Virtually all chronic pain patients experience those around them (chiefly medical practitioners and family members) as doubting the authenticity of their pain experience.
2. Pain is a total lived experience.
3. Death anxiety issues are raised

Such pain experiences of many of his patients are recorded. A typical vignette from the text tells of the pain experience of Howard Harris, a police lieutenant. Harris characterises his back pain as 'pulsing, flashing, stabbing, sharp, gnawing, burning, hot, stinging, tender, exhausted, fearful, punishing, annoying, tearing, nagging.' (63) Howard has been transformed by his illness:

> 'it changed me, I've become fearful, afraid of injuring my back. I never thought about, worried about getting hurt. But now all I think about is the damn pain. I don't want it to get worse. I can't tolerate it. I am afraid of it. Yeah, me, I am afraid of it. I'll be honest with you, I haven't told anyone else Doc, I think it is turning me into a coward' (64).

Howard's experience of trying to gain respite from his pain is indicative of the overwhelming nature of pain. Kleinman explains how Harris has gone through almost every available orthodox and alternative treatment for his chronic pain during the twenty years that it has, as he puts it, 'screwed up my life'. He has seen:

> 'Dozens of physicians of almost every variety: orthopaedists, neurosurgeons, neurologists, anaesthesiologists cum pain experts, internists, family physicians, rehabilitation experts. He has also visited members of health professions that surround pain clinics: nurse practitioners, physical therapists, acupuncturists, medical hypnotists and experts in biofeedback, meditation, behavioural medicine, massage and hydrotherapy. He has attended pain clinics, pain classes and pain groups; he has read medical as well as self-help books on the back. Lieutenant Harris has had four major surgical procedures on his spine and in spite of feeling that the pain became much worse after each he is fearfully contemplating a fifth.' (61-2)

Of all the treatments he has undertaken only ice packs, rest and medication make the pain less intense though nothing makes it disappear.

> ' 'Extreme pain' which Howie mentions with his deepest grimace, his eyes dilated, tearful and intensely focussed in front of him in an expression approaching horror, lasts only a few hours and occurs very infrequently. Yet it is so terrible that he confided in me once it would be better to be dead than have to experience it again – although he immediately added, 'And I'm a born-again Christian and would never consider suicide.' It reduces him to the state of a cringing, terrified survivor feeling utterly helpless and devastated, barely able to hold on.' (63)

Kleinman describes how pain leads to withdrawal and to isolation. For Howie this means going into his room, locking the door, closing the curtains, turning off the light and lying on the bed trying to rest and find a position that reduces the tension of the muscles. He holds an ice pack against his back and tries to cool the hot burning nerves. He is unable to talk to others or the pain worsens. He is unable to tolerate noise, light or pressure. He isn't even able to tolerate his own thoughts. Family life is destroyed and his children and wife are bitter. They resent his pain and find it difficult to express their frustration and anger to him. His son exclaims, 'He's a ghost. We never see him.... I can't stomach hearing about the pain. How do we know it is as serious as he says? I mean, I believe him but you can't see it. He isn't dying or anything.' (68)

The effect of such resentment means that Howie is no longer able to trust others and his confidence in himself and his body have diminished. He also feels bitter but in addition he feels spineless and lost. The frustration is further felt by his medical practitioner who believes that his patient is a 'somatizer' who amplifies his symptoms and disability; a problem patient. Kleinman (1988) states the view of the medical practitioner as follows:

> 'He [Howie] is pathetic. He is half his own problem. He's basically given up. What can I do? He comes to me in pain, I've got to give him something. I don't feel there is much we can do, really. I can't bear to see his name on the list of patients in my clinic.... I feel up against the wall. I've sent him to all the specialists and used all the latest drugs. I don't think we are any longer dealing with a disease, this pain has become a way of life.' (71)

So disturbing are such vignettes of pain experiences gathered over thirty years that Kleinman(1988) finally sums up his life's work by questioning medical science and clinical practice:

> 'What is needed is a kind of care radically different to what is now routinely available... indeed I have come to believe that this life in pain.... teaches us that our science as much as our clinical practice is at fault in the repeated failure to understand pain and it's sources; we are unwilling to take the meaning of pain as seriously as we take its biology.' (73)

Rose (1994) takes the unusual step at the end of her study to comment,

'gaining a first-hand account of what it was like to suffer from chronic pain made me realise how cruel it was to label chronic pain patients as having a particular personality or to ascribe to their symptoms a psychological cause, as if the pain was their fault. What I discovered in talking to these people was that they were desperate to resolve their situation.' (27)

Morris (1991) also affirms a similar stance, 'the story of pain cannot be reduced to a neat parable about bio-medical progress ... It is my premise ... that we need to achieve a new understanding of pain that allows us to recover the voices that mainstream medicine have rendered more or less unheard ... the voices most often neglected belong of course to patients. (2)

Kleinman and Morris's contentious interpretations regarding pain treatment perhaps also go some way to understanding further why there is so little literature to be found that seriously investigates the patient's pain experience. Indeed it is clearly documented that doctors and nurses do not believe the intensity of the pain experience as described by their patients. (Hammond, 1979; Krivo & Reidenberg, 1996; Henriksson, 1995; Vlaeyen, Van Eek *et al*, 1987; Bruera, Fainsinger *et* al, 1992; Swanson, 1984) This is intriguing and fundamental to this study for the victory of pain is significant if those who have closest care for patients in pain doubt the validity of the patients' pain experience.

The literature concerning the undertreatment of pain is not only vast (Marks & Sachar, 1973; McGruney & Crooks, 1984; Twycross, 1975; Cohen, 1980; McCaffery & Hart, 1980; Reuler, Girard & Nardone, 1980; Perry & Heidrich, 1982; Weis *et al*, 1983, Perry, 1984 etc.) but conclusive. The studies are quite clear that doctors and nurses believe that their patients' pain is really less than the patients say it is. Krivo and Reidenberg's study (1996) states that 67% of doctors and 33% of nurses surveyed thought that pain was really less than patients stated. Seers' (1987) research found that nurses consistently underestimated the intensity of patients' pain. For 77% of the time her research showed that nurses and patients did not agree about the intensity of pain with 54% of nurses rating the patients' pain at a lower level than the patients and 13% rating at a higher level than the patients. *Figure 2* shows the averages of 221 separate pairs of nurse/patient ratings.

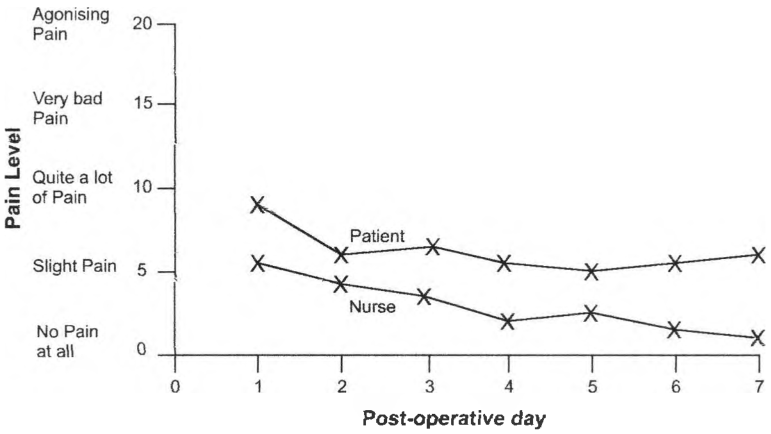

Figure 2 Nurses' and patients' mean daily ratings of patients' pain

As the nurses consistently rated the pain as being less than did the patients, it seems that pain is not assessed systematically (Seers, 1988: 206).

Attitudes towards the effect of pain relief also showed that medical staff disbelieved patients' descriptions of their pain, with 75% of nurses feeling pain killers met the needs of patients whilst nearly one third of patients felt they had not been able to have pain relief when they needed it (Seers 1987). Marks & Sacha (1973) studying the problem in New York hospitals found 73% of patients suffered moderate or severe distress because insufficient narcotic analgesia was administered. A similar study by Sriwatanakul *et al* (1983) found that a substantial number of patients who were suffering from moderate or severe pain were given only 70% of the maximal ordered analgesic dose often at inflexible intervals. Subsequent questionnaires completed by medical staff indicated that the staff's views did not agree with the accepted pharmacological suggestion of optimal dose and duration. Cohen (1980) found 75% of post-operative patients were in moderate to severe pain even though narcotic analgesics had been prescribed.

In a similar vein when interviewing doctors, nurses and health professionals about how they communicate with their patients about pain DiMatteo & DiNicola (1982) found that the professionals were prone to use disconfirming messages, so that often they denied the existence of pain and would not let their patients disagree. Such denial of the existence of the intensity of pain was confirmed in Dangott, Thornton & Page's (1978) study of the interactions of health practitioners' styles with patients. This too showed that health practitioners gave a 'disconfirming response and often a denial of patient's pain.' (30) The results of their study showed that social workers were more attentive to pain indications than doctors or nurses. The study by Baer, Dovitz & Lieb (1970) considered the inferences of physical pain and psychological suffering in relation to verbal and non-verbal patient communication. They found that the people having the greatest amount of physical contact with patients, the nurses and doctors inferred the least pain. Their study showed that teachers and nuns were more aware of pain in patients in stages of their illness than health professionals.

Zborwski's (1969) renowned paper concerning behavioural differences in ethnic groups showed that doctors differentiated 'between correct and incorrect behaviour in pain according to criteria held by their profession ... they expressed their values in describing their patient's behaviour as over-exaggerated, over-emotional and hysterical or as stolid, mature or masculine.' (4) Zborwski's survey showed that according to doctors' opinions some groups of patients took their pain well whereas others were 'nuisances and alarmists'. In effect doctors used qualifying adjectives that implied definite value judgements.

As Bond (1980) also discovered, health professionals admired and highly regarded patients who endured pain with little or no complaint. They rewarded them with admiration, sympathy and more pain-killing medicines whereas those who complained of pain (especially if regarded as unnecessary or excessive) were punished by expressions of disapproval both verbal and practical. Even in emergency departments pain was found to be undertreated (Wilson & Pendleton, 1989; Selbst & Clark, 1990) with 44% of patients with painful conditions receiving no analgesics and 69% waiting at least one hour before receiving analgesics.

Such negative reception by the health professions is experienced by patients in pain as being difficult and destructive to them. Henriksson's (1995) study explores the contradiction between the patient's experience with pain and the inability of the doctors to find organic causes. Patients find the experience frustrating and degrading, reporting a lack of empathy, interest, and disbelief from the doctors. Henrikkson (1995) quotes some of the doctors' comments that cause such frustration, 'It's all in your head', 'There is nothing wrong with you', 'You are overworked and it must be nerves', 'Try to be positive and pull yourself together.' (70) This confusing incongruity between the patients and doctors creates considerable ambivalence on both sides. 'The doctor said, 'You're depressed, you need to get out of the house ... (get) ... a job.' I said, 'I am not depressed I just want to feel better and I love being at home.' I wasn't depressed being at home taking care of my family.' (Henrikkson, 1995: 70)

Understanding pain is central to the medical profession yet these and many other studies (Blackman, 1980; Demjen & Bakal, 1986; Gamson, 1990; Leavitt & Garrond, 1979; Merskey & Boyd, 1978) show that accepting the experiences of patients' pain is a potential problem with no real systematic pain assessment or relief. As Seers (1987) states, 'It seems essential to assess pain individually with patients as they are the only authority on their pain.' (38) The difficulty comes when medical professionals do not even realise their deficiencies in this area.

In light of these facts it seems relevant to question why such negative treatment, undertreatment and limited expression seems the acceptable means of proceeding within some areas of the medical profession and to question why there is so little accountability for the situation.

Dangott, Thornton & Page's (1987) comprehensive review of the literature proposes that in the case of the social workers and medical practitioners, the social workers were more aware of pain indications because they had closer contact with their patients. Social workers were also trained to be aware of both verbal and non-verbal communication signals. Coulthard and Ashby (1975) highlight communication as a key issue. They observe that most communication between doctor and patient are doctor-initiated and information-seeking exchanges rather than patient-initiated information-giving exchanges. The doctor tightly controls the situation, the effect of which is that the 'role of expressive and communicative aspects of the patient relationship are underestimated in importance by the medical profession.' (143) Nash (1974) suggests that pain itself hinders communication in such a way that ill patients often do not hear what is said to them by health professionals. The literature further shows that the technical language of the professionals hinders their ability to communicate with their patients. Patients and doctors do not share the same language or understanding of jargon. (Vowels, 1970; Jan, 1964; Spaan, 1964; Collins, 1955; Skipper *et al,* 1963). Indeed the study by Golden & Johnson (1970) found that out of 25 physicians only one made any attempt to see whether his patient had understood his explanations and diagnosis. Dangott, Thornton & Page (1978) are in fact quite damning of health professionals' communication skills. They suggest that there is among health professionals a 'lack of skills and no available positive model for communicating about pain.' (34)

Why should communication be so poor when listening to, communicating with and observing behaviour are considered such important diagnostic tools? Baer, Davitz & Lieb (1970) wonder whether it is because constant patient contact blinds doctors and nurses to patient pain. They question whether medical professionals feel so overwhelmed by the patient's pain that they have somehow built a protective shell around themselves so that they will not be bombarded by the patient's pain. They also consider whether it is simply that patient pain is so much part of practitioner's everyday routine, that it is something that no longer holds for them the significance that it did in their training days; the 'familiarity breeds contempt' syndrome.

Hunt *et al* (1977) put forward five observations regarding how patients see their own pain and the efforts of doctors and nurses to relieve it. They suggest that:

1. Patients' expectations are often too low, as indicated by the unanimous praise for both doctors and nurses, despite in many cases their still being in pain.
2. There is room for improvement in the use of analgesics in patients with protracted pain as indicated by the high proportion of 'as-required' prescriptions.
3. Doctors do not appreciate fully that the effective analgesic dose varies from patient to patient, as indicated by the presence of remittent pain in patients receiving analgesics regularly every four hours.
4. Nurses accept the presence of unrelieved pain in patients too readily, as indicated by the practice of confining enquiry about pain to drug rounds and by ignoring non-verbal communications.

5. Nurses do not appreciate their potential as agents of pain relief as indicated by their failure to emphasise their specific contribution as nurses. (61)

Such observations however do not entirely explain the pattern of under-medication and poor response to patient pain. Doherty (1979) suggests that the experience of nursing people suffering with chronic or prolonged pain is a draining experience often associated with guilt. Although for the victim prolonged pain is a demoralising and frightening experience often resulting in anger towards the doctor or nurse giving treatment, anger is similarly felt by the professional in reaction towards the individual whose pain will not go away. Doherty (1979) suggests that this failure-frustration-anger-guilt sequence if repeated several times in connection with one patient brings the nurse to associate unpleasant feelings towards that patient. In order not to have to face the discomfort that the patient evokes the nurse may begin to avoid him. Doherty (1979) sees this avoidance as a subconscious attempt to screen out unpleasant reality – in this case failure to alleviate pain and the associated guilt feelings.

Hammond (1979) who argues that pain and its relief have a symbolic role in dysfunctional doctor-patient relationships holds a similar viewpoint. He believes the under-medication of pain is a symptom of a widespread pathology in the doctor-patient relationship.

Hammond (1979) examines the doctor/patient relationship through a critical analysis of the personal lifestyle of the physician. Beginning with the socialisation process of a harsh medical training, Hammond suggests that doctors are created who attempt to deny emotional difficulties involved in patient contact by withdrawing and denying their own emotional needs. He states that as individuals, doctors suffer emotional deprivation themselves. Part of his thesis suggests that the doctor wants to be 'that all-powerful, all-caring figure, but there are few less capable of being all-caring than the intern working 120 hours a week.' (156) He argues that because the doctor is unable to meet the patient's reasonable demands for attention, the doctor fantasises that the patient's needs are insatiable. Because the doctor unconsciously wishes to meet the total needs of the patient he sees his inability to meet them as an enormous failure. Thus even the legitimate demands of the patient are a threat to the doctor, such that the doctor's fear of the patient is real and his defence against it problematic. Hammond (1979) further argues that the patient is therefore forced to sanitise and translate emotional feeling into physical complaint. Thus a patient 'may communicate some illegitimate emotional feelings with a complaint about constipation. This allows the doctor to ignore threatening emotional issues while still responding to the patient.' (157) Hammond(1979) ends:

> 'The tragedy of the suffering patient has many aspects. Unprepared by life, the patient expects solutions that do not exist. The doctor's life experience of overwork and emotional deprivation ill prepare him to face his patients suffering. They become enmeshed in a silent battle for control. Pain and its relief become terms in the conflict…' (160)

Perry (1984a) develops this idea further in a radical and provocative paper. Perry asks 'Could it be that doctors, supposedly dedicated to reduce all suffering, actually have some need for patients to hurt?' (804) Such a concept stems from Perry's striking observation that even after pleas from patients, documentation to staff, departmental pain education and editorials to staff, the staff at his hospital were still persistently reluctant to increase pain medication even when confronted daily with patients obviously suffering extreme pain. This was exceptionally striking in centres where painful procedures were prominent such as burn centres with patients undergoing treatments such as the debridgement procedure. The debridgement process is particularly distressing, for the patient lies awake in a bathtub-sized tank while nurses remove charred dead skin with scalpel and tweezers. Questioned as to why larger doses of narcotics were not prescribed, the answer was fear of 'overdose'. This was a misconception regarding narcotic analgesics.

In order to counter this Perry (1984a) educated his staff at the burns unit on these matters through a series of in-service lectures and discussions where he reviewed the pharmacology of narcotics. This helped reduce concerns regarding over-dosage but created fear of causing 'addiction'. To remedy this Perry put into place a number of educational strategies including reviewing the medical profession's historical ambivalence towards narcotics as well as questions of bias and misleading interpretations. Perry states:

> 'The impressive results of these didactic seminars was how unimpressive the results turned out to be in influencing clinical care. The average dose of prescribed narcotics increased only slightly and staff remained quite hesitant about increasing analgesic dosages to more effective levels. The explanation (rationalisation) was that higher dosages were not actually necessary because the patient did not hurt that much. This resistance proved most formidable. Since pain is by its very nature a subjective experience how can anyone 'prove how much someone else hurts?'' (809)

Perry (1984a) did not give up. He next used a standardised categorical scale and asked 60 randomly-chosen burn patients to qualify their pain experience during hospitalisation. 'Contrary to the popular view, the patients were not inclined to overestimate their pain by rating it as constantly severe, but they did assess their pain as intolerable 'at its worst' during such procedures.' (809) Another two studies followed (Perry and Heidrich, 1982; Perry, in press) both studies gave further evidence of staff significantly underestimating patient's pain severity. Again clinical care was not influenced by such studies and did not lead to any changes by staff regarding patient pain experience. Perry was further intrigued when staff accepted the findings of the studies with respect and co-operation and showed obvious concern about the pain they were inflicting on patients during procedures such as the debridgement procedure (Perry and Heidrich 1982). Indeed many nurses reacting to such trauma developed stress disorders with numbing nightmares, social avoidance, intrusive thoughts and substance abuse. As Perry (1984a) states:

> 'The obvious solution to reduce this suffering of both patients and staff would simply have been to provide more effective analgesia but for some reason this straightforward remedy was repeatedly rejected. In view of these observations, the notion that there was some need for patients to be in pain no longer seemed outlandish.' (811)

Perry (1984a) does not propose that this unconscious need for pain is sadistic, although he does acknowledge that some individuals pursue a medical career as a reaction formulation against unconscious sadistic impulses and then inadvertently inflict pain when the fragile defensive operation temporarily breaks down. He recognises though that such specific psychodynamic does not explain the more general undermedication for pain. Perry (1984a) propounds that 'a modicum of pain in the physically ill is necessary to preserve ego boundaries to distinguish who is ill and who is not and at an even deeper level to provide reassurance that the patient is alive.'

(809) Perry reminds us that the idea that pain is necessary to preserve a sense of oneself and of reality is something Freud, 1930; Anna Freud, 1954; and Mahler and McDevitt, 1982 had previously established. Perry (1984a) comments too that pain serves to define the sick role for doctors; when the patient is the one who hurts the doctor can say 'the patient is in pain, I am not; therefore I am not the one who is ill.' (810) This is similar to the dynamic proposed by Searles (1965) that therapists have an unconscious wish to drive their patients mad. With regard to pain unconsciously offering reassurance that the patient is alive Perry describes patient experiences of being given Panchromium bromide and narcotics, which causes muscular paralysis so that:

> 'they lie in bed fully conscious yet unable to move or feel. To the staff they appear like inanimate machines on automatic pilot – but the patient's own internal experience is quite different … many recall wondering if they might be presumed dead by others and 'buried alive' or worse, they themselves – paralysed, unable to feel, their eyes taped shut to protect the corneas – remember intense anxiety related to being uncertain themselves about whether or not they were alive.' (811)

Perry (1984a) concludes that he acknowledges that the idea of a need for pain is difficult to accept and goes against the pain-pleasure principle upon which Freud constructed his psychoanalytic theories but speculates that the intense regression that accompanies severe medical illness a modicum of pain in the physically ill may 'help to preserve ego boundaries, clearly distinguish who is ill and who is not and at the deepest level, maintain the very sense of being alive.' (811)

Indeed Melzak (1988) has stated it plainly 'pain can … have a major impact on mobility and mortality … it can mean the difference between life and death.' (88) I have described Perry's work at length because his conclusion is very relevant to the centre of this study; pain evokes unconscious responses. Research into unconscious responses created by chronic pain is a much neglected area in medical and psycho-analytic literature.

The conclusion that pain evokes unconscious responses goes some way to gaining insight into why there is so little documented research on the patient pain experience and as to why we are still some way from working successfully with chronic pain. It also can be conjectured that unconscious responses to pain are evident in both the patient suffering the pain and also in those with whom the patient has contact. This might give an additional explanation as to why some health professionals acted so unusually by under medicating pain-relieving drugs. Such an explanation would conform with Langs' theory of conscious denial and unconscious wisdom and leads me to suggest that the work of this study could add to the sparse documentation regarding the unconscious mental functioning of states of intense pain. Communicative theory offers a methodology for exploring such issues.

8. Theoretical Support for the Communicative approach

Although the communicative approach can be described as somewhat radical in relation to previous analytic theory there is evidence to suggest that a number of prominent analysts were to close to defining an ideology very similar to that propounded by Langs.

Smith (1991a) in his historical study of psychoanalytic background goes so far as to claim that, 'Freud came within a hair's breadth of formulating the communicative approach to psychoanalysis which Robert Langs developed over eighty years later.' (4) Smith maintains that Freud was close to adopting similar ideas to those proposed by Langs, on several occasions, but did not follow the ideas through. Smith states, that Freud's (1899) theory of the nature of unconscious mental content, 'Instead of stressing the importance of *past* events-whether memories or phantasies…[instead] gave primary importance to the unconscious perception of *here-and-now* emotional realities.' (4) In his letters to Fleiss (1877-1904), Freud commented that memories and fantasies that emerged might be disguised expressions of our here and now issues. He confirmed this idea in his 1899 paper on 'Screen Memories' in which he suggested that the context of the present in the here and now brought about the memory. However Freud did not relate any of his constructs to himself and his 'here and now ' actions within the therapy. Had he developed such thoughts further it is interesting to speculate that he could have arrived at the same conclusion as Langs.

In 'The Interpretation of Dreams' (1900) Freud maintained that unconscious ideas could only be expressed via a connection to a pre-conscious idea; in 'A note on the Unconscious in Psychoanalysis' (1912a) he proposed a theory of unconscious perception in which he construed that an analyst's unconscious mind could be attuned to a patient's unconscious and the therapist could therefore analyse what was going on; and in (1922) he proffered that even in delusional paranoid states that there was a core of truth to the delusional projections, 'they project themselves outwards on to others what they do not wish to recognise in themselves…but they do not project into the blue, so to speak, where there is nothing of the sort already.' (226) These concepts are not so very far removed from Langs' premise that stories and narratives are also thematically connected to unconscious ideas. Langs, however, proposed that such unconscious ideas would be thematically linked with the patient's unconscious experience of the emotionally charged triggering events of the 'here and now' situation.

Smith (1991a) also points out that Ferenczi,1933; Heimann,1950; Racker,1953; Little, 1951; Balint, 1955; and Searles, 1975 all offered aspects of insight, similar to that proffered by Langs, into unconscious communication between the therapist and patient.

Ferenczi (1933), the eccentric Hungarian neurologist, in his last paper on unconscious perception, considered his patients' statements to be connected to himself. He found much self-criticism within his patients' statements and concluded that patients were unconsciously able to understand analysts and were able to tell analysts in disguised ways what was wrong with them. He described this as a form of 'mutual analysis' in which patients tried to cure the analyst as well as vice versa. He propounded that there were patient-dependent analysts who were involved in their own issues and in such a situation Ferenczi proposed that patients wanted to shock their analysts back to being present.

Myres (1995) concurs that one of the greatest contributions which Ferenczi brought to psychoanalysis was in suggesting the possibility that 'analysands accurately perceive elements of the analytic situation and unconsciously portray these in disguised symbolic form.' (1)

Myers (1995) has uncovered, through retranslating Ferenczi's original clinical notes, information of intrinsic interest to the communicative approach. Myers makes a case that even though Ferenczi made no links to therapeutic frame issues as Langs does, the clinical evidence from his notes supports the notion that the frame is a vital determinant in the analytic session. Myers goes so far as to propose that 'it may have been precisely this connection with frame issues that inhibited Ferenczi from further pursuing patients' unconscious perceptions.' (1)

Such work by Myers(1995) is particularly significant, for it points out some of the difficulties that Langs refers to in trying to gain acceptance for the communicative approach. As Myers points out, it is a difficult task to bring about a stable foundation for an area of knowledge if the interpretation of data is contingent on the conscious and unconscious expression of the researcher.

During the 1950's Paula Heimann and Margaret Little had both developed similar ideas, based on counter transference issues. Heimann, an ex-Kleinean, stressed that the analyst had the potential to unconsciously perceive his patient 's unconscious and that this unconscious perception was superior to the analyst's conscious perception. This is not unlike Freud's ideas in the 1912a paper. However Freud and Heimann only alluded to patient issues thus losing the complexity and understanding that such unconscious potential could be prominent in both patient and analyst.

Racker (1953) in reply to Paula Heimann's paper commented on its inegalitarianism. He posited that within the therapeutic relationship there was a need to have both therapist and patient working on each other - not just on the patient.

Little (1951) propounded that patients had an unconscious understanding of their therapists' psyches but were unaware of their knowledge. She saw it the job of the therapist to bring this understanding into consciousness. She suggested that patients held up mirrors to therapists and that therapists therefore needed to clear themselves of their own issues. 'We often hear of the mirror which the analyst holds up to the patient but the patient holds one up to the analyst too.' (37) She took counter-transference to be a major issue and suggested as did Searles, that analysts have problems with which patients try to assist. She proposed that the analyst's task was to bring to consciousness the, 'great deal of truth about (the analyst) both actual and psychic' (38) that analysands unconsciously possess.

Harold Searles' work has particular significance for the communicative approach. Searles began his work with schizophrenic patients. His work led him to claim that within our inter-personal relationships we needed to cure. Children needed to cure parents; patients needed to cure analysts. He speculated, as did Ferenczi in his description of Mutual Analysis, that in order to get better, patients needed to cure their therapists. Patients, he maintained, consistently communicated to therapists in an unconscious way about their problems. Smith (1991a) notes that Searles' work supported the notion that, 'patient's express their perceptions unconsciously by referring to their analysts in a heavily disguised metaphorical way.' (94)

This links to the later work of Kahl-Popp (1995) who proposes that traumatic processes within the patient are triggered by interventions of the analyst. The hypothesis is elaborated by clinical examples and through a detailed analysis of Freud's writings on Dora (1905b). Kahl-Popp claims that Dora's termination of her therapy could be interpreted differently and not as an acting out of recollections and fantasies, as claimed by Freud. Kahl-Popp asserts that Dora's narratives, when decoded communicatively suggest that Freud's interventions had caused her to feel unconsciously threatened by him so that she reacted with 'negative introjects, symptom formations and later with the termination of the therapy.' (2)

Such analysis and research has caused Kahl-Popp to put forward the following hypothesis:

> ' I believe, the patient follows and comments on both the verbal interpretations of the psychoanalyst as well as interventions which are personally relevant for the patient...the patient's derivatives and symptom-formations bearing a threatening and negative touch in the course of psychoanalytic discourse are possibly encoded messages about how he has been unconsciously perceiving and processing the interventions of the psychoanalyst.' (2)

Kahl-Popp also comments on the need for an understanding of the frame conditions for a successful therapy.

More contemporary still, the work of the cognitive scientist Robert Haskell (1982, 1987a, 1987b, 1987c, 1988, 1989a, 1989b, 1990, 1991, 1999a, 1999b, 2000) shows marked similarities to the concepts put forward by Langs. Coming from a totally different background, and initially knowing nothing of Langs' research, Haskell for the last twenty years has been developing a qualitative and linguistic methodology for analysing and validating unconscious meaning in conversations. His work chronicles how literal stories in conversation are often 'symbolic' or 'metaphorical' references to what is happening in the present social situation. What Langs calls 'derivatives', Haskell calls 'subliteral communication'.

Once familiar with Langs' work, Haskell (1999b) commented that:

> 'unlike most other schools of psychoanalysis, Langs has been concerned with the science of psychoanalytic practice, even to the extent of conducting mathematical research on transcribed protocols of patient sessions. He has also developed a method of testing derivative communications within the therapeutic sessions. Interestingly Langs developed a Darwinian evolutionary framework for explaining the biological origins of derivative phenomena. Langs is no pop psychology guru.' (272)

Dedicating a chapter in his recent book (1999a) and using one of his most recent papers (2000) to make links with Langs' work, Haskell, although differing in some areas, offers the following research data of his own to corroborate Langs' findings.

1. historical antecedents to subliteral/derivative phenomena
2. subliteral/derivative communications
3. a brief linguistic framework for understanding the structure of subliteral/derivative sentences

4. a more complex set of subliteral/derivative linguistic, cognitive, and psychodynamic operations (6)

Haskell concludes that the important aspect of the communicative approach is that it is a testable theory and that Langs' work is sufficiently sturdy and credible to warrant serious systematic research.

It seems appropriate also to comment that as psychoanalysis, cannot be considered a precise science (Smith, 1991a,1998; Grunbaum, 1977; 1979, 1984, 1986, 1993, 1997; Nagel, 1959; Hook, 1958; Popper, 1962; Langs 1999a) that Langs' work therefore contributes systemic research within the psychoanalytic discipline.

9. Robert Langs and the Communicative Approach to Psychotherapy

9.1 Introduction

Robert Langs is the founder of Communicative Approach. (Langs 1976a, 1976b, 1978a, 1978b, 1979, 1980a, 1980b, 1981, 1982a, 1982b, 1983, 1984, 1984/5, 1988a, 1988b, 1992a, 1992b, 1993, 1995, 1996a, 1996b, 1997; Langs & Searles 1980; Langs & Stone, 1980)

The Communicative Approach is a form of psychotherapy dedicated to gaining a better understanding of the human mind and to the relief of individual suffering. It claims to offer a means of adapting to emotional issues with greater insight by giving full credence to the unconscious side of emotional life. Langs maintains that human suffering is derived from a failure to understand the real nature of the mind and reality and he is committed to gaining a better understanding of both. Through gaining a deeper understanding of the human mind and the nature of reality as shown by such an understanding, Langs maintains that we can live a more enlightened and harmonious life with less suffering and misery.

He accredits much of our human misery to our fear of dealing with and truly recognising the impermanence of our existence; to our ultimate fear of death, and to the innate aggressive and violent responses which brings harm to others when we feel under threat.

Langs (2001b) describes it in this way:

> 'Because we are so terrified and disturbed by traumatic emotional experiences - much of it through their connection to harm and death-we use a lot of denial consciously. This denial-ultimately a denial of

> death-is self-protective, but very costly in terms of self harm and harm to others. Unconscious death anxiety unwittingly motivates many destructive decisions, choices and actions.' (5)

Langs considers that we survive through keeping the fear of death in an unconscious mind and only consciously coming to terms with it in times of great danger. He maintains that the mind responds to each stimulus from the external world by analyzing the stimulus and then processing this information either consciously or unconsciously. The gradient of anxiety and emotional death-related trauma connected with the anxiety determines whether the information is handled consciously or unconsciously.

He proposes that there is an evolutionary reason for this. He suggests (2000b) that in order:

> 'For humans to survive, they had to find means of coping with the inevitability of death so that this realization would not render them excessively vulnerable to distraction and harm. The solution that has evolved in this brief period of time is the use of denial in a wide range of forms—blocking out entire experiences or the most disturbing meanings of traumatic events either at the moment they happen or immediately after; focusing on unimportant events and meanings in lieu of those that are critical and with significant consequences; breaking rules and violating laws so as to promote the unconscious belief that because you are able to break these rules, you also are powerful enough to violate or defy the rule that death follows life; and adherence to a wide range of supernatural and religious beliefs without foundation in reality. Existential death anxiety is the core universal dread, and denial of death the core adaptive response of the human emotion-processing mind in response to death-related traumas—and the root cause of emotional disturbances as well.' (3)

Langs suggests however, that the effect of keeping this fear in the deep unconscious has a profound impact on our behaviour, feelings, mental health, relationships etc without our realizing the cause. Langs proposes that the fear of death is ever present, although not in our immediate awareness, and that fear of our mortality is such that we try and create frame breaks so that we can delude ourselves that we are more powerful than death itself. Hence we attempt to outwit that which we unconsciously fear most. The communicative point of view is that such delusion is detrimental to us and causes us untold harm. Langs maintains that although we are designed by natural selection to deny death anxiety, in understanding how we deal with such fears we are more likely to be able to make better choices and live more harmonious lives.

The conscious mind Langs proposes is unable to handle deep gradients of emotional anxiety and as such (and in order to protect our psyche from destruction and disintegration that such immediate anxiety would bring) has evolved as an instrument of denial which misperceives truth, and is the cause of human suffering. Langs considers the conscious mind has an inaccurate understanding of reality and that our failure to understand this falseness is one of the causes of suffering. The conscious mind is prone to avoid, deny or falsify emotional truths. He argues that the conscious mind is inclined to deny anxiety-provoking events and avoid their most disturbing meanings in favour of a flawed and self- deceptive ideal. It is a system that he considers to be highly defensive, particularly in regard to denying the prospect of death. What this means is that we are inclined to be totally unaware of the most powerful and provoking meanings of emotionally-charged events and thus be unaware of their effect upon us. As such, communicative theory proposes that our conscious view of the emotional world is restricted and often in error

The unconscious mind, however, Langs maintains is an instrument of awareness and enlightenment advocating a set of universal and ideal ground rules which can be utilised to bring greater harmony and joy in our everyday lives. He calls this unconscious mental system ‘The Deep Unconscious System’. Within this system there are two deep unconscious sub-systems, a wisdom sub-system and a fear/guilt sub-system. Langs maintains that the deep unconscious system has evolved specifically to deal with ethics and morals and faith and insight in order to bring healing and insight into our everyday lives when decoded and adhered to. Langs argues that we need to focus on the knowledge available through our unconscious mind in order to bring enlightenment and relief from the human misery that our denial-based decisions create, for it serves as a highly reliable system for making emotionally charged choices.

Langs (2000c) describes the deep unconscious system in the following way:

> ‘Operating outside of awareness, the deep unconscious system is relatively non-defensive and quite in touch with the true nature of events and their implications—it seldom misperceives. It therefore serves as a highly reliable system for making emotionally-charged decisions—but doing so requires the use of trigger decoding in order to ascertain the nature of unconscious experience.’ (3)

Langs (2001c), although in no way suggesting that communicative philosophy is in any way religious, (in fact he is adamant that communicative psychotherapy is based on scientific principles), does however recognise that the deep unconscious system as he perceives it, is somewhat akin to the, turning inward, which is demanded within a spiritual discipline. He is aware that both communicative philosophy and spiritual enlightenment (2001c) are:

> based on the belief that much of human suffering is self-appointed and that the most compelling answers to the resolution of this

> suffering resides within. The spiritual quest is for absolute inner truths that lie beyond the mundane somewhere in the deepest core of ourselves—our minds. Everyone from Gautama Buddha to Muhammad to Socrates has told us these simple truths: Look within, find the sources of your pain within, and find the answers to your pain within as well. (2)

Although it seems the communicative approach sees itself as standing alongside such ways of thinking, Langs maintains that he has arrived at his philosophical stance not through any religious conviction but through over thirty years of careful observation of therapeutic interaction. Such observation he maintains consistently showed that although the patient would comment in a particular way about the therapist or therapy, unbidden narratives and stories would pop into the session material, the themes of which would often be at odds with the conscious ruminations given by the patient. Such narratives Langs considered to be unconscious encoded responses by the patient that could bring awareness and enlightenment when properly decoded, to the immediate here and now interaction between the therapist and the patient.

Langs maintains that unconscious concerns of patients expressed in encoded form through such unbidden narratives and stories popping up during psychotherapy sessions were nearly always linked to immediate actions of the therapist.

He observed that within the therapeutic relationship patients unconsciously commented upon certain behaviours and actions by therapists. He argues then, that narrative accounts, dreams and stories told by patients in the therapy session are the unconscious encoded responses to such behaviours and actions and are mainly to do with the ground rules of the therapy.

He terms such events occurring in external reality and bringing about an intrapsychic response as ' adaptive contexts' or 'triggers'. He claims that patients are extraordinarily aware of the implications of their therapist's actions and that consequently patients are able to reveal to their therapists their errors in a disguised way. Patients tell stories or recount memories, the themes of which narratives express the nature of the therapist's error.

Langs proposes therefore that the issue of therapy is not to do with infantile sexuality, inner conflicts, distorting memories or fantasies or a maladaptive way of thinking but with an adaptive interaction that happens between the patient and therapist within the session itself. By listening to, organising and understanding such unconscious responses, Langs established the ground rules for communicative psychotherapy

Within evolutionary science Langs (1996a, 1996b) maintains there is clear evidence for the existence of such an adaptive unconscious mental functioning. He views the unconscious mind, or 'The Emotion Processing Mind' as he terms it 'as a Darwin machine - a huge resource whose adaptive preferences are selected by environmental events and then sustained.' Piaget (1959, 1973, 1979) proposed a similar hypothesis. He propounded that the environment is selectively experienced by the organism and that the organism in turn influences the environment through its behaviours. Langs (1996b) maintains that such a hypothesis is at the heart of the communicative model of the mind, for unconscious communication, experience, adaptive processing are empirically defined in communicative theory. He maintains (1996b) that:

> The communicative approach is essentially an adaptationally formulated theory and therefore naturally intersects with the adaptive foundation of evolutionary theory…as an observation-driven theory, the communicative approach readily intersects with the selectionist principles of the science of evolution. (33)

Thus the full name of the communicative approach, 'The Communicative-Adaptive approach' emphasises Langs' two most distinctive claims about the approach. Firstly, that one of the functions of our unconscious mind is to adapt to immediate emotionally-charged triggering events and secondly, that the communicative approach offers a new way to understand any such unconscious verbal communications.

In stressing immediate adaptation, the communicative approach proposes that coping with external realities rather than with internal fantasies and memories is the primary task of the emotional mind. Reality, especially as it is experienced unconsciously, is afforded more power over emotional life than fantasy. Communicative theorists claim that this position is in keeping with the finding that living organisms through the ages have evolved and been designed primarily to adapt to their external environments. In the communicative approach this means that, for patients in therapy, coping with what their therapists do and do not do is of prime concern, even though important aspects of these coping efforts operate outside of awareness – unconsciously. Langs (1999a) maintains that dealing with inner emotional lives, past and present, is a secondary task of far less importance than dealing with the outer world and especially its traumas. The approach upholds that the functions of the emotion processing mind are triggered by specifically emotionally-charged or traumatic events. Many of these events do not register consciously or enter awareness directly. However the deep unconscious system is capable of perceiving unconsciously and processing almost all events that do not register consciously. As the name suggests, the deep unconscious system has an effective intelligence and wisdom which analyses incoming experiences and processes their meaning. The findings of such unconscious processing enter awareness through disguised narratives which can then be decoded in order to gain the understanding offered by this sophisticated and insightful system.

From the communicative standpoint the existence of an unconscious mental functioning based on an evolutionary point of view offers a less flawed approach than the subjective insights offered by Freud and as such Langs (1996b) proposes four key precepts for the communicative approach to psychotherapy:

1. Patients and therapists are first and foremost adaptive organisms.
2. The immediate environment, broadly defined, is the primary source of emotionally charged trigger events for the adaptive responses of each party to therapy.

   Thus, the central adaptive issues for patients and therapists arise in the here-and-now therapeutic interaction and the vicissitudes of its ground rules and frame.
3. The adaptions made by patients and therapists are carried out through both conscious and unconscious means and processes.
4. Patients' narrative material is two-tiered in that its manifest content reflect direct responses to conscious adaptive issues while its

> encoded contents are responsive to unconsciously perceived adaptive issues. As a rule, these two sets of reactions tend to be very different. (31-32)

Therefore according to communicative theory the human mind possesses an innate functional system devoted to sophisticated unconscious perception of interpersonal events. This system is considered to be able to draw conclusions from potentially damaging inter-personal situations and express these conclusions by means of seemingly unrelated narratives. These encoded narratives can offer health giving directives when they are properly decoded.

Communicative practitioners use the term 'derivatives' for these narratives, which they consider, contain deep unconscious meaning. David Smith (1996) states:

> 'Communicative theory claims that human beings are designed to understand one another. Even when consciously occupied with other matters we silently monitor the behaviour of others. According to communicative theory there are special circuits in the brain (or if you prefer, parts of the mind) which are dedicated to this process. These neural circuits have been evolved over the millennia to enable us to size up our fellow human animals as quickly and accurately as possible. Operating outside of awareness this neural system is rather poetically referred to as the deep unconscious wisdom system (Langs 1993). The deep unconscious wisdom system is an organ for interpersonal perception which has an indirect impact on the unconscious part of the mind.' (102)

Communicative theorists claim that psychotherapy cannot be understood if there is persistence in placing primary emphasis upon the patient and his intrapsychic world They propose that when the adaptive interactional processes occurring between patient and therapist are taken into account many of the problems of therapy become clear. The very process of therapy has its foundations in the affective participation of both individuals. This participation goes beyond simple empathy with the patient's feelings. From the communicative point of view each responds unconsciously to the other, and it is the totality of these processes that creates the therapeutic process

By considering the therapeutic situation as a bipersonal field where both therapist and patient interact, Langs has made it clear that reality stimuli brought by the therapist evoke in the patient an unconscious response that needs to be analysed. From a communicative point of view a proper therapeutic alliance can only be established if the therapist pays attention to the responses shown to her through derivatives and is able to address the issue accordingly.

Of course Freud also stated that stories and narratives carry unconscious meaning and he elicited 'Free Association' to encourage such stories. The major difference between Freudian philosophy and the adaptive approach used by the communicative therapists is that Freudians considered such stories related back to the patients themselves and not to the current external reality

9.2 Communicative Methodology

The communicative approach puts forward a systematic technique, which allows its theoretical and philosophical background to be applied in a practical way. According to communicative theory unconscious ideas are never directly expressed. Instead, the deep unconscious system brings about conscious ideas that serve as disguised representatives of the unconscious information. There needs to be a thematic link between the deep unconscious idea and its corresponding conscious narrative. It is this thematic structure of the derivative that makes us aware of its unconscious significance.

It is by means of these derivatives that the patient tells the therapist his perception of what is going on between them. Communicative theory claims that this unconscious feedback will also inform the therapist about the validity of an interpretation - albeit in an encoded form.

Thus from the communicative point of view derivatives offer the therapist a means to understand the language of the deep unconscious system and they offer the therapist the opportunity to be able to identify important unconscious communications from the patient.

Communicative theory states that derivative communications possess specific formal properties. Firstly derivatives are not on the surface about therapy. The scene is elsewhere and other people and situations are described. Secondly, derivative images are concrete. Thirdly, derivative discourse is discontinuous.

In contrast to this, non-derivative discourse may be intellectualised, manifestly concerned with the therapy, reflective, ruminative, general and abstract. The communicative approach ignores the non-derivative communication and concentrates solely on derivative communication; the narratives, stories, dreams and memories recounted by the patient

In order to know what to do with patient's stories, (their derivative material) the communicative therapist needs to decode the trigger of the stimulus so that the unsuspected unconscious meaning can be revealed. The trigger of the stimulus for the derivative is considered to be related to the therapeutic situation itself and the 'here and now' context. A form of displacement is thought to take place and the therapist or therapeutic relationship is represented by something else in the patient's narrative.

These disguised pictures (or derivative representations of the trigger) are often difficult for the therapist to pick up yet unless the therapist understands the trigger, the unconscious significance of the patient's derivative communications will remain obscure. Patients sometimes allude manifestly and in passing to the trigger and then offer a rich network of derivatives that inform the therapist how the patient has processed the trigger. The theory claims that patients will offer their therapists interpretations of what is going on, through the themes in the narrative material.

Langs (2000b) states:

> 'The critical unconscious meanings disguised in our stories cannot be inferred directly—they can be discovered only through a decoding effort. This decoding method—trigger decoding—is initiated with a search for the decoding key, the current event that has provoked the encoded message (note the role played by coping or adapting). These traumatic incidents take the form of emotionally-charged experiences--triggering events or triggers, for short. In order to properly decode an unconscious (encoded) message, you must know the incident to which it is a response. This enables you to decode a story in light of its evocative trigger—unconscious messages are never conveyed directly or manifestly, but always in disguise. '(4)

Smith (1991a) asserts that there are three basic categories of derivative representation - relationship, function and environment themes. Relationship themes are considered to convey unconscious perceptions of the quality of the relationship between the therapist and the patient. Smith (1991a) propounds that patients tell their therapists about their 'abusiveness, seductiveness, deceitfulness and destructiveness as well as their constructiveness, creativity and contactfulness'. (200) Themes of function and dysfunction are considered to express patients' unconscious awareness of how well or how poorly their therapists are functioning. Environment themes may unconsciously depict the state of the therapeutic frame.

Communicative methodology poses that the trigger, derivatives and an indicator must be present before it is warrented for the therapist to offer the patient an interpretation of the derivative material. An indicator is a direct or indirect manifestation of the patient's emotional pain, shown either as 'symptom indicators' or 'resistance indicators.'

Symptom indicators are considered to reflect the patient's emotional phenomena such as anxiety, nightmare, sadness, despondency, headaches, delusions, etc. Resistance indicators on the other hand are exactly that, indications of resistance, such as failure to attend sessions, lateness, protracted silences, breaking the free-association rule, etc.

A communicative psychotherapist should normally intervene only when the elements of trigger, derivatives and indicator are present. Until that time the communicative therapist normally remains silent. Verbal interventions conform to a particular structure: the indicator is explained through the trigger and derivatives. The therapist begins an interpretation with the patient's best representation of the trigger and then works through the derivative images that link with the trigger. The communicative therapist goes on to interpret their unconscious meaning in the light of the triggers.

Finally, the therapist links the derivatives and trigger to the indicator. Communicative theory claims that the patient unconsciously knows what is needed from the therapist. If the therapist's intervention is correct the patient will respond with validating imagery. As Smith (1991a) advises: 'A communicative intervention is considered appropriate only if it is followed by constructive derivative imagery. If the patient responds with negative imagery after the intervention the communicative therapist concludes that his efforts were seriously flawed.' (214)

Communicative theory claims that there are clear criteria for drawing conclusions about the truth or falseness of an interpretation. The concept of patient validation of therapist interpretations is crucial in this respect.

Communicative theorists claim three main types of intervention that are validated by patients. They are silence, managing the frame and interpretation. Interpretation in the communicative sense is not the same as in the Freudian or traditional form of interpreting fantasies, childhood repressed memories, transferences etc. In the communicative approach the therapist acknowledges the unconscious communication offered by the patient as the therapist considers it represents the immediate situation in which they find themselves. Smith (1998) gives a basic outline of a communicative interpretation, 'I (the therapist) have done (or failed to do) so-and-so. You (the client) unconsciously take this to imply such-and-such about me and our work together. This may be why you are so distressed/resistant right now.' (12)

In the Communicative Approach it follows that a patient can offer supervisory guidelines for the therapist through Models of Rectification.

Within their negative response the patient could offer a positive statement - the patient curing the analyst. These come in the terms of 'should' statements. As the patient tells his story he tells what 'should' be the result, or what 'should' happen. The Communicative therapist is realistic enough to recognise that he is unlikely to get an interpretation completely right and therefore understands that validations are likely to be mixed. Such precepts form the basis for the communicative work in this thesis.

9.3 The Frame

Langs (2001b) maintains:

> 'The role and effects of settings and ground rule conditions on both psychotherapy and everyday life stands as one of the most poorly understood and underappreciated aspects of human emotional life. Among the reasons for this uncertainty is the fact that we use our conscious minds for exploring and formulating our ideas about rules, frames and boundaries, and the conscious mind is entirely unreliable in this respect.' (1)

The concept of the 'therapeutic frame' goes back to Freud's papers on technique (1911b, 1912b, 1912c,1913c, 1914a,1915a) which could be considered to be the foundation of therapeutic groundrules. Freud wanted to create an atmosphere of safety for his patients so that they could feel sufficiently secure to tell him everything and withhold nothing.

Milner (1952) coined the phrase 'frame' using the term metaphorically comparing the frame of a picture to the psychotherapeutic situation. A picture frame separates what is within it from what is without. So too in psychotherapy, the frame forms the 'rules', so to speak, that makes therapy different from ordinary reality.

Winnicott (1954) also wrote on the frame. He called it 'the environment'. He contrasted interpretation and frame management. The frame he suggested had a maternal function, the holding function of the mother, and the secure frame was anything that made the patient feel secure. Bleger (1967) developed Winnicott's position and enhanced the view of the maternal function of the frame.

Generally, then, the frame has been seen as the backdrop of the psychoanalytic situation. It provides a metaphorical container within which analysis can take place. Langs (1988a) however altered the nuance of the frame, for in the Communicative Approach the frame **is** the issue. Langs argues that the deep unconscious system of the emotion processing mind is consistent in its attitudes and assessments of ground rule conditions that make up the psychoanalytic frame.

Langs (1996b) states that extensive clinical experience has shown that patient's 'encoded, unconsciously validating narratives and images' (30) demand a secured frame in order for psychotherapy to securely hold both patient and therapist. Communicative theory insists that the psychoanalytic frame is of fundamental importance. This is because the 'frame' is considered the central component around which derivatives are produced.

The communicative approach maintains that secure ground rule conditions are unconsciously experienced as health giving, whilst departures from those ground rules are seen as harmful. It therefore becomes evident that the therapist's efforts at securing and maintaining the frame are vital. Smith (1996) asserts:

> Mother nature has designed the deep unconscious wisdom system to function in a stable and reliable manner (although like all biological

> systems it will malfunction under certain circumstances). As such it responds consistently to the stimuli which we encounter. Certain features of the therapeutic environment or 'frame' (as it is called in communicative jargon) will almost always elicit unconscious disapproval. Other features consistently elicit approval. By paying attention to just what features of the therapeutic environment receive unconscious approval again and again from one patient to the next it has been possible to form an idea of the optimal way to structure this type of therapeutic environment. (104)

The Communicative approach maintains that a secure frame and consistent ground rules offers the patient a measure of protection while generating an additional measure of danger and anxiety. Langs (1992a) suggests a secure frame offers the following:

1. A basic sense of holding, trust and containment for the patient, where appropriate inter-personal boundaries allow the patient an opportunity to support his or her capacity for reality testing.
2. A potential for a healthy therapeutic symbiosis.
3. The potential for cure through genuine insight and positive identification with a well-functioning therapist.
4. Maximum opportunity for the patient to have open communication on his or her own terms.
5. Establishment of a situation where the dynamics and genetics of the patient predominate over those of the therapist.
6. A reflection of the sanity of the therapist.
7. Restriction of pathological action by patients reflecting the constructive power of the therapist.
8. A sense of separation, paranoid, death and claustrophobic anxieties which create the motivation in the patient to carry out the therapeutic work. (447)

In contrast, Langs (1992a) suggests, if a frame is not secure, if it is deviant, the following is created:

1. A basic sense of mistrust, disturbances in reality testing and poor interpersonal boundaries between the therapist and patient.
2. A shift towards an action-discharge mode of cure.
3. An impairment in basic communication, where the patient's derivative expressions will be concentrated on the deviant ground rule.
4. Negative repercussions for the patient as he or she generates unconscious perceptions of the therapist's dynamics, so that the work of the therapy becomes focussed on the therapist's deviations.
5. A means of pathological defence and gratification that reinforces pathological instinctual-drive tendencies
6. A reinforcement of the pathological superego functions and denial of death where the patient escapes from the necessary claustrom effects brought about by a secure frame.
7. An experience for the patient of therapist's madness. (448)

Langs (1978b) states:

> 'It is my main thesis that the manner in which the analyst or therapist establishes and maintains the ground rules and boundaries of the therapeutic setting and interaction is among the most important means through which he conveys to the patient the essence of his identity and the dynamic state of his own intrapsychic structures, conflicts and balances... As a result, modifications or derivations in the established ground rules and boundaries of the therapeutic setting and relationship have a wide range of deeply significant consequences of which only a certain portion is modifiable through subsequent analytic-interpretive work in the cognitive sphere' (107).

In short the frame is the set of rules to which communicative therapists try to adhere, as they are the rules that the approach maintains their patients universally unconsciously demand. Communicative theory also maintains that failure to adhere to these ground rules brings derivative responses from patients about the violating frame infringement. As a communicative psychotherapist it is important to take the lead from the unconscious information given to you by the patient and to consider the immediate triggers which have caused the encoded narrative. Many of such encoded narratives will refer to frame violation. Smith (1998) outlines the following components as being fundamental for a secure frame:

1. The therapy is totally private.
2. The therapy is totally confidential.
3. There is a fixed location for the therapy.
4. There is a time fixed for each session.
5. Each session consists of the same number of minutes.

These ground rules regulate space, time and the involvement of third parties. They are the most fundamental aspects of the frame. In addition to these there are other features of the frame, which pertain more to role responsibilities:

6. The client pays the therapist a set fee.
7. The client is responsible for paying for all scheduled sessions.
8. The therapist is responsible for attending all scheduled sessions.
9. The therapist is explicit with the client about the ground rules of therapy.

10. The therapist should not coerce or encourage the client in any way.
11. The therapist should not unilaterally terminate the therapy.
12. The therapist is responsible for starting and finishing each session on time.
13. The therapist should subordinate his or her personality to the task of understanding the client.
14. The therapist should spend most of the time silently listening.
15. The therapist's verbal responses should be interpretative.
16. The therapist should conduct the therapy in a manner that accords with the client's unconscious communications.
17. The therapist should not engage in informal physical contact with the client.
18. The therapist should have no contact with the client outside therapy sessions.
19. The therapist should not accept referrals from the client.
20. The therapist should not accept friends or acquaintances of the client into therapy.
21. Gifts should not be given or received.
22. The therapist should take full responsibility for his or her failure to comply with the ground rules. (9-10)

9.4 Death Anxiety

Although the communicative practioner will at all times be working towards a secure frame, securing the frame is frequently problematic. This is because of its intrinsic connection with death anxiety. It is worth quoting Langs' (1999b) views on the secure frame and death anxiety:

> 'It is a system motivated by various forms of death anxiety, of which existential death anxiety is the most dreaded. This moves the system toward denial and a preference for departures from the ideal ground rules of therapy (ideals that are defined through consistent encoded, unconscious validation). This inclination exists because frame violations, which are inherently persecutory of the patient, are a major defense against the existential death anxieties that are activated by secured frames which are basically healing but entrapping……In contrast to the conscious system, the deep unconscious system strongly prefers secured rather than modified frames and reveals a deep appreciation of the therapeutic value of such frames.' (2)

Thus, the difficulty for both patient and analyst in creating a secure frame is in the resulting secure frame anxiety or death anxiety. Death anxiety (thanatophobia) is considered to be a morbid dread of death; a feeling of dread, apprehension, or solicitude when one thinks of what happens after death, the process of dying, or ceasing to be. Death is defined as a state of non-being, the termination of biological and social life.

The analysis by Bond (1994) explores how death anxiety possesses many dimensions such as fear of death of self, fear of dying of self, fear of death of others, and fear of dying of others. Death anxiety has been measured by researchers, such as Lester (1990) and Pollak (1980) with the dimension of death anxiety most often examined being the fear of one's own death; the fear of not being here, ceasing to exist, or dying too young.

Pollak (1980) in his review of empirical studies examined the correlates of death anxiety. Variables such as age, gender, and religiosity have been used in looking at differences in death anxiety. He reports, the findings suggest that death anxiety is a complex construct that interrelates in a variety of ways that are not completely understood with a host of demographic and personality variables. (97)

Lemming (1979) and Malinowski (1948) suggest that hope for a life after death is the only thing that makes the fear of death manageable. Thus religious belief reduces the fear of death for many people by offering hope of eternal life. It is this hope that makes life worth living. Langs and communicative theorists would however consider such religious beliefs as denial of death anxiety.

Bengtson, Cuellar, and Ragan, 1977; Pollak, 1980 and Aday, 1984 suggest that death anxiety is a multidimensional construct and many factors influence whether one will have high or low death anxiety. However it is a basic supposition that everyone experiences anxiety to some extent when they are challenged with the concept of death and it is this basic assumption that underlies the notion of death anxiety. Ernest Becker in The Denial of Death (1973) has shaped much of the reflective thinking about death anxiety into a systematic philosophy.

In psychoanalysis the concept of death anxiety has not been a central component in the formation of the major theories of neuroses. Freud (1920, 1933a, 1937a) briefly touched upon the subject in his later years when he wrote controversially on the 'death instinct.' Freud characterised the death instinct as a biologically transmitted injunction to return to an earlier state of things, which in this case presumes the state preceding life; the state of the inorganic and the inanimate. Stemming from his concept of repetition compulsion (1920) Freud's theories on the death instinct remain controversial.

Langs postulates that the emphasis which he assigns to death anxiety is still not fully understood or valued. He (2001) puts forward a contentious reason as to why this might be:

> Except for the communicative approach, all present-day forms of therapy fundamentally operate as modes of treatment whose interventions and underlying theories and beliefs whose most important function is to deny the inevitability of death and the existential death anxieties that this prospect evokes in all humans—patients and therapists included. It is this denial function that prompts patients to feel better for a while, although the cost in unrecognised pain to self and others is enormous. (3)

For Langs, death anxiety is the issue. He considers it the very crux of our human anxiety, the importance of which has been denied. He maintains (1997, 1999a) that the subject of death has, in general, tended to be neglected in the psychoanalytic literature and has therefore not received a central place in the theory of neuroses. He points out that most human minds dread and deny death and the terrifying anxiety it creates. Death anxiety Langs (2000b) suggests has intense emotional consequences. Consciously we are only aware of a few of the consequences but the main consequences are unconscious and strongly influential. Each traumatic event he proposes prompts death anxiety and although registering outside our awareness its effects are powerful and destructive.

Langs categorizes three types of death anxiety; predatory, predation and existential. Predatory death anxiety he maintains (2001d) has evolved as a reaction to external dangers where an individual is at risk of threat or harm:

> … this form of death anxiety is evoked by a variety of danger situations that put the recipient at risk or threatens his or her survival. These traumas may be psychological and/or physical and may arise

> as the result of natural disasters, toxins, actions by other living species or, as is most often the case, other humans.
>
> Predatory death anxieties mobilize an individual's adaptive resources and lead to fight or flight--active efforts to combat the danger or attempts to escape the threatening situation. With consciously perceived predatory dangers, the immediate response usually includes an activation mentally of conscious system resources and a shutting down of deep unconscious system activities, which tend to not be especially adaptive at times of emergency.
>
> Unconsciously perceived predatory dangers are another matter. They are very common in respect to psychological traumas because they range far and wide—everything from an unnoticed hurtful remark to a therapists' non-validated interventions verbally or in respect to departures from the ideal ground rules of therapy. These experiences are accumulated unconsciously and have strong effects on behavior that depends on the features of the predatory acts. (4)

The second form of death anxiety postulated by Langs, predation death anxiety arises when an individual harms another and suffers the conscious and unconscious guilt connected with such actions, the effect of which is self-punishing and harmful to the perpetrator. The third type of death anxiety, existential death anxiety Langs considers the most powerful and based on the conscious awareness of our mortality. Although there is a conscious awareness of existential death issues our layers of denial and our denial based defenses are such that the intensity of its meaning is reduced or obliterated. Langs (2000) proposes that by evolved design the emotion processing mind responds differently to each of the three forms of death anxiety. Existential death anxiety creates denial in both behaviour and mind. Predatory death anxiety tends to shut down the deep unconscious sub-system as physical and conscious mechanisms come into action, such as the' fight and flight' device. Whereas predator death anxiety, stimulates conscious and deep unconscious guilt in response to the thought or act of harming another.

Communicative theory therefore asserts that the secure frame evokes death anxieties in which both the therapist and patient experience anxiety where the sense of trappedness and death, claustrom and finality pervades. Added to this, the secure frame creates the feeling that we are going to be destroyed in the close space, that we are helpless, and will be attacked and assaulted.

Langs proposes two reasons for this. Firstly in a secure frame the metaphor for life and its limitations is thrust upon us. Secondly, psychotic anxieties of persecution are dramatically felt. Such a frame condition is the motivation for the work of communicative therapy. Within the communicative approach the secure frame is considered the central component of the therapy for communicative theory claims that the frame is the structure of the analytic situation. Interpretation of frame issues is therefore of the utmost importance in the communicative approach.

Susan Ellis (1988) adds to Lang's perceptions by suggesting that the secure frame brings us in touch with time. She proposes that we cannot escape from moments of traumatisation. The secure frame allows us to come to grips with time and the issues of loss and death. The image of loss she suggests is crucial.

Communicative practitioners argue that the key issue for any patient is the need to defend against death anxiety and working communicatively, they claim, can offer moments of insight regarding this that can lessen the extent of their emotional adaptation

It therefore becomes evident that in the communicative approach the therapists' efforts at securing and maintaining the frame, especially when the patient attempts to deviate, 'become the crucial intervention contexts around which the analysis and resolution of the patient's emotional dysfunction takes place'. (Langs, 1992a; 448). Communicative therapists maintain that their management of the ground-rules, framework and boundaries of the therapy create a vital means of healing on the deep unconscious level.

Langs is mindful that facing such death anxiety is a daunting prospect and makes the communicative approach difficult to sustain for both patient and therapist.

9.5 In Summary

Langs (1996a, 1996b, 1997, 1998a, 1998b, 1999a, 2001e) proffers a mental model of the mind which maintains that the mind has evolved two basic systems:

- The emotional mind which responds to stressful events and which activate psychological and mental resources for coping
- The emotion-processing mind, which responds to emotionally, charged events and their conscious and unconsciously experienced meanings. This is made up of two main systems. Both systems work independently of each other and both process incoming information:
    - The conscious system, a system of awareness which handles perceptions using conscious thinking and intelligence
    - The deep unconscious system, a system that has no direct access to awareness but is able to make known its unconscious perceptions through disguised narratives and dreams. This system is made-up of two sub-systems:

- A deep unconscious wisdom/processing sub-system, a sub-system of adaptive intelligence
- A fear/guilt sub-system, a sub-system of ethics and morality

Langs proposes a concept of unconscious processing that is contrary to all previous classical and mainstream psychoanalytic interpretation and theory. Langs (2000b) maintains that the communicative approach exposes and offers correctives for much of what he considers is wrong with our current picture of the emotional mind and today's psychotherapies—he suggests that critical errors in thinking and practice have caused untold suffering throughout the world. It is considered by some to be the first major advance in understanding human emotional life since Freud. Langs claims (2000b) that the communicative approach has shown that:

> Emotional problems do not arise first and foremost from disturbing inner memories and fantasies or daydreams; nor do they arise primarily from consciously known thoughts and patterns of behaviour. Instead, emotional disturbances arise primarily from failed efforts at coping with current emotionally charged traumas. The present–day focus by mainstream psychoanalysts (MP) on the past and on inner fantasies and memories has been replaced in this CA with a focus on the present, as experienced and reacted to consciously and unconsciously—in brief, the primacy afforded by MP to fantasy and imagination has been replaced by the primacy afforded by the CA to reality, trauma, and perception (especially unconscious perception).(2)

Such a radical theory has caused consternation and reflection within classical psychoanalytic circles for what Langs is intrinsically challenging is the credibility and validity of some of the basic Freudian concepts. He poses challenging questions and asks for open debate:

> Is Freudian psychoanalysis a viable theory and form of therapy? Is there convincing evidence for a realm of unconscious effects, and if so, what are their nature? Is there sufficient reason to accept the core

> concepts of Freud's psychoanalysis – 'the unconscious,' transference, resistance, repression, and infantile sexuality? And is psychoanalysis a science, a quasi-science, a quasi-religion, a form of brain washing, and/or a hoax? (1999c)

The communicative approach proposes a way of perceiving our interpersonal relations that is adaptive in essence, evolutionary-based and based on the recognition of the wisdom of the deep unconscious. It is an adaptive approach to and an understanding of, both conscious and unconscious coping efforts in response to emotionally charged triggering events. Langs has developed his work into a comprehensive theory of the emotion processing mind. It is because in this thesis that chronic pain is perceived as an emotionally charged triggering event that I propose that communicative trigger decoding might bring insight into the unconscious perception of chronic pain.

10. Introduction to the Clinical Work

The communicative approach puts forward a technique, which allows its theoretical and philosophical background to be applied in a practical way. Communicative psychotherapy is committed to a scientific approach and its methodology incorporates that attitude. The communicative psychotherapist works within a structure based on listening to the patient's deep unconscious wisdom system, decoding its messages, interpreting them to the patient and waiting for the patient's unconscious validation or non-validation of that interpretation. The clinical sessions will be evaluated according to the communicative framework

The communicative approach demands the therapist keep as secure a frame as possible. The therapist therefore needs to be aware of frame infringements as they occur.

The therapy will use as a point of reference the frame recommendations set out (in abbreviated form) by Smith (1996). They are as follows:

1. A secure and reliable setting in which there is a fixed place, time and duration for each meeting.
2. An appropriate fee to ensure that the therapist is employed by and accountable to the patient.
3. Privacy and confidentiality, with no third-party intrusions.
4. A patient-centred therapist who does not permit his or her personal concerns to intrude into the psychotherapeutic work.
5. A therapist who refrains from any form of coercion.
6. A therapist who refrains from physical contact.

7. A therapist who will confine his contact with the patient to the psychotherapeutic hour and who has no extra-therapeutic relationship with the patient before, during or after the therapy. (104)

10.1 Introducing the Client

A Consultant Child Neurologist diagnosed client 'S' as having 'Complex Pain Syndrome'. His intermittent pain problem had extended over a period of seven years and over the years it had become gradually worse in terms of severity and frequency. He had previously undergone cardiac surgery due to an atrial septal defect and further surgery due to an uretheral stricture. He had been evaluated by a variety of surgeons and physicians including a Consultant Pain Neurologist, who considered whether 'S' might have a pain syndrome, which was part of a complex migraine. He similarly considered whether an epileptic explanation or an abnormality of the cervical spine could be the reason for S's severe pain. However it was concluded that none of these possibilities were supported by 'S's history or clinical findings. The recommendation was that 'S's complex pain syndrome needed to be evaluated as a matter of some considerable urgency as it was having a very negative impact on his life.

'S's Consultant Neurologist described 'S's difficulties:

> 'Typically his pain starts at night. It may be helped in the early stages by lying and relaxing in the bath. But this does not stop the relentless progression of the pain which becomes much more severe and migrates to being retrosternal with the severity being enough to make breathing difficult. This evolution takes place over about one hour.
>
> Other symptoms become common, namely dizziness, feeling very tense and very often but not invariably a vomit without preceding nausea. Following a vomit he often feels much more relaxed and the pain diminishes for a period of time but only to return. Sometimes the

> arm, 'S' says, feels different when he attempts to lift it up and to pick up objects with it.
>
> The duration of his symptoms can extend over a period of between three and four days with gradual resolution during that time. While the symptoms fluctuate over these days for the most part 'S' says his symptoms are as severe as they are after the early evolution.

'S' was referred for therapy by a Consultant Surgeon as further surgery was required. The consultant, 'S', and his parents were concerned about 'S's continued ill health and pain and felt psychological input would be helpful. It was clear that there were a number of unresolved emotional issues connected with 'S's medical history and his pain and it was agreed that weekly psychotherapy sessions up to and after his forthcoming surgery including seeing him in hospital would be beneficial.

'S' underwent his operation and surgeons were pleased that he seemed to make an excellent recovery. Within one month 'S's pain had returned with all the previous symptoms. Devastated, 'S' and his family sought a second opinion in America with the considered leading world authority in this field. Further surgery was recommended to take place in the USA. 'S' and his family returned to this country to await the surgery.

Throughout this time 'S' continued with his psychotherapy sessions. Throughout the sessions the communicative framework was used to listen to 'S's narratives. It became clear in communicative terms that 'S' gave encoded narratives regarding the therapist's inconsiderate treatment of him, her using him, the infliction of pain she put upon him, and at one time his derivatives suggested that he thought that the 'treatment' could kill him. Strangely 'S' also gave encoded indications that the therapist was doing remarkably well and was an exceptional therapist. At first it was considered this might be what the communicative approach called validation, but retrospective communicative supervision and analysis of the sessions proved this not to be the case.

'S's pain began to cause him less distress and he returned to his studies. When he returned to the USA it was agreed with his surgeons that he no longer would go ahead with the surgery. His pain attacks had diminished significantly. 'S' ended his therapy feeling that his pain was not disrupting his lifestyle in the way it had previously. After more than five years 'S' still remains pain free.

10.2 Introducing the Setting

The sessions that will be detailed were once weekly and took place at private consulting rooms at the same time and same place each week. The only exception to this was when one session took place in the hospital following the patient's surgery. Sessions lasted 50 minutes each. There is a practice manger at the consulting rooms and a waiting room. A consultant surgeon referred the client. The client was 15 years old.

10.3 Aims of the clinical work

This research into chronic pain and communicative trigger decoding will explore how chronic pain is perceived by what communicative practitioners refer to as the emotion processing mind. The research will particularly note encoded material relating to death anxiety and the client's unconscious response to pain. Trigger decoding the patient's narratives is likely to give possible insight not only into how the emotion processing mind views pain but also whether pain impacts on the unconscious mind at all. Analysing the session material is the means by which such insight can be gained.

11. A Communicative Analysis of the Session Material

This chapter will analyse the sessions that made up the psychotherapy of the patient ‘S’. The session material will be examined in detail according to the communicative framework and all observations confined entirely to communicative principles.

The communicative approach demands that the therapist attempt to secure the frame within a therapy. According to the communicative approach, frame violations by therapists will create a rich network of derivatives from the patient, which allude to the deviation. The therapy with S. began with two major frame violations that impacted significantly on the encoded material brought to the sessions. The frame violations were as follows:

- The patient had knowledge of the therapist outside of therapy, as he was a student at the school at which the therapist taught.
- The consultant surgeon and S’s parents had asked the therapist to see the patient in hospital when he went through more surgery and the therapist unadvisedly agreed.

S arrived to the first session10 minutes late. He apologised for being late. He explained that he had had to catch two trains and the trains had come at different times to the time he was expecting. The communicative approach maintains that all sessions start and end on time, therefore the late arrival by ‘S’ to the first session would be considered by practitioners of the approach as somewhat ominous and a response to the known deviations to the secure frame.

The therapist began the session by setting out the ground rules for the therapy. The therapist noted her two different roles, that of being teacher and therapist. She suggested to ‘S ‘ that he had not previously been aware of her in the therapy world; he had only been aware of her as a teacher. The therapist suggested that it was strange for him to be sitting with her in the therapy room. She outlined that the sessions were for him to talk about anything that came to mind and that although he had begun therapy because of his forthcoming surgery and his continued pain, he could talk about anything he wished or he could choose not to talk if he wished. The therapist explained that the sessions would last 50 minutes and would be at the same time every week. When he was in hospital and unable to come to the consulting rooms, the therapist would see him in hospital and at home if necessary, again on the same day, at the session time until he was able to return again to the consulting rooms. The therapist concluded by saying that sessions would continue until he decided that he wished to end them.

The communicative stance however is that the patient starts every session, not the therapist. Even if the therapist wishes to set ground rules, the approach requires that the therapist wait in order to allow the patient to encode around the ground rules, as he needs to, and to encode around the rules to which he is most sensitive. Also within the communicative approach there is no ground rule that should permit and give permission for silence; the patient is required to say whatever comes to mind.

More significantly however, according to the approach there is also no communicative ground rule that should promise to see a patient in a hospital or at his home. From a communicative point of view home visits are invasions and are among the most damaging deviations in which a therapist can engage The very promise of such a visit would be considered as frame violating and expresses the therapist's anxieties, not the patient's. It could be said that the therapist was afraid to be abandoned by the patient and by instigating a hospital and home visit it was also clear that the patient was unable to escape from the therapist.

In a situation such as this one, in which a patient was unable to attend sessions because of hospitalisation, a communicative therapist would review the basic ground rules when such an exception arose, and let the patient's encoded material guide her. Communicative theory maintains that encoded material will always be in favour of securing the frame; no hospital or home visits.

According to the communicative approach it is always possible to attempt to recover from a frame violation. Such recovery would entail that the communicative therapist listen to and use the patient's encoded stories to rectify the frame and reveal how such a visit was unconsciously perceived. It is probable that the unconscious perception of such a visit would be considered as seductive and violent. However on this occasion the therapist did not move to secure the frame and the frame violation remained unresolved.

The approach contends that such strong frame violations and 3rd party involvement announced by the lateness of S's arrival to the first session signify that it would be difficult for the patient to encode powerful unconscious perceptions of the therapist. He would be suspicious that as far as he knew information could be leaked to others. In situations like this, encoded themes are often curtailed and reactions reduced so that the most powerful unconscious perceptions are not expressed immediately but at a later time.

This was the case with S. for he responded to the therapist setting the ground rules by asking the therapist if she knew where he was going to have his operation. The communicative position to such a response, of S. not beginning with something from himself but with a question, would be that, S. implied that the therapist knew something in connection with him, and had gained such knowledge possibly behind his back. The therapist answered his question manifestly and then questioned him as to how he felt.

Communicative methodology states that a therapist remains silent until the trigger, derivatives and an indicator are present at which time the therapist would intervene. Answering manifestly and with a question is not considered advisable within the approach. Questions encourage the patient to give non-encoded and manifest meaning only in expressing himself and discourage the free association that is required. The approach contends that questions interfere with encoding and show that the therapist wants unencoded messages. In this particular situation it could be upheld that the therapist did not allow the patient to encode and in particular to encode that he did not want a hospital visit.

After the therapist's manifest response and question S. said the following:

> *I'm worried about some of the things that are going to happen - like the PH. That's horrible, really uncomfortable. They spray this stuff, then put a tube down your nose into your throat. I couldn't move because I could feel it and they kept pushing it down. I didn't want to do anything - just lie there. It was really uncomfortable.*

This was S's first narrative and communicatively would encode his perception of the previous intervention and the frame breaks. From the communicative point of view such encoding would show how an overactive, deviating therapist had been viewed. The themes in his narrative would encode his unconscious perception of being told that he would be visited in the hospital. The themes suggested invasion and helplessness Thus, S's unconscious perception of the therapist in this story was as invasive and overpowering, forcing him into a helpless role. The trigger of the therapist visiting him in hospital and being in a dual role because of the school connection, he perceived as an assault, something harmful. He continued:

> *I've got no control - I don't like being out of control. I was just helpless. I don't like that. Like this dream. I had this dream and I was throwing up because of the smell of the mask and the mask was over my face. I couldn't do anything about it. I knew I was throwing up, but I couldn't get the mask off.*

The encoded derivative suggested that not only was the therapist unconsciously perceived as controlling but was also perceived as in danger of smothering him by her potential visit to the hospital. S's narrative continued:

> *My Dad said it really happened. I really did throw up. I thought I was dreaming, but it could have been other consciousness state or something. The nurse didn't want to change the sheet, but my Dad said she had to.*

From a communicative position this derivative suggested the therapist was not changing the way of working within the therapy. This is non-validation and should enable the therapist to realise her error and to find the correct trigger for intervening both verbally and in securing the frame. The communicative assessment would be that the patient was encoding not to visit him in hospital. The therapist responded, a la Rogers, by simple playback:

> *It seems that feeling the mask and smelling the smell made you panicky and feel helpless and then it was as if you didn't know what was real and what was a dream. Although you felt helpless, your Dad took action.*

Such playback affirmed that the therapist was not responding as a communicative therapist. A communicative intervention begins with a specific trigger and moves to a valid unconscious perception in light of the trigger. From a communicative attitude the therapist had missed the image of not taking care of the patient's needs. The therapist's response was a manifest summary whereas from a communicative position the key would have been to remain silent and allow the patient room to tell a story so that the deep unconscious meaning could unfold.

Communicative theory proposes that if a patient is allowed to free associate and give encoded narratives, the derivatives would offer which triggers were causing most damage. Manifest playbacks are considered to discourage encoding. From the communicative stance this patient was not being given the freedom to encode because of the therapist's continual questioning and staying with the manifest material. Without narratives, encouraged through the therapist's silence, the communicative practitioner would in this situation be unable to ascertain what, if anything the patient's pain was meaning unconsciously

Communicatively, the patient had not been encoding about pain but had been giving encoded messages as to what was happening within the therapy. He was communicating to the therapist that she was getting it terribly wrong. S's next derivative reaffirmed this image as he described the incompetence of one of his nurses who was carrying out the PH procedure. He said:

> *The PH's didn't work. They kept doing it wrong and I kept being wheeled backwards and forwards. The first time they hadn't pushed it down far enough. Then the nurse pushed it some more. When we got to X-ray she'd only done it four centimetres and I had to go back. It took four goes. My throat hurt and I was frightened to move.*

Clearly the encoded message was about not getting it right. The communicative approach maintains that such non-validation is a good time to reassess and find the trigger. Until the trigger is found and an interpretation made around the trigger, the theory upholds that the network of derivatives will continue. This proved to be the case as he stated: *I'm worried about the scar. I don't like scars. I'm not a scar person. Some people like them, but I don't. I'm worried about the scar. I think it'll be about this long, here. (He pointed).*

Communicative decoding suggests that the patient had a fear of being damaged by the therapist. Had the therapist remained silent, communicative theory maintains that the patient would have arrived at the trigger of what he perceived as causing him the most damage. The therapist however did not remain silent but stayed with the manifest content and asked a question: *What does a scar mean to you?*

From a communicative position asking a question in this way provided an invitation to the patient to ruminate and avoid unconscious meaning, which indeed he did by responding:

> *Oh, that's interesting. Nobody's ever asked me about that before. Do you mean what does it look like or in other ways?*

Such manifest ruminations hold no unconscious information. Unless there are narratives, unconscious meaning cannot be decoded and again there cannot therefore be any understanding of how pain is unconsciously perceived.

The patient then narrated the following story:

> *I'm also worried about the drain. Do you know what a drain is? I've got to have this drain. I understand why I've got to have it, but I don't know about it coming out.*
> *Someone told me this story about a man who'd had a drain in his arm and they'd taken the drain out and he'd been released from hospital. Then he started getting a lot of pain in his arm. It was only by chance that he went to the doctor and found that if he hadn't gone, his arm could have gone gangrene and he might even had to have had it amputated.*

There was no doubt that communicatively the patient could be seen to be unconsciously perceiving that he was not in control of things and he was encoding a strong image of medical incompetence that was potentially hugely damaging. The communicative message was clear, the therapist was in control and was harming the patient through her oversights.

The therapist responded to the narrative but from the communicative view the therapist's response avoided the main communicative issues. The therapist stated:

> *I think this story helps me understand that you might be worried that something awful will happen to you. I think your anxiety is linked to whether you can trust people to do their job properly. On one level you were wondering would the nurses be sufficiently capable to know when to take the drain out, after all you felt let down by them over the PH procedure. If they did let you down and do something wrong, I think you're anxious that something awful would then happen to you. I think there's also part of you that feels anxious in connection with your time with me. I think you're anxious that I might not have sufficient professional expertise to look after you properly and that something bad could happen to you if I get it wrong.*

The interpretation suggested that the patient's narrative referred to the therapist's potential lack of expertise. The communicative viewpoint would be that unconscious encoding was the patient's unconscious perception of what was going on right now in the immediate situation between patient and therapist. From the communicative position the therapist had avoided seeing herself as causing the damage and had avoided the triggers relating to the frame infringements. The communicative recommendation would have been for the therapist to remain silent to allow the patient room to tell a further story. Further stories would have led to the deep unconscious revelation of the main triggering event and to possible understanding of the unconscious perception of pain.

Within the first session the patient had offered encoded information about the therapist but very little information about the unconscious perception of pain. It was not until nearly the end of the session that it became clear that from a communicative position the patient was unable to give unconscious information regarding pain because the therapist was shutting off the encoded communication. This was shown by the following comments stated by the patient: *'I'm also worried about the pain. I can't talk about pain. I've had more pain than most people have…'*

Communicatively, *'I can't talk about the pain'* was a rich encoded message, that the therapist was unable to tolerate hearing derivatives about herself. Such an encoded response contained the patient's perception of the therapist's difficulties. The communicative approach would uphold that in his deep unconscious the patient knew that the therapist was shutting off encoded communication and that she would not let him encode about where the pain was—both his and the therapist's. The communicative approach would uphold that the physical issues referred to by the patient, regarding drains, masks, scars, tubes etc were being used repeatedly for encoding purposes. They presented themes of dysfunction and according to the communicative approach such themes express a patient's unconscious recognition of how well or how badly the therapist was doing. Such negative images suggest S. was unconsciously aware that the manifest and defensive interventions by the therapist were inappropriate and damaging

Unable to communicatively hear the encoded messages, the therapist again gave a manifest playback to the patient, to which the patient responded: *'I'm sure other people have had more pain, but I don't want to remember it. I thought about writing a story about it, but I would relive it and have all the thoughts and feelings of the pain.'*

Communicative practitioners would regard S's suggestion of writing a story as confirmation that the therapist had no wish to hear encoded material. S, however, knew he needed to narrate, hence the allusion to writing the story. Communicative decoding of this image would submit that S. was aware that the therapist would suffer too much if he did encode. From the communicative stance the important component was that the patient needed to encode and unconsciously he was showing his recognition of that.

Throughout the session the therapist's interventions had dealt almost entirely with the conscious meaning of the session material and had avoided the unconscious commentary essential for a communicative practitioner to work effectively. Communicative philosophy would advocate that unless a therapist remain with the unconscious content of the session they are likely to self-reveal their own difficulties. Such self-revelation could be noticed in the therapist's immediate response to S's suggestion of writing a story. The therapist commented:

> *It seems scary for you to be back in pain. The thing about pain is that when you're in it, it is all consuming. Nothing else exists in a strange way and you can't communicate it to anyone. The greater you're in pain, the more separate you become, because no one else has any real understanding of it and you have no control and no language to explain it.*

Although such an intervention by the therapist was based on conscious and manifest meaning, communicatively such an intervention would be heeded as the therapist unconsciously revealing her own difficulties and speaking of herself. From a communicative standpoint such self-revelation implied that the therapist was scared, and was breaking away from the patient's encoded communication. It could be conceived that there was a sort of unconscious dialogue going on. The patient would encode *'Let me talk'* and the therapist would reply, *'It's too scary.'*

The patient responded to the therapist's self-revelation in the following way: *'**Well done!** That's what it's like. How did you know? That's just it.'*

Communicative philosophy asserts that conscious agreement is treacherous and seldom valid and a communicative practitioner would remain silent, listening for the forthcoming narratives which would offer the unconscious perceptions of the therapist's previous intervention.

The patient's encoded narrative followed on directly from his conscious response and was as follows:

> *I was just thinking about my game of tennis. I'm pleased with my backhand although occasionally I get it wrong. The best bit is my serve. It's strong and my coach is helping me get it better. He's good. He takes another guy and me. He's better than I am, but I can beat*

> *him if I put my mind to it. My forehand is really good and my coach says that sometimes my forehand is so good he can't return it.*
> *I really like singles because then I'm in complete control of the match and I can play well.*
> *If I play doubles I like to play with a good partner. I like him to anticipate where I will be. If I'm at the net and the ball is being lobbed, I expect my partner to anticipate that and be in the right place - to be in the right place on the court at the right time.*

Communicatively, the encoded message was loud and clear, the therapist couldn't handle the patient, and the patient might as well do the therapy on his own. He wished the therapist was the sort of partner who got it right. Expecting his partner to anticipate and to be in the right place at the right time was a message to the therapist; a communicative Model of Rectification in which a patient unconsciously offered guidance to the therapist. In this case the patient was unconsciously advising the therapist to improve her technique and listening skills. The therapist responded:

> *I think the way you describe playing tennis with your partner is relevant to our situation as well. I think you're anxious that I turn out to be a good partner and that I'll play a good game and not let you down. In a situation where you are uncomfortable because you can't take control, it was important to think that there was another member of the team who would respond well to you and help you play a good game?*

Again the therapist had suggested that the patient's encoded statement was what might possibly happen in the future. The communicative assumption however is that a patient's encoded response reports what he unconsciously perceives is directly happening within the immediate therapeutic situation. Thus the therapist's intervention from a communicative standpoint was too general and without a trigger to be of any real help to the patient.

The patient then encoded further unconscious insight pertaining to the therapist's handling of the therapy. The patient stated: *'Well you know what I mean, if I play badly I can't get myself out of it and the bad play gets worse and worse and is real rubbish. If people expect high things of me I'll do well.'*

The patient had unconsciously intimated that the therapist was becoming worse, was losing the patient's narrative thread and was unable to pull herself out of her dysfunctional rut.

The communicative approach takes seriously the therapist's attempt to work towards securing the frame. It can be seen from a communicative stance that as the first session came to a close the therapist had found it exceedingly difficult to work within a communicative framework.

The session was however highlighting how pain was being perceived by the deep unconscious. From the session content it was emerging that pain was being dealt with manifestly and not in the deep unconscious at all. The deep unconscious demonstrated more concern with regard to the therapy and the frame violations than with the traumatic intensity of chronic pain. In the deep unconscious the therapy still held sway.

The session ended overtime, which communicatively would be considered a secure frame violation. It was therefore surprising to hear the patient recount the following story even though the session was over time. The patient said:

> *'Doesn't time go fast when you're enjoying yourself. (Then he looked embarrassed and blushed). Well it's like when I walk home on my own and I'm thinking by myself and it seems to take ever such a long time and I'm really tired and think I'll never make it. But if I walk home with a friend and I'm talking to him, well, I walk home with a fifth year and a first year - they're at my school - and I know the direction because I know the way by heart and I'm talking to them all the time. When I come to the end my heavy bag doesn't seem to be heavy any more.*

> *All the heaviness seems to have gone whilst we've been talking and the time's gone so quickly and I've got home safely.'*

Such a positive story would normally be considered a communicative validation. Validations, however, generally follow a communicative intervention, which the patient's deep unconscious intelligence regards as truly therapeutic. Such an intervention would have stemmed from adaptive listening and trigger decoding around frame issues. The response given by S. could not therefore be considered a validation; there had been nothing to validate. The session had not detected a trigger or acknowledged any of the major frame issues. Communicative theory determines therefore that such positive imagery must refer to something other than a validatory response.

It is appropriate then from a communicative position to theorise that a form of unconscious denial and idealisation had taken place towards the end of the session.

Session two began with S. encoding the therapist's first efforts of working with him. He recounted:

> *I've got my exam results back. They're all right - mainly C's, a couple of B's - but then I didn't really do the work for them.*

S's encoding gave reference to the therapist's dual role. The encoding suggested that the therapist did not do badly but not well either. S. offered faint praise but admitted that the therapist did not work for or deserve the grades he had awarded. According to the communicative framework the therapist had not done well at all. Either unconscious denial and over-idealisation was therefore still evident or it could be surmised that the deep unconscious system was more generous than a communicative practitioner was. The therapist at that point made an intervention: *'I wonder if your worries about your surgery had anything to do with your grades, because you seem disappointed in the C's.'*

From the communicative stance such an intervention was ill advised; the therapist intervened too quickly and the intervention stayed with the manifest material. Again communicative theorists would surmise that the therapist did not want to hear encoded derivatives.

'S' commented immediately on the therapist's intervention: *'No. I just didn't do the work. I could've done better if I worked harder.'*

Communicative practitioners would recognise that the patient was repeating his previous message that the therapist was not doing the work.

The patient continued:

> *'I don't think I'm going to play golf tonight. My Mum won't let me. I can't see why I can't but she wants me to do my piano practice instead and then she wants to go out at 7.45. X's sister, who usually baby-sits us can't come till 8.30 and my Mum says it's too inconvenient. So I can't go.'*

Communicatively the unconscious representation was confirmed, like his mother the therapist would not allow him to play i.e. to tell stories. The patient was concerned that he must adapt to the therapist's requirements. The communicative approach upholds that therapists wait for encoded stories and allusions –material direct or encoded—to triggers. The therapist did not wait and again commented on the manifest content of the session material. Thus the therapist continued to shut down the patient's communications and resisted the telling of stories.

The patient responded instantly to the therapist's manifest intervention. In a story describing his parents he stated the following:

> *They never listen to me. I tell them my opinion, but they don't listen. If I say anything they just say 'go to your room' or 'if you say one more thing, you're in trouble' - my Dad says that all the time and most of the time I haven't said anything. I don't ever argue with them because they'll just stop me doing things.*

The deep unconscious response was verifying that the therapist had not heard him tell her that she wasn't doing her job. From a communicative position such encoded derivatives proved a non-validation of the therapist's comments. The patient was encoding that the therapist was not listening to him, she was seen to be coercing him and because of the power gradient he could not afford to challenge her. The patient was unable to confront the therapist about her actions because he believed she would stop seeing him.

At this stage in the therapy the therapist approached a communicative intervention. She stated: *I think perhaps you feel I'm a bit like your mum and Dad and don't listen to you and that I even don't let you say what you want to.*

Although the therapist lacked an allusion to the trigger, she was decoding an unconscious perception, which according to the communicative approach would normally create a favourable response from a patient. In this instance however the response was guarded. The patient responded in the manifest suggesting that he, as well as the therapist, had a fear of encoded communication: *No. I know you. I know you listen carefully. When you were a child did you know what you wanted to be?*

Had the therapist then remained silent, communicative theory suggests that the patient would have continued with a story that would encode his deep unconscious perception of the therapist's intervention and frame violations.

The therapist did not remain silent but answered in the manifest. From a communicative standpoint this again reinforced that the therapist did not want encoded material.

S then told the following story:

> *I'm playing in a tournament with my mum's friends in doubles. She's really good. She plays well. I don't expect to win the singles though, because that's against men - its men and boys. People play as well as my coach. He's really old, but he's really good. He's better than me I would say. He's strong and fast. I'm just going into that for the practice, not to win. I go to win in the tournaments for my age.*

Although the theme in the story alluded to an unequal match, that of child versus an adult, the main encoded images were positive regarding an older person close to him being stronger, better, faster. If such encoding was to be viewed as a validation communicative theory propounds that the therapist must have previously made a good communicative intervention. However in this case the therapist had remained in the manifest and had discouraged the patient from encoding. Again it is likely that unconscious denial and over -idealisation was instigated at this stage. What is also relevant is that the session material continued to denote that pain was dealt with manifestly and not in the deep unconscious system, where the therapy still continued to hold sway.

The next derivative encoding that came from the patient was as follows:

> *I remember when I was five years old, and someone had died. I went to the flat with my Dad to sort things out and stuff and I called to Dad 'Look Dad, he's lying on the bed.' I ran to tell Dad, but when we went back no one was there. My Dad said I wasn't lying because I didn't tell lies, so he thinks I really did see a ghost. Now I use him as a sort of good luck charm. If ever I need anything, I ask him to help - please W don't let me get a detention today. Please can I find my mark book - help me W' When I was in junior school we had a book with all our*

> *marks in - like merits and detentions, but not so important - but we mustn't lose them. I couldn't find mine and I said 'Please W help me find it. Don't let me lose it and I found it straight away.' I know he helps me.*

The story told of someone who was a helper. The therapist's previous silence, offering S. the opportunity to relate could have been the trigger for the positive image. However, the therapist had still not alluded to any of the triggers or made a valid communicative intervention that would be helpful to the patient. This suggests that the deep unconscious had still not fully recovered and was continuing to offer unconscious denial and idealisation. It was also S's first story about death and about the denial of death via a ghost. It would be tempting to speculate that such encoding portrayed S's death anxiety in light of his pain but unconscious insight could only be gained through further encoding.

At this point the therapist intervened with a non-decoded, non -trigger related direct observation. Communicative theory asserts that such a manifest intervention would distract from finding the trigger connected to the previous story. This proved to be the case with S. asking the therapist a direct question, which the therapist answered. Answering questions in such a way is discouraged by the communicative approach for it is considered self-revelation and a frame break, which will divert the attention away from unearthing the trigger of the previous derivative encoding.

S responded:

> *Well, it's a year to the day that Joe's sister died and Joe's cracked up and is crying all over the place. When I saw that I said to my Mum he needs a Child Psychologist.*

Although S. was commenting on a television programme the communicative message was clear; the therapist was not coping and needed psychological help. There was also an image of death and loss through death but as predicted, the trigger for such an image remained unclear.

The therapist responded in the manifest. The patient told the following stories:

> *Sometimes teaches at school are horrible. Do you know Mrs W? Do you like her? She took us for English the other day. She'd been horrible for no reason. She'd shouted at us and two boys especially because they hadn't got their reading books, but they'd been away and hadn't known they'd needed it - but she told one of the boys he had to write a 500 word essay on something because he'd forgotten his book. I don't know why she had to be so horrible when there was no need.*
> *Mr E threw me out of the lesson the other day. Did you hear about it? My Mum wrote a letter complaining - it was just because I hadn't stuck a diagram in my book. My Mum was really furious because it was a revision period for the exams. Since then I haven't been able to get on with Mr E. I'd always got on with him before, but now it doesn't seem to be as good. I always used to be really good at English especially in the first year - but now I've got Mr P and he never boosts my confidence or ever tells me what's wrong. They just cross it out or put a line through it. They never tell you what you've done. Mr P just says it's all right about a piece of work, that will do and then he puts it up on the wall with A+.*

The stories offered implicit references to teachers and specifically English teachers. The trigger for such encoding is likely to include the therapist's dual role of being therapist and a teacher (of English) at the patient's school (although not the patient's teacher). However the continuing triggers of the therapist intervening manifestly and not decoding the death images and frame related violations would be considered sufficiently significant to create such negative images. The themes of the stories indicated that the patient was encoding a sense of rejection by the therapist and a recognition that the therapeutic relationship had deteriorated. The derivatives suggested that the therapist was not allowing S. to encode or represent the triggers and that the therapist was throwing him off the scent and avoiding what was really wrong regarding frame violations.

The therapist intervened:

> *Although you're describing your teachers at school there seems to be some messages here for us too. You've told me about people who are unnecessarily unthinking and behave badly, people in power behaving poorly to people who weren't in power. I think that sometimes I don't give you the feedback in the sessions that you're expecting, especially when you've been working very hard here, it makes you feel insecure and as if I don't understand and appreciate you.*

From a communicative perspective such a general intervention which linked the derivatives to the therapist would be insufficient to help the patient. A specific trigger needed to be established and the stories decoded as unconscious perceptions around that trigger. Communicative philosophy advocates that the deep unconscious system is almost entirely frame focussed and that interventions that don't have a frame related trigger are not decoding the intelligence from the deep unconscious system.

From a communicative point of view the remainder of the session lost communicative focus and stayed in the manifest with both patient and therapist avoiding unconscious contact. It could be surmised that encoding ceased because of the types of interventions the therapist gave which were general and manifest and actively discouraged unconscious encoding. Indeed from a communicative position an intervention in which the therapist requested from the patient: *Can you describe what you mean by being good or bad?* thereby directing the patient to remain in the manifest would not only be described as counter-productive to gaining unconscious insight but as a running away from unconscious meaning and especially from death. The death themes within the session were not decoded and the therapist was insufficiently silent for the patient to encode the trigger that had evoked the unconscious perceptions of the therapist as dead for him. Within the session the therapist had been unable to allow both derivatives and triggers relating to pain and death to unfold.

Session three began with the patient asking a question:

> *Hello, how are you? What have you being doing today? Did you go into school? I had a day off. I've been playing football - with X and Y. Do you know them? Towards the end we just knocked a ball around and then we went back to my house. I cooked for them - I made cheese on toast with beans. I fried the bread and the cheese and then I baked the beans in a pan with butter. But I ran out of cheese. I had to use the cheese we'd got that was already grated, but that was okay. We used it all up, but everyone really liked it and was really satisfied.*

When a patient begins a session with a question communicative practitioners uphold that the patient does not want to encode. The trigger almost always points to the patient having been encouraged by interventions of the therapist not to encode.

The details of the story about the food are hard to translate. Although the story showed a positive image a communicative practitioner would go back to a specific intervention to acknowledge its validating principles. In this case there had not been a trigger-decoded intervention. It could therefore be speculated that the therapist had possibly made an intervention of a type that was not known to the communicative approach, an intervention that had different qualities that the patient was validating. It could on the other hand be a form of unconscious denial in which the patient stated that he felt better when the therapist did not intervene around triggers and encoded imagery. The patient continued:

> *Can I talk about what really irritates me? What really irritates me is little children who are dragged around Harrods or some superstore or something by their Mum and they're then walloped because they start behaving badly after three or four hours - that's like a double punishment.*

The theme being encoded was one of punishment and of being treated inconsiderately by someone in charge. The patient then tested the therapist:

Patient *What irritates you? Come on what irritates you? I'd really like to know. Come on.*

Therapist *I don't really know. I don't think there is anything specifically. I wonder why you ask? What brought that to mind?*

Patient *Come on.*

Therapist *Oh, I don't know - unkindness, uncalled for rudeness*

Patient *Do you mean children?*

Therapist *No. Anyone.*

By putting forward so many questions the patient was checking whether the therapist would remain in the manifest. Within the therapeutic relationship communicative therapists uphold that there is always a choice going on unconsciously both in the therapist and in the patient. The communicative practitioner would remain silent or ask the patient to say what comes to mind. In taking such a stance the communicative practitioner would be acknowledging the issues within the therapy, which were going on unconsciously. By remaining silent the communicative practitioner would be stating she would not engage with unencoded material. In this situation the therapist did not remain silent and thus reinforced that she was afraid of encoded information.

S. then made his first reference to a particular frame violation. S. stated the following:

> *In the volunteers club - have you ever given a detention? What would you do if people were rude to you?*
> *If I keep coming to volunteers all the years and I'm good, could I become top prefect? That's an important position. Do you have to be brainy?*

The volunteers club was something that the therapist ran for students. S. had therefore referred to something outside of the therapy for he had gained knowledge of something the therapist did outside of seeing him in the sessions. The therapist attempted a communicative intervention: *You seem to want to do well and be head prefect, but perhaps you're anxious about making the grade. Perhaps also you're anxious that I might not make the grade for you.*

Again the interpretation avoided frame issues and concentrated on the content dynamics. From a communicative attitude the therapist was ignoring the frame deviation that S. had expressed of having knowledge of the therapist out side of the therapy; a reflection on both the inexperience of the therapist and the difficulty the conscious mind has with frame infringements.

S's next story described a further frame violation:

> *Miss, you know Mr E? Do you like him? Do you think he's a good teacher? I can't get on with him now - he sends people out all the time for no reason. It was stupid the way he sent me out for not sticking my diagram in. It's not as if I'd lost it or not done it - I just hadn't got any glue. It was there in my book. I just didn't have that sticky substance he wanted. And to miss the revision for the exams.*

S. was alluding to the therapist knowing other teachers at the school whom he knew. He was also encoding exactly what, from the communicative point of view, the therapist was doing to him; trying to get rid of him. Although he appeared to be afraid of encoding as much as the therapist appeared to be, at least S. was able to encode that the therapist was sending him out. The themes of the decoding referred to an adult who treated a child harshly. The treatment was unjust and inappropriate the patient unconsciously declared. Now he was unable to get on. Arbitrary actions were administered against him. He was being fobbed–off and dismissed unfairly.

The therapist made a general intervention:

> *When you talk about Mr E. you describe how someone in authority over you seems to act pettily towards you so that you're disadvantaged. I think that sometimes you feel that's the case between us here - that I'm in authority and you feel that sometimes I disadvantage you.*

Such a general interpretation by the therapist did not trigger decode around a specific intervention and from a communicative standpoint it was not helpful to the patient. Communicatively it was not therefore surprising that the patient stopped narrating and went into the manifest: *Can I ask you a question? Are you sitting on a higher chair on purpose?*

The therapist replied in the manifest. The patient then told the following story:

> *It's like when I went for my interview at M. It's very posh and important and there was this huge desk. They asked me all these questions. And when I went for my interview at S there were these people asking me questions. My Mum had to sit in a corner and not say anything. I don't know why, but I was really good.*
> *It was like I suddenly got all this knowledge. Like they asked me if I knew where the Queen was offered to go when the war broke out. I thought and then I said Canada - I don't know why, is the Queen Queen of Canada as well? They said 'Well done. Very good'.*

Communicatively, the image of someone being suddenly filled with knowledge could be seen as a validation as the image was extremely strong. The communicative practitioner would link such a strong image to her previous intervention and decoding of a frame violation. However, in this case there had been no mention by the patient to the intervention that had previously been made by the therapist. From a communicative point of view such strong imagery would therefore be somewhat suspicious as a validation and the communicative practitioner would wait for further derivatives. The patient continued:

> *My Mum thought it was America. And there was this awful painting on the wall; a bit like that one and they asked me if I knew anything about it. Well, I didn't recognise it so I didn't think it was famous or anything. I thought about times I'd been to museums and stuff and I said - is it French and painted by a woman? They said 'Yes, well done. That's right'. You see, it just sort of came - I'm good at interviews.*

Again, the patient had given validating imagery of the therapist doing well and being knowledgeable. The imagery was of someone doing well in tests and interviews. Previously, when the patient had been testing the therapist regarding manifest content, the therapist had remained in the manifest and thus from the communicative point of view, had failed the test by staying clear of unconscious communication. It was therefore strange to be having an encoded communication, which gave positive images regarding the therapist's performance.

In response the therapist gave a general intervention after which the most crucial communication came from the patient: '*Is it because of your back you're sitting on a higher chair? What was it like to be paralysed?'*

After the previous two stories, which had avoided the therapist's poor interventions and ignored the therapist's frame breaks, the patient had come up with something major. The patient had referred to personal information he had about the therapist. From a communicative position, such third party information about the therapist would be considered a powerful frame violation. The patient had gained third party information about something vital – the therapist's paralysis which in itself was related to pain and suffering. This was an extremely powerful trigger and from a communicative perspective the communicative therapist would need to understand what the patient's encoded perceptions were about regarding this third party information. The patient continued:

> *I could tell you what it's like, I bet. It would be like being frightened: you'd never walk again. Is that what it was like? Do you ever play sport? Do you play sport now? If you did play sport, being paralysed would be much worse, that's what it would be like.*

In order for a communicative practitioner to gain insight to the encoded perceptions of the previous powerful trigger about the therapist's paralysis, the patient would need to tell a story. However, the patient had not told a story – he had gone back to making statements and asking questions. Following communicative thinking, it could be conjectured that the patient did not tell a story at this point or give encoded information because it was too frightening a trigger to acknowledge. It could be viewed that the patient went back to questions to defend himself from his own encoded narrative. The therapist also demonstrated that such a trigger was damaging for her as well for in her response, the therapist warned the patient off the trigger of her paralysis. The therapist responded as follows:

> *I've noticed whenever I say anything in connection with you, you swap things round so that you focus on me - it's something you seem to be able to do really well.*

The therapist's negative comment was almost a reprimand, symbolising the therapist's unconscious fear of the trigger of her paralysis being alluded to. In the communicative approach, the communicative therapist appreciates that the patient will always be commenting about the therapist. In this case, human nature took over as the therapist became scared and angry of this terrifying trigger concerning her. Both therapist and patient remained briefly with manifest content until the patient asked the therapist if she knew about the Blue Elephant or the White Elephant. He then told the following story:

> *They're the most gorgeously wonderful Taiwan restaurants. Everything is delicious and beautiful. It's so lovely; it's just gorgeous. It's very expensive, but if I want to take someone special somewhere, that's where I'd take them - because it's the most special deliciously lovely place.*

Such positive imagery could be considered an excellent validation of a previous intervention. The positive imagery described how the therapist made a patient feel special. It contained images of nourishment and beauty. From a communicative position, it would be quite extraordinary to have such a validation following the previous intervention from the therapist, warning the patient away from the trigger of her paralysis. It would rather be considered from a communicative position, that such positive imagery was not validation but unconscious denial that was being instigated by the patient. The patient was glorifying in the therapist's denial and avoidance and he was over-idealising her. However, from a communicative point of view, what he was encoding was highly significant. The world of denial he was suggesting was deliciously lovely and it can be deduced that given what both the patient and the therapist would have to deal with regarding the previous trigger of paralysis and death, that such a denial would indeed become a paradise.

The patient continued:

> *I really love it - if I ever needed somewhere beautiful for someone that would be the place - it would show them they were special. They have such gorgeous things, so beautifully made - like fruit carved into things. The people are wonderful. I really admire it. It doesn't matter that it's expensive because it's really worth it - and I'm not paying.*

In this story, the patient continued to over-idealise the therapist and the therapy and unconsciously deny the therapeutic issues that were being revealed. In this story the patient had also encoded another trigger – this time about the fee issue. The therapist was being paid through the patient's parents' medical insurance; thus the patient was not paying the therapist any money. He was encoding that it was indeed a great paradise, and one for which he did not even have to pay. The allusion to the money related to a frame issue and a frame sensitive therapist would have been aware that the patient was not paying and there was an absence therefore of the fee.

The patient continued his encoded description by giving details about how he chopped the heads off the food animals. He mentioned that he felt dreadful about doing such a thing as the food had been so beautifully made and presented.

On one level such an encoding could, from a communicative position, be considered a reference to death anxiety following encoded validation. The patient would be confirming that they had been struggling with the awareness of destruction and death. However these stories resulting from the therapist's warning away from the paralysis trigger could not be considered a communicative validation. Again it could be proposed that what the patient was encoding was unconscious denial instigated by the violence that was being done within the therapy. It seems the patient unconsciously perceived the therapist's actions as something truly terrible. From a communicative point of view this was a comment on a therapist who was not thinking or decoding as required by the communicative approach.

The patient confirmed this in the story he told at the very beginning of the next session:

> *I got my report today. I got two A1's and some B1's and two C's - but I also got a D4. I got that for English. I was amazed - it's because of Mrs P. I know I could have done better, but she never encourages me. She never really helps me. It's because of her, but I can't say anything or do anything. I can't go up to her and say I'd do a lot better if you gave me a bit more support. You can't argue with teachers, you just make it worse.*

The encoded images were of an adult in charge whom he could not challenge and from whom he wanted more. The theme suggested that the patient was afraid to tell the therapist how badly she was doing. He appeared to be in a very vulnerable condition, which from a communicative point of view was very true, in light of the frame violations that had been revealed. The images referred to how the therapist was specifically failing him. His final comment of, *'you can't argue with teachers – you just make it worse'* gave some insight as to why the patient had included such previously positive - toned stories.

Much of the session was negatively toned and the patient recounted stories about school in which the images were of a restrictive environment with people who didn't help him. The therapist then made an intervention:

> *A lot of what you've talked about has been connected with your good report being let down by a bad English grade, that you're unsupported by your teacher and school just goes on too long. I wonder whether that's the same here - that you feel things went well initially, but now perhaps things are going on too long here and that you don't feel the need of it.*

The therapist's intervention did not acknowledge any of the major frame violations that had been revealed. The intervention merely played back the manifest comments made by the patient. The patient then told a story, which reflected his unconscious perceptions of the therapy. The patient asked the therapist what was her favourite television programme and then continued:

> *Mine is EastEnders and my favourite film is Forrest Gump. The first time I saw it, it was in someone's home. There were about 10 rows of seats and I had a private view because we were staying with these people.*
> *It was wonderful - it was before the film had been released. There was this bit in it where he says...*
> *It was so funny. It's about this guy who, although really basic, makes good. He's great. Now I watch it all the time. As soon as it came out, I got a copy. I watch it about two or three times a month.*

The patient had referred to a private place in which he saw the film Forest Gump. He stated how wonderful it was to see the film there. The description of a private place, from a communicative stance would be considered a private space in which he did not have to put up with the therapist and was away from the therapist. The film described, Forest Gump, told the story of someone who was mentally impaired but made good. From a communicative position it could be considered that the deep unconscious was either being generous in stating that the therapist was making good or was unconsciously denying the real situation.

The next session began with the therapist's reminder to the patient that it would be the last session before the two week summer break. The following session after the break would take place in hospital. The therapist stated the following:

> *I'm fine - but I want to begin by telling you that I will be taking a break for the next two sessions and that the next time I will be seeing you will be in hospital, after your operation. I'll come on the Friday our normal day and at the normal time of our session - but we won't be having the next two sessions.*

It is a basic communicative principle that the patient is entitled to begin the session with his problems. In this case, it could be communicatively considered that the therapist was beginning the session with her problems. The communicative position would recommend that the therapist wait to make an announcement of that kind and it would normally be done in the middle of the session; to give such information at the beginning of the session would be seen as overloading the patient. Communicative principle states that the therapist wait to hear what the patient has to say and then introduce such information at an appropriate point and as part of an intervention.

The very promise of such a visit to the hospital by the therapist would be considered hugely frame violating and expressing the therapist's anxieties, not the patient's. In the communicative approach, there is no ground-rule that should promise to see a patient in hospital. Such visits would be viewed as invasive and are damaging deviations to the frame. If the patient had offered stories following such an announcement, there would be no doubt from a communicative stance that the stories would offer that the patient would not want the therapist to visit. It would be considered too seductive and violent. However, the patient did not tell a story, he asked a question. He asked, *'Will I have a drip?'* Again, unconscious encoding was being avoided. The patient was stating consciously that he wished to talk directly about the hospitalisation and the therapist agreed to do that. From a communicative point of view the therapist was saying that she was allowing the patient not to encode.

Within the therapy, a pattern seemed to be emerging regarding working with pain patients. The continual returning to manifest content by both patient and therapist suggested that deep unconscious experiences were dangerous to both the patient and the therapist. It needs to be remembered that in the work with this patient there was his pain, his operation, the secure frame anxiety, the entrapment anxiety and major frame violations to be considered.

The patient remained in the manifest and asked: *Will I have to have a PH? I really don't want to have a PH. I don't see why I'd have to this time?*

The patient's suggestion was that he did not want to put up with the treatment that was being inflicted upon him. Communicatively, that would be considered a response to the previous intervention when the therapist announced her holiday and her visit to the hospital. It would also be conceived that such a comment was the patient stating his perception of the therapist. He had perceived that the therapist did not want him to put into her things that were going to cause her pain. The patient did not want a procedure that was going to harm him, but he was also unconsciously aware that the therapist did not want to hear derivatives that were going to harm her. The patient was aware of the therapist's anxiety in being taken into unconscious areas to which she was highly sensitive.

The patient and therapist continued to discuss surgical procedures in the manifest. The patient referred to his fear of pain. At this juncture the therapist gave an intervention: *It won't be horribly painful - but I think my announcing the break has made you anxious. You're telling me about procedures you are not looking forward to, like me taking the break.*

The therapist considered the announcement of her break as the significant trigger around which the patient had been giving derivative information. However, from a communicative position the imagery that the patient had been given was not about an interruption and it is therefore unlikely that the patient's derivatives were about the break. Communicative methodology states that if the therapist was intending to interpret derivatives around her break, then the stories would have been about somebody being away or about loss or absence. The job of the communicative practitioner is to let the themes direct her to the trigger. The therapist's break was indeed a trigger, but it was not a trigger that the therapist had been lead to by the patient. The patient responded to the therapist's intervention – he stated:

> *I'm tired. I've hurt my wrist. You know the sliding tackles in football. I was playing with A and did a flying tackle and then I must have done something because I've really hurt my hand. It's not swollen but it's tender. I think I'll tell my Mum to take me to the physiotherapist - not for that - for my back. I think I need it. I can feel the knots. They said I'd have to keep having treatment.*

This unconscious encoding did not give positive images. The images were of someone who was injured and who needed help. Communicatively the patient did therefore not validate the therapist's intervention. The intervention had been premature and the patient was stating that the therapist needed help. The patient then continued: *This insurance. Will there be any chance they will stop it - that it won't go ahead?*

At this point the therapist intervened:

> *I know you're asking about insurance and your operation, but I think what you've said is connected with our sessions too. You're asking if someone responsible for carrying something out, like an insurance company, can renege on their commitment and not go ahead. I think you're telling me that my announcing the break is doing just that - reneging on my commitment to be with you for our session times.*

From a communicative point of view, the image suggested that someone was reneging on a commitment. The patient's comment about his medical insurance being stopped might refer to his concern about the possibility of the stopping of the sessions. However, communicative philosophy would state that the way that the therapist had really reneged was by not allowing the patient to encode. The communicative practitioner recognising that the previous intervention had not been validated would have remained silent to encourage further stories.

The patient responded with positive imagery following the intervention. He recounted what a fantastic tennis lesson he had had that day. It is difficult to assert whether such positive imagery was validation or unconscious denial. The patient had not been generating stories of power or frame and from a communicative stance without such stories, it would be difficult for the communicative practitioner to decode unconscious perceptions.

The patient then told a further story: *My friend A was ill last night. He was really bad - he'd had too much popcorn and thrown up in the night four times - but he felt much better this morning.*

From a communicative position, this story was referring to the therapist's previous intervention. The patient was stating that all this popcorn was making him sick. From a communicative viewpoint it did not sound as if the previous tennis image had been validated.

The patient continued by telling a story about wanting to buy some special trainers and to spend some of his birthday money. He continually mentioned that he would do this on the day of the session. The therapist commented that in continually referring to the session day, that he would like her to be particularly aware of something. The therapist then referred to the fact that she would visit him in hospital and so she would see the trainers there.

Suggesting such a visit was a trigger far more powerful than the therapist being away for two weeks and contemplating such a visit would be considered part of a major frame violation. The therapist had announced a major deviation, a change in location in which the therapist would invade the patient's space. A communicative practitioner would not have made such an intervention, for there was no encoded image around a trigger so powerful. However, having made such an intervention regarding a major frame violating trigger, the communicative approach would uphold that the therapist then remain silent so that the derivative images could emerge.

No such images came about and it was becoming evident that a pattern was emerging in which neither therapist nor patient was able to acknowledge unconscious perceptions around a trigger so powerful.

The patient reverted back to manifest content, asking the therapist where she was going during her break. The therapist staying with the manifest content answered the patient. Communicatively, it could be considered that the patient's question *'Where are you going?'* was really referring to the fact that the therapist was going to the hospital. However, neither patient nor therapist would allow such themes to be developed.

The patient then told a positive story about a place that he was going to at Easter:

> *I'm going to A at Easter. Have you heard of X? It's fantastic water sports, scuba diving, hang-gliding, windsurfing, water skiing. My friend's taking me as his birthday present. I'm really looking forward to it.*

From a communicative standpoint, such positive imagery could not be considered validation. The therapist had previously self-revealed in discussing her holiday-a further frame violation. Further insight was emerging: patients with very powerful death anxiety (which would be typical of a pain patient) evoke very powerful unconscious denial.

Such unconscious denial was extended in the further story that the patient told:

> *On Friday all my family from P are coming. We're going to have a special dinner at M. That'll be pretty fantastic. Then on the Saturday, it's my birthday. Then there'll be the lunch. Then on the Wednesday, it's my friend's birthday and my other friend's birthday. He's hired a boat for the day and we'll all be going out on that. Really good.*

Communicative theory upholds that the therapist remain silent at such a time, for it is likely that following such unconscious denial and positive imagery, the patient would revert back to an encoded unconscious perception of what was materialising within the therapy. The therapist however broke out of role and asked the patient if there was anything he wished to ask about his forthcoming hospital visit. The therapist had taken the role of a doctor or a nurse. Communicatively, such an intervention would be considered unhelpful. From a communicative stance, when there was such a powerful frame violation, the therapist would allow the patient to tell stories. The communicative therapist would do nothing else but wait to see how the patient reacted. The patient then stated:

> *In tests why do teachers set you revision, tell you what to revise and then you never get questions on it?*
> *(Purposefully) Why is that? When they've seen the paper and know what's on it.*

The theme the patient was encoding was that he was purposefully being misled to do things that weren't required and was a comment about the therapist's previous intervention.

The therapist's two-week break occurred and the following session took place in hospital. The patient was in bed; it was his third post-operative day. He appeared depressed with no facial movements and lay still. He spoke with a very faint voice, and evidence of surgery remained with tubes, drains, and bags including nose tubes and stomach tubes being evident. Various nursing procedures had gone awry and the patient had been catheterised. When the therapist arrived, the room was full of visitors, the nurse was taking blood pressure and checking the patient was comfortable. The visitors were watching a video.

The communicative view would be that considerable frame violations were taking place above and beyond the major frame violation of the therapist visiting the hospital. It had previously been agreed that at the time of the session, the room would not be occupied and that nursing procedures would not be carried out during the session hour. As the therapist arrived in the room, the patient's mother took the therapist by the arm and escorted her out of the room. The mother began to discuss the operation and all the procedures to the therapist. The mother was distressed. The therapist cut the mother's explanations short by saying that she needed to see the patient. The therapist returned to the room. There was much moving of pillows etc. as the patient had signalled his discomfort. The patient did not acknowledge the therapist. He then weakly asked, *'How was your holiday?'* The therapist remained silent and the visitors left the room. The therapist sat next to the bed, but needed to change the chair. From a communicative attitude, the frame violations that had already taken place and continued to take place were extreme.

The 'session' began with manifest comment. The patient asked, *'How was your holiday?'* The therapist remained silent. The patient asked the therapist if she had seen his stones and he urged the therapist to pass the bottle, which contained the stones to him. The therapist did so. From a communicative point of view, the therapist passing the bottle of stones to the patient created yet another frame violation; a frame violation of physical contact. The patient shook the bottle and passed the bottle to the therapist.

He motioned for the therapist to take the bottle. *'See, look.'* He motioned again for the therapist to take the bottle.

The therapist, remaining in the manifest said, *'They represent a lot of pain for you'*

The manifest content continued. The therapist had difficulty in remaining silent and allowing the patient to encode some narrative. The patient asked '*Where did you go on holiday?'* and urged the therapist to tell him about it. The therapist responded as follows: *It was very hot, but the thing that strikes me most is that a sort of war broke out very near to me between X and Y. You look a bit wounded too. (Motioning to the tubes and bags).*

Such a response could not on any account be considered a communicative intervention. From a communicative position, the therapist was not only self-revealing but was free-associating. It was an extreme response and communicatively it would be considered that the therapist was unconsciously stating that a war was going on in which she was wounding the patient. It was both an unconscious self-revelation as well as a conscious one. However, it is possible to gain insight from such self revelation and free association for unconsciously it could be seen the therapist was stating that there really was an underlying war going on, which the patient had not been able to reveal through his narratives. The patient had been unable to reveal what was happening because the therapist had not allowed him to encode.

From a communicative position, such self-revelation would undoubtedly create an unconscious perception from the patient. The therapist remained silent. The patient then responded with the following:

> *'I don't like that nurse that was here – that big one. I had a very bad night. I needed to go to the toilet and I couldn't go. I kept trying, but I couldn't and it was so painful. There was no one here to help. It was terrible. About two hours later they got someone to put a catheter in'*

Such a response was a direct comment on the therapist's self-revelation. It was the patient's unconscious perception of the therapist, that she had so much inside of her, that she needed help. The therapist intervened:

> *That sounds really horrible, you were in terrible pain and the people who should have helped you weren't there - even though you kept trying to help yourself. I think that's also a comment about me - I'm a person who should be helping you and even though you're trying to help yourself, I wasn't there when you felt terrible pain and you needed help. You had to wait two hours for the doctor and two weeks for me.*

The therapist, in referring to her two-week break, had chosen the most innocuous of all the frame violations. The therapist appeared unaware of the major frame deviations and had picked arbitrarily on the two-week break. The therapist had not allowed the patient to build up the derivative imagery so that he could describe the most fundamental trigger. At that moment a nurse entered the room and interrupted the session. She said *'Hello'*. The patient looked down and went rigid. The therapist was moved away from the bed as the nurse took the patient's temperature and blood pressure. The nurse attempted to put a thermometer in the patient's mouth. He refused and said *'under my arm'*. There was confusion as the nurse hurt the patient in trying to place the thermometer correctly. The nurse moved the bed, and went to take the blood pressure. The nurse spoke to the therapist. The therapist remained silent. The patient said, '*The nurse said, are you my mother?'*

The nurse continued to hurt the patient with the thermometer. She checked the saline drip, and the urine bag, she was dissatisfied and tapped her foot. Hurting the patient again, the nurse removed the thermometer and stated that she would return to do the bags. Silence.

From the communicative point of view, such a situation could not be considered therapy. There had been no privacy and a third party had been physically present within the room. From a communicative viewpoint, only one thing would be possible and that would be for the therapist to listen and receive guidance from the patient's unconscious intelligence. The patient stated *'I feel very tense, I feel very tense'*.

The therapist did not remain silent but stated. *'I wonder if you're tense because I'm here and saw these things happening to you?'*

The therapist had not allowed the patient to narrate, nor had she allowed his unconscious intelligence to offer guidance as to what should happen next. The 'therapy' was then interrupted again and the same nurse returned to the room, checked the urine bag, moved the bed hurting the patient, tidied the sheets and holding both urine filled jugs in full display, left the room. The therapist remained silent. The patient spoke, *'I feel very tense, very tense. I feel I need a run or a swim'*.

The therapist remained silent. The patient stated urgently, *'I want to sit up and go for a walk. Will you help me?'*

The therapist remained silent. The patient tried to move but couldn't. He was in distress and the therapist moved to help him. The therapist helped the patient to sit up and to get ready to stand.

From the communicative framework, the therapist was in total denial of what was going on within the therapy. The therapist appeared oblivious to the many deviations including one of the most intrusive violations, that of physical contact. Further frame violations took place as the therapist helped the patient out of bed. At the end of the session the therapist stated:

> *It is after our session time and I will go now. I will come back at our session time next week. I will come to the hospital or, if you are home, I will see you there.*

From a communicative framework, this had been a most extraordinary session with huge deviations and with the therapist not allowing a single opportunity for the patient to encode. From a communicative stance this session would be considered highly unsatisfactory.

The underlying issues from a communicative point of view would be to consider whether the therapist would be able to allow the patient to encode and whether the therapist would be able to control her own death anxiety and not deviate or compound it.

The following session took place back at the consulting rooms. The patient began the session as follows:

> *I'm more talkative this week. I couldn't really talk last time. What will happen when I get back to school? How will it work? Will I sort of go in for a day? When can I go back? Do you think I can go back in a week? How will I know?*

The therapist responded in the manifest by stating that the patient's GP would be involved and continued to answer in the manifest the questions the patient had asked. The patient, by asking a number of questions and remaining directly in the manifest, was avoiding encoded communication and the therapist, by responding in the manifest, was letting him know in return that she too would keep on that level. From the communicative point of view, intervening in the manifest discouraged encoding and invited non-encoded communication. The patient responded to the therapist's intervention about the GP in the following way:

> *Shall I get X to come and see you and organise the notes? When will I have a teacher, I suppose I don't mind having a tutor if they're all right. I don't mind doing the work sometimes, particularly if I don't understand something. In class, if I ask someone to explain again and then I still don't understand, I feel stupid.*

The intervention had therefore not been validated and the patient was questioning whether the therapist needed help. Even though the therapist had been told again and again, she still seemed not to understand. The patient gave guidance to the therapist:

> *Can you help me revise? I don't know how to revise. I sort of read and read and read and then I get tired and I don't know what to do. Can you help me? Will you help me?*

The message to the therapist was that she had to revise what she was doing. The therapist gave an intervention in which she acknowledged that she needed help. The therapist was trying to get herself and the patient back on track and encoding again. However, the therapist had avoided her hospital visit, which, from the communicative point of view, was the greatest of the frame violations.

The patient then offered the following narrative:

> *There was a bit of a kerfuffle the other day because this bag here- (pointing to the bag attached to his stomach) -the end came out. Not the end in the wound but the other end. Something happened and all this bile and all this gunge came out all over my shorts and everywhere and we had to mop it up. I had to rush back to the hospital. They had to fit me in a new one. It was all right but it was quite a kerfuffle.*

The negative image that the patient had portrayed was of something becoming detached, and causing a mess, which needed clearing up. From the communicative position, the message was that there was a mess underneath all that was going on and it was a mess that the therapist was causing.

As the session continued, the therapist told a story to the patient. Although consciously it could be seen that the therapist was responding to the patient's question, unconsciously from a communicative stance, the therapist was modifying the frame. Such modification from a communicative point of view was considered a further frame violation. Instead of responding negatively to such a violation, the patient made the following positive comments:

> *Some of the nurses were quite good too. I liked them. Some didn't always inspire confidence but some of them were really nice. They tried not to hurt me.*

Again, this could not be seen as communicative validation. There had been no interpretation from the therapist; there had only been frame violation and it appeared that such frame violation had evoked unconscious over-idealisation and denial. Another pattern was emerging following instances of unconscious denial and over-idealisation. After such occasions the patient would then reveal another kind of encoded perception that was powerful in a way that none of the other encoded images had been throughout this session. An example of that could be seen in the following derivative following directly from the previous over-idealisation. The patient stated:

> *But then they say, this won't hurt. I say, 'Well can kick you if it does hurt?'*
> *She says,' Well it might hurt a bit!'*
> *I found out, if they say it won't hurt it means it will hurt. If they say it will only hurt a bit, it will hurt lots. I wonder what it would be like if they say this is it really going to hurt! It probably means you're going to die or something.*

This portrayed a strong encoded image, the implication being that if you really get to things, death would be waiting. The patient unconsciously encoded that the therapist lied to him and that the reason for the lies was that death would be revealed otherwise. The patient continued the story in the following way:

> *I can understand why they have to do it. You can't really tell the patient that it's really going to hurt them. I mean they've been trained in Medical School to do that.*
> *This doctor came in and he said, 'I've got my no pain needle! Do you want me to use that?'*
> *So I said, 'Yes!' He took the blood with the needle and I yelled and he said, 'Oh dear, it must be the wrong one. But he was a young student, he was just learning. He'd got this awful haircut, he looked like Dracula! It was all shaved at the back and came down in a 'V' at the front. It was really bad!'*

The negative images in the story were based upon someone who was dishonest in a particular way. The patient described the person as being like Dracula and he therefore represented the therapist as a vampire taking his blood. The image was one of deception and had been evoked by the therapist telling her story. Communicative theory maintains that radical frame violations will always activate encoded communication. The communicative approach states that such encoded communication is a strong activator of the deep unconscious system. The communicative approach demands that the therapist listen to the imagery given by the patient, so that they can gain access to the encoded material. The communicative therapist would rectify what needed to be rectified from the patient's imagery and interpret it. In this case the patient's encoded perceptions put forward that the therapist was being deceptive. The patient had been told that there would be no pain, but pain had been inflicted. Communicatively, this was a theme of deception and would be linked to the therapist's interventions. The therapist's interventions were taking away from the patient what he was experiencing unconsciously.

The therapist began to intervene. However, the patient interrupted the intervention and told the following story:

> *It was really interesting at H. They were good but some things they never got right. My mum ordered toast and jam for breakfast but she kept getting croissants and marmalade. I ordered baked beans on toast and I got white bread with cheese on it. My mum had ordered croissants the first day and every day she put in a different order for toast and jam but she's still got croissants. She said,' Perhaps if I order croissants and marmalade I might get toast and jam!*

The communicative practitioner would perceive that such encoding was informing her that she had got it wrong. The patient had interrupted the therapist's intervention, deciding that the therapist was not going to be able to give him what he wanted. The therapist had intervened before a trigger was represented. Such non-validation from a communicative point of view would re-enforce that it would be time for the therapist to reformulate and to consider what trigger she had missed.

In the following intervention, the therapist attempted to include the trigger of her becoming a nurse, rather than a therapist. She stated the following:

> *So people get things muddled up. You don't get what you ordered. It makes me think of last week, how you didn't get what you ordered in*

> *me. We have this as our talking time but I ended up doing all the other things, not what you ordered at all! I became your nurse, your helper.*

However, such a trigger was the therapist's association. It had not come from the patient through any of the patient's encoded responses. The communicative approach upholds that a practitioner needs to wait for the patient to reveal the trigger. In the communicative approach, the therapist must uphold the significance of the major frame violation. In this case, the major frame violation was the therapist going to the hospital.

The patient offered a series of narratives as follows:

> *I suppose I could have called a nurse but I didn't want to. You were there. You had to do it. I wanted you.*
>
> *It's amazing at H you know. You know that women who is having all the babies? Well she's there. They told her that they won't all survive but she's going to get a million pounds. The world record is six babies and the doctor said she's got to exterminate three of them or perhaps four and then that would give her twins or triplets or something but she won't and that's because she's going to get the money. She has already got bad press.*
>
> *And you know that girl; the girl whose mother was killed -and sister -in the alley and their dog. Well she's there as well! And the father! Well he is suspected - I think because of the dog- because why would they kill the dog? I think it's because of evidence. If the dog went near him, the dog would bark and they would know! The girl goes along the corridor and if people say anything to her, he says, 'You don't need to answer that.' And he's gone off and got married again!*
>
> *And there's that other women - you know the one with the baby, the one where the baby was stolen! It's been in all the papers. She is there too you know! Every day I was there, H was in the news!*

The images portrayed were of someone who had endangered others for her own gain. The patient was encoding that the therapist was using him for her own purposes. The image maintained that someone did things that were dangerous for him and prevented him communicating. Someone was guilty of a crime, but wished not to be found out. There was a further image of betrayal, that someone who had left was no longer loyal.

Although the patient had offered powerful narrative, it was not clear from the communicative viewpoint how such narratives were connecting to a trigger. However, it was clear that the patient considered that the therapist had exterminated him and other people as well. A communicative therapist, in hearing such encoded derivatives, would ask themselves what they had done that had led to such specific encoded perceptions of them. The encoding gave information about murder, violence and stealing. The patient was stating that in some way the therapy had done absolute violence to him. In order for a communicative practitioner to interpret the patient's unconscious perception, she would need to have an understanding of the trigger. If the patient in forthcoming stories did not allude to the trigger, the communicative therapist in order to gain insight into the derivatives might say something along the following lines:

> *'I mentioned something about the hospital and my mention of that evoked considerable imagery of people doing violence and murder, stealing babies and murdering children. There is something about my visit that you experienced as a murderous, vicious attack.'*

A communicative therapist might try to gain additional insight through focussing on one of the images portrayed in the story, such as the image of the murderous father seeming so calm and visiting his daughter in hospital. A communicative therapist would call upon the significance of the image in making an intervention; the significance being that the father visiting the daughter was also a killer. The communicative therapist might therefore say something like the following:

> *'I visited you and although I seem nice, you are also saying underneath that I am something of a killer.'*

The therapist in this situation attempted to make a communicative intervention. She stated the following:

> *The theme of what you talk about at H's, is about how people use others. In the story of the mother of the babies, you feel she's using her pregnancy to get the money. She's using the babies for the money. The father of the little girl is under suspicion for bad things - and the mother who had the baby kidnapped - that's bad too. The stories are about people harming others. I think there's an element that's somehow connected with us too. I think you feel I'm using you for my own purposes and that in doing so something is being taken away from you or is harming you.*

From a communicative position, it was clearly evident that the therapist in this intervention left out murder. The therapist had backed away from death imagery and had not mentioned the horrific image of someone killing three babies. The therapist's intervention was general and wishy-washy and stayed away from violence and death and the specific trigger that had created such images. The patient surprisingly responded to the therapist's intervention with positive imagery. He stated:

> *Have you seen Independence Day? It's a fantastic movie! It's really good!*
>
> *It's about, well this story is really good, and there's one-man - there's one person who finds out. This person is the only one who gets the signal! You know the signal that the aliens give them from Out of Space. There's only one man who gets the signal! It's a really good movie. (S. describes the movie at length). You should go and see it. Yeah! You should go. I'd give it 9 out of 10.*
>
> *Another fantastic movie is coming up with John Travolta called 'Phenomenal.' That looks really good too. It's about someone who does something with their mind! The highlight's I've seen look really fantastic. I saw the hunchback of Notre Dam as well, but that wasn't so good.*

It was as if such positive images were supporting the therapist backing away. The therapist had ignored the murder and violence and the trigger of the previous narratives. Such positive derivatives could not therefore be relied upon to be validating imagery.

The next session began with the patient describing his pain. The patient stayed with manifest content as he asked a series of questions regarding school. He said the following to the therapist:

> *How's school? How was it today? What's it like? What will happen about me? Do you know about the tutors? Who are my teachers? What lessons am I having? What should I have had today? Will you tell me? How will I know otherwise?*

The therapist acknowledged his need for practical information about school. The patient again pleaded to receive more information:

> *But please will you tell me? If you can't tell me today please will you tell me next Tuesday? Please can you bring me my timetable and tell me my teachers? I need to know. What if I have Mr E again? How would that be? Please tell me!*

The therapist, overwhelmed by the patient's demands, replied:

> *I think you want me to be a teacher today - it seems very important to you. I can tell you what you want to know. The information is in my car and I have to get it*

The therapist then left the therapy room in order to seek the information the patient needed. From a communicative point of view, this was a major frame violation. Not only was it a frame violation, it symbolised a denial of death with the therapist disappearing and then returning. Communicative theory determines that such a major frame violation would create strong encoded communication. Communicatively, it could also be considered that the therapist leaving the room was the therapist's way of confessing that she was doing something deviant, that abandoned him. It was the therapist's unconscious reaction to the violence she had done to him.

The patient responded in the following way to the therapist leaving the room:

> *You know my friend J? His sister, she is 16 years old. She baby-sits for us, well she baby-sits my younger brother and my little sister. She has just done her GCSE's. She got four 'A' stars, two 'A' s and a D.*

Communicative theory could not condone such a story as validating the therapist leaving the room and going to the car. It seemed that such a frame violation was so violent, that unconscious denial has been activated. The patient had previously given encoded messages about murder and killing, which the therapist avoided. It emerges that, with further frame violation, the patient was relieved to get away. The patient continued to give positive images and positively toned stories. Only one small negative image slipped in to the positive stories. The patient accounted a time when he was being photographed with a tiger and there was a photograph of the patient with his head in the tiger's mouth. Communicatively, such an image encoded the danger the patient felt from the therapist.

The therapist remained silent and the patient then told the following story:

> *Well I have this great big fish tank. It's a huge fish tank and I had a crab in it. The crab somehow got out of the big tank. It somehow got out and my dad came home one day and found the crab walking down the stairs. He picked the crab up and put it back in the tank. The crabs have always tried to get out of the tank. But it must have cracked its shell or something because a few days later it died. But in my tank I've got this wonderful Needlefish. You have to feed it live shrimps. So you have to feed the food that feeds the food if you see what I mean!*

The story revealed a death image. The patient recounted how the crab had escaped out of a healthy medium into a different space, where damage was done and death was caused. This image represented the contact between the therapist and the patient at the hospital. The patient was encoding that the therapist's conscious wish to help him at the hospital was an unconscious moment of damage in which he was annihilated. In order to gain a greater perception of the encoded communication, if the patient did not encode the trigger by mentioning the hospital, a communicative therapist would play back the images around the trigger. The therapist still had not dealt with the major frame deviation of her visit to the hospital. Communicatively, it would therefore be quite appropriate to use playback to the patient and intervene that the patient's stories described something about getting out of an environment in the situation where there was health and growth and survival. The image portrayed being touched outside of that space and even though returned to the healthy environment (the sessions with the therapist in her office) the damage had been done and in some way, the damage led to death. The patient continued before an intervention could be given:

> *So down stairs we've got this polystyrene thing where we grow the shrimps and feed the things to the shrimps. Every day you have to feed the Needlefish five or six shrimps, not at the same time- say two in the morning, one in the afternoon and two at night. It's got teeth and a big mouth.*

Again, the patient had encoded an image about devouring and being devoured; there was an annihilatory quality and an invasive quality about the imagery. The patient finished his story by describing beautiful fish, their wonderful colours and how he loved such fish.

The therapist made an intervention:

> *I found the story of the fish was a bit like a parable, a bit like a moral tale - the story of the crab who left the place it should be and went into different areas. The result of this was disaster! The other part of your story told about the fish that were in their right place; they were all beautiful and gorgeous. (S. interrupted me with more stories about beautiful fish.)*

The therapist continued:

> *In a way your story reminds me of us, because I'm a bit like the crab. Initially you knew me in the water as your teacher that's how you were familiar with me. Now I'm sort of coming down the stairs if you like, and out of the tank. I am now in territories that are different. This is a new territory here. I think part of you is telling me it's a bit disastrous when I'm out of the tank, and when I'm here.*

From a communicative point of view, this interpretation was seriously flawed. The error was in the therapist believing the safety of the tank as being the teaching. From a communicative point of view, the tank had to be the therapeutic frame. From the communicative perspective, the intervention pointed out that the therapist had not understood where the healthy environment was. The therapist had not taken the therapeutic environment as the holding environment. Unconsciously, the therapist was saying that she had no wish to talk about the hospital and death. From a communicative standpoint, this was a common defence in which therapists take themes and generalise them instead of decoding the specific image, the specific story to the patient.

The patient's response to what the communicative approach would consider a flawed intervention was to offer positive images:

> *Oh! There's another fish - a big red fish! It's gorgeous; it's all stripes - with orange and red stripes. You know, like the tiger is orange and black, this is really beautiful. It's a big funny shaped fish. It's lovely. Oh! I forgot, I forgot! We've got a sucker! The sucker is the one that*

> *goes round and sucks out the bacteria and cleans things and purifies things.*
>
> *It even goes to the filter and gets the trapped food out. It does a good job. It's a good fish. It cleans the side of the fish tank as well. It makes things clean again.*

Although the story was of a fish that had wonderful qualifies and cleaned and purified things, from a communicative viewpoint, again it could not possibly be seen as a validation. Communicative theorists would surmise that such positive imagery could only come about through intense death anxiety. Throughout the session, the patient did not at any time validate anything connected to the therapist's intervention. Communicative validation of such an intervention would include a story or narrative by the patient that told about a teacher who left an environment or a person in some other profession who left the environment in which they were working. From a communicative position, the patient's continued positive interpersonal imagery confirmed that unconscious denial had been activated throughout the session.

The following session began one hour later than the usual session time as the patient had to attend a meeting with his consultant. Technically, communicative principles uphold that sessions begin on time and that session hours are not changed. The correct communicative rule is that there is no session if the patient is late. From the communicative stance, patient lateness is a signal of their secure frame anxiety and the communicative practitioner would address that.

The patient began the session by saying: *Sorry I'm late, but I've only just got back from seeing my consultant. He's really pleased with me.*

By allowing the patient to begin the session an hour later, the therapist had given him a defence against death anxiety. The patient's comment that he was really pleased with the therapist confirmed that he too was defending against his death anxiety. The patient continued to give positive images:

> *I really like Mr H. He's a really good teacher. He spent two hours with me today and is coming for two hours tomorrow. He's fantastic! I can't think why he ever became a teacher. I mean he knows everything. I ask him about history and he always knows. He's really interesting. He is like an English gentleman. I mean why would someone so clever who could do anything become a teacher? Did he get like that through years of being a teacher or was he always like it? He could have done anything.*

As the session continued, the patient's imagery became more negative:

> *Anyway, I think it's really good - because I been through a lot and I think I deserve a reward, something nice. In return for all the pain I've been through. Look at the last surgery - and did I tell you about the PH's- I really hate them! I can manage any of the rest but the PH's are the worst. It took them six goes to get it right. First it was too high and I had to go back up, then too low and I had to go back up again. I was in agony. Eventually they had to get a specialist. They kept saying this is really unusual, we usually get it right first time! It doesn't inspire confidence.*
>
> *It was like that when they were putting stuff in my arm. That really big a nurse who was horrible put the stuff in much too quickly. I thought my arm was going to drop off! An hour afterwards I kept saying to my mum, 'my arm, my arm!' When she came back to do some more, I wouldn't let her do it. She said, 'it wasn't my fault. I didn't do anything. I was very busy. I had to do it, I was in a hurry.'*

The encoded images were of people getting things wrong, with someone getting something wrong repeatedly. From a communicative point of view the patient had stated that the therapist was not taking responsibility. However, the images were very general and a communicative practitioner would wait for bridging imagery in which the patient would encode the errors that the therapist was making. Communicatively, such errors and encoding would be around frame issues. Although the images offered were negative, of people giving him treatment and getting it wrong, they still remained very generalised. Without the bridging imagery of the frame violations that would bring the communicative therapist to the proper triggers, it would be difficult to translate the unconscious perceptions. Such generalised images could in this situation be considered another level of defence, a form of unconscious denial. There was silence, then the patient stated:

> *I can't remember the pain, that sort of goes, do you know, I can remember my heart surgery, I must have been about 4 years old.*

From a communicative point of view, such a comment was a significant revelation. It clarified some of the devastation the patient was experiencing; his devastation was not only about pain, it was about an illness that caused pain. The patient informed the therapist that he had had early heart surgery and was convinced he was going to die. The need for the defence and the avoidance of death anxiety therefore became clearer. From a communicative position, it could be seen that denial was saving this patient from the destruction of his overwhelming and disorganising horrors, stemming from his early clash with death. The patient continued his story:

> *I can remember my mum saying, 'Count back from 100 to 99.' I started saying 100, and then zonk, I was gone. Two days after surgery I was riding up and down the ward on my bike. There was this man in the next bed who had had the same surgery the day previous to me and he had not moved.*

Communicatively, this encoding would be considered the patient's concept of the therapist. The patient was stating that in some ways the therapist was worse off than he was and was less able to handle things than he could. The patient had referred to multiple surgeries, multiple death traumas and on one level, was also decoding the therapist's surgery.

The patient then asked if he could walk around as his calf muscles were hurting. The communicative attitude to such movement around the therapy room would be that the patient could no longer stand the images that he had built up. The images were about the claustrom and the changing of the time of the session and his being late were all denials of that claustrom.

The next session again began late, by five minutes. Initially, the patient began by asking questions and remaining in the manifest. However, he then recalled the following stories:

> *I went to see 'Phenomenon' on Sunday. It was really nice. It was a good film. Do you want me to tell you about it?*
> *Silence.*
> *Well, if you are going to see it, I won't, but if you're not I'd really like tell you about it. It's a wonderful film but it's ever so sad. I nearly cried but I didn't. It's wonderful! It's about this guy John Travolta who falls in love with a girl, and she has this birthday party and during the birthday party he is zapped by some light. He falls down. He then begins to be able to do things. Like he can read the encyclopaedia very quickly and he can read Portuguese in 20 minutes. He does these really amazing things. He's such a nice guy. The girl is falling in love with him and it's all wonderful. Then the F.B.I. come and arrest him and he hasn't done anything. They experiment on him until they find he's got a brain tumour and that he's only got a certain time to live. The brain tumour has access to part of the brain that we haven't normally developed which is why he can do all these things. Then they want to do open-heart surgery on him to find out all the things but he says no and he escapes. He goes to his girlfriend and then eventually it ends with them having his birthday party but of course he isn't there. It was really good.*
>
> *I'm not a very good storyteller. Not like my friend W. He's really funny. He was telling me this story about L. L. is about 23 year old. He lives in S and he's brain damaged. He does some really funny things sometimes. He came over for my birthday and he just smoked and smoked and smoked and smoked. One day, W. went out with his friends and left L for the evening at his house. When he got back he found a message from his sister .The message said,'7.03 L. rang. 7.04 .L rang. 7.05 L. rang. 7 .06 L. rang. After that, she just put 'L. rang a number of times after this!' When D. got back he'd had left around 17 messages! He does such funny things.*
>
> *She told us this other story because L. is really forgetful he can't remember things. So he can't hold a job down very well. Anyway, he*

> *got this job and he rang W and was really excited that he'd got this job. W. said, 'Well that's good.' W. was really pleased. But you'll never guess what he did! He went on holiday and forgot to start the job. He just didn't turn up for work. So he lost the job.*

The patient was representing the therapist as being brain damaged and off on holiday when she should be working. A practitioner thinking communicatively would note that within the encoding, there was a reference to the hospital and surgery. That aspect of the story did not suggest frame violating encoding, but it did include hospital procedures. It is accepted within communicative theory that a patient with very severe death anxiety will only gingerly offer encoded imagery.

The patient continued:

> *Patient: Pain! Pain is the worst thing. Although I don't remember it all properly. PAIN! PAIN! PAIN! And then getting mended. Getting better. Those are the things that come to mind.*
>
> *You never really remember pain. I know that soon I'll forget what it was like to have the nose tube but I can still remember that. It's like when the Physio. was trying to do my neck, my stiff neck. She moved it. It twisted the tube and blocked my windpipe and I couldn't breathe.*
>
> *Therapist: That was scary.*
>
> *Patient: For you or for me? That is why I kept my neck still like that because otherwise I wouldn't be able to breathe. It really hurt all the time. But I've learnt to control my pain. Because I thought to myself, if I had the choice between having the pain for another few days and then being able to be a professional golfer, or not having the pain, I'd have the pain. I can control it.*
>
> *Sometimes in a dream I can't remember if it's real or it's not real. It's like last night I dreamt that this fish had come out of its shell and was swimming around with no shell on. And I woke up and was looking at the fish tank and was wondering whether it really had come out of its shell or whether it hadn't come out of its shell. Then, I thought and I thought and I thought and of course it hasn't come out of its shell.*

The negative images put forward were representations of the patient's unconscious perception of the therapist. The physiotherapist, twisting his stiff neck was a representation of his work with the therapist. He suggested that he felt the treatment could kill him. His representation suggested that he knew that the therapist was able to use unconscious communication and he recognised when the therapist was not taking up the issues. He was being suffocated, he suggested. Something prevented him from taking in what he needed and his message was that he felt it was the therapist. He suggested that the therapist was confused and could not distinguish fantasy from reality. The therapist had used 'scary', however the story he had told was about confusion; a story about someone who thought they were awake, but in fact were asleep. He was proposing that the therapist stayed in her shell and did not shed it, because that would make her too vulnerable. The implication was that the therapist had not opened up.

Before the following session, S. was re-admitted to hospital. He had the identical symptoms that he had had before the operation. He was later released from hospital and he was able to make the session. The patient began the session by bombarding the therapist with questions. The session material stayed in the manifest and more questions were asked by the patient. Communicative theory would suggest this would be in order to shut out his death anxiety. The patient's questions continued.

The therapist intervened:

> *The things that you just talked about were feeling that people hadn't been concerned about what had gone on, that there had been bad behaviour, and that you wanted someone to do something for you. I think you feel quite let down by me in all that has happened. I think you feel I have not behaved very well that my behaviour is even disgusting. You want me to do something about it*

The therapist had given a very general intervention and without a specific trigger. Communicative therapists build an intervention around a specific image, usually frame related. However on this occasion it was as if the therapist had just picked a theme out of nowhere. Communicatively this would be viewed as indicative of the therapist's unconscious guilt.

The patient responded:

> *Yes I do feel let down, but by having to go back into hospital again. Nobody told me that would happen. They all said that I would be all right. No one has said it might happen again and that I would have to have all these tests done. Now they don't know what's going to happen. I think, that maybe God is punishing me. Perhaps I have done something wrong and God is punishing me for things I've done in my past life. Or God is testing me to make me strong for another time. But why would God need to test me at this early age. I know I have sinned but they were little sins like rowing with my brother and things like that. The sort of sins everyone does. Why would God punish me like this, why am I back in pain in this way?*

It appeared that the patient was unconsciously picking up the therapist's guilt. The images in the story were his perception of the therapist wanting to be punished because she was not doing it right. Communicatively, this was an unconscious transaction in that the therapist did not realise how guilty she felt.

In the final session, the patient began the session by asking a most unusual question – he asked:

> *I am not asking this because I have done anything, but I was just wondering if some murderer came to see you and they had done something terrible, what would you do?*

Instead of remaining silent as would be advised by the communicative approach, the therapist replied with the following:

> *I think that perhaps one of the things you were asking about is issues of confidentiality.*

From a communicative point of view, such a comment was pure guesswork on the part of the therapist. The communicative approach would uphold that what the patient was saying was that he saw the therapist as trying to murder him. The communicative issue would be, 'What had the therapist done that the patient saw her as trying to murder him?' The communicative practitioner would ask herself in response to such a question 'What have I done that he sees me as a murderer?' The communicative practitioner would recognise that, given an opportunity to narrate the patient would encode the answer.

Within this therapy, there had been endless frame violations and therefore confidentiality would not be considered the most significant frame-break. In aiming to trigger decode the patient's narrative material, the communicative therapist would wait until the patient encoded around the trigger rather than jump in with a trigger that was a guess. The communicative approach would see such guesswork as more a matter of defence, than being on the mark. The communicative therapist would wait until she had gained a sense of what frame violation had constituted attempts of murder in the patient's unconscious experience.

The patient asked the question again:

> *No, I don't think I was meaning that, I was just wondered what you would do. I haven't done anything. I'm not asking about me but what I just wondered what you would do. I haven't done anything. I'm not asking about me but what if there was a murderer.*

The communicative therapist would ask herself a silent question as to what this was all about and would allow the patient to tell a story and guide the therapist to the answer. Communicatively, the patient was telling the therapist that she was trying to murder him for some reason. This imagery could have been instigated because the patient had gone back into the hospital. His death anxiety from hospitalisation and the frame violation of the therapist visiting him in hospital could have been reactivated to create such images.

In stating that the therapist was trying to get him away from his question, the patient was inferring that the therapist was aiming to get him away from encoding. What the patient was trying to tell the therapist was what she had done as an attempted murderer and his unconscious experience of that. The therapist intervened with the theme of confidentiality and the patient again brought her back to his question: *'What would you do with the thing about the murderer?'* When the therapist continued with interventions about confidentiality the patient stated:

> *I'm doing really well at school. You know I said I'd try hard? Well I really am. I have got two 'A's' in English and French and Geography. I got 'B's' in Physics and Biology. I'm doing really well.*
> *Have you seen, 'Home Improvements' it's really great. It's lots of fun. I really enjoy it. It's a comedy. I really like looking at it. The chap is marvellous.*

Again, communicatively, such positive imagery could not be seen as a validation. It is more likely that unconscious denial has been induced in recognition that the therapist was unable to listen to the patient. Towards the end of the session, the patient told the following story:

> *Have you seen it EastEnders recently? Did you see it last night? They sacked the old writers. They've got new writers now. It's much better. That's why it's better. This business with Cindy. She's really stupid isn't she? I know Ian's pretending he's got all this stuff over her but there's nothing he can do. It's illegal what he's saying. I mean, why doesn't she just take the kids and go? David's given her all that money and anyway she can go and live at Barry's flat.*

The communicative message to this derivative was clear, the patient was going to sack the therapist. The therapist was not doing her job. Throughout the therapy, the therapist had intervened either with manifest content, or with a very generalised intervention. The patient had now understood the therapist's unconscious message to him, which was not to encode the specific trigger. The patient had wanted to encode around a specific trigger. He had unconsciously wanted to tell the therapist how she had wanted to kill him. From a communicative position, the patient had not been allowed to narrate such specific triggers.

The patient asked if he could go to the toilet and he left the therapy room to go to the lavatory. He had broken the frame by leaving the therapy room. When the patient returned from the lavatory he communicated a most important story:

> *Patient: How long have we got left? We've got 10 minutes 35 seconds left.*
> *You remember when we first met along time ago and I put my hand up and asked you if you had a daughter at E. School? That was a really stupid thing for me to do wasn't it? I shouldn't have done that.*
>
> *Therapist: You felt really put down by me.*
>
> *Patient: No it wasn't that. It was a really stupid thing to do. I think I was trying to show off or something. I've mentioned it before haven't I?*
>
> *Therapist: That particular interaction between us has particular significance to you. It's a bit like now. Me asking you about your family just now was a really dork thing to do. It was stupid, I fouled up. It was like I was trying too hard to be a Therapist.*

The therapist had many years previously taught the patient one lesson of English during which the patient had suggested he knew the therapist's daughter. Consciously the therapist had no recollection of such an event until the patient referred to it, as the therapy was ending. The frame violation was so dangerous that once again in his narrative the patient reverted to unconscious denial and over-idealisation of the therapist.

The final story of the therapy however made it clear as to how the patient unconsciously perceived the therapy. The therapy ended with the patient recounting the following story:

> *Isn't it awful about those old ladies who die sitting in front of their fire and no one hears about it for six months and then they 're discovered in their smelly flat because the body has become decomposed? It's because people aren't sociable any more. When my mum was a little girl she could go down to the park and talk to people and it was all right, but you can't do that now. I really think it's disgusting the way that happens, don't you?*

The story was full of the themes of neglect, of someone who was dying and how there was no communication. At the end of the therapy the patient had communicated something very powerful and very morbid; an image of decaying bodies that were being ignored.

Throughout the therapy, the way the therapist had intervened significantly affected the data that she received and the insights that could be gained. The structure of the therapy was such that the patient was not able to communicate any really powerful derivatives of his experience of the hospital visit and his critical death anxiety. Issues that are raised within this therapy will be discussed in the next chapter.

12. Discussion of the Analysed Session Material

In this chapter the analysed session material will be discussed in detail according to the communicative framework and all observations will be confined entirely to communicative principles.

The most immediate observation regarding the session material was that the encoded narratives within the session were unwavering in their reflection of frame deviations and therapist error. The analysed sessions clearly showed that the patient gave the therapist derivatives asserting that she was doing the therapy wrongly. The many deviations, the manifest playbacks and the therapist‘s discouragement of the patient to encode were indicative of such shortcomings referred to in the derivatives.

The patient offered unconscious perceptions as to why the therapist might be performing so inadequately. The patient's encoded responses suggested that the therapist unconsciously feared the damage the therapy might cause her. The therapist consistently avoided herself and the triggers to any derivatives in her interventions. She therefore shut off any encoded communication in which the patient might allude to an unconscious perception of the therapist, the therapeutic frame and the chronic pain; both his own pain and that which had been and was being experienced by the therapist. Indeed when the therapist became close to a trigger, rather than intervene she intellectualised and became vague. If the therapist did intervene around a frame infringement she always commented on the most minor of the frame breaks and avoided major frame issues. Not only did the therapist continually avoid encoded narrative but also in particular she shunned any death-related narrative. At such times, when death related narratives were revealed, the therapist reverted instantly to manifest content and disregarded all death - related themes. It was significant that the patient was not given the opportunity to allude to the trigger for the encoded themes. The session material suggested that although the therapist was able to talk about and support pain manifestly she was unable to get to the unconscious horrors of the death images as the framework of the therapy activated them.

Such continual disregard and avoidance of encoded narrative especially death-related narrative by the therapist offers some insight into working with pain patients i.e. that a therapist working with a pain patient needs to be able to allow both derivatives and triggers related to death and pain to unfold.

The encoded derivatives also gave insight into what pain meant unconsciously. Such derivatives that were allowed to unfold showed that pain was being dealt with in the manifest and not in the deep unconscious. In the deep unconscious the frame conditions and actions of the therapist held sway.

The question therefore has to be posed as to why the therapist acted in a manner so contrary to communicative principles in that opportunities to reach the trigger were disregarded? It is quite clear that working communicatively is both difficult and complex. Communicative theorists propound that working with frame deviations rather than content dynamics is formidable and unnatural in that it takes one into realms that the conscious mind does not wish to go. From the communicative point of view the conscious mind acts as an instrument of denial and idealisation and wishes to avoid the messages that the unconscious mind brings. Left to its own devices the mind prefers to deal with conscious material and a communicative practitioner therefore needs to work extremely hard and be extremely vigilant in order to stay with unconscious derivatives. This explanation however does not seem sufficient for the extraordinary deviation from communicative principles that occurred within this therapy. In order to understand this particular therapeutic interaction there needs to be recognition of what was going on specifically between this patient in light of the therapist and her history, and the patient in light of his history. Both therapist and patient had particular issues with pain and the therapist with her particular pain history intervened in a way that another therapist who had a different history might not.

When the therapist accepted and responded to surface comments from the patient she was upholding that she would accept manifest material: she therefore put forward to the patient that it was acceptable not to give encoded information. Had the therapist remained silent or suggested the patient say what came to mind she would have determined that she would not engage with unencoded material. She would have endorsed that it was appropriate for the patient to offer encoded material. In participating with surface material the therapist formed a misalliance with the patient to avoid unconscious content. Thus the therapist's manifest interventions prevented the patient from encoding around what was painful in the therapeutic interaction.

Further insight can therefore be gained; a death sensitive therapist and/or pain sensitive therapist will find it particularly difficult to allow both derivatives and triggers related to death and pain to unfold and moreover will have a propensity to shut off patient encoding.

The session material also revealed that the patient too, wished to avoid encoding derivatives around blatant frame deviations. It seemed therefore that an unconscious misalliance between patient and therapist had indeed occurred. Thus in terms of unconscious dynamics the therapist, with her pain-sensitivity wished to avoid encoded derivatives and the patient with his pain sensitivity was keeping the therapist away from where the power of pain really lay.

The situation within this particular therapy situation could now be seen more clearly. A patient in pain, who would most certainly experience the interventions, the conditions, and the frame violations by the therapist in a most horrendous death related way, was in therapy. What could be ascertained from this therapy was that this patient wanted denial from the therapist. The patient gingerly tried to encode but showed a great terror of unconscious derivatives. Such terror of unconscious derivatives was mirrored in the therapy by the therapist who also had a pain issue and feared the horrible derivatives as well. There became a conspiracy of denial between the patient and the therapist regarding encoded communication.

It therefore seems feasible to propose that pain prompts a great need to shut off encoded communication. This was further underlined through the recognition that the therapist could easily support and talk about the pain manifestly but could not get to the unconscious horrors of the derivatives as the framework of the therapy activated them.

It is of fundamental importance therefore to recognise that the therapist was, from a communicative perspective, in denial of what was going on in the therapy. In this therapy it appeared natural for the therapist's mind to stay away from the encoded level of communication, which was so powerfully dangerous to her. Staying away from encoded levels of communication meant that the therapist had reverted to the more traditional form of psychotherapy and was therefore also in denial of her communicative background. From a communicative standpoint what could be confirmed from this process was how the mind naturally worked. The natural tendency of the mind would be to take away violence, take away death and take away murder. Thus communicatively it could be seen that it would be natural also to take away the specific trigger, which related to such powerful images. The communicative message from the session material was that in this particular therapy, it was too dangerous for the therapist to access the power and the violence of what was unconsciously being perceived.

Within the therapy a significant theme re-occurred, the theme of the encoded level of the deep unconscious experiences for a pain patient. Clearly, when working with pain, deep unconscious experiences were dangerous to both the patient and the therapist, more so it seemed than with any other patient. In the work with this patient for example there was his pain, his operation, the secure frame anxiety, the entrapment anxiety as well as other major frame violations to be aware of. This understanding of the level of the deep unconscious experience for the pain patient causes a communicative therapist working with pain patients a very major dilemma. Securing the frame appeared to be highly dangerous for both the patient and the therapist. It would set up a high-risk treatment situation. If the therapist secured the frame the patient would be unlikely to remain in the therapy because the sense of entrapment and death anxiety would appear too overwhelming. If the therapist modified the frame, such modification would create an escape from the deep unconscious experiences and the insights, which a secured frame could bring. Frame breaks signified that both patient and therapist could be exceptions to the basic rule of existential life and death, the rule that death follows life.

This therapy epitomised one of the great communicative problems of how to help patients who are highly sensitive to death anxiety? Whether such patients could stay with a secure frame therapist would be open to question for the patient would be unable to adjust to the horrors from the encoded derivatives that would be involved. Secure frame moments would be dreaded by the patient for they would conjure up terrifying images mostly connected to the premature exposure to death-related issues that the system would feel unprepared to process. Whichever way the therapist worked, either frame secured or frame deviant, there would be unconscious danger and threat. It would be probable that such a critical dilemma would also be shared with patients who had serious and even fatal illnesses, such as cancer and HIV for they too would be extraordinarily sensitive to death anxiety.

The excessive avoidance of encoded material made this therapy extremely remarkable. The patient was about to undergo surgery, to have a major operation and astonishingly none of this was being encoded. Communicatively one would usually expect to pick up some commentaries, something encoded in such a context but this was not the case here.

Similarly, the therapist had introduced a powerful trigger, by announcing a major deviation, a change in location– going to the hospital –but still there was not a shred of an encoded imagery around even that powerful trigger. Both therapist and patient were shutting off encoded imagery. The therapist was shutting down encoded communication and the pain patient, with a very powerful death anxiety, invoked an extremely powerful unconscious denial.

Such shutting down of encoding communication was perplexing, for from a communicative position it is a total psychobiological given that a powerful frame break would become processed. Communicative theory maintains that although a patient might not give derivatives on the spot they would be likely to give derivatives about the frame infringement either before the frame break or after. What happened in this therapy was an obliteration of encoded information happening both before the frame break and after. It could therefore be shown from this therapy that if the death anxiety level was high enough, the therapist and the patient could obliterate the normal processing procedures.

A basic principle for pain patients could therefore be formulated. The principle being that if there was extraordinary strong death anxiety on both the patient and therapist's part such death anxiety would determine the need to use unconscious denial and the need to obliterate encoded communication. Thus pain patients i.e. patients with very powerful death anxiety, invoke very powerful unconscious denial.

The session material also demonstrated an added complexity which became apparent in the highly pain sensitive interaction. The added complexity reflected the unconscious danger the therapist felt from the patient, as well as the unconscious danger the patient felt from the therapist. This was symbolised in the therapy when the therapist left the therapy room ostensibly to acquire something for the patient. Leaving the therapy room was a major frame violation, which represented an unconscious response from the therapist. Communicatively, major frame violations activate encoded communication. Leaving the room was the therapist's way of confessing that she was unconsciously doing something deviant that was abandoning the patient. By leaving the room and returning again the therapist also showed that she was also denying her own death anxiety.

It can therefore be noted that therapists' who work with pain patients would be likely to be inclined to modify the frame and pain patients would also be inclined to modify the frame too. A principle that can be gained from this is that a pain sensitive therapist and pain sensitive patient will be driven to create extreme deviations in order to deny the secure frame, the claustrom and the entrapment of death anxiety.

The underlying issue for such a pain critical unconscious interaction would be whether the therapist could allow the patient to encode? Could a therapist in this situation control her own death anxiety and not deviate and compound it? Communicative theory maintains that the emotion-processing mind is built around denial and that it has evolved to deny death. It could be observed in this therapy that there was total involvement in the denial of the pain and in the denial of death, in both the patient and the therapist. Although this therapy showed an extreme case with both patient and therapist being highly pain and death sensitive, a general principle could be established. The principle would maintain that such denial would be how therapists would be inclined naturally to work with pain patients', in a frame deviant and manifest way, avoiding unconscious derivatives.

This therapy through its excessive frame violations has enabled communicative theory to be expanded regarding its understanding of validations and validatory imagery. Throughout the therapy the therapist continually modified the frame and broke away from the secure frame principle. Following such frame violations the patient responded with positive imagery. Such imagery could not possibly be considered communicative validation for there had been no communicative interpretation and no trigger decoding. Another general principle could therefore be observed. The principle would testify that severe frame violations by the therapist created within the deep unconscious system of the patient recourse to unconscious denial and over-idealisation of the therapist.

This type of unconscious denial used the continued employment of positive images over and over again when there had not been a communicative intervention. Over-idealisation and positive imagery seemed to come out of nowhere and for no valid reason. It could be surmised that this form of unconscious denial was a means of fending off the therapist and keeping her off guard. The patient was not giving the derivatives that would be expected. It was a way of keeping the therapist in a deceptive space so as to avoid the trigger decoding, which appeared so threatening.

Why should this unusual form of unconscious denial be so evident? The patient's defence had been such that not only had he offered grandiose narratives to the therapist but also he had not given the therapist one piece of encoded information that she could link back to a main trigger. It must therefore be construed that the patient's need for defence and avoidance was critical.

Three hypotheses could be proposed as to why this might be. The first hypothesis would maintain that the need for such defence would be linked to both the patient's chronic pain and the devastating illnesses that were linked to the pain and ultimately to the death anxiety that would have been connected to both those issues. This patient had experienced terrifying heart surgery at the age of four years old and a series of further life threatening illnesses since that time. The patient's death anxieties went back a long way, which created a prolonged series of horrors that it appeared he needed to shut out. Understanding of such horrors, it seems, would have been unbearable and disorganising for him and as such he would have been unable to function. The unconscious denial was saving him from the disruption of whatever the horrors would instigate. Had the patient not defended himself unconsciously, communicative theory maintains that he would have been encoding images about the utter terror of going crazy and dying. It is unlikely that this patient would have been able to stay with a secure frame therapist because he would not have been able to modulate the horrific images that would have been involved. This patient therefore reinforced all types of denial and defences. The frame breaks and lateness in this therapy, his walking around the room and leaving the therapy go to the toilet were also part of the denial used. Frame breaks symbolised for both the patient and the therapist that they were exceptions to the rule of existential life and death. It could also be a form of unconscious denial in which the patient stated that he felt better when the therapist did not intervene around triggers and encoded imagery.

The second hypothesis would propose that the patient gave up the pain and the normal communicative manner of encoding because the patient was aware that the therapist was unable to listen to him. The patient had wanted to disclose his unconscious experience of how he had perceived the therapist as wanting to kill him but the therapist had refused to listen. In such a situation it could be surmised that collusion and unconscious denial would be his only means of getting better. The session material suggested that such unconscious denial and over-idealisation occurred when the deep unconscious system perceived there was no capacity for unconscious relationship between the therapist and patient. The transgressions by the therapist were such that it was as if the therapist was unable to hear and take on board any unconscious communication. The patient seemingly aware that unconscious communication was a pointless exercise conserved the energy within the deep unconscious system until the possibility of relationship could be resumed: in effect untruth mirrored untruth. This is shown particularly within the session material when the patient moved towards encoding powerful frame infringements. At such times the therapist not only remained in the manifest but also offered self-revealing information. The unconscious dynamic for such self-revelation would have been the therapist's sense of unconscious danger as the patient introduced the potential trigger. In such situations of unconscious danger, the therapist gave the frame violation of self-revelation, to distract the patient. The patient then glorified such frame violation and congratulated the therapist in his next derivatives. In the session material the patient showed that he not only affirmed denial, but he affirmed self-revealing frame-violating interventions too. In effect the patient's unconscious denial was a form of giving up. It is possible that the patient's loss of pain was also connected with such idealisation and an extension of the unconscious denial that was so significant for him.

The third hypothesis would be that when the deep unconscious system is powerfully and violently traumatised it shuts off the inputs through denial and then when it recovers, the negative imagery appears. Such denial would be considered a reaction to excessive unconscious assault. Also after a sudden outside trauma the system is likely to shut down and show denial for a while.

Langs refers in passing to a similar occurrence happening in the research undertaken by himself and Badalamenti (1992a, 1992b, 1994a, Langs, Badalamenti and Thomson, 1996). A particular patient, whose consultant was verbally assaulting towards her, gave positive imagery at first and then only much later in the session gave negative imagery.

It would be unlikely that it would be just the tendency of this patient to use unconscious denial. (It could however be deemed that because this was an extreme circumstance that this patient used unconscious denial to an inordinate degree.) It would appear though that this was not just about a patient's need for denial. It would be more conceivable that this would be a universal principal: that pain–sensitive patients would show unconscious relief when a therapist deviated from the secure frame. The unconscious relief would be such, that such pain patients' would reach a point where they unconsciously supported such deviations.

Thus, communicatively, it proves most perplexing to work with such hugely pain-sensitive patients. The pain patient's display of unconscious deception encourages the therapist to believe that positive images, which are in fact unconscious denial, are instead validating representations. For the therapist such distinctions become difficult to make. A general principle can therefore be introduced: that when working with pain patients, a therapist needs to be wary of positive images.

Such unconscious idealisation and glorification is not documented to any full extent in the communicative literature. Langs (1995) made a passing comment on such a process when he stated, 'If the I/M load (trauma) has been excessive, this shut-down is often buttressed with derivative (D_UCS) over-idealisation-the insertion of overly positive images in place of devastatingly negative ones.' (167) However, Langs does not develop nor expand upon these ideas. This dissertation however gives evidence that such a system of unconscious shut down holds greater significance than at first recognised. It can now be demonstrated that this particular type of unconscious shut down has greater connections to the communicative theory of systems overload than was initially recognised and links in a previously unfamiliar way to the sources of dysfunctional design. In particular it is worth noting the following links as demonstrated through the analysed session material and which concur with Langs (1995) theory of system overload:

- The syndrome can occur when the patient or therapist is heavily burdened with the ongoing processing of existing emotionally charged triggers and a moderately strong trigger event evokes system shutdown or dysfunction.

- The syndrome can occur when a therapist modifies the frame by revealing personal information about herself or when a third party to therapy does so and passes on especially traumatic information to the patient.
- The syndrome can be noted in patients who fail to produce the necessary encoded imagery or prove unable to recover a significant trigger event and therefore fail to process its meanings and impact .
- The syndrome can occur in patients and therapists from overwhelming events external to the therapy.
- The syndrome can occur if either party to the therapy experiences a sudden illness or injury or life-threatening trauma.

Thus a general principle can be proposed: working communicatively with highly pain-sensitive patients is extremely difficult and system overload is likely to be a recurring problem. If such patients tolerate the meaning of frame violations and the securing of the frame that will come from that, they are endangered in terms of leaving the therapy because the level of unconscious death related images would be too much to tolerate. However, if they do not tolerate the meaning of the frame violation the patient shows that he is ready to support unconscious denial.

From a therapist's viewpoint, working with such patients also becomes highly complex, for if the therapist was able to allow encoding to take place and penetrate the unconscious meaning, the encoded messages would be extremely grim and disturbing for the therapist with images of death being prominent. If the therapist supported the unconscious denial however she could be deceived into thinking that she was doing well.

Thus in this therapy the therapist defended against the disturbing death images by taking the narrative themes of the patient and generalising them instead of decoding the specific image around the trigger. The patient consistently reinforced the therapist's generalised images and colluded with her. The images he portrayed were extravagant and grandiose on occasions and it could be surmised that the level of ostentation the patient expounded was in direct proportion to the level of death anxiety he experienced.

Within this therapy it was not possible to ascertain how the patient would respond to consistent valid communicative interventions. The observational field and the input from the experimenter, in this case the therapist, determined the outcome. In this case what the sessions illustrated was the response to non-valid, highly defensive avoidance interventions by the therapist. The interactions of the therapist promoted denial and the destruction of derivatives. The structure of this therapy was such that the patient was unable to communicate even one powerful derivative around the hospital visit. Valid communicative interventions would have produced another set of communicative insights, if the patient were able to tolerate remaining in the therapy, and as such would have offered further insight as to what was being perceived unconsciously.

The manner of the therapist's interventions reinforced the communicative view that the natural state of the emotional mind is one of denial and avoidance of specifics. Thus communicative therapists working with pain-sensitive patients would be particularly advised to be alert to their own death related issues, for the mind would naturally move toward denial and obliteration of specifics during the therapeutic interaction. Such denial would be brought about through the unbearable quality of unconsciously working over something so close to death. Communicative philosophy would uphold that therapists work diligently to gain some mastery over their own death anxiety in order to help patients to master the death anxiety with which they ultimately struggle. The significant point that is highlighted by the session material presented in this dissertation is that the communicative approach stands alone in recognising the destructiveness of death anxiety within both patient and therapist.

13. Outcomes and Conclusions

The purpose of this dissertation was to explore from a patient's point of view both the conscious and unconscious experience of pain and to show from a communicative point of view how communicative trigger decoding reveals new insights into the unconscious experience of working therapeutically with pain patients.

The following outcomes can be demonstrated from the thesis:

1. The conscious experience of pain

1.1 The literature regarding patient pain experience is a poorly researched area and further research is required.

1.2 The literature documenting patient pain experience, such as exists, indicates that death anxiety is highly significant in the experience of the chronic pain patient. This shows a discrepancy regarding the importance of death anxiety between what is put forward from the point of view of the patient and what is documented in the pain literature. This suggests that death anxiety might have been underestimated in the medical literature as a significant factor in the patient's chronic pain experience. Further research into death anxiety and chronic pain might offer additional insight in widening the understanding of chronic pain syndrome.

1.3 The documented literature confirms that significant cognitive disruption is part of chronic pain syndrome.

2. The unconscious experience of pain

2.1 The thesis demonstrated that chronic pain evokes unconscious responses. These unconscious responses are evident not just in the person suffering the chronic pain but also in those with whom the pain patient comes into contact. It can be conjectured that such unconscious responses can cause inappropriate and harmful acting out, as for example shown by health care professionals in the undermedication of pain relieving drugs. This is a poorly researched area and further research is required.

2.2 Trigger decoding the encoded narratives of a chronic pain patient according to the framework of the communicative approach revealed the following insights:

a) With regard to chronic pain:

   i) Chronic pain was dealt with manifestly and not in the deep unconscious. The deep unconscious demonstrated more concern with regard to the therapy and the frame violations than with the traumatic intensity of chronic pain. Pain imagery that was encoded alluded to the therapist's frame breaks.

   ii) It became evident that when working with pain, deep unconscious experiences were difficult to maintain for both the patient and the therapist, more so it seemed than with any other patient. It was demonstrated that pain prompted a great need to shut off encoded communication.

iii) Pain issues created significant death anxiety issues. Pain issues, which are closely connected to death issues, activated within both the therapist and the patient a dread of encoded images connected with death anxiety.

iv) Pain with its powerful death anxiety, invoked within the patient an extremely forceful unconscious denial.

v) It can be surmised that similar responses would also occur in patients who were suffering from a chronic or fatal illness.

b) With regard to the patient and the therapist:

i) The continual returning to manifest content by both patient and therapist suggested that deep unconscious experiences were difficult for both the patient and the therapist. The therapist was able to talk about pain manifestly but found it hard to reach the unconscious meanings as they became activated by the framework of the therapy. Neither the therapist nor patient acknowledged unconscious perceptions around any powerful triggers. The therapist took themes and generalised them instead of decoding the specific image to the patient. Thus communicative therapists working with pain patients need to be aware that they must allow both derivatives and triggers related to death and pain to unfold.

ii) It became clear that left to its own devices the mind preferred to deal with conscious material. There became a conspiracy of denial between patient and therapist to avoid encoded narrative. This was especially so as there was a therapist who had a pain issue and feared the derivatives also. A communicative practitioner will therefore need to work extremely hard and be extremely vigilant in order to stay with unconscious derivatives.

iii) Therapists would be inclined naturally to work with pain patients in a frame deviant and manifest way, avoiding unconscious derivatives. The thesis demonstrated that a pain sensitive therapist and pain sensitive patient created extreme deviations in order to deny the secure frame.

iv) The therapist, having departed from the ideal frame, was experienced by the patient as predatory and activated deep unconscious predator death anxieties within the patient. The pain patient experienced the interventions, the conditions and frame violations of the therapy in a death related way. The therapist also experienced deep unconscious predator death anxieties, which were responses to the unconscious awareness of causing harm to the patient.

v) Unconscious denial became evident in the therapeutic interaction. Patients with very powerful death anxiety (which would be typical of a pain patient) evoke very powerful unconscious denial. Severe frame violations by the therapist also created within the deep unconscious system of the patient recourse to unconscious denial. Such severe frame deviations by the therapist brought about an over-idealisation of the therapist by the patient. These frame modifications by the therapist invoked positive images from the patient. Such positive images were not validation but the patient's unconscious denial. Such cases of unconscious denial seemed to be connected to the effect of being close to death and death related issues.

vi) When the chronic pain patient was able to offer derivatives, death anxiety issues became such that the therapist created a frame violation to distract him. The pain–sensitive patient showed unconscious relief when the therapist deviated from the secure frame. It can be tendered that the unconscious relief is such, that pain patients reach a point where they unconsciously support such deviations. Therefore when working with pain patients, a therapist needs to be wary of positive images and ascertain whether the positive images are validation or unconscious denial.

vii) Working communicatively with highly pain -sensitive patients proved to be extremely difficult and system overload was a recurring problem.

c) With regard to death anxiety:

   i) Death anxiety became mobilised by an acute situation such as chronic pain. Frame breaks and modifications reflected such death anxiety. The frame was broken in order to avoid death anxiety as frame breaks represented the power to break the rule that death follows life. Therapists who work with pain patients therefore need to be aware that they are likely to be inclined to modify the frame and that patients are going to be inclined to modify the frame too.

   ii) The therapist's own death anxiety was provoked when working with a chronic pain patient. It becomes important therefore that therapists attempt to control such anxiety in order to allow the patient to encode. A death sensitive therapist and/or pain sensitive therapist will find it particularly difficult to allow both derivatives and triggers related to death and pain to unfold and moreover will have a propensity to shut off patient encoding.

iii) Therapist death anxiety may cause significant frame deviation and prevent the therapist from offering valid communicative interventions. If there is extraordinary strong death anxiety on both the patient and therapist's part, such death anxiety will determine the need to use unconscious denial and the need to obliterate encoded communication. If the death anxiety level is high enough between the therapist and the patient the normal communicative processing procedures can be significantly affected.

iv) Communicative theory maintains that the emotion-processing mind is built around denial and that it has evolved to deny death. It could be observed in this therapy that there was total involvement in the denial of the pain and in the denial of death, in both the patient and the therapist. Communicative therapists working with pain-sensitive patients would be particularly advised to be alert to their own death related issues, for the mind would naturally move toward denial and obliteration of specifics during the therapeutic interaction. Communicative philosophy would uphold that the therapist work diligently to gain some mastery over their own death anxiety in order to help patients master the death anxiety with which they ultimately struggle.

v) The communicative approach stands alone in recognising the significance and destructiveness of death anxiety when working therapeutically in a highly pain sensitive situation.

It is appropriate to note that at the end of the therapy the patient's chronic pain had lessened to such an extent that he returned to his place of study. His studies were no longer interrupted by attacks of chronic pain. Five years on the patient remains free of chronic pain.

It is recognised that the paucity of research in this area and the very limited nature of the sample, along with possible placebo effect and other unknown factors mean that no clear conclusions can be made regarding the lessening of the chronic pain. However from a communicative point of view it can be conjectured that:

- The therapist reinforced the patient's denial defences by accepting and engaging in them
- The therapist strengthened the patient's denial system and supported his denial of death
- Such action by the therapist seemed to enable the patient to achieve some form of positive outcome in respect to his chronic pain.

The way the therapist intervened crucially affected the data and insights gained. The nature of the interventions promoted denial and destruction of derivatives. Thus what this thesis shows is a response to non-valid, highly defensive avoidance intervention. Had the work consisted of a majority of valid interventions then there would be another set of insights for working with patients in pain. The interventions of the therapist in this therapy offer some insight into an area that Langs considers to be vital. Langs (1995) states, 'the problem of tracing the effects of therapists' interventions (triggers) on patients, and the related difficulties in recognising the clinical consequences of alterations in how patients process emotionally charged information and meaning, are, I believe, among the most important unsolved issues in all of psychotherapy.' (130)

From a communicative point of view, that the therapist offered a non-valid, highly defensive avoidance intervention shows the natural state of the emotion processing mind, which, according to communicative theory is to blunt, to deny and not get to specific triggers. This thesis alerts communicative therapists that they must be aware of their own death-related issues, which are activated very powerfully and very quickly.

Thus five further general conclusions can be made:

1. That there is a close connection between chronic pain and death anxiety.
2. That a communicative framework offers a philosophy and technique whereby predictions and outcomes concerning therapist input can be a useful tool for analysis.
3. That chronic pain makes the unconscious system particularly sensitive to system overload particularly when there is a frame deviant therapist.

4. Such system overload can be recognised by encoded narratives, which over-idealise and exaggerate the qualities of the therapist, when no communicative intervention stemming from adaptive listening and trigger decoding around frame issues, has been given.
5. In communicative psychotherapy it can be seen that denial is the basic psychological defence mechanism used by the emotion processing mind.

Although this thesis has used a very limited sample, the evidence from the sample supports the hypotheses originally presented: Using communicative philosophy as a framework the following hypotheses were proposed:

- Intense chronic pain causes conscious cognitive disruption:
  The thesis supports this hypothesis as shown by the review of the documented literature explored in the chapter on the Impact, Psychological and Emotional Effects of Chronic Pain. The subjective experience of the therapist described in Appendix A entitled 'Personal Pain Experience' also supports this hypothesis.
- Despite such conscious disruption cognitive functions may remain unconsciously intact:
  This thesis supports this hypothesis as it is considered that the narratives and stories expounded by the patient during the psychotherapy sessions is evidence of cognitive functioning unconsciously remaining intact

- Communicative psychotherapy claims a framework and methodology whereby unconscious mental functioning can be accessed and utilised therapeutically:

  This thesis supports this hypothesis as shown through the scrutiny of communicative theory examined in the chapter entitled Robert Langs and the Communicative Approach and by the chapters which analysed and discussed the patient material using communicative methodology and framework. However, this thesis points out that unconscious mental functioning is liable to system overload and breakdown in a similar way to that which occurs in the conscious system.
- Communicative trigger decoding is the translation process required to understand the information contained in unconscious communication.

  This hypothesis is supported, as trigger decoding the patient's narratives was the central component, which made up the analysis and discussion of the patient session material
- Communicative trigger decoding of unconscious meaning can provide insight into the unconscious experience of pain:

  The thesis supports this hypothesis as shown by the number of outcomes offered in this chapter.
- Information gained from communicative trigger decoding can be used to offer guidelines to therapists working with patients who suffer from chronic pain:

  The thesis supports this hypothesis as shown by the number of outcomes regarding the therapist offered in this chapter.

Although the study supports the hypotheses, and offers a number of outcomes and conclusions in connection with the hypotheses, it is recognised that the limitations of the study are significant and that further evaluation of this approach is clearly necessary involving larger numbers of patients before a more definitive conclusion can be reached. Therefore the main conclusion of the work of this thesis is that the insight gained through communicative adaptive listening, and trigger decoding in the light of therapist interventions and frame related issues has offered insight into the unconscious perception of pain and is an area worthy of further research. Although this is a very small particular study, there is a broader implication concerning the role that death anxiety plays in psychotherapy in general and in particular in the role that death anxiety plays in working therapeutically with patients who suffer from chronic pain which is also worthy of further research.

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15. Appendix A - Personal Pain Experience

As a therapist working with patients in pain and having been a patient in pain myself Miller and Kraus' (1990) description of chronic pain is a highly familiar scenario. It was only as I began to recover over the years and as my pain became more tolerable that I was, in retrospect, able to make links regarding chronic pain and the communicative approach. It was clear to me that in my own case chronic pain significantly disrupted cognitive functioning. Amongst all the many facets of chronic pain, I found in my pain that I was faced with awesome uncertainty. When the calamity of chronic pain struck, it confronted my healthy denial that death would only threaten in the future. I touched my own unconscious death anxiety and it is this terrifying touching of my own unconscious death anxiety that was the significant factor for me in linking the chronic pain experience, my work as a therapist and the communicative approach.

The reason that I wanted to explore working therapeutically with chronic pain patients using the communicative approach was because the philosophy behind the communicative approach is not only based upon an adaptive principle in which coping with environmental infringements forms the main task of the emotion processing mind but also because the role played by death anxiety is seen to be the most crucial and widely found source of adaptive and defensive structures. Unlike the more traditional forms of psychotherapy where defensive structures are based on infantile sexuality and inner fantasies and memories in emotional life, in the communicative approach, it is death anxiety that is seen to be the crux of the matter. The communicative approach is alone in considering death anxiety as a major determining force in the work of psychotherapy theory and practice.

In my own situation the continual dreams I experienced and the unrelated stories I told suggest that I responded both consciously and unconsciously, to the effects or chronic pain. This is especially significant, for I take the stance that traditional psychotherapy, although responding to the conscious factors that the patient experiences are likely to accord unconscious responses to the patient's inner fantasies and memories. However the communicative approach claims that the deep unconscious encoded stories narrated by the patient will encode among other things the impact of death anxiety, along with the unconscious motives for and meanings of the chronic pain. The approach also claims that the communicative therapist will not only make contact with the patient through decoding such narratives, but also the very nature of the approach demands that he/she will also decode and provide insight into these unconscious dimensions. Therefore according to the communicative approach the communicative model offers a conceptual framework from which extensive unconscious perceptions can be uncovered and it is these unconscious perceptions that I considered worthy of research with regard to chronic pain. In this appendix I will give a brief account of my own experience of chronic pain in order to demonstrate the subjective experience of a chronic pain sufferer. In my outline of the experience it becomes clear that cognitive functioning is disrupted and that the construct of death anxiety plays an increasingly significant role. This personal experience of chronic pain will also offer some insight as to why the therapy sessions described in chapter 9 were conducted as they were.

My pain experience began in early January 1992 and is ongoing. It began with a searing pain in my right leg. A visit to the G. P. suggested there was nothing serious, just a pulled muscle. He was wrong and from such a humble beginning stemmed a dramatic series of events that totally altered my way of being. There is no need to go into the events of the illness as such here, except to say I had a serious spinal problem that even now leaves me in constant and continual pain, and affords me limited mobility. I experienced numerous surgical procedures, diagnostic procedures, scanning procedures, nerve-blocking procedures, complimentary procedures, and I have been hospitalised at frequent intervals for serious situations stemming from that initial searing pain. I have had to learn to come to terms with the many changes it has brought to my life, such as, for example, learning to walk again.

Schwarz and Silver (1990) quite wonderfully grasp the crux of the matter:

> Illness tears at the fabric of our lives suddenly, unpredictably and permanently. We are inexorably altered by having been sick as danger and uncertainty inevitably reawaken the infantile assumption of talion. The fantasies stimulated by helplessness are always evocative of conflict and come to form a nodal point in our remembered history. Denial though contributes an essential ingredient to our retrospective vision. (1)

The main effect of the illness and pain was my emotional anguish. Rational thought was usually absent and my state of being was one of helpless stupor in which cognition was replaced either by positive active anguish or total passive, inactive anguish. I was indifferent to everything and felt a kind of numbness. I felt an immense and aching solitude and I could no longer concentrate. I could not concentrate sufficiently to read, write or even listen to music. Even the act of thinking became more and more difficult and exhausting, stalled and then finally ceased. I did not exist.

Freud (1914) acknowledged something similar when he commented:

> It is universally known, and we take it as a matter of course, that a person who is tormented by organic pain and discomfort gives up his interest in the things of the external world, in so far as they do not concern his suffering ... the sick man withdraws his libidinal cathexes back upon his own ego, and sends them out again when he recovers. (32)

I can only partly agree with Freud, in that man does give up his interest in the external world, but I did not see that it was because of the withdrawal of libidinal cathexes. From my point of view I gave up interest in the things of the external world when tormented by organic pain because of the terrible death anxiety that chronic pain brought about.

For me it was more than just giving up the things of the world. The world ceased and my sense of time seemed disrupted. The world as I had known it no longer seemed familiar. I ignored intrusions from the outside because I was too tired and in too much pain to care. My state of confusion and fragmentation was revealed in my sleep through disturbing dreams. I was dismayed at the primitive representations in my dream productions. They were disconnected, chaotic, difficult to recall when awake, and had a nightmarish quality about them. I recall a sense of panic, in one dream, of trying to wake, for I was drowning in the bath. I lay, in my dream, on my back, my head sub-merged in the water with more water tumbling on top. I was unable to do anything about lifting my head or body, I was drowning,

drowning and I could not move. The fear was terrible and comes back to me even now. Even then my denial of my emotional state ensued for I claimed that such dreams were drug induced, nothing more. I pleaded with my surgeon to change the drugs and I fought him every step of the way when he wanted me to take pain-killing medication or wanted to increase my intake of muscle-relaxants, for that would create more dreams of terrible death. My denial was such that it was easier to confront my surgeon's wishes on the drug issue rather than question myself as to what else might have brought about such frightening night terrors.

I have no sense of being involved in anything and my total engrossment with nothingness brought with it a strange distortion of time. The weeks before my hospitalisation when I lay on my back, unable to move almost, passed as minutes. Days in which I did nothing but lie in pain seemed as seconds. I was losing any meaningful awareness for the basis of relationship. Everything lost importance. Schwarz and Silver (1990) comment, 'The potential imminent loss of one's being is something unique to each of us.' (3) It was as if I had touched my own unconscious death anxiety.

I would panic and become anxious at the unexpected and I had a severe inability to be with people whether it be friends, colleagues or even my family. My husband and children would visit me, I would look at them, know they were there, but it was as if I had no connection with them. I did not seem to be in the world. There was a sense of depersonalisation, of being separated from the spiritual nourishment that comes from being in relationships with people. I was separated from a desire to experience life. In a way I did not exist - and therefore did not have to feel.

Like Lindner (1984) I too was astounded at the extent of my own blocking of feeling and my own regression, and I too can only speculate that my 'narcissistic injury was so enormous that I conjured up all my defences in a mighty effort to deny and to reject the imminence of my own demise.' (13)

Subsequently in reading Cousins (1979) I have been able to recognise many of my own feelings - the sense of helplessness at being ill; having a sub-conscious fear of never being able to function normally again; the feeling of separation between myself and the rest of the world; my reluctance at being thought a complainer; the desire not to add to the already great burden of apprehension felt by my family - bringing of course an even greater sense of isolation; my conflict between the terror of loneliness and the desire to be left alone; my lack of self-esteem, and the sub-conscious feeling that perhaps my illness was a manifestation of my inadequacy; my guilt of having done something to deserve being ill; the fear that I wasn't being told everything but the dread of actually knowing; my terror of intrusive technology and my resentment of strangers who came at me with needles and vials and most importantly would I die from the overwhelming anguish of the pain.

My illness challenged and shattered all my previous defensive structures. I had desperately wished <u>not</u> to be helpless, passive or dependent - but had ended up as all of them.

The second effect and most devastating aspect of pain was dealing with the pain itself. The effect of my long -term pain, I know even now, remains unresolved. Pain is so mysteriously 'painful', so elusive to the known self that it verges close to being beyond description. Thus it remains almost incomprehensible to those who have not experienced it. If I could have readily described the pain I was feeling some of the torment I was undergoing might have been comprehended. 'But such incomprehension was not in any way due to a failure of sympathy but to the basic inability of healthy people to imagine a form of torment so alien to everyday experience.' (Styron, 1992: 17) Thus my solitude increased.

Even as I refer to a random section in a Pain Diary that I kept, it is impossible to contact that elusive dynamic nightmarish quality that pain brings...

Tuesday 13th July

a.m. - stiff, very dead leg, back nagging - but mobile and cheerful. Water exercise didn't release the stiffness - seem to have little stamina.
Try to go shopping - mobility becomes worse, walking very poor indeed. Hurts to walk, my limp becomes more pronounced as the pain in my back and leg worsens. I feel shock at my immobility - that I can't walk properly and can only hobble for a short distance.

p.m. -'Supervision' - sitting is painful. I am unable to sit through the session and need to stand and move several times. I am aware that the pain stops my concentration. I ignore the pain but going from standing to sitting makes me gasp. Driving from the hospital to pick up the girls is awful. Back pain is severe and foot and ankle throbbing dreadfully.

Back home pain is so severe I give into it and lie down. I am anxious about picking up H. I don't think I can now drive as pain in foot and back too great.

The whole evening I can do nothing. I lie with the pain. The ankle and heel now are in control. There is no relief from its attack. First the heel then the ankle, taking turns to emphasise their presence, but neither withdrawing from the fray.

I push from my mind the consequences of such pain on any future life-style - but it dawns on me that the consequences are very great. For the first time ever comes the realisation that I might not get better and that I will be a subject for the pain to command - a monarch whose power is very mighty, and from whom there is unlikely to be a release.

Rather, I would though, believe that this is just a bad day and that rest and healing will bring a more peaceful day tomorrow.

Wednesday 14th July

I awake knowing the pain stays with me. It is not as angry or demanding as it was last night but it is not yet fully awakened. It is menacing, threatening in its voracity. I find it difficult to put my foot to the ground; my heel is full of poisoned barbs. I will not be intimidated but I am incapacitated, fighting off anxiety. The pain in my heel throbs incessantly, I am locked into it. I begin to cry soundlessly, the tears wet my blouse. My heel hurts so much that I cannot put my sock on. My ankle wants to explode, my back wishes to join in. I am frightened that I will cry during my meeting.

p.m. I am calm but the pain is very severe. The heel has battled away all day, reinforcements always there. Now I lie still, knowing that any movement brings the sharp knife across my back. Walking is not possible; each step encouraging the foe to attack. I don't know what to do, so I do nothing. I just allow everything to drift through me - that's why I am calm, I just lie still. I observe the pain, noticing how similar it is to the pain pre-operations days - the heel, the ankle, under the knee, the deadness, the hot stabbing needles - but now the back has armed itself and I realise what a formidable army they are together. Although I am calm it feels that I am getting worse not better, that my life is more limited and the pain more overpowering.

Thursday 15th July

The pain still remains - heel, leg, back. It has changed from yesterday's intensity. Today it is like a wall, solid, firm, and immovable. There is no break in its heaviness. My mobility is poor. It is difficult to get breakfast for the girls. Walking is a problem even round the house. I can't seem to make the easiest of decisions. I am tired, I have no energy. I don't know why I'm crying but the tears fall down my cheeks. The day ahead seems very long. My heel and ankle will not leave me alone. My back spasms every now and then - horrid pain that makes me cry out. I know my family feels helpless.

p.m. The pain has lessened. It is still ever present, but it is not in total control. I feel tired and very unattractive, battered. The pain has taken its toll. 'Misery' is a word that comes to mind.

Friday 16th July

I am weary. Walking reminds me that my ankle and leg are operating under a different system. I am in control of the pain this morning but it is a hollow victory for I cannot generate the energy to partake in the day. It is not the pain that defeats me this morning, but its close confidante and friend - 'depression'.

p.m. The pain has lessened and the control has shifted. The pain and I can now co-exist, accepting each other for the moment. My leg is dead, my ankle swollen and throbbing, my back plays hide and seek. But it's okay.

Night - The respite was brief, much too brief - an illusion to think the control had shifted. My ankle, swollen and barbed; under my knee daggers thrust up the thigh, down the calf, testing their prowess, returning and regrouping once again. My heel too wishes to join in I hate this.

Saturday 17th July

My birthday! I ask the pain to let me have this day. Strangely the pain is not the total monarch it was. It allows me a life of which it is a part. My ankle is tight and swollen, my back sore. We muddle along together.

Night - Payment for sitting down for a meal for 2 hours - terrible back pain. Every movement hurts. It's a pain I recognise and used to be terrified of; a total tyrant. Like an iron bar up my back and a series of burning jagged knives with every movement however small, I know all I can do is to lie still and allow its bad temper to reign until the morning. Even the pain in my foot, ankle and leg bow to its superiority.

Sunday 18th July

Repeat of yesterday - a tolerable day coexisting with the pain - but by night!!! All movement is awful. We have friends for supper but I have to leave them and come upstairs to lie down - both sitting and standing are too painful. My ankle and heel are also aggressive - wanting to explode. My ankle is very swollen, my heel very tender, the skin excessively hard and brittle. What would I have been like if I hadn't taken painkillers earlier? I am tired. I would like to escape into sleep. The pain is very bad indeed; very bad. I would dearly like someone to help me - When it's like this there is an intimate yearning for a soul-mate - I do not expect 'cure' now, but a soul-mate would bring understanding and compassion within this pain relationship. I would not feel so alone.

Thus my inability, my almost autistic traumatised state could only be symbolised by the language of battle in my diary as I tried to make sense of the incomprehensible but overwhelming certainty of the pain I had experienced. I feel, even now, quite illiterate about my pain. I am unable to deal with it rationally, often becoming panic-stricken when it is at its strongest. I have undertaken many methods to counteract pain - surgery, pain-treatment, physical therapy, electrical stimulation, chemical treatment, hydrotherapy, alternative therapy etc., but still the pain remains

My experience is likely to be fairly typical of other chronic pain suffers. The recognition and understanding of such an experience is vital in that the pain experiences 'has something fundamental to teach each one of us about the human condition with its universal suffering and death… We can envision in chronic pain and its therapy a symbolic bridge that connects body, self and society.' (Kleinman, 1988, xiii)

However there was also an unconscious element that was part of my chronic pain experience. In retrospect I became aware of the unconscious element involved in my pain experience not just through the constant dreams that were ever present but also through the interaction that took place with my surgeon. Each day my surgeon would come and sit with me, sometimes for an hour or more and we would talk. What strikes me about those months and those daily talks is the bizarre stories I would find myself telling him. At the time it seemed that I would launch into the strangest of tales, which appeared to come from nowhere. For example, my surgeon would be telling me about the surgery he had performed that day or some aspect of his work and I would find myself blurting out a story about Jazz Musicians. 'Why,' I would state, ' when Jazz artists were so technically brilliant and the music they performed so magnificent, were they so terribly destructive? Look at Art Pepper and Chet Baker, brilliant musicians but so destructive.'

Communicatively speaking, such stories that seemed to pop up from nowhere would be considered encoded narratives and although the triggers for such narratives were unclear it can be surmised that the trigger is likely to be connected to the surgeon's impact regarding the surgical procedures and pain. Unconscious communication is worthy of further investigation.

16. Appendix B - Addenda to the Dissertation

1. Comment on the limitations of the study

This dissertation is limited in that any non-quantatative Ph.D dissertation cannot hope to assess the empirical credibility of any psychotherapeutic method. Within this dissertation the interpretations of the therapist were communicatively considered to be highly defensive avoidance interventions. This limited the dissertation in that it was not possible to ascertain how the patient would respond to consistent valid communicative interventions. The dissertation was also limited by the number of the sample. One case study, however thorough and meticulous, is only able to raise issues and not provide answers.

2. Highlight the evidence that Death Anxiety played a major role in the patient's responses to his chronic pain and in the therapist's difficulties in doing the psychotherapy.

The following communicative postulates, derived from adaptive-oriented listening and formulating in the psychotherapy situation are pertinent to this discussion (see Langs, 1993, 1996, 1998, 1999):

'There's a very powerful connection between a therapist's or patient's management of, and responses to, rules, frames, and boundaries and death anxiety. In essence, securing the ideal, unconsciously validated frame, which is inherently supportive of both parties to therapy, creates entrapment anxieties that are strongly connected with existential death anxiety—the link being the idea that we are all trapped in a life from which

the only exit is death. On the other hand, departures from these ideal ground rules—altered or deviant frames—are experienced as persecutory and evoke predatory death anxieties (Langs, 1998, 1999; see below).

The therapist, who intervenes in ways that are not validated unconsciously by patients, including the use or invocation of frame modifications—departures from the ideal frame—is perceived unconsciously as predatory by the patient and as a predator by the therapist him or herself. Because therapists are trained to do therapy in ways that are largely consciously and/or unconsciously harmful to their patients, predator death anxiety is endemic among psychotherapists who unwittingly punish themselves for their consciously unrecognised, but unconsciously perceived, misdeeds "

(Langs -Three Forms of Death Anxiety. Unpublished Manuscript 2001)

The point shown by the dissertation regarding working with a chronic pain patient and a pain sensitive therapist was that deep unconscious experiences were difficult to maintain when there was such sensitivity to chronic pain. Both the therapist and the patient shut off encoded communication regularly and dramatically through continual frame breaks and by constantly remaining in the manifest. The notable aspect of this therapy was the extraordinary number of frame breaks that were initiated. It was as if there was activated within both the therapist and the patient a dread of encoded images for such encoded images would be connected to their death anxiety. The frame breaks that enabled such an avoidance of death anxiety issues were significant:

- The therapist visited the patient in hospital
- The therapist and patient had physical contact at the hospital when the therapist helped the patient out of bed
- The patient had knowledge of the therapist outside of the therapy room

- The patient had knowledge regarding the therapist's personal life
- The therapist was being paid by the patient's parents' medical insurance
- The therapy took place in consulting rooms with a shared waiting area
- Session times were changed
- Both the therapist and the patient left the therapy room at times during the therapy etc etc

It is clear in the points made above by Langs that there is a very powerful connection between a therapist's or patient's management of, and responses to, rules, frames, and boundaries and death anxiety. The excessive number of frame breaks created in this therapy are likely to correlate with the level of death anxiety that was instigated.

In addition to this a key piece of evidence that suggests that death anxiety played a major role in this therapy is shown by the extraordinary number of stories about death, most of them very powerful. It is unusual in any therapy to have such a barrage of stories connected to death:eg. tubes and sprays being pushed down your nose and into your throat, not being able to breathe; mask over the patient's face smothering him; reincarnation; death of his nan; ghosts; Joe's sister dying on television; food animals having their heads chopped off; a film in which the hero is murdered; serious heart surgery; physiotherapist twisting the patient's neck so he cannot breathe; windpipe being blocked; the draining tube coming out of the patient's stomach; Dracula taking his blood; murders; abortions; fish dying; dismembered bodies; etc etc. Death was a major theme and communicative theory propounds that what the death themes followed was a response to the frame violations which were likely to be connected to the chronic pain as explored in the thesis.

In light of Lang's comments on the communicative position regarding death anxiety, the dissertation was able to show that on the occasions that encoding was allowed to unfold that predatory death anxiety in particular was encoded by the patient. For, example, there was an account of the patient's dream in which he described being completely smothered by a mask. He was ‘throwing up’ because of the mask and he was aware of being totally helpless and trapped because he could not remove the mask. Communicatively this image would be seen as a response to a previous frame infringement by the therapist which in this case was the decision by the therapist to visit the patient whilst he was in hospital. The patient perceived the therapist as a predator who was smothering him in reality.

The stories the patient recounted about his visit in hospital also indicated that he unconsciously perceived the therapist in a predatory light and that his own existential death anxieties had been mobilised in the therapy.

> *It's amazing at H you know. You know that women who is having all the babies? Well she's there. They told her that they won't all survive but she's going to get a million pounds. The world record is six babies and the doctor said she's got to exterminate three of them or perhaps four and then that would give her twins or triplets or something but she won't and that's because she's going to get the money. She has already got bad press.*
>
> *And you know that girl; the girl whose mother was killed -and sister -in the alley and their dog. Well she's there as well! And the father! Well he is suspected - I think because of the dog- because why would they kill the dog? I think it's because of evidence. If the dog went near him, the dog would bark and they would know! The girl goes along the corridor and if people say anything to her, he says, ‘You don't need to answer that.’ And he's gone off and got married again!*
>
> *And there's that other women - you know the one with the baby, the one where the baby was stolen! It's been in all the papers. She is there too you know! Every day I was there, H was in the news!*

The stories were about death and dying, murder, violence and stealing with the main theme being that of extermination. The imagery is grim, predatory and difficult to bare because it is experienced as the patient's unconscious perceptions of the therapist as a killer. The patient's predatory death anxiety had been activated by the inappropriate frame breaks of the therapist and the therapist's predator death anxiety too.

The therapist showed her difficulties in responding to death images in the way that she avoided interventions regarding all death-related imagery. For example within one session the patient described two deaths, that of his Nan and that of a television character. The stories followed each other and were about denial of death and loss through death. The patient referred to someone 'being cracked up and crying all over the place' a comment about the therapist's inability to tolerate her own death anxiety and her inability to trigger decode the death themes in which he unconsciously perceived the therapist as dead to him.

The significance of chronic pain and death anxiety is that the encoded images that are portrayed are so terrible and evocative of guilt, conscious and/or unconscious, that they are difficult for both therapist and patient to decode. Thus both patient and therapist were inclined to modify the frame in order to avoid such death anxiety issues—the patient because of predatory death anxiety and therapist because of predator death anxiety.

3. Extend the formulation of the patient's use of denial to include a stronger form of denial like 'obliteration'- a term that suggests a relatively massive shut down of conscious and unconscious responses.

It is pertinent to recognise that there were different levels of unconscious denial instigated by the patient (and therapist) so that the most severe level of unconscious denial could be defined as a form of ' unconscious obliteration'. Instances of such obliteration could be seen for example, when the patient affirmed the frame break of the therapist leaving the therapy room and going to her car by stating,

> *You know my friend J? His sister, she is 16 years old. She baby-sits for us; well she baby-sits my younger brother and my little sister. She has just done her GCSE's. She got four 'A' stars, two 'A' s and a D.*

A positive communication following a major deviation of this kind can represent nothing but denial, and this formulation is supported by the fact that this particular session, which followed the therapist's visit to the hospital, had been full of death related images which the therapist had failed to interpret. The frame breaks had been particularly evident within that session and thus, it appears that when there is extraordinary strong death anxiety on both the patient's and therapist's part, it will provoke a strong need to use unconscious denial and to obliterate encoded communication. If the death anxiety level is high enough between the therapist and the patient, the normal communicative processing procedures can be significantly affected and the level of denial may reach extremes of obliteration.

4. Comment on the finding that the patient's deep unconscious cognitive impairments alternated with sound unconscious cognitive function.

During his keynote address to The International Society for Communicative Psychoanalytic Psychotherapy in New York (October 2001) Robert Langs stated that in his research with Badalamenti (see Appendix B) they had noted in their research that one particular patient, (who was in therapy with a therapist who would be considered by the communicative approach as frame breaking and assaultive,) continually gave what appeared to be validating images following particularly frame breaking moments. However their research showed that these images were later followed up by negative stories.

This dissertation confirms such research and suggests that the 'happy stories' may be forms of unconscious denial. Such unconscious denial typically is followed by negative images that represent accurate unconscious perceptions of the therapist's harmful frame modifications, thereby reflecting a restoration of adaptive unconscious cognitive functioning. This could be seen dramatically throughout the clinical work in this thesis and one of many examples can be found at the very end of the therapy when after a series of frame breaks including the patient leaving the therapy room to go to the toilet. The initial positive imagery that followed such frame breaks finally gave way as the patient ended the therapy by stating:

> *Isn't it awful about those old ladies who die sitting in front of their fire and no one hears about it for six months and then they 're discovered in their smelly flat because the body has become decomposed? It's because people aren't sociable any more. When my mum was a little girl she could go down to the park and talk to people and it was all right, but you can't do that now. I really think it's disgusting the way that happens, don't you?*

5. Draw out the most critical and evaluative comments made in your review of the literature and in the phenomenology section, stressing the points that have the strongest implications for your study.

Most important for my study is the failure of previous investigators to identify within the literature the crucial role that death anxiety plays both consciously and unconsciously in the therapeutic interaction and within the experience of the patient.This research has been able to clarify these missing elements. Death anxiety is an issue explored by this study and the results show where the problems lie and what is needed to correct them. It contributes to the chronic pain and psychotherapeutic literature in that this is the first research to explore and document the communicative approach as a form of psychotherapy for chronic pain patients and to thus focus on the issue of death anxiety.

This study also points to the lack of any major chronic pain research based on the experiences of the patient. In light of this and the findings of the research, the study recommends that the meaning and experience of chronic pain be taken as a starting point and not as a symptom of something else. If the experience of chronic pain be taken as a starting point then the very understanding of how medicine sees chronic pain is challenged. The study propounds that the patients' experiences and emotional responses bring an informative and valued part to the chronic pain experience. As Kleinman (1988) states,

> *'What is needed is a kind of care radically different to what is now routinely available… indeed I have come to believe that this life in pain…. teaches us that our science as much as our clinical practice is at fault in the repeated failure to understand pain and it's sources; we are unwilling to take the meaning of pain as seriously as we take its biology.' (73)*

This study also demonstates that the majority of pain therapies are based upon medical, behavioural and cognitive behavioural programmes and that the use of patients' encoded narratives and unconscious experience as a means of working with pain is a new and unexplored area. Thus the study has been able to show that chronic pain evokes unconscious responses which are activated in both the sufferer of the chronic pain and in those who have interactions with those who suffer from the chronic pain. The awareness that chronic pain evokes unconscious responses goes some way to gaining insight into why there is so little documented research on the patient pain experience and as to why we are still some way from working successfully with chronic pain. This might also give an additional explanation as to why some health professionals acted so unusually by under medicating pain-relieving drugs. Such an explanation would conform with Langs' theory of conscious denial and unconscious wisdom and leads me to suggest that the work of this study could add to the sparse documentation regarding the unconscious mental functioning of states of intense pain.

6. **Summarise your main findings, in terms of the areas involved: our understanding of the subject of chronic pain, the problems that both patients and therapists have in the course of the psychotherapy of chronic pain patients and in respect to the communicative approach.**

- **Our understanding of the subject of chronic pain**

The dissertation points out the lack of any major chronic pain research based on the experiences of the patient. It also demonstrates that the majority of pain therapies are based upon medical, behavioural and cognitive behavioural programmes and that the use of patients' encoded narratives and unconscious experience as a means of working with pain is a new and unexplored area. The dissertation shows that when a patient is unable to be cured of chronic pain the outcome for both the patient and the doctor is ambiguous and unresolved. The dissertation states that such a position confronts medicine with the limitations of it's own theory and practice and is a statement of medicine's reflection upon how it understands pain and its overall philosophy about pain. The dissertation also shows that the literature regarding patient pain experience is a poorly researched area and further research is required.It documents that patient pain experience, such as exists, indicates that death anxiety is highly significant in the experience of the chronic pain patient. This shows a discrepancy regarding the importance of death anxiety between what is put forward from the point of view of the patient and what is documented in the pain literature. This suggests that death anxiety might have been underestimated in the medical literature as a significant factor in the patient's chronic pain experience. Further research into death anxiety and chronic pain might offer additional insight in widening the understanding of chronic pain syndrome.

The documented literature confirms that significant cognitive disruption is part of chronic pain syndrome.

- **The problems that both patients and therapists have in the course of the psychotherapy of chronic pain patients and in respect to the communicative approach**

The outcomes and conclusions sections of the main dissertation give a comprehensive overview of the difficulties in working with chronic pain patients. I refer the reader to that section.

17. Appendix C - Communicative Publications

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