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LA DOULEUR CHRONIQUE ET L'ANGOISSE D'ANÉANTISSEMENT : LA SIGNIFICATION PRIMITIVE DE SOUFFRANCE

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CHRONIC PAIN AND THE ANXIETY OF ANNIHILATION: THE PRIMITIVE SIGNIFICANCE OF SUFFERING

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Résumé Français

Plusieurs études ont révélé des liens intimes entre angoisse et douleur. Or, la douleur chronique met un terme à l'espoir de guérison et la perspective d'une souffrance interminable se présente comme une sombre éventualité pour celui qui en est atteint. Dans le cadre d'une recherche entre psychanalyse et phénoménologie, la présente étude se penche sur les angoisses subies par les malades souffrant de douleur chronique dans le contexte actuel de la réadaptation de la douleur. Pour accomplir son objectif, cette thèse comporte deux volets à la fois séparés et reliés entre eux. Deux recherches encadrent conjointement la problématique de l'étude et ouvrent la discussion sur une réflexion plus vaste sur l'angoisse de mort et sa place dans notre approche de la souffrance humaine. La première recherche utilise la notion de relation d'objet kleinienne pour explorer les témoignages de trois malades souffrant de douleur arthritique rhumatoïde chronique et démontrer comment les angoisses infantiles constituent la signification primitive de l'expérience de leur douleur. L'étude interprète les histoires recueillies au moyen d'un test projectif et démontre comment les histoires des participants fluctuent entre les angoisses d'anéantissement du moi et celles de destruction de l'objet. L'auteur soutient qu'une compréhension de la souffrance primitive est nécessaire, non seulement pour saisir l'histoire infantile de la douleur, mais également pour permettre aux malades de travailler sur la nature idiopathique de leur épreuve. La deuxième recherche se sert d'une approche phénoménologique pour explorer comment la psychologie de la santé interprète la souffrance et la douleur. En réponse à une interview semi-structurée, trois psychologues de la santé décrivent leur expérience auprès de patients souffrant de douleur chronique et expliquent leur compréhension des angoisses associées à la douleur. Le concept de souffrance en psychologie de la santé décrit la douleur que les malades ressentent souvent comme une menace de désintégration. La recherche pose la question de savoir jusqu'à quel point la psychologie de la santé exclut la signification de telles menaces en éliminant la signification primitive de la douleur. Elle indique que le cadre de la psychologie de la santé impose de sérieuses limites à l'écoute de la souffrance, à la subjectivité et à l'expérience de la douleur, en éliminant toute référence au contenu de l'angoisse et à l'expérience intérieure du patient.

Introduction

S'épanouir sans douleur est presque impossible, puisque nos réactions face à l'environnement deviennent alors sérieusement compromises. Cependant, une douleur intraitable peut éveiller en nous des angoisses dévorantes qui peuvent assombrir notre

existence entière (Bakan 1968 ; Scarry 1985). La douleur chronique, contrairement à la douleur aiguë, persiste sans soulagement significatif après trois mois de traitement. En travaillant auprès de patients souffrant de douleur chronique, les psychologues font face régulièrement à la détresse émotionnelle comme faisant partie intégrante de la souffrance. On rapporte fréquemment que la douleur accompagne des sentiments de menace et d'atteinte à l'intégrité du corps et du moi (Szasz 1957 ; Cassell, 1999). Dans des situations de maladie sérieuse ou de douleur chronique, Cassell (1982) décrit la menace comme étant celle d'une « destruction imminente » causant une « violente détresse », ou ce qu'il (1982) nomme, d'une manière appropriée, « de la souffrance ». Les questions concernant la nature de la souffrance et les sentiments de destruction imminente ont suscité des études mettant l'accent sur l'expérience vécue ou sur l'expérience existentielle de la douleur chronique.

En rapportant les introspections d'un patient atteint de douleur chronique, Good (1992 : 41-42) montre comment la douleur bouleverse l'expérience du temps jusqu'au point où le patient peut se sentir prisonnier de l'instant. Le temps, tel qu'on le connaît pour être classé en passé, présent et futur, s'affaisse dans les intervalles de la douleur. Pour la personne qui souffre, la douleur chronique est une agonie sans moment autre ou sans fin. Good décrit clairement comment l'univers du patient devient englouti par la « peur de la dissolution du moi ». Affrontant cette peur, le malade lutte pour demeurer un psychologiquement. Pourtant, lorsque la douleur « inonde la conscience », la sensation de désintégration imminente et d'anéantissement prend le contrôle. Semblable à celle de Good, l'étude de cas de Brodwin (1992:81) signale une patiente souffrant de douleur chronique qui décrit ses terrifiantes impressions d'être suffoquée par l'agonie. Elle se sent

littéralement étranglée par la douleur qui lui fait sortir la vie par la gorge. La patiente décrit sa douleur comme étant « atroce, déchirante, comme si mon estomac était mis en pièces ». Son compte rendu reflète de façon très frappante la pure agression de sa douleur. Dans une autre étude de cas, Garo (1992 : 119) décrit un patient souffrant de douleur chronique dont l'angoisse intense, surnaturelle « présage de possibles "épisodes psychotiques", une "désorganisation de la personnalité" ». En douleur constante, Scarry (1985 : 53) déclare « on ressent que quelqu'un agit sur soi, anéanti de l'intérieur comme de l'extérieur ». En fait, il n'est pas rare que les patients décrivent la douleur comme étant un « monstre » (Byron Good, 1992 : 39) terrifiant qui les attaque et qui les ravage violemment de l'intérieur. En expliquant cette réaction, Scarry (1985 : 52) ajoute que quoique la douleur « se produise à l'intérieur de soi, elle est tout de suite identifiée comme n'étant "pas soi-même", "pas moi", comme étant quelque chose de si étrangère que l'on doit s'en débarrasser immédiatement ». Faire l'expérience de la douleur comme n'étant « pas soi » fait que le patient se sent attaqué de l'intérieur par une entité étrangère au moi ou par un « non-soi » monstrueux. Les chercheurs et les cliniciens témoignent à l'effet que « la douleur est universellement décrite comme étant "elle" (White and Sweet, 1955 :108 ; Cassell, 1976) ou comme étant une "présence étrangère" (Zaner, 1981 : 54-55) ».

Des sentiments observés si fréquemment montrent comment des angoisses grotesques colorent les préoccupations émotionnelles et les perceptions de plusieurs victimes de douleur chronique. La prévalence de telles angoisses chez les patients souffrant de douleur chronique soulève une question importante concernant la nature de la douleur et sa relation avec la menace imminente d'anéantissement. Comment les

angoisses liées à la souffrance en viennent à englober le plus grand sens de l'existence du malade est une question inépuisable qui doit être analysée sous plus d'un angle. Cependant, pour une grande part, la réponse à cette question peut dépendre de comment l'angoisse est d'abord définie et comprise.

Le psychologue existentialiste Rollo May (1977 : 363-64) définit l'angoisse comme étant « notre conscience humaine du fait que chacun de nous est un être confronté au néant ». Il présente la définition du non-être ainsi : « ce qui détruirait l'être, comme la mort, une maladie grave, une hostilité interpersonnelle, un changement trop soudain qui détruit notre enracinement psychologique ». May reconnaît que « l'angoisse est la composante psychique de chaque maladie » (91). Cette association peut être attribuée au fait que l'expérience de la douleur nous met souvent en garde contre une blessure et contre une maladie, et, en fin de compte, laisse prévoir l'approche de la mort. En tant qu'un des premiers signes et symptôme général de morbidité, elle fait pressentir la mort à l'humain. Cependant, May ajoute une information importante à sa discussion sur l'angoisse lorsqu'il explique « que les gens utilisent la maladie de la même manière que les vieilles générations utilisaient le démon – comme un objet sur lequel projeter leurs expériences de haine, de sorte à éviter d'avoir à prendre leurs responsabilités envers celles-ci » (86). Malheureusement, cette intuition importante n'apporte rien à la discussion de May sur l'angoisse, étant donné que celui-ci ne fournit aucune élaboration de plus sur le sujet.

Dans son travail sur la souffrance et sur la maladie, Bakan (1968 : 65-85) puise dans les témoignages clinique et historique pour expliquer la terreur de l'anéantissement dont font l'expérience les patients souffrant de douleur chronique. « La douleur, déclare

Bakan, est un présage de mort au-delà de toutes les options associées à sa gestion » (78). Il soutient que dans les premiers stades du développement du moi, la douleur est ressentie comme étant une menace distincte d'anéantissement. Il réfère à un complexe infantile dans lequel la perception de la douleur est à peine différenciée de la menace concrète de la mort, et il explique comment le moi de l'enfant fait l'expérience de la douleur en tant qu'être à la fois blessé et tué. Bakan reconnaît « l'expérience de la douleur primitive » comme constituant la source intrapsychique du complexe douleur-anéantissement. Il définit le terme « primitive » comme étant « le stade premier du développement du moi », qui comprend les périodes infantile et préverbale. Dans l'idée de Bakan, le moi de l'adulte conserve un sens latent de « je suis blessé et tué », malgré ses capacités manifestes de différencier la douleur de l'anéantissement. En effet, « je suis blessé et tué » constitue l'histoire infantile de la douleur dont le moi s'est lassé, mais qu'il n'a jamais abandonnée.

D'une manière pas tellement différente de la conception existentialiste, la psychanalyse a reconnu la mort comme étant la source première de l'angoisse qui lie au-delà de toutes les expériences ordinaires de l'angoisse. Cependant, Freud (1920) voit la mort comme étant plus qu'une simple éventualité dans la trajectoire de la vie et il lui confère le statut de pulsion (*Trieb*) ou de tendance de destruction innée. Poursuivant la métapsychologie de Freud, Klein (1946, 1948, 1952 et 1958) soutient que dans son développement à partir de la première enfance, le moi prend deux positions dans sa relation avec l'objet primitif. Dans la position paranoïde-schizoïde, le moi et l'objet sont clivés. Le moi primitif projette l'instinct de mort sur les expériences frustrantes et douloureuses, tandis que sur les expériences satisfaisantes, il projette l'instinct de vie. De

cette manière, le moi primitif en arrive à éviter la menace de désintégration apportée par l'instinct de mort, créant néanmoins l'objet mauvais, persécuteur. Comme résultat, un univers en noir et blanc émerge, lourd d'angoisses paranoïdes d'être attaqué et anéanti par un objet persécuteur pouvant contrôler et détruire à la fois la bonne partie du moi et l'objet idéal. Dans cette position, la douleur et la frustration sont vécues comme constituant une menace venant d'une force persécutrice étrangère. Cette angoisse donne naissance à des fantasmes sadiques-oraux de destruction dirigés vers l'objet mauvais et de contrôle tout-puissant comme défense.

Dans la position dépressive, l'enfant intègre les bons et les mauvais objets fractionnés en un tout qui apparaît comme étant la source simultanée de la frustration et de la gratification. Cette qualité paradoxale de l'objet entier fait naître les sentiments d'ambivalence du moi et fait apparaître l'objet comme étant simultanément bon et mauvais, aimé et détesté ou craint et désiré. L'intégration du bon et du mauvais en un tout cause au moi des angoisses extrêmes de perdre l'objet qui est endommagé ou de dépendre d'un objet endommagé pouvant user de représailles. Le moi craint aussi de perdre les introjections qui créent son univers intérieur. L'angoisse dépressive est accompagnée d'un fort sentiment de culpabilité primitif envers l'objet endommagé. Dans cette position, le moi fait l'expérience de la douleur comme étant liée à un objet endommagé et perdu, ou comme étant une forte culpabilité. Cette angoisse met en branle un nombre important de mécanismes de défense, afin de faire taire la culpabilité primitive. Le mépris de l'objet, le contrôle compulsif, le déni de la dépendance et le triomphe par rapport à l'objet endommagé font partie des mécanismes de défense obsessionnels.

Quoique la conception psychanalytique de l'angoisse reconnaisse l'importance de vraies situations de danger, elle admet que l'angoisse est modelée autant par des sources réelles de menace qu'elle est colorée de menaces intérieures et primitives. Ainsi peut-on soutenir que chaque angoisse liée à la douleur porte, à un plus ou moins grand degré, des traces des angoisses infantiles oubliées depuis longtemps, mais jamais abandonnées. De ce point de vue, donner un sens adéquat à la douleur signifie la comprendre comme étant une expérience enracinée dans l'histoire de l'enfance. Dans cette interprétation, la conception de Klein du développement infantile et de l'instinct de mort peut offrir une réflexion importante sur ce qu'on rapporte fréquemment en recherche phénoménologique, mais qui est laissé sans interprétation en profondeur. En fait, la conception de Klein sur la relation primitive avec l'objet peut faire la lumière sur plusieurs qualités primitives de l'expérience de la douleur.

La relation controversée entre le langage et la douleur est perçue comme étant complètement déconcertante. La plupart du temps, lorsqu'une douleur atroce frappe, des cris et des gémissements remplacent les mots et les phrases convenables. Scarry attribue ce manque de mots à une qualité particulière de la douleur, qui nie le langage. Elle fait remarque ceci : « La douleur physique ne résiste pas simplement au langage, mais elle le détruit activement, entraînant un retour immédiat à un état antérieur au langage, au son et aux cris que les êtres humains profèrent avant qu'ils n'aient appris à parler » (1985 : 4). En fait, toute tentative de verbaliser la douleur est engagée par des sons non lexicaux rappelant les vocalisations préverbales de détresse de l'enfance. Les cris de douleur qui exprimaient autrefois le besoin d'être nourri révèlent, chez l'adulte, le retour à un temps antérieur à l'apprentissage de la langue. Si donc de tels cris signifiaient plus tôt une

absence de langage, leur retour au moment de la douleur peut refléter la destruction du langage et un retour aux angoisses préverbales. Scarry déclare clairement que : « Dans la douleur physique, le suicide et le meurtre convergent ensuite. » (53)

Une autre qualité primitive de l'expérience de la douleur est inhérente à son pouvoir de violer le sens de l'objectivité et le principe de réalité en brouillant la frontière entre l'intérieur et l'extétieur. Afin d'expliquer cette qualité, Scarry (1985 : 5) fait remarquer que tous les états de conscience comprennent des objets comme « contenu référentiel ». Elle explique que la colère, le bonheur, la tristesse, la haine, la faim et l'amour réfèrent tous à des objets. La douleur, cependant, n'a aucun contenu référentiel en dehors d'elle-même. De plus, la douleur intense est « vécue spatialement comme n'étant ni la contraction de l'univers jusqu'à la proximité immédiate du corps, ni comme le corps se gonflant afin d'occuper l'univers entier » (35). En pleine douleur, la préoccupation du malade pour le monde extérieur perd son importance au profit de la présence écrasante de son corps qui fait mal. Leder réfère à cette « enflure du corps » comme à un « resserrement spatio-temporel », que Scarry décrit comme étant « une fusion presque obscène du privé et du public » (Scarry, 1985 : 53). Une telle frontière changeante rappelle le manque premier de séparation entre l'objet et la réalité, lorsque des événements somatiques concrets dominaient l'activité mentale de l'enfant.

Par opposition à l'emphase psychanalytique et phénoménologique placée sur le contenu de l'angoisse, la psychologie de la santé explique la douleur comme étant un processus biopsychosocial généré par « un réseau d'événements, à la fois à l'intérieur et à l'extérieur du corps, aussi bien qu'à l'intérieur et à l'extérieur du système nerveux central » (Fordyce, 1989 : 52). Elle soutient que quoique la douleur puisse persister sans

beaucoup de soulagement, son impact affligeant peut être géré, si les patients apprennent à s'adapter à leur nouvelle situation de vie (Turner et Romano, 1989 ; Bradley, 1996). Les psychologues de la santé s'appuient fortement sur des stratégies cognitivo-comportementales pour changer les comportements qui sont sources de mauvaises adaptations et cognitions en comportements adaptés. Dans ce but, Fordyce (1989 : 56) redéfinit la notion de souffrance de Cassell ainsi : « Un stimulus qui produit de la peur, une menace ou l'anticipation de conséquences répugnantes peut mener à de la souffrance, et des comportements indicatifs de souffrance peuvent s'exprimer. » D'après cette théorie, la douleur persistante fait que la victime craint plus de mal, parce que la douleur possède une forte association expérientielle avec une blessure comme facteur antécédent. Selon Fordyce, si l'environnement renforce les réponses qui sont sources d'une mauvaise adaptation et d'une perception exagérée de la douleur chez le patient, cela encourage « l'expression et la continuation de la douleur ou du comportement souffrant et, ainsi, promeut la chronicité » (55).

Cette redéfinition de la souffrnace élimine complètement toute référence à la menace imminente d'anéantissement. En effet, décrire la souffrance en tant que réponse au comportement soulève la question de savoir de quelle manière les comportements indiquant la douleur ou les comportements de douleur diffèrent des comportements exprimant la souffrance ou des comportements de souffrance. En fait, Fordyce maintient ceci : « Ainsi, la souffrance peut mener à l'expression de comportements de souffrance qui sont, ou qui peuvent être, pratiquement impossibles à distinguer des comportements de douleur » (56). Contrairement à cette conception, Cassell et Bakan insistent sur le fait que la peur de l'anéantissement imminente définit la souffrance non seulement comme

étant une expérience humaine distincte, mais également comme en étant une qui exige son propre mode de compréhension. En omettant l'angoisse de l'anéantissement, l'expérience du patient n'apparaît pas tellement dissemblable à une erreur cognitive ou à une réaction excessive face à la douleur, par opposé à une expérience significative qui pourrait être enracinée dans l'histoire primitive du moi. En redéfinissant la souffrance humaine dans les limites des comportements observables et de leurs contingences, Fordyce ne tient pas compte de l'ambiguïté de l'univers intérieur du malade. Comme résultat, Fordyce recommande l'utilisation de la rétroaction comportementale et de la restructuration cognitive, afin de réorganiser les comportements de souffrance en comportements d'adaptation. La stratégie a pour but de réduire la fréquence des réponses qui sont sources d'une mauvaise adaptation et de les supplanter éventuellement par des réponses adaptatives.

Skevington (1995 : 4) déclare que la psychologie de la santé, avec son accent placé sur l'analyse du comportement, « n'envisage pas les gens et leurs histoires, mais elle regarde plutôt l'environnement dans lequel ils vivent et comment l'expérience et l'apprentissage ont modelé leur comportement en tant que victimes de la douleur ». Le béhaviorisme, comme Pérez-Álverz (2004 : 173) l'indique, « considère que les gens sont à l'intérieur de l'univers, et non que l'univers est à l'intérieur des gens ». Le but proclamé de la psychologie de la santé réside dans son effort pour réduire l'ambiguïté subjective de la souffrance à la clarté de paramètres concrets et de mesures. De cette manière, les psychologues de la santé donnent un sens aux angoisses terrifiantes et aux préoccupations étranges basées sur les interactions immédiates et observables entre l'individu et son environnement. Dans leur idée, contextualiser et comprendre la souffrance signifie

traduire l'univers intérieur du malade en comportements et en réponses liés aux stimulus ou dépendant de facteurs antécédents et de leurs conséquences. Les cliniques de la douleur, multidisciplinaires, pour la plupart, utilisent ce cadre béhavioriste pour la gestion clinique de la douleur chronique (Loeser et Egan, 1989, Long, 1996).

Se servant d'un cadre phénoménologique et psychanalytique, l'auteur de la présente étude a exploré non seulement l'expérience du malade, mais également le discours des psychologues de la santé. Le but de l'étude est de jeter un éclairage sur les angoisses éprouvées par les personnes souffrant de douleur dans le contexte de la réadaptation d'aujourd'hui. En tant que recherche psychanalytique, elle cherche une explication au contenu des angoisses liées à la douleur, de sorte à explorer leur signification première. Cependant, en tant qu'étude phénoménologique, elle se penche sur les discours professionnels sur la douleur et sur l'angoisse en psychologie de la santé, de manière à examiner la compréhension normative de la souffrance. Par conséquent, notre étude entretient une double structure, qui comprend deux explorations interreliées. Dans la première recherche, nous nous demanderons jusqu'à quel point l'expérience de la douleur chronique contient et symbolise des relations d'objets primitives et, ultimement, jusqu'à quel point elle renouvelle les angoisses paranoïdes-schizoïdes d'être anéanti par une entité étrangère au moi. Dans notre seconde recherche, nous nous interrogerons sur comment la psychologie de la santé, en tant que modèle prévalant en gestion de la santé, parle de l'angoisse et interprète l'expérience de la douleur chronique. Ces deux questions encadrent conjointement la problématique de notre étude et ouvrent la discussion sur une réflexion plus grande sur l'angoisse de la mort et sur sa place dans notre approche de la souffrance humaine.

D'un point de vue historique, l'étude psychanalytique de la souffrance et de ses symptômes physiques a, jusqu'ici, tournée autour de la notion de conversion, considérant les événements somatiques inhabituels comme étant explicables par leurs causes et significatifs symboliquement en termes de dynamique intrapsychique sous-jascente. Ainsi, la psychanalyse classique percevait les maladies somatiques et leurs préoccupations comme étant des manifestations symboliques de souvenirs réprimés ou comme étant de l'hystérie de conversion (Freud et Breuer, 1895). Plus tard, la maladie psychosomatique a été présentée comme constituant le dérivé somatique du stress causé par les conflits intrapsychiques (Alexander) ou comme étant l'expression d'une structure de la personnalité primitive causée par un traumatisme et par une pathologie du moi (Marty, De M'Uzan et David). En effet, la psychanalyse classique et les théories psychosomatiques ont fermement établi l'horizon du débat, dans lequel le symbolisme du corps est exposé et retracé, de sa cause intrapsychique jusqu'à son dérivé somatique. La présente étude, cependant, est conçue pour s'écarter de cette tradition et pour initier un mouvement en direction opposée, c'est-à-dire du soma vers la psyché. Dans cette veine, elle explore la douleur persistante comme étant une expérience provocatrice d'angoisse, de laquelle le symbolisme inconscient peut surgir. Elle pose la question de savoir si la douleur intraitable ayant une physiopathologie et une cause connues peut raviver les angoisses d'anéantissement et de destruction primitives et ramener au présent la vulnérabilité infantile enfouie profondément à l'intérieur du malade.

Encadrement Épistémologigue

L'encadrement épistémologique de la thèse est basé sur une approche herméneutique critique. L'auteur cherche la vérité possible (et pas probable) dans le sens critique de

l'étrangeté inquiétante qui est cachée derrière la démarche clinique de la gestion de douleur chronique. Cet étude n'écarte pas les cliniciens des patients douloureux comme étant les participants. Par contre, elle consiste en deux recherches avec deux groupes des participants: un des patients et l'autre des psychologues de la santé.

La première recherche, c'est une exploration critique et analytique qui révèle les aspects latents du discours des patients à propos des expériences vécues et terrifiantes de la douleur.

La deuxième recherche, c'est une exploration critique et phénoménologique qui révèle ce qui est renié par les cliniciens à propos des angoisses vécues et rapportées par les patients douloureux.

La petitesse des groupes participants permet à l'auteur d'analyser les discours accueillis en profondeur. Cette analyse profonde du symbolisme archaïque est nécessaire afin de révéler les sens sous-jacent, latent qui ironise les énoncés 'raisonnables' des psychologue par éclaircir les énoncés 'irraisonnables' des patients.

Méthodologie 1

La première étude qualitative pose la question de savoir jusqu'à quel point le fait de subir de la douleur chronique contient et symbolise des relations d'objets primitives et, ultimement, renouvelle les angoisses paranoïdes-schizoïdes d'être anéanti par une entité étrangère au moi. La méthodologie de cette étude implique l'analyse d'histoires collectées au moyen du test d'aperception de thèmes (T. A. T. ; Murray, 1943). En tant que narrations imaginatives sujettes à plusieurs interprétations, les histoires contiennent du matériel qui peut être utilisé pour explorer des références et des allusions à la douleur

et à la souffrance. L'interprétation met l'accent sur le passage entre les deux positions de l'angoisse, pour démêler le contenu latent des histoires. Casoni et Brunet (1989) ont conçu et testé une grille d'interprétation pour le T. A. T. basée sur la métapsychologie de Klein. Les auteurs établissent leur grille d'interprétation à partir de trois catégories de base : 1) l'angoisse ; 2) les relations interpersonnelles ; et 3) les stratégies défensives. Ces catégories sont ensuite divisées en leurs positions paranoïdes-schizoïdes et dépressives respectives. En analysant le matériel, notre étude met un plus grand accent sur l'angoisse que sur les deux autres catégories.

Participants

Un participant et deux participantes qui souffrent de douleur arthritique chronique prennent part à l'étude. L'arthrite rhumatoïde est une maladie douloureuse diagnosticable ayant une physiopathologie connue. Ces trois patients ont été choisis à l'aveugle à partir d'une liste de malades externes en pratique en rhumatologie. Ils ont reçu un traitement pendant au moins 5 années, ce qui a voulu dire une relation intensive avec le personnel en psychologie de la santé. Tous les patients ont terminé au moins une année d'un programme de gestion de la douleur. De manière à permettre l'analyse en profondeur exigée par cette étude, le point de saturation du groupe de participants a été établi à trois. De cette façon, une plus grande profondeur d'analyse a la priorité, de sorte à rencontrer le but d'interprétation de l'étude.

Instrument d'interview

Le test d'aperception de thèmes est le seul instrument de collecte de données utilisé. Le sous-ensemble recommandé pour l'administration générale a été utilisé dans cette étude. Ce sous-ensemble consiste en les cartes les plus communément utilisées et que toute

administration du T. A. T. doit inclure, indépendamment de la différence d'âge et de genre. Ces cartes sont identifiées par des nombres sans aucune lettre :

1. Carte 1 : un jeune garçon avec un violon ;
2. Carte 2 : une jeune femme avec des livres dans ses mains debout devant un paysage de ferme ;
3. Carte 4 : une femme s'appuyant sur l'épaule d'un homme ;
4. Carte 5 : une femme ouvrant une porte donnant sur une pièce à partir d'un corridor sombre ;
5. Carte 10 : une femme et un homme s'étreignant ;
6. Carte 11 : une image ambiguë d'un crucifix au sommet d'un escarpement rocheux ;
7. Carte 14 : un homme ouvrant une fenêtre pour éclairer un endroit complètement noir ;
8. Carte 15 : un homme se tenant au milieu d'un cimetière ;
9. Carte 19 : une maison dans la neige avec une cheminée ;
10. Carte 20 : un homme se tenant sous une lumière de rue ;
11. Carte 16 : une carte blanche.

Durant les interviews, des élaborations furent demandées en rapport avec la douleur ou avec le matériel lié à la douleur.

Données et analyse

Les données consistent en la transcription des interviews. Chaque transcription passe par deux lectures initiales. La première lecture identifie toutes les actions ayant rapport avec les discours qui reflètent les thèmes de l'angoisse paranoïde-schizoïde ou de l'anéantissement du moi. La deuxième lecture explore les actions qui reflètent le thème de l'angoisse dépressive ou de l'anéantissement de l'objet. Les deux premières lectures impliquent une lecture image par image interprétant séparément le contenu latent des histoires. Cependant, la troisième lecture présente une analyse image par image en utilisant les deux premières lectures. Cette troisième lecture rend possible de retracer les fluctuations de l'angoisse dans les cartes et au cours du processus entier. Nous

présenterons maintenant la lecture finale, afin de montrer l'interaction entre les deux positions de l'angoisse.

Analyse et Résultats 1

La participante est une malade à la fin de la quarantaine. Madame A a vécu avec son mari pendant plus de 20 ans. Avant d'être handicapée par la douleur chronique, elle travaillait pour un organisme communautaire. Elle commence sa première narration par des sentiments dépressifs. Sa première narration reflète comment le moi est sollicité par l'objet, mais trop dévasté pour répondre. Elle éclate en sanglots. Le même sentiment d'impuissance se poursuit dans la seconde narration. Le moi ressent d'une manière aiguë la perte de la capacité de maintenir une relation d'objet gratifiante. Le sentiment d'attendre quelque chose d'anonyme devant se produire est mentionné. Dans les troisième et quatrième narrations, l'angoisse dépressive se poursuit. Dans la cinquième image, la narration reflète la peur d'être enlevée. Elle décrit la femme dans l'image comme étant souffrante et menacée par quelque chose d'inconnu. Elle associe la douleur à une force concrète qui peut arracher la vie. Dans la sixième narration, le clivage et le sentiment d'un danger imminent prédominent. Tout au long de sa septième narration, une noirceur menaçante apparaît. Elle élabore directement sur sa douleur et l'associe à « l'épeurante noirceur », qui signifie l'angoisse persécutrice du moi. La personne qui souffre peut seulement fuir cette noirceur épeurante dans ce qu'elle appelle « une pilule ». Dans la huitième, son angoisse paranoïde par rapport à la douleur comme force pouvant dépasser et détruire la vie continue. Elle se pose des questions sur la vie et sur la mort, et décrit la douleur comme « dépassant » la vie. Dans la neuvième narration, le moi essaie de réintégrer la noirceur et la lumière, et conserve le sens de l'intégration. Dans la

dixième narration, son attitude envers la noirceur dénote un changement marqué, étant donné qu'elle ne la décrit plus comme constituant une pure menace. On constate une tentative de réintégrer la noirceur au moyen de la lumière. Cependant, elle se reprend rapidement et révèle son angoisse d'être abandonnée dans la noirceur. Dans la onzième narration, le moi cherche désespérément une lumière abondante. Les choses sont soudainement lumineuses, et il n'y a plus d'obscurité.

Le deuxième participant est une patiente à la fin de la soixantaine. Pendant plus de 25 ans, madame B a vécu avec sont mari, avec lequel elle a deux enfants. Ses enfants sont tous indépendants. Malgré sa douleur arthritique, madame B continue à réussir à travailler à temps partiel. Sa narration commence par la description de l'enfant dans l'image comme étant triste et malheureux à cause de la douleur. Dans sa seconde narration, les caractères en arrière-plan sont un mélange de figures maternelles et de figures en colère. L'ambivalence et la perte révèlent une angoisse dépressive. Dans la troisième narration, le moi traite avec un objet qui bouillonne de colère et menace de partir. Être abandonné par un objet endommagé reflète de l'angoisse dépressive. Dans la quatrième narration, le moi se tient sur le seuil qui divise le bon du mauvais et regarde une entité sans nom, à la fois douloureuse et dégoûtante. Le clivage et l'angoisse paranoïde-schizoïde prédominent. Dans la cinquième narration, le moi semble aspirer à une fusion avec un objet qui voit à tout, afin d'échapper à la peur et à la douleur. Dans la sixième narration, madame B nomme un certain nombre de créatures terrifiantes allant des monstres jusqu'aux têtes de serpents. Ensuite, tout ce qu'elle a nommé est décrit comme étant un portrait de sa propre douleur en tant que terreur concrète. Elle devient soudainement incohérente. Dans la septième narration, il y a les sentiments d'être piégée

et de peur. Alors qu'on présente la douleur, son compte rendu devient de plus mauvais augure. La douleur est associée à la mort, qui est suffocante et froide. Dans la huitième narration, après un début tranquille, elle aborde soudainement le sujet du suicide et parle de désespoir, de perte et de douleur. Les pertes causées par la douleur font que le moi se sent entouré d'objets morts, au sujet desquels il ressent une immense culpabilité. L'angoisse dépressive se poursuit dans la neuvième narration. La perte irréparable est partout. Dans la dixième narration, son angoisse dépressive devient évidente, alors qu'elle fait allusion au suicide. Dans la onzième carte, elle voit le vide ou le blanc comme étant un espace à remplir. Elle révèle ensuite l'autre signification du vide comme étant un espace nul comme la mort laissée par la douleur. L'angoisse de l'anéantissement refait surface encore une fois comme étant la peur de l'anéantissement.

Le troisième participant est un patient à la fin de la quarantaine. Pendant environ 15 ans, monsieur C a vécu avec sa femme et ses trois enfants. Monsieur C a une éducation collégiale. Malgré ses douleurs arthritiques, il continue à travailler à temps partiel et fait tout pour continuer à vivre une vie assez normale. Sa narration commence par la description de comment son moi se sent contrôlé par les objets astreignants jusqu'à l'impuissance et à la culpabilité. Cependant, la deuxième narration de monsieur C ne porte plus sur des personnages contrôlés par d'autres. Ses personnages se sentent plutôt poussés par le devoir et par l'honneur dans ce qu'ils font. Il y a un sentiment à l'effet que le moi doive protéger le bon objet internalisé contre la perte. La troisième narration symbolise la dynamique complète d'être divisé entre l'amour et la haine. L'angoisse paranoïde-schizoïde semble être active sous l'angoisse dépressive concernant la sécurité de l'objet. Dans la quatrième narration, l'objet apparaît encore à la fois comme contrôlant

et comme aimant. Dans la cinquième narration, le moi continue à être ambivalent, mais il se sent moins capable de satisfaire aux demandes d'un objet endommagé. Donc, il y a une culpabilité concernant le fait de ne pas être capable de réparer et de restaurer l'objet. Dans la sixième narration, une lutte contre des créatures bizarres et un sentiment de conflit avec des forces impersonnelles de malheur et de nature bestiale (objets persécuteurs) imprègnent sa description. L'angoisse se transforme en menace d'anéantissement dans un monde dangereux. Le moi se sent résister à l'assault d'une force impersonnelle et tenace, qu'il associe à sa propre douleur. Sa description révèle le complexe d'anéantissement de la douleur. Dans la septième narration, il y a un désir d'échapper à la monotonie du présent, vers le frémissement du futur. La montée rapide de l'angoisse paranoïde-schizoïde a eu un effet d'aggravation et a activé les défenses obsessionnelles contre la perte et la culpabilité. Dans la huitième narration, monsieur C décrit la mort comme étant un événement craint dont on doit faire la conquête ou comme un état bienheureux pouvant être embrassé. Pourtant, dès que la douleur devient une partie de la narration, l'expérience concrète de l'anéantissement devient encore une fois manifeste. La douleur est par conséquent décrite comme rendant la vie pas plus intéressante que la mort, et le moi en douleur est perçu comme n'étant rien de plus qu'une pierre tombale. Le moi se bat contre la menace de l'anéantissement. Dans la neuvième narration, il y a un oasis idyllique de chaleur qui disparaît dans la douleur. Le moi ressent un froid de mort, il se sent blessé et seul, alors que la terreur remplace la chaleur. L'angoisse paranoïde-schizoïde est complètement dévorante ; comme il le dit : « Tout est contre vous. » Dans la dixième narration, le moi s'efforce de réparer et de restaurer l'objet. Mais il y a la peur d'envenimer l'agression qui peut transformer la

réparation en rien de moins qu'un ennui compulsif ou une plus grande destruction. Le moi sort d'une relation de l'objet clivé, pour entrer dans une angoisse dépressive. Dans la onzième narration, l'ambivalence du moi, qui devient plus profonde, menace une fois de plus de ramener la division et l'identification projective, et de faire revivre les angoisses d'anéantissement.

MÉTHODOLOGIE 2

Dans la seconde étude qualitative, nous nous demandons comment la psychologie de la santé, en tant que modèle prévalent de gestion de la douleur, traite de l'angoisse et interprète l'expérience de la douleur chronique. La méthodologie de notre étude implique l'analyse des discours recueillis au moyen d'interviews semi-structurées. Les interviews vont au-delà d'une simple routine question-réponse et adoptent une formule dialogique. Contrairement aux questions de routine, le dialogue invite les participants à réfléchir à la signification de leurs expériences et « même à la réaliser pour la première fois durant la conversation » (Polio, Henley, et Thompson, 1997 : 31).

Participants

Le groupe de participants est composé d'un homme et de deux psychologues féminins de la santé, qui pratiquent dans des cliniques de la douleur multidisciplinaires financées par des fonds publics. Leur travail tourne autour de l'évaluation, de la gestion et du traitement des patients souffrant de douleur chronique. Tous les participants ont bien au-dessus de 5 années d'expérience de pratique en tant que psychologues de la santé. De sorte à assurer l'analyse en profondeur du discours exigée par cette étude, le point de saturation pour le groupe de participants a été établi à trois.

Procédure d'nterview

Les interviews sont réalisées au moyen d'un guide thématique, qui est utilisé pour introduire des thèmes dans le flot de la conversation. Le guide comprend les thèmes et les sous-thèmes suivants :

1. La psychologie des patients souffrant de douleur chronique ;
2. Les angoisses des patients souffrant de douleur chronique ;
    a. Angoisse concernant la perte ;
    b. Angoisse concernant le moi corporel ;
    c. Définition de l'angoisse en tant que concept ;
3. La peur de l'anéantissement ;
    a. L'aggression ;
    b. La persécution.

Dans le premier thème, la psychologie du patient souffrant de douleur chronique permet aux participants de fournir une vue d'ensemble de la condition psychologique du malade. Dans le second thème, les angoisses des patients souffrant de douleur chronique, on demande aux participants de décrire deux types de menaces : a) celle concernant la perte des aspects valorisés de la vie, ou l'angoisse par rapport à la perte et à la destruction de l'objet, et b) celle de la perte du corps en tant que médium de plaisir et d'action, ou l'angoisse concernant le moi corporel. De plus, l'intervieweur fait usage de ce thème pour demander une définition générale de l'angoisse. Le troisième thème, la peur de l'anéantissement, a été utilisé pour explorer la conception des participants concernant les menaces d'anéantissement et de désintégration. L'interview utilise ce thème pour poser des questions sur la nature agressive et persécutrice de telles angoisses.

Données et analyse

Les données consistent en enregistrements retranscrits d'interviews. Selon Lakoff et Johnson (1980 : 22-24), le choix des concepts, des définitions et des métaphores de la

personne qui parle peut mettre en valeur un aspect d'une expérience et en éliminer un autre. Cassell (1975) soutient que les cliniciens utilisent deux genres de pensées : la pensée analytique et la pensée appréciative. La pensée analytique, qui explique les catégories de maladies, est décrite comme étant scientifique, empirique et réductionniste. D'un autre côté, la pensée appréciative intègre les observations d'une manière sélective basée sur des jugements de valeurs. Cassel décrit ces deux modes de pensée comme étant interdépendants. Fondée sur ces indications, notre analyse met l'accent sur comment les actes de langage qui valorisent et qui dévalorisent sont accomplis. La première lecture identifie tous les actes de langage qui valorisent, qui reconnaissent, qui acceptent, valident ou mettent en lumière les thèmes de l'interview. La seconde lecture explore les actes de langage qui dévalorisent, qui invalident, qui dénient, ignorent ou cachent certains thèmes de l'interview. La troisième lecture a pour but d'explorer la relation entre les deux actes de langage dans les trois interviews. En effet, elle a pour objectif de révéler si les témoignages des participants se recoupent dans leur traitement des thèmes. Comme résultats, nous présenterons la troisième lecture et la dernière.

ANALYSE ET RÉSULTATS 2

Le premier thème, la psychologie du patient souffrant de douleur chronique, a ouvert le dialogue à l'expérience du participant avec le malade. Le premier participant dévalorise le fait qu'il n'y ait qu'un seul compte rendu pour ce thème et il pense que celui-ci nécessite une « gamme » d'expériences. Le second participant offre un compte rendu cohérent pour ce thème, qui comprend la perte, la dépression, la frustration, la colère et l'angoisse. Il croit que la peur de la perte est considérable et il reconnaît sa nature profondément personnelle et insaisissable (« douleur privée de ses droits »). Le troisième

participant a fait remarquer comment la souffrance prolongée engendre la frustration, le désespoir et la colère. Elle réfère à la dépression et à l'angoisse comme étant des sentiments importants. Finalement, elle insiste sur l'impuissance comme constituant un ensemble de sentiments. Tous les participants valorisent la psychologie complexe des patients souffrant de douleur chronique, qui met en jeu l'impuissance, la dépression, l'angoisse et la colère.

Le deuxième thème, l'angoisse des patients souffrant de douleur chronique, a permis aux participants de décrire deux principaux types de menaces souvent ressentis par les patients souffrant de douleur chronique : a) la perte des aspects valorisés de la vie et b) la perte du corps en tant que médium d'action et de plaisir. C'est pourquoi l'interview nous a permis d'utiliser ce thème pour explorer la définition générale de l'angoisse en tant que concept théorique.

Le premier participant reconnaît le caractère envahissant des angoisses des patients souffrant de douleur chronique. Elle fait remarquer que la perte des aspects valorisés de la vie peut être ressentie comme constituant une perte d'identité. Elle valorise la rupture avec le corps et le sens de l'aliénation et de la désintégration. Cependant, lorsqu'on lui demande de définir l'angoisse, elle met l'accent sur la réaction de peur physiologique et physique en termes concrets. Dans une tentative de connaître son opinion sur le contenu de l'angoisse, on lui demande jusqu'à quel point la peur de la désintégration pourrait être vécue comme constituant une agression contre le moi. Elle exprime sa surprise par rapport à la question. Elle tente alors de dévaloriser l'agression et, à sa place, valorise la nature concrète de la perte, qu'elle n'explique qu'en termes personnels et interpersonnels. Ensuite, alors que l'idée de la rupture avec le corps est

reprise, le discours du participant change, pour valoriser l'agression. Elle réfère à la relation avec son propre corps comme étant une « bataille ». Quoiqu'elle valorise le thème de la désintégration/agression, son discours se concentre sur comment celui-ci est limité à ses échecs réels à réaliser les aspirations interpersonnelles et sociales, et les demandes n'ayant aucun contenu intrapsychique.

Le deuxième participant approche les angoisses des patients souffrant de douleur chronique en définissant l'angoisse comme étant le sentiment non souhaité de peur qui naît des incertitudes du futur et des insécurités du moi. Dans une tentative d'émettre son opinion sur le contenu de l'angoisse, il réfère à l'angoisse existentielle. Mais il la délimite à une perte interpersonnelle et sociale importante qui ébranle les idées et les attentes face à la vie, et qui menace l'identité du malade. Lorsqu'on lui demande son opinion sur la menace ressentie par le patient comme résultat de sa vie avec un corps qui fait mal, il renvoie à un sentiment de trahison et de punition. En expliquant les menaces violentes dont quelqu'un peut faire l'expérience comme étant le résultat de sa vie avec un corps qui « punit » et qui « trahit », il reconnaît que, pour certaines personnes, blesser peut vouloir dire endommager. Mais il attribue de tels sentiments à une erreur cognitive devant être corrigée. Il a donc dévalué toute signification latente de cette peur. En expliquant la rupture avec le corps, il recourt à la métaphore du corps du malade qui est amputé par la douleur. Quoiqu'il valorise la rupture avec le corps, il prend soin de montrer qu'elle est nettement associée à l'ampleur des blessures réelles.

Le troisième participant aborde les angoisses des patients souffrant de douleur chronique en expliquant le contenu de l'angoisse. Elle reconnaît que l'impuissance est constituée d'une gamme de sentiments qui comprennent les soucis des patients découlant

du fait d'être mal compris des autres, même de l'équipe soignante. Lorsqu'on lui demande une définition générale de l'angoisse, elle valorise l'angoisse en tant qu'ensemble de sentiments d'être menacée qui mèneraient à des réactions comportementales. Dans sa définition, elle explique le danger en termes de « menace envers la personne et le bien-être physique ». Elle valorise le sentiment d'aliénation venant du corps de deux façons. Premièrement, elle reconnaît « un sentiment de trahison » pouvant amener le malade à être « contre son corps ». Deuxièmement, elle décrit comment une telle rupture pourrait transformer le corps en un objet concret (« externalisé », « personnifié ») de peur et d'hostilité (dans une « bataille »). Cependant, elle dévalorise la prédominance de telles menaces et attribue de tels états émotionnels uniquement à des patients disposés psychologiquement. Elle reconnaît que pour ceux qui manquent de compréhension psychologique, le contenu de la souffrance pourrait apparaître plus nettement au psychologue qu'aux patients. Elle pense que les patients, dans l'ensemble, ne craignent que la perte de leurs capacités concrètes qui sont considérées comme étant importantes pour remplir leurs rôles sociaux et interpersonnels.

Le troisième thème, l'angoisse de l'anéantissement, a été utilisé pour explorer les opinions des participants sur la menace de dissolution du moi. Après avoir exposé brièvement les menaces causées par la perte des aspects valorisés de la vie et du corps, nous demandons au premier participant si de telles angoisses peuvent constituer une menace d'anéantissement du moi. Après une longue pause, le premier participant dévalorise ce thème. Malgré sa mention préalable d'une menace pour l'identité, elle réagit avec confusion et surprise à notre question directe. Ensuite, elle rejette l'idée qu'elle est loin de son cadre de pensée. Puis, elle révèle son ambivalence, alors qu'elle

explique les angoisses épuisantes des patients souffrant de douleur chronique. Pourtant, elle évoque l'idée d'une vulnérabilité congénitale pour expliquer de telles angoisses. Elle admet finalement que l'idée « ne correspond pas » à sa conception des patients.

En réponse à une question semblable, le deuxième participant dévalorise le thème en déclarant qu'il « n'a aucune idée ». Une expression non lexicale prolongée (« u : : m ») et de longues pauses ponctuent sa déclaration. Ensuite, il poursuit en parlant de « réellement le perdre » ou de « devenir fou ». Il valorise la présence de tels sentiments chez « certains patients ». Cependant, il définit le moi ou l'identité comme étant un ensemble social de rôles et d'attentes interpersonnelles. D'après cette définition, il décrit la menace de « réellement le perdre » comme étant un « changement dramatique dans les rôles » qui fait que le malade se sent perdu. Quoiqu'il aille aussi loin que de valoriser la scission avec le corps, il n'a pas valorisé le thème de se désintégrer. Il l'a plutôt décrit en termes de ne pas être capable de remplir ses rôles sociaux.

En réponse au même thème, le troisième participant exprime ses doutes sur le terme et sur son adéquation. L'intensité du terme lui-même semble faire partie de la raison pour laquelle elle pense qu'il est inapproprié. Cependant, elle lui donne une reconnaissance conditionnelle en parlant de « peur fondamentale » ou de « peur très solide » qu'elle ne rencontre que dans des situations extrêmes. Elle réitère le fait qu'une angoise si intense n'existe que lorsque la perte réelle culmine en un désastre professionnel, relationnel et financier total n'ayant aucune conséquence intrapsychique.

CONCLUSION

Les histoires des participants renvoient à un sentiment affligeant d'angoisse concernant l'objet endommagé et qui est sur le point d'être perdu comme résultat de l'incapacité du

moi à rendre la pareille. Le moi ressent les remords de conscience aigus d'une culpabilité cruelle et usant de représailles. Faisant face à un objet endommagé, les participants manifestent de l'ambivalence par rapport au fait de dépendre d'un objet qui est en colère et qui réagit. Les narrations démontrent comment le moi utilise des défenses obsessionnelles primitives pour faire taire son ambivalence et comment la situation dégénère alors en un clivage du moi et en angoisse paranoïde suivant l'échec des défenses obsessionnelles.

Les participants ne peuvent s'empêcher de se sentir comme s'ils étaient saisis par une force « douloureuse et dégoûtante », « vicieuse et dure » et « obstinée et acharnée ». Ils font allusion à la douleur comme étant une chose, une entité étrangère qui est capable de détruire le moi. L'association de la douleur avec des attaques agressives est, en fait, une réminiscence de la position paranoïde-schizoïde, lorsque l'instinct de mort produit la menace de l'anéantissement en liant le moi aux expériences frustrantes que vit l'enfant. Les participants à cette étude démontrent comment les sentiments terrifiants de menace ont eu un impact sur leur perception et ont coloré leur expérience de la douleur. À mesure qu'ils racontent leur histoire, les participants superposent leur expérience vécue à ce que l'on retrouve dans les thèmes illustrés et font des références révélatrices à la douleur, à l'angoisse, à la destruction et à l'anéantissement. À travers leur histoire, dès que la narration concerne l'angoisse, des images d'agression et de mort sont évoquées et associées à la douleur comme étant une entité assaillante ou une monstruosité. La peur apparaît aux participants à cette étude comme étant l'expérience concrète d'agression qui menace de détruire le moi et l'objet. La cohérence avec laquelle la douleur apparaît

comme étant la mort et la destruction à travers ces récits démontre l'importance de l'angoisse primitive pour comprendre l'expérience personnelle des malades.

Analyser le contenu de ces angoisses est la clé du symbolisme du corps souffrant de douleur chronique. Les angoisses intenses associées à douleur ont une qualité primitive remarquable qui ne peut être interprétée et explorée qu'à travers l'analyse des libres associations des participants. Pour le moi infantile, la douleur a une qualité persécutrice qui est expérimentée concrètement en tant que peur de la persécution. Des sentiments semblables d'angoisse et de menace réapparaissent dans le moi adulte, qui est saisi par la douleur chronique sans pouvoir faire quoi que ce soit. L'impuissance ravive l'histoire primitive de la douleur du moi et réveille à nouveau les fantasmes et les peurs infantiles. En effet, l'expérience de l'adulte de la douleur chronique mène souvent à des sentiments grotesques qui sont explicables, si leur contenu n'est pas exclu ou ignoré.

D'un autre côté, la psychologie de la santé et la médecine comportementale tendent à expliquer la réaction du malade par rapport à la souffrance comme étant une réponse liée à un stimulus, réponse qui a été élaborée et évaluée cognifivement en tant que tentative d'ajuster la douleur à l'environnement social et interpersonnel basée sur des cognitions apprises pour traiter les événements significatifs de la vie. De cette manière, les angoisses de destruction et d'anéantissement souvent rapportées par les malades deviennent rien de plus que des réponses mésadaptées à la douleur qui sont étiquetées comme étant des peurs disproportionnées. Au mieux, de telles angoisses sont considérées comme étant causées par un manque de soutien social ou par une dépossession de rôle. Si elles sont reconnues, de telles angoisses sont perçues comme étant disproportionnées par rapport au véritable espoir de réadaptation de la douleur chronique. Cette interprétation

de l'angoisse élimine toute référence à l'histoire primitive de la douleur et à la dimension intrapsychique de l'expérience de la douleur. Par cette élimination, la psychologie de la santé évite le besoin d'explorer l'expérience primitive de la douleur du patient. Alors que les images de destruction et d'agression sont ignorées, l'attention clinique se déplace de l'expérience subjective du patient vers les réactions comportementales concrètes et leurs conséquences observables. De cette manière, la signification terrifiante de l'expérience de la douleur chronique est perdue dans l'emphase placée sur l'accomplissement du rôle social, qui élimine de son compte toute référence à l'expérience intérieure du malade.

Dans un résumé de cas, Fordyce (1996 : 41) explique comment ses collègues et lui répondent aux plaintes incessantes de douleur d'un patient par des réactions comportementales négatives, afin de décourager ses comportements de douleur mésadaptés. Comme résultat, pendant qu'ils font la tournée des salles de l'hôpital, ils conviennent de répondre à « toute référence à la douleur en regardant à la fenêtre comme façon de modifier la rétroaction sociale ». Dans un autre exemple, Long (1996 : 8) déclare : « Les discussions sur la douleur n'étaient pas permises entre les infirmières et les patients ou avec les médecins, sauf à des moments spécifiques lors des tournées ou pendant les séances de thérapies. » Fordyce déclare : « Notez que les membres du personnel n'étaient pas pour ignorer les comportements de douleur ; ils n'étaient que très légèrement réceptifs au point de vue *social* et ils portaient une attention spéciale aux efforts du patient pour augmenter le niveau de ses activités » (44). Fordyce (1989 : 55) soutient qu'une telle rétroaction négative « peut décourager et inhiber l'expression de la douleur ou des comportements de souffrance, et par conséquent promouvoir une résolution hâtive du problème de la douleur ».

Quoique nulle part les participants à cette étude ne suggèrent quoi que ce soit de loin semblable à l'approche de Fordyce, leur inclination à éviter de discuter du contenu et de la signification de l'angoisse du patient doit beaucoup au cadre prévalent de la psychologie de la santé tel que présenté explicitement par Fordyce et ses collègues. Dans notre autoréflexion sur le processus d'interview, nous avons reconnu que lorsque les participants décrivaient leurs observations directes et leurs impressions, nous avons moins ressenti le besoin de leur demander de clarifier ou d'élaborer. Leurs descriptions candides comportaient plusieurs observations habituellement rencontrées dans la documentation sur le sujet. Cependant, nous étions anxieux de demander des clarifications lorsque que le participant passait à un ton explicatif. Pendant que nous écoutions leurs explications, nous nous sentions ambivalent par rapport au modèle explicatif utilisé pour rendre compte des états intérieurs de la douleur des patients et de leurs expériences personnelles. Le passage graduel du discours d'un ton explicatif à un ton descriptif semblait avoir une fonction régulatrice et normative, en délimitant la signification des symptômes. En d'autres termes, cela diminuait la vivacité des premières observations et les rendait contrôlées, désambiguïsées et réduites. La saisie de la signification était basée sur la transformation de chaque état intérieur en un reflet d'une matière réelle et concrète. Ensuite, si celle-ci était proportionnée au réel et bénéfique à l'action, elle était considérée comme ne nécessitant aucune modification. Au moment où il passait au mode normatif, le monde intérieur du patient s'éloignait du premier plan du discours pour en occuper l'arrière-plan. À travers ces pratiques discursives, les psychologues de la santé font davantage que traduire diverses ambiguïté des symptômes (Sebeok 1994 : 65-82, et Barthes, 1994 : 202-213), ils construisent une conscience

particulière de la douleur et de la souffrance dans laquelle les patients doivent donner un sens à leurs épreuves et lutter pour saisir la signification de leur souffrance. Pour plusieurs de ces patients, les pratiques discursives de la psychologie de la santé limitent la signification douloureuse de leurs virulentes angoisses, étant donné qu'elles les laissent avec peu d'occasions d'explorer la souffrance au-delà de sa signification la plus concrète et extériorisée.

Aujourd'hui, la gestion de la douleur cherche à redéfinir tous les sentiments subjectifs et toutes les menaces perçues en termes d'évaluation comportementale objective de la douleur chronique, de manière à réduire la réponse « qui est source de mauvaise adaptation ». Faisant face à l'impuissance terrifiante des patients, les spécialistes de la réadaptation tentent de fournir une « dose de réalité », en éduquant les malades par rapport à leur douleur et à la perspective de la réadaptation adaptative. Ce qui reste de l'expérience vécue de la peur, de la dépression et de l'impuissance doit être corrigé par une rétroaction comportementale négative et par un recadrage cognitif. En effet, la psychologie de la santé crée une intervention clinique dans laquelle la signification est préfigurée en mettant l'accent sur le comportement adaptatif et l'expérience subjective est déformée par l'emphase sur la réponse liée au stimulus. Aujourd'hui, la gestion de la souffrance est fondée sur la conception que chaque état intérieur est le reflet d'une expérience réelle, publique ou interpersonnelle dépourvue de fantasme inconscient et qui doit rencontrer l'économie objective de l'accomplissement du rôle social et de la réciprocité interpersonnelle. Les cognitions en tant qu'activités mentales ayant des prétentions objectives à la validité sont plus valorisées que les émotions comme expériences personnelles et préverbales (Nussbaum, 2001 : 93). En

mettant l'accent sur le comportement, l'univers intérieur du patient et le fantasme inconscient perdent leur gravité existentielle et n'ont pas même un rôle marginal dans l'explication de l'expérience vécue de la douleur chronique. Par la suite, une écoute riche en contenu associatif est remplacée par une attitude clinique concentrée sur les réponses liées au stimulus et sur l'accomplissement du rôle social ou sur la dépossession du rôle.

Dans le contexte de la présente étude, le symbolisme primitif du corps en douleur chronique diffère radicalement de celui qui a été discuté par les auteurs en psychosomatique. Réfléchissant sur la douleur, les participants utilisent des discours riches en langage figuratif et en contenu affectif. Dans leurs élaborations, ils ne laissent voir aucun signe de pensée fonctionnelle, non plus qu'on y rencontre quelque signe d'appauvrissement de l'affect, de la verbalisation ou de la relation d'objet. Le symbolisme primitif du corps observé au cours de la présente étude s'étend au-delà de la notion de structure psychosomatique en tant que formation primitive particulière causée par une rupture traumatique entre le désir impulsif et la conscience. On ne constate, en fait, aucune régression massive ni aucune pathologie traumatique du moi. Les participants reconnaissent l'arthrite rhumatoïde comme étant la cause de leur douleur chronique. La physiopathologie de l'arthrite rhumatoïde explique clairement la source de la stimulation nocive et de la nociception. Cependant, chaque fois que le traitement n'arrive pas à fournir des résultats concluants, *être* se réduit à *ressentir de la douleur.* L'éclatement ou la destruction de l'univers du malade reflète l'émergence d'angoisses primitives. Aussi longtemps que les malades ressentent leur corps et qu'ils ont des raisons de réagir désespérément face à leur douleur, leur corps ne serait pas dépourvu de symbolisme. Le symbolisme du corps est le symbolisme des angoisses primitives

réveillées dans le contexte du corps faisant continuellement mal. Poussées à la surface par la douleur, ces angoisses sont des dérivés de l'expérience somatique, et non le contraire. De cette manière, le symbolisme du corps s'étend au-delà de l'origine et de l'étiologie du symptôme, et est en parallèle à l'expérience du corps.

Nous avons tenté de démontrer, dans cette étude, jusqu'à quel point, malgré les associations graphiques des malades, la pratique actuelle de la gestion de la souffrance ne veut pas reconnaître que souffrir de douleur chronique peut virtuellement contenir et symboliser des angoisses primitives d'anéantissement et de destruction. Au cours des dernières décennies, un changement sauvage des catégories nosologiques a inclus dans celles-ci la fibromyalgie, le syndrome de dysfonction de l'articulation temporomandibulaire, le syndrome du colon irritable, le syndrome de la fatigue chronique et le syndrome de la douleur chronique. Cependant, insérer la souffrance humaine dans des catégories de maladies comme des choses nous a permis d'ignorer la souffrance et sa signification intrapsychique. Pour les patients souffrant de douleur chronique et pour la société dans son ensemble, reconnaître ce déni tout-puissant et le contrôle peut signifier aller au-delà de l'approche restrictive qui a effectivement séparé de notre discours toute référence à la signification primitive de la souffrance. D'un autre côté, considérer la souffrance humaine comme constituant une expérience significative peut peut-être nous permettre de voir jusqu'à quel point nous réagissons aux angoisses primitives d'anéantissement et de destruction chaque fois que nous écrivons un projet de recherche, que nous cherchons ou établissons un diagnostic, que nous trouvons ou offrons un traitement, animons ou suivons un programme de réadaptation ou participons à un groupe d'intervention sur la douleur chronique.

DEDICATIONS

To my family, to whom I am indebted beyond measure,

To my friends, to whom I am thankful beyond words,

And to the memory of those, to whom we are beholden for ever,

I dedicate this work.

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In occasions of completing a doctoral thesis, it is a convention to acknowledge a number of people for their generous contribution. However, for thus doing, I feel earnestly driven by reasons beyond those of trite convention. Hence, this acknowledgement recognizes the greater scope of support, collaboration, and encouragement that I was fortunate to receive during my studies. As my debt is large so is my acknowledgement.

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On a personal note, I am indebted to a number of individuals for their contribution to my study, work, and life. First and foremost, I must thank my thesis supervisor, Doctor Marie Hazan who accepted me as her graduate student, and who patiently allowed me to work on this subject matter for about a decade. Without her thoughtful guidance, her wise mentoring, and her poignant critique, this thesis in its present form and actual substance would not have been possible. I would like to thank Dr. Louis Brunet, the member of my committee, whose balanced and methodical criticism significantly improved this study. I am particularly thankful to Doctor Manon Houle, my clinical supervisor, who introduced me to chronic pain and provided me with the generous opportunity to explore this area. Her open and indefatigable spirit has been an unforgettable fount of inspiration for me. I am thankful to Doctor Samy for his inspiring lectures on Klein, and for his role as my external examiner. I like to express my gratitude to Doctor Casoni, Doctor Wolf, and Doctor Drouin for their role as my internal examiners. I am grateful to Doctor Lawrence Kirmayer who spent many hours mentoring me in qualitative research and gave me a new appreciation for phenomenology and ethnography. I wish to express my gratitude to all members of the graduate faculty, and chief amongst them, Doctor Krymko-Bleton, Doctor Letendre, and Doctor Jager for their support. Special thank is due to Doctor Richard, the member of the faculty and the editor of *Filigrane* for her kindness and encouragement.

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However, this thesis owes its substance to no other, than chronic pain patients. They are the rightful owners of the insights which my elaborations try to reveal through the mirror darkly. Alas, no matter how skilful the try, the result is less than satisfying, "For words, like Nature, half reveal / and half, conceal the Soul within." Tenyson's chagrin over the concealment of words is nowhere felt more acutely than in the struggle for giving expression to primitive angst. Even the craftiest *literati* can find the result a humbling disillusionment with the connotative reach and the denotative scope of language. To turn shapelessness into shape and to give the airy "nothingness" a location in discourse is to tread a narrow path at the edge of the precipice where language ends and the terrible bewilderment of soul begins. Although a great deal is owed to all those thanked above, a good deal no doubt divides my argument and my style from theirs. As a

result, the responsibility for any opinion, imperfection, or error rests emphatically with this scribe, as the author.

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INTRODUCTION

> The tragedy is that we are relying on our capacity for thinking to understand what is happening when what is happening stops us from thinking.
>
> Emilia Steuerman, *The Bounds of Reason* (2000)

Chronic, unlike acute pain, persists without significant relief after three months of treatment. Frustrating the curative power of modern medicine, it evades the most reliable assays, and rarely corresponds to the extent of actual injuries or objective process of disease (Wall, 1979, 2000). Working with chronic pain patients, psychologists routinely confront suffering and anguish, with all its puzzling ambiguities. For sufferers, chronic pain brings about significant losses that shake their lives and upset their way of being. Regardless of its kind or duration, "pain defies our ordinary assumption that an experience is either real, that is, rooted in immediate sensory experience of the world, or imagined, that is, the outcome of internal psychological and mental processes" (Scarry, 1985:46). Chronic pain, for its invasive impact, is felt beyond what is conventionally recognized by the physiological concept of disease or injury (Melzack and Wall, 1982:15-26). Hence, its veracity is not infrequently contested, questioned or viewed with scepticism. However, not long after being diagnosed, this so-called questionable agony becomes an agonizing question that blights the prospect of understanding and the feelings of self-sufficiency. When sufferers come to realize that there is no cure or respite, their pain assumes an adverbial quality that interlaces every act, experience, intention, state, or movement. In effect, emotional distress becomes an integral part of being in pain, when life means living painfully.

To relieve suffering and to restore hope and confidence, health psychologists and clinicians have to understand the sufferer's personal experience of pain. If they fall short, patients feel more exasperated about their healing prospect. However, to succeed, they ought to make sense of anxieties and fears that at times make chronic pain a shattering and soul-destroying experience. The task is far from unproblematic, since from professional point of view, understanding means using a generic system of specialized knowledge (nomothetic) to formulate a clinical opinion out of the inchoate and densely meaningful experience of the sufferer. In this process, chances are that we come to recognize and acknowledge only those aspects of suffering that are positively affirmed, and readily explained by our established framework of clinical practice. Hence, it seems reasonable to ask: are there aspects of suffering that are ignored or overlooked, because we may be not ready or capable of confronting them or seeing them as meaningful? Within literature, intractable pain is increasingly described and investigated as lived experience, *Erlebnis* that defies linear, coherent, and detached conceptualization (Good, 1992). Human experience, as *Erlebnis*, unfolds firsthand for the individual by the virtue of being lived, and as such it is said to be irreducible to concept (Benjamin, 1968; Dilthey, 1985). By the same token, chronic pain, in its lived sense, seems to pervade all facets of one's being in a manner so ineffable that defies objectification through spoken words of the ordinary language (Woolf, 1930; Scarry, 1985). It is therefore important to ask: to what extent our clinical understanding of the patient's experience is shaped and preconditioned by how we conceive of suffering and anxiety in our mainstream clinical practice. This question demands serious reflection, since the phenomenology of anxiety,

and pain extends beyond the limits of theoretical constructs, operationalized definitions, and measurement tools. Suffering echoes the individual's past and present at once, and encompasses one's trepidation over future.

Not infrequently, chronic pain sufferers speak of their terrifying anxieties, as though their sense of selfhood is about to disintegrate, dissolve, or annihilate. They refer to their painful bodies as something split from them that threatens their basic integrity, self-sufficiency, and wholeness. In everyday clinical practice, health psychologists and pain rehabilitation workers refer to the patient's terrifying anxieties and bleak helplessness as catastrophizing. As part of today's clinical nomenclature, catastrophizing offers a particular explanation for why distressing anxieties of death and destruction become a source of deep preoccupation for at least a subgroup of sufferers. Where such anxieties surface, health psychologists construe them as cognitive and emotional magnification of pain experience, brought about by a negative over-reaction to hurt, loss, and aggravation. This over-reaction is said to be mediated by cognitive representations—beliefs, attributions, and interpersonal-social expectations—that overstate the nature and the consequence of pain (Sullivan, Thorn, Haythornthwaite, Keefe, Martin, Bradley, and Leefebvre, 2001) and ultimately cause adaptive reactions and behaviours to become disproportionately woeful and to turn into suffering and distress. To undo this cognitive misrepresentation, patients are taught and encouraged to "stick to the facts and check out the assumptions" (Skevington, 1995: 213). In a sense, the remedy is plain and simple: let's educate the patient and their families to see pain as what it is according to the science of pain behaviour and not what they might read into the situation and reinforce interpersonally.

As a result, the sufferer's dreadful and woeful feelings are deemed to arise from significant magnification of pain through unrealistically negative cognitions that are at times sustained by interpersonal reinforcement. However, is cognitive misrepresentation all that is at stake, when terrifying anxieties of destruction consume a pain sufferer? Are such anxieties simply arising from magnifying and then misascribing actual losses to potential events through a biased cognitive appraisal, or faulty information processing? Would catastrophizing persevere as a result of being or having been interpersonally reinforced? How else can pain experience kindle the fear of death and how else can anxieties secondary to pain evoke anguish over death and destruction? Should clinicians focus primarily on the explicit content of cognitions or should they treat cognitive distortions as symbolic clues to a yet deeper set of entanglements? Would it be reasonable to think of cognitive processes as the apex and the mirror of all that shapes someone's experience of pain and suffering? To answer these questions, one has to explore how pain, anxiety, and death emerge in the sufferer's experience. Such exploration cannot assume the preponderance of overt cognitive processes over the experience of suffer, and must adopt an angle much wider than what has been so far prescribed in pain research.

Despite the view that emphasizes misrepresentation, pain within the larger scope of human experience is as much distinct as emergent from death and anxiety (Scarry, 1985: 118; Morris, 1991). Whenever unto death is the sickness, pain is sickness rendered sentient to consciousness and the ultimate harbinger of death. William James must be recognized as the first psychologist who focused on the contingency of life as visibly witnessed through illness and pain (James, 1902/1958). Historically speaking,

contemplating on pain and anxieties of death and destruction is by itself not a new idea. In his work, *The Nature of Things*, the Roman poet-philosopher, Lucretius (*circa* 96-55 B.C.), brings together the trilogy of pain, anguish, and death to reveal how through pain, human suffering involves of deeper anxieties over annihilation and destruction (Charles Segal, 1990). For the ancients, the kinship of pain, anxiety, and death was less a matter of misrepresentation than a tragic enigma, the underside of the human destiny (Μοίραι in Greek, or *Parcae* or *Fata* in Latin), worthy of serious reflection (Morris, 1991:245-255). The ancients, through such effort, uncovered the enigma of death, pain, and anguish within the ethos of their own age. In contrast, modern bio-medical advances in treatment, anaesthetics and analgesics have reshaped contemporary understanding of pain and suffering as what we must first and foremost strive to overcome and alleviate through diagnosis, treatment and rehabilitation (Morris, 1991:9-30). Hence, the human enigma has transformed into a biopsychosocial puzzle with well defined pieces, over which triumph becomes possible, once we understand and fit the pieces together. At the centre of this puzzle, organicity as nociception stands as a constitutional element and makes pain different from suffering as the mere affective sequelae of malaise (Ricoeur, 1994). However, with its invasive impact and indeterminate nociception, intractable pain rekindles the age old enigma of death and pain. Chronic pain sufferers often struggle with grievous questions and trepidations regarding their prospect and future in the face of pain, threat, and anguish. When medical remedies prove ineffective, pain opens the yawning abyss of the questions that Lucretius found in many ways unanswerable but meaningful.

Existentialist philosophers and psychologists have explored pain and the anxiety of death from a perspective that is in many ways akin to the ancients. In their view, as the common sign of hurt, injury, and disease, pain becomes the harbinger of all that can destroy life and bring about perdition and ruination. In this manner, it becomes inseparable from our awareness of finitude or death as the source of anxiety (misprision and Kierkeggard). It is, however, in psychoanalytic theory and practice that the kinship between death, pain, and anxiety is explored and its symbolism is argued in depth. Following Freud's late development of death instinct (*Todestrieb*), Klein's work with children (1920, 1928, 1929, and 1933) inspired psychoanalysts to reconsider the importance of death instinct for understanding infantile anxieties and unconscious phantasies as the germinating ground of adult functioning. Klein argues that even the mature ego ultimately copes with painful anxiety situations of the adult life by drawing upon the psychic material of the earlier time. This primitive psychic material is shown to have developed through early object relation, when the infantile ego struggles with threat of annihilation and destruction. Based on Klein's theory of infantile development, it is from primitive pain and frustration as unwanted and hated experience that the adult's pain perception and behaviour evolve and take shape. Hence, dreadful anxieties of the chronic pain sufferers cannot be taken as misrepresentations, as they are part of the primitive, preverbal history of pain that have returned at the moment of crisis.

At first sight, the object relation theory of infantile pain may seem less germane to what is readily recognizable as pain experience proper. It is quite contrary not only to self-evident common sense, but also to much of the established framework of today's psychology. In many ways, such heavily interpretive approach may even risk being

called fanciful theorizing with little empirical validity and practical value. However, independent reports by many sufferers, clinicians, and researchers have revealed puzzling aspects of pain that one cannot easily dismiss or preclude from explanation as noise in the data, or as cognitive misrepresentations with little significance and import. Nor, can the prevailing explanatory models claim to have dealt with many puzzling aspects of pain sufficiently, either in theory or in practice. The ethnographers often marvel at the deficiency of ordinary language in objectifying pain, and wonder about the preverbal quality of suffering with little insight into the preverbal history of pain (Good, 1992). Researchers often speak of how pain inexplicably involves anger, hatred, and aggression, even when it is known to be the result of natural factors (Scarry, 1985; Bakan, 1968). Others have shown how pain appears to some as an alien entity that has invaded the self (Leder, 1990). Case studies are collected wherein patient report their fear of annihilation in a graphic and chilling manner (Good, 1992; Delvecchio Good, 1992). It becomes, therefore, necessary to ask whether pain has a primitive history, wherein the aforementioned puzzles are rooted, and whether this primitive history can be reawaken and relived as anxieties of annihilation and destruction. Tthese questions allow in a new understanding of pain that involves the primitive core of the sufferer's inner world. However, for answering them, a fundamental rethinking of pain, death, and anxiety is required, a rethinking that is not unyielding to or disdainful of primitive object relation and infantile development.

However, aside from what chronic pain sufferers endure, is there a larger import to such fundamental rethinking? In other words, is there any reason behind this undertaking that might make it significant not only to chronic pain sufferers, but to the

society at large? In fact, exploring the primitive history of pain can have wider implications beyond that of clinical settings. For the most part, such exploration would encourage a reflection on our collective psychology and on our accepted ways of dealing with unwanted, threatening experiences, such as: destruction, loss, and death. Death, whether as existential finitude or as primitive destructive impulse, poses a challenge not only to human understanding, but more importantly to our collective habits of feeling and experiencing; to our cherished ways of living and understanding, or to what social philosophers generally call our situated rationality (Heidegger, 1962). For phenomenology and psychoanalysis, when the spark of understanding radically undercuts the established frame of mind, it risks revealing what is too eerie to accept or to integrate into consciousness (Freud, 1919/2003). In fact, the close affinity between anxiety and death has been described as the uncanny, disquieting undertone of human existence, which we struggle to avoid (Davis, 1989; Becker 1973; Lifton 1983).

If such avoidance is by any means extant, how we make use of disease and pain in the context of everyday life to deal with the unwanted and eerie side of existence can be an illuminating query and can lead to unsettling insights. In his study of anxiety, Rollo May (1977) questions our popular and professional attitude to pain and disease, by warning, "that people utilize disease in the same way older generations used evil—as an object on which to project their hated experiences in order to avoid having to take responsibility for them" (86). May's admonishment about the everyday use of disease contends that pain as the most common part of ailment has become a receptacle, onto which "hated experiences" are projected for the purpose of disowning and discarding them from consciousness. If this insight has any base or existential validity, it would be

indispensable to note that sufferers who walk into rehabilitation centers may bring to clinical encounter more than their pain syndromes. Equally, it is important to recognize that clinicians may be dealing with more than simple magnifications of doom and gloom as catastrophizing. However, we must ultimately ask how discarding hated experiences through disease would impact our everyday psychology and mental health.

In effect, it would seem warranted to say that exploring the primitive history of pain can open a new outlook for the understanding of pain, suffering, illness, and disease and the unconscious symbolic content of these categories of discourse and experience. In this effort, our theoretical scope cannot be reduced and delimited to the prevailing modes of thinking about, or gathering data on pain. Rather, the choice of theoretical and methodological frame must closely follow the sufferers' experience and take into account the subjective experiences of the suffering as meaningful. It is the interpretive approach to pain and suffering that can ultimately lead out the primitive symbolism of content.

In other words, the present study can be construed as an attempt in rethinking the theory and practice of pain management from a phenomenological and psychoanalytic point of view. However, such interpretive project can equally be seen as a challenge to mainstream psychoanalysis which has traditionally focused on how pain as a symptom symbolizes the anxieties of depth caused by psychic conflict. Since Freud's *studies on hysteria* (Freud and Breuer, 1895/2004), psychoanalysts have written extensively on the intrapsychic dynamics underlying pain. Various analytic schools have investigated how psychosomatic illness and somatic preoccupations can arise from repressed conflicts and primitive personality structures. In theory and in technique, the psychoanalysis of pain has hitherto inferred somatic events as the derivative of intrapsychic dynamics. This

postulation has defined the horizon of the debate, wherein body symbolism is constructed from the psyche as the seat of conflict to the somatic symptom as the compromise formation. In contrast, this study does not ask so much how intrapsychic conflict may begets pain as how chronic pain may beget intrapsychic primitive significance. In other words, it asks whether intractable pain reawakens the primitive anxieties of death and destruction, as part of the sufferer's debilitating and agonizing condition and bring back to present, aspects of primitive past that we are terrified to relive and re-experience.

Similar to other human experiences, it is through verbalization, as insight-oriented and self-reflective interlocution, that our unwanted experiences are named, objectified, elaborated, and afforded a place in discourse and consciousness. Where this interlocution is rendered impossible or muted, our core anxieties and unwanted experiences are denied recognition and integration into consciousness. Then, the outcome can be described as a terrible foreclosure of meaning that may lead to a devastating impoverishment of the psyche or inner world. Hence, are there discourses in today's pain rehabilitation that can make these anxieties part of our understanding of suffering? In the context of rehabilitation where such meaning making is most expected, the discourse of health psychologists holds a unique position in educating millions of sufferers about pain. In fact, the prevailing model of rehabilitation largely relies on cognitive-behavioural and interpersonal psychology for defining and managing pain, suffering, and anxiety. Through pain management practices, the sufferer's experience is construed according to what professionals consider as clinically valid problems and sound ways of complaining. Hence, the question becomes whether our prevailing practices allow clinicians and patients to talk about primitive angst associated with pain in a meaningful manner. The

importance of this question cannot be overstated in today's information driven society where the professional discourse steps beyond the clinic boundary, and informs as much the diagnostic criteria as the lay representations of suffering and pain (Handy, 1987; Fox, 1994:152-159).

As a result, this study is comprised of a two-fold query. The first fold asks whether chronic pain patients experience anxieties of death and destruction as a meaningful part of their suffering, whereas the second inquires whether the prevailing discursive practices in today's clinical settings can allow articulation and meaningful elaboration of the primitive complexity of pain. The general aim of this study is to casts light on the anxieties experienced by the pain sufferers in today's context of rehabilitation. To his end, it explores not only the experience of the sufferers, but also the discourse of the health psychologists. In effect, the present inquiry focuses on a problematic that cannot be sufficiently examined if investigated from the patients' end without reflection into the discursive practices of the clinicians.

As a qualitative investigation, the present study negotiates a twofold interpretive framework that brings together two interrelated explorations. As a psychoanalytic study, it seeks insight into the content of anxieties that are commonly reported as being part of suffering from intractable pain. It ultimately asks whether there is any reason to think of a primitive history pain and a primitive significance of suffering. However, as a phenomenological study, it examines the professional discourses of pain and anxiety in health psychology. It asks how this normative understanding legitimizes talking about anxiety and pain and shapes our views of suffering. The two conjointly frame the problematic of this work and shape the journey from the sufferer's pain experience to the

normative clinical discourses that define pain as a social reality. If convincing, this study as a whole should persuade the reader to problematize the prevailing view of pain that naturalizes suffering in order to deal with through proceduralized strategies of modification. If successful, the alternative outlook of this study must emerge as a solid possibility for a deeper reflection on the primitive anxiety of death and its place in our approach to suffering and pain as human experience.

CHAPTER 1

Literature Review: A Conceptual Framework for the Study of Anxiety and Chronic Pain

> Opposer l'être au néant comme la thèse et l'antithèse, à la façon de l'entendement hégelien, c'est supposer entre eux une contemporanéité logique. Ainsi deux contraires surgissent en même temps comme les deux termes-limites d'une série logique, mais le non-être n'est pas le contraire de l'être, il est son contradictoire.
>
> Jean Paul Sartre, *L'Être et le néant* (1943)

1.1. Preamble

Insofar as historical research testifies, our understanding of pain has undergone changes of radical and meaningful nature (Rey, 1993; Morris, 1991). In the context of the contemporary practice, it is the biomedical model that defines pain as a diagnosis by explaining and treating all subjective complaints or symptoms as signs of an underlying disease. Whereas illness represents the patient's subjective experience of affliction, disease is what clinicians objectively diagnose as an underlying physical mechanism (Eisenberg, 1977). Focusing on objective disease, the biomedical model is dedicated to trace every complaint to a specific category of tissue pathology or concrete nosology. This model treats pain insofar as a particular disease can be identified and physically addressed. Pain perception is therefore validated to the extent that it proves to be commensurate to the underlying disease. Biomedical diagnosis becomes rather unyielding, in cases wherein pain perception and suffering exceed *nociception* or the

process of transmission of noxious stimulation from periphery to the central nervous system. For the most part, the disease-oriented understanding of pain precludes the subjective and idiosyncratic suffering and disqualifies any reference to the context of pain. For biomedical model, the only objective context to pain is pathophysiology.

Despite its success in addressing acute pain, solid clinical evidence can testify to the fundamental shortfalls of the biomedical model. In fact, pain perception has been shown to be rarely the same across individual cases of a single disease. This puzzling variability has been attributed to the significance of illness in the sufferer's life (Beecher, 1956; 2000). Hence, the intensity of pain associated with a particular type of injury is expected to significantly vary according to the context of human experience and the bearings of illness on the prospect of general well-being and life (Wall, 1979). The growing complexity of the evidence that could testify to the importance of contextual and personal factors finally brought biomedicine to a concession with its emerging rival, the biopsychosocial model which placed stronger emphasis on the experience of illness.

From biopsychosocial point of view, pain is a complex perception that extends beyond pathophysiology, and involves a much larger range of psychological and social processes that frame and give context to the experience of suffering (Melzack and Wall, 1982). Consequently, the importance of concrete disease as the only true determinant of pain has been drastically reduced. Today, pain perception is understood as "a network of events, both inside and outside the body, as well as inside and outside the central nervous system." (Fordyce, 1989:52). The biopsychosocial view has overhauled past definitions to ensure that what is explained and treated as pain can include the sufferer's experience

and life context. In effect, the sufferer's experience has come to serve as a key for planning pain management (Turk, 1996).

As a preamble to this shift, a new neuropsychology of pain took over the stage and fundamentally revised the very basics of the nociception. Historically, pain was understood as a one-way mechanism of transmission of noxious stimulation from nociceptors in the periphery to the central nervous system (Melzack & Wall, 1982). The transmitted pain signal was thought to prompt the spinal cord and ultimately the brain to generate a perception and initiate proper response patterns. This one-way transmission was described as a process that received no input or modulation from the brain in its ascending path to central nervous system. With the arrival of a new theory, this explanation was finally discarded and nociception emerged as a crosscurrent of influences of ascending (downward from the brain) and descending (upward from the periphery) path ways that led to a complex pain perception.

Today, the gate control theory of Melzack and Wall (1965) informs our understanding of pain. Their revolutionary work finally succeeded to reconceptualize pain perception as a two-way process involving neural inputs from both central and peripheral regions of the nervous system. Their theory suggests that the ascending peripheral inputs are transmitted (by C and A-delta fibers) to the dorsal horns (*substantia gelatinosa*) of the spinal cord, where the cells are organized in layers (*laminae*). Some of these layers (*laminae* 1 and 2) are shown to receive descending projections from brain and act as a gating mechanism that can inhibit or facilitate noxious stimulations from nociceptors (Melzack, 1986). Melzack and Wall (1982) propose that through the descending projections, the brain's cognitive control can mediate the input by inhibitory

or excitatory function of the gate. As a result, transmission through the gate depends not only on the intensity of the stimulation as defined by the extent of injury, but also on the contribution of the central mechanisms of control that mediate the gate. As a result, gate control theory took a giant step forward in explaining the role of the brain and the determining contribution of the cognitive control processes in active mediation of pain experience.

In effect, when an adolescent goes through agonizing rites of passage with an unshakeable look of serenity and forbearance, such mechanism of central control are said to be working in favour of inhibiting pain (Melzack and Wall, 1982). Hence, charged with cultural beliefs and communal sentiments, the teenager can tolerate excruciating pain without falling into fatal shock. As a result, the gate control theory reworked the very basic physiology of pain to show the significant contribution of higher central systems in the modulation of noxious stimulation that occur at the level of the spinal cord, well before reaching the brain. In this manner, cognitive mechanisms are said to modulate the gate that triggers the cascade of neural events which leads to the perception and to the ensuing reactions. Unlike its biomedical predecessor, the gate control theory is not at odds with the subjective experience of suffering, as it changes pain from a simple, one-way sensation to a complex perception involving personal emotions, beliefs, socio-cultural teachings, and developmental history (Loeser & Melzack, 1999).

Soon after the publication of the gate control theory, Melzack and Casey (1968) expanded the model to explain pain as a multidimensional experience. The expanded model maps the function of different systems that serve as the neural corollary for the motivational, affective and cognitive aspects of pain experience. The authors proposed

that beside neocortical tracts and epicenters that are responsible for cognitive-evaluative mechanism of control, there are two other systems involved in the process. The first is known as the neospinothalamic system that connects to ventral posterio-lateral nucleus of thalamus and serves to process sensory-discriminative information. Its overall function allows us to determine the location, intensity and duration, as well as the different sensory shades of pain. In conjunction, the authors identify a second pathway known as the paleospinothalmic system that is phylogenetically more primitive than its counterpart. Its function involves processing the affective-motivational dimension of pain. It transmits information for processing to medial nuclei of thalamus, as well as to reticular and limbic systems. An extensive web of pathways connects thalamus to the limbic system which is responsible for unpleasant affects and aversive motivations that accompany pain. The over all contribution of the cerebral systems, that previously though to be only secondary, gradually was shown to be central to the perception of pain. This revised version of the theory completed a tripartite model, wherein sensory-discriminative and affective-motivational dimensions of pain were explained as the subordinate partners for the superordinate cognitive-evaluative system of control lodged within the epicenters of frontal cortex (Melzack and Casey, 1968).

In an important way, this neuropsychological development instigated the advent of biopsychosocial model which eventually redefined pain as a complex experience involving 4 distinct, but interrelated domains (Loeser, 1980; Turk, 1996). The first is nociception, which refers to the process of transmission of noxious stimulation from nociceptors through the peripheral nerves to the dorsal horns of the spinal cord. Second is the perception of pain that occurs, when the central nervous system integrates afferent

information into the person's past memories, present experiences, and future expectations. The perception of pain emerges, as the central nervous system qualifies what has been received and determines its significance. The third domain is suffering, which involves negative emotional reactions and feelings of threat that are associated with a painful condition. The last domain is pain behaviour, which refers to "what a person does or does not do or say that leads the observer to infer that the patient is suffering from a noxious stimulus" (Loeser & Egan, 1989:7).

Not long after the publication of the gate control theory, Fordyce, Fowler, Lehman, and DeLatour (1968) formulated a behavioural perspective, whereby pain was exclusively explained and managed in terms of pain behaviour controlled by environmental contingencies and interpersonal feedback. Despite its initial success, follow up studies revealed that behavioural strategies were insufficient by themselves in maintaining a long-term improvement (Turk and Genest, 1979, Turk, 1996). In addition, behavioural explanations could not account for the overall change of attitude and belief with regard to pain (Melzack and Wall, 1982: 333-337; Bradley, 1996). Based on the gate control theory, the modification of cognitive processes seemed still crucial, if clinicians were to change the sufferer's appraisal of pain. Eventually, Fordyce's (1976) behavioural intervention was complemented and tempered by an approach that targeted the cognitive-evaluative aspect of pain. Ironically, the techniques proposed for such modification came from strategies used in cognitive therapy for anxiety and mood disorders (Turk and Genest, 1979; Bradley, 1996). In their new application, they of course maintained the same therapeutic targets, but this time with pain being the focal problem and the generative ground of emotional suffering.

As a result, the biopsychsocial redefinition of pain and the resulting therapeutic developments were hailed by researchers and clinicians as a new approach to management of pain beyond the conventional concept of disease that brought nociception and suffering into a single process. Furthermore, in its revised version, the new theory of pain allowed clinicians to assess cognitive, affective, and sensory dimensions of pain, and to make use of cognitive restructuring and behavioural techniques for its management. Hence pain management programs changed direction from anaesthesiology to health psychology and behavioural medicine to implement this new understanding with the promise of taking into account the larger personal experience whereby nociception becomes pain. Multidisciplinary clinics were therefore established to bring together various health care providers who worked to fit together the puzzle of pain, on a case-to-case basis. This shift in the organization and philosophy of pain management translated into a shift in their therapeutic objective. As opposed to disease-oriented approach that sought cure by administering treatment, clinicians in multi-disciplinary pain clinics talked about collaborating with patients and their families to control the symptoms and to restore quality of living. What became important was not if pain continued after rehabilitation, but if the patient continued the live the same life of suffering as before.

As a consequence of this important shift, suffering was eventually afforded a place in clinical discourse as a valid part of pain. The biomedical model and its sensory signal approach overlooked the importance of suffering and illness as meaningful aspects of the lived experience of disease and pain. It reduced all distress to mere derivatives of a physiological anomaly, a mere epiphenomenon of consciousness with unreliable ontological status. In contrast, the biopsychosocial interventions relied on a

multidimensional theory of disease which allowed pain experience to include suffering and illness. They therefore engendered the hope that suffering can become not only part of the heuristic model of pain, but also part of its actual clinical management. However, this shift popularized a new public and professional discourse of suffering, one that was meant to be treatable by prevailing strategies of health psychology and behavioural medicine. As opposed to past, in today's therapeutic culture, suffering and pain are given a new meaning, one that is defined, assessed, and treated according to the discourse and practices of health psychology. Given the magnitude and the scope of this change, it is necessary to ask how this shift to a new model has altered our notion of suffering.

The above question acts as the exegetical stance for the following review of literature. To the counter-question that might ask why such a stance is even necessary, the answer can be that an exegetical stance allows for more than a systematic reading of a given area of research, or a theoretical perspective. For, it allows a wider cross-reading of diverse and dissimilar perspectives to take place around a single concern. However, to the counter-question that might ask why it is exegetical and not just review, the answer can be that as reading and counter-reading, a review must demonstrate concern for the meaning of reported findings in human context. Without exegesis (*ἐξηγεῖσθαι*, literally: "to lead out"), there can be no unravelling of the arguments, no leading out of meaning, and no synthesis of texts. More importantly, this exegetical stance links the following literature review to the problematic of this research which asks what it means to suffer from intractable pain. Refusing the misapprehension of tacit questions, a key requisite of any reflective reading is to make its concerns explicit.

1.2. Biopsychosocial Model and Cognitive-Behavioural Health Psychology

As aforementioned, the new theory of pain finally provided a solid ground for biopsychosocial model to speak about pain as a complex experience comprised of 4 distinct but interrelated domains: 1) nociception, 2) perception, 3) suffering, and 4) pain behaviour (Loeser, 1980). Within the literature, pain is often depicted by 4 concentric rings encompassing one another, from the innermost circle, nociception, to the outermost, pain behaviour. Demarcating the core and the perimeter, these two dimensions are largely deemed as objective dimensions that are amenable to medical assays or to independent observation and measurement. In between these two are the two intermediary circles, perception and suffering that are often characterized as the psychological and subjective dimensions of pain. They involve emotions, mental representations, and cognitions, including cultural and discursive constructions of illness (Turk, 1996). In this manner, conceptually and graphically, the subjective dimensions of pain are depicted as enveloped within the objective crust of nociception on one end, and pain behaviour on the other.

As opposed to biomedical emphasis on concrete injury for operationalization of pain and suffering, biopsychosocial model concentrates on observable pain behaviour and self-reported cognitions or on what sufferers do and say in reaction to pain. While this change of emphasis more than ever confirmed that injury alone is no longer the sole valid indicator of pain, it introduced a new *index of objectivity*, namely that of pain behaviour. If detection of underlying pathology as the biomedical index of objectivity required specialized assays administered under medical gaze, pain behaviour as the psychosocial index of objectivity is readily observable and amenable to environmental monitoring and

control. In this sense, evaluating pain behaviour and cognition was believed to be a more reliable way of understanding pain experience than assessing the underlying injury. As a result, pain suddenly was removed from its locus in the physical interiority of the body and brought into the interpersonal exteriority of the interpersonal environment.

By the same token, the underlying mechanism of pain underwent a dramatic redefinition. The success of control gate theory in explaining pain experience gave cognitive factors unprecedented prominence both in phenomenology (introspective experience) and in pathogenesis (aetiological mechanism) of pain. It highlighted the unique function of cognitive factors in shaping the experience of pain and suffering by modulating noxious sensory stimulations and by appraising the emotional responses to pain. The gate control theory expanded the contribution of cognitive processes through descending pathways to what takes shape at the level of spinal cord and dorsal horn. "Pain", as Melzack and Wall (1983:332) explain, "can be treated not only by trying to manipulate the sensory input, but also by influencing motivational and cognitive factors". The significance of this statement from the authors of gate control theory cannot be overstated.

However, what do these researcher mean by cognitive factors? Where these factors come from and how they do what we are told they do? Are they capable of shaping our feelings and sensations? How far they shape and control our suffering? In fact, what the researchers call cognitive factors have been explained as learned thinking structures that provide templates or models for information processing (Skevington, 1995:109-110). Hence they are said to be in operation, when we mobilize attentional resources; direct awareness to particular events; organize sensory influx into recognition;

create regularities amid rupture; interpret the present in continuity with the past; provide perspective and meaning to situations; estimate prospects and goal approximations, set response options and strategies, assess feedback and outcome, and accordingly modify execution and implementation (Norman, 1986). These structures have become known as cognitive schema or in plural form, schemata. They are said to be representations or mental models and scripts that underlie how we attend, interpret, and relate to ourselves and the world (Bartlett, 1932).

The concept of schema can be traced to Kant's notion of *a-priori* categories of understanding and perception as necessary condition for any knowledge of reality (1781/2003). In his critique of empiricism and solipsism, Kant argued that our coherent and meaningful experience cannot be explained either as the mirror images of reality or as the direct derivatives of rational ideas. He proposed an active process of knowing, wherein "categories of understanding" transform what can be sensible to perception and *pre-given* knowledge of mind. He explained these categories as being independent from experience or *pre-given*; they are inherent properties of the mind responsible for rendering manifold sensations into consistantl knowledge and coherent perception according to a set of rules or *schema*. In recent times, Tarski (1944) adopted the term and brought it from *epistemology* and *ontology* to *formal logic*. His aim was to define the correct form of a true statement. Tarski argued that an unambiguous definition of what is true requires both *material adequacy* and *formal correctness*. He then proposed that formal correctness can be satisfied, if a psoposition assumes the form of a particular sentence, known as *convention* or *T-schema* [For all x, *True*(x) if and only if $\varphi(x)$; this statement satisfies the correspondence theory of truth]. In other words, to the question

that asks what would be the form of a true statement, Tarski answered by proposing a model sentence or a *logical operator*, which has been known as T-schema. His end was to define true statement within a formal language. For him, that formal language was mathematics, in which the schema was a function. *Thus, he redefined schema into what can hold the proper syntax for a true statement according to the rules of the formal language of mathematics.*

In one of its earliest applications in psychology, schema was used by a contemporary of Tarski, in a sense closer to Kant's meaning of the term than Tarskian logical operator. Bartlett (1932) invoked cognitive schema to explain why a story re-narrated across people gets progressively altered to resemble what the group is accustomed or disposed to hear on the subject. In this sense, a schema was explained to be "an active organization of past reactions or of past experiences which must be always supposed to be operating" under all actual experiences (60). In his view, it is the operation of schema that slowly but surely renders the story congruent with the expectations of the narrators and the audience. However, he expressed his far-sighted worries about the inherent deficiencies of the concept:

> "I strongly dislike the term "schema." It is at once too definite and too sketchy .... It suggests some persistent, but fragmentary, "form of arrangement," and it does not indicate what is very essential to the whole notion, that the organised mass results of past changes of position and posture are actively *doing* something all the time; are, so to speak, carried along with us, complete, though developing, from moment to moment." (200–201)

For Bartlet, schema is a remnant of the past, which was incessantly lived in the present; a remnant that is not a vestige or a relic but the "organized mass result" of the past that is "carried along with us". He astutely points out the unexplainable and paradoxical

character of the construct as being "complete, though developing". As a result, he calls remembering "an imaginative reconstruction, or construction, built out of the relation of our attitude towards a whole active mass of past experience" (109). His emphasis on "active mass of past experience" shapes the foundation of his understanding of schema. Nontheless, his dissatisfaction with what the schema denotes can be read as a prescient admonishment regarding the later development of the concept in cognitive science.

With the advent of information technology, the developmental, relational, imaginative, dynamic, paradoxical, and reconstructive qualities of schema, as initially described by Bartlett, were suddenly muted and abandoned in favour a computational model established on the formal manipulation of encoded symbols according to discrete synctactic algorithms (Horst, 1996). Although schemata were variably described in terms of core beliefs, implicit knowledge, learned expectancies, and habitual appraisals, these psychological terms were said to be of no real theoretical value, and dispensable or extricable from the explanatory model of schema (Churchland, 1988; Benette and Hacker, 2003:366-377). In effect, the term was gradually remade to agree with architectural elements and syntactic operations of an abstract computational system. Eventually, it assumed a meaning closer to that of Tarski's syntactic model of logical operator. In this manner, Rumelhart (1980:34) redefined schemata as:

> "a data structure for representing the generic concepts stored in memory .... Inasmuch as a schema underlying a concept stored in memory corresponds to the *meaning* of that concept, meanings are encoded in terms of the typical or normal situations or events that instantiate that concept"

More extreme examples omit any kind of reference to concepts such as, meaning. In his renowned and seminal article on motor learning, Schmidt (1975:240) states, "a schema is

a learned relationship between the input and required output vectors of the controller." It seems hard to believe that this statement applies to anything but a machine application, yet the author means to explain human perception. Having been redefined in machine terms, schema loses all its existential content, its paradoxical character, and its indeterminate human qualities. More importantly, its phenomenological openness to self-reflection and intersubjectivity is circumvented by the physicalism of the mathematical abstractions (for a favourable but rather ironic analysis of this development, see: Brewer, 2000).

Under the shadow of the contemporary computational theory, schema was remade to fit the mechanical character and operations of a computation machine. The language employed for describing cognitive schema—the building block of human thought—appears as though portraying an information system application and not the human world of relating, feeling and thinking. Hence, schema has been given definitions such as: "the situation calculus" (McCarthy and Hayes, 1969); "hierarchical representations" (Sacerdoti, 1973); "scripts" (Schank and Abelson, 1977); "story grammar" (Rumelhart, 1975), and "frames" (Minsky, 1975). In a sense, schema has been literally described as a structure that holds the syntactic templates for manipulation of information as data (Rumelhart, 1980). The manipulation is characterized as a set of operations that transforms sensory information into coherent perception and knowledge of reality for action output.

The actual operations of schemata are explained akin to an information processing module with an output and a feedback loop. Hence, schemata, as knowledge structures, are said to contain information about generic concepts, such as: situations, objects,

events, and actions that are constants of our everyday experience. Within every schema, two kinds of information are structured and stored: 1) attributes (variables) of generic concepts, and 2) the relationship among the attributes (Rumelhart and Ortony, 1977). It is argued that this knowledge structure allows us to identifying particular instantiations of a concept from the torrent of sensory input. Through the automatic process of appraisal, sensory input is attuned to match with schematic templates, or as the case may be, to modify them with least amount of disruption and confusion. As a processing template guiding interpretation, schema is said to play a dynamic function in perceiving objects and comprehending situations, as well as in planning actions and anticipating events. Much of its operation is described to take place below the level of deliberate control as part of automatic information processing (Neuman 1984).

At least one theory describes schemata as operating in an unconscious manner, dissociated from consciousness. Based on the concept of dissociation, Hilgard (1977, 1986) defined an unconsciousness domain for schematic processes that is separated by an amnesic barrier. The notion of unconsciousness, introduced by the author, goes back to the classical works of Janet (1886, 1888, 1889) who proposed that hypnotic and hysteric states are the result of a psychic dissolution of the consciousness. Janet argued that such dissolution reduces conscious processing of stimulation and allows ideas to form beneath the level of consciousness. Such ideas are then dissociated, since the person can no longer recognize them as his or her own. Using contemporary research, Hilgard reworks Janet's conceptualization and proposes his neodissociation theory that defines schematic functioning within an unconscious realm. He argues that behaviour and cognition are structured into a hierarchy of schemata beneath a central system of control that is in

charge of planning and monitoring actions. These schemata can act as independent subsystems to the central control or the *executive ego,* at the top of the hierarchy. Hilgard argued that the executive ego is split into an unconscious compartment by an amnesic barrier. In this manner, the conscious executive ego has no understanding of memories and perceptions that lie across the barrier on the unconscious side. This allows the unconscious to create a parallel system of control whereby "attentive effort and planning are carried out without awareness" (Hilgard1977:2). Hilgard recognized this unconscious realm as being responsible for bringing about hypnotic states through suggestion. As a result, schematic processes form the undergrid of a complex but divided executive ego that is not consciously monitored or controlled at all levels.

In its latest application along the gate control theory, schema has been accorded an important function in cognitive information-processing of pain and suffering. The psychological studies of pain and a wide range of physical symptoms have shown that the way people understand and explain their ailment has a strong association with their level of distress and suffering, as well as with their functional disability and quality of life (Skevington,1995:109-111). What Melzack and Wall call the central mechanisms of cognitive control are said to be operating through cognitive schemata as structured set of ideations or cognitions for processing pain (Dar and Leventhal, 1993; Leventhal and Leventhal, 1993). As a template for information processing, schemata underlie how we structure our inchoate sensations of ailment into coherent perceptions to anticipate risk or opportunity and to act accordingly. Researchers have identified three main areas of cognition as contributing to pain experience: 1) beliefs about pain, 2) perceptions of self-control, 3) expectations regarding illness (Moreno, Garcia, and Pareja, 1999). Ideations

that constitute these areas are said to be part of three distinct but partially overlapping schemata. These schemata are identified as: pain, illness, and self. They are shown to be involved in the selective information processing of pain that results in distress and suffering (Pincus and Morley, 2001).

The question that still remains unanswered is how pain and suffering as a manifold affective experience can be rendered cognitive or can be cognitivized as information processing? Even in terms of common descriptors, Melzack's (Melzack and Torgerson, 1971) study of semantics of pain shows how sufferer's adjectival references can be grouped into three distinct dimensions: 1) sensory-discriminative (e.g. sharp, throbbing), 2) affective-motivational (e.g. terrifying, depressing), and 3) cognitive-evaluative (e.g. annoying, miserable). Later studies using signal detection, paired scaling, and multivariate methods have supported the distinctness of these dimensions (Melzack, 2005). Hence, pain is said to be the result of distinctly identifiable sensory, affective, and cognitive systems that work in parallel in order to process the separate aspects of emerging experience. Nonetheless, in spite of the heterogeneity of this tripartite division, it is the preponderant contribution of cognitive system that is believed to integrate this manifold phenomenon into a meaningful perceptual state. Moreno, Garcia, and Pareja (1999:75) explain the role of cognitive processes as:

> Among the different factors relevant to the psychological assessment and treatment of chronic pain, those of a cognitive nature play a prominent role, due in large part to the fact that pain is a perceptual phenomenon. Indeed, cognitive factors are largely responsible for the final (cortical) part of the perception process, so that, without subtracting importance from the more sensorial and emotional aspects of pain, the final integrating point is cognitive in character.

Pain, defined as a perceptual phenomenon, is said to owe its form and meaning to the higher cortical process responsible for cognition. Assessing and restructuring these processes has therefore been the sole focus of psychological treatment and rehabilitation of pain.

The cognitive organization of perception was first proposed in the field of vision. In their work on visual perception, Pomerantz and Kubovy (1981) showed how perceptual organization is formed not through the analysis of sensory features of an object, but through an early holistic registration involving top-down cognitive processes. By the same token, it has been argued that pain perception is formed not directly from the noxious sensations and aversive affects, but through a cognitive mediation above and beyond other forms of input. As Fernandez and Turk (1992: 214) maintain, "we may possess a *smart* perceptual mechanism that is capable of picking up a wealth of information about pain without the mediation of the (component) sensory and affective variables". In effect, this smartness is attributed to a top-down process that is controlled by cognitive mechanisms (Leventhal, 1982). The result is a cognitive model that "emphasizes the role of the individual's beliefs" and sees the sufferer as "continually appraising and interpreting his or her experience" (Novey, Nelson, Francis, Turk, 1995:243).

According to the cognitive theory, this continuous appraising and interpreting is shaped by cognitive schemata and guided by schematic operations that occasion the sufferer's beliefs about the attributes of pain, the perceptions of control, and the expectations regarding illness. In effect, what patients say and do or how they react to pain is said to be structured by their beliefs, perceptions, and expectations. Without such

cognitive factors, pain perception and behaviour may never assume the necessary organization, and the anxiety and distress may never be experienced as suffering. In cognitive therapy, this emphasis on the underlying cognitive factors has led to the preponderance of cognition over affective experience (Ellis, 1962; Beck, 1976). As Greenberg and Safran (1989:20) point out:

> In the cognitive behavioral approaches, affect has traditionally been seen as a postcognitive phenomena [*sic.*]. Cognitive behavioral theory has maintained that the meaning of an event determines the emotional response to it....Constructs such as automatic thoughts, irrational beliefs, and self statements have been posited as mediating between events and emotional responses to events, and cognitive therapists have tended to focus on the elimination of emotional responses to faulty cognitions by rationally challenging beliefs, by providing schema-inconsistent evidence, and by providing self-instructional training.

Emotion-shaping beliefs or cognitions are described as the product of cognitive structures or schemata that control the appraisal of neural input. By the same token, cognitive factors are explained as more than constitutive aspects, and are afforded the special function of a determinant factor of pain perception and suffering. Even non-cognitive aspects such as attention, arousal, and motivation (or what is known as conative) are explained as involving cognitive processes for contributing to pain experience (Moreno, Garcia, and Pareja, 1999:83).

Studies on pain beliefs, self-perception, and illness expectation have identified the style of cognitive processing and organization that leads to processing bias, erroneous cognition, and emotional distress among sufferers. Such bias is said to distort appraisal of painful conditions and leads to emotional distress. The term catastrophizing is used to refer to a kind of cognitive processing that is shown to be strongly associated with anxiety and suffering related to pain. As a way of thinking, catastrophizing involves bias

appraisal of illness that best serves feelings of doom and gloom and contributes to maladaptive pain behaviour and dysfunctional coping. It is therefore said to be a cognitive process with affective and behavioural dimensions (Sullivan, Thorn, Haythornthwaite, Keefe, Martin, Bradley, and Leefebvre, 2001). When it comes to pain intensity, disablility, and distress, carefully designed correlational studies have shown that regardless of the level of impairment catastrophizing is a reliable and strong predictor (Severeijn, Vlaeyen, van den Hout, and Weber, 2001). Although no causal link can be inferred from such studies, researchers have left little doubt that there is a clear association between negative appraisal and suffering (Turner and Aron, 2001).

Over the past two decades, the concept of catastrophizing has been used to refer to all excessive beliefs and extreme preoccupations of negative kind about pain and illness. As Turner and Aaron (2001) tell us, the term was first used by Albert Ellis (1962), the founder of rational-emotional who used it, when a patient's negative opinion made a situation seem totally unbearable or un-attemptable. However, Beck and his colleagues (1976, 1985) finally defined the construct "in terms of dwelling on the worst possible outcome of any situation in which there is a possibility for an unpleasant outcome" (as paraphrasd by Turner and Aaron, 2001:65). To Beck's formulation, Turner and Aaron (2001:65) add that "such thoughts are tied to the perception of oneself as vulnerable and as being subject to danger over which one has insufficient control". As a construct, it was coined to refer to the manner of thinking, or to the style of cognition that was said to be prevalent among those suffering from anxiety and depressive disorders. Its entry into literature is firmly rooted in Beck's cognitive reformation of anxiety and panic. In his view, those with mood and anxiety disorder tend to think

largely along two different variations of catastrophizing which persistently interprets situational uncertainty as forthcoming peril or misery.

Ever since its appearance in literature 4 decades ago, catastrophizing has been studied and discussed in relation to anxiety and panic disorders, and rather lately with respect to depression (Turner and Aaron, 2001). Before being introduced in pain, as a concept, it played a major heuristic role in cognitive models of affective disorders and particularly of anxiety. As a descriptor, it refers to the looming thought content of anxious individuals. It characterizes their beliefs, expectations, and perceptions as involving negative appraisals. As a result, it has been used to characterize the maladaptive quality of cognitions in assessment questionnaires (Sullivan, Bishop, and Pivik, 1995). On the other hand, it has been recognized as a cognitive process that has been shown to be strongly associated with clinical anxiety and depression. In this sense, catastrophizing is a style of thinking and processing information which has been investigated as a potential factor in the pathogenesis of mood and affect disorders. Cognitive models explain how catastrophizing as a style of automatic thinking contributes to attention and interpretation bias, whereby the individual pays undue attention to unusual internal and external cues, and appraises every uncertainty as threat (Beck, Emery and Greenberg, 1985; Beck and Clark, 1997). Such automatic thinking is believed to create internal models for appraising, perceiving, memorizing, and recalling experiences in a bias fashion, hence aggravate the normal level of stress and lead to a full-blown anxiety.

Such persistent automatic thinking is shown to involve an "internal dialogue" (Davey and Levy, 1998) that admonishes against uncertainties and possibilities. In its

extreme form, it is said to be the "what if..." style of questioning that reads catastrophy into mostly neutral but uncertain events. For its persistent and repetitive quality, this internal dialogue is recognized as having a "perseverative iterative style. Aside from the worry thoughts and worrying thinking, catastrophizing is said to have an iterative quality that takes control of the indinvidual's internal dialogue and diminishes one's problem solving capability. As a result, one's ability to deal with situations and to initiate adaptive response can be affected. Consequently, a sense of vulnerability and helplessness develop which results in anxiety and depression.

For its automatic quality, catastrophizing is identified as a form of thinking that gets triggered by seemingly analogous situations. Robins and Hayes (1993:209-210) describe automatic thinking as:

> "These types of thoughts (or images) are referred to as "automatic" because they typically arise spontaneously, frequently are very fleeting, and may even go unrecognized unless the patient is directed to deliberately monitor them. These automatic thoughts, which reflect the individual's appraisal of a situation rather than the actual objective situation, lead directly to the patient's emotional and behavioral responses. These responses will be maladaptive to the extent that the appraisals are distorted or exaggerated, which will occur when they arise from the operation of dysfunctional schemata."

In the authors' view, "Schemata can be considered internal models of aspects of the self and the world" (208). As such, the authors argue, "Automatic thinking can be considered a surface level of cognition that can be brought into awareness fairly readily by the patient and clinician" (211). In its adaptive form, such automatic thinking facilitates spontaneous and efficient information processing. However, unrealistic beliefs and appraisals can bias automaticity and eventually lead to disproportionate level of affective reaction. As a result, catastrophizing is described as a biased, automatic, and iterative

process that responds to certain situations with worrying threatening thoughts leading to distressful feelings and maladaptive behaviours. Evidently, catastrophizing is explained as rising from cognitive schemata, and as being a cognitive determinant of distressful emotions. In effect, its iterative and automatic qualities are explained through schemata theory, while cognitive theory of emotion is used to hypothesize its operation as being generative of anxiety and suffering.

However, about two decades after its introduction into theory of anxiety and affective disorder, catastrophizing was recognized as a major psychological factor in pain perception and in adaptive coping among patients with arthritic pain (Keefe, Caldwell, Queen, *et al.*, 1987). Subsequently, a number of key studies demonstrated that those with a propensity to catastrophize were prone to more intense pain perception and higher emotional distress (Keefe, Brown, Wallston, *et al.*, 1989). In its earliest usage, the concept was called "awfulizing" and was defined as "a negative bias in the appraisal of threat" (Ciccone and Grezesiak, 1984:1342). In an often quoted article on cognitive determinants of chronic pain, Ciccone and Grezesiak identify 8 patterns of cognitive misappraisal that can be seen as underlying chronic pain. Amongst them, awfulizing as well as "overgeneralization," "low frustration tolerance," and "self-downing" are said to be the key forms of cognitive misappraisal that result in chronicity and emotional suffering. In summing up their view, the authors state that "humans are prone to both misinterpreting and misappraising the nature of reality", and that "mistaken inference is the primary if not the only cause" of suffering, anguish, and chronic pain (1341). Despite this strong cognitive view, researchers are still careful not to infer causal relation, since much of what has been known comes from correlational studies.

As terms such as awfulizing and self-downing changed into catastrophizing, the evidence of its association with higher pain severity, disability and somatic complaint grew stronger. Nonetheless, the evidence of strong and consistent association has compelled research in this area. There are at least 5 major findings that point at the importance of catastrophizing:

> "Catastrophizing has been associated with heightened pain in clinical and in experimental studies with adults and with children. It has also been shown to be associated with heightened disability and to predict disability better than disease-related variables or pain. In addition, catastrophizing has been associated with increased pain behavior, increased use of health care services, longer durations of hospital stay, and increased use of analgesic medication. In the absence of intervention, catastrophizing seems to be relatively stable over time, although there are indications that it may decrease with age (at least in adult samples)." (Sullivan, Thorn, Haythornthwaite, Keefe, Martin, Bradley, and Lefebvre, 2001:57)

When compared to disease-related variables, the predictive value of catastrophizing with regard to pain-related complications tends to be higher. However, the importance of catastrophic thinking seems incontrovertible not only for coping with chronic pain, but also for the outcome of other painful life situations. For instance, in their study on pregnancy pain, Ferber, Granot, and Zimmer (2005:826) report, "Labor pain catastrophizing rather than labor pain intensity predicts postpartum maternal adjustment". Catastrophizing has, therefore, been redefined, as "an exaggerated negative 'mental set' brought to bear during actual or anticipated pain experience" (Sullivan, Thorn, Haythornthwaite, Keefe, Martin, Bradley, and Lefebvre, 2001:53).

In their comprehensive review of the research literature, Sullivan *et al.* (2001) report that the catastrophizing disposition is shown to exist among both children and adults with younger populations suggest that catastrophizing appears early in life, and if left untreated, tends to be an enduring mode of thinking that only declines at older age.

According to literature, pain sufferers with catastrophic thought can improve coping by receiving intensive cognitive-behavioural therapy. This has convinced some researcher that despite its perseverative style, catastrophizing does not show the immutability of a character trait. Nonetheless, it shows a strong association with pain behaviour (all responses one makes or verbally expresses in reaction to pain), as well as to illness behaviour (all solicitous responses of the patient including those for receiving or continuing treatment).

However, what makes catastrophizing peculiar is how as a construct, as an operationalized definition, or as a measurement variable, it tends to be identical to cognitive features of both anxiety and depression. For, it can envoke and accompany both frightful anguish and dark despair. In a comprehensive review of literature, Sullivan and his colleagues admit, "Theoretical accounts of catastrophizing have not been elaborated substantively beyond investigators' operational definitions of the construct" (53). Else where in the same review, the authors point out:

> "Questions regarding the degree to which catastrophizing is a general phenomenon or one that is restricted to pain-related outcomes have yet to be examined. Nevertheless, there are grounds for proposing a general as opposed to a pain-specific view of catastrophizing. For example, catastrophizing has been discussed as a cognitive component of depression and anxiety. The significant relations between catastrophizing, depression, and anxiety (discussed below) are consistent with the view that individuals who catastrophize in pain-related situations might also catastrophize in problem situations that do not involve pain." (56)

Despite an obvious overlap, the authors believe that mapping this concept into existing models of schema-activation, appraisal, attention, and coping may actually provide catastrophizing with a substantive definition and help deflect the argument of construct redundancy. However, such mapping can provide a substantive account for

catastrophizing, insofar as anxiety and depression are kept out of such modeling. Applying any of the aforementioned models to cognitive aspects of depression and anxiety may otherwise lead to a bigger overlap and redundancy for catastrophizing. This raises the question that whether this overlap is by itself meaningful. In other words, even though catastrophizing can be observed in the absence of clinical depression or anxiety (Sullivan *et al.*, 2001), it is valid to ask whether pain catastrophizing has something in common with depressive and anxious mood. If pain catastrophizing and catastrophizing in depression and anxiety have something in common, how should our characterization of pain, anxiety, and depression change to allow for certain continuity among these experiences without becoming reductive?

On the other hand, it would be possible to argue that this redundancy and the lack of substantive definition for catastrophizing may reflect an aspect of pain, and suffering that has not been adequately explored and indeed left out of the discussion, so far. This is an argument that has not been even remotely considered in health psychology, since sensory and affective dimensions of pain are consistently explained in reference to the presumed preponderance of adult cognitive processes. In effect, the psychology of pain is largely articulated from a cognitive-behavioural point of view that clearly favours adult mental representations and responses, for being realistic, workable, and adaptive. By the same token, suffering has come to mean stress that has become unmanageable due to unrealistic cognition, and maladaptive coping. In this view, what is non-cognitive is seen as non-representational and is described in purely physiological terms as neural processes and bodily changes that at best provide input for the cognitive faculty to appraise, interpret, and encode as representations. Assuming a preponderant role for cognitive

faculty has made it hard to define in a substantial manner pain-related catastrophizing and to explain its kinship with negative cognitions in depression and anxiety. In other word, to resolve the question of what constitutes catastrophizing may require considering the link with anxious and depressed mental states beyond what is simply explainable in terms of adult cognition.

However, when pain insensitivity in schizophrenia and psychosis is considered, yet another interesting puzzle emerges regarding catastrophizing and its link to anxiety and suffering. For long, clinical observation reported an astonishing lack of sensitivity to pain amongst patients suffering from schizophrenia and psychosis. As pioneers of the field, Kraeplin (1919) and Bleuler (1911/1951) left the earliest case studies of insensitivity to serious injuries and painful complications among psychotics. Despite case-related reports, population-based studies seemed needed to establish for many, what was clinically described for the few. In their review of research, Singh, Giles, and Nasrallah (2006) show how researchers have revealed the significant prevalence of insensitivity to pain among people with schizophrenia and psychosis. Eventually, studies of experimentally induced pain managed to demonstrate that people with schizophrenia and psychosis are generally less sensitive to pain. In one study of this kind, Mersky, Gillis, and Marszalek (1962), using pinprick and pressure, found that patient with paranoia are specifically less sensitive to pain than those suffering from other types of psychosis. However, this insensitivity to pain is in obvious contradiction with the research that describes catastrophizing as the cognitive style for persecutory delusions and anxieties (Startup, Freeman and Garety, 2006). As Startup *et al.* report, the persistence of psychotic delusions and the intensity of persecutory anxieties are shown to

be positively correlated with the number of catastrophic steps involved in the patient's reasoning. If persecutory delusions and anxieties are associated with catastrophizing as a cognitive style of processing, what can justify the lack of sensitivity to pain among paranoid schizophrenics who are said to be struggling with catastrophic worries? More importantly, if a general theory is to explain pain catastrophizing, how can it at the same time explain the pain insensitivity among paranoid schizophrenics?

By the same token, more interesting puzzles are raised, if we consider the research into the kind of cognitive organization involved in pain catastrophizing. It has been argued that catastrophizing is the result of a excessive enmeshment of key cognitions that define self, pain, and illness (Pincus and Morley, 2001). This theory postulates self, pain, and illness as three distinct but interrelated cognitive schemata, that play an important role in coping with pain, and in experience of suffering and distress. Based on comparing the self-reports of normal subjects with those of pain patients (copers and non-copers), researchers have argued that excessive overlap among the three can cause enmeshment of self, pain, and illness schemata which results in poor self-control, negative beliefs and expectations, and eventually emotional distress. However, cognitive structures among schizophrenics are known to be disorganized, instable, with fluid interconnections and fusions. Yet, such unstable organization and fusing structure seem to contribute very little to highten sensitivity to pain, even though catastrophizing is identified as part of delusional persecutory anxieties. In fact, the lack of sensitivity to pain among paranoid schizophrenic raises serious question about how much hypersensitivity to pain can be explained as a cognitive anomaly. As a result, while cognitive view emphasizes catastrophic misappraisal and misrepresentation as the real

source of suffering, it seriously falls short of explaining the insensitivity to pain among those whose experience of the world is literally haunted by the most terrifying misappraisals and vivid misrepresentations.

Sullivan *et al.* (2001) reports that searching for the aetiology of catastrophizing have brought researchers to identify social learning, unresolved attachment issues, and temperamental sensitivity to uncertainty and fear reaction as possible factors responsible for shifting schematic processes to a bias catastrophic outlook. However, the determinants and the processes that may underlie catastropizing are still shrouded in uncertainty and mystery. Regardless of the definitional and aetiological uncertainty, catastrohizing is clinically viewed as maladaptive cognitive processes maintained by maladaptive interpersonal behaviours. It is therefore primarily seen as a cognitive-behavioural phenomenon and addressed through cognitive-behavioural intervention, with strong emphasis on psycho-education (Skevington, 1995). In rehabilitation, this means cognitive techniques of examining thought patterns, restructuring erroneous schemata, learning new skills and information, and at times using thought-stopping strategies that are used to encourage the suppression of reiterative negative thoughts. In conjunction, behavioural strategies are used to establish and reinforce active coping and eliminate maladaptive illness behaviour through negative feedback. In this vein, as suffering becomes tantamount to cognitive misappraisal and maladaptive behaviours, therapeutic intervention becomes synonymous with rehearsal in corrective restructuring, accurate reasoning, realistic appraisal, and adaptive behaviour. In this manner, biopsychosocial model has advanced psychological understanding of pain, but only insofar as couching all

subjective, inward, and private aspects of suffering into overt cognitions and behaviours of the sufferer.

For biopsychosocial model and health psychology, the importance of behaviour, particularly pain behaviour, can hardly be overstated. Defined as "what a person does or does not do or say that leads the observer to infer that the patient is suffering from a noxious stimulus" (Loeser & Egan, 1989:7), pain behaviour is an over-arching concept that at once encompasses what has been conventionally known as behaviours (what the person does), together with what can be reported as cognitions (what the person says). It is used to make the private experience of the sufferer into a publicly observable phenomenon that can be studied and explained in terms of what can be overtly elicited, measured, and verified by an independent observer with certain degree of consistency. In effect, the concept is meant to render the sufferer's experience overt and public through self-reported cognitions and observed behaviours. This allows the observer to assess the content what is taken to be the sufferer's experience according to the adaptive quality of what the person does and says as a result of pain. For biopsychosocial model, reliance on this overarching concept has allowed a rethinking of pain that still upholds a reliable, valid ground for assessment and treatment of pain.

The preponderance of pain behaviour particularly increases in the practice of health psychology, which as a clinical discipline is dedicated to the use of cognitive, behavioural, and interpersonal strategies for promoting healthy and autonomous living. When it comes to reliable and valid inference of pain, health psychologists place special emphasis on what sufferers do, and say is response to pain. By the same token, when it comes to intervention, they rely on cognitive-behavioural strategies to change what

sufferers say and do in reaction to pain. It is therefore thought that when people change their expressed ideations and behaviours and accomplish good results, they have managed to restore quality of life, to regain autonomy, and to feel less anxious and depressed. In this vein, for health psychologists, the emphasis on pain behaviour extends beyond its mere inferential or observational value and shapes their outlook of therapeutic strategies and interventions.

Consistent with the clinical emphasis on symptom management, health psychology suggests that although pain and disability can persist without relief, its actual impact on life can be rendered manageable, if patients learn to adapt to their new living situation and cope actively with pain (Turner and Romano, 1989; Bradley, 1996). Life with pain is reframed as a new living situation, to which one has to learn to adapt, and with which one has to cope. Health psychology predicts that as patients learn to cope, they become more active, less dependant on others, and less anxious about their prospect. In helping the patient cope, health psychology heavily relies on behaviour modification to change the sufferer's reaction to pain, disability, and loss. Case formulations offer detailed and systematic account of observed behaviours and reported cognitions as a way of establishing what is not working and what needs to be changed ( ). For the purpose of cognitive-behavioural modification, health psychologists need to know how catastrophic misrepresentations, antecedent factors, maladaptive behaviours, and reinforcing consequences, interpersonal and social roles come together (Egan, 1989). Thereupon, therapeutic techniques ranging from operant conditioning (Fordyce, 1996) to cognitive restructuring and suggestions (Turk, 1996, Chapman, 1986) are applied to address what is considered as maladaptive behaviours and catastrophizing cognitions.

Ultimately, all perturbing feelings and mental representations that are labelled as maladaptive are characterized as no other than erroneous, unviable, and unworkable cognitions and behaviours that have to be restructured into coping cognitions and behaviours of viable type. When the content of the sufferer's experience is reduced to maladaptive pain behaviour, it would be logical to describe it as being conclusively contingent upon how cognitive appraisals take account of antecedent stimuli and occasion a course of action in anticipation of consequences. Hence, for health psychology, pain is a subjective perception insofar as it can be felt in the absence of nociception and noxious stimulation. However, it can still be observed, rated, and objective explained based on pain behaviour as a set of cognitively mediated stimulus-bond response . As a result, what was lost when nocicpetion proved to be an unreliable objective foundation for pain is regained in pain behaviour as the objective measure and the verifiable index, to which all subjective aspects can be translated and in terms of which suffering can be remedially addressed. As a result, wherever pain is assessed for research and experimentation, for diagnosis and intervention, or for forensic and disability compensation, it is the assumed inferential authority of pain behaviour that empirically-minded clinicians can trust with confidence.

By the same token, suffering as an integral part of pain experience has not been spared from the ubiquity of cognitive-behavioural discourse. If pain experience can be explained in terms of what patients overtly do or say with respect to pain, suffering can be understood as the fear and threat caused by what people erroneously say and ineffectually do in response to pain. In this sense, it becomes nothing other than exaggerated, catastrophic misappraisals and maladaptive behaviours that can be modified

to adaptive and viable ones. The pioneering health psychologist, Fordyce (1989:56) states, "A stimulus producing fear, threat, or anticipation of aversive consequences may lead to suffering, and behaviors indicative of suffering may be expressed". He reconceptualizes suffering as distressful feelings of "fear, threat or anticipation" that are contingent on the "anticipation of aversive consequences". Similar to any other response, suffering is described in terms cognitive appraisals of antecedent factors and aversive consequences. Hence, for the reason that pain has by and large a strong association with injury and loss, it is said to have the effect of making the sufferer anticipate and fear further harm and grief. This anticipation can be embellished by catastrophizing that would make the patient anticipate greater harm and feel beset by escalating fears without much control or recourse (Bowers, 1968). Such fears render the sufferer incapable of meeting social demands and interpersonal expectations, and further aggravate "the perception of noxious stimuli" and threat (55). According to Fordyce, if the environment reinforces the patient's maladaptive responses and exaggerated pain perception, it encourages "the expression and continuation of pain or suffering behavior and thereby promote chronicity" (55).

In a case vignette, Fordyce (1996:41) explains how he and his colleagues respond to a pain patient's incessant complaint by negative behavioural consequences to discourage his so-called maladaptive pain behaviours. To this end, while doing ward rounds, Fordyce and his colleagues decide to respond to "any references to pain by looking out the window as a way of modifying social feedback" This blatant strategy of showing disregard for what is regarded as unwarranted pain complaint is not unique to Fordyce. In another example, Long (1996:8) states, "Discussions about pain were not

allowed between nurses and patients or with physicians except during specific times at rounds or in therapy sessions". Trying to give this blatant strategy of avoidance a positive spin, Fordyce states, "Note that staff were not to ignore pain behaviors; only to be minimally *socially* responsive and to direct special attention to patient effort to increase activity levels" (44). It would be indeed valid to ask, how "minimally socially responsive" clinicians can get before ignoring suffering? Nonetheless, Fordyce (1989:55) argues that such negative feedback "may discourage and inhibit expression of pain or suffering behaviors and thereby promote early resolution to pain problem."

This redefinition of suffering successfully eliminates all reference to any meaning beyond what is overtly tallied as expressed ideations and observed behaviours that are modifiable by behavioural feedback and cognitive reframing. In effect, describing suffering in cognitive-behavioural terms raises the question that, in what way the behaviours and cognitions indicative of pain or pain behaviour differ from the behaviours and cognitions expressing suffering or suffering behaviour. In fact, Fordyce maintains, "Thus, suffering may lead to the expression of suffering behaviors that are, or may be, virtually indistinguishable from pain behaviours" (56). Fordyce's redefinition casts human suffering within the limits of observable behaviours and verbalized cognitions, and what they may mean according to external reality and environmental contingencies. However, Fordyce's view omits much of the ambiguity of the sufferer's internal world by eliminating any reflection on the content and the manifold significance of pain-related anxieties. It reduces subjective experience to a mere shadow of observable events. In effect, suffering becomes no more than a learned strategy of processing and responding to

noxious stimulation that can be remedied using proper techniques of cognitive restructuring, skill training, and behavioural modification.

Despite engaging with the sufferer's appraisal and ideations, the cognitive approach to pain and suffering establishes no better outlook for understanding the internal world of the sufferer. The patient's feelings of immanent threat are often seen as misinterpretation of hurt caused by nociception. Hence, as part of today's therapeutic routine, patients are often told that hurting does not "represent a threat to well-being" or harm (Bradley, 1996:132). This differentiation between hurting and harming is reinforced as a key part of cognitive restructuring aimed at alleviating anxiety and suffering. Yet, reducing the perceived threat to "cognitive distortion" or "cognitive errors" (Lefebvre, 1981) detracts from exploring the significance of such anxieties. Consequently, the reason why pain invokes such deep anxieties is explained as "learnt beliefs" (Turk, 1996:13-20) that erroneously picture pain as catastrophic, mysterious, and uncontrollable. The emphasis on cognitive variables that mediate the experience of pain and suffering culminates in the concept of catastrophizing as a schematic structure and process responsible for the misrepresentation of noxious stimulation. All worrisome mental representations that are incongruent with objective information are seen as leading to maladaptive coping style in real life. In effect, cognitive approach presupposes correspondence with, and adaptation to the real life contingencies as the only criteria for examining the perceptions, beliefs, and mental imagery involved in suffering. As a result, Williams and Keefe (1991) suggest training programs for patients with "mysterious" indeations about pain, in order to acquaint them with the objective nature of their painful condition. However, no question is ever asked regarding the potential

meaning of the ideations that picture pain as "a mysterious phenomenon". Despite the fact that catastrophizing fails to explain the vicissitude of pain experience among psychotics and schizophrenics, cognitive psychology treats the sufferer's anxious representations as dysfunctional castrophic thinking that requires corrective restructuring into rational thinking (Ciccone and Grzesiak, 1984). However, such restructuring has shown to have unstable long-term effects and a high rate of relapse (Turk and Rudy, 1991). Yet, the evidence of relapse has also been met with more restructuring of the same kind. As a result, Johnson and Kanzantzis (2004:208) suggest a more extensive and systematic use of homework to "to enhance treatment outcomes and maintain therapeutic effects beyond the end of treatment."

Skevington (1995:4) states that health psychology "looks not at people and their histories, but at the environment in which they live and at how experience and learning have shapes their behavior as pain sufferers". In other words, the proclaimed goal of health psychology lies in the effort to reduce the subjective ambiguity of suffering to the clarity of concrete environmental parameters and behavioural observations. Behaviourism, as Pérez-Álverz (2004:173) states, "considers that people are inside the world, not that the world is inside people." Likewise, health psychologists make sense of the internal world of the sufferers based on observable interaction between the individual and the environment. In their view, contextualizing and understanding suffering means translating the internal world of the sufferer into behaviours and stimulus-bond responses mediated by cognitive factors that are contingent on antecedent events and consequences. Multidisciplinary pain clinics, in most part, deploy this cognitive-behavioural framework for clinical management of chronic pain (Loeser & Egan, 1989, Long, 1996). In fact,

today's chronic pain rehabilitation is shaped by the way health psychologists talk about pain and suffering and reconstruct its meaning in terms of a cascade of stimulus-bond responses mediated by an imperfect cognitive faculty prone to misrepresentation. As a result, the gruesome images conjured up and the terrifying anxieties stirred deep within the stream of consciousness of those who suffer from prolonged painful conditions are deemed as by-products of misrepresentation. They are germane to health psychology only as far as their restructuring into adaptive, rational thinking may be of concern. Ultimately, the discourse of health psychology reconstructs suffering from a private, meaningful, ambiguous experience to a mere deviation from public norms of functionality and adaptability. This reconstruction filters out and inhibits the alternative notions of pain, suffering, and anxiety as a composite subjective experience with multiplicity of meaning that may involve more than adult, reality-oriented cognition, and observable, environmental contingencies.

1.3. From Phenomenological Studies of Pain and Suffering

Is there, however, any other perspective for clinicians to understand suffering and to relate to sufferers? To this end, one has to look conceptually and theoretically beyond the limits of cognitive-behavioural health psychology. Therefore, it is necessary to ask how other psychological paradigms construe pain and human suffering, and explain the strange imagery and inflated representations of pain. In contrast to the emphasis on objective norms of functionality and adaptability, it is widely acknowledged that pain accompanies subjective feelings of threat and harm to the integrity of the body and the self (Szasz 1957; Cassell, 1998). Although such feelings are more or less true of every

serious illness, chronic pain suffers are reported to experience the protracted and terrifying impact of anxiety, anger, and depression (see review by Robinson and Reily, 1999). Denying the sufferer any sense of control and any prospect of termination, chronic pain seems to engender a deep sense of threat (Bowers, 1968). If acute pain alerts us to imminent harm, chronic pain makes us deeply anxious about our well-being and prospect. Not infrequently, the ordinary concern about unusual sensations turns into a "morbid health preoccupation" (Salkovskis and Warwick, 1986). For those pain patients whose distress leads to the state of suffering, these morbid preoccupations are coloured with a sense of threat to the integrity of the body, and feelings of dread over the annihilation of the self.

As the fear of annihilation, phenomenology and psychoanalysis consider anxiety as a profoundly meaningful, emotional state that can serve as the key to the understanding of human experience (Freud, 1926; Heidegger, 1962, 1985). Although they differ in their definitions and outlook, they unequivocally proclaim anxiety as the emotion, most reflective of the ordeal of being and becoming a person, particularly in its modern sense. They see beneath our most mundane actions, the unique human awareness of death as an ever-present possibility, and as a source of profound anxiety. In their view, "I will die," rather than "one will die," (Heidegger: 1985:316-7) becomes the inevitable possibility that we anxiously strive to understand, to overcome, to control, to transcend, and to deflect (Kierkegaard 1957; Jaspers, 1971).

Under the shadow of this possibility, as Heidegger (1962, 1985) maintains, life becomes Being-toward-death (*Sein-zum-Tode*). He argues that death makes us acutely aware of our finitude, and anxious about the temporality of being. He explains anxiety as

the mood (*Stimmung*) that attunes us to what is generally taken for granted as *Dasein* or as being-there. In this sense, Heidegger calls anxiety the ground-mood that discloses the ever-present possibility or the indefiniteness (*Unbestimmtheit*) of death as the ground of being. In his view, living resolutely in the face of death allows one to see how illusively the public (*Das Man*) and shared views disburden and shelter us from death. In this sense, those anguished can no longer accept the way of the crowd, as they feel ill-at-ease (*unheimlich*) with the commonly shared, all-to-familiar sense of being. As anxiety tunes the person to the possibilities of *Dasein*, "the meanings and truths making up the fabric of the world become alien to the individual" (Hoffman, 1993:203). The anxious individual can no longer trust the publicly avowed truths, as anxiety of death shows "the fabric of the world" to be illusory. In this manner, existentialism promulgates anxiety as the key to the authentic understanding of human condition. They recognize anxiety as "the disturbing and 'uncanny' mood, which summons a person to reflect on his individual existence and its 'possibilities'." (Cooper, 1990:128). From phenomenological-existential point of view, the anxiety of death associated with pain cannot be reduced to maladaptive misrepresentations and embellishments, or misappraisal of noxious stimuli. To the contrary, as a lived experience largely invisible to others, pain is observed to set a rupture between everyday world of shared experiences and the liveworld of the suffering patient. When attending to the world and making sense of persistent agony becomes unworkable, terrifying anxiety necessitate new horizons of meaning that lie beyond the limit of shared beliefs and dominant discourse.

Familiar to every personal history, are experiences of conflict, rupture, and pain that have caused intense and conspicuous anxiety. Yet, depending on their resolution and

significance, such experiences are later recalled to mind as challenges, or banished from consciousness as unwanted experiences. In effect, anxiety paradoxically involves both the harrowing and the inspiring experiences that shape our sense of identity. As every life resembles a journey between birth and death, what lies in between is in many ways fused with, and characterized by anxiety which equally accompanies exhilarating and terrifying anticipations. Similarly, living is not devoid of pain, even for the most gratifying examples of life. In fact, as pain is emblematic of injury, harm, loss, and hurt, its presence occasions a sense of threat that is often the hallmark of every anxiety situation. The kinship of anxiety and pain that often becomes palpable in suffering may be said to arise from a deep existential parallel between the two that we undeniably live, from birth to death.

Undoubtedly, an intrinsic quality of being alive is irritability or the ability to feel pain. Without such ability, thriving becomes impossible, as responding to environment becomes seriously impaired (Melzack & Wall, 1982:15-19). Yet, intractable pain stirs in us consuming anxieties that can overshadow our entire existence (Bakan 1968; Scarry 1985). Given the importance of pain for our lives, anxieties associated with an aching body cannot be simply explained and dealt with as experiences that are extraneous to the context of being, and to the process of becoming an individual. How such anxieties involve the sufferer's greater sense of being is an important and inexhaustible question that must be explored from more than one point of view. Despite their obvious differences, psychoanalysis and phenomenology can provide a valuable theoretical framework for understanding the anxieties associated with pain. In fact, their

introspective and reflective approach to human experience seems necessary for a meaningful grasp of human suffering.

Based on narrative of suffering and illness, Cassell (1982) and Bakan (1968) argue that the dread of impending annihilation defines suffering not only as a distinct human experience, but also as one requiring its own mode of understanding. In suffering, the patient is not only ill with pain, but feels the overpowering threat of being destroyed and helplessly reacts to such violent threat. In situations of serious illness or chronic pain, such preoccupations become "severe distress" or what Cassell (1982) calls suffering. Although generally defined as negative emotional reactions to pain, suffering rises from a particular kind of distress.

> "Suffering occurs when an impending destruction is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner...although suffering often occurs in presence of acute pain...or other bodily symptoms, suffering extends beyond the physical. Most generally, suffering can be defined as the state of severe distress associated with events that threaten the intactness of the person." (640)

In effect, although the feelings of threat can be induced by unusual physical sensations, its experience can expand "beyond the physical" and trigger deeper threats at the basic level of existence.

In a more recent work, Cassell (1999:531) states, "suffering is the affliction of the person and not the body." As such, suffering is a personal experience, which involves how the afflicted person perceives the severity, the effect and the meaning of pain. Focusing on this personal dimension, Cassell reminds clinicians that disease and the body are more than just "directly observable, objectively existing, and purely material state of affairs" (533). He emphasizes the living body of the person whose current affairs have to

be meaningfully woven into the fabric of past experiences. In Cassell's view, pain and affliction constitute an impending destruction, when they tear the person's fabric of life and become senseless. However, the prevalence of such deep threats among pain patients seems contrary to the fact that most instances of chronic pain are not in-themselves fatal or life-threatening, even though the suffers lose control over their lives. Therefore, the nature of psychological mechanisms that activates such deep fears remains obscure. As a possible explanation, Cassell goes as far as recognizing the subjective nature of suffering, and advocates for a "non-discursive" and "intuitive" thinking that does not rely on propositional, verbal reasoning to understand suffering. He finds such intuitive thinking more appropriate for diagnosing and treating suffering for those who work closely with the afflicted.

Questions about the nature of pain-related suffering, and the ways of talking and thinking about it, have prompted studies to focus on the existential or lived experience of chronic pain. In his phenomenological reflection on illness, Schutz (1971:218-22) recognizes that being ill engenders two types of ruptures in the world of the sufferer. First, it imposes on patients a sentient condition that is not shared or felt by others. If common sense provides the security of living in an "everyday world" shared and cohabited by others, Schutz maintains that illness ruptures the sentient commonality of experience between the self and the other. Suddenly, one feels a pain that no one else can experience and lives in a discomfort that no one can share. For patients, the felt symptom is a solitary experience, isolated from the everyday flow of the public world, and partitioned from the immediate experience of others (Sebeok, 2001:66-70). Although those around them definitely react to their ordeal, only patients can experience the

sentient quality of the pain, and its debilitating effects. Second, Schutz points out that in our everyday world, the self acts as an agent capable of authoring actions and assuming control. However, this rather confident sense of agency is possible as long as the self remains comfortably embodied. Without the able body, the self loses its self-assuring sense of embodiment, and eventually the sense of agency. According to Schutz, illness breaches the embodied self and undermines the unison between the body and self. Hence, the self feels being acted upon by an aching body, as the preoccupation with body grows to a disproportionate level. In reaction, Schutz maintains that the self assumes distance from the body, and begins to feel un-whole, ruptured, or "divided."

As chronic pain puts an end to the hope of recovery, the ruptures in the self-other and in the self-body engender a terrifying sense of threat. Melzack and Wall (1982:54) remind us, when pain is acute, it "encompasses the unpleasantness of past injury and the hope of future recovery". Since acute pain is responsive to treatment, the prospect of healing can reassure the sufferer of rather uncomplicated recovery. Certain about the future, the patient can tolerate the ruptured world of illness to let healing take place. However, in chronic pain, the prospect of permanent agony overshadows the present and the future. Melzack and Wall candidly state, "The pain becomes evil—it is intolerable and serves no useful function" (55). The authors' observation precisely reflects the feelings of patients who see pain as wickedly pointless or as senselessly malicious. Ethnographic case studies have elaborated on this experience of malevolence and evil. Reporting the introspections of a chronic pain patient, Byron Good (1992:41-42) demonstrates how pain shatters the experience of time. He reports that the patient feels trapped in moment. Time, as known to be ordered across past, present, and future,

collapses into intervals of pain. The flow of moments is consumed by intractable agony, punctuated by moments of relative calm that is bereft of joy or hope. In a vivid manner, Byron Good demonstrates how the patient's "inner time" slows to halt, while time, as experienced by the rest of world, "speeds by and it is lost" (1992:42). For the sufferer, chronic pain is an agony without a discrete course or an end in sight.

Not infrequently, the diagnosis of chronic pain does not foster any prospect of comfort, or any sense of reassurance for the patients. Good (1992:39) maintains: "as locus of pain, the body takes on agency over and against the self". Feeling acted upon, the self is beset by the aching body. No longer in control, the person feels separated from, and controlled by the body in pain. The self-body unity caves in, and the pain becomes a menace to the overall integrity of the self. Using the discourse of the patient, Byron Good reports this sense of threat.

> "In this context, Brian's repeated expressions of concern about "losing control" have special meaning. The word "control" appears thirteen times in the manuscript at eight points in the interview. Twice he expresses concern about his ability to control pain or that monster banging about in his body. Once he describes himself as a "victim of life rather than someone who has some control over it." Once he describes his ability to control time, to regain what has been lost. And four times he discusses the terror that he simply may lose control....This theme expresses a profound fear of dissolution of the self and the experienced life world. The assumption that the world possesses stability is replaced by a sense of arbitrariness, a feeling that will is required that control is necessary to maintain the self and the world. Together with the attacks of panic and anxiety, the pain floods the consciousness, dominates inner time, and breaks down the ordered relationship between the conscious self and the world to which it relates. The pervasiveness of the body expands its boundary, shuts out attention, and threatens dissolution....Thus, the world of chronic pain, the separate world inhabited by its sufferer, is at the same time a world unmade." (42)

Good vividly describes how the patient's world becomes engulfed by "the fear of dissolution of the self". As the threat gains intensity and thrust, the sufferer struggles to remain psychologically together. Yet, when pain "floods the consciousness," the sense of imminent disintegration and annihilation takes over. The fear of "dissolution of the self" overcomes the patient whose lifeworld is shattered by the pain. The lived experience of the patient appears as one ruptured by agony, fraught with fears, and beset by helplessness.

As a result, chronic pain sufferers describe their experience of impending destruction as that of being violently attacked, being helplessly diminished, or being aggressively invaded. In another ethnographic case study, Brodwin (1992:81) reports a chronic pain patient who describes her terrifying feelings of suffocation by pain. "It starts off like being short of breath, then gasping for the air," says the patient, "it's like having an elastic around my neck, preventing me from breathing". For her, suffering from an asphyxiating pain seems terribly real and vividly dreadful. She literally feels being strangled by the elastic-like pain that squeezes life out of her. The same patient portrays her pain as "agonizing, tearing, like my stomach is being pulled apart". Her account vividly portrays the sheer aggression of her pain. It is this violent threat that makes her feel shaken and panicked. In fact, she states, "I panicked, I felt really odd...because I had this incredible feeling of anxiety...I was very tense, my stomach was in knots". This excessive anxiety is commensurate to the violent threat felt by the patient. In another case study, Garro (1992:119) describes a chronic pain patient whose intense, trance-like anxiety "portends to possible 'psychotic episodes,' 'personality disorganization.'" In fact, derealization and depersonalization can accompany intense

episodes of pain. In pain, Scary (1985:53) states, "one feels acted upon, annihilated by inside and outside alike". As a result of such extreme anxieties, Garro reports that the patient continues to feel ravaged, long after a period of intense pain has subsided. The patient clearly states, "even though my sense of my pain diminished, my sense of myself was also so diminished that it hadn't achieved anything" (122). In effect, the short-lived periods of relief only allows the patient to become cognizant of the damage to the self. Byron Good (1992:39) reports his patient feeling under attack from "a monster banging about in his body". It is not uncommon for patients to describe pain as a terrifying monster, or as a vicious creature that is violently attacking and ravaging them, from within. Explaining this reaction, Scarry (1985:52) points out that although pain "occurs within oneself, it is at once identified as 'not oneself,' 'not me,' as something so alien that it must right now be gotten rid of." Experiencing pain as "not-me" makes the patients feel aggravated and harassed by an ego-alien entity, or from a monstrous "non-self" within them. Such excessive and tangible anxieties of annihilation drive the patient into total helplessness and despair. Delvecchio Good (1992:59) quotes a patient who says, "I cannot envision a future that has anything worth looking forward to." A sense of helplessness overshadows the patient's prospect, as intractable pain violently takes over. The devastating impact of suffering erodes the self, and dims every glimmer of hope for the sufferer.

In many ways, what these case reports aptly describe cannot be simply reduced to an outlandish series of misappraisals of suffering. From phenomenological point of view, what becomes important is how this existential parallel of pain and anguish is lived in the experience and consciousness of the sufferer. Hence any explanation of suffering must in

one way or another rise from the sufferer's lived and articulated experience rather than from the disinterested gaze of an observer. In other words, any explanation of suffering must in one way or another rise from the sufferer's lived (*Erlebnis*) and reflectively articulated experience (*Erfahrung*), rather than from the disinterested gaze of an observer. Scarry's (1985) valuable historical and literary analysis of lived and reflectively articulated suffering makes an important revelation. She argues that uncontrollable, intense pain unmakes the world of the sufferers, as it shatters the language and obliterates the world beyond the body in pain:

> "It is the intense pain that destroys a person's self and world, a destruction experienced spatially as either the contraction of the universe down to the immediate vicinity of the body or as the body swelling to fill the entire universe. Intense pain is also language-destroying: as the content of one's world disintegrates, so the content of one's language disintegrates; as the self disintegrates, so that which would express and project the self is robbed of its source and its subject." (35)

The disintegration of the world, language, and self closely echoes what chronic pain patients often recognize as the dissolution of self. This unmaking and shattering can be regarded as the core of the sufferer's vulnerability, shrouded in the mysterious haze of indeterminacy that makes pain a source of both fear and fascination. It is at this juncture that the prevailing public discourse (*das Man*) seeks to subdue pain and to put suffering to the service of normative discourse, as it is made part of the shared mundane reality.

Far from being a personal misappraisal, Scarry reveals how historically and culturally this vulnerability and indeterminacy is recognized and remarkably used in social domination. She argues that, although pain is lived as a world-shattering experience, it can be also a reality-producing opportunity. As a lived experience (*Erlebnis*), pain can shatter the world of the sufferer by reducing it to ineffable agony and

anguish. On the other hand, when human creativity utters the unutterable, pain as a reflectively articulated experience (*Erfahrung*) can undercut the normative construction of the mundane reality. In contrast, the failure on the part of the society to render a first-person account of the pain or to reflect back on the first-person body that lives the pain leads to "debased forms of power".

> "The failure to express pain--whether the failure to objectify its attributes or instead the failure, once those attributes are objectified, to refer them to their original site in the human body--will always work to allow its appropriation and conflation with debased forms of power; conversely, the successful expression of pain will always work to expose and make impossible that appropriation and conflation." (14)

The potential for undercutting the normative and interposing a new perspective is one reason why pain and suffering are often the object of a larger disciplinary and institutional "effort that seeks to locate, identify, and act upon it" (Frank, 2001:355).

In effect, how pain is seen from the standpoint of the normative discourse can in many ways be contrasted with how it is lived inchoately or reflectively articulated in a manner that exceeds discursive norms (Holmes and Chambers, 2005; Wandless, 2005). Reflecting on the normative discourse of pain, Morris (1985) situates our understanding of pain in a larger historical context to reveal how distinctly pain becomes nothing other than a sign of disease in contemporary society. As a sign of physiological anomaly, Morris argues, pain becomes devoid of meaning and merely reducible to nosographic categories. In his view, it is this meaninglessness that has created the "invisible epidemic" of painfulness or the larger than life problem of chronic pain in the contemporary society where search for illusive cure has replaced the search for meaning.

However, despite the critique of pain as the sign physiological anomaly, what Morris, Scarry, and many others may be missing is how suffering as an integral part of

pain, as well as of any prolonged and serious illness has been reduced to a sign of cognitive-behavioural anomaly. Hence, abandoning the disease model for a biopsychosocial approach has been perhaps an incomplete remedy, since the anguish and anxieties associated with pain are still seen as anything but meaningful. In fact, suffering is yet to be seen as what makes a person feel other to oneself. As a scholar surviving chronic illness, Arthur Frank (2001) candidly describes this othering quality of suffering and eruditely voices his recalcitrant disconnection against the normative dictum that commands him to speak and instruct him to reconnect. As his reflection treads between ineffability and uttering, he relates his "contrasting illness experience" that marks his struggle with chronic illness in the absence of pain. His long passages oscillate between impassionate explanation and anxious plea, allowing no ellipsis:

> "My contrasting illness experiences convinced me there are dichotomies, but these are within the category of suffering. These dichotomies began in my feeling of being disconnected from my life as I had been living it and from the lives of those around me. Suddenly, they (including my recently healthy self) were standing on one shore, and I was in a small skiff being carried toward an opposite shore. I could still call to them and they answered, but the distance separating us was growing rapidly. In contemporary academic usage, I was becoming other to the person I had been and to those who knew that person. The feeling of becoming other has nothing to do with social support—I had generous support. It was precisely my high quality of support, along with my absence of pain or physical distress, that placed my suffering in such stark relief. My sense of being set apart had nothing to do with any material resource I could imagine having had.
>
> Let me tell a story that illustrates this sense of disconnection and begins to suggest why suffering is so difficult to define and to research. As part of the preoperative routine before my biopsy surgery, I was interviewed by a nurse who asked me, at the end of her inventory of required questions, how my wife and I were coping with my possible cancer. I told her that we had a new baby, my wife was still recovering from a difficult pregnancy and birth, and we were doing very badly indeed. Her reply confirmed my worst suspicions about medical pretenses to caring and also taught me much about suffering. "You have to talk to each other," she admonished as she closed her clipboard and left. End of

> interview; no follow-up was offered. Of course she was right; we certainly needed to talk to each other. But our suffering was why we could not talk. Our suffering was what we could not say. We feared saying what we felt, and we feared our words could never convey what we felt but would reduce those feelings to complaints and specific concerns. "Don't you know," I wanted to shout to that nurse as she walked away, "it's what your patients can't say."
>
> Suffering involves experiencing yourself on the other side of life as it should be, and no thing, no material resource, can bridge that separation. Suffering is what lies beyond such help. Suffering is the unspeakable, as opposed to what can be spoken; it is what remains concealed, impossible to reveal; it remains in darkness, eluding illumination; and it is dread, beyond what is tangible even if hurtful. Suffering is loss, present or anticipated, and loss is another instance of no thing, an absence. We suffer the absence of what was missed and now is no longer recoverable and the absence of what we fear will never be. At the core of suffering is the sense that something is irreparably wrong with our lives, and wrong is the negation of what could have been right. Suffering resists definition because it is the reality of what is not. Anyone who suffers knows the reality of suffering, but this reality is what you cannot "come to grips with." To suffer is to lose your grip. Suffering is expressed in myth as the wound that does not kill but cannot be healed. (254-55)

Frank's helpless appeal is met by a ritual of repudiation, congruent with the current behavioural model that stipulates, "Discussions about pain were not allowed between nurses and patients or with physicians except during specific times at rounds or in therapy sessions." (Long, 1996:8) As a scholar of medicine and literature, Frank is, of course, no naive patient. Hence, being disclaimed makes him more determined to reclaim his undeniable ordeal: ""Don't you know…it's what your patients can't say." Although pain patients in general may not be able to make such graceful defense of their suffering, what they feel cannot be presumed to be in any way less than what Frank reflective articulates. His eloquent portrayal of suffering as "the reality of what is not" alludes to his fateful confrontation with non-being through loss as "another instance of no thing, an absence."

Franks concept of "no thing" echoes the existential concept of non-being or nothingness. In his broad review of literature, the Existentialist psychologist, Rollo May

(1977:363-64) defines anxiety as "our human awareness of the fact that each of us is a *being confronted with nonbeing*". In his account, he offers the definition of nonbeing as "that which would destroy being, such as death, severe illness, interpersonal hostility, too sudden change which destroys our psychological rootedness". In this sense, anxiety is understood as our experience of *non-being* that involves the threat of destruction and death. Although May refers to anxiety as "the primal and original reaction" to threat and sees fear as "a later development," he does not reduce their difference to simple maturation in the perception and evaluation of danger. Rather, he emphasizes how anxiety involves a quality of danger that makes it entirely distinct from fear.

> "We speak of anxiety as basic not only in the sense that it is the general, original response to threat, but also because it is a response to threat on a basic level of the personality. It is a response to a threat to the core or essence of the personality rather than peripheral danger. Fears are the responses to threats before they get to the basic level. (225)

For those who confront such core threats, the *being* faces its antithesis in the *non-being*. Hence, anxiety becomes the experience of the ultimate otherness that stands opposite of being and threatens to annihilate the self. In other words, it is the radical dread of otherness that is experienced, when we confront non-being and death as a personal possibility. This is how Frank describes the essence of suffering as "experiencing yourself on the other side of life."

May adds an important insight to his discussion of anxiety, when he observes "that people utilize disease in the same way older generations used evil—as an object on which to project their hated experiences in order to avoid having to take responsibility for them" (86). This revelation admonishes to how public discourse (*das Man*) has appropriated disease to the service of self-denial and self-repudiation. But, how such

appropriation would become possible? Regrettably, this important insight remains mute in May's discussion of anxiety and illness, as he provides no further elaboration on this precarious, contemporary, social disposition. In other words, he stops short of unravelling the significance of such projection and self-repudiation, which would not only deepened investigation of pain, but also shed light on the relation of pain and imagination.

The phenomenological analysis of pain and imagination unravels the underside of May's insight. As Scarry contends, intense pain destroys the world, by reducing the universe to the immediate aching body. In contrast, she points out that imagination constructs an unreal world made of unreal objects. In this sense, if pain annihilates the sentient experience of the real world objects, imagination (fantasy) creates the experience of a world made of unreal objects (163-164). However, Scarry's phenomenology of pain and imagination misses the subtle dynamics between the two. In *The Wall* (1957), Sartre's hero, Ibietta acutely experiences this fantastic transfiguration of body in pain. Reflecting on Ibietta's soliloquy, Oliver (2003) demonstrates how the obliteration of the real transfiguers the body in pain into an unreal object of fantasy:

> "But Scarry understands this obliteration in terms of unmaking the real instead of entering an unreal state. In Sartre's story however the body not only unmakes, but "makes" us experience an unreal state. The body creates an enormous vermin, tying us to itself, swallowing the entire world. Ibietta's body gradually invades his whole existence. Sartre meticulously scrutinises a subtle progression of this invasion. On the one hand Ibietta experienced mere bodily suffering. His body was trembling and sweating and stinging with many pains. But the more the night progressed, the more this physical suffering gave way to indifference (Sartre, 1957, 229ff). Ibietta gradually reported pains in his neck and head, which he could not call "real pains", but something even worse (Sartre, 1957, p. 231). His suffering body was progressively giving way to pain, which made all sensory experience unreal. He described this state as a horrible calm: "my body, I saw with its eyes, I heard with its ears, but it

> was no longer me; it sweated and trembled by itself and I didn't recognise it anymore. I had to touch it and look at it to find out what was happening, as if it were the body of somebody else" (p. 235).
>
> Ibietta's body became the focal centre of his attention. His body was his entire *object*. But in a peculiar way this object remained a state. He was feeling his body, but *as* an object. Unlike Scarry's Ibietta, Sartre's Ibietta was indeed in a state of pain, which became its imaginative object. Pain made his body a figure of fantasy, an imaginative object, a vermin, which he was tied to... Ibietta was experiencing an unreal state, he was imagining a state that was his utmost reality. Pain made him experience a sensory unreal state." (42)

Obliterating the sentient experience (*Empfindung*) of the real, pain occasions the transmogrification of the "body in pain" into an unreality laced with rampant fantasy. However, how such imaginary construction becomes a receptacle for the projection of hated experience is a question that requires a deeper exploration into unconscious phantasy.

Although this conclusion, if judged by the evidence of the argument, may seem to be largely based on literary examples, it has been corroborated by the empirical research which indicates the significant contribution of subjective and personal factors to suffering and pain behaviour. In a study designed to investigate the influence of personality factors (neuroticism and extraversion) on pain, Wade, Dougherty, Hart, Rafii, and Price (1992) analysed four stages of sufferers' experience: 1) nociceptive-sensory, 2) perception of unpleasantness, 3) pain suffering, and 4) pain behaviour. Using a canonical correlation analysis, the authors showed that personality factors contribute significantly to the stages 3 and 4, while their contribution is small to the first two stages of pain. Referring to the results of this important study, Gendrault (2001:35) argues, "It is at this level that the vacuum created by pain experience is filled not so much by stereotypical data, but instead, by private, personal, and subjective data."

1.4. Psychoanalytic View of Pain, Anxiety, and Suffering

Clinicians often confront a serious quandary: either they would make sense of the terrifying images of body in pain, or they repudiate it in the name of functional and adaptive norms. As intense and persistent pain can turn the experience of the aching body into an imaginative and terrifying unreality, what meaning this construction can assume is a question that a serious investigation of pain cannot easily ignore. Ignoring this question would foreclose the meaning of distressful representations reported by the sufferers, and reduce them to errors of cognition or misrepresentations. On the other hand, if investigation focuses on the range of conscious significance, it may never result in making sense of the meaningful irrationality of such constructions both at the individual and collective levels. Furthermore, restricting the investigation to the conscious meaning may complicate any explanation of pain experience among sufferers with thought disorders, psychotic disorders, and dissociative orders, where the self, language, and experience are not coming together, seamlessly. These concerns make it necessary to look beyond conscious range of significations and to consider the unconscious side of imagination.

As aforementioned, for many sufferers, the experience of the body engenders terrifying feelings of "dissolution of the self" and "obliteration of the real". As the threat of non-being becomes the main emotional preoccupation for many chronic pain sufferers, pain becomes the only reality and indeed a bizarre and terrifying one. Researchers and clinicians testify that "pain has almost universally been described as 'it'" (White and Sweet, 1955:108; Cassell, 1976) or as an "alien presence" (Zaner, 1981:54-55). Such

thing-like, alien entity is experienced as an estranged object that acts upon the self (Schutz, 1971; Good, 1992), and deprives the self from the sense of ease and autonomy. In effect, when pain portends to anxiety of annihilation, it triggers extreme revulsion and disgust that is at times extended to the entire body. Children refer to pain as the "The most disgusting ever." A 5-year-old girl was reported simply saying, "Oh, somehow you feel sort of anxious. Like, you don't know what to do." (Kortesluoma and Nikkonen, 2006) In fact, May acknowledges that "anxiety is the psychic component of every disease" (91). For the most part, this can be attributed to the fact that the perception of pain or affliction commonly alerts us to injury and harm that are characteristic of disease, disorder, and ultimately death. At some point during its course, every disease can become anxiety-inducing, as it subjects the afflicted to discomfort that makes ordinary living impossible. Bodily aches as the most common symptom of disease impact our sense of being and make us shrink away from life. "Pain", Bakan bluntly states, "is a harbinger of death beyond all options associated with its management" (78). As one of the first signs and a general symptom of morbidity, pain portends to situations of loss, rupture, hurt, damage, injury and eventually death. Bakan acknowledges this moribund portent, in spite of the prevailing practice in pain management to focus on non-threatening, controllable experience suffering.

In his work on suffering and disease, Bakan (1968:65-67) draws on clinical and historical evidence to explain the dread of annihilation experienced by pain patients. Exploring the phenomenology of experience, he describes how pain perception recedes from the skin, and sinks deep into the body. As oppose to other senses that extend beyond the skin to grasp distal objects, pain is meant to reflect primarily the status of the

hurting body. "The distality of pain is less than zero." (66) Despite its inner-receding quality, the ego mostly treats pain and its bodily locus as a thing-like entity distinct or split from the self. To explain this reaction, Bakan turns to psychoanalysis and depth psychology. He argues that in the early stage of ego development, pain is experienced as the concrete threat of annihilation. He refers to an infantile complex, in which pain perception is hardly differentiated from with the concrete treat of death. He explains how the infantile ego experiences pain as at once being hurt and killed.

> "In the early stage of ego development, there is a rather primitive pain-annihilation complex in which pain and the sense of the possibility of annihilation are not yet separated. We may, in our own more mature and sophisticated stage of ego development, analyze the primitive pain experience into two components of pain per se and annihilation. But primitively the ego experiences pain as an undifferentiated "I-am-being-hurt-and killed." (80)

In his reflection on pain and annihilation, Bakan acknowledges the "primitive pain experience" as the germinating ground of their entanglement or complex. He defines primitive as "the early stage of ego development" which in most part involves the infantile and pre-verbal period. In Bakan's view, the ego retains a latent sense of "I-am-being-hurt-and-killed," despite the manifest adult capabilities in differentiating pain from annihilation and in objectivating fear. Although his overall discussion is not firmly grounded in psychoanalytic theories of infantile development, he clearly recognizes the importance of "pain-annihilation complex" as the enduring psychic remnant of the ego's primitive legacy.

While May (224-226) attributes the fear of destruction to the inability of the person to objectivate intense danger, Bakan believes such perception involves the ego's infantile development. During this period, pain and annihilation are experienced as a

single phantasmatic complex. Thus, the threat of annihilation and the feelings of impending destruction rise from the primitive history of pain that rests in antechambers of the unconscious, within the core of adult psyche. In Bakan's view, although "I-am-being-hurt-and-killed" constitutes the infantile history of pain that the ego has been outgrown, it has never been left behind or totally abandoned. It remains only latent, ready to be reawakened by actual circumstances. Segal explains this universal quality of the adult ego, which is as much an aspect of "normal" development as it is of the pathogenic one:

> "No experience in human development is ever cast aside or obliterated; we must remember that in the most normal individual there will be some situations which will stir up the earliest anxiety and bring into operation the earliest mechanism of defence." (35)

Although the psychoanalytic view of anxiety recognizes the importance of real dangers and noxious situations, it acknowledges that anxiety is as much caused by real sources of danger as it is by intrapsychic and primitive threats. Hence, the patient confronts objective threats involving noxious or painful stimulation in here-and-now, with a primitive history. In this manner, every pain-associated anxiety bears to greater or to lesser degree, traces of infantile anxiety of a time long-gone but not forsaken. What is however of particular significance is how this view can explain some of the distinct qualities of pain experience that keeps puzzling the students of pain. Based on what Bakan demonstrates, to take adequate account of the psychic components of pain experience requires at least two things. In the first place, a deeper discussion of the theory of infantile development is necessary to explain the intrapsychic importance of pain-annihilation complex. In the second place, the discussion must use the theory of infantile development to shed light on the distinct and primitive qualities of pain experience as revealed by phenomenological research.

Due to the sheer diversity in theory and practice of depth psychology, it is necessary to review how psychoanalysis has thus far understood and defined pain, before advancing further into this area. As the present study concerns itself with the psychology of pain and anxiety, it is important to deliberate carefully upon the greater analytic inquiry into the psychology of the bodily symptoms. The psychoanalytic investigation of pain as a symptom of intrapsychic conflict has a well evolved history that expands over two continents and spans beyond two centuries. Ever since Freud, psychoanalysis has tried to show how unconscious conflicts are relevant to pathogenesis of physical symptoms. For the most part, the analytic work has challenged us to see how body and pain fundamentally can involve intrapsychic symbolism. Insofar as history testifies, psychoanalysis began with the study of unexplainable physical symptoms and mysterious pain. Freud and Breuer (1895) recognized hysterical complaints as symbolic representations of the split off and repressed memories of traumatic and emotionally intolerable experiences of their patients. Their views revealed the importance of the symbolic dimension of physical symptoms, which Freud (1910) deciphered by analyzing their unconscious meanings. His recognition of the repressed emotional conflicts was indeed a break from his predecessor Pierre Janet whose well publicized view at the time held sway over the study of hysteria.

In his theory of mental illness, Janet (1886, 1888, 1889) argued that elaborate symptoms, found in hysteria, were caused by a psychic dissolution or loosening (*la désagrégation psychique*) that diminished self-control, reduced the conscious processing of stimulations, and made the patient highly suggestible. He observed that where consciousness narrowed (*rétrécissement*), the self lost its capability for synthesizing

somatic sensations and stimulations into personal perceptions. To this narrowing, he referred as psychological dissociation (Janet, 1887). In his view, the idea of sub-conscious did not involve repression and unconscious conflicts; it largely meant a registry for stimulations that by intensity fell beyond or below the threshold of consciousness. Janet stressed the synthesizing function of the self, and argued that the narrowing (*rétrécissement*) of the self meant letting this integrating function loose (*désagrégation*) beyond the realm of conscious, personal perception. In his view, a degenerative predisposition for loosening caused the doubling (*dédoublement*) of the synthesizing faculty across the divide between conscious and sub-conscious. By the means of this doubling, complex set of activities evolved at the sub-conscious level, which resulted in the formation of elaborate symptoms and fixed ideas beyond the patient's grasp and control (Janet, 1893). Janet (1891) viewed over-stimulation caused by trauma as an exacerbating factor that could set off the degenerative predisposition of the patient. To remedy hysteria, Janet proposed the use of hypnosis for making corrective suggestions, along with involvement in craft making and simple activities.

In contrast to Janet, what Freud (1905a) found in his case studies could not be attributed simply to a congenital predisposition for psychic dissolution. He encountered a strong resistance on the part of the patients to recall memories that involved the pathogenesis of the symptoms. He recognized that these memories were resisted for their disturbing lack of congruence with the self. Freud (1910) acknowledged the pathogenic nature of psychic conflicts caused by the intolerable memories of a sheering trauma or a forbidden impulsive desire. He managed to show how these memories induced deep anxieties, and how their resurfacing involved intense pain. To avoid this agony and to

ward off the anxiety-inducing materials, these memories were banished form consciousness through the mechanism of repression (*Verdrängung*). Freud's analytic work showed that forgotten memories were buried deep in the unconscious only to become manifest through the formation of the symptoms. Within the intricate hysterical symptoms of his patients, he discovered the symbolic, albeit distorted and compromised, manifestations of the underlying pathogenic memories. In effect, Freud's interpretation unravelled the repressed meaning of seemingly meaningless and exaggerated hysterical symptoms. His analytic approach conferred the status of causality to the repressed memories and conflicts of the patient, and made the cause of the symptom synonymous with its unconscious meaning. In his analytic technique, he stressed the symbolic latent content, and highlighted by the same token the need for understanding body symbolism (Freud, 1900 and 1905b; Synnott, 1993:24-27).

The case of Elisabeth von R. was Freud's (1895) earliest study of the analytic treatment of pain as the only symptom (chronic pain in lower limbs) and the case of Emmy von N. was his earliest study of treatment of pain as a mixed symptom (pain in lower limbs). However, Freud's research on pain began much before his studies on hysteria. As a neurologist, he took a keen interest in pain and spoke about its mystery and its importance across the span of his long writing career, as the founder of psychoanalysis. By 1895, Freud abandoned hypnosis as a mainstay of his therapeutic technique, and committed himself to development of psychoanalysis. In *Project for a Scientific Psychology*, Freud (1895:306) offers his most rudimentary definition of pain based on quantity of excitation, and attributes its aetiology to the unmanageable intensity of stimulation. In a rather mechanical manner, he argues that sensory stimulation beyond

certain level can become noxious. However, his early analytic work with hysteria (Freud, 1895) generated more than a theory of repression and talking cure. In effect, Freud realized in an unexpected manner the limits of his scientific training as a neurologist and the inadequacy of a reductive mechanical approach:

> "I have not always been a psychotherapist but was trained, like other neuropathologists, to use local diagnosis and electro-prognosis, and I myself still find it strange that the case histories that I write read like novellas and lack, so to speak, the serious stamp of science. I have to console myself with the thought that the nature of the object rather than my own preference is clearly responsible for this; local diagnosis and electrical reaction are simply not effective in the study of hysteria, whereas an in-depth portrayal of the working of the inner life, such as one expects to be given by novelists and poets, together with the application of a few psychological formulas, does allow me to gain a kind of insight into the course of hysteria. Case histories such as these demand to be judged as psychiatric, but they have one advantage over the latter, namely the intimate relationship between the story of the patient's suffering and the symptoms of their illness..." (The case of Elizabeth von R., 165)

Freud's candid and reflective account of his deviation from scientific method intimates a paradoxical sense of apprehension and confidence about the growing similarity between his case studies and literary texts. However, as his resolute search for understanding leads him away from the scientific canon, he discovers a new appreciation for the personal lives of his patients and their. In their "inner world," he finds a source of valuable insight into illness, neglected by procedures of science. This important methodological transformation as one of the major achievements of *Studies in Hysteria* is often overlooked by commentators. In this sense, these early caseworks awakened Freud to more than just repression, unconscious symbolism, and talking cure. Through them, Freud essentially developed a deep and lasting appreciation for the personal and subjective experience of pain, illness, and suffering, an achievement that was at odds with the intellectual habits of his time and is still dismissed as anecdotal, more than 100 years

after its publication. However without this turn to subjectivity, it is doubtful that what eventually followed could have at all been possible.

After hysteria, Freud's discussion of pain continued, albeit after a pause, and became an important part of his theory of instinct and instinctual gratification. In the original text, he often made used of two German terms to refer to the concept of pain, *Unlust* and *Schmertz*. Gendrault (2001:36) explains the difference between these two terms:

> "For instance, the German words *Unlust*, or unpleasure, and *Schmertz*, or pain, have both been translated from German texrs to English as "pain." *Unlust* or unpleasure which can be referred to as suffering, belongs mostly to the ethical and psychological realm. *Schmertz*, on the other hand, refers to pain arising from soma, even though it rejoins dialectically the domain of mental processing and thereby the construct of *Unlust*."

Freuds shift from *Schmertz* to *Unlust* marked a change from neurology to psychology and mental phenomenon. This change that was evident from the study of hysteria only gathered momentum as Freud further developed the psychoanalytic theory and technique. However, the shift was never eliminative; he never precluded one side for the other. It was rather an illuminative shift whereby pain (Schmertz) and unpleasure (Unlust) finally become two ends of a continuum. It is therefore hard to say where one stops and the other one begins. Yet, as we will see Freud attempts to show that when one suffices to induce the entire continuum of suffering.

Freud's view of pain follows a long and winding path of development. After hysteria, he revisits the concept of pain, in On *Narcissism: An Introduction* (Freud, 1914), wherein he describes how pain can cause the sufferer to withdraw from the external world, and from all that is not directly germane to the suffering. He explains this withdrawal as an instance of the divestment of libidinal energy. However, it is in Beyond

the Pleasure Principle (Freud, 1920) that he further develops his notion of anxiety and pain. Freud explains pain as the rising tide of afferent excitation as the result of noxious stimuli breaching the "protective shield of the body" (31). He then adds that such breaching causes an overinvestment (hypercathexis) of libidinal energy to the site of injury or undermined organ as a protective measure to diminish anxiety. He describes "the element of fright" "as caused by a lack of preparedness for anxiety." Seeing pain as being intertwined with anxiety and threat, Freud confers the status of a pseudodrive on pain whose aim is to initiate action to terminate injury and harm. Freud continues his libidinal theory of pain and anxiety in *The Ego and the Id* (Freud, 1923). He once again turns his attention to the psychology of pain which he describes, "a thing intermediate between external and internal perception, which behaves like an internal perception even when its source is in the external world." (22) Designating a liminal position for pain at the boundary of internal and external, Freud expands his earlier formulation of organ to ego hypercathexis. He argues that pain leads to an overinvestment of libidinal energy on the Ego as "bodily ego" (26). Thereby, Freud expands his definition of pain to a perception at the service of the ego development, a perception like touch, through which ego acquires "its special position among other objects in the world of perception (25). This development further brings together the analytic study of pain and ego development. His idea of pain along with pleasure as ego's perceptual means of positioning itself in the world evolves into a larger social reflection in *Civilization and Its Discontent* (Freud, 1929). In this key work, Freud reflects on the philosophical view, and formulates a tragic view of life, where pleasure is only the reduction of pain, irritation, and frustration, whereas pain (Unlust) is regarded as the governing feature of life. However, In

Inhibition, Symptom and Anxiety (Freud, 1926), Freud finally offers his late theory of pain and anxiety. He distinguishes physical pain as accompanying narcissistic cathexis and mental pain as relating to object-cathexis. He states, "The transition from physical pain to mental pain corresponds to a change from narcissistic cathexis to object-cathexis." (171) In this manner, as Ego recognizes the loss of the object, it makes an important transition to mental pain. In effect, Freud demonstrates his commitment to phenomenology of pain, when he manages to provide a non-physiological explanation for physical pain. He also clarifies the distinction between and anxiety and pain to explain their interconnection. Freud explains pain as analogous to anxiety, in that they both serve as "a warning of the danger of loss" of the body, body part, or the object (59). But, he specifies pain as "the actual reaction to the loss of the object, while he sees anxiety as "the reaction to the danger that the loss entails." (170) In short, by growing beyond the physiological concept of pain and quantitative definitions, Freud develops an appreciation for the phenomenology of pain and thereon continues to establish a metapsychology of ego development based on pain and anxiety.

Following Freud, the clinical study of hysteria took many turns and twists. By and large, the later effort expanded the focus to include a larger investigation of the relation between psychological suffering and physical ailment. As a result, what took shape borrowed, integrated, and furthered ideas from both Freud's psychoanalytic and Janet's psychological theories. Chief amongst later developments were two rival schools that have exerted significant influence on the study of the psyche and soma. Franz Alexander, the founder of what came to be known as the Chicago School, proposed the idea of psychosomatic medicine. Although Alexander (1954) accepted Freud's definition

of hysteria, he recognized a distinction between symbolic conversions of internal conflicts and what he called the psychosomatic disease. He argued that as opposed to voluntary motor reactions, involuntary visceral reactions involved adaptive response to stress at the vegetative level. For lacking representational content and motivational control, these vegetative responses were said to be devoid of symbolic meaning and hysterical symbolism. Emphasizing the non-symbolic and vegetative mechanisms, Alexander (1955, 1961) viewed emotional conflicts and trauma as contributing to the physical straining of the body through excessive mobilization of cardiovascular and neuro-endocrinal systems. He maintained that such stress-oriented mobilizations, if left unmitigated, could aggravate organic predispositions and strain vulnerable organ systems to psychosomatic disease. In this vein, whereas the meaning of symptom was for Freud central to the aetiology and cure of hysterical conversions, such matters played a contributing role in Alexander's psychosomatic medicine. In fact, he argued that emotional conflicts contributed to the pathophysiology of psychosomatic disease, by setting in motion the non-symbolic stress response at the vegetative level. In Alexander's view (1954), the meaning of any conflict was deemed clinically important insofar as specifying the stress (*i.e.*, oral incorporative anxiety with gastrointestinal manifestation), and the affected organ system (*i.e.*, peptic ulcer of digestive system). In this vein, the abreaction of the intrapsychic conflict was redefined from the key remedy to a subsidiary intervention that is undertaken as part of a medical treatment. As stress reaction became a vegetative response bereft of mental representation, the theoretical emphasis on the preponderance of the repressed content in symptom formation diminished. In effect, Alexander's psychosomatic medicine accepted the irredeemable lack of symbolic content

and significance that in many cases seemed puzzling, and called for a shift to medical intervention in conjunction to psychotherapy.

In contrast to the theory of vegetative response, the Psychosomatic School of Paris offered a different theoretical approach to explain the bedevilling absence of body symbolism in psychosomatic illness. In their influential work, Marty, de M'Uzan, and David (1963) recognized the lack of symbolic content as part of a complex psychic structure. Their detailed clinical observation revealed to what extent psychosomatic patients lived a life impoverished in terms of emotion, object relation, verbalization, and imagination. The authors described the striking relational poverty with regard to both internal and external objects. In their case studies, the absence of affective experience was all-too-pervasive, making life mechanical and listless for those suffering from psychosomatic illness. Nocturnal dream activity and diurnal reverie were both diminished to null, markedly incapacitating imagination. All symptom anomalies were reduced exclusively and rigidly to somatic complaints and preoccupations which seemed completely cut off from any mental elaboration. The authors observed a pervasive rigidity and sterility of verbalization. So striking was the verbal constriction and so concrete the thinking process that the authors used the term, "operative thought" (*pensée opératoire*), to refer to the mental activity of the psychosomatic patients (Marty and de M'Uzan, 1963).

However, Marty and his colleagues did not search for a physiological process or a purely degenerative predisposition to explain the pervasive lack of symbolic content demonstrated by patients. From the very beginning, they (de M'Uzan and David, 1960) recognized their task as that of explaining not psychosomatic illness (*maladie*), but

psychosomatic patient (*malade*). The authors explained the illness as a result of a specific psychic structure that failed to admit the impulse to the consciousness. As a result of this failure, the unconscious was severed and split away from any conscious representation, making mental activities totally devoid of affective content, and without any association with fantasy, dream, or reverie. Relying largely on an economic model, Marty and his colleagues explained that the partitioning of unconscious directed the impulse away from the ego's elaborating and integrating functions, and projected the energy into concrete somatic disturbance of bodily functioning. The authors identified the mechanism of projective duplication (*reduplication projective*) as being involved in the creation of a double and isolated order of somatic events, segregated from the impulse desire and unconscious.

Underscoring the importance of explaining the patient (*malade*), Marty and his colleagues argued that psychosomatic structure is a primitive (*archaïque*) formation marked by a deeply partitioned unconscious and overly concrete mental representation. To establish their point, the authors found it necessary to explain this structure not only in its own terms, but also in differentiation form neurosis and psychosis. As a result, the formation of the psychosomatic structure was recognized as a preverbal development distinct from others. The pathogenesis of this structure was said to involve a fundamental alteration of the boundaries of the ego (de M'Uzan 1967, 1983, and 2000) that caused an irredeemable split between the self and non-self. As a result of this alteration, the ego was reduced to the concrete body-ego, preoccupied with concrete sensory-motor representations. Direct trauma, early and prolonged neglect, and the persistent lack of congruency between maternal care and impulse desire were shown to be the source of the

over-excitation that undermined the balance of the psychic economy; shook the ego at its seams (*ébranlement*), and strained the synthesizing function of selfhood (*identité*). Although the possibility of constitutional predisposition was not totally overruled (de M'Uzan, 2003), it was only considered as a contributing factor in the overall process. Above all, the ego's total failure in admitting and integrating impulse into consciousness was explained based on the central notion of being shaken at the seams (*ébranlement*). In this manner, the absence of symbolic content in psychosomatic illness was not seen as arising from non-symbolic vegetative processes or constitutional factors. Beneath the concrete somatic preoccupations, Marty and his colleagues revealed a massive dissociation of mental activities from the affective source of impulse desire. In effect, the absence of body-symbolism, the concretization of mental activity, the contraction of verbalization, the suppression of fantasy, and the partitioning of the unconscious were all explained as part of a primitive psychosomatic structure caused by the ego's experience of being shaken at the seams. By and large, their psychosomatic theory of ego disintegration and identity distortion is predicated upon the notion of traumatic over-stimulation and not on the notion death instinct.

Aside from the aforementioned schools of thought, three authors have made major independent contribution to the study of pain. The first is Anna Freud (1952) whose study on children offers a new understanding of how pain and bodily symptoms are interpreted and given meaning. Her work expands beyond the predominant analytic model of pain as the symptom and symbolic expression of intrapsychic events and conflicts, and looks at pain and other physical symptoms as bodily events with intrapsychic interpretations. She point out:

> *The mental interpretation of pain.* - The manner in which the child invests bodily events with libidinal and aggressive cathexis and significance creates a phenomenon which has baffled many observers. Parents and others who deal with young children comment frequently on the remarkable individual differences in children's sensitivity to bodily pain; what is agonizing for one child may be negligible to another. The analytic study of such behavior reveals as different not the actual bodily experience of pain but the degree to which the pain is charged with psychic meaning. Children are apt to ascribe to outside or internalized agencies whatever painful process occurs inside the body (accidental hurts, fall, knocks, cuts, abrasions, surgical interference as discussed above, etc.) Thus, so far as his own interpretation is concerned, the child in pain is a child maltreated, harmed, punished, threatened by annihilation. The "tough" child "does not mind pain," not because he feels less or is more courageous in the real sense of the word, but because in his case latent unconscious fantasies are less dominant and therefore less likely to be connected to the pain. Where anxiety derived from fantasy plays a minor or no part, even severe pain is borne well and forgotten quickly. Pain augmented by anxiety on the other hand, even if slight in itself, represents a major event in the child's life and is remembered a long time afterward, the memory being frequently accompanied by phobic defenses against its possible return.
>
> According to the child's interpretation of the event, young children react to pain not only with anxiety but with other affects appropriate the content of the unconscious fantasies, i. e., on the one hand with anger, rage, and revenge feelings, on the other hand with masochistic submission, guilt, or depression.
>
> The correctness of these assumptions is borne out by the fact that after analytic therapy formerly oversensitive children become more impervious to the effect of pain. (75-76)

Anna Freud's emphasis on pain as an active construction led by unconscious fantasy provides a key insight into the psychology of bodily events. She emphasizes the role of unconscious fantasy over the actual sensory quality of pain and offers. More importantly, her formulation complements the earlier theory of libidinal body cathexis with the economy of aggressive energies. Although she is not clear as to how such cathexis and fantasies shape the experience of pain and body, she recognizes two distinct kinds of feelings: 1) those of a sadistic, angry, and vengeful quality, and 2) those of a masochistic, depressive and guilty type.

Szasz (1957) is the second key author. His study of pain begins by elaborating on the ego-body relationship. His analysis adopts an object relation stance and posits body as an object, in relation to which ego essentially finds its definition. In this sense, Szasz not only views ego and body as inseparable, but also argues that ego's desire to master the body leads to progressive integration of ego and body during maturation. Szasz describes both pleasure and pain as affects that are at once private and public. He attributes this duality to the fact that at all times ego is simultaneously directed toward body and another person. Hence, the experience of one involves the experience of the other. Szasz believes that pain functions as a signal similar to anxiety. However, while ego reacts to the threat of object loss with anxiety, it experiences the threat to body as pain. Szasz also expands the notion of pain to include certain aspects of learning. He expands the interpersonal dimension of pain as the biological signal that results in soliciting help, or as an infant demand nursing. As a result, pain represents symbolically the demand for the object both past and present and what the ego has learned through fulfilment of such demands.

The third key author is Nasio (1996) whose recent publication has rekindled much interest in the psychoanalytic theory pain. Like Szasz, he views pain as an affect. However, unlike Szasz, he describes pain as secondary to tissue damage distinguished by an imaginary peripheral perception. He argues that the degree of the ego involvement is relative to the extent of injury. Hence, extensive injury forces the ego to abandon the peripheral perception and become the body. Nasio distinguishes injury from its mental representation. He argues that despite ego's misperception pain rises from the mental representation rather than from the wound itself. He proposes that the real sources of the

pain is in the brain where nociception is processed in the dark recesses of the ego, in the id that generates the painful emotion. Using a Lacanian model, Nasio proposes a tripartite model of pain. The register of real is said to entail somatosesnsory perception of the physical abrasion. The register of imaginary subsequently holds the experience of the body as peripheral to the ego wherein the injury is seen as a secondary body. Ultimately, the symbolic register holds the promptly shaped and largely conscious mental representation of the spatio-anatomical location of the wound. Yet, what Nasio really achieves is the formulation of a dual system of parallel processing comprised of an internal and external perception. The former is said to entail somatosensory perception, while the latter essentially contains psychic elements. In addition, the former often seems to underlie the sensations of "I am hurting', while the latter lies behind the feelings of being overtaken by pain (as the source of the affect). Like Freud, Nasio views pain as a drive whose aim is to safeguard the body as a protective shield.

The above review of the psychoanalytic literature traces a rough historical trajectory for the on-going discussion in the area of pain. As Gendrault (2001:38) points out, psychoanalysis has studied two pathways of pain perception: the psychosomatic and somatopsychic. Those focusing on the psychosomatic pathway have been interested in contribution of unconscious factors to the pathogenesis of pain (i.e., studies in hysteria, and Chicago and Paris schools of psychosomatic medicine). Their writings explain unconscious conflicts, dynamics, and structures as psychic elements underlying the pain that symptomatically reveals the unrevealable. However, those following somatopsychic pathway tend to see pain as a bodily event that resonates deep in the unconscious and

occasions an affective perception that involves a variety of psychic influences (Anna Freud, Szasz, and Nasio).

Although Freud shows an interest in both, much systematic effort has concentrated on the former pathway while the latter has received marginal attention and disjointed treatment. At best, the literature appears to be partial toward issues of hysteria, somatization, hypochondria, and psychosomatic illness as the clinical ground for analytic study of pain. However, it can be argued that this partiality is the result of a lack of clear understanding of the far-reaching potential of the somatopsychic pathway for the study of body symbolism and the psychology of disease. Consequently, a much larger ground has been left unattended by psychoanalyst, namely that of the unconscious significance of bodily affliction, pain, and suffering which involves the greater field of caring for the ill as opposed to the more circumscribed area of caring for the mentally ill. In fact, the study of the somatopsychic pathways can deepen the phenomenology of illness and suffering by shedding light on the unconscious construction of the body in pain, and by making sense of the terrifying images of suffering that today are largely deemed as catastrophizing and misappraisal. In fact, such understanding is needed if we are to have a psychoanalysis of disease and disease symbolism that can generate much needed insight into the public attitude toward health and into the professional ethos of the our social institutions. Hence, it is from a somatopsychic outlook that the psychoanalysis of pain is to be read and rewritten.

By the same token, the foregoing review of the psychoanalytic literature from a somatopsychic point of view, reveals the following. First, based on Freud's original approach to illness experience, pain cannot be reduced to a biological event or to a

generic, third-person definition which eliminates all account of the sufferer's experience and inner world as shaped by personal biography. Second, the experience of pain, regardless of its origin, means being exposed to harm through the injuries of the body as the ego's primary protective shield, or through loss of the object, in relation to which the ego is primordially defined. Third, as pain involves confrontation with a hurtful element, it signifies threat both to the basic integrity of the ego and to the object which resonates deep in the inner world of the patient and beyond the limits of consciousness. Forth, as pain resonates into unconscious, its sensation puts into motion unconscious material that thereafter engender the affective perception of pain. Fifth, from early infancy, pain along with pleasure, plays a key role in mediating the ego-body and ego-object relation which defines the development of adult ego and adult capacities. Sixth, for its fundamental role in the shaping of the individual's inner world, pain has to be seen as "a thing intermediate" (Freud, 1923: 22) between, biological and psychic, adult and infantile, external and internal, present and past, conscious and unconscious, private and public, redemptive and torturous, and scientific and literary. Lastly, in the words of Anna Freud (1952:75-76), "The manner in which the child invests bodily events with libidinal and aggressive cathexis and significance creates a phenomenon which has baffled many observers... According to the child's interpretation of the event, young children react to pain not only with anxiety but with other affects appropriate the content of the unconscious fantasies, i. e., on the one hand with anger, rage, and revenge feelings, on the other hand with masochistic submission, guilt, or depression."

Yet, Anna Freud's evocative postulation suffers from an obvious lack of metapsychological consistency. Her notions of aggressive and libidinal cathexis clearly

support an economic model of psychic energy, whereas she emphasizes the key role of unconscious fantasy which is closer to a model of unconscious based on psychic reality. Second, although she highlights unconscious fantasies, she does not make any mention of its actual operations in shaping the child's reality. Third, she speaks of anxiety in contrast to the feelings of anger, rage, and revenge on one hand, and submission, guilt, or depression on the other, without reflecting on any deeper link between anxiety and the bipolarity of rage and depression. Lastly, she names as pain-related affects (i.e., anger, rage, guilt, and depression) what seem to be in many ways the derivatives of aggressive impulse. Yet, she as well refers to libidinal cathexis without explaining its operation, or showing its contribution. Despite these inconsistencies, Anna Freud offers a succinct synopsis of pain-related affects experienced by the suffering child. The literature of chronic pain has reported the same polarity of emotions for many sufferers and in fact more intensely in the case of those who are not able to manage their painful condition (Roy, 2004). As a child analyst, her account well corresponds with what Bakan (1968:80) calls "the early stage of ego development" where the ego experiences pain as "I-am-being-hurt-and-killed." However, the polarity of feelings noted by her and the primitive stage of ego development proposed by Bakan can both be better understood, and more directly linked to the unconscious construction of pain, if we consider the development of psychoanalytic theory of primitive development.

Freud's (1920) metapsychological postulation of death instinct (*Todestrieb*) as a destructive instinctual force was crucial not only for understand repetition compulsion beyond pleasure principle, but also for explaining the infantile anxiety of annihilation revealed in child analysis (Schwartz, 1999:216-20). In an effort to further this

postulation clinically, Klein (1928, 1929, and 1933) redefined the concept of anxiety, to include the destructive impulse, and to take account of the pre-oedipal or primitive stages of development. She used novel techniques such as play therapy to access the primitive significance of anxieties experienced by children. She demonstrated how such unmanageable feelings are engendered during the infantile period as part of primitive object relation, by death instinct. Emphasizing the early, preverbal development, Kleinian object-relation sought to understand the most primitive unconscious forms of mental activity, which Klein and her colleagues identified as unconscious phantasy. Susan Issacs (1952:82) defined the concept of phantasy as the mental representative of instinctual impulses, and described it as "the primary content of unconscious mental processes." Through her child-analysis, Klein uncovered that phantasies reflected not only concrete experience physical impulses and events, but also all primitive object relations. In other words, the early mental life has been described as containing concrete bodily events and impulses as the infant's somatic reality, as well as the primitive interpretations and elaborations of such experiences which begin at the very basic loving or hating the object.

In this sense, phantasies are undifferentiated physical reactions, thoughts, feelings, and actions that are reflect the primitive ego's object relation and shape the core of psychic reality or the inner world of the infant. Hence, the infant experiences the pain of hunger as a deadly attack by a persecuting object. The fear induced by this object is enacted through the infant's relation with the breast. "An example of phantasies influencing the reaction to reality," Segal (1964:14) states, "may be seen when a hungry, raging infant, on being offered the breast, instead of accepting it, turns away from it and

not feed". The infant's reaction is a clue to the phantasy of breast as something other than a feeding and comforting object, but one that is now seen as bad or repulsive, and its approach may be seen as an attack that has to be avoided. Anxieties of annihilation, fears of disintegration, and the primitive mechanisms of defence are all aspects of infantile phantasies.

It is from the phantasies of the primitive ego that Klein traces the emergence of the adult ego. Klein argues that the primitive anxiety of annihilation emerges at the time when "early ego lacks cohesion and a tendency towards integration alternates with a tendency towards disintegration, a falling to bits" (Klein, 1946:4). In her view, from the very infancy, the primitive ego feels threatened by a mix of real, painful frustrations, and the innate destructive impulse or death instinct. She explains that "the fear of the destructive impulse seems to attach itself at once to an object—or rather it is experienced as the fear of an uncontrollable overpowering object" (4). In fact, she recognizes this distinct internal source of threat, as the single most important, intrapsychic source of danger. Unlike classical psychoanalysis that views anxiety as the result of oedipal repression of the libidinal impulse, Klein sees anxiety as being essentially the function of the death instinct. It is this pre-Oedipal anxiety that is the most primitive form of anxiety experienced by the ego. In short, Kleinian object-relation revised Freud theory of development using the important findings of child analysis the revealed above all the role of the death instinct and the importance of unconscious phantasy.

Klein's analysis of primitive, pre-oedipal phantasy reveals that the ego assumes two positions in relating to the object. These positions involve their own inherent phantasies, anxieties, and defences. She explains the first position as the paranoid-

schizoid position that begins at the time when the ego is not fully differentiated from the object and lacks stable integration. Segal (1979) summarizes Klein's view and elaborates:

> "Because the early ego is very weak and unintegrated, under the impact of anxiety it tends to fragment and to disintegrate. The terror of disintegration and total annihilation is the deepest fear stirred by the operation of the death instinct within.
>
> From Beginning of life there is a struggle between the life and death instinct. Splitting, projection, and introjection are the first mechanisms of defence. At the behest of life instinct the ego splits off and projects the death instinct outward. At the same time the life instinct is partly projected in order to create an ideal object. In that way out of chaos a primitive organization emerges. The ego splits into a libidinal and a destructive part and relates to a similarly split object." (116-17)

This projection of death instinct into the bad object externalizes the destruction and allows the ego to ward off the threat of disintegration, whereas the projection of libido creates the good object. Out of such projection, emerges the persecutory objects, which are merely part-objects and not whole and integrated objects. As such, they are split from their good part-objects, to be kept in a denigrated state as opposed to the idealized status of their counterparts. The introduction of this split between good and bad, which encompasses both the ego and the object, constitutes the paranoid-schizoid position. In this black and white world, fortifying the ego means introjecting the good as an idealized object to increase the ego's sense of intactness against the attacks from the bad persecutory objects, and build an inner world of goodness. The core anxiety of this position is the fear of the bad objects as the persecutors that can destroy both the good part of the ego and the ideal object. This fear gives rise to omnipotent denial, wherein oral-sadistic phantasies of destroying the persecutors come into effect. The function of

these phantasies is to redirect the oral aggression of the ego towards the persecutory object, and deny the psychic reality or the psychic content.

In what Klein calls the depressive position, the infant integrates the good and bad part objects into a whole that is no longer split. The whole object, therefore, appears as the simultaneous source of frustration and gratification. This paradoxical quality of the whole object gives rise to the ambivalent feelings of the ego, and makes the object appear as being simultaneously good and bad, hated and loved, or feared and desired. The integration of good and bad into a whole object causes the ego extreme anxiety regarding the earlier aggressions and their injurious effects. Such state of concern for the object makes the ego depressively anxious for 3 principal reasons: 1) for losing the damaged object altogether; 2) for depending now on a damaged object; and 3) for losing the introjected good object that makes up the inner world. The depressive anxiety sets in motion a number of important mechanisms of defences to ward off the primitive guilt and deny any dependency on the object. First, the ego can develop *contempt* for the damaged object to disown guilt and deny loss (i.e., I hate you, why should I care for you). Second, the ego can avoid the guilt by obsessively engaging in compulsions to *control* the object and to deny dependency (i.e., I don't depend on you, but I am in control of you). Third, the ego can avoid anxiety by resorting to a sense of *triumph* over the object and feel having no need to care for the fate of the damaged object (i.e. I got what I wanted, why should I now care). Segal explains these manic defences as being essentially based on three elements: contempt, control, and triumph.

For Klein, the most primitive experience of anxiety can be traced to death instinct and aggression in the infantile, pre-oedipal stages of development. The ego, in the

paranoid-schizoid position, projects the destructing force of the death instinct into the bad object, and deals with it in the form of concrete persecutory objects. In the depressive position, the ego completes the process of separation from the object, reintegrates the parts into the whole, and feels anxious about the fate of the object as the receptacle of the ego's destructive impulse. In Klein's view, the ego may revisit same primitive anxieties later in life, if it is thrown into crisis by pain, illness, and other forms of distress. Klein (1952) explains:

> "The emotional and mental processes during the first year of life (and recurring throughout the first five or six years) could be defined in terms of success or failure in the struggle between aggression and libido; and the working through of the depressive position implies that in this struggle (which is renewed at every mental and physical crisis) the ego is able to develop adequate methods of dealing with and modifying persecutory and depressive anxieties—ultimately of diminishing and keeping at bay aggression directed against loved object." (93)

Klein's insight simply states that the adult ego ultimately copes with any danger situation of life by drawing upon the material that is developed through resolving paranoid-schizoid and depressive anxieties. Understanding this insight means to grasp how ordinary threats can reawaken our infantile anxieties over the death and destruction of the self, or of the love object. In effect, Klein's theory of primitive anxiety can shows us, how under the sway of death instinct, the primitive ego splits noxious or frustrating stimulations into an alien non-self and projects unto them the aggressive impulse, which turns pain into an annihilating and persecutory object. As a result of infantile splitting and projection, any painful stimulation is experienced as fear of annihilation (death), coming from the persecutory attacks of bad objects. The ego can then launch attacks against such dreadful and dreaded objects without any qualms or concern.

Klein's theory of primitive mental state as the underside of adult functioning can explain May's uncanny insight, "that people utilize disease in the same way older generations used evil—as an object on which to project their hated experiences in order to avoid having to take responsibility for them." (1977:86) The experience or the prospect of pain and illness often means exposure to a throbbing and incapacitated body that exposes our fundamental vulnerability and anxiety with regard to bodily malfunction and threat. Intersubjectively, this feeling of vulnerability is often understood as a cognitive lack of information about the disease. In this sense, the demonization of the illness may reflect the diminished ability of the public to understand and to contain deep states of anxiety in an emotionally meaningful way. To aggressively and destructively disown experiences, before which we can not rely on personal or collective resources for integration bears the definite marks the primitive process explained by Klein. May tells us that contemporary attitude demonizes illness by what he calls the projection of hated experiences of the self to disown them. This is no doubt an uncanny observation that avers the need for a better understanding of the primitive significance of pain.

As frequently observed and reported, chronic pain patients refer to their pain as an "alien presence" (Zaner, 1981), "a monster" (Good, 1992), or an "ominous it" (White & Sweet, 1955; Cassell, 1976) that is split from "I." In her phenomenological study of pain, Scarry (1985:53) states, "In physical pain, then, suicide and murder converge, for one feels acted upon, annihilated, by inside and outside alike." Although it is certainly not Scarry's intention to argue for any primitive understanding of pain, her observation inadvertently reads as a telling description of the feelings of being internally and externally haunted, by suicidal and homicidal forces. Bearing a striking resemblance to

Klein's persecutory anxiety, Scarry's description shows how the persecutory non-self threatens the patient from the inside (suicide) and the outside (murder). From Kleinian point of view, an elaboration of infantile anxieties can explain the phenomenological findings of Scarry and substantiate them as meaningful according to the infantile development of the ego.

Klein's view of primitive development can shed light on the contentious relation between language and pain. It is observed that for the adult ego, verbalizing pain is fraught with serious limitations (Good, 1992). In most part, when intense agony strikes, cries and groans replace proper words and phrases. Bakan (1968:64) points out that talking about pain is generally problematic, as one often has to borrow words from other senses, such as: dull or burning from tactile sense, blinding from vision, dizzying from equilibrium, bitter from taste, stabbing or throbbing from kinetic. On the other hand, Scarry points out the inherent incapacity of language for expressing pain. She cites Virginia Woolf (1930) who issues a damning indictment against English language for its shortcoming with respect to pain.

> "English which can express the thoughts of Hamlet and the tragedy of Lear has no words for the shiver or the headache...The merest school girl when falls in love has Shakespeare and Keats to speak her mind for her, but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry." (194)

Scarry attributes this paucity of words to a particular quality of pain that negates language. She points out, "Physical pain does not simply resists language but actively destroys it, bringing about an immediate reversion to a state anterior to language, to the sound and cries human being makes before language is learned" (4). In fact, any attempt to verbalize pain is interjected by non-lexical sounds reminiscent of preverbal distress

vocalizations of infancy. Pain cries that earlier expressed the need for nursing, reveal in adulthood a reversion to a time before learning language. Hence, if earlier such cries meant an absence of language, today they speak of the destruction of language and the adult system of articulation.

Scarry reminds us that language posits subjective states as objects for reflection and dialogue. In her view, it is in fact this objectifying function that significantly fails, when pain takes over. From Kleinian point of view, the primitive experience of pain is indeed outside the purview of language. Not having fully developed a sense of separation, the infantile ego struggles with fusion and disintegration, as the ego and object are both split. Primitive object relation is blurred by projection and introjection that dim the boundary between the internal and external. The primitive mental activity is dominated by somatic phantasies, wherein innate preconceptions meet realization of the object to create conception or thinking (Bion, 1961). Without adequate integration and separation, the experience of object remains extremely concrete and the ego cannot properly develop or use verbal symbols (Segal, 1957). As a result, primitive pain experience remains beyond the reach of language. This preverbal history remains a fundamental quality of pain that can as much frustrate the *literati* as it besets pain patients.

Another primitive quality of pain inheres in its impact on the sense of objectivity, or the reality principle. Chronic pain blurs the boundary between the internal and the external. To elucidate this quality, Scarry (1985:5) points out that all states of consciousness involve objects as their "referential content". She explains that anger, happiness, sadness, hatred, hunger, and love all refer to objects. In each case, what the

speaker means is loving someone, being hungry for something, or being sad about a situation. Scarry points out that intense pain is "experienced spatially as either the contraction of the universe down to the immediate vicinity of the skin or as the body swelling to fill the entire universe" (35). In effect, pain as "concrete aversive experience" (Leder, 1990:73-75) can occur without a referential content or an object. In addition to being objectless, once in pain, the external world only becomes significant insofar as it is deemed germane to the predicament of the body, and not in its own right. Leder refers to this "swelling of the body" as the "spatiotemporal constriction" in order to highlight how patient's experience of time and space constricts, as pain expands. He shows how such expansion confounds the ego's experience of reality. The over-expansion of the body and the constriction of the external world leads to "an almost obscene conflation of private and public" (Scarry, 1985:53). Such shifting boundary is reminiscent of infancy, when the infantile ego cannot maintain a sense of separation, and concrete somatic events dominate the mental activity of the infant.

1.5. Conclusion: The Choice of Theoretical Frame

By and large, Kleinian theory of infantile mental states sheds light on many unique and adverse qualities of pain and suffering, qualities that have consistently been reported by introspective studies of pain, but have repeatedly perplexed empirical research. From historical point of view, the psychoanalytic study of pain and physical symptoms has hitherto revolved around the notion of conversion. Seeing unusual somatic events as causally explainable in terms of intrapsychic dynamics, classical psychoanalysis investigated pain as the symbolic manifestation of repressed memories, or as hysterical

conversions (Freud & Breuer, 1895). Later on, psychosomatic illness was introduced as the somatic derivative of stress caused by psychic conflicts (Alexander), or as the expression of primitive personality structure caused by trauma and ego-pathology (Marty, De M'Uzan, and David). In effect, classical psychoanalysis and psychosomatic theories have established the horizon of the debate, wherein body symbolism is expounded and traced from the intrapsychic cause to its somatic derivative. This study is, however, designed to depart from this tradition and to initiate a movement in the reverse direction, from soma to psyche. In this vein, it explores persistent pain as an anxiety-inducing experience, from which primitive, unconscious symbolism can arise. This study asks whether intractable pain with a known cause and pathophysiology can rekindle the primitive anxieties of annihilation and destruction and bring to present the infantile helplessness, fear, rage, and guilt buried deep within the unconscious.

To this end, a qualitative study, encompassing the discourses of chronic pain patients, is designed to investigate whether suffering enfolds anxieties of death and destruction that mark the primitive significance of pain. If suffering chronic pain contains and symbolizes aspects of primitive object relations, the return of paranoid-schizoid anxieties of being annihilated by an entity alien to the self cannot be easily trivialized as such return may reflect the primitive history of pain. To explore the latent content of the interview material, the analysis follows what Klein (1955:128-129) has charted as the effective method of interpretation:

> "It is an essential part of the interpretive work that it should keep in step with fluctuations between love and hatred, between happiness and satisfaction on the one hand and persecutory anxiety and depression on the other."

Focusing on anxiety fluctuations is not only central to the interpretation of transference, but is the key for leading the analyst to the primitive content of experience. In this investigation, the interpretive process has to keep pace with the fluctuations between paranoid-schizoid and depressive anxieties, as pain experience and suffering resurfaces in the narrations and free-associations of the participants.

> However, whether patients experience such anxieties as part of their pain is one part of the overall question, whereas the other part is whether clinicians' normative views and discursive practices are reflective and cognizant of this complexity. Today's dominant discourses of health as much promulgate an expert view of pain as shape the lay representations of suffering (Handy, 1987; Fox, 1994:152-159). In the context of rehabilitation, health psychologists hold a unique position in explaining pain to millions of sufferers. In fact, the prevailing model of pain management largely relies on the discourse of health psychologists for defining pain, suffering, and anxiety. In the process, the sufferer's experience is constantly construed and elaborated, based on what is clinically considered as valid complaint (Mishler, 1984).

Using a phenomenological and psychoanalytic framework, the present study explores not only the experience of the sufferers, but also the discourse of the health psychologists. Hence, the second part of this study encompasses the discourses of experienced health psychologist who reflect on pain and suffering from a point of view that is at once clinical, disciplinary and yet personal. The analysis concentrates on how discursive practices construct human suffering in clinical context, and what range of signification is normalized as the focus of today's rehabilitative effort. The study demonstrates, what befalls preternatural experience of suffering when emphasis is placed on adult cognitive processing, realistic ideations, and adaptive norms of functionality. As a result, the ultimate aim of this study goes beyond investigating the anxieties of pain sufferers, and involves today's practice of health psychology in rehabilitation.

To this end, the present study maintains a twofold structure that includes two interrelated explorations. As a psychoanalytic study, it seeks insight into the content of

pain-related anxieties in order to investigate their primitive significance. However, as a phenomenological study, it examines the professional discourses of pain and anxiety in order to reflect critically on today's normative understanding of suffering. In the first investigation, it asks to what extent, suffering chronic pain contains and symbolizes primitive object relations, and ultimately renews paranoid-schizoid anxieties of being annihilated by an entity alien to the self. In the second, it asks how health psychology as the prevalent model of pain management speaks of anxiety and construes the chronic pain experience. These two questions conjointly frame the problematic of this study, and open the discussion for a wider reflection on the anxiety of death and its place in our approach to human suffering.

CHAPTER 2

The Epistemological and Methodological Frame for Depth Psychology of Pain

> Une expérience scientifique est (...) une expérience qui contredit l'expérience commune.
>
> Gaston Bachelard, *La formation de l'esprit scientifique* (1938)

Not infrequently, phenomenology and psychoanalysis have been rebuked for their noncompliance with conventions of scientific research. Their reliance on qualitative methodologies and case studies has been interpreted as lack of empirical vigour. Whereas Psychoanalysis has for sometime been disparaged for not being falsifiable (Popper, 1959), phenomenology has been criticized for lacking the distance of a third-person perspective (Dennet, 2003). In both cases, the critique is essentially the same. It questions the evidential ground, on which these two paradigms stand, and warns against the fickle reliability and validity of their constructs and inferences. As a result of what critics call the lack of adequate correspondence with empirical evidence, phenomenology and psychoanalysis are often described as mystifying and tautological, leading only to obfuscation of the cognitive and behavioural processes.

In particular, a dispute has been raging for some time over the epistemological status of the psychoanalytic theory and research. At the core of this heated discussion, a number of protagonists have been painstakingly debating over the present and the future of psychoanalysis. Today, we can hardly come across any psychoanalytic text that has not been affected by this deeply nuanced debate. In spite of the growing diversity of

issues, the cross-continental and cross-Atlantic forays of discussions have revolved around at least three key epistemological issues: 1) as a body of knowledge whether psychoanalysis should submit to the standard of science or entirely assume a hermeneutic spirit, (i.e., Grünbaum, Habermas, Ricoeur); 2) as a clinical discipline whether psychoanalysis should use methodologies of empirical science to validate its concepts and findings (i.e., Stern, Fonagy, Wallerstein), or remain resolutely an inquiry of latent meanings (i.e., Green), and 3) as an interpretive approach whether psychoanalysis should be open to possibilities of narratization (i.e., Spence, Schafer), or focus on specificity of psychic reality (i.e., Caper, Steiner). Like all epistemological and methodological debates, the underlying concern remains the problem of truth and the methodology of its discovery.

This study concerns itself with epistemological issues only to the extent necessary for addressing the ontological questions raised with regard to pain and suffering. "It cannot be sufficiently emphasized," as states Dicenso (1990:xvi), "that critical attention to ontological questions is inseparable from reformulation of the problem of truth." By the same token, what is offered in this chapter is a "reformulation of the problem of truth" that is inspired by the "critical attention to ontological questions" raised earlier with regard to pain and suffering. The questions, posed in this study, indeed concern the biopsychosocial model as part of the "ruling scientific paradigm" of research (Kuhn, 1962), together with the notions of empirical methodology and truth. Such critical questions call for an equally critical methodology. Such a methodology must open the path for a critical inquiry, while satisfying at least three epistemological questions: 1) what kind of truth statement this research is meant to establish; 2) why it becomes

necessary to deviate from the norms of scientific research to establish such truth, and 3) through what methodology such truth statement can be reached and verified.

The answers to these three questions, in effect, comprise this chapter which begins by examining the scientific rationality and ends by presenting the logic and methodology of the present study. In other words, the methodology of this research is based on an epistemological framework that rises from the critique of the neopositivist project of scientific discovery and empirical research. Even though this chapter takes us away from reflection on pain, it does not take us away from the psychoanalytic study of pain. For, such study inevitably requires a sound methodology that can explain the logic of its truth claims. Without a psychoanalytic critique of established methodology of empirical science, a proper analytic methodology would be unattainable.

2.1. The kinds of Truth Statements and the Subject-Object Distinction

It is commonly claimed that science is the empirical investigation of all natural phenomena and as such its findings are based on positive reality and impartial to the observer's disposition, viewpoint, fancy (conscious fantasy), and phantasy (unconscious fantasy). We are persuaded that scientific method can explain life with rigorous accuracy and objectivity. We, therefore, openly solicit scientific research for predicting future events, or for finding reliable interventions. In today's information and technology driven society, fostering the instrumental rationality of prediction and control has become, more than ever, the exclusive province of science. Consequently, going against the advice of scientific community is seen as offending the natural harmony and risking disease, injury, disaster, pestilence, and famine. The ambivalent blend of apprehension

and reverence that were historically reserved for divine oracles and scriptures are now accorded to scientific literature.

Scientists claim that this level of trustworthiness requires a reliable methodology of knowing that is not corrupted by the observer's subjectivity. Valid knowledge, according to them, must be objectively verifiable on an empirical basis that guards objectivity against the intrusions of fancy, phantasy, prejudice, preconception, beliefs, and values. Hence, to know an object means successfully muting the presence of the knowing subject by the means of the methodologies of experimentation, observation, measurement, analysis, and inference. Through strict observance of methodology, scientists try to recast themselves into a disinterested observer and operationalize their objects as an entity or a thing, observable and measurable from distance. This recasting of the knowing subject is meant to eliminate all social and psychological traces of the subjectivity from the process of knowing, while the operationalization of the object is meant to remove any reference to aspects, not directly observable or reducible to measurement. For social and human studies, the practice of science is particularly meant to generate subjectless knowledge or knowledge purged from the subjectivity of the observer and the observed.

In fact, scientists insist that the strict compliance with experimental procedures can adequately circumvent confounding effects of extraneous variables. They propose that our safe way to objective knowledge is no other than methodological positivism that ensures the integrity of the data for hypothesis testing. In their view, scientific methodology can effectively isolate facts from their social, cultural, and psychological

context, by controlling what is extraneous to factual evidence needed for inferential reasoning. Once scientific findings are objectively gathered, tested, and reviewed, the influence of psyche, society, and culture becomes immaterial and unimportant. In effect, we are reassured that scientific methodology can render our world explainable, predictable and controllable by distilling the process of knowing from all extraneous influences of the human world.

However, this obliteration of subjectivity is predicated on the presumption of an ontological distinction between subject and object, a distinction that sees factual reality as the obverse of the non-factual knowledge. For this reason, knowing is presumed to take place in a world fashioned by the objects of knowledge that are independent from the knowing subject, and distinct from human perception, belief, discourse, fancy, and phantasy. In this manner, the world out there is said to exist positively as a pre-subjective given, based on which we can assess the adequacy of descriptive and inferential propositions. Such a world stands at a distance from those who attend, experience, reconstruct it through their lives, feelings, and imaginings. Hence, this world can be described and explained objectively by a disinterested observer as what it is, rather than as what it better be or not be, or as what it can possibly be.

Despite scientists' claim of natural neutrality of the objective world, it is in fact through the pursuit of human aspirations, hopes, and imaginings that we have historically shaped the world around us into a complex and meaningful system of objects (Baudriallard, 1968) and social institutions (Berger and Luckmann, 1966). In this world of human constructions, social scientists view the meanings of lived experiences (*Erlebnis*) as nothing more than personal opinions (*doxastic*), which must be challenged

by impersonal scientific knowledge (*epistemic*). It is therefore scientists' hope to redeem objective truth statements by occluding subjective meaning statements about being and life. In this manner, scientists strive to capture the pre-ideational stratum of experience as the factual evidence for all inferential reasoning and truth claims. While science is proclaimed to offer the empirical methodology of knowing, it would be valid to ask: 1) whether the presumption of a factual world as distinct from human experience can be trusted, and 2) whether validity and reliability of knowledge can be reduced to a matter of methodological procedure set to eliminate human subjectivity.

When methodology becomes the preponderant criterion of valid knowledge, any critique of scientific rationality that illuminates the psychic and social pre-conditions of truth and understanding loses its *raison d'être.* For science, methodology and its procedures hold an important place, as they have circumvented the need for such critique. When methodological procedures can successfully remove all *a priori* assumptions, the question of "what are the preconditions of knowledge," comes to mean very little. As soon as we believe that experimental procedures suffice to safeguard knowledge against subjective and contextual effluence, any critique becomes at best redundant. When procedures can make knowledge objective and observers disinterested, it would be nothing more than trifling to ask: "what it socially and psychologically means to do science." In that event, as long as control procedures are in place, the critique of subjectless knowledge would be of little relevance to the validation and valuation of knowledge. This emphasis on procedure and methodology, in effect, assumes a unique epistemological ground beyond any psychological and social critique, whereupon science can stand poised to remedy the ills of the world and the follies of the human speculation.

Such knowledge is said to have precluded the pre-conditions of its production by the virtue of its well-controlled methodology. Eventually, as the empirical status of knowledge becomes a matter of methodology, empiricism as the test of knowledge through experimentation loses its openness to self-reflection and its suppleness to human experience and comes to allow meaning only to the extent permitted within the limits of procedures and methodology. What lies outside these procedures has to be reduced through operationalization, or has to be denied empirical or ontological status altogether. In other words, what cannot be procedurally valid must be non-veridical on the whole. In effect, this emphasis on methodology has led to formalism or an obsession with forms and procedures, and has overshadowed more serious concerns over the substantive aspects of knowledge production.

Recognizing the importance of going beyond methodological procedures, social constructionism as a theory, and as a well established research practice has problematized the subject-object distinction as a basic epistemological tenet of the neopositivist methodology. It argues that what we take for granted as reality is a social construction occasioned by symbolic interaction of human subjects. For social constructionists, the human world as the world of speaking subjects is built through "practices which form the objects of which they speak." (Foucault, 1972:49) These practices, for their involvement of speaking, are identified as discursive or "a system of statements constructing an object." (Parker, 1992:5) Through discursive practices, proper objects of experience are given identity and boundary. In this process, interested views and personal perspectives shape not only the human experience, but also the very substance of social and human reality. Consequently, science is said to do more than just finding the reality out there.

Science as the discursive activity of the community of researchers constructs a sense of what is real and how this reality can be properly operationalized, observed, explained, categorized, predicted, controlled, and harvested. By thus doing, science creates an intelligible order that is responsive and serviceable to human desire.

The emphasis on the world-making function of language among social constructionists is reminiscent of Heidegger's (1962) and Wittgenstein's (1953) critique of the naturalist notions of the "objective" world. Wittgenstein argues that language is a system of perfectly meaningful statements according to its everyday use. For Wittgenstein, in its everyday use language brings life to a community of speakers and makes it sensible. He argues, "to imagine a language means to imagine a form of life" (sec.19, p.8). His philosophy makes language coextensive with life. Although he believes in a world outside language, he argues that such a world is revealed in our understanding through language. Hence, nature comes to us as natural sciences or as the product of the evolution of mathematics as a formal language. On the other hand, for Heidegger, language is a historical and mutating practice. He still acknowledges the world as being out there (*Dasein*), yet this world can be only disclosed through language which shapes what is revealed. Hence, even though what exists appears out there independent from language, it is language that allows the interpretation and representation of what is out there. In Heidegger's view, representation is always interpretation, and as such the world is disclosed to us as a matter of interpretation. In fact, Heidegger (1950/1971:191) describes human being as being born in language, hence we speak the language to which we are born and in that sense, "we leave the speaking to

language." What here can be very important is the difference the separates Wittgenstein from Heidegger, as Reé (1995:212) explains:

> But there is a conspicuous difference between Wittgenstein and Heidegger in their understanding of language. For Wittgenstein, language is, properly speaking, beyond criticism, because it is its own criterion: "all the propositions of our everyday language, just as they stand, are in perfect logical order," as he puts it in the *Tractatus*, and philosophical error arises only when that order is misunderstood or disobeyed (*TLP* 5.5563; see also 4.003, 6.53). For Heidegger, on the other hand, "everyday language is a forgotten and therefore used-up poem" (L 208), and the task of thinking is to listen out for the poetry we have lost.

This critique of everyday discourse separate more than only two philosophers; it in fact has created two divergent epistemological attitudes from relatively similar premises. Heidegger anxiously senses beneath the warn-out language of quotidian, a lost poetic possibility that is concealed from view, a possibility that if captured, restores the "lost poetry" and vitality to thought, language, and action. It is to this point that we shall shortly return to qualify the notion of truth statement. Yet, it is evident from what has been said that Heidegger and Wittgenstein formulate a serious challenge to subject-object distinction based on the formative and constructive function of language.

When reality is mediated by discourse, objectivity becomes an intersubjective construction, and representation becomes interpretation. Then, search for truth requires keen understanding of interpretation. "In relation to the problem of truth," as states Dicenso (1990:145) "the interpretive nature of human experience takes on increased significance as one moves from simple perceptual givens to more complex social and existentially relevant judgements." Yet, is it the *"interpretive nature of human experience"* that discursively constructs reality through language? Or, is there something fundamentally more human than language that is intersubjectively brought to bear on

reality? Wittgenstein's notion of language as a system of utterances, and Heidegger's notion of language as a historical entity both answer affirmatively to the former question. However, Heidegger's remark about "the lost poetry of life" leaves the second question open. Hence, one still can ask: does language interpretively discloses the world, or does language brings something uniquely human to the world and discloses "what appears" in the light of what is most human?

In essence, the aforementioned question asks what makes the human nature so interpretive and human action so constructive. To answer to this question, Berger and Luckmann (1966) offer one of the most important and influential accounts of the social construction of reality as part of a uniquely human need for externalization and objectivation through language:

> Human being is impossible in a closed sphere of quiescent interiority. Human being must ongoingly externalize itself in activity. This anthropological necessity is grounded in man's biological equipment. The inherent instability of the human organism makes it imperative that man himself provide a stable environment for his conduct. Man himself must specialize and direct his drives. (55)

In this sense, the anthropological need for a stable environment leads to "humanly produced, constructed objectivity" (61). This construction comes about through objectivation as the "process by which the externalized products of human activity attain the character of objectivity." The authors identify language as one such objectifier. However, both externalization and objectivation are explained "as moments in a continuing dialectical process" that culminates to internalization "by which the objectivated social world is introjected into consciousness in the course of socialization." (61) As a result, through socialization, human being finally introjects into consciousness what was once externalized into the social reality and experienced as objective reality

external to consciousness. For Berger and Luckman, the interpretive nature of human being involves constant the externalization of human needs and internalization of reality. In their view, the assumption of a sacrosanct distinction between consciousness and the world precludes this ongoing process of externalizing and internalizing.

Although the authors effectively challenge the subject-object distinction, they leave behind a series of serious blanks and unanswered questions. Would biological drive simply engender action and objectivation as a reflex without any mental corollaries or psychological representative of biological drive (*Trieb*)? In what manner the processes of externalization, objectification and internalization are comparable to what psychoanalysis call projection, projective identification, introjection? Would externalization and internalization involve states of desire, feelings, anxiety, and aggression? What is really being externalized, a biological drive to attain a stable environment or a desire to reduce the self or the other (alter) to self-sameness (identity)? In short, are these processes biological, verbally accessible and essentially rational, or do they involve meaningful overlaps with primitive object-relations, preverbal phantasies, and possibly irrational?

The aforementioned questions are obviously meant to reveal a different kind of construction of reality, one in which a deeper psychic undercurrent of unconscious phantasies are mediating intersubjectivity. In fact, the world constructed by operations of unconscious phantasy becomes more than a discursively or biologically mediated experience, as it acquires latent meaning as an object of primitive love and hate. Within Kleinian object relation, the term phantasy has been defined as "the mental expression of instincts." (Segal,1964 :12). Unconscious phantasy is said to be the most archaic form of

mental activity that predates language. Analytic work with children demonstrates that biological instincts have in fact psychological corollaries as phantasies that contain objects of love and hate, as well as the primitive anxieties and defences. In this sense, phantasies are "not merely an escape from reality, but a constant and unavoidable accompaniment of real experiences, constantly interacting with them." (14) As accompaniments of reality, they remain active throughout life. Phantasies both mediate reality and change as a result of experience. In this manner, the concept reflects the psychological complexity and lifelong ramifications of the early development, and challenges all assumptions of *tabula rasa*, somato-sensory concreteness, and biological minimalism.

Although Berger and Luckman reveal a dialectical process beneath the naïve realism of subject-object distinction, they ultimately create a naïve realism of their own by biologizing the notion of subjectivity or interiority and in-wardness as a biological drive with no symbolic content of its own. Hence, the question of what content is being exactly externalized is still left in ambiguity. However, judging by today's status of psychoanalysis in sociological theories (O'Niel, 2001), sociologists are least prepared to answer such questions. In fact, social theory offers very little systematic account of how unconscious phantasy may suffuse both intersubjectivity and discourse, and subtend the social construction of reality. As a result, the significance of primitive phantasies, as well as the function of projection, projective identification, and introjection, as ways of shaping the intersubjective space, are neither systematically explored nor adequately expounded (Steuerman, 2000).

Much of what has been uncovered about how primitive phantasies mediate the consensual experience of reality and social dynamics originates from psychoanalytic work in the areas of group therapy (Bion, 1961b ; Hinshelwood, 1987), and organizational and institutional behaviour (Jacques, 1953, Menzies Lyth, 1960). These studies reveal the operation of primitive object-relations in generating the emotive and conative undergrid of rational thought and language (Bion 1961, Segal, 1957), to which our intersubjectivity and discursive practices are welded. In other words, phantasies hold the primitive source of our emotional and intellectual life, as concrete ways of feeling and thinking originally generated by the interaction between the *internal world* of the infant and the *external reality*. Throughout life, meanings generated by primitive object relations remain ready for "deployment" into our relations with others, in here and now (Meltzer, 1981:178). As Jacques (1953:21) states:

> "Individuals may put their internal conflict into persons in the external world, may unconsciously follow the course of the conflict by means of projective identification, and may re-internalize the course and outcome of the externally perceived conflict by means of introjective identification."

Through projection, projective indentification, and introjective identification, group relations become shared and reciprocal ways of being and experiencing reality. As opposed to Berger and Luckman, Jacques views externalization and internalization as inserting aspects of psychic reality into the relational complex that underlies life. By engendering dynamics of relating, feeling, talking, and acting within the group, phantasies confer meaning to reality. Such meanings are constitutive of our sense of identity and our experience of reality.

Evoking similar experiences in others, phantasy engenders what Hinshelwood (1995) calls "relocation of identity." This relocation takes place, when different parts of

an individual's self are projected into the members of a group and enacted as interpersonal dynamics among the members who hold the projected parts and evoked sentiments as their own. For an individual, phantasies lead to what Spillius (2001) calls "a complex system that involves the individual's own unique way of being, of relating to the world, of maintaining his balance." (367) However, Within a group, Hinshelwood argues that relocation of identity can lead to unique group dynamics and social reality wherein there would be an interpersonal dispersal of ways of feelings, perceiving, thinking, and interacting. Through primitive mechanism of defence, the intersubjective experience of reality is shaped.

If we accept that reality can be mediated by unconscious phanasy, the epistemological relation between subject and object in the act of knowing must radically be overhauled. Such overhaul begins from reconsidering cognition and cognitive processes. As an infantile way of thinking and feeling, phantasy is recognized to be "the primary content of all mental processes" and "the basis for all unconscious and conscious thought process." (Isaac, 1948:85). As Mitchel (1986:23) points out:

> In Klein's concept, phantasy emanates from within and imagines what is without, it offers an unconscious commentary on instinctual life and links feelings to objects and creates a new amalgam: the world of imagination. Through its ability to phantasize, the baby tests out, primitively 'thinks' about, its experiences inside and outside.

As opposed to cognition that derives from without, to form representations within, phantasy "emanates from within and imagines what is without." This creates an ironic situation. For, thinking and cognition are said to evolve from primitive phantasies (Bion, 1961), to which they remain unconsciously tied, even for adult ego. In this sense, cognitive representations of actual objects have their roots in the ethereal region of love

and hate that emanates from primitive object-relations. If cognition is therefore meant to create a sense of what is real, by the virtue of its primitive history, it enfolds in its depth the desire for what better be (loved) or not be (hated). As opposed to cognitive processing that is held to the standard of what is real, phantasy reflects how objects are sought based on primitive love and hate. As a result, unconscious phantasies are at work, when cognitive acts (*cogitations*) result in cognitive objects (*cogitata*) that serve as the schema or template for external reality. Through projection, projective identification, and introjection phantasies take on the external reality in the name of an internal world and construct our complex web of experience (Spillius, 2001).

A world mediated by unconscious phantasy has far-reaching ramifications for human understanding and the commonly upheld distinction between subject and object. As aforementioned, Heidegger establishes his critique of subject-object distinction by contending that representation (*Vorstellung*) is interpretation (*Deutung*). He, therefore, sees interpretation inherently linked to language as a historical entity that shapes meaningful representation. In contrast, Kleinian object-relation offers the notion of phantasy, and views the preverbal object relation as the source of intrapsychic elaboration that underlies discourse and constructs the experience of reality. As a result, it gives a new meaning to why representation is inescapably interpretation:

> "Through introjection and projection a complex phantasy world of self and internal objects is slowly built up, some of it conscious but reaching into the unconscious depths…This internal world is imaginary by the standards of the material reality, but possesses what Freud calls 'psychic' reality—that is the individual concerned it feels real at some level, conscious or unconscious, and it is also real in the sense that it affects its behaviour." (Spillius, 2001: 365)

In representation, the materiality of the world is interwoven into phantasies of primitive love and hate. Although such phantasies "are never articulated in words, though words may be the means unconsciously used to communicate them by evoking them in an external person." (366) Hence, what mediates reality exceeds language, for phantasy is more fundamental to the development of the subject and intersubjectivity.

In this manner, Kleinain notion of objectivity as mediated by phantasy can exceed Heidegger critique of subject-object distinction. Heidegger believes in a world that exists out there independent from language (ontologically independence of object from subject). Yet, this world can only be disclosed through language (epistemological dependence of object on subject). As opposed to Heidegger, the feminist critique of epistemology on the other extreme refutes ontologically independence and argues against the independent materiality of the world (see Butler, 1993). In this debate, psychoanalysis offers a measured alternative that maintains an ontologically independent world but expands beyond the realm of presence to redefine materiality. From Freud's description of '*fort*' '*da*' (Freud 1920:8-11) to Klein's notion of phantasy, psychoanalytic theory has concerned itself with more than how presence is disclosed to the thinking subject or how thinking can evolve from interacting with objects. In contrast, psychoanalytic theory reaches beyond the presence of the object, and focuses on how absence of the object is fathomed and made full of presence through phantasy. According to object relation theory, it is by overcoming the painful and dreadful phantasies of absence that the capacity to think (Bion, 1961) and to symbolize ultimately develops (Segal, 1954).

As a result, subjectivity is said to have a "negative origin" in emotional overcoming of the absence of the object, the absence that is experienced by the infant,

through anxieties of disintegration, annihilation and destruction (Keylor, 2003: 216-226). Steuerman (:18) uses Klein's anxiety positions to explain the intersubjective ramifications of the struggle of the subject with absence:

> For Kleinians, there are two basic configurations of the mental world, and these two basic positions are exemplary of two ways of dealing with inetrsubjective reality. In the paranoid-schizoid position, the world is split into: the good and the bad objects, the bad ones being exclude, denied, destroyed or projected outside. Anxiety, which is generally intense, is of a persecutory type, due to the attacks on the object. In the depressive position, there is an attempt to apprehend the object more as a whole, good and bad. This position seeks to integrate parts of oneself which had been split off and denied. The depressive position, which in spite of its name is actually the position where we are freer from our more destructive aspects, in the recognition of the others that form our world, of how dependent I am, for my own happiness, on the endurance and existence of others. The paranoid position is the destructive denial of the existence of the world of the intersubjective relations, and the manic attempt to restore the fiction of an isolated and omnipotent subject (myself, all good), who sees the other as a different sort of being (bad and completely distinct from my regal self).

Although psychoanalysis recognizes the world to be independent from the psyche, it attributes its disclosure to interpreting the anxieties evoked by the experience of its absence than to construing its presence. Based on the negativity of thought, the presence of the object—by itself unthinkable—becomes thinkable when its absence is experience. While we are here reviewing the various critiques of the subject-object distinction, this negativity of thought has far reaching implications for what constitutes truth claim from psychoanalytic point of view.

Nonetheless, to summarize this part of the discussion, it is evident from what has been said that the truth claim of psychoanalytic or phenomenological findings can not be assessed by a methodology that presumes a subject-object distinction as its point of departure. Based on philosophical arguments of Heidegger and Wittgenstein, such

presumption has already been effectively challenged and fruitfully overcome by social constructionist theory and research as an accepted alternative to the data-oriented study of social facts. However, psychoanalysis *qua* Kleinian object relation effectively provides a distinct view of the ontological and epistemological relation between subject and object, that treats objectivity and subjectivity, absence and presence, phantasy and reality, rationality and irrationality, and verbal and preverbal as moments of experience that are inseparably intertwined and meaningfully involved in a dialectical process. As dialectical binaries, these are not so much contrary or mutually exclusive categories as they are contradictions immanent in human experience (For an elaboration of this theme see the discussion of being and non-being in Sartre, 1938). Such a dialectical process is said to underlie the construction of reality wherein subject-object distinction involves a fluid relationship between psychic reality and external reality.

As a result, the proper epistemic object of psychoanalysis is the dialectical process of transference-countertransference, and by extension, all intersubjective situations wherein objective reality fades into primitive phantasy, and in turn, primitive phantasy reifies into reality. Undoubtedly, such perspective would be at odds with neopositivist criteria that insists on the distinction of ideas from facts, and upholds validity as the correspondence of ideas to facts. Yet, applying the neopositivist criteria of objectivity to phenomenology and psychoanalysis is no different from asking marine biologists to start their research on underwater life forms from the premise that insists: only the creatures on the surface of the land can be considered as objective forms of life. By the same token, psychoanalysis and phenomenology begin from the shoreline where the perceptible solidity of the real precipitously disappears into the mysterious oceanic

depth of subjectivity and intersubjectivity, a depth that inspires communion with profundity in the search for meaning as insight.

2.2. The Uncanny Truth and the Deviation from Scientific Truth

Assuming a distinction between subject and object, neopositivist approach insists on verification of truth against reality in empirical settings. To countervail the correspondence theory of truth, it would be necessary to define the kind of truth that psychoanalysis and existential phenomenology intend to establish, and to show why it deviates from scientific truth. One aspect of this truth can be said to be its self-reflective quality that questions the preconditions of knowing, or asks what makes knowing possible.

This question was originally formulated by Kant's critique (1781/2003) and thereafter developed into a number of diverse theories of knowledge. Through his first critique, Kant argued that knowing is a transcendental process rising from *a-priori* categories of mind, rather than from experience with the real. In his view, "though all our knowledge begins with experience, it by no means follows that all arise out of experience." (1) In his view, the transcendental ego (*Das Ich-Denke*) brings to a given experience the pre-given conditions of knowing. Thus, the knowing mind owes its accomplishment not to the presentation of reality in the mirror of consciousness, but to its innate categories for thinking and making sense of experience. For being beyond experience, these categories were said to be transcendental.

After Kant, knowing as the main operation of the mind (*Geist*) was rediscovered to be intersubjective rather than transcendental. Subject was explained historically based on an on-going process of conflict and self-becoming. Hegel proposed a dialectical dynamics of mutual transformation between what "begins from experience" and what is "not rising from experience." He redefined "what begins from experience" not as crude reality. For him, it is history that affords us all "that begins from experience," as we are born into a society with a pre-existing order of intelligible things. In this manner, what is reality at any moment (*Ding-für-sich*) was someday an unreality, a mere possibility of mind (*Ding-an-sich*) that is now turned into a particular actuality (*Ding-an-und-für-sich*). In his view, it is through self-particularisation that mind projects itself outward only to reclaim itself back and to make yet anew another process of self-particularization.

In Hegel's dialectic, there exists an interaction between the two polarities or between that "which begins," and that "which is not rising" from experience. Hegel (1807/1971) reformulates subject-object binary into the subject-object totality wherein subject and object are necessary and indivisible terms of a single process. In this totality, human beings reshape nature and create history. More importantly, in this totality, "what is not rising from experience" is perpetually self-actualized, only to get self-negated. Gadamer (1976:119) explains the objective of Hegel's epistemology in the most succinct and useful terms:

> It showed that consciousness and object are in fact only two sides that belong together and that any bifurcation into pure subject and pure objectivity is a dogmatism. The series of dramatic developments that constitutes Hegel's Phenomenology of Spirit rests directly on an awareness of the fact that every consciousness that knows an object alters itself and hence also necessarily alters its object once again.

In this manner, Hegel (1812/1969) describes the self or the thinking agency (*Das Ich-Denke*) as changing, much like the reality that it changes. Hence, the categories of thought as preconditions of knowing are by no means fixed and ahistorical. Rather, they are in process of becoming, as they come to be and cease to be constantly. This is known as Hegel's ontologization of categories of thought and logic.

In his later work, Hegel made an important distinction between mind (*Geist*) as rational and collective agency, and psyche (*Seele*) as a personal agency of feelings. Hegel (1817/1971) recognized something not quite rational at the core of subject-object totality, regarding which he remained ambivalent throughout his later writings (Mills, 2002; Berthhold-bond, 1995). He referred to it as pit (*Schacht*), or abyss (*Abgrund*) and described it as unfathomable (*Ungründlich*) and nocturnal (*Nachtlichen*), and as part of the feeling soul (*Fühlende Seele*) and life of feeling (*Gefühlsleben*). In this nocturnal abyss, "a world of infinitely numerous images and presentations is preserved without being in consciousness." (EG 453) Moreover, he recognized phantasy as part of imagination or as poetic imagination, to which he referred as "symbolizing, allegorizing, and the poetic power of imagination." Hegel sees phantasy as the place where sign, symbol, and language begin (For a thorough elaboration of this theme see Derrida, 1972).

After Hegel, an understanding of intersubjective mind, as posed along a historically constructed reality, emerged on the epistemological scene. Hegel's philosophy of mind changed the attitude to truth and made his successors to focus on two new questions: 1) what would constitute the intersubjective character of knowing and mind, and 2) how such intersubjective and historical constitution would change through practice of critical reason and action (*praxis*). In effect, Hegel's redefinition of mind

opened before us a new perspective, wherein knowing and reason could be understood as part of historical and social process of being and becoming. From this perspective, truth is no longer the inert feature of an idea, "but instead takes shape and appears in the midst of human affairs." (Disenco, 1990:26) This realization has changed the notion of truth to an event that rises from social and historical conditions, and it has a prospective character that can undo and change such conditions by revealing the hidden alternatives of being and action. Hence, knowing as critical practice was said to rise from human affairs, and to lead back to them in a struggle to reveal and uncover the critical beyond.

From this history, a different notion of truth has emerged, one that is not based on correspondence (i.e., positivist and realist) or coherence (i.e. idealist and rationalist), one that in fact rises from subject-object relation rather than distinction. However, when relation replaces distinction, truth becomes not only a matter of "what is the object," but also a matter of "what is the relation in which object is experienced." It is this latter question that creates the notion of truth as uncovering which implies undoing concealment. The uncovering calls into question the relation in which the object is experienced to uncover the preconditions of knowing that create a self-soothing experience or a knowledge that comfortably affirms our habits of mind. Form the viewpoint of truth as uncovering, it is only by seeing how knowing creates soothing self-sameness that new possibilities of understanding (*Verstehen*) can emerge. In this manner, truth as uncovering requires the subject to understand (*Verstehen*) and to explain (*Erklären*) the objects, while trying to uncover the process from the habits of thinking and the preconditions of knowing that are implicit in the relation with the object.

The term, understanding, refers to the primary process of grasping the intrinsic meaning intended and shared by those who have lived an experience or authored a text (Dilthey, 1988: *Verstehen*). On the other hand, The term, explaining, is a secondary process that relies on the first to elucidate the extrinsic meaning of an experience in terms of causal relationships, or as a text in relation to other events or texts (Dilthey 1988: *Erklären*). To understand in self-reflective manner is to become at the same time aware of the pre-conditions of subject-object relationship. Through such awareness, knowing can reach beyond the normative language and methodological frameworks, to articulate a new understanding. In effect, the resulting knowledge breaks the soothing habits of thought in order to create new possibilities for subject to relate to object. Such overhauling of habits and relations can result in critically valid outlook of understanding, explaining, practicing, and changing.

To change the subject-object relation becomes possible, when knowing becomes critically self-reflective. In this manner, a critical exploration of self-soothing habits of subject's relation to object becomes as crucial as the detailed observation of facts, itself. For, facts are disclosed to mind through a relation wherein the subject is as much the maker as is the observer of truth. Through revealing how subject relates to object, one can uncover what has been left nameless (out of common discourse) or misnamed (distortions of common discourse) in the normative subject-object relation.

When it comes to questioning the preconditions and habits of today's established way of relating to empirical objects, the task is not unlike the story told by Borges (1970) about the imperial cartographers who undertake to draw a detailed map of the empire. In a surreal turn, their relentless obsession with all things objective results in a map as big as

the empire itself that not only unfolds over the entire dominion, but also displays the mapmakers in the act of drawing. In a sardonic twist, they end up neither removing themselves from their map, nor uncovering the imperial dominion from beneath the expanse of their gigantic atlas. The surrealism of the story is in many ways more than real, in the sense that no matter how objective, our replicas of reality not only ultimately carry their makers, but also cast a lasting shadow over what was once their original object. However, this irony must not make us conclude that truth is arbitrary and that there is nothing at stake. On the contrary, the critical approach to truth agonizes over what is at stake. It demonstrates how the discourses and practices that stipulate our accepted methodological habits circumscribe subject-object relation to create a self soothing construction of reality as self-sameness. Hence, the unconcealed truth invites the reader to consider a new subject-object relation that starts from the critique of the established one and asks the reader to assess its validity in terms of both its critical and its observational values.

As an effective method and philosophy of unconcealment, existential phenomenology recognizes that what exists appears out there independent from human agency and language, yet all that appears can only be disclosed through language. Without language as interpretation, there would be no disclosure and no representation. Heidegger reminds us that being human means being born in language. In this sense, as "we leave the speaking to language," so we leave the interpretation to it. For Heidegger, disclosure and interpretation in unreflective manner makes subject-object relation nothing but a self-soothing practice, to which he refers as inauthenticity or resignation to the unreflective tranquility of the public (*Das Man*). Inauthenticity is, in effect, an escape

from finitude as Being-toward-death (*Sein-zum-Tode*). Heidegger argues that the awareness of the temporality of being makes us anxious about our finitude. It is this mood (*Stimmung*) of anxiety that attunes us to what is unreflectively taken for granted in our being-in-the-world. Thus, Heidegger calls anxiety the ground-mood that discloses indefiniteness (*Unbestimmtheit*) of death and makes us reflective about temporality as the ground of being. In this sense, those aware of temporality feel anguished and can no longer accept the way of the public (*Das Man*), and realize how normative views condemn us to the monotony of an unreflective life. Heidegger temporality has largely been left obscure, yet it is clearly the experience of time as living history that involves non-being.

Living resolutely in the face of death makes one feel ill-at-ease and uncanny (*unheimlich*: unhomely) with the commonly shared, all-to-familiar sense of being. As anxiety tunes the person to the possibilities of *Dasein*, "the meanings and truths making up the fabric of the world become alien to the individual" (Hoffman, 1993:203). The individual in existential angst longer feels at home (*Heimlich*: canny) with the publicly avowed truths, as anxiety of non-being makes "the fabric of the world" appear in tatters. In this sense, through the concept of angst, existential phenomenology asks for an emotional re-orientation to the phenomenal world that as Heidegger believes would inevitably lead to a new disclosure, language, and interpretation of Being. As a result, Heidegger challenges habits of thinking with the habits of feeling before asking us to reflect on our habits of interpretation and language.

Heidegger's re-orientation to temporality of being is no doubt uncanny, as it upsets the subject's abode of taken-for-granted meanings. And, it is indeed from

uncanny that psychoanalysis like phenomenology begins its reflection on truth, as the unconcealment of the eerie and the un-homely. Ironically, Freud (1919) characterizes his study of uncanny as an "aesthetic investigation." Published at the end of the Great War, and only one year before his major work on death instinct (Freud 1920, *Beyond the Pleasure Principle*), *The Uncanny* offers Freud's application of psychoanalytic theory to Gothic art. In effect, by the reason of his designation as an aesthetic study, his theory of uncanny has not been received as a serious work in epistemology and hermeneutics, even though it has been cited extensively in art and literary criticism. However, for Freud, aesthetics is less concerned with the theory of beauty than with the quality and expression of everyday feelings.

In his investigation, Freud recognizes the marginal interest shown at the time by aesthetics in the phenomenon of uncanny as "the realm of frightening, of what evokes fear and dread." (123) Questioning the habits of feeling, he contrasts the abundant interest shown in "feelings of a positive kind" with the rather meagre inquisitiveness about "repulsion and distress." For Freud, this disparity betrays the repression of the unwanted and the *risqué*. He, therefore calls into question the habits of thinking that views the evocation of dread as a reaction to uncertainty. What at the time was called the theory of "intellectual uncertainty" (139) can be compared to today's cognitive theory of dread that attributes fear reaction to an encounter with strange uncertainty as defined by total lack of clarifying knowledge. Freud argues against the theory of intellectual uncertainty of stimuli, as he points out a variety of everyday examples wherein a disposition toward the embellishment of fright can be observed. He sees the rich and widely projected images of dread and fear as a proof of a much deeper involvement of the

psychic dynamics that link together Gothic art, the ordinary ghost stories, nightmarish dreams, pre-modern belief systems, and woeful fantasies. For Freud, uncanny entails the return of "superannuated ideas" hidden at the heart of the mundane realism of the modern life. In his view, these images serve as the mythic prototype for a banished past.

To explain the psychic dynamics of this return, Freud builds a parallel between the recurrence of the historically surmounted traditions that were thought to be long-gone, and the return of the psychically repressed thoughts that were felt to be forgotten or outgrown. In Freud's view, such return involves the subterranean region of consciousness wherein unwanted and hated relics of the past namelessly live on, beneath the cherished images of the present, waiting to return. In this sense, uncanny is the emotional quality associated with the return of what has been split off from the self and banished from understanding. It is acutely felt as part of the experience of gothic art and or brought about through analytic interpretation as unconcealment. In this sense, the repressed images of past remain latent but vibrant, waiting to resurface and to evoke dread. In all manners, such return is indeed uncanny as it springs from within or from the comfort of the home and not from any foreign territory that lie without. Prefacing Freud's text, Haughton deservedly emphasizes this sense of uncanny:

> It is associated with the moments when an author, fictional character or reader experiences the return of the primitive in an apparently modern and secular context. For Freud as uncanny theorist, however, this is also a survival from the abandoned psychic culture of our own childhood, bearing the Gothic signature of our own earliest terrors and desires...For Freud, though, those nightmarish myths and primitive beliefs themselves are only estranged childhood fantasies writ large. 'The Uncanny' reminds us not only that there is no place like home, but that, in another sense, there is no other place. For Freud, our most haunting experience of otherness tells us that the alien begins at home, wherever that may be. (Freud 1919, the Uncanny: xlix)

As what is uncanny makes us feel no longer at home with ourselves, it make us feel at home nowhere. In this way, "the uncanny becomes an experience whereby that which had or has been familiar becomes suddenly and inexplicably alien and strange." (124) Through return of the repressed in everyday life the familiar as taken-for-granted becomes suddenly alien. This is indeed the same effect that analytic interpretation evokes, when by revealing the latent content to consciousness, it dispels the aura of familiarity and self-evidentiality of rationalizations.

Freud shares with Heidegger the appreciation for uncanny as the feeling that re-orients the subject to the possibilities of new meaning in the world of experience. Yet, in Freud's estimate, uncanny does not necessarily lead to authenticity. In this sense, even though it means the return of the banished, it does not mean its resolution or integration. In fact, it is the quality of the integration of what has returned that decides the fate of the process. However regardless of this important difference, for both authors, this eeriness at home portends to a possibility of understanding beyond the self-soothing illusions of the present. Freud sees this possibility in the banished past within, while Heidegger finds it to in the disquieting resurfacing of non-being. In Heidegger's word, "everyday language is a forgotten and therefore used-up poem" (208) that can be restored by salvaging its lost poetry. For psychoanalysis on the other hand, everyday life is a world standing on a repressed double (*Doppelgänger,* Freud, 1919:) that has been denied all stance in discourse and conscious mind. Hence, it is not the lost poetry, but the banished phantasies that the psychoanalytic interpretation seeks to unconceal.

If knowledge is perspectival, psychoanalysis argues that it is not primarily from the subject's position in language, social structure, cultural habitus, or political discourse

that perspective is articulated. But, it is from the transposition or insertion of the subject's unconscious phantasies into the lived experience of the object as the other that the perspective of knowing and relating takes shape. It is this transposition that makes all other instances of social and discursive positioning uncanny, as it colours them with the concrete hue of the emotional experiences of infancy that is split from the self and made into "the alien at home." To reveal this unconscious transposition means to unconceal how this "alien at home" operates in the intellectual habits of the mind as the enduring primitive meaning of relating to the object as the other. Hence, "the alien at home" is that of which we are unconscious, as we assume an object in the act of relating, speaking, and knowing.

However, it would be a valid question to ask: what may warrant such unconcealment as proposd by psychoanalysis? Going back to the correspondence theory of truth, the map as the replica of the reality appears as the ultimate act of representation, in which no trace of its maker must be ever detected. However, unconcealment seeks to show that the cartographers' frame of primitive phantasies and perspectival discourses have been part of the map all along, in spite of all claims to the contrary. In effect, the truth as uncovering is meant to reveal how through successive maps, elaborate realities are constructed to hide the trace of the mapmaker. Such endeavour must not be construed as an attempt to debunk science as a mere fraud. Rather, it must be understood as an effort in showing that scientific methodology cannot obviate the need for self-reflective critique of subject-object relation. Hence, no matter how strict the data-gathering methodology, self-reflective critique must still ask how this knowledge occasions an intelligible order that selectively takes stock of human experience and denies painful

aspects of being, or in Heidegger's term to go beyond the warn-out poem and to discover the lost poetry of the banished parts of the self.

However, such self-reflective questions are not posed for the sake of arriving at an ultimate truth that is untainted by distortions of human fancy and phantasy. To the contrary, regardless of how we create an intelligible order, knowledge is never disengaged from its subjective context and from the social and psychic reality. Yet, critique does not become futile, when knowledge remains hopelessly tainted and oblique. For, the function of critique is to make scientific knowledge and neo-positivist methodology less emotionally seductive, or less capable of breeding the kind of intellectual and moral complacency that can lead to unchecked and self-deluding complicity with omnipotent phantasies of being in control of the object or in fusion with it. In effect, when any knowledge, even psychoanalytic knowledge, presents itself or its methodology as being beyond self-reflective critique of subject-object relation, seduction becomes the inevitable outcome. If rationality is to be true to its end, it must remain self-reflective in order to reveal irrationality as its internal double (*Doppelgänger*) and not as its external obverse. In this manner, the question becomes to what extent any purported impartiality and objectivity enfolds its double, without being able to account for it. By the same token, the self-reflective critique of knowledge is an ongoing investigation of how prevailing regimes of knowledge partake in the practice of seduction, by projecting and reifying their double into an antagonist and divert their anxieties to a unwanted and debased alter as opposed to the self.

As a result, every attempt in knowing must be examined as potentially mystifying the subject-object relation and human condition by creating an intelligible order of things

that can engender seduction and hegemony. By definition, hegemony refers to forms of action and discourse, whereby self-soothing and forgetful practices are justified as sensible and realistic methods, accepted on pragmatic and natural basis, and enforced through routine and everyday practices. Hegemonic discourses occasion collective forms of persuasion that reconcile people to the disciplinary regimes of knowledge and power (Castoriadis, 1986) that validate knowledge within a controlled perimeter. Through common-sense distinction of subject-object, hegemonic practices mischaracterize reality as being "out there" or as "the given," rather than as being "constructed" through psychic, social and historical processes. When reality is seen as being the natural state of affairs, achieving one-on-one correspondence with the so-called naturalness becomes the ideal of "real" knowing and by extension the principle of "real" being. Consequently, being natural and living natural are naively exalted over the attitude that tries to qualify the construction of this naturalness.

As aforementioned, at the heart of this attitude to knowing and being lies in the assumption of a fixed subject-object distinction and opposition that is taken as a matter of unshakable epistemological ground for neopositivism. This sacrosanct assumption shapes the disinterested methods of observation, wherein valid knowledge is appraised as both prespectiveless and subjectless. It is the same assumption that allows neopositivism to disregard the opacity of subject-object relation, and to promote indifference to any critique of what is persumed as real, given, natural, practical, rational and normal. On the other hand, the self-reflective critique of knowledge seeks to unconceal how the prevailing regimes of knowledge partake in the practice and reproduction of seduction, as they project and reify their uncanny irrationality as an external other in order not to

assume responsibility for it. Freud's concept of uncanny as the return of alien at home is of great value in such self-reflective effort, as it allows us to redefine the fundamental terms of subject –object relation.

2.3. Methodology of Unconcealment and Verifying Truth in Subject-Object Relation

In quantitative research, objects of inquiry are operationalized into measurable quantities detached from the subjectivity of the observer as experimenter. In this methodology theory is important insofar as it generates testable hypotheses that can lead to the discovery (Heidegger, 1962: *Entdecktheit*) of generalizable statements. Such generalization is predicated on the inferential statistics and its particular application of probability logic. By definition, probability logic infers an event or a relation as *statistically significant*, when its *presence* can be shown to be more *prevalent* than chance occurrence (Carnap 1953; Hempel, 1952, 1964). Thus, *statistical significance* is defined against *blind chance*. Statistical techniques based on probability estimates infer events and patterns of relation between two or more variables according to regularities detected between or amongst them. The golden rule of statistical inference maintains that the best predictor of the future behaviour is the past behaviour. Hence, *regularities* observed, measured, and recorded from a sizable sample of representative members of a population are used to infer and to predict the behaviour of the whole population. In this manner, the kind of truth established is probable truth which states it is *generally* (significantly probable) true that given event "A," event "B" is the outcome. However, the same proposition cannot be claimed to be *necessarily* true. In this approach, truth claims about

events, A and B, are taken to be realistic descriptions of the relation and properties of these events.

Similar to many qualitative investigations, the present study uses a hermeneutic approach. As a result, requirements of empirical science and inferential statistics do not guide the methodology, analysis, and reasoning of this study. As aforementioned, the hermeneutic approach is established on the subject-object relation, rather than distinction. Hence, it views truth as the product of the relation that the subject establishes with the object, and comes back to itself through the object, in a self-reflective manner. In hermeneutic analysis, the subject begins from questioning the accepted mode of knowing in order to occasion a new way of relating to the object and ultimately to itself.

To this end, as Gadamer states (1990a:153) "over against the whole of our civilization that is founded on modern science, we must repeatedly ask if something has not been omitted..." In fact, the omitted is "what is to be met in all human orientation to the world as *atopon* (the strange), that which does not 'fit' into the customary order of our experience." (Gadamer, 1976:25) Through act of interpretation, what remains otherwise hidden not *from* but *in* our experience and consciousness, is given disclosure and brought to unconcealment in order to transform "the customary order of our experience." In this manner, interpretation is a self-reflective act that seeks to understand primarily what is hidden to experience from within as a way of establishing a new subject-object relation and a new self-reflective attitude (Davis, 1978;). Without reflection on preconditions of knowledge or "given preunderstanding," one cannot say what has been left no place in language and discourse. "Reflection on a given

preunderstanding," Gadamar (1976:38) states, "brings before me something that otherwise happens behind my back." Hermeneutic is, therefore, "the art of interpretation through transformation." (Ferraris, 1996) In other word, it is the art of understanding the object through transforming subject-object relation that ultimately leads back to the subject's self-understanding.

As opposed to statistically inferred *probable truth*, hermeneutic approach establishes *possible truth*. In effect, hermeneutic practice asks, what would be *possibly true*, if we reach beyond "the customary order of our experience" and understand the uncanny that has no place (*atopon*) in discourse. In this sense, when it comes to precedent, truth as possibility relies on a different kind of evidence. Probable truth takes into account the regularities of "what has been happening" in order to generalize to "what would generally come next, or happen." In contrast, possible truth allows for the abandoned irregularities, dismissed oddities and neglected ruptures to be considered as precedent and as evidence of uncanny truth. Possible truth is about dismissed and denied meaning of the uncanny and as such its claims are established on interpretation of dreams, play content, daydreams, slips of tongue, hysterical symptoms, marginal practices, emergent oddities, sordid idiosyncrasies that are often discounted, omitted, denied, ignored, or simply forgotten in the secreted junkyard of everyday consciousness. Possible truth begins where the uncanny is passed over and is not seen as a meaningful portent. In contrast to probable truth begins with the ratio of the a desired event on all *equally possible* cases, possible truth questions how we define events of *equal possibility* to show that they are not independent from human interests and phantasy that form the preunderstanding of possibility. In short, possible truth can be distinguished from

probable truth on at least three grounds: 1) its focus is what is felt as uncanny; 2) its evidence is what is discarded as having no meaningful potent; 3) its content is what has not been afforded a place in discourse; 4) its method is what has been denied in neopositivist subject-object distinction.

What has been so far explained as possibility or possible truth refers only to critical application of the term which is distinct from the normative notion of possibility as explained either in mathematics, or in pragmatics. The critical possibility is the result of questioning the established frame of feeling, thinking, and talking. In contrast, the normative view of possibility is largely established on a quantitative calculus. The science of possibility is a mathematical theory that describes possibility as a method of dealing with data uncertainty (Zadeh, 1978). What is known as possibility theory is generally viewed as an alternative to probability theory in dealing with specific kinds of uncertainty, for which possibility theory has proven to be a more efficient method. Based on this definition, the difference between possibility and probability has been reduced to formal methods of computation for dealing with uncertainty. To estimate possibility, a calculus (Max/Min and Max/Times) different from the probability calculus (Plus/Times) is used.

A rather commonplace example may better elucidate the difference between probability and possibility from mathematical point of view. One can demonstrate the distinction between the two by the means of an event with a low probability but good possibility. For instance, winning a lottery such as 6-49 for a buyer named "M" is a highly improbable event. The odds are 1 to the factorials of 49 for every combination selected by M. One can therefore say that it would be highly improbable for M to win.

But, does it mean that it is impossible for M to win? Can M be convinced that since it is improbable for him to win, it would truly be impossible for him to win and he should not buy tickets? That is of course an untenable argument. For, as long as 1 chance over the factorials of 49 exists, it would be possible for M to win, even though it is highly improbable. In fact, if M bought a ticket and won, it would be no surprise from possibility point of view. But, it would be a surprise from probability point of view. If possibility of an event is reduced to null that event is said to be false. For example, it is impossible for the sun to revolve around the earth.

It has been said that for events involving human judgement, the possibility theory can serve as a better model of decision making than the probability theory (Zadeh, 1978). This can particularly be the case when an event is viewed as extremely positive or negative. For instance, what M would do if the jackpot prize reaches 10 million dollar for the week's draw. Would M decline to buy tickets on account of low probability, or would M buy one in the light of the good possibility? How possible is that possibility, anyway? In that case, what decides the goodness of the possibility: the high likelihood of having at least one winner for the draw, or the subjective appeal of the prize? Same point can be made regarding buying a life insurance policy. If M is imagined to be a young, fit, active, working, and healthy person with dependents, what are the probabilities of M's dying a sudden and premature death? Would M still buy a policy based on possible event of sudden death, or would M decline based on low probability of a sudden death among his cohort? What makes the possibility of a certain event appear as good or strong? Are human beings more inclined to act based on possibility that are deemed good or bad, or are we creatures of probability? These are not easy questions to answer, but they show a

realm of uncertainty beyond probability, wherein the fate of uncertainty would not be decided on the basis of probability. Here, the possibility of a much desired event seems all the more plausible than the low probability of its happening. In fact, despite their repeated loss, most buyers keep purchasing lottery for the reason of its alluring possibility and prove probability to be a bad predictor of their future behaviour.

What mathematical theory of possibility and inferential statistic fail to consider is the relation between probability and possibility in the world shaped and reshaped by human desire, action and understanding. For an event to be possible, it only requires to have a chance happening of more than zero. Whereas for an event to be probable it needs to have a minimum chance happening of 19 times out of 20 ($p = 0.05$). Yet, people and individuals commit themselves to actions, events, and discourses based on what they believe their possibilities *are* or *can be*. It is, in fact, from what people hold as possible that probabilities of action and truth are fashioned. In this vein, regularities and likelihoods established on observed frequency and sample size miss to recognize that the purpose of inference is not always to find the most likely truth. Rather, inference can lead us to the previously unknown and unrecognized possibilities that can transform our understanding and create new horizons for insight, meaning, and human action.

Although possibility according to mathematical theory can facilitate certain aspects of decision making, it transfigures possibility from a critical notion to a computational function. Computationally speaking, possibility is a way of dealing with uncertain data to create reliable certainty. In contrast, critical possibility is a way of confronting the certainties of knowing and being by dismantling our habits of understanding, and by undoing the customary order of experience. In effect, critical

possibility runs in the opposite direction of computational possibility, in order to unconceal new understanding. Mathematical possibility helps decision making to go from uncertainty to relative certainty by the means of computing as the ultimate method of pattern making. Hence, the difference between certainty and uncertainty would be reduced to what can be made part of a pattern (a set in this case) and what cannot. However, such understanding if applied to the realm of meaning, can generate a deceptive effect, as the radical difference of unknown and uncertain can be denied in favour of known patterns and their stability. Gadamer (1976:11) candidly notes this effect by stating how hermeneutic possibility steps beyond the statistics and methodology of science:

> It is an extreme example, but it shows us that science always stands under definite conditions of methodological abstraction and that the successes of modern sciences rests on the fact that other possibilities for questioning are concealed by abstraction. This fact comes out clearly in the case of statistics, for the anticipatory character of the questions statistics answer makes it particularly suitable for propaganda purposes. Indeed, effective propaganda must always try to influence initially the judgement of the person addressed and to restrict his possibilities of judgement. Thus, what is established by mathematics seems to be a language of facts, but which questions these facts answer and which facts would begin to speak if other questions were asked are hermeneutical questions. Only a hermeneutical inquiry would legitimate the meaning of these facts and thus the consequences that follow from them.

Restricting the possibilities of critical rationality can be the inevitable outcome, when statistical and computational methods are used for assessment of knowledge. By going from uncertainty to certainty, the calculus of possibility theory reduces the critical ability of thought to the mere play of patterns of certainty with no appreciation for the uncanny.

However, mathematics is not the only branch of thought that has been grappling with possibility. Within logic, possibility has for some time been the focus of discussion.

Through the analysis of the ordinary statements of possibility, Hacking (1975) differentiates two kinds of possibility which he calls: *possibility for* and *possibility that.* For instance, on can state:

1) It is possible for Jane to do the exam,

2) It is possible that Jane will do the exam.

In the first example, the statement indicates Jane's ability to do the exam. It says the event is possible, for the reason that Jane can make it happen. Hence, Hacking calls this possibility *de re.* In the second, the possibility is based on what the speaker knows of the situation surrounding Jane and the exam. It says that based on what appears it is possible that the event will happen. According to Hacking, this latter statement is an epistemic or *de dicto* possibility.

However, Hacking's differentiation between these two kinds might prove to be not so solid, when possibility comes to signify what is permissible for the Jane to do. For instance, "it is now possible for you to talk" is a statement that tells to Jane what has become possible for her to do at a given time. This possibility has little to do with Jane's actual ability for talking. However, it indicates a precept that lifts an injunction on talking for Jane. In that case, the statement is a *de dicto* possibility without being necessarily epistemic. For, it states a command of authority telling her what she can do. Yet, that is not all. Since, such statement of authority may carry a *de re* meaning as well. Its *de re* effect depends on how far Jane may believe that this statement is stipulating when her real possibility begins and ends. In other words, if Jane accepts this *de dicto* statement of possibility that say: it is *now possible* for Jane to speak, it becomes *then possible* for her to speak (*de re*). In this example, what would possibly happen depend on

how far *de dicto* possibility can persuasively command Jane into accepting *de re* possibility. If it fails, Jane might decide to protest and not to speak. Then under conditions of protest or transgression *de dicto* possibility collapses and becomes untenable.

It goes without saying that permissibility is not restricted to imperatives of power or to dictates of authority. As understanding and explaining are both predicated on language, what is truly permissible and possible is what is afforded a place in discourse. In this sense, what exceeds the resources of discourse surpasses articulation, and remains nameless and absent as far as the explicit content is concerned. Reflecting on this limit of expressible, Ricoeur (1981) points out:

> A quotation from Humbolt will lead us to the threshold of this new field of investigation: 'Language as discourse (*Rede*) lies on the boundary between the expressible and the inexpressible. Its aim and its goal is to push back still further this boundary.' Interpretation, in its proper sense, similarly lies on this frontier. (176)

When the boundary of the expressible grows unyielding and impermeable, knowing and thinking can become unreceptive to the ineffable unknown. Interpretation can then open understanding not to what lies beyond language, but to what is inexpressibly hidden at the heart of language and reason. It is through interpretation at the frontier of expressible that possibilities of meaning and truth are unraveled and the meaning of the uncanny is unconcealed.

In his more recent publication, Hacking's (2006) explication of two forms of possibilities, although useful, is utterly incomplete. His argument effectively demonstrates two ways of talking about possibility without exploring the relation between the two in the pragmatics of speech act. As a result, it does not adequately

illuminate the various ways in which these two forms of possibility may inter-penetrate one another in ordinary discourse and practice. In particular, Hacking shows little interest in discussing how through permissibility, *de dicto* and *de re* lose their distinction and assume a dialectical relation. In many ways, Hacking's distinction between *de dicto* and *de re* resonates the distinction between subject and object in neopositivist epistemology. And much the same, it effectively leads to creating a mode of thinking wherein a dynamic relation between the knower and the known is discounted in favour of a de-ontologized distinction. In contrast, critical possibility begins from a dialectical relation between the knower and the known, in order to show how *de re* is interpreted by the conventions of *de dicto*, and how *de dicto* is transformed by the expansion of *de re*. Thus, critical hermeneutics suspects such assumptions of distinction, and examines their validity in terms of their ontological vicissitude (*Schicksale*) in order to show that the very idea of possibility challenges both common language and prevalent understanding.

If possible truth—as meant in critical hermeneutics—radically departs from probable truth, what possibilities can be regarded as true and what must be deemed false? From epistemological viewpoint, the response to this question allows the hermeneutic practice in psychoanalysis to avoid open-ended acceptance or indiscriminate suspicion of all. For analysis, bringing into language what had never belonged to discourse and what was heathenized and denied from consciousness and understanding, cannot become an arbitrary act of random reconstruction. However, if all that have been argued so far about subject-object relation, unconscious phantasy, critical possibility, and interpretive reconstruction hold true, what can possibly be taken as fact or proof in psychoanalytic investigation? Would not our explanations become nothing more than hypostatized

theories with no point beyond them? Would not our interpretations become any thing other than soothing stories of metaphoric value for persuasion? These questions are concerned with the problem of facts, proofs, and relativism of explanations.

In ordinary parlance, *fact* is what can serve as evidence for or against a statement, while *proof* is the reasoning that presents facts as such evidence and reveals their evidential value. In the case of simple assertions based on overt perception, facts and proofs become indistinguishable. For instance, if I say: John is not in this gathering, one can point him out in the crowd and simply refute my statement. In this case, the proof is therefore ostensible rather than reasoned. However, for complex explanatory models dealing with complex phenomena, facts and proofs are two distinct but interrelated aspects of reasoning. In its common sense meaning, *facts* are self-evident knowledge that by the means of *proofs* as reasoned arguments, come to support or challenge a statement that is not self-evident, by itself. Without proofs, facts are of little value, and without facts, proofs are unsubstantiated. On the other hand, facts become only self-evident or patently obvious according to the perspective, context, and pre-understanding of the observer. Facts are normally observed and interpreted in accordance with the observer's perspective and theoretical orientation. In this sense, facts are not simply observed, as the research question, choice of constructs, operationalization, design and inferential reasoning determine what can be considered as facts or fiction. For instance, mathematics translates facts (observations) into units of computation, while discourse studies translate facts (spoken material) into units of speech act. Hence, we refer to facts by designations, such as: physical, empirical, hermeneutic, logical, historical, sociological, and more. But, are there such things as psychoanalytic facts and proofs?

How can they be found and how can they be examined and verified? To answer these questions, it would be necessary to review what psychoanalytic interpretation is and what it tries to unconceal as truth. Furthermore, it would be essential to show what facts are observed through analysis; what reasoning is applied; what proofs are built; and what inferences are made.

The question of what constitutes psychoanalytic facts and proofs has been discussed from two major viewpoints: 1) the psychoanalytic theory, or 2) the analytic situation. Green (2000) must be credited as the chief representative of the former approach. He argues that Freud's notion of *deferred action* (*Après-coup, Nachträglichkeit*) defines the nature of psychoanalytic evidence, so that only mnemonic traces of the events that assume meaning at a later point in time—as they are brought to present context—can be considered meaningful evidence. In this manner, deferred action reflects the temporality and causality of the psychic phenomenon from past to present. Hence, observation in "here and now" (i.e., infant observation) cannot in-itself constitute a meaningful psychoanalytic fact without having been retraced through unconscious distortions and symbolism from recent context to an earlier one. In this manner, past events assume significance and become analyzable facts only later in life. If deferred action is the necesary requisite of psychoanalytic fact, direct observations and interpretation in the here and now are of little valid use.

Although Green's argument with regard to deferred action as the defining feature of psychoanalytic fact represents an important line of reasoning, it tends to be for the most part one-sided. Green misses an important point by emphasizing on what is interpreted through deferred action. He confuses the ontological and the epistemological

status of the fact and holds the former confined to the latter. In this manner, phantasy becomes delimited to the evidence of phantasy that is uncovered later in life, and psychoanalytic fact to the strict terms of evidentiality as belated symbolism and causality through deferred action. The deferred action as belated meanings born entirely in present from mnemonic traces of the past is radically different from deferred action as belated remaking of primitive psychic reality in a way befitting the external reality of here and now. Although Freud's (1895, 1917) reference to this term describes how unconscious phantasy can assume belated meaning, it is no where definite that such meaning is the only one that is ever assumed or that is the only one with which psychoanalysis is to be strictly concerned.

Whether from theoretical or form technical point of view, the function of psychic reality cannot be reduced to strictly belated meanings, regardless of the role of phantasy in early development of symbolization and mental processes during infancy. Green's argument is in many ways the extension of the one made by Anna Freud and her supporters during the "Controversial Discussions" of 1940's (see King and Steiner, 1991; Steiner 2003) against Klein's discovery of unconscious phantasy and infantile development. In Klein's view, phantasy is coextensive with all conscious mental and external events, and mediates every experience of external reality from infancy to adulthood. Meltzer (1981:178) explains this relation between the internal and external as that of two parallel worlds:

> [Klein] made a discovery that created a revolutionary addition to the model of the mind, namely that we do not live in one world, but in two—that we live in an internal that is as real a place to live as the outside world...Psychic reality could be treated in a concrete way.

The idea of two parallel worlds that are in meaningful interaction from infancy goes beyond Freud's idea of mnemonic traces that are strictly rendered meaningful through differed action. In infant observation, the observer interprets a complex experience that includes only by observing the infants, but also "the feelings evoked in the observer as well." (Frosh, 2001:628-9) In this manner, infant observation has revealed behind the mundane interactions of the infant an inner world of archaic phantasies from which one can see the emergence of selfhood.

As opposed to Green's emphasis on analytic theory, there are others who explain the uniqueness of analytic facts based on the analytic situation. Ricoeur (1977) must be recognized for introducing psychoanalytic facts from the viewpoint of analytic situation. In his view, proof takes shape in the context of analysis that reveals the evidence as facts. In his editorial preface to Ricoeur, Thompson provides an unambiguous outline of his position and argument that is most useful:

> Ricoeur's current approach to this question reveals a shift away from his earlier work, where the emphasis was on the structure of psychoanalytic theory. His starting point now is the analytic situation, which determines what counts as a 'fact' in psychoanalysis. The relation between fact and theory is, in addition, much more complicated than that alleged by the traditional empiricist account. These preliminary considerations prepare the way for Ricoeur's suggestion that the type of truth claim raised by psychoanalysis is very different from the notion of truth presupposed by the observational sciences. For the truth claim of psychoanalysis is inseparable from the self-recognition achieved through the process of narration. Nevertheless, the explanatory dimension of psychoanalysis provides means of proof which are not contained in the narrative structure itself. It is in the complex articulation of psychoanalytic theory, interpretative procedures, the therapeutic treatment, and the narrative structure of analytic experience that the means of proof, and hence the criteria of a good psychoanalytic explanation, ultimately consists. (Ricoeur, 1981:24)

He, therefore, focuses on features of the analytic situation that guides the fact-finding and arrives at what he calls the narrative structure of analytic process. For Ricoeur, analytic

situation serves the purpose of bringing desire to discourse through narratization that restores the true historicity of human experience. Hence, analysis becomes "constructing or reconstructing a coherent story or account from tattered remains of our experience." (271) Ricoeur's emphasis on reconstruction of life histories as narratives that can be understood and followed has served as a foundation for the views of Schafer (1992) and Spence (1982) who see narratization as central to both therapeutic and epistemological spirit of psychoanalysis.

However, the emphasis on cohesion, construction, and reconstruction can be a greater problem for psychoanalysis than the empiricist critique. The idea of cohesion highlights the syntagmatic aspect of narration (i.e., splitting explained in terms of "degrammatized symbol") and takes the emphasis away from integration as intrapsychic dynamics (260). The integrative process does not necessarily result in narrative cohesion, as "integration achieved is never complete and defences against depressive conflict bring about regression to paranoid-schizoid phenomena, so that the individual at all times may oscillate between the two." (Segal, 1964:ix) From Kleinian viewpoint, cohesion can be only a by-product of integration and its value is relative to the quality of mourning and the capacity for reparation. In contrast, Ricoeur's argument promotes cohesion as a necessary requisite of narrativity for stories that can be followed. The insistence on construction of such stories can in fact introduce a level of indeterminacy in theory and practice that would transform analytic facts and explanations into inescapable circularity and indefinite plasticity. Secondly, Ricoeur's notion of "bringing desire to discourse" fails to reflect the radical difference between the preverbal nature of the primitive object relation and language. The radical difference of what is inexpressible is not best served

by the word, desire (*Begierde*). For his emphasis of language and narration, Recoeur's notion of fact is first and foremost a hermeneutic event and only secondly an analytic one.

Unlike hermeneutics that is the exegetical discipline of texts, psychoanalysis is a clinical discipline concerned with the inner experiences and psychic dynamics of suffering (*Unlust*). Historically, it began not from the interpretation of texts, but from attending to patients whose suffering was beyond understanding, explanation, or treatment. "No text as such," states Steiner (1995: 442), "has in its own etymology also the meaning of sufferance which the word patient carries with it." As a discipline dedicated to sufferance (*Unlust*), it has emerged from clinical case studies to show how suffering can be interpreted (*Deutung*), understood (*Verstehen*), explained (*Erklären*), and treated (*Behandlung*), all as parts of a single process of analysis. Its effort has generated insight (*Einsicht*) into psyche, or into the inner depth of the subject, with its archaic origins, phantasmatic content, and mystifying operations. Its theory has been used to explain the dialectic of absence and presence, inner and outer, past and present, canny and uncanny, real and phantasized, and rational and irrational. Beyond analytic situation, the findings of psychoanalysis have illuminated the anguish that permeates human life in a manner that encompasses the self and the other.

As a result, the hermeneutic aspect of psychoanalysis is not the art of avoiding the misunderstanding of a text, as its surface reading of definition indicates (For a depth reading comparable to analysis see, Gadamer, 1975:179). But, it is the art of working through the painful distortions of being that arise from the split off parts of the self and objects, parts that have been tangled with infantile desire and hatred, and parts that have

been scotomized beyond conscious understanding. In effect, psychoanalysis, following the vision formulated by Freud, has unveiled a different kind of misunderstanding, one that is part of our normalized thinking. Reflecting on Freud's extraordinary vision and unconventional diction, LaPlanche (1997:653) states:

> The sharpness of his vision is testified to by terms like "internal foreign body" or "reminiscence." They define the unconscious as an alien inside me and even put inside me by an alien. At his most prophetic, Freud does not hesitate over formulations which go back to the idea of possession.

He, therefore, continues his remark:

> From the moment the unconscious is brought back from its alienness to what one could call, along with theologians, an *intimor intimo meo* ['something more inward than my inwardness']—we can only observe a return to centering: there is something in me which I've split off from, denied, but which I must re-assimilate. Certainly, the ego is not the master of its own house, but it is, after all, nonetheless at home there. (659)

In this sense, whereas critical hermeneutics speaks of *the pre-reflective being-in-the world, the pre-understanding of experience* and the role of language as the *pre-given*, psychoanalytic hermeneutics focuses on "alienness within." More importantly, for critical hermeneutic, *angst* originates from non-being as human finitude, whereas for psychanalysis primitive anxiety is the function of death instincts as the destructive impulse that operates within the psyche from birth to death.

Kleinian object relation traces this "alienness within" to the preverbal phantasies that form the core and the dynamics of *psychic reality*. In his original definition, Freud (1917:368) states, "...phantasies possesss *psychical* as contrasted with material *reality*...; in the world of the neuroses it is psychical which is of decisive kind." Later development in psychoanalysis showed the role of psychic reality to be more all-encompassing than that initially explained by Freud with regard to neurosis. Psychic reality is shown to

underlie mature functioning and cognition. In particular, it is shown that primitive mechanisms of defence bring psychic reality to bear on our knowledge and perception of material reality, and on our interaction with the world. With the discovery of the significance of psychic reality, the hermeneutic as "the art of avoiding the misunderstanding of the other" has to changed meaning to: avoiding to misapprehend the *other within* for the sake of relating to the *other without.* In other word, psychoanalytic hermeneutic makes sense of transfer and countertransfer in order to understand the unkown within. For psychoanalysis, it is the unchecked distortion of feelings, actions, and thoughts in relating to others that is at stake.

Being acutely cognizant of this ineffable "unknown" at the heart of language and reason makes psychoanalysis *qua* Kleinian object relation distrustful of the de-ontologized positive binaries, such as: reason *vs.* unreason, subject *vs.* object, known *vs.* unknown. Thus, a different notion of thinking can be proposed, one that is "conversant with what is unknown" at heart of accepted reason. Steuerman explains this notion of thinking as:

> The idea of becoming 'conversant with what is unknown' is so distant from the traditional ideal of knowledge as mastery of the object presented, that Strachey translated 'unknown' by 'what (the patient) has now become acquainted with'...
> For Klein, Bion and the contemporary Kleinians, thinking cannot be dissociated from our very concrete emotional experiences of the world. It is a capacity for making links which can be traced back to the very early, preverbal, 'non-reasonable' experiences with the mother as a vulnerable baby. Thought does not come 'after', as a mature achievement of reason. Thought and reason bear also the unthought and unreasonable, and it is only by becoming 'conversant' with the pain and suffering as well as with the love and pleasure that we experience with the 'other' that we can pay tribute to our mature rational capacities as a human. This is not a solitary but an intersubjective achievement. (97)

Psychoanalysis brings forth the possibility for integrating the split off aspects of primitive object relation, wherein thinking and emotionally relating to the object have essentially remained intertwined. In this sense, interpretation steps beyond what is discursively manifest meaning to reach what lies beyond in the heathen region of the psyche where split off parts of the self and object are fomenting the primitive phantasies and the individuals unconscious inner world (Segal,). In Ricoeur's view, through interpretation as recollection of the inexpressible, the critical hermeneutic of suspicion becomes a hermeneutic of reminiscence (35). From Kleinian object relation point of view, through interpretation as "re-collection," the critical hermeneutic of suspicion can become a hermeneutic of integration, mourning, reparation, empathy, and gratitude.

As Steuerman reminds us, the novelty of Freud's notion of "unknown," even for Strachey, was hard to grasp. This difficulty reflects the utter alienness of the concept to the kind of thinking that sees knowledge as a means to an end (instrumental rationality) and initiates inquiries from a subject-object distinction (positivism). Freud interchangeable uses of words such as unrecognized (*Unerkannt*) and unknown (*Unbekannt*) are quite deliberate and begins from one of his first major analytic publications, *The Interpretation of Dream* (Freud, 1895). In this work, he presents his theory of interpretation together with his views on symbolic distortion and unconscious. In this text, Freud describes the unknown in more than ordinary terms to emphasize its obstinate quality beyond expressible. He, therefore, states:

> There is often a passage in even the most thoroughly interpreted dream which has to be left obscure; this is because we become aware during the work of interpretation that at that point there is a tangle [*ein Knäuel*] of dream-thoughts which cannot be unravelled and which moreover adds nothing [*keine weiteren Beiträge*] to our knowledge of the content of the dream. This is the dream's navel, the spot where it reaches down into the

> unknown [*den Unerkannten aufsitzt*]. The dream-thoughts to which we are led by interpretation cannot from the nature of things have any definite endings [ohne Abschluss]; they are bound to branch out in every direction into the intricate network [*in die netzartige Verstickung*] of our world of thought. It is as some point where this mesh work [Geflecht] is particularly close that the dream-wish grows up, like mushroom out of its mycelium. [German phrases added from Freud's original] (564)

In this passage, Strachey has been quite candid with the word unknown. In the light of later discoveries, Freud's early description is prescient and discerning. His choice of literary allusions and figurative expressions reflects his deep understanding of the *radical otherness* of the unknown and its refractory nature to literal meaning and propositional statements. Lying beneath the dream-content as dream-thoughts, the unknown keeps branching and bifurcating into a meshwork of meaning beyond interpretation and into "our world of thought." This underside of our thoughts, dreams, symptoms constitutes the hidden side of the rationality.

Freud is quite to the point that the act of interpretive unravelling is never perfect, since what is revealed always leaves behind other irresolvable entanglements. Analysis, if successful, would no doubt become transformative. But, in spite of its transformative effect, it cannot have claim to any emancipation (*pace* Habermas). As Steuerman points out:

> There will never be a thorough 'chimney sweeping' as the first patients in analysis hoped for. We cannot clear out the unconscious for, without it, conscious thought cannot exist. We can hope to achieve, however, a changed understanding of ourselves, one that acknowledges the role of the other subjects and non-rational elements in what we used to think as solely 'ours'. (15)

Psychoanalysis simply seeks the relentless undoing of the painful distortions of life in order to expand human capacity for thinking and feeling. The resulting transformation, if successful, provides a better self-reflective ground for contentment and justice. But,

emancipation is beyond the scope and the horizon of analysis, as it involves matters of historical and social reality and not psychic reality alone. In this manner, the need to renew the critique of rationality and to undo sufferance remains stable, since every act of integration is only an optimal and not a terminal accomplishment. As new forms of being, feeling, and thinking become themselves unreflective conventional practices, they eventually shift into a new common sense or a new normalized science of objectivity cleansed of the subject.

This critical endeavour can only be meaningful, if analytic interpretation and the ensuing process of psychic integration are neither seen as a realistic recollection, nor pursued as unbridled narratization. Realistic recollection turns psychic reality into nothing more than a repressed replica of real of the past, whereas unbridled narratization assumes a plastic psychic reality that can be rewritten ominpotently in the present. As argued before, analysis *qua* Kleinian object relation is a reconstruction, whereby aspects of occurring interaction are traced to psychic reality. These aspects of reality are re-examined in terms of infantile phantasies that are shown to have certain constant qualities and recognizable operations on the individual's mental world. Refering to Klein's anxiety positions, Steuerman states, "there are of two basic configurations of the mental world, and these two basic positions are exemplary of dealing with intersubjective reality." (18) Analytic interpretation makes recourse to "these two basic configurations of the mental" to retrace and reconstruct how intersubjectivity is mediated by psychic reality. The specificity of these two positions provides a frame for psychoanalytic observation and identification of facts. The content of anxieties rising in the

intersubjective world or in here and now serves as the clue for analytic interpretation to retrace elements of the two basic positions of primitive object relation.

In the process of observation and interpretation, *facts* are aspects of reality that arise from the subject-object relation (transference and countertransference) and invoke the eeriness and anxiety of the unknown. Hence, it is the feelings of the uncanny in the relation between the observer and the observed that reveals what can at any moment assume the status of fact and call for *proof*. The analytic proof is a process of walking back and forth between the psychic and the material reality reflecting on the nature of anxieties and feelings experienced by the analysand and invoked in the analyst. In this process, the uncanny as fact is traced to the psychic reality of the infantile phantasy to interpret the latent content or the unknown (*Unerkannt*), and is retraced back to the material or actual reality through insight to unconceal the primitive significance of the events in here and now. Ultimately, psychoanalytic interpretation is intended to reveal how ego's experiences of actual events are mediated by primitive phantasy. Through such reconstruction, the primitive feeling-I (*Ich-Fühle*) is restored to the adult thinking-I (*Ich-Denke*). In this manner, the reason rediscovers its living roots in the infantile phantasies of love and hate, and thereupon "what is re-collected" and "the one who re-collects" are both transformed to create new capacities for thinking and feeling.

As a result, psychoanalytic findings can be *validated* according to the transformative effect in analytic setting, or in a discursive situation that leads to a *new capacity for understanding and working through sufferance*. When psychoanalytic theory is applied to intersubjectivity as texts, discourse or socio-cultural phenomenon, its effect can be said to be revealing the uncanny unknown and to open *new possibilities for*

thinking and feeling, possibilties that are denied within our habit of thinking. For, they question our thought and raise questionable feelings about us. For instance, Freud's study of human discontent under civilization opened a new way for looking at the relation between individual and society. He argued how modern civilization despite having evolved from much yearned love of the family and community, inevitably leads to growing feelings of guilt and self-punishment. His analysis of the unconscious underside of civilization was valuable, since it opened a new chapter for future inquiries in the direction of the uncanny emotional underworld of culture. Although future studies questioned Freud's argument, no one can deny that his application of psychoanalytic theory to the problem of civilization potentiated a new capacity for thinking and feeling with regard to civilization and culture (a new sensitivity among researchers), and consequently changed the way we speak about ourselves as members of a civil society. This must be considered as the validity of his argument, as it changed the subject-object relation—in this case, self and society—by making it open to examination of unconscious feelings that underlie culture and modern life. Despite the subsequent development of disagreements and differences, the direction and the tenure of discussion introduced by Freud have continued in the works of many contemporary thinkers. In other words, the value of Freud's insight in creating a possibility for reflective studies on culture and civilization surpasses the actual degree of correspondence between his every argument and the reality. As a result, the validity of his work can be assessed in terms of its critical impact on defining subject-object relation within a community of researchers or within the greater arena of public self-reflection, as well as in terms of introducing a new area of inquiry hitherto non-existent.

By and large, reported psychoanalytic findings are ultimately *possible truths* and not probable truths. For, they do not tell us what can be probably true from regularities of the past. Rather, they surprise us with what can be a definite possibility of truth behind the uncanny irregularities of the present if interpreted in terms of archaic past. The analytic emphasis on the temporality of all occurring experiences stands in contrast to the neopositivist and realist assumption that "an object can be effectively represented (and as Heidegger has shown in his critique of technology, represented means mastered) in here and now of the atemporal presence." (Steuerman, :92) In this manner, the kind of possible truth that psychoanalysis offers is a critical one, as its existence has been denied out of consciousness and discourse and made unknown (*Unbekannt*) and unrecognizable (*Unerkannt*). By recognizing this unrecognizable truth, psychoanalysis expands human experience, feeling, thought, and deed to include an understanding of what was once denied. To this end, analytic findings reveal how the re-integration of *the unknown* can become a *true possibility* for a given situation. In this sense, they open possibilities of transformation or of transformative action for working trough sufferance.

When it comes to how primitive unconscious phantasy mediates our experience, a similar need for critical possibilities of understanding and action can be felt. It would not be an overstatement to say that the real focus of psychoanalysis lies in psychic reality. Although psychic reality is dismissed by our habits of thinking, when it comes to sufferance, it has shown to be not dismissable. For, psychic reality holds the eerie unknown, to which discourse and rationality remain vulnerable without a possibility of integration. Psychoanalysis offers a way to reflect on the "unconscious forms of relating and participating in an intersubjective world." (Steuerman, :xv) It is through this

reflection that *causal explanations* are formed to retrace our relating and participating to the unconscious phantasies. As a result, the *causal explanations* of psychoanalysis unconceal and explicate the uncanny ways in which what was lived in primitive past comes to determine or set limit to what is lived or can be lived in present. Steuerman expands this point by stating:

> But unless we recognize that thinking and reason, as measures of our humanity, are not abstract developmental processes, but concrete emotional experiences developed from very early interactions, we may not fully comprehend the level of unconscious fantasies that shape our mature abstract reasoning and argumentative processes...The fundamental contribution of psychoanalysis to such a project is the recognition that our capacity for thinking and tolerating separateness and difference has to acknowledge an unconscious world which can attack the most basic links that make understanding possible. It also shows that the unconscious, unknown world encompasses more than can be known by 'abstract', purely cognitive processes. (36)

This notion of unknown at the heart of the self and at the core of reason shapes the psychoanalytic critique of normative rationality, and defines the psychoanalytic approach to human suffering. In this sense, psychoanalysis is the systematic study and treatment of the abiding cunningness of unreason that underlies the world of intersubjectivity.

The application of psychoanalysis to qualitative or interpretive research can reveal how rational thinking systematically avoids genuine understanding as it continually faces the unknown within. In effect, when applied to observation in human context, psychoanalysis can make the observer refigure its position *vis-à-vis* the object by pointing out the docility and complacency of the normative preconceptions of thought in confronting the eerie unknown. As Waddel (1988:313-14) argues, such self-reflective method does not rely on objectivity as subjectless knowledge:

> It is a method with no claim to impartiality or objectivity. Rather the reverse, it is one rooted in subjectivity of particular kind—with the

> capacity to look inward and outward simultaneously; one that struggles to prevent observation being clouded and distorted through preconception.

Waddel's emphasis on psychoanalysis making no claim to subjectless impartiality cannot be taken lightly. Being rooted in a critical subjectivity, psychoanalysis makes the observer acutely aware of the uncanny relation between internal and external, rational and irrational, and subject and object. It is through this awareness that new possibilities of relating and participating in the intersubjective world emerge.

2.4. Conclusion: The General Choice of Method and Design

In what has so far been elucidaed, an epistemological approach for conducting psychoanalytic, qualitative research has been worked out in order to reduce the reliance of the present study on research epistemologies that are antinomic to the critical and self-reflective spirit of psychoanalysis. To this end, concepts such as possible truth, fact, proof, interpretation, understanding, and explanation were redefined based on psychoanalytic critique of modes of thinking epitomized by common sense and neopositivism that rely on subject-object distinction, and on correspondence-coherence theories of knowledge. It has been shown that the historical and disciplinary roots of this critique expand beyond the history and the scope of psychoanalysis. Today, whether in philosophy or in sociology and anthropology, rethinking discrete facts in terms of meaningful worlds of constructions has generated a different kind of knowledge based on subject-object relation, wherein objectivity is intersubjective. Yet, contemporary psychoanalysis has made a unique and controversial contribution to the understanding of intersubjectivity. It has proposing that the objectivity is irredeemably intersubjective, and yet the intersubjectivity is helplessly mediated by unconscious and primitive object

relations. Hence, for rationality to fulfill its promise of illumination, we have to rethink thought and reason as bearing unthought and unreasonable. The rationality, that fails to be conversant with the *unknown within,* may advance toward the *unknown without*, with narcissistic and omnipotent phantasies. Long before Freud and psychoanalysis, Vico (1744/1984:129-30) grasped this insight, even though misidentified the true location of the unknown, and he admonished:

> Man in his ignorance makes himself the rule of the universe (...) So that, as rational metaphysics teaches that man becomes all things by understanding them (*homo intelligendo fit omnia*), this imaginative metaphysics shows that man becomes all things by not understanding them (*homo non intelligendo fit omnia*); and perhaps the latter proposition is truer than the former for when man understands, he extends his mind and takes in the things, but when he does not understand he makes the things out of himself and becomes them by transforming himself into them.

Contemporary psychoanalysis reminds us of this unknown as ensconced within reason and traces its origin to psychic reality, where primitive phantasies operate as an "imaginative metaphysics" beneath our yearning for knowledge and control.

Although psychoanalysis has made a substantial contribution to the critique of reason, its contribution to epistemology has been less solid and fraught with ambivalence and indecisiveness. It is definitely beyond the scope of this work and the ability of this author to remedy this shortfall. However, it is a matter of necessity for this work to establish its methodology on a foundation congruent with its mode of reasoning. To apply methodologies appropriate for empirical research to a psychoanalytic study is no less unrealistic, incomprehensible and mystifying than to choose for an empirical study the methodologies proper for psychoanalysis. Such manner of espousing contradictory and paradoxical ideas may only breed arguments and findings that have the semblance of

doing things right without ever doing the right thing. In more scholarly terms, such disregard for historical debate can only mean ignoring the importance of fundamental quandaries, in reaction to which every epoch has created distinct paradigms in order *to ensure their dialogical treatment.* Hence, for this scribe, hammering out a fitting methodology is not a matter of intellectual entrenchment, but a matter of logical consistency and dialogical continuity with the history of the quandaries and paradigms, to which I utterly owe my inspiration and reasoning.

As aforementioned, the methodology of this study relies on a psychoanalytic and phenomenological approach that is not compatible with the empirical logic of hypothesis testing. By and large, mathematical probability used for such tests allows us to infer a hypothesized event as *statistically significant*, when its *presence* can be shown to be more *prevalent* than chance occurrence. Thus, *statistical significance* is defined against *blind chance.* The result of statistical analyses is positivistic knowledge that treats all objects of inquiry as measurable quantities detached from the subjectivity of the observer. The resulting knowledge purportedly leads to the discovery (*Entdecktheit*) of discrete facts (Heidegger, 1962:118). In contrast, the hermeneutics discloses (*Erschlossenheit*) an event or a relation as *existentially significant*, when through interpretation (*Deutung*) it explicates (*Auslegung*) and "work out" (*Ausarbeitung*) an understanding (*Verstehen*) of the uncanny (Unheimlich) and the unknown (Unerkannt) that lies within the subject-object relation. The ultimate goal of the hermeneutic knowledge is to make the unknown and the uncanny expressible and intelligible against the conditions of its indeterminacy, inexpressibility and namelessness, in order to "work out" (*Ausarbeitung*) angst and sufferance.

As psychoanalysis and phenomenology have taught us, every representation is interpretation. Thus, "what can be interpreted and revealed in discourse" ultimately determines the horizon of "what we can consciously know or relate to." In this sense, our horizon of meaning and understanding is never without the absence of the un-interpreted. It is however the horizon of our feeling that alerts us to the enduring evocations of that which has remained un-interpreted and occluded from discourse. "Working out" means to uncover and give meaning to the presence of the un-interpreted (the unknown), in order to address the angst of the un-interpretable absence (nothingness). To this end, interpretation has to unconceal the meaning of the uncanny. For, without interpreting (*Deutung*) what is eerie, there would be no meaning (*Bedeutung*) for suffering. For interpretation to become unconcealment, it has to begin from the process of "critical dismantling" (*Abbau*) of the taken-for-granted habits of thinking in order "to break through the conceptual surface" and to retrieve (*wieder-holen*) the "living roots" of meaning (Caputo, 1993:272). Hence, the significance or the adequacy of hermeneutic truth claims must properly be evaluated against *the meaningful working out of human suffering for greater capacity of thinking and feeling*, and not against the blind chance.

By the same token, the objective of this study is to disclose (*Erschlossenheit*) the nameless and the uncanny qualities of chronic pain experience in the discourse of the sufferers, and to reveal the condition of their namelessness in the discourse of health psychologists. These are two interrelated, but independent interpretive objectives. The analysis of the discourse of the sufferers focuses on the evocative references to anxiety and pain to reveal the eerie side of their experience; the side that has to be brought back to discourse without being ruled out as catastrophizing in advance. However, the

analysis of the discourse of health psychologists bears a double significance. For me as the author of the study, the discourse of health psychology reflects not only the dominant paradigm for clinical management of pain, but also the paradigm in which I was initially trained as a clinician for dealing with chronic illness and suffering from a biopsychosocial perspective. In this manner, reflecting on the discourse of the participants is in many ways a self-reflective practice that questions what has shaped the very ethos—the habit of thinking and feeling—of my own clinical introduction to pain. Hence, the findings of this study are as much about the clinical context in which suffering is named for clinicians and patients, as it is about my own introduction to clinical management of pain that continues to be the so-called air of our practice.

As the study includes both chronic pain sufferers and health psychologists, it is a two-sided query which can be carried out by a two-fold design. In other word, as two distinct but interrelated questions are being investigated, two studies are designed and carried out, with two different participant groups. To match the distinct characters of each question, the methodological rubric is expanded to gather two different discursive materials: 1) projective stories, and 2) semi-structured interview responses. On the other hand, to maintain the interconnection between the two studies, their shared conceptual frames and interpretive goals are made explicit and their findings are condensed into a conclusion that offers insight into how the existing clinical discourse of suffering takes stock of the lived experience of chronic pain. In a sense, they conjointly define and address the problematic of this study and complement one another to create a unitary insight. The findings and insight of this study can be deemed possibly true, if they can afford *existentially significant* interpretations of suffering. That is when the resulting

explication (*Auslegung*) can work out (*Ausarbeitung*) an understanding (*Verstehen*) of the nameless uncanny (*Unheimlich*) and the inexpressible unknown (*Unbekannt*) that has been occluded as unrecognizable (*Unerkannt*) from discourse, but has eerily remained vivid in experience of pain.

In this study, little attempt has been made to arrive at narratized forms through consolidation and solidification of elements of experience and discourse. The discourse analysis used in this study remains acutely sensitive to the distiction made in literature between *inchoately lived experience* (*Erlebnis*) and *reflectively articulated experience* (*Erfahrung*). Although this difference has been defined from diverse angles, it is Benjamin's (1968:155-200) original formulation of these terms that underlies the analysis of the present study. He speaks of these two forms of experience as distinct moments of a dialectical process in the development everyday psychology of modern subject. In short, he defines "inchoately lived experience" as a sequence of disjointed impressions with little organization, but with highly felt sensations and feelings that can equally carry the poignancy and dullness, the sorrow and joy, and the peace and frenzy of the lived event. Inchoately lived experiences are expressed with all the disjointed, extreme and contradictory qualities of a felt event. On the other hand, "reflectively articulated experience" is the restructured feelings and thoughts of an event that are figured and organized out of the initially confused impressions. Such experiences are integrated into and recollected as part the person's accumulated experiential history. Although they carry less of those originally felt contradictory qualities, they can be articulated and shared with others in a coherent manner, or become the object of further self-reflection.

In this sense, in lived experience it is the event that overtakes the person, while in articulated experience it is the person that overtakes the event.

The distinction between *Erfahrung* and *Erlebnis* has been the topic of serious reflection in phenomenology. Heidegger (1970) is for the most part responsible for its extensive treatment and its complex historical analysis. In contrast, psychoanalytic literature has not given this matter due reflection. In one of the rare examples, Thompson (2004:21) states:

> The first is the German *Erfahrung*, which contains the word *Fahr*, meaning "journey." Hence, *Erfahrung* suggests the notion of temporal duration, such as, for example, when one accumulates experience over time, including the accruing of wisdom that comes with old age. The other German term for experience is *Erlebnis* , which derives from the word *Leben*, meaning "life." Hence, the use of the word *Erlebnis* connotes a vital immediacy in contrast to the more historical perspective of *Erfahrung*. When, invoking *Erlebnis*, the speaker is emphasizing a primitive unity that precedes intellectual reflection.

Thompson points out that in his earliest references to the experience of pain (*Unlust*), Freud (1912) relies on the notion of *Erlebnis* rather than that of *Erfahrung*. He marvels at the phenomenological emphasis in Freud's writing, and states, "there are aspects of Freud's conception of experience that are surprisingly consistent with Heidegger's and compatible with the ontological dimension of human experience." (21) However, Freud's *Erlebnis* relates to the pain experience engendered by the "underworld" of the psyche or that which is strange within us. Ironically, Heidegger is not able to refer to experience of what seems as foreign by using Erlebnis (Berman, 1992). Hence, his famous phrase "the experience of foreign" reads as *die Erfahrung des Fremden*, which casts strange or alien not as an immediate aspect of the self but as an externality to it. In

this sense, Heidegger has turned away from Freud's phenomenological notion of the repressed unknown within, to project and externalize an alien without.

Due to the historical importance of differentiation between Erfahrung and Erlebnis, this analysis is careful not to impose cohesion and linearity on the gathered discursive material, allowing for the lived experience of the participant to emerge. In this manner, it is the fragmented, incomplete, and impressionistic side or underside of the discursive material that is given priority. The analysis deliberately avoids consolidating utterances and solidifying interpretation into the sequenced format of progression and denouement. To the contrary, the reader is provided large sequences of material and is given the opportunity to experience the actual feelings and evocations of the process. The aim is obviously to allow the reader experience the brittle apparitions of *the uncanny* that glimmers across the utterances in the course of the interviews and swiftly disappears almost as soon as it is intuited. For each set of materials, two different analyses are provided: 1) the analysis of each individual interview and 2) the analysis of each item across the interviews. Both analyses concentrate on the speech act to show how the participants by talking about what they are asked, they speak of "what they feel like" and ironically "what they do not feel like saying" emerges without much effort. Depth interpretations are not made as the only meaning enfolded in the material, but as a possible meaning that can allow the reader discern *the unknown* in "what suffering pain is felt like" and in "how suffering pain is explained." It is through revealing the underside of the utterances that the analyses reveal how the participants feel and think about suffering and how they define their experience with pain as a personal reality or as a clinical entity.

The first study investigates the analytic question of the primitive significance of anxieties experienced by chronic pain sufferers. For this study, projective testing is used as a means of gathering stories that are rich with free associations. These stories provide the basic material for a psychoanalytic interpretation that focuses on the experience of anxiety and pain. The participants are three chronic pain patients who are suffering from Rheumatoid Arthritis. The data is gathered by recorded interviews that are transcribed as a set of narrations. The analysis is based on a grid that allows interpretation of stories according to theoretical categories of Kleinian object relation. This study asks whether the analysis of the discursive material can meaningfully uncover the primitive significance of anxieties associated with the sufferer's experience of chronic pain.

The second study is meant to explore how health psychology construes the anxieties associated with chronic pain. By the nature of its problematic, this investigation falls appropriately within the scope of critical psychology and phenomenological research. This study uses a semi-structured interview procedure as a means of gathering discursive material that can reflect the participant's professional views and practices. The participants are three experienced health psychologists who are in active practice of managing pain. The presentation of the material emphasizes the dialogical nature of the interviewing process to reflect the spontaneity of the exchange. The material is analyzed to show how interview themes are validated or invalidated by various speech acts that reflect the professional discourses of health psychology. This study asks whether the analysis of the material can meaningfully disclose how the primitive significance of pain-related anxieties and suffering is concealed in the discourses of health psychology.

As aforementioned, the overall problematic of this research necessitates the use of a complex two-fold design, and the involvement of two different participant groups. The selection procedure for the participant groups was subject to the accessibility and availability of the individuals. Hence, it did not fully comply with the conventions of random sampling, as required in statistical analysis with an inferential logic for probable truth claims (Greenberg, 1951; Harville, 1975; Easterling, 1975; Efron, 1978). However, the discourses of a limited number of participants can still reflect something about pain in general, if the analysis can adequately unconceal a possible truth claim at the heart of the participants' lived experience. In other word, whereas the quantitative approach ensures the representative quality of the sample by its random selection or sampling strategy to make probable truth claims, the qualitative approach relies on the richness of the participant's lived experience and discourse to uncover a possible truth claim. The adequacy of the interpretation is determined based on how methodically the manifest content of the material has been worked out to reveal the latent or hidden content without doing away with the inchoate lived experience of the participant. As a result, only a small number of participants are interviewed in each study to allow for an exhaustive and in-depth analysis. A special emphasis has been placed on the repetitive reading and of the discursive material to allow the appreciation of its evocative and affective nuance, and to void excessive fragmentation, arbitrary sequencing and thematization.

As there is no ultimate or truly conclusive act of unconcealment, what emerges in every instance of interpretation is what can be disclosed through a given subject-object relation. In fact, as every interpretive act is limited, it is destined to become eventually a new form of concealment that is in need of future interpretations. Hence, the question of

generalizability of an interpretation cannot be simply decided by asking how often subsequent attempts can literally uncover the same understanding that was once unconcealed. To the contrary, it is reasonable to expect that later attempts show an interpretive continuity toward the same direction as the one indicated by the earlier interpretations. For this research, the primitive symbolism of the body in pain constitutes the direction, to which this interpretive study is pointing by investigating the primitive significance of suffering and anxiety. Yet, to elaborate meaningfully and self-reflectively on the relation between the hidden (latent) and the expressed (manifest) in discourse, this study asks not only what is hidden, but also how it is hidden in the greater context of clinical practice.

CHAPTER 3

Qualitative Study of Suffering in the Discourse of Chronic Pain Patients

3.1. Methodology

The methodology of this qualitative investigation involves the analysis of stories collected by the means of the Thematic Apperception Test (TAT; Murray, 1943). The TAT has been used as a research tool, where nuanced material was required for exploring implicit aspects of the participants' psychology and inner world (Morgan and Murray, 1935; Cramer, 1996). Feelings, conflicts, and phantasies that are not accessible through self-report or introspection, are made explicit by interpreting the TAT results (Abrams, 1999). As a technique of qualitative data gathering, the TAT has a long history of application across diverse areas of research. By presenting ambiguous pictorial themes, the instrument elicits open-ended narratives from the participants whose stories are as much about the image in front of them as about their internal states and private feelings.

Using Kleinian object relation theory, Brunet (1998) offers a compelling criticism of the common misapplication of projective tests as a direct keyhole to the unconscious primitive content. He questions the common misapprehension of assuming direct correspondence between narrative elements and unconscious phantasy as latent content. He reminds clinicians that in the proper analytic sense, the unconscious content does not get revealed in a straightforward manner. In fact, it becomes manifest through symbolic distortions that are characteristic of manifest content. Such distortions have to be recognized, from the very first step, by any process of interpretation. Presuming a direct

correspondence between latent and manifest content can indeed contribute to further distortion of psychic material. As a result, if open-ended narrations reflect any latent content, such content is complicated by distortions of primitive symbolism. In Brunet's view, working through such distortions allows the interpretation to reveal the latent content in an idiographic manner that reflects the participant's individuality and unique experience. Brunet offers a model that emphasizes three main criteria:

1- Administrating the tests in a way that affords greater freedom to the participant without much restriction, redirection or interruption;

2- Analyzing the chain of association within a response-sequence to a picture, as well as between response-sequences to pictures

3- Framing the analysis with an explicit theory of psychic reality, unconscious and personality that can delineate anxiety, conflict, object relation, and defence mechanisms, as well as the ego's ability for tolerating anxiety, and the relation between the superego and the ego.

As a time-honoured means of accessing latent content, free-association is considered an integral part of analytic technique. Using a method of administration and analysis that is strongly oriented to the participant's chain of association strengthens the analytic quality of the process. In fact, what Brunet suggests makes narration similar to Klein's play technique, as it offers the participant unrestrained opportunity to play with elements of story telling—themes, plot, characters, setting, and imagery—in order to develop a rich chain of association.

However, in its original sense, the TAT is largely dependent on classical psychoanalysis and ego-psychology. As an assessment instrument, it is used to reveal

latent material of Oedipal nature to evaluate the basic personality structure and ego functioning. In contrast, Kleinian object-relation emphasizes the pre-Oedipal phantasies, and offers an understand the personality from an infantile viewpoint as opposed to the Oedipal one. From Kleinian object-relation perspective, it is not the dangerous feelings or inhibited desires that are projected, but split aspects of the self and the object—containing infantile destructive or libidinal impulse—that are projected to create persecutory (all bad) or idealized (all good) part-objects. Hence, projection for Klein is far more complex, primitive, and phantasmatic, since together with splitting it form the first anxiety position. As a solution to this basic theoretical discrepancy between the original TAT interpretation and the Kleinian approach, Casoni and Brunet (1989) have suggested a new framework for the purpose of the personality evaluation by the use TAT. The author's framework is comprised of an interpretive grid based on Klein's metapsychology that emphasizes infantile object relation and anxiety positions. The grid contains three basic theoretical categories: 1) anxiety, 2) interpersonal relations, and 3) defensive strategies. Casoni and Brunet sub-divide the categories to reflect a hierarchy of concepts:

1- Anxiety:
   a) Schizoid-Paranoid Anxiety
   b) Depressive Anxiety
2- Interpersonal Relation:
   a) Paranoid-Schizoid Type
      i. Split Part Object
      ii. law of Talion
      iii. Envy
   b) Depressive:
      iv. Whole Object
      v. Ambivalence
      vi. Concern for the Object
3- Defensive Strategy:
   a) Schizoid-Paranoid Type:

i. Denial
ii. Splitting
iii. Projective Identification
iv. Introjective Identification

b) Depressive Type:
i. Reparation
ii. Manic Defences
- Contempt
- Control
- Triumph

The authors test the grid with a sample size of adolescents, and demonstrate the reliability of the categories. Based on this grid, Casoni and Brunet offer two scoring procedures. The first one is strictly binary established on the presence or absence of a category, whereas the second one requires the scorer to judge any present category as playing a determinant role, before actual scoring. Obviously, as the authors point out the second procedure allows for more interpretive flexibility and makes the process more theoretically meaningful.

Although the grid proposed by Casoni and Brunet shows significant consistency in personality evaluation, the purpose of the present study is limited to investigating the primitive significance of anxiety associated with pain. Hence, a much more focused interpretive strategy is needed to trace and interpret such anxieties without extensive elaborations of the psychic reality. On the other hand, the absolute distinction between anxieties related to pain and characterial anxieties is only of limited import for this study, since pain-related anxieties are explored as lived experiences of a person with a character and infantile history. In any given situation of distress, the experienced anxiety bears the distinct marks of the person's infantile past, as well as the particular hue of the actual experience of agony. In other words, if what is regarded as anxiety associated with pain involves much deeper and infantile dreads, it is the purpose of this analysis to make such

dread explicit. As a result, the participants are asked for further elaborations, where they use the pictures to speak about pain or about their feelings. Such elaborations not only enrich the material, but also render pain and suffering the focal part of the free-association.

The stories as open-ended, imaginative narrations contain self-reflective material which the analysis uses for the purpose of exploring the shifts in the participants' perception and experience. Exploring such shifts can yield phenomenological clues to anxieties experienced by the participant at the latent level (Klein, 1955). To this end, the categories of the aforementioned interpretive grid are used as a guide for the analysis of the stories, and not as a scoring grid. A small sample is chosen to ensure a higher degree of depth in the analysis. To gather a wider range of associations, the TAT protocol is administered in the manner outlined by Brunet (1998).

3.1.1. Participants

One male and two female participants, who suffer from chronic arthritis pain, take part in this study. Rheumatoid arthritis is a disease with a very well established pathogenesis that can be objectively diagnosed. The three patients were chosen blindly from a pool of rheumatology outpatient practice. They were undergoing treatment and clinical management of pain for at least 5 years, as they continued to live with their families. These participants come from intensive involvement with health psychology for pain management as a major aspect of their experience. Hence, they all completed at least one year of pain management training.

This study asks how possible it is for pain patients to experience primitive forms of anxiety as part of their suffering. As the research question is not predicated on probable truth, the satiation point for the participant group has been set at three to allow the in-depth analysis required for uncovering the possible truth. In this manner, greater depth in analysis is prioritized in order to meet the interpretive and critical goals of this study.

3.1.2. Instrument

The Thematic Apperception Test is used as the sole instrument of data gathering. The subset recommended for general administration for males and females, as well as for young boys and girls was used for this study. This subset includes the most generally used items of the test, and it is used across gender and age in every administration. These items are identified with numbers without any letters. The Card numbers below identify the pictures in the set, while their order reflects that of the actual administration.

1. Card 1: young boy with violin,
2. Card 2: a young woman with books in her hand standing in front of a farm landscape,
3. Card 4: a woman holding onto a mans shoulder,
4. Card 5: a woman opening the door bending into a room from a dark corridor,
5. Card 10: a woman and man embracing,
6. Card 11: an ambiguous picture of a rood on top of a rocky cliff,
7. Card 14: a man opening a window to light from a totally dark space,
8. Card 15: a man standing in the middle of a graveyard,
9. Card 19: a house in snow with chimney,

10. Card 20: a man standing beneath a street lamp,

11. Card 16: a blank card.

3.1.3. Procedures

Participants who initially agreed to the process, were given an interview at their homes for administration of the TAT. The participants were asked to take part in a study that investigates the relation between pain and emotions. They were given a consent form (Appendix I) prior to the interview, which provided them with written information regarding the objective and the use of this study. Each interview was completed within a 35 to 40-minute period. The interviews emphasized an open and unrestrained approach. Elaborations were asked if pain or pain related material is expressed by the participant.

3.1.4. Data and Analysis

The data consists of transcribed interview recordings. For the purpose of reflecting finer verbal elements, Jefferson's (1978) dramaturgical notation system was, in part, adopted for this study.

=	Sudden beginning or ending
/	Repetitions
x:	Extension of the preceding sound
xx	Stressing the underlined utterance
XX	Loudly uttered
(.)	Short pause
(...)	Long pause of at least 2 seconds
(2)	Pauses of specified length
...	Skipped part
[]	Added explanations

The model known as sequential organization was used for presenting the material. This model emphasizes the sequence of "adjacency pairs" that are defined as discourses exchanged in a given turn between the interviewer and the participant (Schegloff, 1977). To capture the interplay between the two interlocutors, every research must set these

pairs according to the nature of the interview and the intended analysis. Hence, each adjacency pair may include more than one actual conversational turn and involve a set of questions and answers. Since this study emphasizes the participants' thematic stories, the adjacency pair is defined as the entire presentation of a Card (a pictorial theme), and all the solicited elaborations. The non-lexical expressions such as "Oh" or "Hm," as well as pauses and repetitions have been retained to preserve the conversational quality of the speech act.

Each transcript undergoes two initial readings for analysis. The first reading identifies all speech acts, which reflect the themes of paranoid-schizoid anxiety or the annihilation of the self. The second reading explores the acts, which reflect the theme of depressive anxiety or annihilation of the object. The first two readings are intended to reveal anxieties for each narrative. The aim is to show how the participants allude to pain, as they fluctuate between anxiety positions. To make this fluctuation explicit, the result section presents the first and second readings together. In this vein, it becomes possible to observe the interplay between the two anxiety positions over pain related issues, as the participants presents the stories. The first two readings are within-picture interpretation that treats each picture, individually. Finally, the third reading is intended to explore the between-picture fluctuation of anxiety, for the three interviews. To this end, the third reading retraces each participant's anxiety fluctuation across the cards to reveal the actual sequence over the entire process. All the readings are established on the interpretive grid introduced by Casoni and Brunet. However, as the aim of this study is

not personality assessment, the grid is employed in limited sense, mainly for identifying anxiety positions.

With regard to the question of validity, Giorgi (1975) defines the criterion for qualitative research as "whether a reader, adopting the same view point as articulated by the researcher can also see what the researcher saw." To satisfy the criterion of validity, the reader must be allowed to fully identify the point of view of the researcher. One way of facilitating a transparent reading of the researcher's stance is to present the analysis from the first-person point of view. Such perspectival clarity is adopted in this research; hence the analysis is written from a first-person point of view. In addition, the Discussion section presents the interviewer's self-reflective material that was collected as part of the journal of research. This practice will allow for an added transparency with regard to the author's stance and reactions during the interview and through the process of analysis.

3.2. Analysis and Results

3.2.1. First Interview—First and Second Readings

The first participant is a female patient in her late 40's. Ms. A has been living with her husband, for more than 20 years. They have two children. Her son lives on his own, while her younger daughter is still living at home and works part-time to finish college. Ms. A is a practicing, religious person. Her home reflects her faith; it is adorn with commonly known religious icons. Ms. A has college education. Before being disabled by her chronic pain, she was working for a community organization. Before we begin, she reminisces of her work and life before arthritis with mixed feelings of joy and sorrow.

As she describes her pain and her ordeal, her mood becomes sombre and her emotions visibly change. She finds herself useless to her family and friends, and sees her body as incapacitated by uncontrollable pain. I started with the first card.

> I: I am going to show you some pictures, one at a time. You can make up a story as dramatic as possible about the picture. Tell what has led up to the event in the picture and explain what is happening, what the characters may feel, and finally what is going to happen. Speak your thoughts as they come to you. You can make the story as elaborate as you want. Now, I will show you the first one and you can begin.
> P: Okay. The person is looking at a violin that is calling him, and he is very discouraged, very sad. I don't know what about! He doesn't quite know what to think of it, what to do with it because he's feeling sad. The violin is just sitting there in front of him and he looks as if he knows what to do. But he can't do anything with...[crying].
> I: He cannot do anything?
> P: He gets pretty discouraged. It is awful for him. It is like under his sad stare the violin is melting.

The depressive feeling is immediately revealed in the boy which is identified as being "very discouraged and very sad" in front of the violin. The violin as the object was seen as "calling him." She referred to the figure in the picture not as a boy or a child, but as "the person," which makes the figure more adult-like and less distant from her own age. The ego and the object were presented as the child and the violin. Despite knowing what to do, the ego is helpless in front of the object. The ego feels being beseeched by the object, however, is too overwhelmed to respond. Under the "sad stare" of the helpless ego, the object (violin) "is melting." The ego feels guilty for failing the object, and the object is melting as a result. The depressive anxiety is prominent.

> I: What can you make up about picture number 2?
> P: A man is working his field and, on the farm, and he is (.), and it looks like a lady is watching him and the girl is standing beside, or in front of them, looks like she's ready to go to school and they're all just kind of standing there and the man is holding his hand out and I see a horse in the background too. I'm not quite sure what they're going to do maybe they're off sitting and waiting for nice weather or something like that, you can't

> tell from this picture what is going on. The lady is just kind of standing there looking as if nothing can be done, or else just waiting for something to happen. The girl too, is looking and waiting for something. There are several buildings in the background and trees and they're all sort of looking the same direction except the girl is looking away.

Her narration began from the figures in the background (a man working in the field and a lady watching him), and moved to the one in the forefront (the girl). Feelings of helplessness are again repeated. "Not knowing what to do" is reiterated. The figures in the picture are described not as interacting with one another, but as disconnected. She cannot find a story that can connect the elements. The loss of ability to maintain gratifying object-relation is quite evident, as her discourse reflects disjointedness of elements. She did not elaborate on the girl in the forefront. The girl (which may represent herself or her daughter) is described as wanting to go to school. Yet, a sense of waiting for something to happen, some unknown doom, has replaced hope, and reflects the ego's deeper anxiety. She noted that the girl does not look in the same direction as the other characters in the background. A sense of conflict becomes more obvious at this point. The anxiety is changing, although it is not yet crystallized. Yet, there are signs of "waiting for some thing to happen" that signifies a threat of paranoid nature.

> I: Picture number 3, what do you make up?
> P: A husband and wife, possibly, friends maybe. Looks like he's going away [crying aloud]
> I: You cry, is this reminding you of something?
> P: Yes, reminds me of my relationships.
> I: Your relationships?
> P: My chronic pain involves my husband too.
> I: Ummhmm and how is he reacting to you?
> P: He's quite angry at times.
> I: Angry with you?
> P: I don't think with me but just with the situation that he is into.
> I: How about you, how do you feel about your relationship?
> P: Well I feel like, like I spent a lot of time just looking after me and so it feels as if I can't give a whole lot in my relationships.

I: How bad is your pain?
P: It's very bad some days. It seems to be all that I can think of some days.

In this exchange, she quickly switches to her own life. The depressive anxiety becomes clearly manifest, as her fear of losing the object is expressed. Pain diminishes her capacity to care for the object. She feels rather guilty for focusing on herself and not being able to tend to her relationship. As the ego feels withdrawing from and losing ground with the object, the object appears as damaged and hurt. She, however, manages to deflect this anger from herself to the situation. The anxiety is depressive and her reference is to her own life.

I: What you can make up for Card number 4?
P: This lady is opening the door into a new room, or into a room with flowers and lamp and books, looks like she's having trouble walking into the room. She's kind of stooped over, maybe afraid to go into the room? Almost looks as if she's trying to look what's in there first before she goes in...to see if it's a place she'd like to be. She is scared of something
I: Is she afraid of going in?
P: It looks like it, yeah. I can say she is pretty scared, I can't say of what though. What ever it is, it must be quite scary. She is going from a safe place into where she can expect harm.

She starts revealing signs of paranoid-schizoid anxiety. Splitting and projective-identification has divided the scene into safe and unsafe places. The character is moving with apprehension into the unsafe zone. She talks about the scary harm that looms on the other side. Projection of the aggressive impulse makes the other side dangerous and threatening. The figure in the picture is intent on going in, but is stopped motionless, stooping over to examine the threat. The splitting allows the figure to stand at the threshold, with her back to safety to peer at the other side. Splitting marks the paranoid-schizoid position. It provides the ego with a sense of safety at the onslaught of terrifying threat.

I: What can you make up for Card 5?
P: Two people showing each other that they care about each other (.) that they love each other. Both of them, I think look like they are comfortable (.) happy to be there. The woman is scared from something and is seeking the embrace the man. It makes her feel safe. But, she is not sure at the same time may be what scared her can snatch her away. I don't know. May be she can't trust the man who is holding her. May be she is in pain. She must have pain.
I: What about pain?
P: Pain takes her away from everything (...). It is, it makes fear things.

Her narration reflects what she describes as fear of being snatched away, which constitutes a paranoid-schizoid anxiety. The threat of being taken is persecutory. The ego feels that the good object, no longer offers a comforting shield (i.e., "may be she can't trust the man who is holding her"). Her final reference clearly indicates how she experiences pain as a concrete force that can take her over, and snatch her away. The pain is described as taking on a persecutory character.

I: What can you make up for Card 6?
P: This looks like a lot of confusion (.) a lot of rocks on the road or (.) yeah it looks like rocks on the road. It's a little hard to see what's (.) exactly what there is there. (..) Maybe a bird, maybe an insect of some kind. It can be road, a dangerous one. Doesn't look like anybody could get through this road, if that is a road (.) doesn't look like anybody will be able to get through there at all.....Looks confused, confusion.
I: Confusion?
P: Umhumm: (10) [looks scared]

She perceives the picture as confused. She sees something that can be a bird or an insect, but she identifies a dangerously untraceable path on the edge of the precipice. The splitting between a bird and an insect, and the dangerous road ahead are elements that symbolize her paranoid-schizoid anxiety. She feels anxious to the point of confusion, as shown by repeated pauses and by her fidgeting. Finally, she falls into a 10-second-long

pause that mutes her narration. Silence replaces the linking of ideas and words. I waited before introducing the next card.

> I: How about Card 7?
> P: It's very confused (2) would be (2) take a lot of effort to get through. There's a lot of scary darkness there with a little bit of light as the person is looking out a window, it looks like(.) a bit of a window with darkness all around. Looks like the person is looking for the light and has tried to open a window. He is desperate for the light [scared].
> I: Seems you are becoming emotional. What are you feeling?
> P: [crying] Sometimes that's how I feel, there is not a lot of hope (3) there is a lot of darkness.
> I: Where is this darkness?
> P: Around me!
> I: Where does this darkness come from?
> P: From the pain and not being able to see my way through it except sometimes there is a little bit of light, maybe a new pill or something that the doctor can give me that helps me a little bit. Uhh (.) maybe, it's just feeling a little bit better some days (.) gives a little bit of light...a little bit of hope.

She describes a man surrounded by menacing darkness with nothing more than a small window of light, and a sense of desperateness. Then, she turns her attention to her own situation and recognizes the darkness that she is in, because of her pain. Like the man in the picture, she is caught in a "scary darkness" that signifies her own paranoid-schizoid anxiety. The ego can take refuge from this scary darkness to the power of "a little" pill that is less than ideal. The good object is failing and paranoid fears of pain as scary darkness are consuming. Her voice resonates tension.

> I: What can you make up for Card 8?
> P: Now! This looks like a graveyard (2) with somebody standing over it. It could be a sign of total loss of control. I suppose it could also be a sign of taking control of a life.
> I: Taking control in front of what?
> P: In front of the pain, I think.
> I: Is this man in pain?
> P: Doesn't look to be in terrible pain, maybe some. He has his back hunched, he's (2) yeah he might feel a little pain. But he's sort of looking at gravestones there, possibly thinking of life and death.

I: Life and death?
P: Well sometimes I (.) sometimes I'm happy to be able to do the things I can. Sometimes I wonder what I'm worth. Whether my life is worth anything or not. [crying]
I: So you find yourself questioning life?
P: Yes I do. I want to have a positive look on life because that's the kind of person I've always been. And I want to fight that pain, to fight that, that is overtaking me.

Her initial reflection on "loss of control" in a graveyard, later on, reveals to be about pain as a force that can overtake and destroy her life. Her paranoid-schizoid anxiety is still strong. She wonders about the fundamental duality of life and death, and reflects on her life after pain. As she reflects on her loss, she feels the pain snatching her life away. The force "that is overtaking" reveals her paranoid-schizoid anxiety of annihilation.

I: What about Card 9?
P: That looks like a house in the middle of a snowstorm (.) with light in the window. There is some black in there I'm not sure what that looks like but (.) what that is. Darkness, part of darkness, I guess.
I: What does this darkness remind you of?
P: This darkness reminds me of some of the pain that I have, the darkness that I experience with my pain. And (2)/and yet there is also the lightness in the whole thing, that I sometimes think I feel that way...I feel dark but then the next time I feel like things aren't so bad. And even when the storm is there I still feel hopeful sometimes. That life is good.

She struggles with integrating the darkness and light, and maintain an integrated wholeness. Pain is the darkness, at least in part, and there is the light and the hope that she tries to integrate. However, she cannot bear the integration and the depressive anxiety. She resorts to reassuring herself that life is good. There are attempts toward reparation and restoration.

I: What about Card 10?
P: This looks like a person standing out in the evening. When things are dark all around and can't see very well in the night. But there is the light of the lamppost still shining there. That's how a person feels a little bit of light coming over them. Can't see too well, 'cause it still is dark in the distance. The person is just standing there, part of his face can show

and part of it is dark. Looks like he is just hunched over in a way (2) a little bit there, hands in his pockets.
I: What do you think he feels in that darkness?
P: He could just be enjoying the darkness, enjoying being outside and (.) having a walk. He could feel unhappy...he could feel sad, rejected.
I: Rejected?
P: Rejected. Yeah that could be how he would feel.

Her attitude to darkness shows a marked change. She no longer sees it as purely scary and menacing. She is hopeful that the darkness can be illuminated no matter how faintly and even enjoyed. There is an attempt to reintegrate darkness with light, however she quickly reverts, and reveals her vulnerability, as that of being rejected and abandoned in darkness. In effect, although the initial reintegration helps assuage paranoid-schizoid anxiety, the depressive anxiety regarding a damaged object seems to be emerging.

I: See what you can see on this blank card. Imagine some picture there and describe it in detail. Now look at it and imagine something.
P: Oh boy. It's a whole new way to look at things (.) a blank page.
I: You seem getting emotional now.
P: Yeah, I guess it leave you thinking that there are different ways of looking at things. I could see it as a whole new way of living.
I: Do you want to give a story for it?
P: I could see myself as being free of pain, being able to do all the things I used to do, like shopping, going for walks, doing my work at work and at home, being able to socialize with people (.) just being able to do the things that I would like to do (.) a whole new page of life.

At this moment, the ego desperately looks for an abundance of light in the sea of darkness. Things are suddenly described as bright with no sign of gloom anywhere. The denial has managed to supplant the all-pervasive darkness. Denial seems holding sway to dispel dread. The white page has provided a blank or an erased slate to be recomposed omnipotently.

3.2.2. Second Interview—First and Second Readings

The second participant is a female patient in her late 60's. For more than 25 years, Ms. B has been living with her husband, with whom she has two children. She has two sons from an earlier marriage. At the present, all her children are living away from home. Ms. A's husband suffers from a chronic health condition of his own. Despite her arthritis pain, Ms. B still manages to work part-time. As she and her husband are both ill, her home shows signs of a distressed life. It seems she does not receive enough help to manage the situation at home, with her husband. Ms. B has high-school education. I started with the first card, after few background questions.

I: What do you make of Picture Number 1:
P: He looks really sad.
I: Who looks really sad?
P: The little boy (...) looks like he might have pain on the side of his head (...) on either side of his head. There is something wrong with his mouth, looks like he might have been hit, hit hard, or something aching in his mouth. His eyes are droopy, maybe from pain, or from being scared.

Ms. B's description emphasized sad and unhappy feelings which she associated with pain. Her references to an aching mouth and to being hit or "hit hard" are both significant. She talks about "droopy" and "scared eyes." The ego obviously associates suffering from pain with being battered, or being subjected to aggression. In effect, the anxiety is over pain as concrete aggression, and has a persecutory quality.

I: Card Number 2
P: Um:, (...) Am I supposed to relate pain to this picture or just anything [tense voice].

She seemed suddenly confused, as to what she must be doing. It looked as though she wanted to make sure that she understood the process correctly, or that she has said the right thing. However, her body language revealed some ambivalence regarding the

process. Her voice sounded tense. The open-ended storytelling induced strong anxieties and made her feel vulnerable at the onset.

> I: You can tell me a story about this picture, using your imagination, and make it as dramatic as possible, regarding what you see.
> P: Well, there's a young girl with books, she must like to read. There's a lady that looks like she's pregnant. Ummm, there's a young man with a horse, maybe ploughing a field or doing something in the field (2).
> I: What do you think that girl feels?
> P: Ummmm, sad maybe.
> I: Why do you think she's sad?
> P: She's not smiling. She's either sad or deep in thought. That's worrying her. I don't see any pain there but something is missing in her life. she's deep in thought. Looks like he might be angry, the man behind her in the farm is angry with her.

Her description begins from the forefront and moves to the background. Her narration offers very little story telling to connect the figures and elements together. A pregnant woman and a young man are identified in the background. The background figures are split between a motherly character and an angry young man ploughing the earth. The man is angry with the studious girl in the foreground who is described as sad and worried over missing something, which alludes to depressive feelings over loss. As the story lacks a coherent plot so the ego feels unable to maintain whole-object relation, while the reference to something missing reflects anxiety for the object. The ego is struggling to integrate an active, angry side and a passive, motherly one. The anxiety is markedly depressive, but there is a great deal of instability and ambivalence in her narration.

> I: Card 3
> P: God! Angry again.
> I: Who is angry?
> P: The man (...) looks like he's angry. The woman is trying to talk to him. Looks like he's trying to turn away or he's turned away from her. He looks angry.
> I: Does he look angry?
> P: Um-hmm, very much.
> I: How do you think the woman feels?

P: Concerned. She's concerned, looks like she's concerned about him, wondering why he isn't more considerate, wants him listen to her maybe.
I: You think he is not listening to her?
P: Ummm - he's wanting to pull away from her anyway. That's about all I can see on that.

The ego is dealing with an object that is seething with anger and threatens to leave. The rejection and abandonment seems imminent. Unable to restore and repair the object, the ego is anxious over the well-being of the object, and about the pending loss. Being abandoned by an angry and damaged object alludes to the depressive anxiety.

I: Picture 4
P: There's a lady checking on something that's in the room, or (.) looking at something, doesn't look like she's gonna come in, she's either talking to someone, gonna talk to somebody, she's looking at something in the room, something painful.
I: Is she seeing something in the room?
P: Looks like it.
I: What do you think she's seeing?
P: She's not happy about what she's seeing.
I: She's not happy?
P: No. Not at all
I: How unhappy is she?
P: She looks what I'd say, disgusted.
I: Disgusted?
P: Maybe, or concerned a lot. Yeah, you could look like that if you were just concerned, she doesn't look startled, I don't think...no I wouldn't think she's startled. She's not happy, more like disgusted.

The ego is standing at the threshold that splits the good from bad, and is peering at a nameless entity, both painful and disgusting. On the other side of the threshold, there is the bad object that causes pain, revulsion and unhappiness. Splitting shapes the core elements of the narration, and alludes to paranoid-schizoid anxiety. Pain is associated with the threats of the bad object.

I: Picture Number 5
P: They look like they're resting (...) peaceful. Sleeping?
I: The two couples?

P: They're a couple (.) yeah. They look like they might love each other (...) really care for each other. Yeah.
I: What do you think the man feels?
P: Umm, concerned maybe, he cares (.) and feels. He feels something, like he cares. I don't know whether it is sad or maybe sad, I don't know, maybe relaxed, loved, I don't know.
I: How do you think the woman feels?
P: Looks like the same way. Really concerned. Caring for each other.
I: What do you think she's concerned about, that woman?
P: The man. They're concerned about each other, I think. Feelings for each other.

She talks about the couple being relaxed and caring, in each other arms. But, the words, sad and concerned, were repeated as the undertone of the narration. The ego seems yearning for fusion with an all-caring object, as the man is described. There is total bliss with an idealized object, free from any anxiety. The concern for the object clearly marks the situation as depressive anxiety.

I: Picture Number 6.
P: What in the world is that? I don't know what that is. I either can't see or, is it a bug? No, must be on the side of a mountain somewhere, anyway rocks and cliff, a dangerous and steep cliff.
I: What do you see on the cliff?
P: I don't know what that is, looks like a bug, I don't know. And this looks like a snakehead coming out of the rock. I can see eyes, can't be a snake, maybe a dragon. No, it hasn't got a head for a dragon. I don't know, looks like a bug on this side here. The other side looks like some kind of monster.
I: Monster?
P: Yeah.
I: What do you think this monster is about?
P: I don't know, somebody's imagination I guess or maybe a creature from a long time ago, or something that is interested in whatever's on the rock, a bug or whatever.
I: Um hmm.
P: It does look vicious.
I: Doesn't?
P: No. It does. Whatever's there, they are two and looks like they're watching each other very carefully.
I: Why do you think they watch each other?
P: I don't know. It is just looks like that's what they're doing. Ummm they're kind of facing each other, I think. I can't tell what that bug or

whatever is there watching. I can't tell which end is looking. It could be watching somebody, could be that it, that his head is at the other end and that he's watchin' him that he's okay, could be that.
I: Umhumm
P: I would like to know what you think that picture is [tense voice].
I: I can tell you after the session, now you can tell me what you see.
P: Okay.
I: Is that important for you to know what I think?
P: Yes, this thing is just like my pain. The whole thing, it is rough like the rocks and vicious like those monsters. Sometimes is dark, hazy. I don't know, but I can feel it even now.

She names a number of terrifying creatures, from monsters to snakeheads, and makes it clear that what she is describing is vicious. Her narration identifies two monsters that are carefully watching one another. She reveals a world occupied by bizarre creatures. Being terrified, she tries to recruit me and solicits my explanation and advice. As anxieties of paranoid-schizoid position come to the surface, her voice becomes tense. Then, suddenly, all the aforementioned horror becomes a portrait of her own pain as concrete monstrosity, hard and vicious.

I: What do you think about this picture? Can you tell a story? Picture Number 7.
P: Well, it's a dark room and uhh, a man I would say is looking out the open window into daylight. He's umm, looks peaceful, is lookin' at kind of like maybe he's take off in thought.
I: Why do you think it is so dark there?
P: Maybe (...) maybe he's locked up (....) he can't get out (...) he's up real high and can't get out.
I: You said maybe he's locked up?
P: Yeah. If he was up high he'd be locked up and they don't give him any light. Yeah, this room has only, I don't know (.) only has one window maybe and there should be light in the room, though only if the window is open. I don't know (...) So, it must have something to do with the way he feels maybe.
I: What do you think he feels?
P: Maybe he's in pain.
I: Maybe he's in pain? How bad is he in pain?
P: Really bad pain. He's locked up in darkness and scared.
I: So how can this darkness be explained?

P: Well, if it's because of pain he has no life at all if it's like that, like as if it's dark, black, dreary, suffocating. Locked up and strangled in darkness. [her voice is tense]

Her narration begins with the entrapment of the man in the picture. As pain is introduced, her account becomes more personal. The ego feels entrapped in a dreary and suffocating darkness. The darkness of pain is "strangling," with little way out. The anxiety of annihilation is presented as images of pain associated with a death, as terrible as suffocation by strangling. These are concrete forms of aggressive attacks that are lived as part of pain experience.

I: Picture Number 8, what can you make up?
P: Oh man, I don't know. I don't know. Funny looking thing, ha, ha, whatever it is. [dismissive tone] I don't know. Hands look sore. Not happy whatever it is, it's not happy.
I: Why is it not happy?
P: He wants to die maybe. Everywhere, he's around a bunch of tombstones and dead stuff. Maybe he doesn't want to live anymore.
I: Why?
P: Cause he's in probably so much pain, that doesn't look very good. Looks like he's really, something is really wrong. The arms are together like there's no where to go.
I: What feeling does this give you?
P: Sad, lonely, really, really sad, upset...lonely.

She starts by trying to make light of death (a funny looking thing). Then, she acknowledges soreness and unhappiness. Suddenly, her mention of suicide reveals the nature of her anxiety. The ego confronts much guilt. The loss is described as pervasive (tombstones are everywhere). Losses, caused by pain, are making the ego feel surrounded by dead objects, for which the ego feels responsible. Life is "sad, lonely, really, really sad, upset" under the spell of pain. Pain experience has brought to present depressive anxieties.

I: Picture Number 9

P: I don't know (...) looks like a grey winter (...) Um, I don't know (...) seems a little house, maybe. I don't know (...) seems a little house covered by snow, lots of snow, maybe lots of snow and ice. Lights are on in the house maybe and it's warm. Not sure if it's cozy. I don't know. It seems like a warm house in the middle of ice, snow, and grey cold.
I: Who do you think lives in this house?
P: Eskimo (...)I don't know. Looks like there's lots of ice and snow...must be Eskimo. Man, woman, happy I would think. It looks like somebody would be happy in there, maybe cozy.

Under depressive anxiety, the ego feels surrounded by grey winter cold. There is a little house with light. Yet, she is not quite certain, if it is a warm and cozy place. The scepticism about warmth in the middle of ice and snow implies the ego's concern about the internal object. Psychic reality is grey, cold, and icy. The expression, "I do not know," punctuates every sentence. The ego seems caught in irreparable loss and depressive anxiety.

I: Picture Number 10
P: Looks like it might be an elderly man sitting there. I don't know what he's sitting on....hunched over, yeah, a hydro pole, telephone wire or power wires, raining, dark.
I: How is he feeling?
P: Sad. He's up high, I think. He's up high somewhere. He's alone, sad.
I: Where is he up high?
P: I don't know (...) it seems, looks like he might be on a high hill or something, or on top of something.
I: Why do people get up high?
P: I don't know. I don't know, maybe he's gonna jump somewhere or jump down.
I: Do you have any idea where?
P: No. I don't know. Maybe there's an edge (...) there could be an edge that he could jump off. Or (...) uhh I don't know. I'm not very good at this.

Her depressive anxiety becomes evident as she talks about suicide. She never mentions it, directly. She alludes to it as "jumping off." There is a sense of helpless with utter

despair and sadness that is consuming the whole story. She finds herself not being able to go much further, and stops.

> I: In this part, I'm showing you a card, you can look at it and use your imagination and make up whatever comes to you. There is not much on this Card - Number 11
> P: There's nothing on that card. Like, I don't know what to say (...) there's nothing on that card, it's blank (tense voice).
> I: What does it make you feel or think?
> P: I don't know (...) could draw something on there or write something on there or it's a clean piece of paper. I don't know what to say. It is empty, it is nothing (tense voice).
> I: Would the emptiness make you think something particular?
> P: Empty....yeah. Probably an empty feeling when you have so much pain and you get to feel that way lots, like there's nothing, only emptiness like death. I don't know.
> I: Empty feeling when you have pain?
> P: Ummm! (2) yeah, I guess.
> I: What does that emptiness make one feel then?
> P: Well either, I don't know (.) you fight for to try and get help in every corner and when you're still having pain then you don't know what's going to happen to you. But it's a scary feeling, quite scary actually like being taken, like being attacked.

Initially, she sees emptiness and blank as a space to be filled and made up for. The tension in her voice gives away her anxiety. She, then, reveals the other meaning of emptiness as a death-like void, left by pain. In that emptiness, the ego feels as though being "attacked and taken." The anxiety of annihilation resurfaces, as the threat to the object disappears into the threat to the ego.

3.2.3. Third Interview—First and Second Readings

The third participant is a male patient in his late 40's. Mr. C has been living with his wife and three kids, for about 15 years. Despite his arthritis pain, Mr. C does everything to maintain an active lifestyle. He still works part-time. Mr. C has college education. He is a farmer with many skills, who needs his physical strength for his work. But, he

finds himself unable to do what he knows best, the farm work. I started with the first card.

> I: Card Number One
> P: Well this guy looks like he is being forced to do something he doesn't want to do (.) like practice his violin. Umm, he looks like he'd rather be outside playing somewhere, perhaps that's what is going on, his parents have caught him outside or went and fetched him from outside playing with his friends and forced him to come in and practice his violin and he's not really happy about it, by the looks of things (.) looks like he's bored stiff to be honest with you. Umm I think he's wishing he was somewhere else.

He describes the child in the picture a "guy" in front of something that he does not want, but is obliged to do. Being controlled by the object to the point of helplessness is what the narration implies. At the same time, there are feelings of contempt for the object and its demands ("he's wishing he was somewhere else"). There is a sense of punishment imposed on the child by the controlling parents. The ego feels punished and forced into being bored stiff by the punishing object.

> I: Card Number Two
> P: I don't know. That girl looks like she's on her way with the books in her hand, on the way to school, or to the library or something and she's looking at her family and how hard they have to work and struggle to make ends meet and she's putting in as much effort and work as she can to maybe make her life a little bit better. Maybe for her children. Umm, maybe for her family too. Uh, she's hoping for better things in the future, I think
> I: How do you think she is feeling or thinking about the future?
> P: I think she's fearful of it, and optimistic.
> I: Can you tell me why she's fearful?
> P: That she might not accomplish what she wants to accomplish.
> I: What is she optimistic about?
> P: She may also accomplish it.

Mr. C begins from the forefront and moves to the background figures. He relates a story that connects the elements together. However, his narration makes little reference to the figures in the background. The description of the girl's motive changes course from that

of being controlled by the demands of the object, to the one of duty and honour toward others (the object). This change of course allows the ego to avoid aggression toward the object, and to evade the ensuing guilt. The ego is ambivalent about the object and struggles with possibility of integration and reparation (fearful and optimistic).

> I: Picture Number 3
> P: Umm, Jeez, I don't know. This guy looks like he's distracted by something. Umm, his wife or girlfriend who's maybe trying to stop him from doing something that he maybe shouldn't do, or maybe make him stay and he wants to go someplace else or do something she doesn't want him to do, or is risky to do. Really don't know. He looks intent on something out of the picture, it could be anything. Could be some place he wants to go.
> I: Can you tell me where he wants to go.
> P: He's got something he needs to do. He's got a job, to do or, it could be, it looks like they might be in a lounge or something, there's people in the background. Uh maybe someone has angered him and she's trying to stop him from, escalating the situation or (2) or maybe he's just gotta go somewhere and do something, something like a fight that scares her, or (.) anything like that I guess, I don't know, for sure.
> I: You talked about her, the woman, being scared and his being angry. How do you see these two things related?
> P: Well, she may be fearful he may get hurt and maybe his temper doesn't allow him to think about those things.

The conflict in the picture confuses him, as he keeps repeating "I don't know." What he describes as happening between the couple symbolizes two intrapsychic dynamics. First, the ego feels split between love (the woman) and hate (the man). The love struggles for safety, where aggression is a threat. Second, the bad object as the nameless "it" ("it could be anything") both angers and threatens the ego. In describing the man, he first refers to having to do a job, but then calls it anger. He moves from neutralization to aggression. Splitting and the struggle for control under grave threat reveal the paranoid-schizoid anxiety of the ego.

> I: Picture Number 4

P: Umm. I'm not sure what this woman is up to. She looks like she is checking rooms for something; maybe she's checking on a child that's supposed to be doing some homework or something. Or she's just making sure that the curtains are drawn and the lights are out. Its' bedtime and she's on her way to bed or something. And (...) she just, I think is looking around to ensure all's well before she retires for the evening. Just the opinion I get from that picture and her face.
I: Does her face tell you something?
P: She looks tired. (2) Umm (2) not really worried, just tired.
I: Not really worried?
P: Not really. There might be a little bit of worry around her eyes but she's just making sure everything's' okay before she turns in. She's more tired I think, than anything.
I: You think when she retires she goes to sleep, she will have a good sleep? a good day? She has finished her day?
P: I think so. I think so (...) she's tired from either getting something accomplished or doing something constructive that day. Not much else makes you tired (...) that kind of tired.

The woman is "checking on a child that is supposed to do home work" or "just makes sure that the curtains are drawn and the lights are out." The object seems to be both caring and controlling. However, the narration focuses on the all-caring object and describes an absence of fear, threat, and sadness. Suddenly, everything is described in much positive light with only a tinge of worry, which he does not specify. The ego is ambivalent toward the object. Depressive anxiety is evident.

I: Picture Number 5
P: Umm. I think these two people have been together for quite some time and uh, they love each other very much. And he's telling her so, I think (2) probably not something he does much. That's the feeling I get from that one.
I: What do you think the man feels for this woman?
P: I think he loves her very much.
I: Why he does not say that often?
P: He doesn't know why, he is not good in that sort of things and he feels sad.
I: Is she accepting it?
P: Yes. Yes she is. Like I say she wants to hear it, I think they've been together a long time.

He relates a man that feels not quite able to satisfy the demand of his beloved, when it means expressing his love for her. Mr. C, to reassure himself about the durability of the relationship, keeps reiterating that the couple have been together for a long time. There is a desire to deny what might be a damaged object and the possibility of loss. He talks about not being good at fulfilling the wishes of the object and feeling sad about it. This alludes to an undertone of depressive anxiety.

I: Picture Number 6
P: I can't really see what that is. Umm, It looks like some kind of a trail across a gorge in the mountains or something. Looks like there is a line of people on the trail. I can't really make out what is in the front there. Looks like somebody struggling with an animal or something, that's stubborn, doesn't want to go, like my pain. I'm not really sure. Maybe, uh, maybe reminds me of pictures I seen in the Yukon of the gold rush where there were many people goin', searching for their fortune (.) and they were just lined up, one after the other. Goin' looking' for something.
I: You think they are going to get to the gold, when something stubborn like your pain is standing in their way
P: Most don't. Most work in vain and in pain, but the odd person does make it and that's what driving all of them. They all want to be that one person that does find their fortune.
I: How about the gold? What do you think about that gold?
P: Well I think the trip has been made many, many times because somebody has built a bridge and made a road. Umm: I think this is something that is like a quest or a journey that many people have made (.) over many, many years.
I: How safe is it?
P: Doesn't look very safe. It's a rather perilous, painful journey by the looks of it. The road is narrow, there is loose rock, there is ah I would say it's the road less traveled.
I: What would you do if you were on a road or a path that is less traveled and you have to go through it?
P: Well, you plan ahead as far as you can and you watch your step. You make sure that every step you make is a safe one.
I: What happens if a step is missed?
P: Well then, there are going to be consequences, what kind I don't know (.) you have to be ready for anything. To be on your guard I guess.
I: How deep do you think the gorge is?
P: It's deep enough that if you fell, you wouldn't know it when you hit the bottom.

Struggle with bizarre creatures, and a sense of strife with impersonal forces of misfortune and brute nature (persecutory objects) shape this narration. The anxiety is over the annihilation of the self, in a world that few can make it, on a path that is less traveled, and in a quest that is too risky. In this world, many toil in vain, bearing a stubborn pain (it doesn't go away) that is not unlike his own. The over-toiled people of this story land can only hope to be that odd one who makes it (the idealized object). Yet, every mistake is fatal and every threat is so serious that has to be anticipated well in advance. He manages not to make any mention of death. When asked about mistakes or about falling into the abyss, he used euphemism ("It's deep enough that if you fell, you wouldn't know it when you hit the bottom") to avoid mentioning death. The ego feels fighting an assault from an impersonal, stubborn force that is associated with pain. Pain appears as part of the attacking nameless force. The struggle is in vain, since the ego feels caught for survival in a dangerous situation with not so much luck. The denial of death is meant to wards off the paranoid-schizoid anxiety that is patently prevalent.

I: Picture Number 7
P: Umm. I don't know (.) this guy I think is dreaming about other places too. Umm, looking off in the distance, wondering what's on the other side I think. What's next. Maybe he's got the wanderlust. He wants to see what's down the road, a little away, experience a little bit more. He's tired of the room he's in, that's why he's got the lights out. He doesn't want to look around anymore, he's lookin' out the window.
I: Why is he tired of the room he's in?
P: Because that's all he's known. He would like to see something different. He's a young man. He hasn't seen much yet and he has a desire to see more and experience more. He's just gazing in the distance, trying to figure out a way to go do that.
I: Do you think he's going to find a world he wants out there?
P: No.
I: Why?
P: Because I don't think people know how good they have it until they leave and then (2) and then they appreciate what they have. [showed sadness]

There is a desire to escape from the monotony of the present (perhaps the boredom imposed by pain), to the thrill of the unknown future. Going beyond, in a novel direction, is strongly yearned ("wanderlust"). There is a sense of wanting to get away. However, there is also the opposite sense of being tied up to something underappreciated, from which the man has to break free to appreciate its true worth. A sense of regret after "wanderlust" is described. The ego desires to escape from the annoying boredom with a sense of manic defense and acting-out. The ego is however ambivalent and recognizes the grievous possibility of loss.

I: Picture Number 8
P: Jeez, I don't know about this guy. Kind of reminds you of the horror movies and stuff that you see. Uhh, he's in the middle of a graveyard, now is this something that he enjoys death or umm (.) or is he mourning it? I really don't know. He uhh (.) I really don't know what kind of impression I get from him, could be either one. He could be mourning his losses or could be comfortable with death and he likes to surround himself with it. Or (2) I really don't know...maybe he fears it and he's trying to conquer his fears.
I: How do you think he can conquer his fears?
P: By facing it?
I: By facing death?
P: Yep. By (...) I really don't know (...) by facing the fear of dying [tense voice]
I: What else is there?
P: He looks like he's in pain and he's fearful I believe.
I: In he in pain, of what exactly he might fear?
P: I don't know...death by the looks of it. Uhh (...) I don' know. He uhh. Could be a bunch of reasons why somebody would be in a graveyard. He doesn't seem to be looking at one tombstone in particular so that makes me wonder why he's there. Could be trying to conquer fear I guess (....) or he likes the peace (....) maybe he feels peaceful there, in death you become part of the earth and return to peace. May be he is in pain, so much pain that standing alive is no different than lying dead. His face is no different than the tombstones around him.

Mr. C tries hard to relate the emotional state of the figure in the picture. Initially, the ego reveals its anxiety over death. In fact, death is described as a fearful event that has to be conquered, or as a blissful state that can be embraced. Talking about this duality might be an attempt to ward off the threat of annihilation, or the paranoid-schizoid anxiety. Yet, as soon as pain becomes part of the narration, the threat of annihilation becomes undeniably concrete. Pain makes life no more than death, and the ego in pain is no more than the gravestones, with which it feels surrounded as the symbol of the lost object.

> I: Picture Number 9
> P: For some reason that reminds me of a little cabin up north (...) up in the bush...always buried in snow and the chimney was stickin' out and there was always smoke comin' out (...) there was always (...) made you feel welcome. Umm (...) it was uhh...really peaceful there. It was (...) life was simple (...) no problems (...) you just kept warm and did your work. People were friendly. There was no, uhh what's the word I'm lookin' for. There was nothing that was politically incorrect or it didn't matter what you did, you were accepted, as you were, if you were honest that's all that mattered. Uh:h (...) and everybody was right open. You could count on them when somebody said somethin' you knew it was gonna be that. You could count on peoples' word.
> I: Is there any pain inside this cabin?
> P: Umm. With pain, there's only loneliness. That's painful and that hurts and wounds deep. Everything is against you. When pain comes, it's cold, way colder than what you have been used to. I mean dead cold. You become alone and that hurts more sometimes. There are things work can't fix. Uhh, that's about it, I think.

The narration initially describes an idyllic place of warmth and togetherness. But, as I inquire about pain, the idyllic oasis of warmth disappears. The ego feels dead cold, wounded, lonely, and helpless. Dread and despair replaces warmth. Paranoid-schizoid anxiety suddenly becomes consuming ("everything is against you").

> I: Picture Number 10
> P: This reminds me of the guy that was looking out the window. He's on his way. He's seen some things and now he's wishing he was back in that window. He's standing on the street, alone, wishing he was home. That's what that makes me think of.

I: How is he feeling?
P: Lonely. Disappointed. Umm the grass wasn't any greener. And he wants to go home.
I: Is there any pain waiting for him at home.
P: Not really, no at home. There's pain (.) there's pain where he is and home is comfortable. There isn't any pain at home. It's just what has always been, uhh, not real exciting, just comfortable, not much to worry about at home.

To return home following a venture alludes to the restoration of a previously broken tie. If manic acting-out was a way of evading the damaged object and guilt, returning means the possibility of reparation and mourning. The ego recognizes the comforting prospect of repairing the object, but calls it "not really exciting." As the ego acknowledges its dependence on the damaged object, a deep ambivalence resurfaces. There is the fear of stirred-up aggression that can transform reparation to no more than compulsive boredom or utter despair. The ambivalence makes home painless, but unexciting as opposed to the elsewhere that seems painful, yet exciting. Under the sway of manic defence and ambivalence, pain has acquired an ironic quality.

I: Now, I'll show you a card. Use your imagination, and make a story, imagine one of your own.
P: Okay.(6)
I: Make up something for it even though the card is blank.
P: Okay. Humph (2), well (2) I don't really know (2) don't know (2) uhh (2) I don't know. Makes me think of a future where you can plan things but you really don't know what's going to happen. It's a blank picture (2) you can try and fill it in with some things but the chances of them happening are anybody's guess. All you can do is put in the effort and hope despite the pain.
I: Where is the pain in the picture?
P: Uhh. The pain is the unknown I guess (2) uhh, it could be good, could be bad. I guess the pain is the unknown, the worry of what may be or the anticipation of what can be. I guess it's just not known for sure. That is why it is like death. It can be scary and relentless, when attacks.

Insofar as the blank card is perceived as a void, it can be filled with something. Beneath the idea of filling the void, there is the anxiety over reparation. He ruminates about the

possibility of really being able to do it. He feels much uncertain about filling the void. He struggles to ward off the guilt, as he ruminates over the equal possibility of good or bad outcome. The ego's deepening ambivalence once again threatens to bring back splitting and projective-identification, and revive anxieties of pain as concrete experience of annihilation. In the end, he once again speaks of scary and relentless attacks of pain.

3.2.4. Third Reading

The First participant begins her narration with depressive feelings. The ego feels being beseeched by the object, but is too ravaged to respond. Through ravaging the ego, the aggressive impulse, as guilt, torments the object and makes it melt. The same sense of helplessness is again repeated in the second card. In the grip of depressive anxiety, the narration begins from the distal elements of the background and retracts to the proximal ones. The ego acutely feels the loss of ability to maintain gratifying object-relation. Her discourse only reflects disjointedness of elements. A sense of waiting for something to happen, some unknown doom has replaced hope. In the third card, the depressive anxiety continues, as she specifically describes how pain constricts her capacity to care for the object. The ego feels withdrawing from, and losing ground with the object, that appears as damaged. In the fourth card, there is a fluctuation and the paranoid-schizoid anxiety emerges. Splitting and projective-identification has divided the scene into safe and unsafe places to let the figure stand at the threshold, with her back to safety, and peer at the other side where threat is looming. The splitting provides the ego with a sense of safety at the onslaught of terrifying threat. Paranoid-schizoid anxiety pervades the narration. In the fifth picture, the narration reflects the fear of being snatched away, or a paranoid anxiety that something threatens to highjack the ego. The ego feels that the

good part-object no longer can offer a comforting shield. Her reference clearly indicates how she experiences pain as a concrete force that can take her over, and snatch her away. Pain is taking on a persecutory character. In the sixth card, the splitting and the sense of looming danger predominate. Paranoid-schizoid anxiety makes her feel confused, and a 10-second-long pause finally mutes her description. For the seventh, she describes a menacing darkness with nothing more than a small window of light. There is a sense of helplessness. She elaborates directly on her pain and associates it with the "scary darkness," which signifies the persecutory anxiety of the ego. The ego can only take refuge from the scary darkness to the power of "a pill" that is admittedly less than ideal. In the eighth, her initial reflection on the loss of control reveals the ego's paranoid anxiety over pain as a force that can overtake and destroy her life. She wonders about the fundamental duality of life and death, and reflects on her life after pain. As she reflects on her loss, she feels the pain snatching her life away. The force "that is overtaking" reveals her paranoid-schizoid anxiety of annihilation. In the ninth picture, the ego struggles with integrating the darkness and light, and maintain an integrated wholeness. Pain is the darkness, at least in part, and there is the light and the hope that she tries to integrate. However, the ego cannot bear the integration and the depressive anxiety. She resorts to reassuring herself that life is good. An idealized object returns. In the tenth card, her attitude to darkness shows a marked change. The ego no longer sees it as purely scary and menacing. She is hopeful that the darkness can be illuminated no matter how faintly and even enjoyed. There is an attempt to reintegrate darkness with light, however she quickly reverts, and reveals her vulnerability, as that of being rejected and abandoned in darkness. In effect, although the initial reintegration helps assuage paranoid-schizoid

anxiety, the depressive anxiety of abandonment by a damaged object comes back to threaten the ego. In the eleventh card, the ego desperately looks for an abundance of light in darkness. Things are suddenly described as bright with no sign of gloom anywhere. The denial has managed to supplant darkness. Denial seems holding sway to dispel dread. The white page has provided a blank or erased slate to be written omnipotently.

The narration of the second participant begins by describing the sad and unhappy feelings which she associated with pain. The ego associates suffering from pain with being battered, or being subjected to aggression. In effect, the anxiety is over pain as concrete aggression, and has a persecutory quality. For the second picture, she seems initially confused, and somewhat shaken and doubtful. Her body language shows some ambivalence regarding the process, and her voice sounds tense. Then, she begins her narration from the forefront and moved to the background. Her description offers very little story telling to connect the figures and elements together. The background figures are split between a motherly character and an angry young man ploughing the earth. As the story lacks a coherent plot so the ego feels unable to maintain whole-object relation. The integration of the whole-object is compromised. The ego is struggling to integrate an active, angry side and a passive, motherly one. If splitting becomes deeper, it can result paranoid schizoid anxieties. In the third picture, the ego is dealing with an object that is seething with anger and threatens to leave. The ego is anxious over the well-being of the object, and about the pending loss that cannot be repaired. Being abandoned by an angry and damaged object alludes to the depressive anxiety. In the fourth, the ego is standing at the threshold that splits the good from bad, and is peering at an nameless entity, both painful and disgusting. On the other side of the threshold, there is the bad object that

causes pain, revulsion and unhappiness. Splitting shapes the core elements of the narration, and alludes to paranoid-schizoid anxiety. In the fifth picture, the ego seems yearning for fusion with an all-caring object. There is total bliss with an idealized object, free from any anxiety. There is an attempt to escape bad object and pain. For the sixth, she names terrifying creatures, from monsters to snakeheads, and clarifies that what she is describing is vicious. As anxieties of paranoid-schizoid position come to the surface, her voice becomes tense. Then, suddenly, all horror that she has described become a portrait of her pain as concrete terror, hard and vicious. For the seventh, the ego feels entrapped in a dreary and suffocating darkness. The darkness of pain is "strangling," with little way out. The anxiety of annihilation is presented as images of pain associated with a death, as terrible as suffocation by strangling. Pain is dark and strangling. These are concrete forms of aggressive attacks that are lived as part of pain experience. For the eighth, she mentions suicide that sheds light on the nature of the sadness and anxiety. The ego confronts much guilt. The loss is described as pervasive. Losses, caused by pain, are making the ego feel surrounded by dead objects, for which the ego feels responsible. Life is "sad, lonely, really, really sad, upset" under the spell of pain. Pain experience has brought to present depressive anxieties. In ninth, under depressive anxiety, the ego feels surrounded by grey winter cold. The scepticism about any warmth in the middle of ice and snow implies the ego's concern about the internal object. Psychic reality is grey, cold, and icy. The ego seems caught in irreparable loss and depressive anxiety. In the tenth, her depressive anxiety becomes evident as she talks about suicide. There is a sense of helpless with utter despair and sadness that is consuming the whole story. In the eleventh, Initially, she sees emptiness and blank as a

space to be filled and made up for. She, then, reveals the other meaning of emptiness as a death-like void, left by pain. In that emptiness, the ego feels as though being "attacked and taken." The anxiety of annihilation resurfaces, as the threat to the object disappears into the threat to the ego.

The narration of the third participant begins by describing how the ego feels being controlled by the object to the point of helplessness. The ego feels frozen and petrified by guilt. For the second picture, he starts from the forefront and moves to the background figures. He relates a story that connects the elements together, but makes little reference to figures in the background. The ego avoids the object and the wards off the possibility of aggression and the ensuing guilt. The ego is ambivalent about the object and struggles with the possibility of integration and reparation. Depressive anxiety is salient within the two initial narratives. For the third picture, he initially feels confused, for two reasons. First, the ego feels split between love and hate. The love struggles for safety, where aggression is a threat. Second, the bad object as the nameless "it" both angers and threatens the ego. Splitting and the struggle for control under grave threat reveal the paranoid-schizoid anxiety of the ego. For the fourth picture, the object seems to be both caring and controlling. However, the narration focuses on the all-caring object and describes an absence of fear, threat, and sadness. Suddenly, everything is described in much positive light with only a tinge of worry, which he does not specify. The ego is ambivalent toward the object, and fears aggression. Depressive anxiety is evident. In the fifth picture, there is a desire to deny what might be a damaged object, and the possibility of loss. He talks about not being good at fulfilling the wishes of the object and feeling sad about it. This alludes to an undertone of depressive anxiety. In the

sixth picture, struggle with bizarre creatures, and a sense of strife with impersonal forces of misfortune and brute nature shape the narration. The anxiety is over the annihilation of the self, in a dangerous world. The ego feels fighting an assault is associated with pain. Pain appears as part of the attacking nameless force. On the other hand, the denial of death is meant to wards off the paranoid-schizoid anxiety that is patently prevalent. In the seventh picture, there is a desire to escape from the monotony of the present (perhaps partly the boredom imposed by pain), to the thrill of the unknown future. There is a sense of wanting to get away. However, there is also the opposite sense of being tied up to something underappreciated, from which the man has to break free to appreciate its true worth. The ego desires to escape from the annoying boredom with a sense of manic defence and acting-out. The ego is however ambivalent and recognizes the grievous possibility of loss. In the eighth picture, the ego initially reveals its anxiety over death. In fact, death is described as a fearful event that has to be conquered, or as a blissful state that can be embraced. Talking about this duality might be an attempt to ward off the threat of annihilation, or the paranoid-schizoid anxiety. Yet, as soon as pain becomes part of the narration, the threat of annihilation becomes undeniably concrete. Pain makes life no more than death, and the ego in pain is no more than the gravestones, with which it feels surrounded as the symbol of the lost object. Depressive anxiety is patently prevalent. In the ninth picture, the narration initially describes an idyllic place of warmth and togetherness. But, as I inquire about pain, the idyllic oasis of warmth disappears. The ego feels dead cold, wounded, lonely, and helpless. Dread and despair replaces warmth. Paranoid-schizoid anxiety suddenly becomes consuming. For the tenth, he talks about returning home following a venture. It alludes to the restoration of a previously

broken tie. If manic acting-out was a way of evading the damaged object and guilt, returning means the possibility of reparation and mourning. The ego recognizes the comforting prospect of repairing the object. As the ego acknowledges its dependence on the damaged object, a deep ambivalence resurfaces. There is the fear of stirred-up aggression that can transform reparation to no more than compulsive boredom or utter despair. The ambivalence makes home painless, but unexciting as opposed to the elsewhere that seems painful, yet exciting. Under the sway of manic defence and ambivalence, pain has acquired an ironic quality. For the eleventh, the blank card is perceived as a void that can be filled with something. Beneath the idea of filling the void, there is the anxiety over reparation. He ruminates about the possibility of really being able to do it. He feels much uncertain about filling the void. He struggles to ward off the guilt, as he ruminates over the equal possibility of good or bad outcome. The ego's deepening ambivalence once again threatens to bring back splitting and projective-identification, and revive anxieties of pain as concrete experience of annihilation. In the end, he once again speaks of scary and relentless attacks of pain.

CHAPTER 4

Qualitative Study of Suffering in the Discourse of Health Psychologists

4.1. Methodology

The methodology of this qualitative study involves the analysis of discourses collected by the means of semi-structured interviews. As a technique of qualitative data gathering, semi-structured interviews are conducted by the means of a thematic guide. The guide offers a list of themes that must be introduced and explored by the interviewer in a manner compatible with the ongoing conversation between the participants and the interviewer. A number of authors (Brener, Brown, and Canter; Kaufman, 1994; King 1994; Rubin & Rubin, 1995; Kvale; 1996) have favoured this interviewing procedure for at least 4 types of research undertakings:

- When the complexity of discourse demands further explorations of unpredictable nature;
- When questions have to take into account the information presented during the course of interview;
- When participants are interviewed for their in-depth experience with the subject under study;
- When interviewer intends to explore areas of tacit knowledge or personal attitudes, values, and beliefs.

The interpreGiven the interpretive goal of the present study, the above reasons are likewise valid for the methodology of this research. Thus, the interview procedure in this

study is designed to emphasize a conversational approach directed by an interview guide. The interviews go beyond a simple question-answer routine. Polio, Henley, and Thompson (1997) have argued that dialogue "is an aspect of conversation rather than of question-and-answer" (35). The authors maintain that in dialogue, the participants go beyond simply answering a question, as they find themselves describing "the experience to an involved other". In effect, as opposed to routine questions, dialogue invites the participants to reflect on the meaning of their experiences, and "even to realize it for the first time during the conversation" (31). In addition, dialogue is the very ground of self-reflection, as every reflective activity requires the use of external or internal dialogue. Hence, an open and inviting conversation facilitates self-reflection, and fosters deeper revelations about the subject matter.

4.1.1. Participants

The group of participants consists of one male, and two female health psychologists, who are practicing in publicly funded, multidisciplinary pain clinics. Their work revolves, in large part, around the assessment, manage, and treatment of chronic pain patients. All participants had well above 5 years experience in this area. Their intensive therapeutic involvement with patients enabled them to play a key role in the process of clinical management of chronic pain. In order to allow the in-depth discourse analysis required for this study, the satiation point for participant group has been set at three. In other words, this low satiation point is predicated on the logic of possible as opposed to probable truth which denies frequentist notions of quantity for depth. In this manner, greater depth in analysis is prioritized in order to meet the interpretive goal of this study.

4.1.2. Instrument

The instrument is a thematic interviewing guide that is used for introducing themes within the flow of conversation. The guide includes the following themes and sub-themes:

1- The psychology of chronic pain patient;

2- The anxieties of chronic pain patients;

   a. Anxiety over loss

   b. Anxiety over Body-ego

   c. Definition of anxiety as a construct

3- The fear of Annihilation

   a. Aggression

   b. Persecution

The first theme, *the psychology of chronic pain patient,* allows the participants to provide an overview of their observations and the highlights of sufferers' psychological condition. The second theme, *the anxieties of chronic pain patients,* asks the participants to describe two types of threats: a) losing the valued aspects of life or anxiety over loss and destruction of the object, and b) losing the body as the medium of pleasure and action, anxiety over the body-ego. In addition, the interview makes use of this theme to ask for the general definition of anxiety as a construct. The third theme, *the fear of Annihilation,* was used to explore the participants' view on threats of annihilation and disintegration. The interview uses this theme to ask for the participant's view about the aggressive and persecutory nature of such anxieties.

4.1.3. Procedures

Participants were randomly selected from a group of experienced health psychologists who initially agreed to be the interviewed. The participants were asked to take part in a study that investigates the relation between pain and anxiety. They were given a consent form (Appendix I) prior to the interviewing session, which provided them with written information regarding the objective and the use of this study. Each interview was completed within a 40 to 60-minute period.

4.1.4. Data and Analysis

The data consists of transcribed interview recordings. For the purpose of reflecting finer verbal elements, Jefferson's (1978) dramaturgical notation system was, in part, adopted for this study.

=	Sudden beginning or ending
/	Repetitions
x:	Extension of the preceding sound
xx	Stressing the underlined utterance
XX	Loudly uttered
(.)	Short pause
(3)	Two second pause
...	Skipped part
[]	Added explanations

The model known as sequential organization was used for presenting the material. This model emphasizes the sequence of "adjacency pairs" that are defined as discourses exchanged in a given turn between the interviewer and the participant (Schegloff, 1977). To capture the interplay between the two interlocutors, every research must set these pairs according to the nature of the interview and the intended analysis. Hence, each adjacency pair may include more than one actual conversational turn and involve a set of questions and answers. In this study, every excerpt contains at least one pair of interviewer-participant exchange as an adjacency pair, as well as all solicited

elaborations. The non-lexical expressions such as "Oh" or "Hm," as well as pauses and repetitions have been retained to preserve the conversational quality of the speech act.

Each transcript undergoes two initial readings for an analysis of discourse. In their studies of metaphor, Lakoff and Johnson (1980:22-24) demonstrate how our choice of concepts, definitions, and metaphors can highlight one aspects of experience and hide another. Hence, as we talk about ourselves, about others, or about objects, our discourse determines what gets to be talked about and what remains out of discourse. Cassell (1975) uses a similar argument regarding the clinical thinking in medicine. He argues that clinicians use two kind of thinking: analytic and valuational. Analytic thought is described as scientific, empirical, and reductionist. On the other hand, valuational thought allows us to integrate observations selectively, based on human value conceptions. Cassell describes these two modes of thinking as interdependent. The present study uses this insight to investigate not only what is selectively integrated and affirmed, but also what is excluded and denied value. Analyzing the discourse of the participants, the study shows how valuating and devaluating speech acts are performed. The first reading identifies all *valuating* speech acts, which acknowledge, accept, validate, or highlight the interview themes. The second reading explores the *devaluating* speech acts, which invalidate, deny, ignore, or hide certain interview themes. To show how the participants move or fluctuate between these two modes of discursive actions, the result section presents the first and second readings together. In this vein, it becomes possible to observe the interplay between the valuating (highlighting) and devaluating (hiding) discourses in each interview. Following the first two, the third reading is intended to

explore the relation between the two speech acts, across the three interviews. In other words, the third reading reveals how participants overlap in their treatment of the themes, when the analysis is applied across interviews.

With regard to the question of validity, Giorgi (1975) defines the criterion for qualitative research as "whether a reader, adopting the same view point as articulated by the researcher can also see what the researcher saw." To satisfy the criterion of validity, the reader must be allowed to fully identify the point of view of the researcher. One way of facilitating a transparent reading of the researcher's stance is to present the analysis from the first-person point of view. Such perspectival clarity is adopted in this research; hence the analysis is written from a first-person point of view. In addition, the Discussion section presents the interviewer's self-reflective material that was collected as part of the journal of research. This practice will allow for an added transparency with regard to the author's stance and reactions during the process of interview and analysis.

4.2. Analysis and Results

4.2.1. First Interview—First and Second Readings

The first participant was an experienced, female health-psychologist in her early 40's. She has been working with adult chronic pain patients for about 8 years. A public sector employee, she has been providing care to a large variety of patients, in a multidisciplinary setting. She described herself as a health psychologist, who mainly uses group modality of intervention to help patients cope with pain, disability, anxiety, trauma, depression, and grief. The interview took place at her office. She appeared as eager to start. The

interview began after signing the consent form. I asked her about the psychology of chronic pain patients. Initially, she reacted to the immensity of the possible answers.

> Q: All right. In terms of your observations of their psychological reactions what do you see in chronic pain patients?
> R: O::h, that's a bi::g question!

She emphatically pointed out the magnitude of my question, which was seemed to point at a single definition. She devaluated any closed definition of the psychology of chronic pain, on the ground of its sheer scale. I reassured her and continued.

> Q: An outline would be good because we are going to go into detail.
> R: Ok. Psychological reactions to pain, I think, uh, it runs the gamut from depression and anxiety to, I think, um, denial, uh, somatization of um, the distressful feelings associated with it. Those are the big ones that come to my mind.

She spoke of a "gamut of psychological reactions," that could entail affects (anxiety and depression), defences (denial and somatization), and distressful feelings associated with pain which she referred to as "it." At this point, her initial reaction became rather clear, as she valuated the psychology of chronic pain as a multitude ("a gamut"), and not a singularity. I asked her to elaborate on specific anxieties of pain patients.

> Q: You mentioned anxiety and (.) in fact, that is one of the major issues it seems with chronic pain patients. Would you please elaborate on that?
> R: Anxiety is/is almost universal with chronic pain patients because pain is threatening to people. It threatens their who:le life as they know it prior to pain…

First, she valuated the pervasiveness of anxiety among chronic pain patients. Then, she valuated the threat of pain as one directed toward the patient's "whole life." I asked her to elaborate on different anxieties of chronic pain patients and their meaning.

> Q: …What about threatening the valued facets of their lives, what we call, let's say loved objects, or valued aspects of the patient's life. How do you see that?

> R: Well u:m, I guess the way I would understand your question is by how people invest different aspects of their identity and what they invested in. ...They are kind of the glue and if they end up with a chronic pain problem and can't do all those functions then that threatens their relationships and their way they built and derived their identity. ...

In her observation, the loss of love object was described not only as the loss of something that is loved, but also as a greater loss of identity. In other words, she valuated the symbolic meaning of such loss for patient as the "glue" of identity. However, the participant defined identity as "built and derived" from "functions and actual relationships." Her discourse makes no note of the primitive and developmental history of the self or the ego. Hence, I continued to the next question.

> Q: ...one other aspect of the loss that you mention uh, might involve the comfort level with ones body. How do you see that?
> R: Hm, um (2) interesting question. Some people re:ally stand out in my mind and there they give a sort of rejection of a, um (2) what's the right word for how some people actually, (.) it's almost like their identity becomes separated from their body, they reject themselves, they don't accept that body anymore because it no longer fulfills the function that they expected of it. It almost becomes an other, it is like an othering process because of the pain, ...

She acknowledged the second question as "interesting." She began looking for "the right word" to capture what she had in mind. Perhaps she had never articulated this observation before. She called it the "othering of the body" to capture one's the patient's sense of alienation and estrangement regarding the body as an "alien presence." Her elaboration valuated the split with the body and the transformation of the body to a "thing."

> Q: ...You spoke about how much they distance themselves from their own body for example, what do you think in terms of their psychological integration, are they staying integrated?
> R: I think there is, and (3) I think I was just saying that, I think that is what I meant to say, there is a sort of disintegration but how aware they are of it, but I do think there is a division in themselves.

> Q: When we talk about anxiety, with regard to this disintegration, as a health psychologist how do you explain anxiety or define anxiety?
> R: A couple of ways depending, you know in my seminar, we talk about anxiety in a very sort of a physiological way. You know, we talk about all the physical reactions that people have, when they are experiencing anxiety, but I think um, we also talk about it as kind of akin to fear or threat um, to tell, I guess, is the typical way I would present it to people.

She once again valuated the split with the body, but added the sense of disintegration to it. She valuated the sense of "division" in the patient, even though she was not certain about patients being able to recognize it. On the other hand, in defining anxiety, her discourse valuated the physiological process of fear response, and took no note of the psychological content of anxiety. In effect, she devaluated any psychological elaboration of anxiety (i.e. depressive and guilt-ridden over loss of the object, or persecutory and schizoid over the loss of the self). At this point, I asked her about to what extent such threats might constitute a sense of aggression. In my first attempt at this question, I carefully worded myself to allow her express what comes to her mind.

> Q: With this threat [disintegration] that you were speaking about, is there something that involves aggression for example.
> R: Oh, um (3). You know I think, I'm not sure if I understand your question but I'll say when I say threat it's not aggression, well maybe it is, what I'm thinking is sort of people expectations of the future. What will I be like in the future? Will I be in a wheelchair? So those kinds of threats to, um, a person perceived level of ability and, um, declining ability and so that's what I mean by a threat.

Initially, she became pensive for 3 seconds. Although she understood my question, she appeared not so sure about its significance. First, she devaluated the theme, and then modified her response to a partial valuation. Then, she again tried to devaluate the theme of aggression by underscoring the loss of future expectations, and by showing such loss to be at the core of the problem. Up to this point, her discourse was overall expanding to

valuate interview themes. This was a shift to a constricted way of talking, and a move away from the theme of aggression. I used one of her earlier elaborations to reintroduce the theme in a manner that includes some of her earlier remarks.

> Q: You talked about how the person feels separated from his or her body, the chronic pain sufferer. In that case, do you see or have you observed that the chronic pain patient feels at times aggressed by the pain?
> R: YES./Yes. I think that it is like a battle. And, I think, it fits with that kind of othering, it's like a war between me, who I think I should be who I see myself or expecting myself to be, and then this sick person, this unable person, and a rejection like. Here's what I want it to be and here's what society expected me to be, and here's what I am, here's what it's going to be in the future, even less able. And, I reject that and I resist. ...

As my question reminded her of the estranged body, her discourse expanded to valuate the theme of aggression. She offered the metaphor of a battle, wherein aggression could flow between the self and the body. Her battle metaphor went beyond simple aggression, and conjured up the image of an enemy invasion or attack. In fact, the metaphor valuated the theme of persecution. This was a sudden change in speech-act perspective that expanded once again to acknowledge the interview themes of aggression and persecution. This came about, when I intentionally pointed to the estranged body as the aggressor and persecutor. Then, she could valuate the felt-experience of aggression and attack ("fits that kind of othering"). However, her example once again reverted back to the anxiety over interpersonal expectations and social feedback, without any reflection on primitive history of pain. Finally, I introduced the theme of anxiety of annihilation.

> Q: ...in general, given that part of growing up is in fact about dealing with many situations or many occasions of helplessness and the anxiety associated with those situations, that are danger situations of early childhood that we all go through, not just those who are traumatized, and given the anxiety in those helpless situations of early

> childhood involves the fear of death, basically, and of annihilation. How much do you think, this developmental experience is relevant to feelings associated with chronic pain?
> R: Hu::m (2) It's not sort of a um, (.) the way I think about things. I don't think it sort of fits with my conception. I think the way that I would see it is that, you know, that at least those who I see, you know, there are normal levels of threat to self that children have an opportunity to learn to master. And these people that I'm seeing, there is, I don't know how or who can master this stuff that I see in them. Or, perhaps they are a vulnerable group to begin with. Maybe, they were born with some sort of vulnerability to not cope, because I know there are probably other very resilient folks who get through with the chronic pain. Um, but, um, as far as your question goes I guess it just doesn't fit with my way of thinking about people.

The theme of my question was how childhood fears of annihilation and helplessness might be relevant to adult reaction to similar anxieties in chronic pain. After a long pause, she devaluated the theme. Although she earlier talked about disintegration and the threat to identity, she reacted with confusion and surprise to my direct question. As she regrouped, she talked about her problem with this theme. First, she rejected the idea as being far from her mind-frame. Her ensuing explanation revealed some degree of ambivalence, as she was unsure how to explain the patients' consuming lack of mastery over feelings of distress, to which she referred as: "this staff that I see in them." She did not qualify what she meant by "the stuff," although it was obviously referring to the patients' fears, over which she appeared ambivalent from onset. She acknowledged that it is not possible to say how one can master "this staff that I see in them." Yet, in explanation, she evoked the idea of a congenital vulnerability, or a condition developed in pre-natal period. This remark devaluated a psychological explanation for the issue of anxiety of annihilation. Finally, she acknowledged that the idea "does not fit" her view of "people."

4.2.2. Second Interview—First and Second Readings

The second participant was an experienced, male health-psychologist in his mid 40's. He has been working with adult patients whose main presentation consisted of pain and disability. As part of his job, he managed a large variety of patients who received treatment in an active rehabilitation program. He described himself as a health psychologist, and specified the modality of his intervention as one-on-one. Pain, disability, and anxiety were the reasons why many of his patients needed help. The interview took place at his residence. He appeared as eager and welcomed my presence. The interview started with signing of the consent form. Then, I asked him about the psychology of chronic pain patients.

> Q: from your experience with chronic pain patients, what do you qualify as the psychological reactions to pain?
> R: As a general outline of their psychological reactions to pain. Um (2). Apparently there is a violation of expectations uh, I believe that part of the expectation ...that, they will come into the health care system and there will be some cure, some uh, ability for health care professionals to relieve their pain, and often the belief that medical diagnostic tests can reveal the cause of the pain and somehow eliminates constant pain. . ... One of the most common pieces of their discourse uh, at the beginning of the program ...is that "I'm not the same person I used to be". In most cases, it's certainly the loss, uh, the threat of loss is quite significant. ...And the other is, coming from grieve and bereavement literature that have come up with "disenfranchised grief" which happens when one can't see the loss, therefore it doesn't exist. There is a parallel, I think, in the grief experience of chronic pain patient, so that a person can be grieving and other people may not know that. ... And with the pain, it's there, it's present but, others can't see it, other people can't see it, so they disenfranchise the person with such experience. They don't validate their experience.
>
> Q: In terms of feelings, what have you seen?
> R: I can name feelings about loss, for example grief, uh, that is multi-dimensional and entails, um, sadness, uh, anger/anger at pain being present and continuing. The desperation, and frustration, ve:ry significant frustration which may turn into anger, or may become a completely separate emotional experience for them. Uh, anxiety, um,

> and that takes in a whole range of different ways of being anxious at different points in their journey.

The participant acknowledged the disturbing violation of hope that pain engenders, as it becomes incurable. He pointed to the objectification of pain as something to be removed. He recognized the patient's loss of accustomed identity ("I am not the person I used to be"). He described how loss is "multidimensional" and how anxiety may assume different forms. In addition, the participant characterized pain and loss as experiences that are intangible, and are therefore inaccessible to others for interpersonal validation. His description clearly valuates the split and rupture that pain and loss create between the patient and others, and between the patient's past and present. He pointed at the transformation of frustration to anger as "a completely separate emotional experience" for patients. His emphasis on anger, desperation and frustration obviously valuates the distressful feelings associated with pain.

> Q: As a health psychologist, how do you define the concept of anxiety?
> R: Um, it is a typically un:wanted emotional experience (.) of nervousness of, uh, sometimes, manifests itself as fear to a range of things, ah, or to uncertainty of future. ...It, somewhat crosses over into ah, self-esteem and security, the feeling of security or insecurity ah, confidence or lack of confidence. And so, an example would be the discharge anxiety, as a person coming to the end of the program, it's not uncommon, at all, to experience anxiousness over separation from the program, from the treatment. That means they are out there on their own if you will.

He explained anxiety as an "unwanted" feeling, and made reference to fear reaction about future uncertainty, as one concrete example. The participant then made reference to self-esteem and the feelings of insecurity regarding self, which could suggest the idea of threat to the self. He continued by offering an objective example about the patient's anxiety over being discharged from the rehabilitation program (termination anxiety). He

offered some elaboration regarding the content of such insecurities or anxieties, when he added, "that means they are out their own if you will." Yet, he did not explain how patients experienced the feelings of being cut off from a source of support. In effect, the content of anxiety was ignored and devaluated.

> Q: You talked about loss, and you talked about how much loss in fact impacts the experience of the patient. There is definitely a loss in valued aspects of life for the patients. Valued aspects of life are being lost as a result of pain. Now, how do you see the impact of this kind of loss on the patient or on their sense of who they are?
> R: For Some people I think it can become an existential kind of angst like, um (.) so what is life anymore, what's the purpose of life. ...It shows itself in terms of a loss of a sense of future, future possibilities, and future hopes. That some of the, if you will, secondary losses that would happen are the loss of the future, and of dreams and hopes and the visions of what again ties into assumptions and expectations about the self or about the life. ...Particularly, there can be also a loss of the self of or self-identity. For the first time when this loss erupts, it would be like asking so who am I now. Part of the challenge then becomes the process of self-redefinition as who they were has changed ...to who are they now and what they struggle with.

He acknowledged existential angst, which by definition, reflects the anxiety of being, *être*, confronted by nothingness or non-being, *néant* (May, Sartre, Heidegger). However, the participant's elaboration of this angst emphasized "the purpose of life" as tied to "the assumptions and expectations about the self." In effect, he highlighted a particular meaning of existential angst as the anxiety over self-actualization, or as the worries over the "sense of future, future possibilities and future hopes." His elaboration bore no reference to the felt-experience of nothingness, and the dread of annihilation. Hence, he devaluated this sense of angst. In his view, identity is an expected and valued "role set" that a person enacts in interaction with others. Losing this set requires a major revision of assumptions and expectations regarding future. Hence, patients can learn to change their assumptions to include "who are they now and with what they struggle." He

devaluated the anxiety of falling apart or impending destruction. My next question meant to clarify that to what extent his notion of existential angst includes the split with the body, and the feelings of violent disintegration.

> Q: One of the losses that we see that affects the individuals in pain. Is the loss of the sense of having a body as the medium of pleasure. The relationship changes with body as presumed medium pleasure as a result of pain. How do you see that in your patients, can you explain it?
> R: Part of it seems to come through as almost (.) a: betrayal (.)/a betrayal by the body to the person, that the body doesn't work the same way because they can't call on the body to do things that it used to do. In terms of pleasure, ah, whether it has specifically something to do with sexuality and sexual pleasure for some individuals but, you know that the presence of pain means that a secondary loss of potentially, ah, sexual relationships. If you think of something like a person who in his life before pain, before the accident, was involved in sports uh, not quite a while ago, quite an active person, then the loss for such individual is the body can no longer do things. If they try to do some of the things that they did before, some sports activity, we often use the phrase "They are going to pay for it", which means "They are going to pay for it" through the pain afterward, and so they can't. Many people feel they can't do those things anymore. That's part of the loss as well as part of the distress, just in terms of anxiety. The other thing, in terms of loss, you're talking about loss and asking about particular loss but, in the past, the emotion of depression and sadness was typically the predominant emotion that was related to loss. Actually, what is being debated right now, what's being found more and more in the literature and is being debated in terms of redefinition of DSM-IV, is that there is actually a large degree of anxiety in loss.

He referred to the sense of betrayal associated with the loss of agency for the self ("body doesn't work the same way because they can't call on the body to do things"). As an example, he talked about the loss of sexual pleasure and relationships. However, he did not elaborate on the content of the anxiety over betraying body. In his description, the sense of being punished by the aching body was clearly reflected ("they are going to pay"). He valuated the presence of anxiety in loss and grief. Yet, there was no attempt to see how this anxiety could implicate that aforementioned sense of punishment and

betrayal or violation of identity. In short, the participant devaluated the anxiety over an attacking, destroying, and devastated body. I felt, therefore, that further elaboration could clarify these issues.

> Q: And, ah, with regard to losses of the body or to the body suddenly becoming less familiar to the person as a result of pain, what do you see happening there? How the patient feels about his or her own body with regard to anticipation of harm or pain coming from the body?
> R: Uhm/Uhm. (.) Well, I have a strong connection where there is the idea of ah, hurt equals harm. In the terms of the program that I work in, which is an interdisciplinary program, much of what the physical staff tries to educate clients around, is the difference between hurt versus harm. Some clients have the idea that if something hurts for example the body in the rehabilitative process, if it hurts when they try to do it, then this is not a good thing. Some people equate hurt with harm, something damaging happening in the body. This is not obviously the case in all situations, and so part of the education is how rehabilitation, in terms of physical conditioning of the body, often entails a soft muscle tissues. Obviously, it hurts to rehabilitate muscles, that doesn't mean there's physical harm going on, but to sort those two impressions out is quite difficult for some clients.

My question was intended to explore the primitive threats experienced due to alienation with the aching body. Although he earlier described how the body appears as treacherous and punitive, he did not see "harm" as being related to such feelings. In response, he recognized that for some people hurting felt like harming, which he attributed to a cognitive mislabelling without any primitive significance. His discourse devaluated the primitive threats that could arise out the aching body. To explore more directly, I asked about the split with the body.

> Q: Do also see certain degree of the detachment from body?
> R: Sometimes, not always. For some people it is like the amputation metaphor that ah, some people almost treat a part of the body like it is a foreign body, like it is an appendage, it's there but it's not very useful. That's more so the cases with people whose limps or body part are more and much more severely affected by the accident as opposed to soft muscle tissue injuries.

The answer to this question was exceptionally short. He used the metaphor of "amputation," which certainly exceeded the connotations of "detachment from the body," offered in my question. Then, he continued by saying how some patients could perceive their body as "a foreign body," or "appendage." Further elaboration on the content of the patient's feelings about this foreign body could have revealed aggression and persecution. However, the participant added that more likely such feelings are related to the severity of actual injuries, or the real intensity of tissue and organ damage. Hence, he devaluated the aggression and persecution. I, therefore, outlined the some of the key themes, and asked the last question.

> Q: We talked about the loss of the body as the medium of pleasure. We talked about the loss of ah, personhood as a result of losing the valued aspects of life. ...I wonder with these losses and with the associated anxieties, ah, how much do you see in your patients ah, anxiety of annihilation or of falling apart?
> R: U::m (4) Falling apart. Um (2) I don't have a clue. Um, (2) I guess, it really depends on what you mean by falling apart and what each client would, uh, mean by that would be different. Um, that's. There's not so much if they are falling apart. It's kind of the concept of really losing it, going crazy. Ah, um, not so much that. I think most of it is about falling apart around the change in/in self-identity, of who the person thinks they are or can be. So for example, the falling apart is about can't get to do a role—meaning their previous role before being a chronic pain sufferer. They have seen themselves quite different as active or as maybe a key person in the family, maybe even directing things or organizing things, for someone falling apart looks like ah, ah, a drastic change in roles. Whether they, themselves sort of go in the direction, or whether the family maybe places them in a different position, so they are no longer thought of, in the same role. AH/ah, (2) I lost the other thought I had. (2) O:h, ok. Around identity that, for some people, not so much the falling apart, but that, some individuals see themselves as handicapped or disabled. Sometimes they use those words, sometimes not, sometimes they use, you know, a collection of words and phrases to depict that disability as a kind of identity. Ah, they maybe talk about a limb or part of their body in a sense, that's no good anymore, that's gimpy, or that's ah, ah, useless and so there again it's kind of a foreign sense, they'll talk about a part of the body as if it was

> disconnected and a different part or a different ah, uselessness from the rest of the body.

The participant devaluated the theme of annihilation by stating that he does not "have a clue." A drawn-out, non-lexical expression ("u::m") and a set of long pauses punctuated the statement. Then, he redefined the meaning of annihilation ("really losing it" and "going crazy") as "role dispossession," or as being stripped of roles that are essential to one's life. As a result, the participant devaluated the theme of annihilation by redefining it as the dissolution of role set, and not as the dread of impending destruction. Following this redefinition, he confirmed its prevalence in "some patients" who have undergone serious role changes. In effect, he described the threat of dissolution of self as an objective "drastic change in roles." After a moment of confusion where his thoughts were interrupted, he gathered his ideas to describe disability as a new kind of identity for some. He described the sense of alienation from a body part, involved in this new identity. Although he valuated the alien presence of the body ("it is kind of a foreign sense"), he could not valuate the anxiety of annihilation or of falling apart as in any shape related to such splitting with the body.

4.2.3. Third Interview—First and Second Readings

The Third participant was an experienced, female health-psychologist in her late 30's. She has been working with adult chronic pain patients for 10 years. A public sector employee, she dealt with a large variety of patients in a multidisciplinary pain clinic. She described herself as a health psychologist, who uses one-on-one and group modalities to help patients cope with pain, disability, anxiety, and depression. The interview took place at her residence. She was eager to begin. The interview started after signing the consent form. I asked her about the psychology of chronic pain patients.

Q: In terms of feelings, what do you see as feelings and emotional states associated with chronic pain?
R: Um, anger, especially the longer people have lived with pain. Um, anxiety and depression, um, fear that the pain will never go away. Hopelessness, um, that is sort of felt in terms of a gamut.

She valuated feelings of anger, anxiety, depression, and hopelessness. She called hopelessness a gamut. She valuated hopelessness not as a single experience, but as a complex one. We continued.

Q: Would you like to offer some explanation with regard to what anxiety is from a health psychology point of view, from your practice point of view?
R: Ok, um, the content of what specifically they would experience anxiety about or u:m =

Q: = Yes, the content and as well, ah, a sort of general definition of what is anxiety.
R: Ok, um, I think in terms of what the patient would experience um, with anxiety, is um, anxiety toward the health care profession, um, and the inability of others to help them and, um, I guess they would be very concerned, anxious um, of getting to be in more pain or being told that they were fraud. Ah: , is that getti:ng =

Initially, she seemed uncertain and sought my active involvement as an interlocutor. She did not hesitate to ask, if I meant the content of anxiety. She, then, explained the patient's helplessness with respect to the inability of healthcare professionals in providing solution for pain. She acknowledged that patients are fearful of being dismissed as a fraud, since their ordeal is not tangible for others. Her observation reflected the split with others that the private experience of pain could impose on patients. She valuated the anxiety and helplessness that patients experienced in relation to others understanding of their ordeal and the effort to cure it. We continued thereon.

Q: = Yes/Yes. Now with regard to the actual definition of an anxiety from health psychology point of view what do you see or how do you define anxiety?

> R: Oh, that's very interesting. (2) Your talking theory! U::M (.) in terms of psychology how do I define anxiety. U:M, (2) I guess in a specific application anxiety would stem from a perceived threat towards a person and their physical well-being. And, the resulting action to deal with, I guess, the fear of physical harm that is coming to them, and following that there would be the behavioural manifestations of feeling threatened.

She showed reservation about the theoretical implication of the question. Then, she valuated anxiety as feelings of being threatened that would lead to behavioural reactions. In her definition, she explained the danger in terms of "threat to person and physical well-being." The word, "physical," was repeated which emphasized the concrete aspect of the threat as a threat to the very existence.

> Q: Ok. So, you spoke about threat and the threat against the being of the person and now one of the areas of threat for the chronic patient can be, or said to be, the loss of valued aspects of life, how do you see that, how do you see the patient reacting to this loss?
> R: Well it depends on the patient I guess and their personality prior to the pain, um, at times there is hopelessness and a helpless resignation. Um, and uh, at times coupled with that is a heavy/heavy/hea::vy reliance on the medical profession to help them or someone else to make it better for them. Um, the other type would be those that are quite angry at their own limitations, but then again they will look to others to help them out. I would expect the ones that are more, um, or have more agency or would be able to deal with it themselves wouldn't come into my office because they would be working really hard on their own, and are probably more functional; they wouldn't have the same losses as the others.

She explained how patients' reaction to loss was part of their personality. This statement could have meant a valuation of the patient's personal history. She pointed out that helplessness drove patients to treat medical professionals as all-powerful healers. When frustrated, such desire was reported to turn to anger. Her observations described the primitive idealization and denigration that resurfaces as patients desperately plunge into helplessness. Her observations on "helplessness and resignation" acknowledged the

overwhelming effect of anxiety on the patient. However, she made no mention of the precise nature of the threat felt by the patient. My next question explored the issue further.

> Q: So you see them in the situation of being threatened for the loss of valued aspects of life. Some of them can take care of themselves and others turn to you or to other professionals for help, to take care them with regard to feelings of loss. How anxious they are about losing themselves in front of such threats?
> R: I don't think they perce:ive it that way. (2) Um, (.) perhaps some are a little more insightful, and would be that their roles are being diminished and their ability to fulfill those roles, partners, parents, workers that sort of thing. Um, I don't think I actually heard a lot of people talk about it in that abstract of events, it seems much more concrete and immediate. I can't perform this act therefore I'm having this reaction versus I'm losing parts of myself or parts of my role. Um (.), Ya.

She devaluated the theme of the threat to the self. After a sudden and long pause that followed, she acknowledged that more insightful patient could only discern the diminishment of their social roles ("partners, parents, workers," etc.). The question asked about patients' experience of losing themselves in reaction to important losses in life. In response, she dubbed such reaction, "that abstract of events", which was not commonly accessible to patients. She valuated in its place the "concrete and immediate" concerns. In her view, even insightful patients could only understand the significance of loss as far as its impact in diminishing their role set. The loss was, therefore, explained in objective terms.

> Q: So, another example of anxiety inducing situation that they might face as part of their experience, um, is the threat (.) of not being able to use or to enjoy their own bodies. Our bodies are our medium of pleasure in a sense, and when the patient's body is in constant pain then what do you expect to see in that case, with regard to anguish or with respect to anxiety?
> R: U:m, (3) for those people, (.) I'm trying to find the right words (.) a sense of betrayal. They feel betrayal um, they feel that there bodies

> have betrayed them and that in some ways they are not one with their bodies, but they are one against their bodies. Y:a, and frustration that the rest of the world operates differently and yet they have this internal battle um, even though they sort of externalize their body in a way of an object to be angry at or frustrated against or feel grief over, like bereavement if they know that it will never get better. So I think their body becomes personified in a way. Y:a.

She valuated the felt experience of the body as an alien object. Hence, she clearly identified the split with the body. First, she acknowledged "a sense of betrayal" that could lead to hostility ("they are one against their bodies"). Second, she described how such split could turn the body into a concrete object ("externalized", "personified") of fear and hostility ("they have this internal battle"). Finally, she valuated bereavement over the irredeemable loss. Her observations acknowledged feelings of alienation, anger, and struggle with regard to the pain-ridden body.

> Q: So do you see that [alienation from body] quite often in your chronic pain patients?
> R: Only for people who are quite insightful and psychologically minded would they be able to delineate things clearly. Um, would I see it in patients but them not seeing it for themselves? Probably, fairly frequently, I would say.

However, as I explored the pervasiveness of the split with the body, she devaluated its ubiquity and attributed such feelings only to psychologically minded patients who can articulate themselves. She made a reference to "them not seeing it for themselves," as opposed to her seeing it for them. Her view did not reflect the primitive, non-verbal origin of patients' feelings as the possible reason why such states resist articulation. Rather, she attributed these states to patients' psychological mindedness. She maintained how such feelings could appear more clearly to her, rather than to the patient.

> Q: You basically talked about two types of situations: that of a the loss of the person's body, the threat of the loss of the person's body, and

> the threat of the loss of others. Now, you also talked about patients being angry at their bodies. How do you think that this situation of feeling their bodies causing them grief, causing them pain, and making them feel worried, anxious about their lives, about their existence, basically impacts the patients. Do you see this as feeling a sort of threat of being annihilated?
> R: I'm not sure annihilated would be the appropriate word. (3) Um, I would see it at a more concrete level. They would get, I guess, an economic threat, a social threat, a relational threat that they could become anxious about, um, if the pain would prevent them from working or acting in different capacities in their lives. Um, (2) I'm just thinking about the word annihilation. Ultimately, yes, a deep seated fear, but a core fear that all these forces; the relational, the occupational, the economical, if you would take those to the extreme and they had anxieties about all of these individually, and they were all to occur of course people can imagine fairly well when they are anxious, would result in their total annihilation, because they would have no relationship, they would have no financial needs, they would have no source of work, if they lost all relationships and all purpose for living. So taken at the extreme end of a continuum maybe annihilation could be an appropriate word in terms of their anxiety.

At first, she expressed her doubt about the word and its appropriateness. What seemed inappropriate was the intensity of the dread that the word, annihilation, connotes. Her long pause after her initial devaluation of the theme was significant. However, using the word, "ultimately," she initiated a conditional acknowledgement of this theme. She spelled out in concrete realistic terms ("the relational, the occupational, the economical") the cumulative process, through which anxiety of annihilation could come about as a result of undergoing intense losses. Despite referring to "core" or "deep seated fear," she tried to explain the anxiety of annihilation based on the cumulative effect of real losses. On the other hand, she devaluated the primitive significance of such anxiety.

4.2.4. Third Reading

The first theme of the interviews, *the psychology of chronic pain patient,* opened the dialogue to the participant's experience with chronic pain patients. The first participant

devaluated a single account for this theme. She qualified the theme as involving a "gamut" of experiences that includes anxiety, loss, denial, and somatization. The second participant was able to offer a coherent account for this theme that included loss, depression, frustration, anger at pain, and anxiety. He called the threat of loss significant, and acknowledged its deeply personal and intangible nature as the source of helplessness for the patient ("disenfranchised grief"). The third participant pointed out how prolong suffering engenders frustration, hopelessness, and anger. She named depression and anxiety as important feelings. Finally, she described helplessness as a multitude of feelings ("a gamut") experienced by the patients. All participants recognized the complex psychology of chronic pain patients. The participants valuated helplessness, depression, anxiety, anger as the main highlights of this theme.

The second theme, *the anxieties of chronic pain patients,* allowed the participants to describe two types of threats often felt by chronic pain patients: a) losing the valued aspects of life, and b) losing the body as the medium of action and pleasure. As well, the interview made use of this theme to explore the general definition of anxiety as a theoretical construct. The first participant recognized the pervasive anxieties of chronic pain patients. She valuated the symbolic significance of such losses, and pointed out that the loss of valued aspects of life can be experienced as the loss of identity. As well, she valuated the split with the body, and the sense of alienation and disintegration ("othering"). However, when asked to define anxiety, she emphasized the physiological and physical fear response in concrete terms. In an attempt to seek her opinion about the content of anxiety, she was asked, to what extent the fear of disintegration could be

experienced as aggression against the self. She expressed her surprise regarding the question. She first devaluated the aggression, and emphasized the concrete nature of losses as limiting to grief over personal and interpersonal expectations. Then, as the idea of split with the body was recapitulated, the participant's discourse changed course and valuated aggression, and described the self-body relation as "a battle." Although she valuated the theme of disintegration/aggression, her elaboration focused on how patients' felt-experience could only rise from grappling with interpersonal and social expectations.

The second participant approached *the anxieties of chronic pain patients,* by defining anxiety as an unwanted feeling of fear. He evoked uncertainties of the future and insecurities of the self, in order to suggest how this fear might involve the self. In his example, he presented the patient's anxiety of termination, but without any elaboration on the content of what is being felt. In an attempt to seek his opinion on the content of anxiety, I asked him to elaborate on the anxiety over the loss of valued aspects of life. Referring to existential angst or anxiety of being confronted by nothingness, he explained how loss could affect the concrete assumptions and expectations about life. Then, he valuated the significance of such losses, in threatening the person's assumptions about life. When asked about the threat experienced by the patient as a result of living with an aching body, he referred to a sense of betrayal and punishment. Finally, I asked the participant to explain the violent threats one might experience as a result of living with a treacherous and punitive body. In response, he recognized that for some people hurting felt like harming, which he attributed to a cognitive mislabelling. Hence, he devaluated any implied significance. As I probed deeper into the split with the body, he offered the metaphor of "amputation." He continued by describing how some patients could

perceive their bodies as an alienated part or "appendage" as a result of their concrete injuries. Hence, he valuated the split with the body. Yet, he tried to show that is clearly associated with the extent of actual injuries.

The third participant approached *the anxieties of chronic pain patients,* by explaining the content of anxiety. She acknowledged helplessness as a gamut that includes the patients' worries about being misunderstood by others, even by the treatment team. She explained how anger replaces frustration, as patients face significant loss. When asked about the general definition of anxiety, she valuated anxiety as feelings of being threatened that would lead to behavioural reactions. In her definition, she explained the danger in terms of "threat to person and physical well-being." The word, "physical," was repeated once again to emphasize the concrete aspect of threat. I ask her about the loss of body as the medium of action and pleasure. She valuated the sense of alienation from the body. She clearly acknowledged two significance of the split with the body. First, she acknowledged "a sense of betrayal" that could lead to hostility, or to being "against their bodies." Second, she described how such split could turn the body into a concrete object ("externalized", "personified") of fear and hostility (in a "battle"). I asked her if she has been confronting such feelings in her practice. However, she devaluated the ubiquity of such threats, and attributed such emotional states only to psychologically minded patients. She acknowledged that in those lacking psychological understanding, the content of patient suffering could appear more clearly to the psychologist, rather than to the patient. In most part, patients were said to fear only the loss of concrete abilities that could be important to fulfillment of social roles.

The third theme, *the anxiety of annihilation,* was used to explore the participants' view about the threat of dissolution of self. After outlining the threats caused by the loss of the valued aspects of life and the body, I asked to what such anxieties might pose an annihilation threat to the self. After a long pause, she devaluated the theme. My question also made a reference to childhood fear of annihilation and helplessness and asked the participant to reflect on their relevance to similar adult anxieties in chronic pain. Although she earlier talked about the theme of disintegration and the threat to identity, she reacted with confusion and surprise to my direct question. Then, she rejected the idea as being far from her mind-frame. Her ensuing explanation revealed some degree of ambivalence. To explain the consuming anxieties of chronic pain patients, she evoked the idea of concrete, congenital vulnerability. Finally, she admitted that the idea "does not fit" her view of patients.

In answer to a similar question, the second participant devaluated the theme by stating that he does not "have a clue." A drawn-out, non-lexical expression ("u::m") and long pauses punctuated his statement. Yet, he recognized the meaning as "really losing it" or "going crazy," which both signified the sense of dissolution of the self. He valuated its prevalence in "some patients." However, he redefined the self or the identity as an objective social role set and interpersonal expectations. He described the threat of dissolution of the self as a concrete "drastic change in roles". Although he went as far as valuating the split with the body, he did not valuate the theme of falling apart. Rather, he described it concretely in terms of role dispossession following an accident that leaves the person in pain.

In response to the same theme, the third participant expressed her doubt about the word and its appropriateness. The intensity of the word or the experience seemed to be part of the reason, why it was called inappropriate. In the light of what she had previously been explaining about the significant losses and fears, the threat of annihilation seemed to be a credible anxiety for the patients. However, she offered a conditional acknowledgement. While talking about "core fear," or "deep seated fear," she struggled to reserve the threat of annihilation for extreme of situations. In other words, she valuated anxiety of annihilation only as the accumulation of objectives losses that affect all areas of the person's life. There was no elaboration of the intrapsychic origin of such fear. She reiterated that such anxiety could exist only as the culmination of loss into total demise of the patient's "vocational, relational, and financial" life.

CHAPTER 5

DICUSSION AND CONCLUSION:

Pain, Suffering, and Possibility of Meaning

For the participants of this study, the psychological impact of pain is primarily experienced as constriction of the ego's ability to care for the object and to maintain a fulfilling relation. To the participants, the discontent of the actual objects contains and symbolizes aspects of the damaged primary object. Their stories reflect primitive guilt over an object that is damaged. They reveal a deep sense of guilt and ambivalence over depending on an object that is damaged. Their narrations reflect how the ego uses primitive manic defences to ward off this ambivalence. Contempt, control, and triumphalism toward the object are elements that emerge with the image as a response to guilt. Predictably, manic defences at some point renew the more infantile mechanisms of splitting and projective identification, which bring back anxieties of paranoid-schizoid position. In effect, the participants narrate stories that make ample references to splitting, and indicate projective identification. Their narratives reflect anticipation of a pending doom from a pervading darkness and evil. The dread of being attacked and taken over by something that has damaged the object and the self becomes the pervasive association. The participants cannot help but to describe this menacing force as "painful and disgusting," as "vicious and hard," and as "stubborn and relentless."

In addition to anxieties provoked by loss, the excruciating nature of chronic pain causes deep feelings of anguish and revulsion. Sufferers often refer to pain as "it" or as a

thing-like entity that is alien from the self. From phenomenological point of view, intractable pain is shown to cause fears of dissolution and of the self. The sufferers feel "being acted upon" by a cruel and spiteful force that literally nullifies every mundane sense of pleasure and comfort. When other perceptions expose us to the harsh reality of being, we might avoid paying them much attention. However, every effort to avert attention from pain creates only stronger intrusions as a crude reminder of the obdurate nature of chronic pain. For many, pain makes living a constant strife for short relief between periods of agonizing upsurge. Sufferers always wonder how they are going to pay later, for the present moment of relief or joy. They are weary about their prospect and feel having no control. Unable to feel joy without the fear of later pain, sufferers feel diminished and under attack by a terrifying force.

This association of pain with aggressive attacks is, in fact, reminiscent of what Klein (1952:62) explains regarding the infant's experience of pain from the very onset life after birth:

> "It would appear that pain and discomfort he has suffered, as well as the loss of the intra-uterine state, are felt by him as an attack by hostile forces, *i.e.* as persecution. Persecutory anxiety, therefore, enters from the beginning into his relation to objects insofar as he is exposed to privation."

Klein does not simply explain the primitive anxiety of persecution as the mere result of the infant's somatosensory underdevelopment or inability to alleviate discomfort. In tandem with all other factors, Klein recognizes the function of the death instinct as the infant's aggressive impulse that is projected unto the discomforting and painful aspects of the external events, to create the bad or persecutory object. On the other hand, the life instinct is projected unto the gratifying and comforting aspects, which results in the creation of the good or idealized object. As a result, painful experiences of infancy

become the concrete container of the death instinct, and as such they are split off from the comforting experiences to protect life against the threat of death and annihilation. During this period, the self and the object equally lack integration, as the instinctual duality of the self is split and projected unto the object to create an object relation, in which pain and discomfort becomes a concrete persecutor. Thus, to understand infant's emotional life and the primitive mechanism of defences, Klein emphasizes the function of the death instinct, as well as the instinctual duality between life and death.

These two elements of primitive object relation are central to the understanding of the stories in this study. In the participants' associations, these two features are distinctly recognizable. First, the experience of pain is associated with "scary darkness," that is "black, dreary, and suffocating" and "no different from lying dead." Every significant upsurge of pain is experienced as a violent, life-destroying attack that threatens to snatch life away. The participants' reference to pain is associated with images that reflect threats coming from an anonymous and violent element. Their imagery reflects paranoid fears and splitting. For them, chronic pain contains and symbolizes aspects of the bad, persecutory object that attacks, annihilates the ego. Associating the pain with a dark force allows the ego to resort to oral-sadistic phantasies against the pain as the bad object. Second, not only an aggressive force capable of attacking and annihilating (i.e. "an angry young man ploughing the earth.") appears in the narrative associations, but also a good object capable of life giving (i.e. "a maternal figure standing in the background") emerges at the opposite end. The two are at times juxtaposed to split the scene between safety and danger, where the ego as the main figure is standing in the middle looking wearily at something "disgusting and painful."

Therapeutically, the presence of the good object can provide an opportunity for integration, and for reducing the oral-sadistic phantasies of the ego.

As a result, in addition to what research has as yet described, the participants of this study reveal intense and crushing anxieties that do not assume overt, panic-like manifestations. They rise from the depth of the psyche, and become best accessible through thematic storytelling. As stories are related about the cards, participants make telltale references to their own pain and anxiety, and draw together their lived experience with what they perceive in the cards. Across their stories, wherever the narrative theme involves anguish, the images of aggression and death are consistently associated with pain that is attacking, overtaking and destroying. The consistency, with which pain appears as death and destruction across these narratives, confirms the crucial importance of such imagery for understanding the primitive history of pain. For these participants, pain becomes the concrete experience of aggression that threatens to destroy the self and the object.

In other words, the analysis of the stories, in this study, reveals how participants' stories fluctuate between anxieties of the annihilation of the self, and those of the destruction of the object. Moreover, the present study reveals how pain overpowers the ego and undermines the adult object relation that is based on the whole object. Analytic approach shows that these anxieties are far from meaningless or exaggerated responses. In contrast, they are crucial to the understanding of the primitive significance of anxieties associated with pain. In the absence of such understanding, pain loses its infantile history, and sufferers are denied the opportunity to grasp the infantile nature of their suffering and to integrate projected aspects of their psychic reality. Without such integration, many

pain sufferers will be driven to utter despair by constant upsurge of paranoid-schizoid anxieties that are followed by the oral-sadistic phantasies of the ego.

On the other hand, the participating health psychologists acknowledge the difficult emotions that beset the patients. However, their discourse bears no reference to the notion of suffering and the anxiety of annihilation. Despite its well-recognized place in the contemporary conceptualization of pain, suffering does not assume its place in the discourse of the participants. In fact, its nearly absence sets the stage for talking about the anxieties of the patients, without any reference to the threat of annihilation and the horrific preoccupations of the sufferer. Instead, the participants first talk about the loss of valued aspects of life, which is identified as a significant cause of anxiety and grief for the patients who no longer can enjoy a sense of personal continuity and fulfillment. Then, they describe the anxiety over the alienated aching body, and acknowledge how patients perceive their bodies with much consternation as a punishing, attacking, or betraying entity that is split into an alien presence. Despite their initial observations, they do not recognize this estranged, punishing body as a source of violent threat to the integrity and constitution of the self. Instead, patient's diminished capability to fulfill social roles is repeatedly emphasized as the main source of anxiety, and as the valid locus of its meaning. Thus, if pain engenders anxiety, it is for the reason that sufferers feel less capable to fulfil social and interpersonal expectations, with which they identify, and through which they self-actualize. Failing to live up to such expectations is the focus of the participants' discourses of anxiety and suffering.

This view of suffering is justified by a compatible psychological outlook that explains the self in terms of the set of roles that an individual plays as part of social

interaction with others. The self is thought to be the shaped by identifying with others' perception of oneself (Cooley, 1902), or by enacting and incorporating social roles (Goffman, 1959). In the more recent incarnation of this theory, the self is viewed as a social construction that lies not in the individual but in the relationship between individuals, which is continually shaped and reshaped by their practices (Potter & Wetherell, 1987; Kitzinger, 1992). As Fuller (1988: 19-20) states, "account of social interaction does not require that social agents have any private mental content such as desires or beliefs, distinct from their publicly defined role-expectations." Therefore, all internal states must be most readily explainable in terms of observable responses to the external world. Likewise, the participants speak of identity as the socially defined roles we play while interacting with others, in order to actualize ourselves. In their view, these roles shape the self according to commitments, hopes, assumptions, and expectation that are learned and relearned in social interaction. As a result, understanding the sufferers means to explain their emotional states in terms of the patients' inability to perform in their habitual role sets or role dispossession. In their view, the anxiety of the patient is most readily explainable in terms of their particular role dispossession. This view of the person's identity casts the sense of selfhood within the bounds of social and interpersonal interaction and limits the meaning of anxiety to "what one can accomplish" in such interactional context. As a result, little can be said about the inner world of unconscious phantasies, infantile object relations, and primitive anxieties that sufferer may bring to social context and project upon reality.

To the contrary, in suffering, the question is not so much about "what I can accomplish or enact" as it is about "whether I will last." This distinction becomes clear

when one of the participants speaks of existential angst as the anxiety of self-actualization which he subsequently defines as the question of "what I will accomplish." However, the existential angst, by definition, refers to the anxiety of being, *être*, confronted by nothingness or non-being, *néant* (Sartre, 1943; May, 1977). As aforementioned, phenomenology and existentialism acknowledge the certainty of personal death ("I will die," rather then "one will die") as an ever-present possibility, and as the source of our uniquely human anxiety (Heidegger, 1985). In contrast, health psychology offers a view of suffering, wherein all anxieties associated with pain are merely explained on the basis of the actual loss and concrete role dispossession. Hence, the anxieties of destruction and annihilation, that are experienced and reported by many sufferers, are only viewed as cognitive mislabelling and maladaptive learned responses to an otherwise manageable noxious stimulation and its social and interpersonal effects. This interpretation of anxiety eliminates any reference to the primitive history of pain, and to the intrapsychic dimension of pain experience. In effect, health psychology obviates the need to explore the patient's subjective experience of suffering and makes little mention of this key aspect. Consequently, the focus of clinical attention shifts from the subjective content of patient's experience to the concrete behavioural reactions, and to the ensuing observable interpersonal consequences. However, illustrating the importance of this shift requires further consideration of its clinical implication.

In a case vignette, Fordyce (1996:41) explains how he and his colleagues respond to a pain patient's incessant complaints by negative behavioural consequences to discourage his maladaptive pain behaviours. As a result, while doing ward rounds, they decide to respond to "any references to pain by looking out the window as a way of

modifying social feedback" In another example, Long (1996:8) states, "Discussions about pain were not allowed between nurses and patients or with physicians except during specific times at rounds or in therapy sessions" Fordyce states, "Note that staff were not to ignore pain behaviors; only to be minimally *socially* responsive and to direct special attention to patient effort to increase activity levels" (44). Fordyce (1989:55) argues that such negative feedback "may discourage and inhibit expression of pain or suffering behaviors and thereby promote early resolution to pain problem."

Although nowhere the participants of this study suggest anything remotely similar to Fordyce's approach, their inclination to steer clear of discussing the content and meaning of patients' anxiety owes much to the prevailing framework of health psychology as unequivocally presented by Fordyce and his colleagues. In my self-reflection on the interviewing process, I recognized that as participants were describing their direct observations and impressions, I felt less in need of asking for clarification or elaboration. Their candid descriptions conveyed many observations, commonly shared in the literature. However, I felt anxious to ask for clarifications as the participant changed to an explanatory tone. As I was listening to their explanations, I felt ambivalent over the explanatory model used to elucidate pain patients' internal states and personal experiences. The gradual shift of discourse from a descriptive to an explanatory tone seemed to play a regulatory and prescriptive function in delimiting the signification of symptoms. In other words, it diminished the liveliness of the initial observations, and rendered them regulated, disambiguated, and reduced. The foreclosure of meaning was predicated on making every internal state a reflection of a real and concrete matter. Then, if commensurate to the concrete and beneficial in action, it was deemed not

needing any modification. As they switched to the prescriptive mode, the internal world of the patient receded from the foreground of discourse to the backstage. In tandem with such change of speech act, I realized that my own affective state had to mirror a similar disengagement to make room for compatibility and open hearing. As the interview continued, it became harder to maintain this emotionally neutral hearing.

Reducing the subjective ambiguity of symptoms (i.e., pain, suffering, anxiety, and fear) is not limited to health psychology (Cassell, 1975). As their prime objective, clinicians must identify all presentations or symptoms as signs of a diagnosable problem (Sebeok 1994:65-82, and Barthes, 1994:202-213). Every clinical discipline is made of a corpus of professional discourses that construct a codified and organized way of talking about, and looking at symptoms (Foucault, 1976, 1979). This codified talk functions as a "gaze" through which symptoms are inspected and seen as an object. Such talks bear a shaping influence on public and professional attitudes to human suffering (Foucault, 1980; Fox 1994). Clinicians learn to conduct themselves within the limits of professional discourses, while patients are encouraged and instructed to grasp their ordeals within such limits. In this manner, the discursive practices of today's clinicians shape the limits of what can be considered as a valid signification, and set the limit for what can be a valid problem (Mishler, 1984). Through these discursive practices, the clinicians do more than reading various ambiguities of symptoms; they construct a particular consciousness of pain and suffering, in which patients struggle to make sense of their ordeals and to grasp the meaning of their pain. For many of these patients, the gaze of health psychology denies the grievous significance of their searing anxieties, as it leaves

them with little opportunity for exploring the suffering beyond its most concrete and external significance.

It has been argued that losses experienced throughout life can reactivate infantile anxieties and phantasies. Segal (1964:80) explains that any situation of loss in adult life may contain and symbolize infantile object relations, and can reawaken primitive anxieties.

> "The depressive position is never fully worked through. The anxieties pertaining to ambivalence and guilt, as well as situations of loss, which reawaken depressive experiences, are always with us. Good external objects in adult life always symbolize and contain aspects of the primary good object, internal and external, so that any loss in later life re-awakens the anxiety of losing the good internal object, and with this anxiety, all anxieties experienced originally in the depressive position."

For chronic pain patients, actual losses may likewise contain and symbolize primitive anxieties. In view of this argument, the present study asked whether the sufferer's anxious and depressive states enfold at its heart a deep intrapsychic significance.

Although the aetiology of pain is not shrouded in any mystery, its relief and alleviation have been fraught with setbacks and disappointments. Where treatment falls short of providing satisfactory relief, time is experienced in terms of the episodes of pain and daily experience is reduced to pain experience. Without any recourse or remedy, *being* becomes *being-in-pain.* In a bluntly restrictive manner, the scope of experience shrinks to one element, that of pain. This inescapable entrapment in agony brings to present the ego's primitive history of pain. Primitive anxieties, buried deep within the self, resurface to be relived, as a terrifying sense of helplessness becomes all-too-pervasive. What has been called the shattering or the unmaking of the world of the sufferer can be viewed, in analytical sense, as the annihilation of the self and the

destruction of the object. As a result, identifying the exact pathophysiology and aetiology of the pain does not dispense with body symbolism or does not end the domain of unconscious influence. As long as sufferers feel their bodies and have reasons to react helplessly to their pain and hurt, their bodies would not be devoid of symbolism. The symbolism of the body is the symbolism of the primitive anxieties reawakened in the context of the persistent aching body. As these anxieties are reawakened by pain, they are the derivative of the somatic experience, and not *vice versa*. In this manner, body symbolism goes beyond the origination and aetiology of symptom and runs parallel to the experience of body, which whether in rest or in labour, and whether in comfort or in pain retains its symbolism.

On the other hand, health psychology and behavioural medicine tend to explain the sufferer's reaction to pain as a stimulus-bond response that has been elaborated and appraised cognitively as part of attempting to fit pain into the social and interpersonal environment, based on learned cognitions for processing significant life events. In this manner, the anxieties of destruction and annihilation, often reported by sufferers, become no more than maladaptive responses to pain that are labelled as disproportionate fears. At best, such anxieties are viewed as engendered by a lack of social support or by role dispossession. Such anxieties, if acknowledged, are deemed incommensurate to the real prospect of chronic pain rehabilitation. This interpretation of anxiety eliminates any reference to the primitive history of pain, and to the intrapsychic dimension of pain experience. Through this elimination, health psychology obviates the need to explore the patient's primitive experience of suffering. As images of destruction and aggression are left overlooked, the clinical attention shifts from the patient's subjective experience to the

concrete behavioural reactions and observable consequences. In this manner, the terrifying meaning of the chronic pain experience is lost in the emphasis on social role fulfillment that eliminates form its account any reference to the inner experience of the sufferer.

Today's pain management seeks to redefine all subjective feelings and perceived threats in terms of objective behavioural appraisal of the chronic pain, in order to reduce the "maladaptive" response. Facing the patients' terrifying helplessness, the rehabilitation specialists try to provide a "dose of reality," by educating the sufferers about their pain and the prospect of adaptive rehabilitation. What remains as the lived experience of fear, depression, and helplessness have to be corrected by negative behavioural feedback and cognitive reframing. In effect, health psychology engenders a clinical intervention, in which meaning is prefigured by stressing adaptive behaviour, and subjective experience is foreshortened by emphasizing the stimulus-bond response. Today's pain management is predicated on seeing every internal state as a reflection of a real, public, or interpersonal experience that is devoid of unconscious phanatsy and that must fit the objective economy of social role fulfillment and interpersonal reciprocity. Cognitions as mental activities with objective claims to validity are valued above emotions as personal and preverbal experiences (Nussbaum, 2001:93). By emphasizing behaviour, the patient's inner world and unconscious phantasy loses its existential gravity and plays not even a marginal role in explaining the lived experience of chronic pain. Subsequently, a listening rich in associational content is replaced by a clinical attitude focused on stimulus-bond responses and social role fulfillment or role dispossession.

This study has tried to show to what extent despite the sufferers' graphic associations, today's practice of pain management has remained unwilling to recognize that suffering chronic pain can potentially contain and symbolize the primitive anxieties of annihilation and destruction, reminiscent of the infantile ego. Given the importance of the subject matter, there are perhaps two ways to write something that can serve as the final comment to this conclusion. The first is to write the final words as an extrapolation that merely sums up the findings and arguments of the study. The second is to revisit the existential problem behind the conception of the study, and ask whether the problematic at the heart of the investigation is still admonishing us in the same fashion as before. In a manner closer to the latter but not very far from the former option, it is useful to reiterate that the participant's vivid associations reflect primitive anxieties that run contrary to the objectifying approach of today's pain management and health psychology. As disquieting as it may be, to reveal in the mainstream pain management a resistance toward the anxiety of death, this revelation still leaves in dark a greater source of worry. Put into a question, it can be asked how we then reach out to life, when the denial of anxiety of death, as annihilation and destruction, is so deeply rationalized in our society.

In his colossal study of *Death, Desire and Loss in Western Culture,* Dollimore (1998) characterizes the association between death and desire as the preponderant metaphor of the pre-modern age. Beginning with the myth of Adam, craving was denounced as the source of suffering, pain, and death, or as the ultimate instrument of evil in the lapserian interpretation of creation and fall. As desire represents the force of human aspiration for living, the association of desire and death ultimately alluded to the kinship of life with death. One can therefore conclude that for much of human history,

life and death were associated as a necessary and meaningful ontological contradiction. However, this metaphor gradually faded away, albeit not entirely, as part of the modern reorganization of everyday life and human consciousness. In what became modern consciousness, death became irrevocably separated from desire and life. In fact, a major characteristic of modernity lies in our increasing trust in the technologies that can eliminate suffering and pain, and find a way to satisfy every individual craving (Ferguson, 1995). The single minded pursuit of happiness engendered a strong confidence on our ability to pursue a pain-free life of lasting virility. The idealization of the technologies of virility and pleasure followed a decisive splitting of life and death. In our postmodern age, this tendency has reached its zenith. As people face more than ever a rapidly shifting system of values and outlooks, they can no longer make sense of decease and origination, life and death, being and nothingness, and pleasure and pain (O'Neil, 1995). Hence, the grievous *meanings* (the emphasis on plural) of such contradictions are in risk of being actively denied by the prevailing therapeutic philosophies that reduce human suffering to a depthless experience, devoid of any dialectic of latent and manifest significations (Nussbaum, 2001:93).

Pain and suffering constitute a serious challenge to this denial of depth. As there is no escape from chronic pain, the sufferer feels that there is nothing beyond the aching body. The self shrinks away from the external world and the immediate reality. The outlook of the self freezes and hardly expands beyond the skin which no longer can contain the self. Chronic pain reactivates terrifying primitive anxieties and triggers a reversion to a preverbal state in which the extreme concreteness of experience with the object does not allow verbalization. Every effort to objectify pain through language is

fraught with disappointment, as pain resists common tropes of communication. In the words of Emanuel Levinas (1989:40):

> "In suffering [physical pain] there is an absence of all refuge. It is the fact of being exposed to being. It is made of the impossibility of fleeing or retreating. The whole acuity of suffering lies in this impossibility of retreat."

Chronic pain ruptures the self-body unity required for the pursuit of pleasure in the world shared by others. As a result, chronic pain shatters the idealization of the collected consciousness (*Das Man*) constructed by the technologies of virility and pleasure. It makes the sufferer feel overtaken by the aching body, as a persecutory object. To pain, there is universally an overpowering sense of estrangement. The bodies of chronic pain patients seem no longer their own as they cannot readily submit to reassuring public idealizations that define their bodies and their bodily functions. Under duress, the patients graphically describe their anxieties as a violent monstrosity of aggression and annihilation. Suddenly, the forgotten and denied psychic depth, with all its primitive fears, becomes a terrifying part of the present.

Theories that strive to account for and remedy these anxieties based on reality appraisal for adaptive response can hardly offer any sense for the horrific imagery of aggression and destruction that permeates the introspective accounts of chronic pain. In what is costmary, these terrifying preoccupations are inventoried as cognitive errors, without any insight into their significance. In fact, the sufferers' imagery of aggression and annihilation reflects more than a misappraisal of reality or a panic-ridden exaggeration of events. Chronic pain is a world-shattering experience wherein every publicly shared and collective sense of idealization that protects the ego against primitive anxiety of annihilation collapses. The mood of anxiety makes the sufferer see death as

uncanny beyond the reassuring views of the public. Sufferers feel immediately exposed to a menace that can annihilate the self and destroy the object. In fact, what befalls the pain sufferer, candidly mirrors what we will see if we look beyond the common-sense idealizations (*Das Man*).

Contemporary authors have already developed this insight into an extensive practice in culture critique (Lasch, 1979, and 1984; Sánchez-Padro, 2003). As a result, it is not the purpose of this work to open and to discuss this socio-political dimension. However, psychoanalysis as the psychology of depth reminds us that death cannot be explained as the mere nullity or the terminal distination of being. Nor, is it clinically justifiable to delimit the threat of annihilation to the actual possibility and eventuality of death and loss. As a destructive impulse lying deep within our psyche, the death drive renders life morbid, before making it moribund. As a drive, death does not simply mean ceasing to be alive as much as it becomes the distortion and devastation of life, if it is denied. In this manner, the omnipotent denial of death necessitates and forcefully creates the total denial of the primitive significance of human suffering, the intrapsychic dynamics of human destructiveness, and the psychology of depth.

Over the recent decades, an untamed permutation in the nosographic categories has introduced fibromyalgia, temporomandibular joint disorder, painful bowel disorder, chronic fatigue syndrome, chronic pain syndrome, and a number of other less known diagnoses. It can be argued that reshaping human suffering into thing-like categories of disease has allowed us to ignore suffering and its intrapsychic signification. In the case of health psychology, even when the intervention is meant to rehabilitate and not to cure, the omnipotent denial of primitive anxieties and subjectivity remains strong. For the

chronic pain patients and the society at large, recognizing this omnipotent denial and control may mean going beyond the keyhole approach of the ever-growing and ever-narrowing pain syndromes that have effectively partitioned from our discourse any reference to suffering, subjectivity, and psychic reality. On the other hand, looking at human suffering as a meaningful experience in intrapsychic sense can perhaps allow us, patients and clinicians, to see that to what extend we are reacting to the primitive anxieties of annihilation and destruction whenever we write a research proposal, seek or make a diagnosis, find or offer a treatment, plan or undergo a rehabilitation, or participate in a chronic pain advocacy group.

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APPENDIX

Consent Form

This research is conducted by Farzad Zare-Bawani as part of a Doctoral Thesis in Psychology under the direction of Prof. Marie Hazan, Ph.D., at University of Quebec in Montreal. This research is about the emotional significance of chronic pain experience. As a participant, you can offer this study your understanding and experience with chronic pain, through an interview procedure. If you are a chronic pain sufferer, your interview involves telling stories about a set of hand drawn pictures. The interviews are transcribed and subsequently analyzed.

Your participation in a semi-structured interview is needed for the completion of this study. Your identity will be safeguarded. In no way, the findings of this research may harm your personal or professional credibility or reputation. After the completion of the project the records are safely eliminated. You can ask for a copy of the completed thesis, if you are interested.

If you consent to such participation, please complete the next section, and sign after printing your name:

By the present, I, ..., agree to participate in this research, based upon the above information. I understand that for my participation, I have the option of asking for compensation.

Signature of the Subject..... Date:.....

Signature of the Researcher..... Date:.....