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Psy-Knowledge and the Problem of ‘Pain Without Lesion’

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Psy-Knowledge and the Problem of 'Pain Without Lesion'

by

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Abstract

This thesis examines the two most significant responses to the problem of pain without lesion by the Western psy-complex in the last 150 years. Through a close reading of disciplinary discourses, it specifically examines the differential techniques and vocabularies deployed by expert practitioners of psychoanalytic psychiatry (1895 – 1961) and cognitive psychology (1963 – 1995) in their efforts to render pain without lesion, a definitionally intangible and subjective phenomenon, into an identifiable, knowable, and workable entity. In doing so, I examine the way that the mind was brought into the question of pain by influential psychiatrists and psychologists: Freud, H.S. Sullivan, and Szasz in psychiatry, and Ellis, Beck, and M.J. Sullivan in cognitive psychology. In psychoanalytic psychiatry, pain without lesion was understood as a symptom of hysteria, which was caused by the unconscious conversion of emotional suffering into physical pain. The goal of psychoanalytic treatment was to increase patients' self-knowledge and help them experience a broader range of emotions. Addressing chronic pain, cognitive psychology focussed instead on "pain cognitions," peoples' mental and emotive reactions to pain. The goal of their treatment was to teach patients how to monitor their thoughts so that they could identify and change cognitions that made pain worse. In this thesis, I consider the implication of these discourses in shaping the range of possible experience for those in pain, the assumptions they reveal about human nature and responsibility, and the degree to which they do and do not consider those in pain as socially positioned. I argue that the cognitive approach to pain without lesion is less equipped to consider aspects of the patient's lifeworld that were once important in psychoanalytic considerations of pain, and that revisiting psychoanalytic ideas regarding the relationships between mind, pain, and the lifeworld may benefit contemporary pain researchers.

Preface

This thesis is original, unpublished, independent work by the author, E. Knox

Acknowledgement

This thesis is indebted to the help, patience, and generosity of many. First, I would like to thank the administrators and instructors in the Department of Sociology for ensuring my time in this degree was edifying, smooth, and even enjoyable. I must also thank Basak, Megha, Santanu, and Naomi, my fellow research assistants, for their comradery and mentorship, which kept me sane and smiling during times of hard work and intellectual growing pain. I am grateful to Drs. Martina Kelly and Pratim Sengupta for constantly inspiring intellectual growth, and for punctuating it with good humour and well-timed winks. I especially thank Dr. Sengupta for so emphatically convincing me that I deserve a seat at the academic table and to apply for my PhD. I am very appreciative to Dr. Scott McLean for employing me on such an interesting research project, and for our valuable conversations on Foucault. More than anyone else at the U of C, I owe thanks to Dr. Ariel Ducey, who I have had the pleasure of knowing in the capacity of supervisor, employer, instructor, and graduate program director. Without Dr. Ducey's extraordinarily patient guidance, generous help, and doses of "tough love," this thesis would surely have taken another year to finish. Work on Dr. Ducey's criticaldatasense project planted the seeds of this research while providing edifying and well-paid work throughout the course of my degree. To be a student of Dr. Ducey's is to learn and be intellectually challenged in an environment where it is safe and genuinely fun to take risks. I will always be thankful for the way she encouraged me to trust my instincts, to have more fun with my work, and to take myself a little more seriously.

Dedication

To Sam, who makes life beautiful.

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Chapter 1: Introduction, Background, Literature, Key Concepts, and Analytic Approach

Introduction

This thesis examines the two most significant responses to the problem of pain without lesion by the Western psy-complex in the last 150 years. Through a close reading of disciplinary discourses, it specifically examines the differential techniques and vocabularies deployed by expert practitioners of (1) psychoanalysis and (2) cognitive psychology in their efforts to render pain without lesion, a definitionally intangible and subjective phenomenon, into an identifiable, knowable, and workable entity.

In doing so, I examine the way that the mind was brought into the question of pain by influential psychiatrists and psychologists of the last 150 years, all of them men in positions of privilege in Europe and North America whose work profoundly shaped the ways in which people with pain could make meaning of their experience and seek care and treatment. It is an exploration not of patients' experience as such, and the variable ways that was likely made sense of by those who sought treatment for pain and those who provided it, in specific institutions and settings of practice, *but of the boundaries and definitions these men projected onto the experience of pain*, which no doubt established the contours of that experience for many, even if it did not determine it. In this thesis I will refer to these boundaries as discourses or regimes of truth (Weir, 2008).

Unsurprisingly, the possible role of anxiety about pain, or emotional aspects of the experience of pain, seemed to become important to these psy-clinicians when patients presented the problem of "pain without lesion," or what seemed to be organically unexplained pain. These were, after all, practitioners of the nascent psy-complex (Rose, 2010), who were also looking to establish legitimacy for a clinical domain that considered the role of emotions and perceptions in illness. But, in their work, these men did not project

identical boundaries and definitions around how and whether pain should be taken up. At this stage, my working assumption is that their definitions and their differences matter for our understanding of the present-day experience of pain and how it is taken up in medicine, at least in the overdeveloped West.

After presenting an overview of the concepts and approaches that orient my approach in this chapter, in chapters two and three I present a close analysis of how the problem of pain without lesion was understood by leading figures of what Nikolas Rose (2010) calls the psy-complex, and, to a lesser extent, how these understandings positioned pain without lesion in relation to biomedicine. The evidence in chapters two and three is oriented toward a few key threads in this history: what ways of being did these psychiatrists and psychologists make available to people with pain? What kinds of explanations, considerations, and factors were made relevant to the experience of pain, and what was rendered irrelevant? How did these psychiatrists and psychologists view their patients and their own role in alleviating their patients' suffering? These are questions anchored to the critical perspectives of Michel Foucault, Ian Hacking, and Nikolas Rose – who have considered the "psy-sciences" as disciplines which configure subjects and selves in ways that allow for more effective governance (in the name of productivity, order, etc.), and which may entail forms of attention and categorization that allow for forms of expression and treatment that might be experienced as humane and even free-ing, but that also foreclose possibilities for expression and encourage treatment that may result in harm, violence, and silencing. In the conclusion, chapter four, I present a synthetic discussion of the different ways these regimes of truth allowed for enduring pain without lesion to be understood, experienced, and treated, but in light of a present context in which chronic pain has arguably become endemic (Zajacova et al., 2021) and in which the "social" is increasingly recognized as an important factor in explaining and treating chronic pain (Holopainen, 2021). People with pain have minds, but

they are also socially positioned, for instance in relation to gender, race, and class. As will be seen, these realities are sometimes taken up in psy-discourses of pain, but in the conclusion I provide a more critical reading of these appearances.

Origins of the Thesis

The origins of this research lie in the work I have done as a research assistant for my supervisor, Dr. Ariel Ducey, over the last two and a half years on a project funded by the New Frontiers in Research Fund. In 2021, our team created an interactive, public theatrical experience which attempted to denaturalize dominant medical and psychological discourses around pain through interactive performance (Sengupta et al., 2022). The installation emerged, in part, from a series of research interviews with health care providers who treat pain about their experience in the clinic, and the sensory and technological ways in which they come to understand their patients' pain. Leading up to this, one of my early tasks in this project was the transcription of an interview with a rheumatologist with experience working with Indigenous patients and communities. The rheumatologist described the indeterminacy of her patients' pain, the way that it was never clearly or unambiguously known. To my surprise, she also reported that while objective outcome measures like joint counts and lab tests provided insight into the physical progression of arthritic disease, the degree to which such markers were present was often not indicative of the amount of pain her patients actually felt. Pain's association with organic pathology, in other words, was often tenuous. She believed that much of her Indigenous patients' pain was the result of emotional suffering and intergenerational trauma. As the treatment she prescribed could only target inflammation and rheumatic pathways, a major part of her job was differentiating arthritic pain from that which stemmed from these other sources. At the time, this struck me as incredibly strange and interesting. Previous reading I had done on data in healthcare led me to see the discipline of biomedicine as one characterized by a preoccupation with objectivity in both clinical and

research domains. Because pain that cannot be causally tied to any abnormalities in the body exists only as subjective experience, it seemed to me that there was something of an incompatibility, or at the very least tension, between the epistemological commitments of modern medicine and certain kinds of pain.

As a research team, we decided to take this tension as a starting point for a review of the peer-reviewed pain literature. As we were primarily interested in how this tension played out in the work of clinicians and their interactions with patients, we decided to analyze the work published in *The Clinical Journal of Pain*, the leading pain journal with a clinical focus: "timely and thought-provoking articles on clinical dilemmas in pain management" (The Clinical Journal of Pain, n.d.). A variety of interesting and surprising findings emerged. Most relevant for the purpose of this thesis was the fact that the majority of research published in this journal came from psychologists, and not neurologists or physicians as we had expected. The subject matter these psychologists addressed was rarely the emotional suffering or intergenerational trauma invoked by the rheumatologist, but categories of pain-related thought referred to as "pain cognitions." The most frequently invoked pain cognition was *pain catastrophizing*. Pain catastrophizing was usually positioned as a predictor of pain levels, mental distress, and disability. It was also increasingly being tested for its efficacy as a predictor of how well patients responded to treatment, in the hopes of establishing standardized criteria that could distinguish those who would from those who may not respond to treatment programmes favorably. While the concept of pain catastrophizing was obviously psychological in origin, it was positioned as useful to all clinicians engaged in treating pain.

In this subsection of the discourse on pain, the mind was taken to be an important component of understanding and treating kinds of pain where knowledge of the body was not enough to successfully treat pain. This took place especially in discussions of certain kinds of *chronic pain*. Technically, chronic pain refers to any kind of pain that is felt for more than

three months. The conversations in *The Clinical Journal of Pain*, however, centered around a more specific kind of chronic pain. The authors in this journal were by and large not interested in instances of enduring pain that were able to be understood and acted upon in the terms of anatomy and physiology, e.g., the pain associated with cancer. These researchers were instead interested in chronic pain in which the organic cause was either unknown or in which treatment of the seemingly organic cause of pain did not in fact lead to the cessation of pain. Because of their focus on lack of organic cause, I argue that the object of these researchers' inquiry would more accurately be described as enduring *pain without lesion*, in which "lesion" refers to tissue damage caused by disease or injury.

As it was clear that pain catastrophizing occupied such an important position in the discursive landscape of pain treatment, I began this work with the intent of investigating the history of pain catastrophizing. Analytically, my first task was to understand what exactly was meant by the term itself. It was clear that this phenomenon was seen as undesirable, but the precise part of the human person it implicated was less clear. I began reading the early pain catastrophizing literature with the objective of understanding whether the concept referred to a state, a trait, or a behavior. Part of the reason this interested me was that I felt that whatever the answer was would carry different presuppositions regarding how responsible the patient was understood to be for their condition. As I discussed earlier, catastrophizing turned out to be understood as a "cognition," the mental handling of information, or a kind of behavior that takes place in the mind.

However, in reading this early literature, a new analytic horizon opened up for me. Chronologically, the first article on Scopus to develop the notion of pain catastrophizing – "Cognitive distortion and cognitive errors in depressed psychiatric and low back pain patients" (Lefebvre, 1981) – was concerned with the question of why some chronic pain patients developed depression, while others did not. In justifying his investigation of the link

between depression and chronic pain, the author cited previous literature showing an association between the two, which I read. To my surprise, these articles described the link between depression and pain using concepts and theories completely alien to the ones which I had thus far been exposed. I had left the realm of positivistic cognitive psychology. These articles described depression as something that, while typically higher in those with chronic pain than those without, was also understood as the repressed and converted cause of pain itself. This was often referred to as *psychogenic* pain – pain generated by the mind or psyche. Tracing the citations of these papers further back, I came to understand that the notions of conversion and psychogenic pain originated in psychoanalytic theory and Freud's theorization on hysteria.

This finding impressed on me the fact that there have been various attempts to understand pain without lesion in psychological terms which included rendering it workable through talk (as opposed to pharmaceutical or physical) therapy. Thus, I decided to alter the scope of my thesis to a consideration of the discursive areas that were above all concerned with the role of the mind in the experience of pain without lesion. Broadly, these discursive realms emerged as psychoanalytic psychiatry and cognitive psychology.

As a sociologist, these disciplinary discourses interested me because their emphasis on the mind meant that, in theory, they considered patients as people, and not as biological organisms. Unlike biological organisms, people have social locations and histories. My reading of these two discourses was guided by a consideration of which elements of life and the human person were and were not deemed pertinent to the problem of pain without lesion. This meant that while reading, I read for both positive and negative forms – looking for what was explicit and present, but also what was absent or implicit. Therefore, I have not included in this thesis an examination of contemporary and historical discourses of biological psychiatry, clinical neurology, and anesthesiology, in which there is also considerable interest

in pain. Broadly speaking, in these disciplines the patient is firstly understood as an organism that is to be understood biologically and treated physically or pharmaceutically. Though much of today's medical and clinical research on pain comes from biological psychiatry, neurology, and anesthesiology, it is meaningful that the leading "clinical" journal of pain focuses so heavily on psychological concepts. The concept of "pain catastrophizing" has emerged as central in considerations of the treatment of lesionless chronic pain and the organization of pain treatment. Though psychological considerations of pain are not the only discursive thread contributing to the treatment of chronic pain today, it is an undoubtedly important one that warrants isolated analysis.

Important historical research has been carried out on pain without lesion in the "early modern" period, primarily the 19th century. Synthesizing the historical analyses of Foucault (1963/2012a), on the epistemic ascent of pathological anatomy, and Rey (1998), on the medical treatment of pain, with his own analyses of Romantic literature, Morris (1991, 1998) argues that the early 19th century saw a narrowing of cultural understandings of pain, by which the medicalized notions of localized, lesion-induced pain were widely proliferated and internalized. Morris argues that poetry from the likes of Byron and Shelley affirm the existence of another kind of pain that eluded the logic of the clinic – a sort that exists independent from lesion and that may be better understood through notions of self-creation and emotional journey. For him, this proliferation and internalization of the clinical gaze rendered pain without lesion invisible in both the clinic and the popular imaginary.

Goldberg's (2012) work on the writings of American neurologists from 1850-1900 both support and challenge the assertions of Morris in interesting ways. Goldberg argues that, during this period, neurologists frequently encountered instances of pain that were not accompanied by observable lesion. Instead of dismissing and trivializing such cases, neurologists argued that such pain was indeed still caused by lesion that had yet to be

discovered. Two popular hypotheses for the nature of such hidden lesions were that the damage existed at the molecular level – too small to be discerned by the naked eye or microscope, and that the lesion was situated in an unknown and difficult to access region of the spinal column. In order to make pain clinically relevant, these physicians had to invent a lesion that they could not see. Goldberg (2012) argues that this practice is best understood as a reconciliation between the Victorian "social and cultural concern with pain and suffering itself" and the privileged social position of neurology patients on one hand, and the 19th century epistemological commitment to localized tissue pathology on the other. In later work, Goldberg (2017) expands upon this idea to include notions of cultural uncertainty and mechanical objectivity. Although he does not take social or cultural factors into account, Hodgkiss (1991, 2000) shows that the invocation of unseen/discovered lesion to make sense of lesionless pain was frequently practiced by British, French, and German neurologists of the 19th century.

In the future I hope to conduct the additional research needed to establish an analytic connection between my work on how lesionless pain became identified as a problem of the mind, workable through talk, and this historical literature on pain without lesion. This study does not attempt to capture a complete history of pain without lesion and how it was scientifically regarded across disciplines. Rather I attempt a genealogy that starts with a question of the present – how, in discourses of chronic pain treatment, did pain catastrophizing come to be understood as so important – that is anchored in sociological questions (i.e., gender, ethnicity, class, collective trauma) and a close reading of authoritative texts.

Key Concepts and Analytic Approach

Foucauldian Approaches: Archeology and Genealogy

In this thesis, I am interested in the way the problem of pain without lesion has, at different points in time, intersected with psy-discourses or regimes of truth pertaining to the human mind. I will argue that the response of the psy-complex to the problem of lesion-less pain has taken roughly two forms over the last 150 years. I show that the radically different form of these responses is due both to changes in the nature of lesion-less pain *qua* problem (its social location and prevalence) and the supersession of the psychoanalytic regime of truth with the cognitive psychological regime of truth. To aid me in my analyses of discourses of truth, I of course turn to Foucault's archeological method. To aid me in my analyses of lesion-less pain as a problem, I turn to Foucault's methodology of genealogy.

Foucault's archeological approach is concerned with the structures and procedures which regulate discourse and subsequently shape and delimit that which becomes known as true. Foucault argues that there are a variety of regulative techniques contributing to this process, and that the nature and relative importance of each one varies throughout time (Foucault, 1981). The regulative technique this thesis engages with is Foucault's notion of the *disciplinary control of discourse*. Foucault argues that to conceive of disciplines as sites in which truths about certain subject matter are created or discovered is to miss something important. He argues that hypotheses must meet certain structural requirements if their truth or falseness is to be adjudicated within a disciplinary discourse. In other words, discipline acts as a kind of specialized sieve that filters for propositions of a particular form. Hypotheses are screened on the basis of three elements: (1) the objects they address, (2) the concepts or vocabulary they draw upon, and (3) their theoretical horizon. It is important to note the first element, objects addressed, refers to something more specific than object of inquiry or subject matter. Rather, it is the properties of the object of inquiry that are taken to

be appropriate and relevant. In his lecture, "The Order of Discourse," Foucault (1981) illustrates this by showing that while botany has always addressed plants, in the sixteenth century botanical discourse included discussion of the symbolism of different plants, while by the late 17th century such discourse was limited to propositions regarding the physical structure of the plant.

The form each element (objects, concepts, theoretical horizon) of the hypothesis takes must match those of the discipline in order for it to be produced as an object of discourse, an idea that officially exists and can thus be proposed, considered, and eventually recognized as true or false. Referencing Canguilhem, Foucault (1981) refers to this state of alignment in which propositions can be produced as judicable discursive objects as being "in the true" (p. 60). Other Foucauldian scholars have referred to the ever-policed boundaries of "the true" as regimes of truth (e.g., Rose, 1979). Propositions and hypotheses that fall outside the true are excluded from the discourse, and thus, in some sense, do not exist. Discursively, they cannot materialize, and instead dissolve into the void.

For Foucault, discourses of truth and the disciplinary policing that shapes them are not merely epistemological abstractions, but have meaningful ramifications for the human experience. In *The Birth of the Clinic: An Archeology of Medical Perception*, Foucault (2012) argues that the structuration of medical discourse by discipline (and other techniques of discursive control) demarcate the very way physicians perceive the human body and come to define its normal and pathological states. For Foucault (2012), the particular configuration of these demarcations constitutes one of the "conditions of possibility of medical experience" (p. 35). In other words, the disciplinary policing that upholds regimes of truth plays a big role in the way both clinicians and patients come to see and experience themselves, each other, and the body. The way physicians come to perceive the human body informs that which comes to be known as normal or pathological and how the pathological is diagnosed,

assessed, and treated. This obviously guides the experience of the physician when performing their job. It also informs the experience of patients in two ways. First, and most obviously, these discourses of truth determine the techniques of diagnosis and treatment that patients are physically subject to, i.e. whether they experience bloodletting, intubation, fumigation, etc. Second, and less obviously, discursive truths inform *what it is like* for the patient to experience these techniques. In the confines of their discursive regime, do patients understand these techniques as punishment, privilege, or admonishment? Do they experience themselves as sinners, sufferers, or insufficient? It is this second, discursively mediated, notion of experience that Foucault focuses on; in his words: "the games of truth and error through which being is historically constituted as experience; that is as something that can and must be thought" (Foucault, 2012b, p. 3). Other Foucauldian scholars have elaborated on this notion of the discourses of the human sciences' influence on being, and extended it beyond the clinic and into everyday life – including Nikolas Rose and Ian Hacking, whose work I discuss in the next section.

My analysis in this thesis is also indebted to Foucault's later, genealogical approach. Building upon Nietzsche's *On the Genealogy of Morality*, Foucault (1977) elaborated his genealogical method in the essay *Nietzsche, Genealogy, History*. In this essay, he differentiates his approach to historical analysis from traditional historiography by critiquing the latter's allegiance to the establishment of linear, uninterrupted trajectories between contemporary things and their origins. For Foucault, an analytic oriented toward stable forms and continuity bore too close a resemblance to eschatology. He considered such approaches man-made appeals to narrative coherence that were ultimately naïve and obscurantist. The genealogist, Foucault maintained, would instead recognize that the course of descent through which contemporary practices and institutions emerge are not tidy pathways defined by progressive instantiations of principles like justice, reason, or altruism, but are instead

discontinuous, wildly and erratically terraformed by the authoritative responses made to specific exigencies. This is well illustrated in Foucault's (1975/1995) deployment of the genealogical method in *Discipline and Punish*.

Foucault argues that it is the authoritative responses to such exigencies that constitute inflection points in the historical course of institutions like the prison, schools, and the military. In tracing the descent of modern institutions, then, genealogy is a history of practice, techniques of management and problem-solving. Though my thesis does not fully chart the emergence of contemporary psy-discourses of pain or contemporary pain medicine, I draw on the genealogical attentiveness to problems and responses as a way of understanding history and disrupting the notion that contemporary psy-knowledge is the way it is due to progressive instantiations of scientific reason and new knowledge.

Ian Hacking and Human Kinds

In his analysis, Hacking (1996) has focused on the classificatory practices of the human and social sciences, referring to the categories they create as human kinds. Hacking argues that in order to become objects of human and social scientific inquiry, types of people must be recognized as somehow relevant to life in contemporary western society, i.e. they are seen as people we ought to control, emulate, help, or protect ourselves from. We hope that by understanding what makes them who they are and making them the objects of causal analysis, we will be able to control, emulate, prevent, help, or protect ourselves from them better. As classificatory categories, human kinds segment particular kinds of attributes and behaviour. Attributes and behaviour constitute kinds only when they are widely held to *define* a specific type of person, e.g., alcoholics, teen mothers, geniuses, or the homeless. Despite the clinically neutral terms these taxonomies are presented in, Hacking argues that they are normatively oriented. With few exceptions, the phenomena the social and human sciences

segment into kinds are typically ones considered deviant, and discussions of deviance both necessitate and prop up correlative states of normalcy which are rarely explicitly defined.

Hacking argues that the discursive creation of human kinds is generative, which is to say that it creates, or "makes up" new kinds of people. While this may sound like standard nominalism, Hacking argues that the making of human kinds constitutes a special, dynamic kind of nominalism. For him, the classification of people fundamentally differs from the classification of other things insofar that humans interact with their labels and respond to the treatment such labelling entails. Though the specifics of discourse may belong to researchers and clinicians, its generalities become public property. Hacking argues that discourse about human kinds provide individuals of that kind with a conceptual framework outlining a way to be a person, to experience oneself, to interact with others, and to live in society. Influenced by a self-conception they did not previously have; classified individuals think and live differently. In this sense, they become an ontologically different kind of person than they were before being classified. For example, while there have likely always been people with what we now call autism, it was not until 1943 that people were able to experience themselves in these terms, and thus the discursive proposition that this is a type of person indeed begot a new kind of person.

While Hacking does not utilize Foucault's language of the disciplinary policing of discursively acceptable objects, concepts, and theoretical horizons, he does acknowledge that different discourses address different elements of the human person and therefore produce different kinds of people – even while addressing the same subject matter. As an example, he briefly compares the discourses of two expert bodies addressing the problem of alcoholism: Alcoholics Anonymous and the pseudonymous Alcohol Research Foundation. Alcoholics Anonymous regards alcoholism as a moral failing to be remedied through introspection, confession, submission to a higher power, and the amendment of interpersonal relationships.

The Alcohol Research Foundation, on the other hand, regards alcoholism as a disease caused by genetics that is to be addressed on biochemical grounds through medical treatment. Though both institutions address the same subject matter, they conceive of the issue on completely different grounds. Patients of either program will thus come to understand themselves, alcohol, and alcoholism – its causes, consequences, and cure – in completely different manners. As these competing understandings are internalized and lived out, two different kinds of alcoholics are produced. Fascinatingly, Hacking speculates that the alcoholics under each discursive framework would "tend to have projections, expectations, and (probabilistic) law-like regularities different from those of the other lot" (p. 373).

Nikolas Rose and the Psy-Complex

Where Hacking takes aim at the human and social sciences more generally, Rose (2010) hones in on what he calls the *psy-complex*. By psy-complex, Rose refers to the cluster of disciplinary discourses and practices explicitly concerned with understanding and working upon the human mind. Rose argues that in contemporary Western society, the vocabulary and techniques of the psy-complex are ubiquitous, incorporated into the workplace, clinics, prisons, schools, pop culture, and more. Like Hacking, Rose believes that these discourses are generative and enormously influential on the way we come to experience ourselves and our lives. However, where Hacking speculates on the way that human and social scientific discourses inform the conditions of possibility for the experience of humans *qua* kinds, Rose considers how psy-discourses inform the conditions of possibility for human *being* itself. This is to say that Rose is concerned with our understanding of what it means to be a human, an individual, or a self. For Rose, humans have conceived of the self in different ways throughout history. Much of his work can be read as a genealogy of the contemporary self. For Rose, understanding the criteria and standards by which we currently understand ourselves and others is incredibly important, as it is through these terms that we perceive,

evaluate, and experience the happenings of our lives, our interactions with others, the larger social world, and questions of ethics and politics.

For Rose (2010), it is around "psychological norms of truth" that "we have come to think, judge, console, and reform ourselves" (p. 96). As it encompasses various disciplines, Rose recognizes that the psy-complex has no single uniform "theory of the subject" – which is to say a framework regarding what it means to be human from which notions of human ideals, norms, problems, and solutions emerge. However, based on his historical analyses, he argues that our contemporary era's theories of the subject share "a common family resemblance" or common character that is inextricably bound to notions of freedom, autonomy, and choice. Rose argues that the mode of selfhood promoted by the psy-complex emerged with the development of liberal democracies, in which it became desirable for subjects to regulate and police themselves in certain ways. For Rose, it is the psy-complex's inseparability from the ideals of freedom and autonomy that make it so all-pervading and influential. He argues that when one enters into direct or indirect relationship with a psy-expert (a researcher, professor, consultant, psychotherapist) it is not a relationship of domination and subordination. Indeed, when we are subjectified, molded, taught how to be and think and feel, at the hands of the psy-complex, we are on the receiving end of a very soft power which promises us not only truth and certainty – as many disciplines do – but the knowledge required for self-understanding and self-improvement. In being shaped by authority we feel empowered. Rose is critical of this free and autonomous theory of the subject.

> Subjects are not merely 'free to choose', but *obliged to be free,* to understand and enact their lives in terms of choice under conditions that systematically limit the capacities of so many to shape their own destiny. Human beings must interpret their past, and dream their future, as outcomes of personal choices made or choices still to make yet within a narrow range of possibilities whose restrictions are hard to discern because they form the horizon of what is thinkable" (Rose, 2010, p. 17).

In part, this thesis tells the story of how people with enduring, organically unexplained pain have been obliged to be free in the psy-complex – how they have been expected to think about themselves and work on themselves given their suffering resists amelioration through the tools and techniques of biomedicine.

The Clinical as Moral

Where Hacking, Rose, and Foucault gesture toward the fact that the range of possible experiences enabled by medical and human-scientific discourses are narrow, other scholars have investigated the nature of this narrowness itself from the outside, as it were. Although my analysis in this thesis arguably sticks to the path established by Hacking, Rose and Foucault in that it examines psy-discourses from within their own logic and premises, it is also important to acknowledge the counter-discourses that have and could exist, in this case around the experience of pain. In the conclusion of the thesis I discuss some of the aspects of pain without lesion that these discourses arguably miss, and therefore where counter-discourses are necessary. Dominant discourses in the psy-sciences around pain without lesion are as moral as they are clinical or epistemological – these psy-practitioners' conceptions of themselves and their patients involve the valorization of certain kinds of conduct and ways of living, and a devaluation of others. Making up people involves a kind of moral regulation (McLean, 1997) in which taken-for-granted forms of social domination are sustained, reinforced, and even created.

For instance, Carol Gilligan's (1982/1993) classic, *In a Different Voice*, convincingly revealed the existence of a form of moral life that was essentially invisible to powerful male psychologists because it was more commonly expressed by women, and because their understanding of the moral was established largely through their work as and with men, and therefore reinforced gender hierarchies that the psychologists could not even perceive as such. Though Gilligan's critique extends to the work of Freud and Piaget, this text is

primarily a critique of Lawrence Kohlberg's stages of moral development. Kohlberg's stages of moral development is a theory of how the capacity for moral reasoning develops over the course of six stages from infancy to adulthood. Because each successive stage requires the mastery of increasingly "complex" and "mature" psychological functions (like empathy and abstraction) one's place on this scale is a measure of both moral and cognitive development. After conducting a study in which she interviewed 29 women of various ages considering abortion, both before and after they had made their choices, Gilligan started to observe a moral-developmental moral arc that did not align with Kohlberg's model. Indeed, when scored against Kohlberg's model, adolescent girls and grown women consistently and systematically rank lower than their male counterparts. These observations led Gilligan to argue that this state of affairs does not represent a deficiency on behalf of women, so much as it represents the fact that Kohlberg's conceptual model, created by men on the basis of their interpretations of all-male samples, purports to describe a universally human experience, when it really only accounts for the experience of men. For Kohlberg, the height of moral development lay in the application of abstract principles like human rights. Gilligan, however, found that women's moral reasoning was often concretely rooted in their sense of responsibility for others.

Research on medicine has likewise shown that knowledge and practice is never determined by "clinical" considerations alone – the clinical is always also moral (Kaufman, 1997). For example, Ducey et al. (2020) analyzed how the dynamic of knowledge and values in pelvic floor surgery allowed for the adoption of a device-procedure that caused widespread harm and became the basis for the largest mass tort litigation in United States history. In this investigation, researchers employed the concept of "mindlines" to account for the way epistemological and moral conceptions of good knowledge and responsible practice came together in clinical practice to cause certain evidence, innovations, and practices to "just

make sense." The criteria by which the surgeons they studied deemed surgery a failure or a success were exclusively anatomical and structural ones. With an anatomical mindline, surgeons understood it as their moral responsibility to repair the anatomy of patients, and it is in part this that led to the rapid uptake of transvaginal mesh that would later be shown to be harmful. Because it fell outside the bounds of the anatomical mindline, many surgeons failed to see patients' subjective experience as relevant, or at least as posing any potential resistance to their moral-clinical view that their responsibility was to repair anatomy. This research informs a more recent project to examine the ways in which that which "makes sense" is imbued with moral weight, and shapes not just what clinicians sense, perceive, say, and do; but allows them to feel what they do is "right." This feeling of rightness can therefore also be dangerous, and help explain why clinicians often do not notice the ways in which their perceptions or practices may cause or sustain harm (Dutta et al., 2022). The voices of the psychologists and psychiatrists included in this thesis often convey a sense of rightness, of moral or normative confidence that their way of understanding organically unexplained pain is the morally correct one.

Chapter 2: Hysteria and Organically Unexplained Pain as the Responsibility of Psychiatry

In the late 19th century, a central way in which pain without lesion came to be registered as a meaningful experience in the psy-complex was as a symptom of another disorder: hysteria. Hysteria was a diagnostic category through which physical symptomology without apparent organic cause could be reconceptualized as the somatic manifestation of psychic pathology. While other clinicians had previously hypothesized that hysteric symptoms, including pain without lesion, may have psychic cause, the first to develop a robust theoretical framework of how, exactly, the psyche worked on the soma were Freud (1856 – 1939) and Breuer (1842 – 1925) in their 1895 book, *Studies on Hysteria*. Essentially, Freud and Breuer argued that the psyche was capable of repressing emotionally painful memories, but that this repression caused the memory's affective energy to discharge through abnormal, i.e. somatic channels.

Studies on Hysteria is widely considered the first psychoanalytic text, and it is from this work that the discipline emerged. Though it grew to address more than just hysteria, the body of psychoanalytic discourse that emerged over the next ~70 years was always preoccupied with the relationship between somatic ailment and psychic happenings – perceptions, feelings, and emotions. In doing so, psychoanalysis emerged as an important discursive and clinical space in which the domains of psy and medicine were negotiated in relation to one another. After the psychoanalytic theory of hysteria was established, pain without lesion was usually deemed psychogenic and referred for psychoanalytic treatment, a segregation which removed the phenomenon from the gaze and consideration of non-psychiatric medicine. The lesion-induced pain addressed by medicine and the lesionless pain addressed by psychoanalysis were thus considered ontologically distinct entities with unique aetiologies and loci of treatment.

While lesionless pain was considered neither a necessary nor sufficient diagnostic criterion of hysteria, hysteria was nevertheless a conceptual and medical category that demarcated the terms through which people who suffered from pain could make sense of themselves, their lives, and their suffering. Further, in the psychoanalytic discourse, pain was always treated as a not only common, but elemental feature of hysteria. Hysteria, psychoanalytically conceived, was the physical displacement of psychic suffering, and what is pain if not the most primordial form of suffering? While my thesis only focuses on *enduring* pain without lesion, much of the psychoanalytic literature on hysteria concerned experiences of situational pain like vaginismus and dysmenorrhea, and transient, though recurring and severe pain like migraine or pain in the abdomen, back, joints, and extremities.

In so far as pain without lesion has always been one of the most common symptoms of hysteria, explanations for the causes of hysteria are therefore often also explanations for the experience of pain without lesion. While hysteria was not always conceived of in psychoanalytic terms, my interest in the interaction between lesionless pain and psy means that the vast majority of this chapter concerns the work of three psychoanalytic writer-clinicians: Sigmund Freud[1] (1856 - 1939), Harry Stack Sullivan (1892 – 1949), and Thomas Szasz (1920 – 2012). While the discursive contributions of each fall within the theoretical horizons of psychoanalysis, each presents a unique and, at the time of their writing, new way of understanding the relationship between the mind and lesionless somatic suffering, and thus new elaborations for how such suffering should be treated.

[1] Though *Studies on Hysteria* was co-written by Freud and Breuer, the material I draw on comes, almost exclusively, from the case studies and theoretical elaborations contributed by Freud. Breuer's chapter lays out aetiological mechanisms that, in some important ways, differ from Freud's. It was the ideas of Freud, and not Breuer, that laid the groundwork for psychoanalytic understandings of pain without lesion.

Hysteria I: The Entanglement of the Physical and Mental

Hysteria as an illness boasts a long history and was originally conceived of in physical terms. Though as a disease it has traditionally been characterized by multiple symptoms, organically unexplained pain has, since the beginning, been among the most common. Veith (1970) identifies hysteria's origin in the Kahun medical papyrus, the oldest known Egyptian medical text (dated 1900 B.C.E.), which identifies a variety of ailments experienced by women as the result of errant activity of the womb. While some of the ailments were described in terms of functional (e.g., blindness, bed-boundedness, lockjaw) or physical (e.g., bleeding, swelling) symptoms, the majority seem to concern various aches and pains, exclusively or in conjunction with other complaints. The language of "hysteria" itself is thought to derive from the Hippocratic Corpus – a compilation of Greek medical treatises penned in the fourth century B.C.E. – which contained a variety of case studies in which a wide range of symptoms are deemed *husterikos*, or "of the womb." Such symptoms included dizziness, belaboured breathing, heart palpitations, teeth grinding, and pain in the neck and groin. The Hippocratic texts also included symptoms like muscle contractures and, hazily, the 'sacred disease' (epilepsy). While the surviving Egyptian documents did not offer explanation for how the womb gave rise to such maladies, Hippocrates himself seemed to suggest that sexual abstinence could lead to the dehydration and atrophy of the womb, causing it to rise in the abdominal cavity and exert painful and damaging pressure on other organs. These writings influenced the medical scholarship of the Romans who in turn influenced physicians in Europe, likely due to the scholarly networks of the Roman and Holy Roman Empires.

During the Christian Middle Ages, a shift took place and experiences of lesionless pain, convulsive fits, paralysis, and blindness were explained in terms of supernatural visitation, demonic possession, and witchcraft. In the mid-sixteenth century such

constellations of phenomena would again be described in terms of "hysteria," and for the next three centuries etiological theories for hysteria proliferated to include vapours, spleens, uterine matrices, and menstrual disorder. Increasingly, subjective symptoms like anxiety, confusion, and strong emotions were considered. By the nineteenth century, while uterine theories of hysteria were still in play, it had become increasingly fashionable to explain bodily phenomena in terms of a sensing, communicative nervous system (Veith, 1970).

The preoccupation with the nervous system led to more elaborated aetiological considerations of the organically unexplained pains that were considered part and parcel of hysteria. The body's interconnectivity via nerve networks made it conceivable that pain in one part of the body may be caused by an unobservable lesion elsewhere, and the idea of transmitted signals meant that temporal, in addition to spatial, distance could separate lesion and pain (Hodgkiss, 1991). Tate (1830) postulated that hysteria was the result of irritation within "the upper dorsal portion" of the spinal cord and considered soreness of the spine and pain without lesion to be "diagnostic symptoms" of hysteria.

Charcot rather definitively introduced a new perspective in 1882. A neurologist, Charcot also understood hysteria to be caused by an injured or diseased nervous system. Unlike other neurologists at the time, however, he believed that hysterical symptoms only occurred within dissociative states of consciousness (Ellenberger, 1970). Though the legitimacy of his findings has since been questioned, he supposedly demonstrated that hysterical symptoms could be ceased and induced under hypnosis. From this he deduced that the dissociative state that constituted hysteria was the result of accidental self-hypnosis and that the defining feature of hysterics was a damaged nervous system that made it physiologically possible for them to enter hypnoid states. While he was primarily concerned with explaining the muscular movements and paralysis associated with hypnotic/hysterical states, he also discussed matters of innervation and increased sensitivity of the skin, muscles,

and other "special senses," which likely at least in part addressed the pain so often associated with hysteria. Interestingly, despite believing that the pathophysiology behind hypnotic-hysterical states could one day be explained in purely physical terms, Charcot's experience led him to maintain that such damage could be incurred by psychic trauma, namely extreme experiences of fear. This idea was extremely influential on Freud, who studied under Charcot from October 1885 – February 1886. Ellenberger (1970) argues that while Freud misunderstood and overstated the originality of some of Charcot's ideas, his short time with the French neurologist was an existential encounter insofar as it impressed on him how our immediate psychic reactions to events are more lingering than ephemeral, and can, unbeknownst to us, exert great influence over our lives and bodies.

Freud, Hysteria, and Disentangling the Organic and Psychic

So inspired, Freud returned to Vienna and, alongside Breuer, devoted the next decade of his career to the study of hysteria. In terms of knowledge production, their work as private physicians for the daughters, wives, and widows of wealthy Austrian men culminated in the 1895 publication of *Studies on Hysteria*. Taking Charcot's connection between fright and hysteria as their starting point, the two physicians made a point of systematically identifying the traumatic event that preceded their patients' first hysterical symptoms. To their surprise, thorough interviews rarely revealed anything that they considered sufficiently traumatic, leading them use hypnosis or nascent free association methods to "reawaken" the relevant memories. The tenacity of such memories has since been called into question but is of little relevance in this discussion. What is important here is that Freud and Breuer (1895/1937) took the hidden nature of such memories to suggest the existence of a *condition seconde*, or second mind, that operated independently from one's normal, conscious awareness. They also found that retrieved memories were remarkably "well preserved," meaning that once recounted they were more vivid, detailed, and factually accurate than regular memories.

Freud and Breuer took this to mean that the emotional impact of the remembered event was also perfectly preserved within the psyche, and therefore the body. Freud and Breuer understood the body and mind as two parts of the same energetic system. They believed that emotionally unpleasant experiences conferred a certain amount of nervous energy, or affect, to the experiencer, who, if healthy, responds in such a way that this affect is discharged, and energetic equilibrium is maintained. They called this process *abreaction* – examples of which included crying, insulting someone who has offended you, and enacting revenge.

If one cannot immediately abreact, then the memory retains its affective, or energetic-emotional, potency. In healthy individuals this is not a problem as the traumatic memory will, over time, become associated with memories and ideas that are "antagonistic" to its accompanying affect. For example, if I almost drown, the "emotional tone" of that memory will be characterized by fear. But, as time passes, this recollection becomes attached to memories of how I was rescued, how I am now safe and healthy, and perhaps subsequent non-traumatic trips to the beach. Through this process of association, an affective attrition takes place and the psychic remnants of the trauma are defanged. Problems occur, instead, when memories are banished to the *condition seconde* where their accompanying affect cannot dissipate via association or abreaction. Freud and Breuer came to believe that hysterical symptoms, including pain, were involuntary expressions of this pent-up energy, forcibly discharged via the cerebrospinal system. Under these conditions, the repressed memory thus assumes pathogenic qualities, and hysterical pain is considered psychogenic. The two termed this somatic manifestation of repressed affect a *conversion reaction*.

Through their largely ad-hoc treatment of these women, Freud and Breuer accidentally discovered that hysterical symptoms "immediately and permanently" ceased if, during therapy, they "succeeded in thoroughly awakening the memories of the causal process with its accompanying affect, and if the patient circumstantially discussed the process in the

most detailed manner and gave verbal expression to the affect" (pp. 3 – 4). In other words, if patients could recall their buried memories, meticulously recount them, and unflinchingly relive their emotional toll ("recollections without affects are almost utterly useless"), they would experience a cathartic discharge of nervous energy and their symptoms would cease (p. 4). If a full emotional reckoning was not immediately achievable, then the relocation of the memory from the *condition seconde* to conscious awareness at least made the discharge of affect via association possible. This therapeutic approach came to be known as "the talking cure." That a verbal reckoning with one's trauma was sufficient, and indeed necessary to remediate a problem understood as the pathologic distribution of energy incorporates the mind (as opposed to only the nervous system) in an interesting way. Objects and processes of the psyche are imbued with a physical realism, a definitive weight, and causal potential in the objective realm. There is some debate regarding whether Freud and Breuer regarded psychic happenings as *being the same thing* as neurophysiologic functions, or whether they were subjective co-incidents that, through the verbal direction of consciousness (talk therapy), were traceable and manipulable in a way that neurophysiological functions were not. The following quote lends support to the former position:

> The causal connection of the causative psychic trauma with the hysterical phenomena does not mean that that the trauma, as an *agent provocateur* [original emphasis] would release the symptom which would then become independent and continue as such. On the contrary, we must maintain that the psychic trauma or the memory of the same acts like a foreign body which even long after its penetration *must be considered as an agent of the present* [emphasis added] (p. 3).

In specifying this, Freud and Breuer depart from Charcot, who hypothesized that psychic trauma damaged the nervous system, which in turn made it physiologically possible to enter hypnoid-hysteric states. For him, psychic trauma was the agent provocateur that, once experienced, induced the nervous system to function in a way that gives rise to hysterical symptomology. In Freud and Breuer's account, on the other hand, psychic trauma is not so ephemeral. Indeed, through the representational mechanisms of memory, something

important is left behind. A new object is introduced to the psychic ecosystem where, like any system, its existence is relational, not discrete. In the energetic equilibrium-seeking model of the mind, the ego will normally interact with this trauma-object actively (through abreaction), or passively (through association with non-traumatic thoughts and memories). The hysteria-causing confinement of a psychic object to the *condition seconde*, however, occurs because a combination of psychic elements conspired to act defensively. Indeed, these ideas of the defensive psyche and *condition seconde* were what set Freud & Breuer's work on hysterical pain apart from the rest.

The patient whose course of therapy Freud identified as the birthplace of his theory of the defensive psyche and conversion was in fact a young woman suffering from what we would likely now call chronic pain. Elisabeth von R., the patient in question, was a 24-year-old woman who had for two years suffered from severe leg pain that rarely abated and worsened with walking, circumscribing her mobility and independence. Over the lengthy course of her treatment, Freud concluded that Elisabeth's pain was caused by her repressed love for her dying sister's husband. She found this assessment extremely upsetting. In Freud's words:

> When I summed up the whole situation with these prosaic words: "You were really for a long time in love with your brother-in-law," she complained of the most horrible pains; she made another despairing effort to reject the explanation, saying that it was not true, that I suggested it to her, it could not be, she was incapable of such baseness, and that she would never forgive herself for it (p. 112).

After this, however, they recounted Elisabeth's past interactions with her brother-in-law, which "on retrospection showed a fully developed passion," and her pain stopped shortly after (p. 112). The fact that this worked affirmed for Freud that this was the pathogenic ideation responsible for her hysterical pain, but the intensity of Elisabeth's initial rejection of this explanation led him to believe that her original suppression of romantic feelings, while not a conscious decision, was in some ways instrumental and advantageous. So long as these

troubling feelings were converted into physical pain, she was able to avoid an emotionally painful reality in which she would bear the pain of unrequited love, guilt, moral failure, and potential familial rifts. Acknowledging her feelings had inter- and intrapersonal ramifications. Within her social context, this secret had the potential to affect her close relationships and social standing. Intrapsychically, these desires stood in contradiction to her moral sense of self – her understanding of who she is and how she ought to be. This delivered the double disturbance of realizing there are parts of herself she could not control, and parts of herself she did not like. Indeed, on more than one occasion Freud seemed to imply that those more concerned with moral conduct, etiquette, and decorum were more likely to experience hysterical conversion than those who are not – imbuing the disease with a kind of tragic nobility. In response to Elisabeth's distress, he offered two consolations, "namely, that one is not responsible for one's feelings, and that her behaviour, her sickness under those circumstances was sufficient proof of her moral nature" (p. 112).

This resonates with Freud and Breuer's earlier allusion regarding how social relations inhibit abreaction and encourage hysterical conversion in "saints, nuns, abstinent women, and well-bred children" (p. 7). Freud, having already established conversion as the *mechanism* of hysteria, then argued that it took place for the *purpose* of defence against ideas and experiences that some part of the psyche deemed unacceptable. The psychic happenings responsible for hysteric pain could then be thought of as a disciplinary apparatus, or an internalization of the prohibitions and commandments that formally and informally organized late-Victorian Austrian bourgeois society. The conversion of affect into somatic phenomena, like pain, was one possible outcome of the psyche's arbitration between conflicting ideas. Freud's understanding of unconscious psychic activity as possessing an intentionality and following a hidden logic differentiated him from other theoreticians of hysteria and, for more than half a century to follow, would serve as a mainstay in future psychoanalytic theories of

organically unexplained pain. However, no matter how psychological his theories became, he always maintained that there was a neurological component to hysteria. In addition to attributing reason to the presence of hysteria, Freud proposed a theory of symptomatic determination, or why people with hysteria experienced the symptoms they did.

Judging Responses to Psychogenic Pain

In this way, Freud seemed to give to hysteria, and any pain associated with it, a sort of scientific legitimacy: it was rooted in mind-body relations and processes that could be explained and for which psychiatry had a ready treatment, even if the pain itself was not strictly organic. Freud wrote that "a patient suffering from an organic pain…will be able to describe it definitely and calmly; it may perhaps be lancinating, appear at certain intervals, and extend from this to that location, or in his opinion it may be evoked by this or that influence" (pp. 97-98). Miss von R. could not explain her pain in this way, because the origins of her pain were more complex. Freud and Breuer also distinguished between kinds of pain and their possible relation to hysteria. Nerve pain was readily accepted as a hysterical symptom, but rheumatic pain (pain in the muscle accompanied by knots) required more careful diagnostic consideration to discern whether it was psychological or organic in origin. Elisabeth von R.'s pain was diagnosed as hysteric, as opposed to organic, because of (1) the manner in which she described her pain, and (2) her reaction to stimulation of the painful area. Nevertheless, Freud's account gives the impression that he regarded Miss von R.'s pain as legitimate, and that he viewed her experience or account of pain with sympathy. Freud seems to suggest that as an hysteric, her response to her pain could not be other than it was.

For patients with other sorts of psychic disorders, however, Freud's way of describing their pain was much different, and seemed to problematize the patient in a very different way. The patient's response to their pain might also be attributable to their psychic disorder, but it

was a response Freud seemed to regard with less sympathy. The situation of the neurasthenic, or "a hypochondriac afflicted with anxiety neurosis," for example, was quite different:

> …in describing his pain [the neurasthenic] gives the impression as being occupied with some difficult mental problem, something far beyond his powers. His features are tense and distorted as though under the domination of a painful affect, his voice becomes shriller, he struggles for expression, he rejects all designations that the physician makes for his pains, even though they are undoubtedly afterwards found to be correct. He is ostensibly of the opinion the language is too poor to give expression to his feelings. These sensations are something unique, they never existed before, so that they cannot be exhaustively described. It is for this reason that he never tires of constantly adding new details, and when he has to stop, he is distinctly controlled by the impression that he was unsuccessful in making himself understood to the physician. All this is due to the fact that his pain absorbs his whole attention. In the case of Miss v R. we had just the opposite behaviour and we had to conclude from this that she attributed sufficient significance to the pain, but that her attention was concentrated on something else of which the pains were only the accompanying phenomena, perhaps on thoughts and sensations which were connected with pain (pp. 97 – 98).

Freud projects an image of the neurasthenic as an irrational and difficult patient, as "shrill," as rejecting physicians' reasonable and correct explanations of his pain, as never tiring of adding new details (no doubt irrelevant), because "his pain absorbs his whole attention." This contrast makes clear that Freud's notion of "hysteria" does not carry the moral and emotional valences that it seems to our present-day context. The term "hysteria" for Freud did not carry the association of irrationality or illegitimacy. Hysterics like Miss van R. were not "catastrophizers," as explored later.

Hysteria II: Sullivan, Szasz and Separating the Physical from the Mental

The Hysteric in Context

Though they both operated within the broader framework of psychoanalysis, Harry Stack Sullivan (1892 – 1949) and Thomas Szasz (1920 – 2012) positioned psychiatry on a scientific and conceptual ground quite different from Freud, as illustrated through their very different understandings of hysteria. In re-configuring hysteria, they also reconfigured the ways in which a patient with lesionless pain could be interpolated into psychiatric understanding and care, redirecting the psychiatrist's attention to the patient as *someone for*

whom illness or pain might be a means to an end. The patient should be regarded, according to Sullivan and Szasz, as someone who existed in a social context that it might be to their benefit to manipulate. Therefore sickness and pain might be seen as adaptive performances, whether conscious or not.

Szasz, (1961/1974) was a well-known critic of psychiatry, whose most famous book was called *The Myth of Mental Illness*. Szasz argued that while physical illness could serve as a metaphor for psychological problems, psychiatric nosology should not be positioned on the same ontological plane as physical illness. For Szasz, psychiatric diagnoses are not inherently bad, but the presentation of them as real, scientific-materialist diseases is dishonest and dangerous. Dishonest insofar as it obscures the moral values, judgements, and prescriptions therein, dangerous because the dissolution of the boundary between disease and non-disease made medicine a more far-reaching and powerful institution of social control. In short, he did not think psychiatry should be medicalized. In making these critiques, Szasz regularly invoked old case studies of hysteria to show how they could be accounted for by his non medicalized psychiatric framework – which I will touch on later in this chapter. He invoked hysteria because this was the condition many people pointed to in order to argue that psychiatry was indeed medical, as it, at least sometimes, dealt with conditions of the body.

Szasz's work sought to break free from the notion of an "entangled" relationship between body and mind. He set out to develop a purely psychological alternative framework that could account for psychogenic bodily phenomena, like lesionless pain, without invoking the nervous system or any other part of the body. He thus sought to demarcate the psychological from the physical. This will be discussed in more in-depth terms, but to understand how Szasz came to see pain in this way, it is important to first understand how the work of Harry Stack Sullivan, who is accredited with foregrounding social contexts in understandings of the mind, influenced Szasz. Sullivan's re-configuration of hysteria placed

it in an interpersonal and social context, but one that looked quite different from the lifeworld of patients that Freud invoked, which was constituted by trauma, memory, and displaced desires. Szasz made a world for patients constituted by interactions with others that constantly mold our self-esteem.

Sullivan: Hysteria and "Problems of Living"

In the 1930s a new wave of thought took hold in American psychiatry called interpersonal psychoanalysis, which emphasized the importance of cultural forces and interpersonal enmeshments in considerations of the mind and mental disorder. In other words, more importance was granted to the external realities with which the mind engages, as opposed to the previous focus on the interactions between intrapsychic forces (Evans III, 2006).

This movement seems to have emerged from the work of the American psychoanalyst Harry Stack Sullivan (1892 – 1949). Sullivan, influenced by George Herbert Mead as much as Freud, argued that all human thought and behaviour is, knowingly or not, oriented toward others. Even our innermost sense of self can be thought of as a continually reified amalgamation of the appraisals others make of us (H. S. Sullivan, 1940/1953). Given that the mind is formed and animated by interpersonal considerations, for Sullivan, conceptualizing neuroses as entities or processes unfolding in pure intrapsychic cultures was nonsensical. Indeed, for him, conditions like hysteria were themselves best understood as distorted modes of relating to others. Sullivan argued that the phenomena that had, over time, been reified into psychiatric diagnostic categories were at their core "problems in living," or learned and habituated modes of interacting with others that induce suffering and disharmony (Evans III, 2006). He thus argued for a reconceptualization of psychiatry as the "science of interpersonal living."

For Freud, bodily symptoms of hysteria, like pain, had meaning insofar that they possessed some symbolic or associational connection to a causal intrapsychic conflict. That the conflict was experienced in the body, and not the mind, was a testament to how mentally unpleasant the acknowledgement of this conflict was. Beyond this, hysterical symptoms – while alarming, and sources of real suffering – were ultimately incidental to the pathologic intrapsychic conflict resolution. The symptoms were not directly treated, but rather work was done to find out what was going on in the psyche. That repressed conflict transmuted into bodily phenomenon and not, say, free-floating anxiety or placeless dread, was an oddity of the human mind-body nexus.

For Sullivan, the embodied nature of hysteria is meaningful because physical illness provides a blameless "out" to many of the difficulties that arise on the interpersonal playing field. Unlike Freud, who maintained that Elisabeth's issues with walking were the symbolic-energetic expression of the hopelessness she felt over her forbidden love, Sullivan argued that hysteric symptoms were ways to "directly achieve unacknowledged goals" by means of "preying on sympathy" (H. S. Sullivan, 1940/1953, p.111). To illustrate this, he provides an example of a married couple wherein the wife, feeling undervalued by her husband, decides to deny him sex. After some time of sexual frustration, her husband, a man with a "strong hysterical disposition:"

> Wakes up at some early hour in the morning, probably at the time when his wife is notoriously most soundly asleep, and he has a frightful attack of some kind. It could be literally almost anything, but it will be very impressive to anyone around. His wife will be awakened, very much frightened, and will call the doctor. But before the doctor gets there, the husband, with a fine sense of dramatic values, will let her know, in some indirect way, that he's terribly afraid he is losing his mind. She is reduced to a really agitated state by that (H.S. Sullivan, 1947, pp. 204 - 206).

This "frightful attack" was unconsciously enacted with the intent expressing hostility toward his wife. Because Sullivan conceived of hysteria as a distorted mode of relating to others, he

needed to identify the components of this distortion that were to be worked upon in therapy. In his words:

> The hysteric has a rather deep contempt for other people. I mean by this that he regards other people as comparatively shadowy figures that move around, I sometimes think, as audience for his own performance. How does this show? Well—hysterics may be said to be the greatest liars to no purpose in the whole range of human personalities—nothing is good enough as it is. It always undergoes improvement in the telling; the hysteric simply has to exaggerate everything a little… When they talk about their living—their interests, their fun, their sorrows and so on—only superlative terms will suffice them. And that, in a way, is a statement of the inadequacy of reality—which is what I mean when I say that hysterics are rather contemptuous of mere events and mere people. **(**H.S. Sullivan, 1940/1953, p. 210).

Hysteric symptomology thus stems from the fact that those with hysteria regard others as less important than themselves, and therefore do not interact with them in an honest and straightforward way.

It is interesting that Sullivan, who made the proto-dramaturgical claim that "personality is made manifest in interpersonal situations, and not otherwise," singled out hysteric symptoms as especially performative (H.S. Sullivan, 1940/1953, p. 32). I take this to mean that while our interior world is ultimately oriented toward others, the degree to which we consider the complexity and interiority of our interlocuter varies. For Sullivan, what is being produced in this performance, and indeed in all interactions, is one's self-image. By experiencing a "frightful attack" in the middle of the night, one can express hostility without experiencing themselves as an aggressor. Another way in which one's self-image could be protected through hysteric symptomology was the manifestation of a disabling condition. The self-admission that one's goals were not achieved due to personal shortcomings is painful and damaging to the self-esteem as it implicates a deficiency in personhood and ability. Physical illness and disability, on the other hand is of the body and therefore out of our control. The distinction between understandings of human beings *qua* biological organisms and *qua* persons seems pertinent here. This could also be thought of as the distinction between body and mind. When illness strikes, the story goes, we are victims of fortune, biology, and the

tragically fallible nature of human anatomy and physiology. It is out of our control. Shortcomings that arise from such circumstances, then, are immune from *moral* scrutiny – which is instead reserved for behavior understood as determined by that which makes us people as opposed to organisms; the quality of our decision-making, capacity for delayed gratification, long-term thinking, work ethic, social acuity, and degree to which we harness our agential potential. The belief that failure resulted from physical illness, while not a total corrective, helps to preserves one's belief that, had it not been for circumstances outside of their control, they could successfully navigate the social system in which they find themselves.

An important element of Sullivan's psychotherapy would then be the identification and acknowledgement of one's interpersonal goals, and direction on how to conduct their interpersonal relations in a more honest and harmonious way. While Sullivan did not directly address the problem of pain without lesion, his previously quoted statement that the husband's midnight attack "could be literally almost anything but it will be very impressive to anyone around" leads me to believe that he would consider it possible that instances of lesionless pain could be hysterical. Even if he did not, however, his interpersonal reorientation of psychoanalysis proved to be incredibly influential, and his conceptualization of hysteria most definitely went on to impact those with lesionless pain through other clinicians. I have come across multiple papers in my research in which lesionless pain is understood, at least in part, as an expression of hostility toward either the treating clinician or family members (e.g., Albronda, 1957; Engel, 1959).

Szasz: Pain as Errant Communication

One person whose thinking was particularly influenced by Sullivan's theorization on hysteria was the Hungarian-American psychoanalyst and critic Thomas Szasz (1920-2012). Szasz became famous in the social sciences and a pariah in psychiatry with the publication of

his book, *The Myth of Mental Illness,* in 1961. In this text he builds on the work of Sullivan to argue that hysteria, along with all mental illnesses, should reconceptualized as forms of disordered communication. Before the publication of this book, however, these core ideas were originally developed in the context of treating pain without lesion in his 1957 book *Pain and Pleasure: A Study of Bodily Feelings*.

Though Szasz opposed the medicalization of psychiatry, he recognized that many people struggled with "problems of living," and could benefit from psychotherapy. Here, those who struggled could learn more about themselves and their problems and receive advice regarding conduct to avoid and pursue. Szasz argued that psychoanalytic conceptions of hysteria that resorted to entities, substantives, and energies were inaccurate imitations of medical etiology.

In his consideration of pain, Szasz claimed that organically unexplained pain can be explained as a matter of errant communication – between the ego and the body, and the ego and others. He argued that neurological explanations of pain, while medically useful, should not be the basis of psychological theories of pain. He believed that psychological data could not be causally linked to physical phenomena and vice versa. He compared the relationship between psychological and physiological studies of pain to that between petroleum chemistry and the history of the petroleum industry. Though oriented toward the same general phenomenon, their actual objects of study, data sources, and methodologies differ in a way that makes causal or covariant positioning of data illogical.

For Szasz, the basic experience of pain was, psychologically, best understood as a two-pronged phenomenon. The first component of pain was a communication signaling danger sent by the body system to the ego. The body system refers to whatever is recognized by the ego as one's body. This is *not* the corporeal body itself, but the mind's dynamic, internalized representation of it. This stipulation means the theory is inclusive of phenomena

like phantom limb pain. The second component of pain is acquired in early childhood when our natural expressions of pain result in help from others who lessen our pain. Thus, while the original expression was in no way goal-oriented, pain, from a very young age, takes on the interpersonal meaning of asking for help. Szasz refers to these two components as the medical and communicative meanings of pain, and argues that one never occurs without the other. For Szasz, when the source or nature of pain proves inconducive to medical explanation or treatment, a psychological investigation of the pain's potential communicative meaning may prove fruitful. For Szasz, the body system's message of danger to the ego (interpreted as pain) may be sent in response to bodily disorder but may also be a response to emotional or relational needs for which one desires help:

> We may summarize the chief motives of the communicative meaning of pain as follows: It arises out of a need which may be that of a bodily disorder, or it may be another need. The *experience* and expression of pain is an attempt to satisfy this need. While the nature of the experience and its expression lean upon the primary model of pain, the *actual meaning* of the experience differs essentially from that of the primary model [emphases added] (Szasz, 1957, p. 90).

> In all situations where the direct communication of a need is inhibited, either by external reality or by inner standards (or by a combination of the two), pain may be experienced and expressed. In this respect pain is like a "neurotic symptom," brought about by a regressive compromise solution of a currently insoluble conflict (p. 92)

Of note is that for Szasz, unrecognized non-bodily needs are not only communicated to *others* through the expression of pain, but to the *self* in the form of a real experience of pain in the body. In other words, the sufferer is not malingering. Psychologists study pain *qua* psychic experience, and the *feeling* of pain arising from bodily disorder does not necessarily differ from that which arises from other needs. Our minds always localize pain within the body. For Szasz, proof that this is true lies in the fact that people go the doctor, and not the psychiatrist when seeking professional help with their pain.

> All patients with the predominant symptom of pain whom I observed as a psychiatrist were referred to me by physicians. None came of their own "free will." This fact is consistent with the thesis that to the person experiencing pain the symptom connotes

> some derangement of the bodily machinery, and accordingly medical or surgical relief is sought (p. 92).

What differentiates pain arising from bodily and non-bodily needs is its meaning. Metaphorically comparing pain to a ringing telephone, Szasz argues that this way of thinking expands the horizon of knowledge that can be gained from psychological considerations of pain, allowing us to move past questions like "how can we stop this infernal noise?" and ask, "what does the person on the other end want to tell us?" "Why is he so persistent in his demands to be heard?" and perhaps even "who is he, anyway?" (p. vi).

To illustrate just how this theory of communicative pain can be used uncover the meaning of organically unexplained pain, Szasz invokes an example from his clinical practice that he believed to be paradigmatic of this sort of issue. This case concerns a girl in her late teens who, for two years, had experienced recurring attacks of severe pain in her abdomen, pelvis, and lower back. Like many people who have suffered from pain without lesion, this young woman sought medical treatment, but received neither a conclusive diagnosis nor relief from her pain. After two years of testing, she visited a "large diagnostic centre" in which she was referred to Szasz for psychiatric treatment. Prior to the onset of her pain the patient had undergone significant familial trauma. Her mother unexpectedly died following a non-emergent diagnostic surgery and her father killed himself a year later. She moved in with an older sister with who she wasn't particularly close and came to feel very isolated. Her pain began shortly thereafter. For Szasz, a notable event in this patient's case history occurred two months into the course of therapy when her pain became too severe to attend some sessions, and she requested that therapy be terminated. Szasz responded by "rather authoritative[ly]" (p. 96) insisting that she continue treatment.

What is rather remarkable about Szasz's work is his consideration of the response of significant others (including the psychotherapist) to the sufferer's intractable pain, and the impact this has on the pain experience. He foregrounds the way that the intensity and

intractability of this young woman's pain confused, angered, and scared her family members. They felt they could not understand her, nor she them. The situation with physicians was hardly any better. Szasz argues that this experience constituted a trauma in itself. It led her to believe that:

> No one really cared whether she was well or ill and, further, that no one understood what was wrong with her and that no one was capable of helping her…My urging the patient to continue the treatment gave her the realistic support and reassurance to which one is entitled when one's trust in human helpfulness is shaken (p. 96).

This quote speaks to the isolating effect of medically untreatable pain. If we take the experience of pain as a cry for help, it is understandable that we should feel abandoned when it is not answered or understood. Szasz goes further to argue that, because "the expression of pain is so fundamentally associated with asking for and getting help, it follows that pain suffered in silence, or persistently unrelieved, may readily be interpreted as punishment" (p. 86). Here, again, Szasz appears to be invoking lessons learned during childhood. Whether the basis of this interpretation is found in corporal punishment or denied care is not made clear. Perhaps he referred to both.

For Szasz, pain without lesion is fundamentally a cry for help. The sufferer possesses an emotional need that they do not have the skills, knowledge, or opportunity to recognize and straightforwardly express. With the help of a psychiatrist the emotional need can be identified, one can realize where the problem in their life really lies, and subsequently learn to make things better. Of the patient discussed, Szasz claims that:

> [She] was greatly improved after about one year of treatment. Pain occurred very infrequently. Instead, a much broader spectrum of human emotions was experienced, and she could regard these as reflections of her relationship with the people about her. She was no longer alienated from her family. She concluded that they had little in common, and she now had a consciously more distant and more comfortable relationship with them. (p. 97).

Through the course of psychotherapy, this patient was able to reframe and improve her relationship with her family members. Interestingly, for Szasz, an improved relationship

did not always entail increased closeness. Where before her distance from her family had made her feel rejected and inadequate, she could now accept that they were simply different, that this was okay, and that she could feel a different kind of affinity for them than she may have once felt was required. This realization was likely tied up in "the spectrum of human emotions" that were once less accessible to her, and whose inaccessibility led her emotional hardship to be expressed as physical pain.

Pain as Communicative and Instrumental

While Freud in some sense acknowledged the impact interpersonal relations could have on the emergence of psychogenic pain, Sullivan and Szasz brought this component of the lifeworld to the fore. Freud wished for his theory of hysteria to be accepted in medicine which required a physiological grounding. He believed that future advancements in neurology would be able to account for his schema of displaced nervous energy. While physical evidence of this displacement was not found, in the decades following *Studies on Hysteria*, psychiatrists were able to get around this by invoking the central nervous system. Though their site of intervention was the psyche, this allowed them to maintain their somewhat insecure and peripheral position within modern medicine.

Sullivan and Szasz saw the rightful purview of their discipline very differently. Though Szasz was far more explicit in this critique, the two believed that problems addressed by psychiatry were not diseases, but problems in living that primarily amounted to difficulties relating to and interacting with others. Though patients were treated on a one-on-one basis, it was one's interpersonal life that became the site of assessment and therapeutic intervention.

In terms of moral assessment, Sullivan's conceptualization of those with hysteria was undoubtedly negative, and he, much more than Szasz, seemed to believe that those who suffered from it were of a certain kind or personality. The picture he paints of the hysteric is one who is fundamentally dishonest to themselves and others. The hysteric, in his view, is

incapable of acknowledging unflattering elements of themselves – a hostile temper, failed ambitions – that, if witnessed and conceived by others will materialize as truths about their personhood. In a sense they are too attached to their positive self-image, which forever remains positive because their inadequacies and unsavouriness manifest in obfuscated forms. In a way that is likely connected to this inflated self-concept, the hysteric has little regard for others and thus, on some level, is fine with deceiving them.

While Sullivan did not directly discuss the problem of pain without lesion, it is interesting to speculate on how he would judge one's reaction to their lesion-less pain. The significance of such a reaction would likely be conceived of differently by interpersonal and intrapsychically oriented psychiatrists. For Freud, Elisabeth reacted to her pain the way she did because her condition was complex, the manifestation of a mind-body nexus that was rarely activated and could therefore not be communicated in the way regular pain can. For Sullivan, one's reaction to their pain would not so much reflect the commonality or strangeness of the pain experience but would rather be taken to provide insight into what, if any, interpersonal benefits stood to be gained from it. If one's reaction to their pain was understood as exaggerative, it may be taken to mean that the pain was indeed manifested in order to gain sympathy, get one's way, or improve one's self esteem.

Szasz's conceptualization of pain without lesion is in some ways similar and in other ways very different than Sullivan's treatment of hysteria. In general, it is a more compassionate account. Most notably, in his discussion of unrelieved pain psychically feeling like punishment, Szasz acknowledges the profound suffering involved in embodied, psychogenic suffering, whereas Sullivan only acknowledges the interpersonal benefits that the hysteric stands to gain. While Szasz agrees that lesionless pain is oriented toward others, he emphasizes that this expression stems from a place of hurt and emotional need, as opposed to a place of immaturity and self-delusion. It is construed more as a request for help than an

expression of hostility or manipulation. Further, Szasz seems to take more of the lifeworld into account, whereas Sullivan's depiction of the hysteric's need for sympathy and an inflated self-esteem are not contextualized. Perhaps it is because Sullivan already laid the groundwork of such an interactional approach that Szasz was able to approach the issue with more nuance. Most notably he considers the role trauma plays in alienating one from their own emotional state and needs, and the way strained and alienated relations with those from whom we expect help – like family members, physicians, and other authorities – can instill in people the message that the type of help one needs cannot be directly asked for.

Szasz's work on pain without lesion does not address the question of how one reacts to their pain. In his writing he seems to take patients' pain at face value, remarking on it getting better or worse throughout the course of therapy. I imagine that because Szasz understood his patients' pain as a help-seeking behaviour, he did not conceptually distinguish their pain from the way they spoke of it. Szasz traces the logic of the psychogenesis of lesionless pain to childhood lesson that when we cry out in pain we will be helped and comforted. Following this logic, I would argue that if/when Szasz encountered someone reacting to their pain in an exaggerative or "catastrophic" way, he would likely assume that their unmet emotional needs were very severe, or had been left unmet for a very long time.

Chapter 3: Catastrophizing and Organically Unexplained Pain as the Responsibility of Cognitive Psychology

In chapter two I discussed how psychoanalytic regimes of truth responded to the problem of pain without lesion. After the psychoanalytic/Freudian theory of hysterical conversion had been developed, instances of enduring pain in which a physical basis could not be attributed were usually deemed psychogenic and referred for psychiatric treatment, no longer the concern of non-psychiatric medicine and researchers. However, in the wake of World War II, it became increasingly apparent that medicine's theoretical account of organic pain – specificity theory – obscured some important, and increasingly witnessed, realities of how pain "worked." Increasing numbers of physicians and medical researchers began to feel that they were no longer justified in writing off pain without lesion as an entirely mental phenomenon, delegating its treatment to psychiatry.

As part of medicine's expanded attention to the problem of pain, cognitive psychologists rather than psychoanalysts emerged as the designated experts in the treatment of enduring pain without lesion, working within the medical research apparatus and alongside physicians to give previously unregistered kinds of pain conditions and pain experience medical, as opposed to psychiatric, legitimacy and visibility. In part, this seems to have been an effect of the types of patients presenting with pain in this period – World War II soldiers and veterans – and the increased incidence and prevalence of pain conditions. These patients exerted new practical and moral pressure on medicine to respond to pain.

In the process of this discursive upheaval and disciplinary boundary-shifting, the authoritative terms by which those with lesionless pain could afford meaning to themselves, their lives, and their suffering were radically altered. Much of this came from the fact that the cognitive psychological "theory of the subject," that is, a disciplinary theory of what human beings are and do, is very different from that offered by psychoanalysis. Unlike the

frameworks of psychoanalysis in which a large and powerful portion of the mind is conceived of as a fundamentally mysterious Other that acts contra to our waking will, the mind as conceived in cognitive psychology is fundamentally unified, far more transparent, and has the potential for intentional self-direction. Work on elements of the mind relevant to the experience of pain did not necessitate a thorough excavation of patients' histories and lives, but instead took place through skills training.

This chapter examines one of the most significant features of this landscape, the appearance of pain catastrophizing and the pain catastrophizer, as a clinical category and a target for intervention. Pain catastrophizing is one of the most popular concepts evoked in clinical and basic pain research today. The verbing of catastrophe originated in the nascent clinical cognitive psychology of the early 1960s and is indeed still invoked as a "cognitive error" (more on this later) in the cognitive-behavioural treatment of depression and anxiety. The concept was first associated with pain in the late 1970s, and since then has taken on a life, weight, and meaning of its own amongst pain researchers.

The emergence of pain catastrophizing was conditioned upon two turns in the conceptualization of the relationship between mind and body in the understanding of pain. First, was "gate control theory," which offered an apparent scientific, neurological basis for the role of non-organic factors in the experience of pain; and second was the emphasis on psychological factors in this framework and their elaboration and refinement into "cognitive schemas" that are thought to filter, perhaps even determine, the experience of pain.

Medicine Reconsiders Pain Without Lesion

Bonica, Beecher, and the Limits of specificity Theory

Post WWII, the non-psychiatric medical regime of truth surrounding pain was, in large part, that of *specificity theory*. Specificity theory developed in the context of experimental sensory physiology and held that the human body possessed a structurally

specialized system of receptors and transmitters that, upon activation by noxious stimuli, worked to generate and transmit pain impulses directly from nerve endings to an equally specialized pain centre in the thalamus. Neuroanatomic and anaesthesiologic research in the first half of the 20th century was conducted through the lens of specificity theory, and all major findings were understood as reinforcing its truth (Baszanger, 1998). Classifications of previously undifferentiated fibre types, the association of different levels of myelination with different kinds of pain, and the success of nerve blocks in surgical and experimental contexts buttressed the consensus that the problem of pain had been, in large order, medically solved. Pain was caused by the noxious stimulation of specialized nerves which in turn sent pain signals through known neural pathways to a known part of the brain. While "noxious stimulation" was often induced by way of electric shock or extreme heat in experimental settings, in the context of the clinic the noxious stimuli was taken to be lesion – some observed or assumed tissue damage caused by disease or injury.

If physicians could not identify a causal lesion or if anaesthetic procedures on the surrounding nerves did not ameliorate the pain, the pain was assumed to be psychogenic. The patient would be referred to a psychiatrist, from whom they would receive psychotherapy based on one of the psychoanalytic frameworks discussed in chapter two. Medical and psychiatric regimes of truth thus did not share or in any way co-manage the problem of pain. The lesionless pain addressed in psychiatry and the lesion-induced pain of medicine were understood as ontologically distinct entities with different aetiologies and treatment requirements. The requirements for clinical recognition in medicine were the presence of a lesion, to which causality could reasonably be attributed, and a response to treatment that aligned with the expectations of specificity theory. If these conditions were not met, patients were no longer considered suitable objects of medical care or inquiry. The subjective experience of pain, in and of itself, was not an object that medicine attended to. Medicine

attended to the pathological variation of material entities like cells, tissues, and organs using physiological and functional concepts like irritation, inflammation, and degeneration (Foucault, 1981). Subjective experiences like pain and fatigue were clinically relevant insofar as they indicated underlying pathology and could therefore guide the work of diagnosis and treatment. Pain, then, in the absence of lesion, fell outside the ontological borders of medicine – there was simply nothing to be done. The only requirement for pain's consideration under psychoanalysis, on the other hand, was that medicine had rejected it as an object of treatment. Thus, a functional kind of ecosystem emerged in which all the cases of lesionless pain that specificity theory could not address found their home under a very different regime of truth in psychiatry.

It seems this arrangement, which went on for over half a century, functioned because pain without lesion was, at the time, a rather rare occurrence. Even if there were instances of pain that did not seem to fall neatly within either category, these cases would have been too infrequent to incite major changes in the boundaries of medical discourse. Correspondingly, the rapid increase in people, mostly veterans, presenting with lesionless pain during and proceeding WWII presented medicine with a previously unencountered problem, to which it was forced to respond by reformulating pain – regardless of its cause – as something that is always physical and psychological in ontology, and must accordingly be treated on both fronts.

World War II: Pain as Percept and Reaction

A reality of war is that it begets a great deal of injury and pain, and in the process exposes wartime physicians to more of it than they would usually see. Indeed, it appears as though during WWII, a new kind of lesionless pain was made visible to physicians en masse. This was a pain that originated straightforwardly, accompanying a severe injury, but that persisted long after the causal injury had healed. American anaesthesiologist John Bonica

(1917 – 1994) was disturbed to find that many of these patients did not respond to nerve blocks administered during or after the period of tissue damage, completely flying in the face of specificity theory (Baszanger, 1998). Henry K. Beecher (1904 – 1976), another American anaesthesiologist, also encountered pain experiences that defied all he had been taught.

First, after three years of administering both emergency and procedural anaesthetic care to wounded soldiers, Beecher came to feel that patients' emotional state in early recovery greatly impacted their recovery (Stahnisch, 2015). He seemed to believe that the grief and stress of war combined with severe injury put soldiers in an impressionable state in which the way they were treated and classified by physicians and military authorities would make or break their recovery. While Beecher expressed concern over soldiers' well-being and healing, he also noted the implications this held for the institutional success of the military:

> Important from the military viewpoint is the inescapable fact that the patient's permanent outlook is powerfully and lastingly influenced by events at this time. Examples: The unwarranted lighthearted statement by a medical officer that the patient will go home now that he is wounded, although later proven untrue, has done its damage, and it becomes in many cases impossible to reestablish the qualities of a good combat soldier in the healed patient. A disease labelled "shell shock" is often incurable; whereas if it be called merely exhaustion, a good response to treatment is obtained, etc. The early hours after wounding are important for establishing a point of view in the patient that will be of help in his early return to duty. More study of this period by psychiatrists is needed (Beecher, 1946, pp. 102 - 103).

Second, in his treatment of 225 freshly and seriously wounded soldiers – afflicted with "compound fractures of long bones; extensive peripheral soft-tissue wounds; penetrating wounds of the thorax; penetrating wounds of the abdomen; and penetrating wounds of the cerebrum" – he found that ¾ of them refused morphine, despite not being in a state of shock (Beecher, 1946, pp. 104 – 105). After the war, Beecher (1956a) compared this data on analgesic request to surgical patients in a civilian hospital and found that 83% of the latter requested narcotics. Neither Beecher nor Bonica knew how to make sense of these violations of specificity theory. Both felt troubled by their discipline's grasp on pain and started looking for possible explanations upon their return to civilian life.

Beecher (1956a) found that European wartime physicians of early 19th century had written about the same phenomenon, and that later in the century, a small network of American philosophers and psychologists (Marshall, 1894; Mezes, 1895; Strong, 1895) had proffered a solution to this quandary. Marshall, Strong, and Mezes all essentially argued that the experience of pain consisted of two elements that the English language was poorly equipped to parse apart, but to which the German language granted insight. In German, the opposite of *lust* (pleasure) is *unlust* (unpleasure). *Unlust* encompasses a great deal of unpleasant emotional states like despair, shyness, vexation, listlessness, etc. In the English language, however, pain is construed as the opposite of pleasure, which "forces the word 'pain' into a double service" (Mezes, 1895, p. 22). Thus, we are forced to speak of the "pain" of both heartbreak and a broken bone. These are obviously not the same thing, so, as a clunky remedy we construct a rigid bifurcation between physical and emotional pain. These theorists wanted to understand the nature of pain more precisely, and in doing so developed a framework in which pain is an entity of a dual nature: a physical sensation which invariably "calls forth" certain ideas, emotions, memories, and thoughts. It is the blend of the two that results in the experience or felt reality of pain (Strong, 1895, p. 347). Though these ideas were never widely taken up by the medical discourses of their time, Beecher found them extraordinarily compelling; describing them as "bring[ing] order into this apparent chaos" (Beecher, 1956a, p. 1609).

Beecher, (1956b) summarized these ideas in an article published in the *American Journal of Medicine,* deeming the two components of pain to be "sensation" and "reaction." Contemplating the aforementioned disparity in the pain experienced by civilian versus battlefield surgical patients, he came to believe that the psychic reaction to noxious sensation is "influenced by the subject's concept of the sensation, by its significance, by its importance and degree of seriousness" (p. 108). In other words, the meaning one attributes to their pain,

its cause, and its potential consequences shapes the experience of pain itself. He argued that upon their removal from the life-threatening battlefield to the relative safety of the hospital, wounded soldiers often felt euphoric – they were lucky to be alive. Civilians on the other hand, understood their surgeries as "depressing, calamitous events" that would disrupt the order of their lives and induce financial hardship (p. 110). For him, this made it clear that "emotion can block pain…by affecting the reaction to the original sensation," though the relative contributions of sensation and reaction to the pain experience varied from situation to situation (Beecher, 1956b p. 110). When pain treatment is effective, Beecher argued, it is by virtue of "lessening or blocking the original sensation or…by altering the processes of discrimination, memory and judgement which follow" (p. 108).

For Beecher, a devoted researcher, the most concerning part of his proposal was the implications it posed for the enterprise of experimental pain. If his hypothesis was true, he argued, then information about the development and control of pain collected in the laboratory would have little to no relevance within the clinic because experimentally induced pain would never be imbued with the same meaning as that induced by illness or injury. For him, "not much imagination is required to suppose that the sickbed of the patient in pain with its ominous threat against his happiness, his security, his very life, provides an entirely different milieu and reaction than the laboratory" (p. 109).

If the subjective significance of one's pain is an object the clinician or researcher must now address, it is important, Beecher argues, that they recognize that "real" clinical pain has the potential to negatively colour all aspects of the patient's life, and may thus carry great emotional import (Stahnisch, 2015). Pain is also usually accompanied by some degree of uncertainty regarding how and when it will unfold. This makes it very different from experimental pain, where one knows exactly when the pain will cease, quite literally leaving it at the laboratory door.

Pain research thus needed to take place in the clinical setting. In a sense, this claim, from one of the country's leading anaesthesiologic researchers, could be seen as one of the first indicators regarding the forthcoming shift of medicine's epistemic/disciplinary boundaries with regard to the problem of pain. If the relationship between stimulus and pain was no longer direct, but mediated by activity of the mind, then psy-experts would be needed to properly understand the development and management of even the most straightforward clinical pain. Because the mediating activity of the mind was so situationally specific, the work of psy-researchers could not take place outside the clinic, as was the norm in experimental physiology. If this framework were to be accepted, the disciplinary borders of medicine would need to expand, absorbing, to invoke Foucault, the objects, concepts, and epistemic horizons of some psy-discipline, at least when it came to the problem of pain.

The proposals for discursive innovation made by Beecher in this six-page paper are significant. In effect he presented pain as a new and alien clinical object. Instead of exclusively addressing the body – lesion, receptors, nerves, fibres, impulses, transmission, sensation – Beecher argued that we must also address the person – reaction, judgement, interpretation, memory, milieu, *meaning*. Interestingly, Beecher does not, in this paper or any of his work, suggest that specificity theory was due for an overhaul. Instead, like many before him, he vaguely invoked some yet undiscovered element of the central nervous system, "internuncial neurones" connecting the thalamus (pain centre) with the frontal lobe ("higher" mental function). By doing so, his proposition, though likely received as strange, was able to fit into the discourse of medicine.

Upon return from the war, Bonica followed an intellectual trajectory that was in some ways strikingly similar to Beecher's. For him, it was not variation in pain response to wounds, but the failure of nerve blocks to alleviate injury-induced pain and instances of pain that outlasted causal injuries that led him to doubt the efficacy of specificity theory

(Baszanger, 1998). Like Beecher, he turned to older texts that fell outside the American medical/physiological mainstream, and in so doing happened upon some very similar ideas. Bonica was influenced by Charles Scott Sherrington (1857 – 1952) an esteemed British neurophysiologist. Sherrington's (1906) research concerned reflexes, and as such, noted that animals, when exposed to potentially harmful stimuli, would reflexively withdraw before displaying behaviour that suggested anger or fear: bared teeth, flat ears, hiding, etc. Eventually, he found that if he severed a specific neural pathway within the spinal cord, animals would not withdraw from painful stimuli nor display distress. However, if he maintained this pathway but removed a part of the brain associated with "higher," less reflexive behaviour, the animals would still withdraw from painful stimuli but would not demonstrate behaviour that suggested agitation, fear, or distress. Sherrington thus concluded that what we call pain is better understood as a two-pronged phenomenon consisting of (1) the activation of a physical reflex arc that protect us from physical harm and (2) an emotional component, which likely also serves a protective function.

Bonica's horizon for understanding and working on pain was thus expanded. Like Beecher, he now had two planes through which previously unintelligible instances of pain could be assessed: the somatic and the psychic. He too could now draw on the objects, concepts, and theoretical horizons of a psy-discipline, and began to regularly collaborate with psychiatrists in his practice.

Like Beecher, Bonica came to doubt the transferability of experimental pain research into clinical treatment, as the emotional composition of the former is almost non-existent, whereas in the clinic it is always present (Baszanger, 1998; Bonica, 1990). Bonica, however, came to expand upon this distinction in a very different way than Beecher did. Bonica extended the logic of pain kinds differentiated by level of emotionality to adopt the position that a *continuum* of pain kinds existed, ranging from the neurologic (minimal psychic

involvement, maximum sensory perception) to completely psychogenic (minimal sensory perception, maximum psychic involvement). All seven categories involved both the mind and body.

For Bonica, all instances of non-experimental pain should receive medical and psychological attention, whether or not the pain was psychic or organic in origin. The relative contribution to treatment by medical and psy-clinicians would vary based on which category the patient fell in. Beecher, on the other hand, did not engage with the question of psychogenic pain. Bonica's scheme incorporates psy objects, concepts, and theoretical horizons in a decidedly psychoanalytic form. Within his framework, psychogenic pain, for example, is described in terms strikingly similar to Freud's account of Elisabeth, 55 years prior, in which guilt is displaced from the psyche to the soma for the benefit of the ego.

Gate Control Theory and the Possibility of Controlling the Pain Experience

The major turning point through which these psychological reactions became reconcilable with a physiologically/structurally conceived medical regime of truth was Melzack & Wall's (1965) *gate control theory*, formally introduced in *Science*. Ronald Melzack (1929 – 2019) was an experimental psychologist and Patrick D. Wall (1925 – 2001) was a neuroscientist. Throughout the 1950s and 60s they had been keeping up with the work of Beecher (see Stahnisch, 2015), and the small handful of other critics of specificity theory. These included Livingston's (1953) considerations of enduring pain in injured factory workers and phantom limb pain; and Freeman & Watts (1948) finding that lobotomized patients felt, but were not emotionally distressed by, pain. Melzack's gravitation toward these critical perspectives was in part formed by a project he worked on in his doctoral studies, in which he found that terriers who had been "abnormally socialized" i.e., raised in isolation, behaved and reacted to stimuli very differently than their normally raised counterparts. Melzack lit a match to see how the dogs would respond to fire, and, akin to Sherrington,

found that “they kept sticking their noses in it, and although they would back off as though from a funny smell, they did not react as if it hurt” (Wood, 1989). Like Beecher and Bonica, they felt that medicine’s current conceptualization of pain was missing something important.

Drawing from these observations and Wall’s neuroscientific background, Melzack & Wall proposed a theory essentially arguing that, before they can make it to the brain where they are apperceived as pain, nociceptive impulses must first make a stop at a “gate-like mechanism” located in the dorsal horn of the spinal cord, just before the first synapse that allows transmissions to travel up the spinal cord. The horn consists of two gelatinous layers, specialized transmission cells, and various fibres that work together to inhibit and stimulate, or “close” and “open” the gate. This is of course a metaphor, and there is no structure in the spinal column opening and closing. Instead, the activation of certain spinal fibres animates a special kind of “interneuron” which makes the synapse less prone to releasing a kind of neurotransmitter that will be sent to the brain as a pain signal. The activation of other spinal fibres, however, inhibits this special “interneuron” which means that more pain-inducing neurotransmitters will be released. A wide-open gate, or completely inhibited interneuron, means that pain will be felt with high intensity and a closed gate, or fully activated interneuron, means that pain will not be experienced. Usually this “gate” is not fully open or closed but exists somewhere in between. It is this dynamic interplay between stimulating and inhibiting influences, they argue, that account for differences in the intensity and quality of pain experienced by different people in different circumstances (Baszanger, 1998; Melzack & Wall, 1965).

Importantly, inhibitory and activating fibres can be stimulated through both physical and mental means. Relevant to the psy-disciplines was the fact that impulses originating from the brain were posited as being both activating and inhibiting influences. It was argued that these impulses originate from “cerebral activities like attention, emotion, and recall of prior

experience" (Baszanger, 1998, p. 57). Based on her analysis of various "manuals of internal medicine," Baszanger (1998, p. 57) argues that gate control theory was not widely accepted by Western medicine as a whole until the 1990s. It was however, immediately and enthusiastically embraced by the burgeoning contingent of physicians who were interested in attending to this new clinical object of pain.

Now that it had been established that pain could be attended to on the psychological level, psy-researchers were justified in investigating the efficacy of psychological treatment on pain outcomes. But before anyone could work upon this newly established psychological modulatory path, they first needed to establish the psychological states, traits, or characteristics that could reasonably contribute to gate inhibition/activation. This project would prove to be extraordinarily successful for experimental cognitive psychologists. Within two decades they would supersede psychoanalytic theory as the site of psy-expertise regarding pain without lesion, claiming ownership of pain catastrophizing – "one of the most important psychological predictors of the pain experience" (M. J. Sullivan et al., 2001, p. 53) – making them authoritative players in the management of this new, dually psychic and somatic clinical object that we would come to call chronic pain.

The Basis of Catastrophizing

While gate control theory provided a scientific (i.e., neurological) justification for the involvement of psychologists in clinical pain research, to understand the plane of objects, concepts, and theoretical horizons that their inquiry presupposed necessitates an understanding of some key concepts from two cognitively oriented schools of psychotherapy that emerged in the 1960s: Albert Ellis' Rational Emotive Behavioural Therapy (REBT), and Aaron Beck's Cognitive Therapy (CT). Both REBT and CT were marketed as active, pragmatic, and time-limited alternatives to psychoanalysis. In so doing, they did away with the psychoanalytic aetiology of specific symptoms and instead developed a simplified

schema in which emotional distress was the product of irrational/distorted cognitions. In the name of pragmatism and faster, more accessible treatment, the lifeworld of the patient was pared down to their evaluative cognitions. It is from these therapeutic models that the vocabulary of "catastrophizing" comes. Although Ellis and Beck did not develop these systems with hysteric/lesionless/chronic pain in mind, an understanding of them is still important because it is in their image that practically all subsequent clinical-psychologic pain research and treatment programmes have been made.

Albert Ellis: Stoicism and Irrational Beliefs

Although he himself did not address hysteria or lesionless pain, an important figure in the emergence of pain catastrophizing is the American psychotherapist Albert Ellis (1913 – 2007). It is from his work developing a new therapeutic system that the term catastrophizing first emerged. Unless stated otherwise, the information on Ellis that follows comes from his 1963 book *Reason and Emotion in Psychotherapy.*

Ellis was originally a psychoanalyst who specialized in the treatment of depression, anxiety, and hostility. Some years into his practice he began to have doubts about the efficacy of his therapeutic mode. He felt that the techniques available to work on the unconscious simply did not work with some clients and that good time and money was lost trying to do so. He found himself frustrated with the passive nature of psychoanalysis, which emphasized that patients should arrive at insights regarding their psychic conflicts, needs, and desires on their own time. The logic behind this is that the experience of realization is more impactful when arrived at on one's own than when taught by an authority figure, but Ellis argued this was dubious. He believed that the combination of his expert knowledge, clinical experience, and well-integrated psyche meant that he could identify patients' problems long before they could and had advice to offer. He felt this was probably true of most therapists.

Further, he began to feel that while psychoanalytic theory provided the concepts and techniques to reveal the *original cause* of neuroses, it had little to offer in terms of understanding the mechanisms through which they are *perpetuated*, and thus did not provide adequate direction on how they are to be are overcome. Indeed, it may be recalled that the three frameworks explored in chapter two all emphasized the aetiology of hysteria, and to some degree implied or presumed that an understanding of the main causal or motivating factors would lead to the condition's cessation. Ellis argued that this should not be assumed. In his experience, it was quite common for patients to understand the origins of their neuroses, to understand that they suffer because of them, and to yet still be held in their grip.

This became Ellis' starting point. By emphasizing maintenance over cause of mental disturbance he, in a sense, reoriented the therapeutic gaze, shifting it from the past to the present. Unsatisfied with the answers psychoanalysis had to offer, Ellis looked elsewhere. In doing so, he drew largely from the philosophical work of the Stoics. By his own admission, the therapeutic system he came to develop was informed more by philosophy than it was by existing psychological/psychiatric theories and research (Ellis & MacLaren, 1998). I will briefly outline some principles of stoicism pertinent to Ellis' work.

Ultimately, the work of the Stoics is concerned with the topic of living well, or what Foucault (1988) called "the art of living". For the Stoics, to live well was to live in accordance with nature, which has two major implications. The first is the acceptance of one's fate. For the purposes of this thesis, it is enough to say here the that the Stoics believed that the Universe/Nature/God was a rationally ordered system in which nothing was left to chance. To live a good and happy life was to conform one's will to their fate. Second, the Stoics believed that what distinguished the nature of human beings from other animals is their capacity to *reason*, that is, to intentionally employ logic in pursuit of the truth (Baltzly, 2019). Because reasoning is what makes us human, we will become our best and happiest

selves if we strive to perfect and consistently apply our reason. The Stoics believed that perfect reasoning would lead one to live virtuously, and that to live virtuously was the only necessary and sufficient condition for happiness. Virtue was broadly understood as wisdom, justice, courage, moderation, and the fulfilment of one's personal, social, and professional responsibilities (Stephens, n.d.).

Thus, for the Stoics, happiness was achieved through the discipline of one's reason. An important element of this was freeing oneself from passion. Passion, or *pathê*, refers to powerful impulses or emotional states that one *undergoes*, in which the active, reasoning mind is "brought under" and no longer in control. Regular emotions and impulses differ from passions in that, when experiencing them, we remain in the driver's seat and can respond and react to things in reasonable ways. Regular emotions are therefore appropriate, but the passions are bad for the soul. The Stoics demarcate two primary passions: appetites (e.g., lust), which arise in the face of things we believe to be good, and fears (e.g., despair), which arise in the face of things we believe to be bad (Baltzly, 2019).

The Stoics argued that people's assessments of what is good and bad for them are usually incorrect. For them, the only sufficient and necessary condition for happiness is the enactment of virtue (wisdom, justice, courage, moderation, fulfilment of responsibilities). Symmetrically, the only thing guaranteed to make life miserable is the enactment of vice, broadly understood as foolishness, injustice, cowardice, and intemperance (Baltzly, 2019). Everything else, they maintained, is indifferent. While some such "indifferents" are recognized as being preferable to others (health to disease, wealth to poverty, acceptance to rejection), none are necessary conditions of happiness nor sufficient conditions of misery. Unhappiness, for the Stoics, thus usually comes from incorrect value-judgements; specifically the assessment of indifferent things as good or bad, and the assessment of bad things as good or indifferent (Baltzly, 2019; Inwood, 2003). For example, one may

experience distress when they are ill because they understand illness as bad, when it is really merely indifferent. The only thing that is bad i.e., guaranteed to cause misery, is that which could threaten one's virtue. By incorrectly believing indifferent things to be bad we cause ourselves to suffer needlessly.

For the Stoics then, the ability to assess our *immediate impression* of something's good or badness is the key to happy living. It allows us to rationally (i.e., intentionally guided by the knowledge of what is *really* good and bad for us) choose how to react in any given situation. This ability, a component of reason, is called *prohairesis*, which roughly translates as will, choice, or volition. Epictetus (AD 50 – 135) goes so far as to say that the volition to challenge our immediate impressions is what separates human beings from animals (Inwood, 2003). To avoid falling into unhappiness we must make sure our reasoning abilities are sufficiently disciplined.

Thus, ultimately, for the Stoics, a happy life requires three interrelated things: (1) the knowledge of what actually is and is not necessary for happiness, (2) the ability to distinguish correct from incorrect impressions regarding something's goodness/badness/indifference, and (3) the avoidance of emotional states (passions) that hamper our reason and render us incapable of the first two points.

Ellis was very impressed by all this. The Stoics provided a way of knowing and working upon the psyche that was grounded in the present, yet oriented toward the future. Engagement with Stoic material was supposed to be preparatory endeavor. Most Stoic writing is presented as a series of (a) truths about what it means to live happily, and (b) techniques by which these truths can be internalized in the hopes of responding to future challenges more reasonably. With its forward-facing orientation, Stoicism could be said to possess a different theoretical horizon than psychoanalysis. In the Stoic regime of truth, the question of why a particular person fears the specific indifferents (e.g., surgery, pain) that

they do, to the degree or intensity that they do, would not be asked. In other words, the question of why Person A is terrified of dogs and unbothered by rejection while Person B is terrified of rejection and unbothered by dogs would not arise as a logical or natural line of inquiry. This is because the two regimes have different causal frameworks. Specifically, psychoanalysis seeks to articulate a multicausal aetiology that explains why a particular symptom arose. Stoicism, on the other hand, presents a simpler schema in which human suffering has a single cause (insufficiently developed reason/volition) and a unique path (reason + event = emotional state) This approach seems to address unhappiness of all kinds, and is not tailored to specific symptoms or kinds of suffering. In a sense, the psyche is made workable by reducing the human person to a single, simple property: reason.

For Ellis, the reduction of people to a single property within the therapeutic context was not necessarily a bad thing. While psychoanalytic theory incorporated many elements of the lifeworld in its insights regarding why people suffer the way they do, he wanted to take a more pragmatic approach that focused on reducing the degree to which his patients suffered going forward.

Drawing from the Stoic assertion that most suffering comes from errant value-judgements, Ellis came to understand that each of his patients possessed a tacit yet powerful system of beliefs, or "life philosophy," that served as a framework for how they were to perceive the consequences and emotional significance of that which happened in their lives. Like the Stoics, Ellis believed that a great deal of suffering stemmed from the interpretation of relatively benign happenings as reasons to be miserable.

Independent of Stoic thought, Ellis argued that most of these beliefs were not acquired through experience, but through "verbal indoctrination." Because the human experience of reality is so symbolically mediated, our conception of whether *x* is good, bad, or indifferent is informed just as much, if not more so, by information about *x* imparted to us

through words and gestures as it is by our primary experiences with *x*. Invoking Pavlov, Ellis argues that for a dog to have the impression that a behaviour was bad for it, i.e., not conducive to a good life, it would first need to associate a negative experience with the enactment of that behaviour. Humans, on the other hand, regularly experience distress over possible occurrences that they have never experienced, like getting fired, because at an earlier point in life someone directly or indirectly told them that it would be terrible if they were ever fired. Ellis argued that this verbal conditioning was generally acquired from our parents or authority figures, but that as time goes on we, mostly unknowingly, verbally re-indoctrinate or re-condition ourselves through the internal verbal repetition of these sentences. So while one may have originally learned from their father that only second-rate people get fired, one's continued belief in this statement is the result of continually telling themselves that "Getting fired would mean that I'm a worthless person" every time they considered the possibility. Ellis believed that it was sentences like this that led people to experience undue emotional distress. In his words:

> Every human being who gets disturbed really is telling himself a chain of false sentences—since that is the way that humans seem almost invariably to think, in words, phrases, and sentences. And it is these sentences which really are, which constitute his neuroses (p. 28).

Under this new framework, Ellis' job was then to (a) get patients to recognize that an important part of their subjective experience consists of verbalized thoughts, the content of which regard our assessment of what in the world if good, bad, neutral, etc., (b) help patients identify what thoughts are causing their distress, and (c) demonstrate to the patient why their line of reasoning is irrational. Going back to the example of someone who believes "getting fired would make me a worthless person," Ellis would say something to them along the lines of "while it may be true that your father will see as worthless if you get fired, there is no reason why your definition of worthless should be the same as his. You are making his

definition of you your definition. It is this highly creative, *self*-defining act on your part which manufactures your disturbance" (pp. 29 -30).

So how exactly did Ellis conceive of rational and irrational thoughts? Unlike the Stoics, Ellis did not invoke the four cardinal virtues as the standard against which thoughts and feelings should be evaluated. Instead, he created a typology of what he believed to be the ten most widespread illogical ideas which "seem inevitably to lead to widespread neurosis" (p. 61). For the purposes of this discussion, only the following, "Irrational Idea No. 4," is pertinent: "the idea that it is awful and catastrophic when things are not the way one would very much like them to be" (p. 69). For Ellis, much suffering, then, is needlessly incurred because we confuse preferences with dire needs.

Ellis argued that experience was never value-free, that we are always evaluating our moment-to-moment phenomenological input as good, bad, or somewhere in between. As such, we are always telling our selves some kind of evaluative, verbally-structured sentence, even if we are not aware of it. This unawareness, however, is not commensurate to Freudian notions of the unconscious, but rather refers to those thoughts which we do not immediately apprehend – not because they originate and act upon us from an inaccessible realm, but because their constancy renders them invisible.

Ellis' work, through his focus on verbalized cognition and self-talk, opened up a new and eminently accessible way of making the psyche knowable. His main job, as a therapist, was communicating his theory of mind to the patient in order to establish a common framework so that they could learn to distinguish good (helpful) from bad (not helpful) thoughts. He taught them how to survey and self-correct the contents of their consciousness, which at the time was very novel.

Aaron Beck and Cognitive Schemas

The work of Beck was in many ways very similar to that of Ellis. Beck also trained and worked as a psychoanalyst but turned away from it due to methodological concerns (Rosner, 2014). He too drew deeply from the Stoics. Both believed that emotions are caused by thoughts which themselves are the result of underlying belief acquired from previous experience. Ellis called these sentences and irrational beliefs while Beck called them cognitions and schemas. As previously mentioned, one of Ellis' top ten most prominent irrational beliefs was "It will be catastrophic and awful if things don't go the way I would very much like them to go." Beck also incorporated the notion of catastrophic evaluations, though here the distinctions between him and Ellis require elaboration. Though they may initially seem subtle, this transition is vital in making sense of what contemporary clinical-psychologic pain research and treatment is.

Ellis' concern with his irrational beliefs was that they heightened the emotional stakes of occurrences and possibilities not worthy of such upset. He believed that our culture indoctrinated people into thinking in much more emotionally dramatic terms than was necessary or wise. People experienced great distress because they had been taught that that is how they should feel if *x*, *y*, or *z* were to happen.

For Ellis, it was the chronic state of living with these irrational beliefs that led to neurosis. As such, the challenging of these beliefs was central to his therapeutic method. He did this in terms of logical analysis, which is to say the isolation and evaluation of the premises of beliefs. For example, if, after working with Ellis, a patient came to realize that the sentence causing their anxiety was "If I go to lunch I'll probably say something stupid and all of my friends will realize I'm a loser, and God, that would be crushing;" Ellis would say "So what if you say something stupid? Isn't that your right? Your friends may very well

think you're a loser, but should that make you see yourself that way? Being liked is a preference and not a dire necessity, you'll probably make friends in the future," etc.

Beck took a different approach. While he also challenged his patients' beliefs, he did so not through a formal-logical takedown of definitional premises, but by teaching patients to see their evaluative thoughts as hypotheses, not facts, that needed to be empirically verified against reality (Beck, 1970). The techniques used to do this are not pertinent. What is important is the idea underlying them. Beck's conception of schemas (beliefs that inform our cognitions) is far more phenomenological than Ellis' conception of irrational beliefs. Where Ellis' irrational beliefs inform the perceived emotional consequences of events, Beck's schemas inform the very way we interpret reality (Beck, 1963). In his words, "a schema constitutes the basis for screening out, differentiating, and coding the stimuli that confront the individual. He categorizes and evaluates his experiences through a matrix of schemas" (Beck, 1979, p. 13). It is through schemas that we mentally structure our world, and through which we are able to transform raw sensory input into cognitions.

Beck argues that we have myriad schemas which are activated in different situations. If someone has a particularly "idiosyncratic" schema, it results in cognitive distortion, which is to say that our perception of the world becomes skewed. Though we do not realize it, our beliefs (schema) have subtle effects on our attention (Beck, 1963). For example, if my "roommate schema" consists of the belief that "she despises me," I will be hypervigilant in analyzing her signs of discontent but may completely fail to notice expressions of friendliness. For this reason, Beck argues that cognitive distortions constitute a sort of self-fulfilling prophecy. Because our expectations and beliefs (schemas) filter and structure our conception of reality, our interpretation of the world is likely to confirm what we expected it to, thus strengthening our belief that we see the world as it is. Beck understood this general phenomenon as "cognitive distortion," and argued that there were seven particular forms

("cognitive errors") it could take. One of them was *catastrophizing*, which he defined as the assumption that one must "always think the worst. It's most likely to happen to you" (Beck, 1979, p. 261). His advised intervention was to "calculate *real* probabilities. Focus on the evidence that the worst did not happen" (Beck, 1979, p. 261).

Pain Catastrophizing and the Pain Catastrophizer

Because our culture is so saturated with cognitive therapeutic language and logic, the innovations of Ellis and Beck may come off as unremarkable, but the development of their therapeutic systems represented a turning point in the history of western clinical psychology. Emotions are difficult things to work on, perhaps as elusive and overpowering as pain. By making the case that cognition influences emotion, and that by learning techniques of self-observation one can work on these thoughts, a previously mysterious and volatile component of the human soul (emotionality) became knowable and workable. This workability came through the simplification of the psychoanalytic consideration of the patient, with their innumerable influences and complex lifeworld. By considering so much information, it seems, the psychoanalytic gaze was never able to pivot toward the future. For better or for worse, the combined efforts of analyst and patient were fixed on the present, working away at the puzzle of how we wound up *here*. In looking for something more pragmatic, Ellis and Beck, in a subtle way, had to divide their gaze between present and future. Their primary concern was the cessation of emotional hardship, of attempting to lessen its future frequency. In order to make such predictions, the equation needed to be simplified. The lifeworld was reduced to activating events, and the patient to their ability to self-monitor and work upon the right thoughts.

I believe that this simplification, of the patient, pared down to cognition, and the lifeworld, pared down to activating events, provided a new and, to many, compelling way of knowing and relating to the psyche. I would also speculate that this simplified framework

more readily lent itself to quantitative regression and causal analysis than psychoanalytic theories did, which holds great currency for an "insecure science" (Hacking, 1996) like cognitive psychology hoping to prove its objectivity and usefulness.

For these reasons, and perhaps others, Ellis and Beck's (though mostly Beck's) framework of knowing and working upon the mind was rapidly taken up and adapted by various researchers. One major evolutionary shift of their work was that of coping strategy research. Ellis and Beck invented a way of looking at the human mind in terms of irrational and distorted self-statements, assumptions and beliefs. Beck emphasized the way that cognition could be systematically distorted to make life emotionally difficult. In a sense, these elements of the psyche were created by them. Other researchers, including many psychological pain researchers, took these as a starting point, and instead of looking for the presence of irrational and distorted cognitions, they looked for the absence of specific "adaptive" cognitive skills and responses. While some research on coping strategies may precede Beck, most of it came afterwards. It seems as though researchers were interested in taking up his idea of cognitive distortion and seeing if someone's cognizing could be distorted in a good way, i.e. so as to pay less attention or become less upset by pain. It is out of this realm – research on cognitive coping strategies – that catastrophizing first came to be associated with pain.

Michael J. Sullivan and the Pain Catastrophizing Scale. The psy-discipline of cognitive psychology has produced chronic pain sufferers as knowable objects through the classification of the ways these people think about their pain. Most prominently, these researchers have come to know those with chronic pain by the degree to which they consider their pain in "catastrophic" terms. The most common method of assessing pain catastrophizing is the use of M. J. Sullivan et al.'s (1995) Pain Catastrophizing Scale (PCS). While other measures exist, pain catastrophizing is overwhelmingly operationalized through

this tool, which has been cited over 6700 times in the 25 years since its inception. It has been translated into several languages (Chinese, Bengali, Brazilian Portuguese, Farsi, French, and Norwegian, to name a few) and been formally incorporated into assessment protocols in pain clinics around Europe and North America (Sullivan, 1995/2009). In developing the PCS items, M.J. Sullivan drew on three previously published studies that used the term catastrophizing, in reference to pain, in slightly different ways. In chronological order of publication, these are:

1. The effects of hypnotic susceptibility, suggestions for analgesia, and utilization of cognitive strategies on the reduction of pain (Spanos et al., 1979)
2. The use of coping strategies in chronic low back pain patients: relationship to patient characteristics and current adjustment (Rosenstiel & Keefe, 1983)
3. Spontaneous cognitive strategies for the control of clinical pain and stress (Chaves & Brown, 1987)

All authors of these papers are psychologists, with the exception of Rosentiel, a rheumatologist. Immediately apparent is the fact that each title features the term *strategies*. Cognitive coping strategies are intentional thought processes that make stressful situations less distressing and more manageable. During this era of cognitive research into hypnosis, many studies were done in which, prior to exposure to some sort of experimental pain, subjects would be "administered" a suggestion that the forthcoming stimuli would not hurt them, some hypnotically and some not. Such suggestions usually contained a set of instructions (i.e., "Imagine your arm is numb, or made of rubber," or "you are relaxing on a beach, listening to the waves crash"). These studies found that such suggestions were successful in reducing pain both with and without hypnotic induction. Interestingly, it was found that the extent to which these suggestions worked in reducing pain levels was strongly mediated by pre-test levels of hypnotic susceptibility, regardless of whether or not

participants were hypnotized. It was then generally concluded that it was possible to reduce experimentally induced pain levels through cognitive strategies if experimenters (a) told the subjects that it would work and (b) taught them how to do it.

Chaves & Brown (1978) and Spanos et al. (1979), however, identified a potential problem in such conclusions. Each raised the point that it may be unwise to attribute the analgesic effect to the administered strategy itself. Participants may have completely ignored the strategy or used their own. Both researchers set out to remediate this problem by asking participants themselves to describe what was going through their minds during painful experiences. The work of Spanos et al. and Chaves, & Brown therefore represents an important inflection point in the history of pain psychology. While work had previously been done on the efficacy of suggestion and cognitive skills training in pain reduction, such studies failed to consider individual variation in "untrained" or natural cognitive environments. Their research conceptualized types of people operating with differing configurations of cognitive strategies – what Ellis might have called beliefs and Beck might have called cognitive schemas – thereby "making up" "pain catastrophizers."

Chaves & Brown (1978) interviewed dental patients post-procedure. Coping strategies were not given to patients ahead of time. In a sense, they wanted to survey patients' indigenous coping strategies to better understand how these may interact with administered ones. Transcripts were evaluated for the "presence of cognitive coping strategies and catastrophizing ideation" (p. 272). The researchers considered coping and catastrophizing to be mutually exclusive categories. The only place in the paper where they explicitly define catastrophizing is in the abstract, where they define it as "cognitive activity which exaggerated the fearful aspects of their experience," in juxtaposition to cognitive strategies which were "designed to minimize pain and stress" (p. 263). Indeed, at points in this paper, "catastrophizing ideation" is used synonymously with "maladaptive ideation." It seems that

the two were understood to be two sides of the same coin – thoughts that could make a painful, stressful situation better or worse. No significant differences were found in terms of pain between the two groups, but catastrophizers reported significantly more stress.

Spanos et al. (1979) took a different, though similar approach. The pain they looked at was experimental, not procedural, and they utilized different control groups. Some participants underwent hypnotic induction, and others didn't. Half of each group was delivered an analgesic suggestion via tape recorder, but importantly, the suggestion contained no instructions on *how* to reduce pain, only that it would be reduced:

> This time when your hand is in the water you will feel much less pain than you did the first time; you may in fact feel no pain at all. The hand that will be in the water is already beginning to become numb and unfeeling. As I talk, your hand is becoming more numb, more and more numb and insensitive. It is becoming less and less able to feel pain. When it is placed in the water it will continue to feel numb and insensitive. It will continue to become more and more numb, insensitive, and unfeeling (Spanos et al., 1979, p. 285).

The primary outcome was the degree and directionality of change in pain ratings from the first to the second cold pressor test. Like other studies in this field, Spanos et al. found that whether or not subjects were hypnotized was not of statistical significance. Participants were interviewed after the second test and asked to recount, in as much detail as possible, what had gone through their minds during each test. Authors analyzed interview transcripts, quantifying the number of coping strategies used and splitting the group into catastrophizers and non-catastrophizers. Unlike Chaves & Brown, Spanos et al. did not conceive of catastrophizing and coping in binary, mutually exclusive terms. Indeed, 40 out of the 64 catastrophizers utilized one or more coping strategy. The authors classified participants as catastrophizers if:

> They reported becoming fearful immediately before or during the second trial; if they imagined painful events during this trial, for example, "I kept thinking of fliers shot down in the North Sea during winter in World War II"; if they indicated having anxiously wanted to leave the situation, for example, "I kept thinking I can't stand this much longer, I want to get out"; or if they focused on and exaggerated the unpleasantness of the situation (Spanos et al., 1979, p. 285).

Thus, like Chaves & Brown, they identified exaggerated appraisals of situational danger as catastrophizing. Unlike Chaves & Brown they identified more specific content types of catastrophic thought (pain-associational, cessation wishes), but perhaps more importantly, they paid attention to the processual form of these thoughts. Note that both examples of catastrophizing statements begin with "I kept thinking…" Whether or not these are real participant quotes, this ruminatory characterization is significant. Essentially, the authors found that regardless of how many coping strategies they employed, catastrophizers' pain scores consistently increased. Non-catastrophizers who used strategies' pain levels decreased, while non-catastrophizers who used no strategies' pain levels remained basically unchanged. Thus, while the *absence* of catastrophizing was not enough to reduce pain, its presence was enough to make pain worse and nullified the effects of coping strategies that quite significantly helped others. The authors explain this in terms of attention regulation. In their own words:

> One interpretation of this finding suggests that, by and large, cognitive strategies are effective to the extent that they *direct attention away from the painful stimulation* [emphasis added]. According to this hypothesis, the catastrophizers focused primarily on unpleasant aspects of the situation but periodically (and with little success) attempted to shift attention to other things. Because they were *unable to sustain attention to their strategies* [emphasis added], these subjects benefited little from their use. On the other hand, the noncatastrophizers were able to sustain attending to their strategies. *To the extent that they did so*, *they failed to attend to and elaborate upon the painful stimulation and, thereby, experienced less pain than they otherwise would have experienced* [emphasis added] (Spanos et al., 1979, pp. 288-289).

Like a pharmaceutical compound interacts with the body's endogenous chemical makeup, so too do administered cognitive coping strategies interact with one's endogenous forms and patterns of thought. Chaves & Brown hoped that by better understanding patients' spontaneous responses to pain, more effective cognitive strategies could be tailored and prescribed. In doing this, they took as their data the mental experience of pain and classified what they saw in terms of adaptive and maladaptive behavior.

Finally, the work of Rosenstiel & Keefe (1983) was important because it applied these concepts of spontaneous or self-developed coping strategies and applied it to the problem of chronic pain. Rosentiel & Keefe conceptualized catastrophizing as a cognitive coping strategy among five others: diverting attention, reinterpreting pain sensations, coping self-statements, ignoring pain sensations, and praying or hoping. Though they ultimately believed pain catastrophizing to be maladaptive, they seemed to understand coping mechanisms as any attempts toward self-regulation and control, some of which are helpful and some of which are not. Since the prevalence and usage of coping strategies amongst those with *chronic pain* had not yet been systematically investigated, one of the major goals of this investigation was to act as a census for the type and frequency of coping strategies in patients with chronic lower back pain. To do so, the authors developed and standardized questionnaire. The survey listed six cognitive and two behavioral coping strategy subscales that each contained six items, numerically scored. Finally, there were two questions regarding perceived effectiveness of one's coping strategies: "control over pain," and "ability to decrease pain" for a grand total of 50 questions. They called this the Pain Coping Questionnaire. Survey data was collected from 62 patients and factor analyzed to identify potential relationships between different coping strategies. Principal component analysis identified three groupings that accounted for 68% of variance. One of these groupings was deemed "helplessness," and subsumed catastrophizing, low activity levels, low sense of control over pain and a low sense of ability to treat pain; the latter two items being from the two questions regarding the effectiveness of coping strategies. There were no significant differences in pain ratings between the helplessness group and others, but this group showed the lowest levels of "emotional adjustment to chronic pain," indicated by the presence of depression and anxiety.

Thus, when constructing the PCS, M.J. Sullivan drew from Chaves & Brown the notion of threat magnification, from Spanos et al. the idea of maladaptive pain-related attention regulation, and from Rosenstiel & Keefe the notion of helplessness.

The PCS user manual defines catastrophizing as "an exaggerated negative mental set brought to bear during actual or anticipated painful experience" (Sullivan, 1995/2009, p. 4). In cognitive psychology, sets refer to the antecedent states of "readiness" we inhabit that prime us to react to stimuli in certain ways. Swimmers exemplify "motor set" when they prepare to dive at the sound of the starting gun, and our tendency to clearly hear our name through the rumble of a crowd betrays an element of our own "perceptual set." "Mental set," on the other hand, refers to the goals, expectations, and beliefs that inform the mental processes we use to *solve problems*. Psychological research on problem solving is closely tied up in discussions of creativity, and mental sets are often discussed as barriers to be overcome. At their worst, they are fosterers of inflexibility that close the mind to new solutions via calcified patterns of thought. The American Psychological Association's *Dictionary of Psychology* states that it is "essentially synonymous with the older term *einstellung*," (VandenBos & American Psychological Association, 2015, p. 642), which is the German term for attitude. What constitutes this exaggerated, negative attitude toward real and anticipated pain, and why has it achieved such prominence? To address this first question requires an examination of the PCS itself.

Pain catastrophizing, as it is commonly operationalized in the PCS, consists of three modes of thinking about one's pain: helplessness, rumination, and magnification. The scale consists of the following 13 questions, which are answered using a five-point Likert scale spanning "0 – not at all" to "4 – all the time."

Table 1

Questions from The Pain Catastrophizing Scale (PCS)

Helplessness	Rumination	Magnification
I worry all the time about whether the pain will end	I anxiously want the pain to go away	I become afraid that the pain will get worse
I feel I can't go on	I can't seem to keep it out of my mind	I keep thinking of other painful events
It's terrible and I think it's never going to get any better	I keep thinking about how much it hurts	I wonder whether something serious may happen
It's awful and I feel that it overwhelms me	I keep thinking about how badly I want the pain to stop	
I feel I can't stand it anymore		
There's nothing I can do to reduce the intensity of the pain		

Like all psychological constructs, these categories are not used as neutral descriptors of pain-related thought but are normative and value laden. Enquiry of this kind above all presupposes that what is psychologically pertinent to the problem of pain without lesion is the way that sufferers consider or think about their pain, and that some ways of thinking about pain are better than others. Analysis of the kinds of thought problematized can help shed light on the value system undergirding the discipline from which these concepts emerge.

The questions encompassed by the *Helplessness* subscale pertain to three things: (1) the way one regards their own ability to endure their pain, (2) the way one regards their ability to reduce the intensity of their pain, and (3) how they anticipate their pain to be in the future. Embedded in the way these phenomena are framed are the normative assumptions that (1) people can, and therefore, if it is their lot in life, should, tolerate being in unexplained pain for long, potentially indefinite, periods of time without experiencing extremely negative emotions or withdrawing from life, (2) there are things people with lesionless pain can do to reduce the severity of their own pain, and they should therefore know about and implement these things, and (3) people should be optimistic in their prognoses of their own pain.

The questions encompassed by the *Rumination* subscale pertain to the frequency with which one thinks about their pain and its cessation. Embedded here is the idea that being in pain does not mean that pain must dominate your thoughts. People, this perspective presumes, can be in long-term pain without thinking about it all the time, and should therefore manage their attention in such a way that they think about pain as infrequently as possible.

Finally, the *Magnification* subscale seems to concern (1) how one anticipates their pain will be in the future, (2) to what degree one anticipates serious consequences of their pain, and (3) the degree to which one's pain makes them think of other painful events. The way these phenomena are conceptualized suggests standards or ideals regarding one's imagination. This is to say the way people think about events or things that they are not currently experiencing. The framing of this construct suggests that people should control their thoughts regarding that which has not actually happened so that they tend toward optimism, and should not spend time speculating about unpleasant outcomes.

The work on pain catastrophizing and research on pain-related "coping strategies" that preceded it suggests that cognitive psychology's notion of proper conduct in the face of pain without lesion valorises self-discipline in the observation of one's own mind, the modification of problematic thoughts and emotions, and responsibility over the management of one's own condition. It is in relation to these ideals – the degree to which they are met or missed, as codified by tests and scales – that those with lesionless pain are made knowable in this psy-discourse. It is on this basis that the population of lesionless pain havers can be recognized as individuals – entities differentiated from one another – and their differences can be worked upon through research and treatment. In other words, the enactment of this discourse merges its norms and values onto the human person after which they become attributes of the person that can be evaluated.

Prior WWII, the neurological/neuroanatomical advances and development of nerve blocks that arose out of the guiding framework of specificity theory led medicine to largely understand pain as a problem that had been solved. In the medical context, pain essentially *was* lesion, insofar as it was lesion that was treated. Lesionless pain had no business in medicine and was dealt with by the psychoanalytic regime of truth.

However, when the events of WWII made it clear, at least to some physicians, that the relationship between pain and lesion was not so clearcut, the epistemic and disciplinary boundaries that demarcated the treatment of lesionless pain by psychiatry and lesion-induced pain by medicine started to shift. Beecher and Beck both felt theories which brought the mind into non-psychogenic experiences of pain helped make sense of what they had witnessed. These observations, especially those made by Beecher, contributed to the development of the gate control theory of pain. The advent of gate control theory, and its assertion that all pain could be mediated by physical and psychological variables, meant that an alliance could be formed between medicine and psy. In theory, medicine went from treating lesion to treating the person, as pain was now medically understood as an experience (Baszanger, 1998).

It also appears to have resolved the strict conceptual boundary that had previously existed between psychogenic and organic pain. There is some ambiguity as to why this is the case. One explanation, and I believe this would have been the position of Bonica, may be that because the experience of lesion-induced pain consisted of both psychic and physical elements, the same must be true for psychogenic pain. Thus both psychogenic and organic pain could be treated by the same treatment team. Another explanation may be that the space gate control theory opened up for the existence of pain that endured beyond the healing of lesion created a kind of catchall category that encompassed all cases that, years ago, would have been deemed psychogenic, but without the necessity of invoking psychoanalytic theory.

The relationship between mind and pain is very different in the time period demarcated here (1963 - 1995) than it was in the time period demarcated in chapter two (1895 - 1961). While the three psychoanalytical frameworks addressed in chapter two had their differences, they were all unified in that they sought to treat hysteria through an increased understanding of the self and the authentic expression of inner needs. Indeed, all three understood hysteric pain as a pathological substitute for a more genuine kind of suffering. In these frameworks, pain signaled a deeper truth about the sufferers psyche.

Post WWII, however, pain was conceived of as something the mind reacts to. This likely goes back to the Stoic notion, popularized by Ellis and Beck, that the most important part of being human is our ability to choose how we respond to that which happens to us. The research on coping strategies from which pain catastrophizing emerged is interesting to consider in comparison with psychoanalysis. In these cognitive studies, pain is invariably seen as a problem/stressor, and it is assumed that when a normal or healthy person is faced with pain, their mind begins working to reduce distress and pain. If they don't do this there is something wrong with them. In cognitive psychology, our psychological selves are considered in relation to the experience of pain insofar as we react to it.

Chapter 4: Discussion: The Psy-Complex and Ways of Knowing, Experiencing, and Treating Pain Without Lesion

In this thesis, I examined the two most significant responses to the problem of pain without lesion by the Western psy-complex in the last 150 years. Through a close reading of disciplinary discourses, it specifically examined the differential techniques and vocabularies deployed by expert practitioners of (1) psychoanalysis and (2) cognitive psychology in their efforts to render pain without lesion, a definitionally intangible and subjective phenomenon, into an identifiable, knowable, and workable entity. Both of these psy-disciplines have, at separate points in time, been considered preeminent sources of expertise on the handling of pain without lesion.

In this conclusion, I highlight some of the key elements in, and differences between, the ways the experience of pain without lesion could be "in the true" in the psy-complex of the twentieth century, especially between the major discourses of psychoanalytic psychiatry and cognitive psychology. I provide an integrative analysis of the evidence presented in chapters two and three along several main lines: what was considered relevant about a patient in relation to their pain experience; the nature and distribution of responsibility between patients and clinicians, the "treatments" considered possible and legitimate, and images of the self and others that are encouraged or allowed. In particular, I attend to the ways in which more "social" aspects of chronic pain do and do not become visible in these discourses. "Social" here refers in part to what might today be considered "social determinants" of health – inequity and inequality stemming from racialized and gendered social positions; experiences of trauma made more or less likely by social conditions; the ways in which some lives are structurally established as more or less valuable; and (considered to a lesser degree) the political economic conditions of medical and health care work that may impact our societal response to suffering. That is to say, we live in a society in which chronic pain is

now considered to be widespread and endemic and in which medical professionals and clinicians are increasingly called upon to consider the social determinants of health and their patients as people with social positions living in particular social conditions (Zajacova et al., 2021). In this case, how do the psy-discourses examined here allow for, or not allow for, attention to these present concerns in the situation of pain without lesion? But "social" also refers to the kinds and forms of sociality that are allowed for in the psy-complex – our ways of seeing ourselves and others, of thinking about what is normal and what is deviant, and of what falls under the purview of the clinic – what needs to be treated. Nikolas Rose (2010) argues that psy-discourses are best understood "as a body of critical reflections on the problems of governing persons in accordance with, on the one hand, their nature and truth and, on the other, with the demands of social order, harmony, tranquility, and well-being" (p. 20).

What Counts in the Experience of Pain

In Freud's *Studies on Hysteria,* women with pain without lesion were produced as knowable subjects through a framework wherein memories with energetic potential could, in certain circumstances, be made forgotten and their energy expressed as physical pain. Within this framework, the primary elements that were used to understand and manage individual cases of pain without lesion were the qualities of pain, the repressed memory, and the relationship between the two. For Freud, pain without lesion both concealed and revealed. While it obfuscated a truer, more legitimate form of mental suffering, the specificities of the pain could offer clues – often rather obscure – as to what the repressed memory regarded. For some individuals the relationship between the qualities of their pain and the repressed memory were more associational, and for others the relationship was more symbolic.

In the case of Elisabeth and her repressed love, the relation between leg pain and familial-romantic inner conflict was associational, impressed upon her psyche years before

when she coincidentally experienced organic leg pain and psychic conflict regarding romantic desire and familial obligation. Though the first instance of leg pain was organic and the second was a conversion reaction, each took place in the same leg and was characterized by a cramping quality. Thus, by looking back in a patient's life history for another time when the same kind of pain had been experienced and then mining that period in their life for psychic conflicts, insight may be gleaned as to the content of the current repressed memory.

In France, Freud learned from Charcot's work with the poor that hysterical symptoms were induced by trauma that damaged the nervous system. However, when he returned to Austria and none of his wealthy patients could recall a causal trauma, he did not investigate other potential causes or mechanisms, but instead assumed that they had experienced a trauma that they could not remember. While one could attempt to explain this in in terms of Freud's fidelity to Charcot, their accounts of trauma and hysteria diverged in too many important ways for this to be the full story. It will be recalled that Charcot hypothesized that, in some people, traumatic events damaged the nervous system and that this damaged nervous system induced hysterical symptoms. Freud, on the other hand, hypothesized that the traumatic event did not damage the nervous system, but that the memory of the trauma itself continually acts, like a foreign body, upon the mind-body nexus in a way that induces hysterical symptoms. In his own words, "we must maintain that the psychic trauma or the memory of the same acts like a foreign body which even long after its penetration *must be considered as an agent of the present* [emphasis added]" (Freud & Breuer, 1895/1937, p. 3).

Freud conceptualized memories – our accounts of that which we experience – as objects that when unchecked, lost, or out of place induce pathological processes, and that when accounted for and known constitute normality. That *this* was the way he connected the previously associated concepts of trauma and hysteria makes it clear that his account of the normal and the pathological was one that deeply valued self-knowledge. Indeed, while the

trauma of Charcot's patients largely concerned violence and train accidents, Freud extended his definition of trauma to include emotional pain.

Part of the reason why these memories were so emotionally painful is because of the difficult knowledge they imparted to these women about themselves. While unrequited love of any kind is emotionally painful, the realization that one has fallen in love with the husband of their dying sister is, among other things, the realization that one is capable of, to use Elisabeth's words, "baseness" of an unforgiveable degree.

While the aetiology of specific symptoms was of the utmost importance for Freud and the other psychoanalytic theoreticians, such was not the case for the cognitive psychologists who became involved in the research and treatment of pain from the 1960s and onwards. As discussed in chapter three, gate control theory gave these clinicians and psychologists free reign to test what cognitive variables were associated with heightened or lessened pain, but at no point did they try to establish a distal cause. Cognitive psychologists of this ilk were interested in cause in a more proximate sense, that is the relatively simple and discrete factors that precipitate changes in pain. To invoke Foucault, because the theoretical horizons of this clinical branch of cognitive psychology are rooted so entirely within the subjective, these precipitating factors always took the form of cognitions.

The Responsibilities of Patients and Clinicians

These differing approaches to the relevance of the causes of pain without lesion of course were inseparable from the tools for treatment that each discipline had available and saw as viable, and from the ways that clinicians seemed to view their patients and their responsibilities in relation to them.

For Freud, the suffering patient bore no meaningful responsibility for the pain they experienced. Though the conversion of emotional suffering to somatic pain was initiated by the mind, it was not the mind as traditionally conceived, but rather the unconscious *condition*

seconde, an inner realm hidden to and outside the control of conscious awareness. Specifically, it was the unconscious mechanisms of repression and conversion that were responsible for hysterical pain. Indeed, in Freud's account, the unconscious mind did not simply *do*, but *acted* with intentionality. For Freud, repression and conversion were stratagems of the unconscious, devised with the objective of protecting one's conscious ego – their conscious, experiencing "I" – from that which it deemed unthinkable. Effecting change in a motivated and intentional manner, the subconscious thus assumed the role of causal agent, while the suffering person was construed as more of an inert victim. This notion of the unconscious – endogenous yet fundamentally alien to the thing we call self – means that hysterical pain is fundamentally a story of heteronomy. Heteronomy may be understood as the opposite of autonomy, the influence exerted on us by the forceful will of an Other.

It will be recalled that for Freud what triggered the mechanisms of repression was a psychic conflict. It was a conflict between some desire, thought, or impulse that the person experienced and their inner, psychic disciplinary system which adjudicated the acceptability of such things. These desires and thoughts wished to be expressed or consciously acknowledged, but if the inner disciplinary apparatus won out then they would be repressed and mis-expressed as hysterical symptomology, potentially hysteric pain. The guiding ethic of the inner disciplinary system was not random, but rather an internalization of the prohibitions and commandments of the bourgeois, late-Victorian Austrian society in which Freud and his patients found themselves. Thus, in addition to not being at fault for the happenings of their subconscious, Freud instilled his patients with a kind of nobility.

For Freud, hysteric pain could only be cured by the full recollection and abreaction of the repressed memory. Thus, the fact that hysteric pain, itself an obfuscation of a truer suffering, transpired within a system defined by hiddenness had major implications for treatment. Because the causal conflict is not accessible to the sufferer, regular interview

techniques would not suffice in attempts to uncover it. Almost definitionally, the waking character of the hysteric afflicted could provide no insight as they would find the causal conflict anathema. Their waking disposition, personality, and morals would provide no help. Instead, the therapist had to work like a detective or an investigative journalist and look for clues wherever they could. The fact that the subconscious worked so ardently to repress it meant that the causal conflict likely concerned a thought, feeling, idea or experience that the waking mind would find abhorrent and deny identification with. This meant that the causal conflict, whatever it was, most likely pressed against the limits of some norm, prohibition, or commandment. A close relationship between analyst and analysand was therefore required.

Though the particularities of their pain and repressed memories varied, for Freud, all his patients fundamentally suffered from self-alienation. They did not know themselves well enough and required professional help to know themselves better. For him, it was better to reckon with uncomfortable truths and feel the accompanying emotional hardship than it was to ignore that which we would rather not know. With his patients he sought to turn their "hysterical misery into everyday unhappiness" (p. 232). He fully believed that cure was possible, and that it depended on the ingenuity and talent of the clinician.

If the story of hysterical pain – lesionless pain as made knowable by psychoanalysis – is a story of heteronomy and self-knowledge, the story of chronic pain – lesionless pain as made knowable by cognitive psychology – is one of autonomy and reactivity.

In psychoanalytic considerations of pain without lesion, nothing was as it seemed. What appeared to be a randomly acquired physical ailment was a manifestation of unseen suffering, the distorted expression of which followed a motivated logic. The cognitive theory of the mind, on the other hand, is much more aligned with views of the self as a unified, self-directed, and straightforward entity. At the core of the treatment-oriented branches of cognitive psychology is the notion that the emotions people experience in response to events

are mediated by evaluative cognitions. Evaluative cognitions are the thoughts we have in which we work out whether apperceived stimuli are good or bad for us. If we interpret them as good, positive emotions like contentment or hope will follow, and if we interpret them as bad negative emotions like inadequacy or fear become likely. Cognitive psychologists argue that these evaluative cognitions constitute a core element of human subjectivity that we engage in all the time, even if we are unaware of it. This unawareness, however, is not commensurate to Freudian notions of the unconscious, but rather refers to those thoughts which we do not immediately apprehend – not because they originate and act upon us from an inaccessible realm, but because their constancy renders them invisible.

The role of cognitive clinicians, then, is to share with their patients a frame of reference that will allow them to identify the evaluative cognitions which cause them emotional distress, explain why these amplify distress, and model alternative cognitions that will reduce their suffering. Unlike Freud's model where it is the analyst who is responsible for unearthing the causal conflict and inducing abreaction, this model of cognitive review and correction demands responsibility of both the clinician and the patient. While the clinician certainly bears a good deal of responsibility for passing on the techniques of self-examination, the fact that evaluative cognitions are constantly generated means that patients must learn to self-manage them. Even if a therapist could change a patient's cognitions for them during therapy, most of the patient's waking life is spent outside of therapy, so they would continue to be plagued by these issues the rest of the time, and their quality of life would not be meaningfully increased. Where the psychoanalytic treatment of hysteric pain consisted of a one-time (though long in the making) uncovering of something hidden, or the interpretation of something obscured, cognitive treatment entailed an ongoing recognition, surveillance, and challenging of something that is immediately present.

On Patients as People Who are Socially Positioned

This meant also that in some ways, the cognitive-psychological approach tends to be less interested in, or less equipped to consider, aspects of patients' lives and lifeworlds which informs how they live and what they do. For instance, a fair amount of research has been done comparing levels of pain catastrophizing between men and women and some has examined differences between ethnic groups. While gender differentials in pain catastrophizing have been examined in the context of acute, experimentally induced pain and chronic pain, analyses considering race differentials in pain catastrophizing appear to only have been conducted in contexts of experimental pain. It is unclear why this is the case. In the studies considered here, pain is "experimentally induced" using the cold pressor test method. A cold pressor test consists of getting participants to immerse their hand or arm into a container of ice water for as long as they can, with a cap of one or two minutes. The amount of time that participants can keep their hand in the water is usually recorded, as are their self-reported pain ratings and pain catastrophizing scores. Three studies conducted by Sullivan et al. (1995; 2000a; 2000b) used the cold pressor method on healthy undergraduate students, and all found that women had higher pain catastrophizing scores than men. Also using the cold pressor method on healthy undergraduate students, Hsieh et al. (2010) found that Chinese Canadians experienced more pain and catastrophized more than their white classmates, and (Forsythe et al., 2011) found that (a) women experienced more pain and catastrophized more than men, and (b) that African American students catastrophized more than white students. Considering chronic pain contexts, Jensen et al. (1994) and Keefe et al. (2000) both found that women catastrophized more and experienced more disability and pain than men. While it does not appear that research targeting race or gender differentials in pain catastrophizing have been conducted in the last decade, these differences are well established and known within the discourse.

The dry nature of the paragraph above reflects the mono-dimensional status and lack of meaning accorded to gender and ethnicity in discourses of pain catastrophizing. As a discipline, cognitive psychology has an investment in its work being considered scientific and objective, and indeed, its privileged status in the world of pain medicine may depend on it. A major part of being considered scientific in the contemporary era is the production of generalizable relationships of cause and effect. Individual differences thus must be reduced to as great a degree as possible, in order to produce a theory of the universal human being. In the studies cited above, race and ethnicity are granted the status of a dummy-variable covariate. While this is typical, it is not uncommon for studies of this kind to elude mention of race and gender altogether or to gesture at these characteristics only once in a seemingly obligatory "participant demographics" section.

Cognitive psychology differentiates pained individuals on the basis of their pain-related cognitions, most commonly the degree to which they catastrophize. Though the discipline must technically recognize the existence of gender and race because the rest of the world regards them as meaningful categories of difference, they are not, and, I argue, cannot be meaningful characteristics within the institutional and epistemic parameters of this discourse. That this is the case does not mean that the people conducting this research are misogynist, racist, or personally indifferent to the influence of race and gender on one's life chances. However, if we follow the Foucauldian notion that disciplines discipline difference and differentiate individuals so that their differences can be *managed*, worked upon, optimized, and corrected, then indeed the only possible utility of gender and race here is to flag who catastrophizes the most, so that their *catastrophizing* can be managed. In the institutional and epistemic configuration in which this discourse operates, gender and race cannot be worked upon. They are not characteristics that can be changed, mitigated, or reduced. Thus, in a system that understands the provision of health-promoting services only

as interventions enacted upon the individual – as opposed to say, population level preventative measures – immutable characteristics like gender and race cannot be meaningfully utilized, only perfunctorily registered.

That the cognitive psychological pain research is poorly equipped to consider issues of race and gender does not, of course, mean that the discipline has no gendered or racialized character. All of the thinkers profiled in this thesis – both of psychoanalytic and cognitive allegiance – are white men from the Global North. It is on the basis of their interpretations of humans: our nature and our problems, that we have understood enduring, lesionless pain over the last century and a half.

I will not speculate on why women and POC catastrophize more than men and white people when faced with pain. For this I have no answer. I do, however, think the differential is meaningful. That women and POC consistently register as more deficient/pathologic/problematic on measures of pain catastrophizing suggests that the model of the normal human mind upon which this construct rests may more accurately be a model of the pained comportment of white, Western men. What if the establishment of this ideal has positioned the pained comportment of women and POC as inferior, when they are actually only different? That the demographic distribution of pain catastrophizing scores skew in a way that posits white men as the most normal and that the concept itself was developed by white men is likely not a coincidence. I borrow this line of thinking from Gilligan's (1982/1993) *In a Different Voice*. It is a line of thought that is important and worthy of deeper consideration than I am able to grant it here. Here, I only pose the question: what would it mean if pain catastrophizing was a tendency that manifests differently in different people, but that the details of such conduct could not so easily be construed as better or worse than one another?

While the discipline claims that reductions in pain catastrophizing will result in less pain and disability, this truth is not as solid as the mounds of peer-reviewed studies may suggest. Though statistically significant positive correlations between pain catastrophizing and disability and pain catastrophizing and pain intensity are fairly consistently shown, causality has not been established. The cause-effect orientation of these variables is assumed by all researchers and clinicians within the discipline, because doing so is a condition of being in the discipline as it is currently epistemologically and institutionally configured. It is the way the field disciplines them to think.

My work on this matter has left me agnostic with regard to pain catastrophizing. I believe there is great value in teaching people strategies to endure hardship and feel that our mental states to some degree contribute to the pain we feel. I cannot, however, shake from my mind the unequal, patterned distribution of chronic pain in our society. Chronic pain in Canada is disproportionately experienced by women, Indigenous peoples, drug users, veterans, the homeless, and the poor. What is happening? With patterns this clear, how can we in good conscience reduce this to an issue of individual thought? Though it manifests in the bodies of individuals, must there not be some "social facts" at play in the production of this pain? Are the externalities molding this situation so impossible to capture, so impossible to change?

In becoming familiar with the literature on pain catastrophizing, I came across an article called "The relationship of sociodemographic and psychological variables with chronic pain variables in a low-income population" written by (Newman et al., 2017) at the University of Alabama. Through a battery of quantitative questionnaires, bootstrap resampling, and reversed mediation modelling, the researchers found that pain catastrophizing "mediated the effects of primary literacy and poverty status" on pain interference, pain severity, and disability." Their findings lead them to conclude that "the

experience of chronic pain within this low-income sample is better accounted for by psychological factors than sex, age, race, poverty status, literacy, and education level" (p. 1687).

Alabama is the 6th poorest state in the United States (Alabama Possible, 2018). While statistical vocabulary shrouds these claims in an air of clinical neutrality, to use the language of *mediation* is to say that pain catastrophizing explains the relationship between poverty and pain. Poverty, this seems to suggest, is related to chronic pain only to the extent that poverty makes one prone to pain catastrophizing. Interestingly, these researchers frame chronic pain as "a pervasive condition that is *complicated* by economic, educational, and racial disparities" (p. 1687). By eschewing the etiology of chronic pain, researchers in cognitive psychology can ignore questions of *why* those in poverty are more likely to experience chronic pain, and instead see poverty as something which makes pain worse, and that's harmful effects can be reduced to matters of individual psychology. This article was published in *Pain*, widely considered to be the most prestigious journal in pain medicine.

While teaching the poor stoic strategies for enduring hardship likely did some good, I cannot help but think of the following quote from Szasz's (1961) *The Myth of Mental Illness,* in which he considers the invention of the guillotine.

> Clearly, Guillotin's work is humane or inhuman, depending on which side of the issue we examine. From the point of view of making execution less painful for the executed, it was humane. Since it also made things easier for the executioner and his employers, it was inhuman (pp. 23 - 24)

In addition to permitting those who govern to ignore possible structural causes of chronic pain, there is one more potential for large-scale harm I see in pain catastrophizing and contemporary cognitive approaches to chronic pain research and management writ large. The discursive terms of the life sciences are not confined to the researchers and clinicians who create them but permeate into the larger discursive realm of everyday life where they provide the terms and frameworks through which regular people accord meaning to their

lives and experiences. As discussed, the conceptual framework of cognitive psychology allows no meaningful way in which the influence of race, gender, or trauma can be incorporated into the story of one's pain. Indeed, in this current discursive landscape the terms by which chronic pain can be reckoned with are flimsy, likely unsatisfying, and place blame squarely on the suffering individual.

Regardless of whether or not the symbolic aetiology of Freud's hysteric pain or the communicative aetiology of Szasz's semiotic pain were factually correct, the sufferers' lesionless pain was assumed to be rife with meaning, there for a reason, and, for the psy-clinician, invited investigation and attentiveness to the patient's inner problems, pains, and struggles. In Freud and Szasz's frameworks the goal of treatment was to uncover repressed, painful memories and to become better acquainted with one's unexpressed emotional needs, respectively. While Szasz differed from Freud in many ways, the two were unified in that their approach recognized that people do not always understand the roots of the problems they face and that developing a close, trust-based relationship with another person can be therapeutic. Because both believed the emotional source of their patient's problems to be hidden from the patient themselves, no piece of information about their lives was considered insignificant. Traumatic events and situations loomed large in the practice of both, as each believed that the mind sought to protect itself from that which it considered traumatic, which often resulted in a truncated knowledge of oneself that worsened suffering and required the help of a trusted outsider. Freud and Szasz reportedly both had success when it came to treating pain without lesion. Their therapeutic processes may have worked in precisely the way they hypothesized them to have. It is, however, interesting to speculate on the potential positive effect their treatments may have had, even if not for the reasons they imagined. Even if these people's lesionless pain was not *caused* by an inner emotional conflict or need, it is

likely that every living person on earth has some kind of inner emotional pain or "problem of living" that could benefit from regularly speaking to a sympathetic listener.

After closely reading *Studies on Hysteria*, I can say with confidence that Freud held those ten patients in high regard, devoting enormous amounts of time to understanding the particularities of their lives and struggles, and frequently remarking on the admiration he held for their intelligence, humour, morality, and fortitude. Szasz demonstrated the same attentiveness toward his patients and even higher levels of respect. He has, in multiple publications, decried Freud's comments on the inferior intelligence of women, and his attitude toward the therapeutic relationship as hierarchical one. Though Szasz saw the client-therapist relationship as one between equals, and Freud saw it as one between a superior and subordinate, for both of them the therapeutic relationship was not just a conduit through which treatment was delivered, but constituted an important part of the treatment itself. Szasz made this explicitly clear when, in speaking about the treatment of pain without lesion, he emphasized the importance of demonstrating to his patient that she could trust people to be there for her, to support her, to provide help and not abandon her after she had been left feeling abandoned and misunderstood by physicians family members in the face of her pain.

Freud and Szasz did not talk about race in their writings, and it is likely that their theories were based on encounters with predominantly white, upper middle class clientele. However, their mode of treatment was so individualized that it seems they certainly would have tried to consider the influence of racism if their clients were racialized. In their case studies they frequently mention details like "was from a middle-class Protestant family in Maine" or "Came from a small Catholic household in the Bavarian Alps." While they never make it explicitly clear how these details of class, religious, ethnic, or cultural origin are taken into account, given their attentiveness to familial dynamics and mores, it is almost

certain that they did; at the very least they probably held on to the information as something that *could* prove useful in the course of treatment.

All of this is to say that in the psychoanalytic frame of reference, patients' pain was imbued with meaning. Through the course of therapy a narrative tapestry was woven, in which the story of one's pain and suffering incorporated the most significant difficulties of their lives, and, at the end of which, they were left with a deeper sense of self-knowledge and experienced a broader range of emotion. Even though it was a difficult reason, their pain was there for a reason, and in a very real sense they emerged on the other end of the experience improved. Forged by fire, in a sense. As was previously discussed, in the psychoanalytic frame lesionless pain was not considered to be the responsibility or fault of the patient because the matter was so complex, so overdetermined by a variety of factors, and had nothing to do with the will or choice of the patient.

In the cognitive account of chronic pain, on the other hand, rich stores of meaning with which one can accord their experience of pain and suffering are not so readily available. To start, patients are offered no reason or causal explanation for why they acquired the pain they have. Their pain is random, their suffering meaningless. The experience that colours so much of their life exists in an eerie vacuum of bad luck. They've been dealt a bad hand. Further, in this framework and as opposed to psychoanalysis, here patients are given no answers regarding the cure or cessation of chronic pain. Instead, the name of the game is management and improvement. Though they are given no answers regarding why their pain began, or according to what logic they can expect it to end, something resembling an answer is provided for why their pain persists and why it is disabling. The answer given to them in this, our now dominant psy-framework, is that they think about their pain in the wrong way. Cognitive psychologists likely acknowledge that changing one's pain-related cognitions and the vigilant self-monitoring this necessitates is challenging. However, it is, if one wants to get

better, a necessary challenge. It is also a challenge that is the responsibility of them and them alone. Further, and as was previously discussed, this particular regime of individualization cannot meaningfully account for non-cognitive factors like ethnicity, gender, or trauma in accounting for the patient's pain – unless it is to flag them for being more or less at-risk for pain catastrophizing or other "maladaptive" pain cognitions. It is known by cognitive psychological professionals that these demographic characteristics can make a patient's work against pain catastrophizing more challenging, but such challenge is understood in exclusively quantitative, and not qualitative terms. The relationship between different instantiations of trauma, gender, ethnicity and chronic pain is one in which the former three change the degree to which one will experience pain catastrophizing which will then influence the experiential nature of their pain. Gender, ethnicity, and trauma themselves do not directly make contact with one's pain, and thus do not become a meaningful part of the story. They are factors relevant insofar as they make the challenge of pain catastrophizing easier or harder to overcome.

While it may be easier for some people to overcome than others, the whole conceptual framework of pain catastrophizing still relies on the assumption that the normal human mind is one that is relatively autonomous from its prior experiences and environment, responsible, diligent, self-monitoring, and willful. People who continuously struggle with chronic pain must then understand the continuance of their pain in terms of personal failure and a lack of mental fortitude. That which is external to the person or antecedent to the here-and-now of their pain cannot be used to legitimately understand their experience.

Why Cognitive Psychology Won

Nikolas Rose (2010) argues that the notion of selfhood now dominant in the psy-complex emerged with the development of liberal democracy, and is consistent with a form of governmentality suited to political economy of neoliberalism and late capitalism. While

this thesis is not organized to describe the larger social and institutional context that precipitated the replacement of psychoanalysis by cognitive therapy as the dominant psy-discourse, my research has left me with a few, preliminary thoughts on the political-economic factors that were important in the shift in the conceptualization of pain without lesion. It seems psychoanalysis was supplanted by cognitive psychology as the site of expertise on pain without lesion not because of the former's internal inconsistencies or theoretical incoherence, as is often charged, but because the techniques by which psychoanalysis made lesionless pain knowable were unable to keep up with post-war demand.

In the years following WWII cases of pain without lesion skyrocketed, primarily as a result of soldiers who had been injured during war. What used to once be a curiosity read about in psychoanalytic journals was now something that physicians and psychiatrists were encountering more and more frequently. As will be recalled from the previous discussions of Freud and Szasz, in psychoanalysis lesionless pain was the product some kind of need, emotion, or conflict hidden out of view within the recesses of the psyche. The uncovering of this hidden variable was a deeply involved and time-consuming process in which the goal of the analyst was to maximize their understanding of an endlessly idiosyncratic being. The process emphasized retrodiction, which meant that a lot of focus was given to the patient's past experiences, as these were thought to be important in the understanding of what their current problem was. This process was very time consuming and expensive. Patients were usually prescribed therapeutic courses of 4+ hours of one-on-one talk therapy a week for several months, if not years.

The new regime of cognitive pain psychology took form around the problem of inventing new ways to make individual lesionless pain patients knowable in psychological terms. They did this through the systematic capture of well-defined pain cognitions through standardized apparatuses like questionnaires. The cognitions captured in the beginning of this

era concerned coping strategies, but this work would later give rise to what we know as pain catastrophizing. Because cognitive psychology was concerned with in-the-moment cognitions – understood as simple evaluative sentences people tell themselves – thought by people while they were in pain, the elements of human subjectivity they deemed pertinent to this problem were easily captured in questionnaires (Rose, 1988). While psychoanalysts knew they were looking for a hidden emotional need or desire, the specifics of this could take myriad forms. The process was open ended and exploratory. Cognitive psychologists, on the other hand, by objectifying the cognitions they deemed important into questionnaires that were given to patients/test subjects, were able to ensure that the characteristics they deemed important could be occasioned and evaluated at will. This was a quick, easy, cheap, and predictable technique of assessing patients on the basis of properties of a mind-pain theory on demand (Rose, 1998). Unlike in psychoanalysis this data could be treated statistically and be used for predictive purposes. This allowed for the faster collection and circulation of information.

The development of chronic pain centres in the 1960s meant that these researchers had easy access to large numbers of individuals with chronic pain that allowed them to collect comparable data on all of them easily. They were able to analyze this data in a way that allowed them to create norms. This is in contrast to psychoanalysts, the average one of whom would likely not see very many instances of lesionless pain during their career.

Conclusion

Akin to devices like microscopes and telescopes, the normative conceptual frameworks of the psy-disciplines provide a perceptual opening through which individuals can be seen, coded, and compared. They can be rationally assessed, known, and worked upon. The definition of new psychological concepts in response to problems, like pain without lesion, simultaneously create and make practicable new elements of human subjectivity (Rose, 1998). It is important to remember, however, that these frameworks are,

necessarily, as limiting as they are illuminating. In creating and demarcating the terms through which the mind and its problems are understood, other interpretations are tacitly denied or remain unthought. Under these regimes of truth, how are we seen? To what extent are we known? The answers to these questions matter.

Table 2

Summary of Differences between Psychoanalytic and Cognitive Psychological Responses to the Problem of Pain Without Lesion

	Psychoanalytic Psychiatry	Cognitive Psychology
Clinical Object Addressed	Hysteric pain	Chronic pain
Element of the Mind Addressed	Internal conflict, negation	Cognitive error (positive forms)
Theory of the Mind	Heteronomy	Autonomy
Intent of Talk Therapy	Expert interpretation (analysis)	Skills training
Role in Knowledge Production & Treatment	Exclusive site of expertise and treatment	One part of multidisciplinary treatment
Form of Research Data and Output	Qualitative	Quantitative

In the last 150 years the psy-sciences have included two major responses to the problem of lesionless pain that render such pain as rooted in the mind and workable through talk: psychoanalysis and cognitive psychology. Nevertheless, while each seeks to understand the mind, their responses to pain without lesion were radically different. To use Foucault's terminology we could say that, while they attended to the same subject matter, the two disciplines addressed different objects, employed different conceptual and technical instruments, and were generally informed by different theoretical horizons. Psychoanalysis addressed pain in terms of its meaning, in pursuit of some greater truth about the sufferer that it signalled. Cognitive psychology, on the other hand, addressed pain as a stressor, for which one ought be prepared to respond.

Indeed, when thinking of the way cognitive psychology addresses pain, it often feels more accurate to say that this discipline addresses the self, or the one who feels pain. If we are to think of it in these terms, the part of the self that is addressed is what the Stoics called *prohairesis*, the soul's ability to choose how it responds to external events. Thinking in these terms, concepts like coping strategies, or the recognition of maladaptive thoughts all seem like efforts to strengthen this recently re-illuminated part of the mind. Indeed, cognitive psychology's theory of the person seems to revolve around the idea of rationality and reason. As discussed near the end of chapter three, the cognitive investigations of coping strategies indicate a theory of mind which assumes that when the human person is faced with stress or difficulty, it is in its nature to work to minimize the pain and/or emotional distress of the situation. Specifically, it is in its nature to get to work *internally*, as opposed to working to change external circumstances, so as to remain and cope with the situation at hand. Space and time prevent me from unpacking this further, so for now I will only comment that this conception of human nature sounds like someone who would continue to be productive regardless of the material conditions in which they find themselves, and that this seems to align well with the operations of neoliberal governance. Sometimes it is unclear as to whether or not the cognitive psychological experts generating this discourse believe that this picture of the human person is typical, or whether it is an ideal to be striven for (Rose, 2010). Regardless, this is a different picture than the one painted by psychoanalysis where, sometimes, on some level, people may want to be in pain – either because it spares them deeper turmoil, or because it may help them fulfill an emotional need.

The cognitive psychological conception of pain without lesion undoubtedly takes fewer elements of the human person, their lifeworld, and social context into account. This was in large part due to a pragmatic, time-limited, resource-minded shift in focus from aetiology to treatment. In part, this may also be due to the disciplinary reorganization of pain

treatment. In the heyday of psychoanalytic psychiatry, the responsibility of knowing and treating hysteric pain fell squarely within the purview of psychiatry. While hysteric pain may not have always been a common complaint, to the extent that this problem existed, psychiatrists had a heavy moral imperative to respond. When pain contradicted the expectations of specificity theory, it was up to psychiatry and psychiatry alone to paint the picture of what was happening.

While cognitive psychologists undoubtedly felt a moral imperative to respond to increasingly widespread pain and suffering, cognitive pain psychology developed in the post-gate control epistemic landscape, in which chronic pain was seen as a complex, multifactorial phenomenon most appropriately treated through a combination of physical and psychological interventions. The onus of chronic pain treatment did and does not fall on cognitive psychologists alone. Hypothetically, cognitive psychological understandings and treatments of pain could be perfect – improving pain to the extent that it can be improved through psychological intervention – and yet one's pain may not completely cease because it is being maintained by physical factors that are insufficiently understood or undertreated. This, however, is not the responsibility of the cognitive psychologist. Further, within the framework of psychoanalysis, the mind was an opaque and frequently deceptive realm whose workings required expert interpretation and finesse. In cognitive psychology, on the other hand, access to pain cognitions is relatively straightforward. The cognitive therapist provides patients with a framework for recognizing and evaluating these thoughts, and provides training on how to monitor and alter them. While the quality of this training is surely understood as contributing to treatment outcomes, this therapeutic mode relies on the continual work and vigilance of patients, meaning it is ultimately the patient who is responsible for the success or failure of treatment. All of this is to speculate that the diffuse responsibility held by the cognitive therapist in the treatment of chronic pain, so different

than the responsibility borne in psychiatrist's relationship to hysteric pain, could be one of the factors accounting for the discipline's more limited response to the problem of pain without lesion. If the onus for treating chronic pain today rested entirely on cognitive psychology (though I do not argue it should), it is possible that its theoretical framework would consider more elements of the human person and their life.

Regardless of its cause, the limited scope of cognitive pain psychology seems to have contributed to the discipline's success in becoming a valued perspective in the multidisciplinary treatment of pain. The conceptual framework of cognitive schemas and cognitive error easily lent itself to quantification via survey and statistical analysis in a way that the psychoanalytic framework of repression and conversion did not. The administration of surveys meant that the psychologically pertinent elements of patients could be assessed easily and cheaply. The philosopher of science Ian Hacking (1996) argues that in the contemporary age, quantified and statistically treatable information has more currency and is more readily accepted as "knowledge" than qualitative information produced by verstehen, in part because it can be used for predictive purposes.

True as this may be, I argue that it is still important to draw attention to the fact that the cognitive psychological approach is less equipped to consider aspects of the patient's life and lifeworlds that were once important in psychoanalytic considerations of pain without lesion, like ethnicity, gender, trauma, class, and general social context. Given the unequal, patterned distribution of chronic pain in our society and the fact that chronic pain is still so often treatment resistant, it may behoove pain researchers to draw on the past for inspiration of future investigations. Baszanger (1998) argues that the epistemic and disciplinary shifts that occurred in the wake of gate control theory meant that in its treatment of pain, biomedicine was required to address a person instead of a lesion. I suggest the rendering of the human person as a set of standardized pain cognitions, mental and emotive reactions to

pain, seems hardly less reductive than a preoccupation with lesion. Providing psychoanalytic talk therapy for all chronic pain patients is not feasible, nor is it likely the best solution. I do, however, believe the psychoanalytic response to pain without lesion to be valuable insofar as it denaturalizes today's hegemonic form of pain psychology, showing that the conditions of possibility for the experience and psychological treatment of pain are not as rigid as they may seem. I believe that a revisiting of these discourses has the potential to expand the imagination of contemporary chronic pain researchers in their goal of solving this wicked problem.

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