Frances Sommer Anderson

Active Pause June 2008

Frances Sommer Anderson, Ph. D., a psychologist and psychoanalyst in New York City, specializes in treating musculoskeletal pain and other mindbody disorders. She teaches psychotherapists, yoga teachers, physical therapists, and other bodyworkers about pain, trauma, and the patient-therapist relationship. Her teaching appointments include Faculty, *National Institute for the Psychotherapies Training Institute* and Clinical Assistant Professor of Psychiatry (part-time), NYU *Medical School*. She is Editor of *Bodies in Treatment: The Unspoken Dimension* (2007, The Analytic Press/Taylor & Francis Group) and Co-Editor with Lewis Aron, *Relational Perspectives on the Body* (1998, The Analytic Press).

Serge Prengel, LMHC is the editor the *Relational Implicit* project (http://relationalimplicit.com).

The following is a transcript of the original audio. Please note that this conversation was meant to be a spontaneous exchange. For better or worse, the transcript retains the unedited quality of the conversation.

Serge Prengel: One of the things I get from your work is that pain is not a simple concept; it's something pretty complicated.

Frances Anderson: Yes it is, and I think that's so important for anyone trying to help someone in pain. Pain, from what we have learned from the pain researchers in the past 50 years or so is, and this is something that Freud understood more than 100 years ago and contemporary pain researchers have pointed out, that pain is a complex subjective experience. It's a perceptual process that requires us to be conscious or aware. It involves sensations, usually sensations that come from the surface of the body and the internal organs, and it involves emotions because sensations that come from the external surface of the body pass through the limbic system, which is associated with an emotional reaction and emotional memories of sensations from the past. And it also involves the higher brain centers, the cortex, which is associated with thinking and evaluating and complicated belief systems about sensations. So, we have then, pain as a complex subjective experience that involves sensations, emotions, and thoughts.
S P: So you talk about a subjective part, so conceivably people could experience pain without an external input.

F A: Definitely. And, in fact, very fascinating research I think that underscores this is a lot of the research done by an outstanding psychologist, pain researcher Ronald Melzack and his colleagues, who have studied people born without limbs, and those people can actually experience sensations in the absent limb. So, this kind of research, including research on people who have severed spinal cords, who can still feel their sensations in their limbs, led Melzack and his colleagues to produce more research that shows that there is no one center in the brain that perceives pain…that actually pain is the result of a pattern of responses in different areas of the brain, in response to sensations that come from the outside, from the viscera, or even from our thoughts. An example of that is a session with a patient who came to me because of pain in his neck, and that pain was relieved through our talking work examining the emotional circumstances that surrounded the beginning of the pain, which was not due to a trauma…just he woke up one morning with pain in his neck and the

pain continued for several months…and he had it evaluated very carefully medically, and there was no medical or structural basis for the pain. And as a result of our work in understanding his emotions at the time that the sensations of pain developed, we were able to relieve his pain…and as we began to work on helping him deal with the emotional stressors in his life, there was a session in which we were talking about a complicated family relationship that he had had since he was a child, and as he was going into the details about a recent interaction with that person, his neck started to hurt. So that's a very dramatic example about how thinking and talking about a situation can evoke emotions that are associated with sensations in the past, and those sensations can come up in the form of pain.

S P: And that's the perfect example of the popular expression "a pain in the neck."

F A: Absolutely!

S P: So, this is something that maybe therapists can relate to in the sense of an example of a psychosomatic pain. But it's…for many of us, the idea of pain not being really directly related to some kind of an input, some kind of a stimulus, is difficult to follow.

F A: It is, because, as sophisticated as we have become medically, and in the area of psychosomatics and psychogenic mechanisms and body work, our Western medical system is still being plagued in a way…by the mind-body dualism and Descartes' model that led to the model of pain being one in which pain was associated with some physical injury or structural problem or disease, and it was assumed that there was a 1-to-1 correspondence between disease or structural problem and the experience of pain. And we've come to learn that that is not at all the case; it's far more complicated.

S P: So, what are the things that create, that contribute, to the experience of pain as it is constructed?

F A: Well, in the beginning of life, if we think about how we learn to call sensations "pain," how do we learn to call sensations "pain?" We learn that through our interactions with the primary care giving others around us when we are infants, and as we continue to grow physically and develop cognitively. The care giving others and the culture in which they live and we live give labels to sensations. Now, the care giving others can't see the sensation as pain. They can only see an infant or child's behavioral expressions in reaction to something: facial expressions, the sound of an infant's cry, the way the infant is moving around. So the mother or father, for example, they interpret behaviors of the infants to indicate that he or she is in pain, and they respond however they respond to that. So, you can begin to see how complicated this gets, because since we can't measure pain objectively in any way, the way we can measure blood pressure or temperature, we have to infer that someone is in pain. And for children, infants and children before there is language, we get those labels through interactions with people who are taking care of us. And then the culture shapes how much pain is acceptable to experience. There are gender influences, and I think we are still certainly being affected by the notion that one should be tough, and particularly if you're a guy, you shouldn't' show pain, and maybe women can tolerate pain more easily than men…there are a lot of stereotypes if you think about it. So there's a developmental process that underlies what we come to describe as "pain" for ourselves, for each of us…and that developmental process lays down the template for how we begin to interpret sensations from our body, and sensations that are caused, for example, when we have thoughts that evoke painful or unpleasant

emotions in reaction to those thoughts. So we have the developmental process, which is very important, and in treating someone who's in pain, it's…if at all possible, it's good to learn as much as we can within the framework of how we're offering care to that person. If we can learn about their early experiences of being soothed, of being cared for, did they have early experiences of being in acute pain or chronic pain? Because that can make a very big difference for coming to learn in terms of how pathways in the brain are actually affected. So if a child has been through very difficult medical illness that requires lots of injections and medical treatments, that's going to affect how they experience later circumstances, in which they might have to undergo similar procedures.

S P: Yeah, so you're talking about pathways in the brain…and so this is in contrast to the model in which there would be one pain center and the direct connection between the stimulus of physical pain, and then sensation of pain, and because of these pathways is where all of these different influences are manifested.

F A: Yes, there is no one pain center. There are multiple pathways in the central nervous system that become sensitized to certain kinds of stimuli coming in that are noxious, and then they tend to react more quickly in terms of labeling an experience as painful.

S P: Right, and the key word there is "labeling."

F A: Mm hmm, labeling.

S P: Yeah.

F A: And then, so we have those early experiences, developmental experiences, of having experienced pain. Also, in that developmental process, if a young person has been in the presence of someone in acute pain or chronic pain or some kind of medical illness or disability, that can also…it in effect lays down certain memories of how easily another person's pain can be relieved or not. And that comes also to affect what their sets of expectations are. This is where the thoughts and beliefs, the cognitions, become important, and past experience leads one to expect that they will be relieved or not. So, on the topic of the component of developmental processes…we've identified those influences, and then other factors that affect our experience of pain in the present are certainly the nature of our current living situation, how much stress we're under, that can affect how much pain or how much unpleasant sensation we can tolerate. And, then another area that has become of great interest recently, particularly in treating soldiers who are involved in the war in Iraq…there's been an increase of funding for the study of acute traumatic pain, which is a very positive direction for research funding these days. And what they've come to understand is that if one is acutely injured, the sooner treatment can be given in terms of a massive shutdown of signals from the injured site, a massive shutdown of the signals interfering with the signals going into the brain can actually prevent a chronic pain problem from developing. So, as soon as a soldier or anyone is subjected to serious physical injury, the sooner anesthesia can be given to block those signals to the central nervous system of the brain the better, because very massive stimulation, noxious stimulation, to the brain, destabilizes the entire brain's operating system, so to speak. And it can, if the pain goes on, the acute pain goes on, for a long period of time, it can be very difficult to recover. And one way that this research is being used in planned surgical interventions, when someone is going to have surgery, really of any kind, but there are certain surgeries like lung surgery, and certain orthopedic procedures that are bound to produce lots of pain, the pain control anesthesiologist will often give an epidural before the surgery, several hours before the surgery, to

shut down pain signals to the brain so that while the person is under general anesthesia, the actual pain that could be going to the brain, even though one is under anesthesia, those pain signals will be prevented from going to the brain. And that produces a better post-operative recovery and reduces the chances that a chronic pain situation will develop.

S P: So there's a lot in what you're saying, and I want to just try and ask a couple of questions about that. #1 is that if you have an extreme experience of pain that's lasting, that creates an imbalance in the nervous system and a stronger chance of experiencing chronic pain, and #2 that there is a difference between general anesthesia and the epidural because the epidural blocks the sensation of pain from coming to the brain, whereas general anesthesia doesn't.

F A: It doesn't. Yes.

S P: And, so that would explain that people under anesthesia may not have the experience of pain because they were asleep, but that they would experience later traumatic effects.

F A: Yes. And this is where the phrase we're now using "the body remembers"…the body, the brain's central nervous system, remembers, even though the person has been under general anesthesia, unless they've had an epidural, and the epidural goes into, you know, the spinal cord, and actually blocks signals below the epidural…the level of the epidural blocks those signals to the brain.

S P: Yeah, so that certainly changes a lot of just the regular conception of pain as something that has a simple mechanism.

F A: Mm hmm, and that's-- could I just say one thing about that?

S P: Yeah.

F A: That's a very useful thing to remember in case anyone you know is going to have a surgical procedure…to ask about the pain control that's going to be used. And up until recently, because of all this new research, people didn't think about it very much, and so I, in treating anyone I see…people who come to me not because of pain or whatever, if they're going to have a surgical procedure or someone they know is going to have a surgical procedure, I believe very much in that kind of psycho-educational piece about pain, so that they can be proactive in their medical care. And then if we have a patient or client who has had a surgery in the past, or a recent surgery, and they're coming to us because of some pain concern, it may in fact have something to do with those procedures. So this is another reason to try to find a way to ask about people's past experience with pain, including surgical procedures, so that we begin to have a sense of some of the forces that might be at work in affecting how they experience their body now, particularly when it comes to pain.

S P: Mm hmm. So you know your statement in the last sentence was how they're experiencing their body in reference to pain. So what happens during sessions when you deal with patients who bring up pain, either strong, acute pain or chronic pain…could you give us some examples?

F A: If a patient is coming to me because of chronic pain, it would be because they've been referred to me by a physician. And that physician will have some point of view about the source, the etiology

of the person's pain. I have done a lot of work since 1979 with Dr. John Sarno, and I know you know about Dr. Sarno, and many of you listening may have heard about it. Dr. Sarno is a physiatrist at Rusk Institute NYU Medical Center, and he very much believes in the powerful effects of emotional stress in actually generating a pain experience, and certainly maintaining it even after some initial injury is long past. So, many of the patients come to me having seen Dr. Sarno and been educated by him, first examined, but then educated by him about the anatomy and physiology of pain and the role that emotions play. So we're working with a theory, i.e. a diagnosis, about the source of their pain, so we, the patient and I, in a talking frame, start to examine, identify, what emotional factors are at work in their psychological/pain situation. So someone comes in for an initial consultation, and I ask for a brief history of their physical pain and what interventions they've had, and then we begin together to…I ask: what was happening in your emotional life, in the year or so before your pain developed? And then I ask very particular questions about the exact circumstances in which the pain started. Sometimes it's a gradual onset, and then reaches a level that's pretty intolerable, sometimes it's a sudden onset…someone will wake up one morning with a pain in their back, or their shoulder, or their neck, as in the example of the person I mentioned earlier—the pain in the neck, and of course we have been conditioned to check to see what we've done. Did we sleep in a funny position? Did we overexert ourselves physically? Did we bend the wrong way? Did we work out too hard at the gym? Those kinds of things naturally come to mind because that's what we've learned in our culture. So if this patient is coming from Dr. Sarno, he's already talked with them about that, and we start to instead ask: well, what was happening the day before, the night before you woke up the next morning and your neck was hurting? And so once the person is able to start to tune into what was going on in their emotional life, how they were feeling, that can open up a very different way of working with their pain…so that we're not-- I'm not, for example doing pain management with that person. I'm not doing relaxation exercises or hypnosis; we're trying to help them begin to experience their emotions that most likely they were dissociated from. And so that's how I begin to work with someone who comes with a diagnosis from Dr. Sarno. I do see other people who have pain conditions; I always talk with their physician first to see what the understanding is. Sometimes I do pain management because there are certain conditions that are associated, like peripheral neuropathy, either congenital or secondary to a condition like diabetes that can produce severe, almost intolerable pain in the feet and legs and hands. And in those situations I would use some kind of imagery, educate the person about certain breathing techniques, to help them slow down their reaction to the sensations they're having. And that's where the-- referring back to the beginning of our discussion today, when I said pain is a complex subjective experience, and it involves sensations, emotions, and thoughts and beliefs…for someone with, for example, peripheral neuropathy, we would be acknowledging their sensations that are painful, and we would be trying to help them with their reactions to the sensations, their emotional reactions-- devastated, overwhelmed, for example-- and their thoughts and beliefs. Their thoughts and beliefs may be "I can't get any better." I've heard horror stories about how people with peripheral neuropathy feel "I'll never get any better," so that's a blend of a belief "I can't get better from this pain because of things that I've been told," and "those things that I've been told make me feel overwhelmed, and so what's the use?" which will then only reinforce more pain because the more we react negatively to the pain or the more reactive we are to it in a panicky, anxious way, actually the more intense it can be…become. So that's the situation in which I would use pain management.

S P: Yeah. And so, in a way, when you were saying that pain is complicated, there's bad news and good news. Bad news is it's complicated, but the good news is because it's complicated, you actually have more ways to find places where there's a grip to act on it.

F A: Mm hmm, and certainly, body work can be one of those interventions. Because I was trained at Rusk and was on the staff at Rusk Institute for 13 years, I was so fortunate to learn about an interdisciplinary approach to any kind of physical disability. And so I really value what people from different disciplines can offer a person who's in a complicated situation when it comes to pain.

S P: Mm hmm. And the other part, what you were saying earlier about people who came from say, Dr. Sarno, is that you know by having seen Dr. Sarno, they already were buying into the idea of the pain coming from an emotional cause, so that they were willing and ready to have that shift of what to pay attention to.

F A: Mm hmm. Yes. And I've told Dr. Sarno that-- who believes in psychoanalysis and a psychodynamic approach—I've said: Dr. Sarno, when you make your diagnosis of tension myoneural syndrome, or tension myositis syndrome, that's what it used to be called, that's the medical diagnosis. I said: what you're doing is giving a psychoanalytic interpretation; you're linking the mind and the body. And so then once that link is offered to the patient, you know, sometimes they're relieved, sometimes they're resistant but willing to explore. Once that link is made, it's easier to begin to explore the emotions that are-- have contributed to the pain. And, by the way, this is not to say that the sensations that they are experiencing are not real. Psychosomatic, psychogenic, to use those terms, they are often to the patient's ears meaning that "my pain isn't real; it's all in my head." Well that's not what it means at all; the pain is very real. But what is causing the pain is not necessarily a structural problem in the knee, or the foot, or the back, it's this complicated perceptual process that we've been talking about today, that involves sensations plus emotions plus cognitions, the way we evaluate and what we've come to believe about what causes pain.

S P: Well that feels very powerful, that sense of different understanding of where the pain comes from, giving a possibility of action instead of that feeling of powerlessness in front of the expression of pain.

F A: Mm hmm.

S P: And I wanted to check with you if this would be a good place to stop our interview, if there's something that you might want to add, or should we leave it here.

F A: Well, I would like to add that I developed my own pain symptom and during the time that I…about 5 yrs after I began working with Dr. Sarno's patients. And so I find that that has really helped me be a more effective clinician in working with people with pain. And my experience of trying to understand and recover from my own pain "syndrome," we could call it, has been so powerful, it's influenced my professional life. It's led me to look in professional literature and body workers I've gone to, and I actually was moved so much by it that I wrote a chapter for the book that I edited that was published last year, "Bodies in Treatment: The Unspoken Dimension." I write about my own discoveries, and my own long journey in understanding the origins of my own pain symptom. And that might be helpful to people. I'm certainly hoping it's helpful, to professionals and to people in pain who might read it. That book is written for a professional audience, and it is an effort on my part to bring an interdisciplinary focus to psychoanalytic treatment, in terms of bringing in practitioners who do body work, and how body work approaches can be useful in the talking frame. Adjunctively, very often, because of New York State, people who work in the talking

frame are not licensed to touch patients. So we have to find some way and ways to kind of integrate body work and the talking frame. So I think that might be of interest to those listening.

This conversation was transcribed by Laura Shapiro.

© 2008. All rights reserved. *Active Pause* and its web address (activepause.com) should be properly cited when these contents are used in any form.