Suffering and salutogenesis

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SUMMARY
In considering pain and suffering, some considerations will appear about epistemological beliefs shaping the clinical practices of health-care workers. With this, we try to understand the usual omission of human suffering in the training of many health professionals. So, we emphasize the role of the pathogenic paradigm in how human suffering is viewed in health care. In contrast to those who see suffering only as pathogenic, we defend that suffering can be a source of significant learning for both the sufferer as well as those who undertake caring in certain circumstances. We therefore argue that it is necessary to educate for health and not only for illness, choosing a holistic paradigm: Aaron Antonovsky’s salutogenic model that encloses positive aspects of human suffering when it is lived with an internal sense of coherence.

Key words: suffering; pain; salutogenesis; internal sense of coherence

INTRODUCTION
This paper shows, on the one hand, the limits of biomedicine in understanding and caring for suffering and, on the other, it provides a theoretical frame in which suffering is presented as a potential positive source of learning. Antonovsky (Antonovsky, 1988) and Cassell (Cassell, 2004) are the main authors in this endeavour. The first created the term salutogenesis, focusing on the positive aspect of suffering and the second is considered the major authority on this subject in medicine.

Suffering is often identified with pain, even though the terms refer to different realities. Pain correlates always with a physiological dimension, but this does not occur always with suffering. Accordingly, we encounter both continuity and discontinuity between pain and suffering in the way people give meaning to their lives and that can be a very important step to train insightful and compassionate health-care persons (Le Breton, 2000).

PERCEPTION, EMOTIONS AND PAIN
In clinical practice, pain is usually identified, more or less consciously, by a bodily-physical (even a micro one) signal of damage. Pain is considered as a manifestation of physiological negative changes which can usually be diagnosed by the use of technology. On this view, pain implies physiological abnormality in the structure of an organ or in tissues. That is why many health professionals conclude that all real pain can be diagnosed at a physiological level. But sometimes this is impossible, and those who groan with pain are said to be mistaken (‘there is nothing wrong with you . . .’) or to be suffering from ‘psychological factors’ (Cassell, 2005).

This kind of diagnosis reveals a widely held belief in contemporary health care. In fact, we speak as if the psychological did not really exist: it is ‘just’ mental and, in other terms, the mind lacks any physiological basis. We articulate as if the living mind is not immersed in a body: this view comes from a mind–body split whose cultural roots, of course, can be traced back to Ancient Greece [Nevertheless, contemporary research shows that just as brains serve bodies, structures deriving from evolutionary and developmental events can transform (and be transformed by) body–world activity]. Cognition is distributed between neural structures, cultural
processes and how a body adapts to circumstances. Supporting this view, [...] neural imaging shows the brain to rely on simultaneous activity in many areas. Many international institutions are aware of problems caused by such beliefs about pain. In seeking to overcome them, the International Association for the Study of Pain (IASP) has redefined pain as ‘an experience associated with actual or potential tissue damage, or described in terms of such damage’ (IASP, 2010).

Nowadays, it is recognized that pain is a personal experience with a deeply subjective dimension, from which it follows that there is a need to assume the emotional experience of (in) pain. Once this is done, one can bring a subjective experience to the fore in a way that is generally not done in the biomedical world. The current IASP definition, however, also relates to clinical practice as described above. Recognition of the potential tissue damage marks the definition out while begging an important question. What is potential tissue damage?

That definition is based on a paradigm of linear biochemical mechanics, raising the issue of what happens if no tissue damage is found? Either the person is lying, or she is actually feeling pain. Well, if the cause is unknown, would it not wiser to admit our ignorance than using a setting that questions this perception? In reality, to label pain as ‘psychological’, ‘psychosomatic’ (or with related expressions) is alike to dismissing it as unreal. Where health professionals have this type of approach they can provoke suffering by making patients feel helpless, angry and misunderstood. Sometimes, they may even begin to wonder about their own mental sanity! ‘It is difficult to describe the effect of being told you are not really ill when you are. The disjuncture between private experience and public image is so severe; you can easily become obsessed with establishing the truth. [...]’ [(Munson, 2000), p. 32].

Within the same paradigm, we find related prejudice in describing physiological symptoms as ‘stress’. This happens because most health professionals are deficient in academic training about what it is (and it is not) reckoning as stress. They may use often the word ‘stress’ due to the difficulty in assuming that they do not know the origin of the problem (in a linear epistemological model, there must always be a single cause). Surely, people with signs of physiological pain are often under great stress; however, this may be more an effect then a cause. Frequently, the roots of pain/suffering are neither discovered nor hypothesized; in that context, to a certain extent, to some grieving persons is given a diagnosis that depends on an empty word (stress) (Evans and Finlay, 2001).

Whatever the causes of painful phenomena (often multiple), they exist in a body. More, in any organic metabolism, nervous, endocrine and the immunological systems (at least peripheral ones) are essential to experience, namely pain. The central nervous system is more robustly linked to what we consider as (observational) psychosocial factors. This is applied in spite of dealing with a single body, the healing of a fall, or in a bad dream during sleep. As yet, we do not know how to describe these processes, but reduce them to absurdity shows lack of respect to those seeking relief for pain. Definitely, it must never be forgotten that such processes stay behind the main reason for looking for care from health professionals.

**THE INNER WORLD OF SUFFERING**

The meaning of suffering varies from culture to culture. So, we can find different modes of considering it (Le Breton, 2000). In Oriental cultures, for instance, suffering is easier viewed as being closely integrated in life than in the West (think about Buddhism, for instance). Nevertheless, historically, West has also had many ways of considering and feeling suffering (Ariès, 1977). Even if we referred to a historical period like the current one, we can discover a variety of perspectives. We choose Eric Cassell’s definition because it is widely used and elucidates us of suffering experiences that are sometimes undervalued.

For him, suffering is ‘a state of severe distress associated with events that threaten the integrity (intactness) of a person. [...] Suffering requires consciousness of the self, involves the emotions, has effects on the person’s social relationships, and has an impact on the body’ [(Cassell, 2004), p. 32 and 224].

Though not strictly related to this topic, this definition suggests that many non-human animals do not suffer, but feel only emotions and pain. This matches with the Portuguese scientist Damásio’s (1999) distinction between feeling emotions and sentiments; he defends that the latter demands activity in brains that have phylogenetically developed the neo-cortex or, in a word, consciousness. In his view, we must not classify consciousness as an independent *substantia* as did Descartes.
Serious distress happens in what people recognize as an inner dimension, and is often associated with emotions such as anxiety, and feelings of sadness, frustration, impotence, etc. The fact that it is an inner experience makes it less easily noticeable to an observer, especially if this person does not possess detailed information about the suffering person.

Some people, of course, do not desire to see suffering in others even when it is expressed in evident and palpable ways. This kind of disrespect is both a humiliation of the other and a strategy of running away from something that one does not wish to look at. This may happen either because the other’s suffering might make one feel guilty, or it may be because it reminds one of one’s own inner grief which is being carried from meeting to meeting, perhaps even carried across medicated sleep. At other times, people keep away from others’ suffering because it is used as emotional manipulation such that their distress becomes a flag of victimization that induces blame.

The state of severe distress is defined as happening ‘inside’ the person and, so, accent the subjective dimension of suffering. The skin thus is a symbol, at the same time, of the barrier that separates us from the world and the boundary through which we bond with others. It gives us consciousness of a rich and complex bodily world that is not determined by the ‘environment’ but which, even so, has a syntax and/or a grammar shared with other members of Homo sapiens sapiens, although also making us unique. People who suffer usually complain about damage to internal organs such as the heart, head, etc. This may well, for instance, lead to complaints about constriction or ‘inner’ anguish. Still, even if ‘auxiliary’ diagnostic tests do not identify evidence of a local damage, health professionals should be cautious of concluding that suffering is a ‘psychological’ problem. The causal locus of massive internal distress can present external symptoms associated with the ill-esse, be it relational or physiological. Certainly, even in the case of bodily diseases, we blame our malaise into something that we think as external to us, as a virus or a bacterium. Whilst illness arises without direct association with contamination, we describe its origin as something that originated outside us.

Actually each body has its own way of producing meanings, which come up from the interpenetration of body and environment. The mode as people express the dissolution of a body reflects on something (considered) bad that affects a human being as bodily markers; this process surely influence fundamental organs (e.g. heart, liver, viscera). It is not sufficient to sense; organisms must also create purposeful interpretations of the myriad of sensory stimulations they are subject to. Doing so, they do not turn out to be isolated incoming impulses but are quite integrated into a form that the body understands and can act upon appropriately (Henry, 2002).

We know that an organ can have a negative effect only when incorporated in a body; further, it is accepted that this incorporation connects the body by the neural metabolism, the bloodstream, etc. Therefore, even if one considers only the physiological aspect, it is infrequently the case that organic malfunction can be traced to just an organ, cell or group of molecules. Considering all the extent of a human being, things are even more complex. Even as we may declare that the cause of suffering is external, we must neither confound this with the effect (pain), nor look for explanations by a single cause (Antonovsky, 1996).

As a result of being sick, we also face questions concerning the meaning of life and death, what we are doing here, and how we affect others. Are we in passage to another dimension of life or is this the last step in what preceded (Silva, 2012)? There is no way that such factors can be avoided from a sick person’s distress. Additionally, it is at once clear that these factors do not drop into tidy categories. Nonetheless, they echo through the lives of the sufferers: apprehension and powerlessness can thus be traced to a multiplicity of worries, sorrows, pain, impotence and frustrations. This can outline a sense of internal disintegration accompanied by visceral pains.

Suffering is regularly described as ‘consuming’ or by analogous metaphors. This may manifest itself as a crisis of physical identity or, in other cases, by sharp and sudden weight loss, for example. Certainly, suffering may communicate giving up the struggle with regard to a person who ceases to be aware of her (or his) self since a ‘self’ exists only while it moves itself toward an aboutness, as it is called (However, as Hoffmeyer notes, “this outward reference rests upon a corresponding inward reference […]” (Hoffmeyer, 2008), p. 6]).

Human beings can nevertheless live with suffering with no connection to any physiological disease. This is underpinned by social factors that include mourning ([Alves, 2012], pp. 795–818], vulnerability, rejection, torture (of any kind),
unemployment, disloyalty, isolation, living without shelter, memory loss and fear, among others. It happens, also, for instance, when we are in love with someone who discards us from his/her lives.

Given that suffering is subjective, people can live it without causing distress to others. For anyone who acts like caregiver, it is important to ask the person for whom they care about both their feelings and its context. As caregivers, we have to create empathy for that person’s crisis of identity. Certainly, the specificity of subjective human suffering is shown by the fact that it can happen on any level exactly because it is related to the whole person.

**CONSTRUCTING MEANING WITH SUFFERING**

Epistemological holism (Rorty, 1989) argues for a long time that a living organism is not just the sum of its components (e.g. organs), defending that the whole is greater than the sum of its parts. Thus, a person cannot just be considered an amount of organs, or even of its dimensions because components of organs are also vital to the constitution of the whole. In what concerns the knowledge of bodily parts, we have to recognize the value of the pathogen paradigm. This has been achieved by investigating how physical structures and how mechanics’ laws affect human beings. On this approach, as signalled above, suffering tends to be identified with pain. In other traditions, new evocative insights are brought to the same biological processes. These different understandings support a salutogenic paradigm where thought lies on tertiary prevention.

Aaron Antonovsky’s salutogenic research is founded on the idea that there is complexity in noise, studying women who had lived in subhuman conditions such as those who survived concentration camps 30 years before Antonovsky’s inquiry. Even though the unspeakable suffering they had beared, most viewed themselves as happy persons; this was reflected in their physiology since they had less diagnosed diseases (gynaecological, in particular) in contrast with women who did not go through so many problems (Antonovsky, 1988). He then concluded that health is not only absence of disease and that these women had learned how, in dealing with very difficult situations, to generate health or equilibrum across human dimensions, according to Alma Ata Conference.

Antonovsky’s research reveals that health associates external factors with a particular subject’s aptitude to solve problems and build solutions to the experience of suffering. This results from the use of natural, environmental, physical, biochemical, emotional, interpersonal, sociocultural and spiritual modes of resistance (GRR). They usually are considered as giving rise to a sense of comprehensibility, a sense of manageability and a sense of meaningfulness (Lindstrom and Eriksson, 2006).

These resources emerge from the interaction of our genetic propensity with our individual’s ontogenetic history. They lying on flexible and creative resources that come into play when the body’s equilibrum is at risk. They can be recognized in those who give an internal sense of coherence (SOC) to their lives; they assign inclusive meaning to existence and what they view as pertinent (even if negative) events. The story they articulate to themselves is considered a meaningful way of punctuating events that make them who they are today (Oliveira, 2013).

As a consequence they perceive themselves as unique and irreplaceable human beings. Generalized resistance resources can, in themselves, supply to an individual, group or population’s ‘internal sense of coherence’ (SOC). Whilst relating to each other there is no precise predictability in how efficiently each kind is used (Antonovsky, 1988).

An SOC develops over the lifetime and provides a basis for positive correlations between perceived health, mental health and quality
of life. Antonovsky therefore defends that any health professional should aim to promote a person’s SOC. It may thus be necessary to place people in new situations, counsel them on new relationships, activities and other associations while presenting how to deal differently with problems by giving meaning to their daily lives. That would, though, place new responsibility on health professionals. They would be required to understand the emotional ties that increase a person’s homeostatic mechanisms and, surely, the nature of their life-in-community, viz. the person’s homeostatic mechanisms and, surely, the degree to which incorporation of idiosyncrasies is possible (Eriksson and Lindstrom, 2008). In fact, affects and feelings enrolling others constitute our identities (or the perception of our identities) more effectively than a physiological disability, or a disease. Nevertheless, if health professionals set out to reduce human suffering (including medically diagnosed pathogenesis) they could also relieve the perception of losing the sense of self. Feeling the harmony with those we trust, love and respect, proportionates to those who are unwell a sense of fulfilment even in the smallest of life’s events.

Authors as different as Alasdair MacIntyre (MacIntyre, 1999) and Richard Rorty (Rorty, 1989), among others, emphasize that human solidarity can switch suffering into a source of continuous learning. Cassell [(Cassell, 2004), p. 38] remarks that situations which cause suffering may persist and yet acquire new meanings. Indeed, just such transcendence is the major cause of resistance to suffering: when people transform themselves by taking greater responsibility for the meaning of their lives. One also obtains considerable relief from suffering when feeling loved by loved ones.

Equally, sharing others’ suffering makes them suffer at levels of intensity not only in proportion with the depth of the relationship, but also in terms of how meaning is credited to the suffering. When looking for treatment from a health professional, a patient (or a suffering doctor) expects an analogous kind of behaviour for both him/herself and the family. If professionals are to encourage an SOC in their patients, or at least in suffering people who have no detectable disease, they must overcome an usual lack of academic prep for this aspect of professional practice (Oliveira, 2010).

Suffering arises both from pain and from a threatened person’s integrity; it lasts while the person does not feel whole. It arises when everyday experiences emphasize loss of meaning, sense of self and/or of others. Suffering can, however, be lived as experience that provides learning; it can provide us an inner wealth that helps to put up a sense of our world that restores lost or threatened integrity.

The framework of suffering can turn it understandable, even tolerable, separately of the degree of pain to which one is subject. Undeniably, the salutogenic strategy par excellence happens where/when noise disturbs order. When this happens, suffering can encourage us to look for life own meaning, providing an equilibrium beyond health. In some traditions, it can be called ‘wisdom’ or ‘sanctity’. Chronically ill/suffering persons can attain this aim only when they personally choose to frame their experiences in this way.

REFERENCES


