Physical Pain and Humanistic Psychology

Edwina Milner

Disease or accident can interrupt a person's life at any age. Unfortunately there are no medical cures for many physically debilitating long-term or degenerative diseases, spinal or neurological injuries, and there are limitations to the relief of related chronic pain. It can be extremely difficult to change from an 'able-bodied' to a permanently 'disabled' self-concept, with the loss of valued and accustomed ways of experiencing the world and the prospect of pain every day. It can happen to any of us.

During the past year I have been making a tentative study of this, plotting the most commonly reported losses and changes against Maslow's Hierarchy of Needs. My results seem to clarify the need for psychotherapy, counselling and pain management programmes that are seeking upward progress to check the foundations on which they hope to build. The lowest level in Maslow's hierarchy is physiological. In the context of intractable pain this is initially dealt with in Western medicine by prescribing drugs. But when these and similar interventions don't particularly help, medical professionals can become frustrated, even angry, and the patient may become labelled as attention-seeking, a malingerer or neurotic.

A Downward Spiral

Pain is an invisible and subjective phenomenon. When a person's experiencing is denied by others (who may include family and friends — for most people expect doctors to cure all ills) they are totally alone. Feeling judged, misunderstood and in ongoing physical pain, their lives can

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take a downward spiral. Losses may include career, income, being unable to fulfil usual roles, play with the children, pursue enjoyable hobbies, have a social life. They may need help with simple tasks, feel that they are a 'burden', be grieving, tending to become isolated. Many move on to paying for alternative therapies because traditional medicine has not offered what they seek, but still find little relief beyond that of the caring attitude of the therapist. By the time they are referred for psychological help they may be reliant on drugs, walking sticks, surgical corsets; have anxiety, confusion, loss of confidence, reactive depression, learned helplessness, low self-esteem — and may well have become neurotic or suicidal along the way.

Humanistic psychology is against human diminution and invalidation of experience, and is about potential, about mind and body unity — unity of the whole person, body, feeling, intellect and spirit. Examination of subjective experience may reveal a need for a more humanistic, holistic approach, rather than labelling people and prescribing drugs. This is what I would very much like to encourage.

Abraham Maslow

Maslow wrote of the survival tendency, and of the actualising tendency which leads to the enhancement of life. He studied 'healthy' people and pointed out that the pursuit of higher levels cannot begin until the individual is free from the domination of having to satisfy, at least partially, their lower needs. He referred to the physiological level as a conative–affective phenomenon, largely determined by physical sating: 'food, sleep, and so on, and as by-products, well-being, health, energy, euphoria and physical contentment'.

Here is a problem for newly 'disabled' people. Such satings may obviously be frustrated, for example by loss of sleep, appetite or sexual interest. This has a knock-on effect to higher levels. In seeking to escape pain and frustration they may turn to using alcohol and drugs. They perceive danger, may fight to maintain past levels of satisfaction, deny their experience, or protectively take flight to their bed. Pursuing a 'cure' or relief from physical pain may become an overwhelming need. Maslow believed that basic needs and higher meta-needs were rights as well as needs. He defined neurosis and psychological maladjustment as deficiency diseases, explaining that deprivation clearly leads to emotional illness. And deprivation is just what newly disabled people are aware of. What they took for granted is gone. Instead of seeking fresh stimulation and new experience, they are reduced to 'deficiency motivation' in the extreme.

Is Pain 'Real'?

Perhaps the easiest way to feel this for yourself would be to imagine having toothache but no dentist, or severe cramp and no hand to soothe it. Pain demands attention. The resulting split between mind and body may produce a storm of emotional reaction to deprivation as months pass by and it becomes apparent that there is no release. Any pre-existing splits in the personality may become larger with the realisation that life's hopes and expectations may now be unattainable. Not only may experiencing be distorted or denied, but the newly disabled may fear 'passing through the eye of the nameless horror which the ordinary person desperately struggles to avoid', as Alvin Mahrer puts it.

A lack of medical explanation for the pain does not mean that the experience isn't real; it is important to be believed. Stephen Tyrer presents many schematic models illustrating the complexity of assessment. Pain from scar tissue, mechanical change or neural sensitivity can only be described, not actually seen. It can also originate in stress or spiritual sickness manifesting itself as organic disease. But because people in pain may be expressing negative thoughts and emotions they can too easily be thought to be seeking attention. Many have no such motives, they just want to get back to where they were. In the UK eleven per cent of the population have chronic pain; many take pain-killers, anti-inflammatories and anti-depressants which have side-effects, because they know of no other way to turn.

'A Way of Life'

At present there are ten large residential pain management units in the UK where the emphasis seems to be on learning coping skills through cognitive-behavioural therapy. Headed by a medical director (often an anaesthetist) they are generally staffed by a team of psychologists, physiotherapists, doctors, occupational therapists and nursing staff. They aim to reduce or eliminate drug-taking, teach behavioural pacing plus stretch, exercise, relaxation, visualisation and other techniques, and use supportive cognitive statements to challenge negative thinking.

But whilst they report successes, the programmes do not suit all people. Coping strategies may be taught as a 'way of life'. But pacing of all activity by using a timer which bleeps frequently through the day to remind its user to stand up, sit, or lie on the floor every few minutes can be frustrating, and the person may feel self-conscious, socially odd. This is of course a mechanistic alternative to listening to your body, intended to break the 'overactivity–underactivity cycle' of doing too much followed by enforced bed rest. There are also some 200 pain clinics where the emphasis is on treating pain with drugs, although some run smaller pain management sessions perhaps once a week.

Pushing Down Deeper Potentials

Humanistic psychologists might reject the very orientation used; Mahrer goes so far as to describe such therapies as 'downright murder of the self' which I feel is particularly true if cognitive therapy is used outside a pain management unit without the inclusion of other strategies to increase physical effectiveness. It cannot be assumed that a person has had rehabilitation; people who have diseases and injuries which are not life-threatening may have received only a limited amount of help, even none at all, in finding ways and means of maintaining or increasing self-efficacy. 'Effectance' is a level which David Wright added to Maslow's hierarchy, and I feel that this is important.

People in physical pain are in ongoing trauma; they need to talk over and over their experiences, often to the point of repelling all listeners. In pursuing a 'cure' for possibly many years, they have faced repeated failure of treatments and may have been bruised by the very agencies designed to help. Ruminating can be a way of finding meaning and experiencing a necessary grieving process, of dealing with impor-

tant losses, deep emotions, and incredulity at the prospect of this pain lasting forever. Denial is often part of this process, denial which can be healthy in the short term, filtering thoughts of what may yet to too awful to bear. Mahrer relates to changing the relationship of the potentials, saying that bodily pain is the relationship of the person to what is percolating within. I find that his theory seems to transpose well into pain management ideas. A common fear may be that of nonbeing. Beaumeister refers to suffering as stimulating a need for meaning, and Frankl (who survived Dachau and Auschwitz) said 'he who has a why to live can bear with almost any how.'

Maslow wrote that a single moment of ecstasy could change the way a person lived, and after his first heart attack wrote of plateau experiences brought about not only by beauty but through tragic events, such as recovering from depression and serious illness, or even confronting death. This is the more positive side of trauma, of opportunity. But although transformation can take place without psychotherapy, it can be a long and stony road for people in chronic pain.

Where Are You?

There is a need for more pain management units, self-help and support groups. I would like to see more humanistic involvement. My study is aimed at gaining insight into providing whatever therapy people need. So far this includes plotting coping and noncoping changes against the work of Maslow, Carl Rogers and John Rowan, and the routes that people take. Ideally I think this should be new paradigm participatory research with the collaboration of the participants themselves. I am just one of them.

Further Reading

JoAnn LeMaistre, *Beyond Rage: Mastering Unavoidable Health Changes*, Alpine Guild, 1985

Abraham Maslow, *Motivation and Personality*, Harper & Row, 1987

M. Rigge and C. Hogg, *Living in Agony*, College of Health, London, 1990

Alvin Mahrer, *Experiencing; A Humanistic Theory of Psychology and Psychiatry*, University of Ottawa Press, 1989

John Rowan, *Ordinary Ecstasy: Humanistic Psychology in Action*, Routledge, 1988

Stephen Tyrer (ed.), *Psychology, Psychiatry and Chronic Pain*, Butterworth Heinemann, 1992

A fuller version of this article, including hierarchies and theories demonstrating the application of coping and non-coping strategies, plus more text, is available for £3.00 from Edwina Milner, 74 Clifton Road, Ashingdon, Essex SS4 3HJ. Pain Concern UK produces a useful factsheet, which can be obtained by ringing 01227 712183.