The different suffering modalities, from Paul Ricoeur's text «Suffering is not the pain.» and its relevance in the non-conventional therapies.

Abstract

From the lecture of Paul Ricoeur's text «Suffering is not the pain. », we intend to show how a therapist of non-conventional therapies can do a better work by being aware that the person (patient) that requires his services is someone who can suffer and endure suffering.

Having this human characteristic in mind, the therapist, through his work, can intervene in a more conscientious way in the reconstruction of the narrative identity of the person. Not only that, but also to obtain the person self-esteem, that is often affected in a disease, pain or suffering situation. That sometimes passes by making the person responsible in the control of the complaints, when possible.

We also want to show how sometimes experiencing pain during this kind of treatment is often the key to release the pain or suffering caused by the disease that harms the person.

Key-Words: Ricoeur, pain, suffering, non-conventional therapies, disease, narrative identity, self-esteem.

Text

Reflecting on some ideas present in Paul Ricoeur's text, «suffering is not the pain.» (Ricoeur 1992), in the communication delivered at a psychiatric colloquium in Brest, our purpose here is to show how his thought can bring some light, not only to the clinic in general but specially to the practice of the non-conventional therapies.

Ricoeur's purpose in this presentation is to think «the most common and universal human experience of suffering. In addition, my contribution is not intended to guide the therapeutic act, but only to clarify our understanding of the human, while being able to suffer and endure suffering» (Ricoeur 1992). This suffering, which «raises the proper structure of medical ethics» (Ricoeur 1996).

The goal of our doctoral thesis is to find, philosophically, the *care* in the therapeutic encounter, based on Paul Ricoeur's philosophy and his fragility or fallibility notion. This notion was forgotten by all modernity and gave origin to a scientific medicine that forgot the care with suffering.

In our view, all kind of therapy helps the patient, and the therapist, in the formation of its own identity. Thinking the therapy as a practice of care implicates helping the patient fighting with his disease. The care search to ease the body's suffering in its material and contingent aspects and it requires empathy to be exercised.

In the Greek world, care had a "psychological meaning given that it designated the concern and the restlessness related with the body and its needs" (Lefèvre 2006). By the time of Christianity, suffering was seen as in the image of Christ suffering, therefore, as something that redeems from sin. In this conception there is a valorisation of the positive meaning of suffering, as salvation. With the advance of modern science we find in the XIX century a purely scientific medicine. This kind of practice loses interest in the suffering body and therefore on the act of taking care. The experimental medicine and anatomo-clinic objectify the disease and pain of the patient, making use of the organic causes of the disease.

Beside that, the scientific and social prestige of the doctor, as well as the functions hierarchy in the hospital between the medical team and the caregivers, lead to the

disinterest of the doctor on the living experience of the patient, leaving this kind of care to the nursing team.

Ricoeur begins to show in his presentation that there is some confusion in the use of the terms pain and suffering, with which he does not identify. This confusion happens mostly because of the Cartesian dichotomy body/soul that influenced, as we know, medicine until not so far ago. Thus Ricoeur's text helps us to understand the disease not only as something objective, but as a "global suffering", physical, mental, social and spiritual pain.

Nowadays even in molecular biology investigation pain is understood differently from the Cartesian dualism, as Jorge Tavares said in his article *The lesion that gives pain and the pain with no lesion:"* pain is not only or it is not always a pathological event. It is also a way of a normal relationship between the person and her environment, of the awareness of one's corporality or experience of finiteness. The small number of people which don't have pain since birth present a low life hope and rarely get to the adult age.» (Tavares 2001)

In 1943, G. Canguilhem, reminds us in his «Essais sur quelques problems concernant le normal et le pathologique.» that medicine rises precisely from the call of the patient and the attention given to his suffering. The care of the person who suffers is the medicine's reason for existing. Canguilhem distinguish the fact of being sick from having a disease, but he is not restricted to this. (Lefèvre, 2006) The clinic for Canguilhem consists of finding the subjective experience of the disease, through the exam of the patient and his words. Therefore, it goes beyond the scientific investigation.

The clinical work, namely, departs from a translation of the lived own-body experience, that is sick, to get to the medical language of the objective-body. To do so the doctor has to take into consideration the patient's point of view. Clinic is not separated from therapeutic in this author's point of view that want's to recover the Greek medicine function of taking care, against the reduction of medicine to pure science.

Today this clinical work takes the person and places her into the centre of clinical medicine as a sufferer subject that participates with the doctor in the treatment. The philosophy of care renewed by the emergence of the patient as a person has to reflect on the juridical, politic and social implications of the wild individualism that we live in. (Lefèvre 2006)

Since the 80's of the XXth century we observe the development of a preventive medicine and a regular medicalization of daily life. Chronical diseases, increase of the average life, hope and the discovery of the essential vulnerability of human condition were the great motive of the attention given to the *care*.

Viktor von Waisäcker had already showed in the first half of de XIXth century, that disease is an event, it is a part of one's own biography whose continuity comes to disturb the person and whose major characteristics are: the feeling of a contradicted life, the loss of usual references, deep isolation, dependency of the care of others, fear of death and a change in the intimated conscience of time (Benaroyo et al. 2010). For V. Waisäcker clinical activity can be conceived as a solicitude and responsibility task. The patient context is important to the therapist since he should have into consideration the patient's speech that narrates the suffering caused by the disease that affects him. It is the pain, the suffering that makes the person come out of it-self finding the other through the word, through the outburst, so he can come back to it-self and reconfigure his own sense. Doing this the patient can overcome pain and suffering. On the caregiver side, pain calls him to the life hardness, makes him get out of his selfishness, helping to understand and feel compassion to the other's suffering. In this conception, one's itself has the possibility to overcome pain and increase the ability of donation to the other.

Modern reflection divided man between sensibility and understanding. Philosophical meditation about finitude can only begin according to Ricoeur's when proper body and its language is considered. It is in the relationship with my body that I become aware of my finitude. However, at first, my body is not thematic, it appears as an opening to the world, it is the «original mediator between myself and the world» (Ricoeur 1991). The body is not only a vehicle of existence in the world, it is an intrinsic part of that

existence, it is pain, it i's the possibility to give to feel and to be able to feel the other. The body alerts us to our passivity and grants us the possibility of 'talking', either verbal or bodily. The big question is that it is the human being is simple in its animal nature and double in its humanity, it is fragile, it is more than a body and soul, it is disproportion and ulterior. Because if the body limits us, confining us to a space and time: it also limits us by physical pain, by disease. And it's still a reflection of our emotions. The bad experience that leads the patient to therapy shows up in suffering and are of the testimony order (Ricoeur, 1968). Well, this testimony needs attention and interpretation of the signs.

In the therapeutic encounter attention to language is fundamental, so the long path to access the human being is important in our investigation due to the hermeneutic character of the care of therapies that we practice. The person's narrative is often embodied in the lament language in the therapeutic context. People with the ability to do it often show even if they do not have the conscience of it, that the disease is exacerbated by the narrative of a suspended life. When this narrative is not well understood it can affect even more the patient health condition and exasperate his lament narrative. «It's true: suffering demands narrative. » (Porée, 2012)

However it also requires comprehension in the link between lived time and narrative. Ricoeur has dedicated himself to this task in his *Time and Narrative* work. Narrative appeals to the other and integrates the personal living in the collective living. It also helps the person to understand herself in the construction of her own narrative identity.

> *«Narrative identity emerges as the result of a well examined life, witch narrative clarifies through the cultural effects and the works that make it happen. Psychotherapies show, on the other hand, how life stories are corrected by the successive narratives that are made about them that a subject, or a people, can ultimately recognise themselves in the stories that were told about them. Therefore there is circularity between the various narratives of identity and the posterior reception of those texts. This circle of mimesis is not, however, vicious. On the contrary, it is virtuous. That is why narrative can keep time and identities narrated, but always in a different way.» (Leão 2016)*

The incapacity of making sense on the "itself" identity, through narrative, due to the disease situation, opens to the philosophical reflection about suffering. The person's fragility and vulnerability thus require a kind of care and attention from the therapist in a way that the patient can recover his health and narrative capacity, but also for his ipseity.

In the therapeutic encounter, no matter it's nature, there's always a fragility and a vulnerability that are aggravated by the suffering, physical and/or moral, that seek to be restored and mediated through the other that welcomes and guides the «himself». This orientation occurs inside his own kind of work by restoring the patient health, its narrative reconfiguration, and consequent enrichment the patient's ipseity.

A therapist is a caregiver and because of that he should be aware of the fallibility structure of the other when he listens to the lament, the complaint and suffering of the other that in this case is in a disease situation. Especially since, in our view, if men is not a coincidence with himself, if he is fragile, a mixture as Ricoeur tells us, a divided being, a disproportion and capable of fail, in a situation of illness these characteristics are more exacerbated. Here stands the value of care and the importance of a narrative approach, where we can think therapy as a way of enable human capacities. In this case, the therapist will have its work made easier because he has in consideration the fallibility as a condition and the true centre of men disproportion.

These therapies are distinguished by their refusal of the mechanical and anonymous model of care application; they are a form of care that we can also understand resorting to the ethics of care that have developed in the United States and Europe in the last years.

> *«The ethic of care supposes an anthropology of vulnerability, an ontology or one world, taking into account the dignity of dependency and a philosophy of caring.»* (Brugére 2011)

The ethics of care, which were developed by the feminism way, pay less attention to vulnerability in itself and more attention to the implications of the relations with others. It's a relation ethic: «Being vulnerable means having need of others, more precisely of the care of others.» (Satereau, 2015) With Ricoeur we can think of a new

vision of vulnerability, different from the one that sees vulnerability as a condition of the most weak. Thinking man as a *capable being*, agent and sufferer, he allows us to think vulnerability as something proper from the human condition. When the capacity of the capable man is harmed or somehow diminished he becomes a sufferer. Human capacity is not granted. «The capable man is one where the power to act can be prevented.» (Satereau, 2015)

Man's fragility is therefore a call to autonomy, it is by the contingency imposed by vulnerability that man becomes autonomous. This impotence/powerlessness to act can be intrinsic to the person or can be imposed by social instances that deprive people of becoming autonomous.

We can attest vulnerability, according to Ricoeur text «Suffering is not the pain.», because of two axis: the act-suffer axis that is related to the power to act in the relation with itself and in the relation with the other; and the itself-other axis and its relational dimension. In contrast, when one's have full confidence in his ability there is a capacity to act and in that acting one is able to attest it-self: «believing that I can is already being able of doing.» (Satereau, 2015)

The self-esteem according to Ricoeur, depends on the relation with others and this relation is also a source of vulnerability. It appeals to our responsibility with ourselves and to others. The esteem of itself is to our author «the ethical limit of human acting.» (Ricoeur, 1992) Once again, we can't forget how the disease affects the patient's identity, so it becomes necessary to understand the narrative records from which the patient expresses his suffering: «the caregiver should be listening to what, through narratation, makes the patient suffering unique.» (Satereau, 2015) Suffering, with all that comes with it, can affect and transform one's narrative, culminating in a loss of meaning and self-esteem. Therefore it is necessary to help the patient, for therapeutic success, to create a «therapeutic intrigue that convinces (the patient) that the medical treatment proposed to him is an integral part of the care that is given to him.» (Ricoeur, 1992) Thus relieving his suffering. This loss of meaning and self-esteem can occupy the self-relation «the tendency towards a lack of self-esteem, to culpability.» (Ricoeur, 1992) and Ricoeur gives examples of the loss of a loved one, mistaking guilt

with suffering. Another situation where Ricoeur shows us the loss of self-esteem is the one felt by the person in suffering: «as a robbery or a violation by the other» (Ricoeur, 1992), with the consequent tendency towards victimization.

Returning now to the two axis where our author distributes «the suffering phenomena»: the axis of the relationship between each other, in which I quote «suffering happens at the same time as an alteration of the relation to itself and the relation to others» (Ricoeur, 1992) and the axis of the relation act-suffer where «suffering consists in the diminution of the capacity to act» (Ricoeur, 1992), registered by the word. It seems to us, with this explication of the different axis of suffering, that Ricoeur intends to show to the caregivers the lines and the structure that they should be aware of when they are in a therapeutic encounter with a suffering person, regardless of their form of action.

In the first axis, Ricoeur identifies several negative levels of how the relation can be affected and resumes it in a word: separation. From the lowest to the higher level we find: first, the living experience of each «sufferer is unique» (Ricoeur, 1992); the second level is the incommunicability level, the incomprehension and incapacity of others to help me that generates «a loneliness of suffering» (Ricoeur, 1992); the third level appears through the hand of «the enemy that makes one's suffer through insults or slander» (Ricoeur 1992); the fourth and more intense level caused by the «imagined feeling of being elected by suffering» (Ricoeur 1992) from which raises the question "why me?" (hell of suffering), besides the self-inflicted suffering, of which we have already spoken in the subject of self-esteem.

As for the second axis, to act-suffer, Ricoeur registers «four levels of efficiency» (Ricoeur 1992), which return «to the previous paradox of the intensified self and the separated self from the other» (Ricoeur 1992), crossing and demanding each other. Our philosopher makes a parallel in the reading made in *Soi même comme un autre* about the word, the acting, the narrative and the moral imputation with the suffering and its «wounds that affect alternatively the power to say (complaint), to be able to do (to act in the passivity of suffering), be able to narrate oneself where inter-narrative is interrupted and to be able to esteem oneself as a moral agent» (Ricoeur 1992).

We note, with this presentation, the applicability of Ricoeur's thought to real life, to the daily situations. In this particular case Ricoeur proposes a phenomenological approach of the malaise to the physical disease. It is the suffering, as we already seen, the reason of being of the therapeutically relation that is established.

Knowing this type of philosophy the Non-Conventional therapist can act more consciously, helping the reconstruction of the narrative identity of the patient restoring the esteem of itself, by applying techniques that are proper to his area. This is achieved, not only by relieving the patient's complaints, but also by making the patient responsible for controlling the emergence or resurgence of complaints since it is frequent that some patients do not take responsibility for their own actions that contribute to the disease situation, and they don't assume by some reason, that they have to change their behaviour in order to improve their health condition.

Sometimes in our professional practice, we see a painful experience during the patient treatment that can generate suffering. This kind of pain can be the key to the liberation of that pain/suffering caused by the pathology/complaint that takes the person to seek help. In our daily life as therapists it is common to see the different reactions when we apply several treatment techniques. From the astonishment in the patient face during the painless needle application, with some exceptions, to the surprising answer to the question "Am I hurting you too much?", because the pressure of the TuiNa massage is, in most cases, painful, the answer is: "it's a good pain", or "it is a pain that feels good", "it is a pain that relieves" or even "do what you have to do, I just want to get better". The pain dissipates and transforms into a sense of a well-being as health is recovered along the treatments. Of course, there is also people that can't take this kind of pain in the same way, which can reveal a lot from the physical and emotional condition of that person.

These comments, made most of the time from people that are not aware of the kind of reflexion that we are making in our investigation, leads us to think in the presence of a certain resistance to suffering, as a statement of the desire for getting better, even though in pain. It seems that the person has an internal and innate notion that bearing a momentary pain can lead her to fight the disease that affects her. Suffering is a full

existence experience and an experience of the unbearable (Ricoeur 1992), but not always an experience of destruction. Suffering can be an occasion for self-reconstruction and even in the passivity and incapacity that affects the sick person, it can show some resistant forms of suffering that bring improvements and minimize the possible weakening of the person by the repeated suffering or pain. The work of a therapist or caregiver is to help in that path, making use of the techniques that he has to help the vulnerable person. However, we want to clearly state that, such as Ricoeur, although «built suffering in a sacrifice that is considered worthy» (Ricoeur 1992) can be adopted by some people, «it's not a way we can teach» (Ricoeur 1992), nor even promote in the case of this kind of therapies. We just observe that this kind of reaction happens with most of the people that search for this kind of technique.

To Ricoeur it is implicit a "hermeneutic understanding of suffering" in care services. Therefore the importance of attention to the language of the subjective suffering, where the subject is an agent and the sufferer and his action can be conditioned, and his narrative identity reconfigured according to the improvements that he achieves also influencing his relation with itself and with others, at the personal, professional and social level.
Thus that hermeneutic should be in the base of medical or therapeutically ethics.

In the resolution of acute pain, which usually results from a tissue injury, accompanied by some anxiety that disappears as the person gets better. When this pain does not respond to the treatment, one might fall into a chronic pain where the initial anxiety caused by acute pain, can give place to suffering, depression, despair, inability to act, a decrease in the capacity to act on intimacy, on small day to day tasks and even incapacity to work. There are even studies that point to the fact that some people who "gain" from chronical pain might become difficult to treat if they are parted from their work for too much time. Indeed, in some cases the social and professional isolation of the sick person should be avoided (Cantista 2001).

Suffering can lead, with its decrease or banishment, to readjustments of our habits, our life style, so we can live healthier. There is always something positive that you can

learn. Redefining our limits by regaining total or partial health, can reconfigure our self-esteem. There is hope in suffering.

To quote Ricoeur, «the first sense of suffering, namely, to endure, that is, to preserve in the desire to be and in the effort to exist despite... Is this 'though' that delineates the last frontier between pain and suffering, even when they dwell in the same body» (Ricoeur 1992)

As therapists affected and challenged by the suffering of the "other" and by their demand for meaning, (Ricoeur 1992) we can only say that we reconfigure ourselves daily in our own narrative through the pain or suffering of the other, making it somehow our own. Sometimes it decreases or raises our own suffering. However, we stand attentive to listening to the suffering of others, recognizing the value of the care to give to the vulnerable person due to suffering or pain. Even without being able to answer to the question that Ricoeur leaves us with: «by what reason exists what should not be?» (Ricoeur 1992). Although we are not able to answer that question we do our best trying to minimize the pain and suffering.

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