Medicine of the Person
64th International Meeting
25th- 28th July 2012
F – SANCEY-LE-LONG

Dr Frederic von ORELLI (CH)
27/07/2012
Translation: Gerda Mathiessen-Garbers

Pain – a technical problem ?

Introduction

I would like to share something with you of my encounters with patients who suffer chronic pain, and thereby also to impart some reflections on pain and the experience of pain. What is there in any case for pain? What are the technical possibilities and where do we come up against technical limitations? What does constant pain signify in the life of a person? How can I influence my patients' experience of pain? And finally: How does the Medicine of the Person bear specifically on my work with chronic pain patients?

I recently witnessed the fact that my attitude and inner state have a direct influence on the effectiveness of my technique from one of my chronic pain patients. I've been seeing the 55 year old lady for quite some time almost every month because of various pains in her stomach following several operations, in her back due to a narrowed spinal canal, and in her neck due to arthrosis. Once she explained to me that the treatment had had a very ill effect on the last occasion. She had only experienced a very slight and brief alleviation of the pain and the injections had hurt more than usual. Because of another patient, I was effectively under time pressure and had to catch the train afterwards. I thought: the patient is coming as always because of her familiar pains, she will receive her injections and then she will be freer of pain for another month. After all, there is not much to discuss in such a case. Hence, I treated her as usual with the injections. But even if it was technically exactly the same as usual, yet in thought I was already on the train. I had not told the patient this; however, she sensed that I had no time and reacted to this in her body.

I want to show you by looking at a special patient how technique and inner development complement each other. Walter will accompany us throughout the whole lecture.

A strong, at that time 65 year old, likeable man of 190 cm height came to me six years ago, totally frustrated on account of his extremely painful yet desensitised feet. Six years earlier, on one of his beloved mountain walks, he had broken his femoral neck through a fall and had to be operated

on. The operation was due to be conducted in spinal anesthesia. During an incision into the back, something must have happened that caused the patient to experience extreme pain, so that ultimately a general anesthetic was necessary. Then came a rude awakening: not only did Walter have a loud whistling noise in his ears, but he could no longer feel his feet, and yet he felt them as if jammed in a vice. Neither the tinnitus nor the harrowing pains in his feet could be explained by the operation or the anesthesia. Subsequently, he could only walk with extreme pains and the tinnitus nearly drove him mad.

After three years of fruitless therapies he went one evening into the woodshed, wanting to amputate his feet with the chainsaw – so frustrated was he on account of the doctors' inability to help. To this day he cannot recall why he put down the saw again without cutting off his feet.

By way of his example, I want to give you firstly a closer understanding of the different types of pain, so that we know what we are talking about and how realistically the treatment options must be evaluated.

Pain components

How does pain arise and of what components can it be assembled? A mental image of four components of pain helped me a great deal to get into conversation with the patients and lead them towards a somewhat broader understanding of their pains. This model of the four components of pain does not of course claim to explain everything; but it does away with the still widespread belief that, besides physical and emotional pain, there is nothing else.

- ***Nociceptive component***

The first of the four components is the nociceptive component. When a pain-sensitive tissue or organ is injured, electrical impulses arise in the nociceptors, sensitive corpuscles on the nerve endings. These leap along the nerves by way of switch-points in the spinal cord/medulla, into the cerebral cortex and into the limbic system. Firstly, there arises the sensation of pain *per se*, in terms of the localisation, the nature of the pain and association with something familiar. Hence is triggered the reaction: moving away, lying still, or staunching the blood. The limbic system generates the corresponding feelings of shock, fear or strength to overcome. We are all familiar with this. In Walter's case, when he fell with the broken femoral neck, the pain was primarily nociceptive. The typical nociceptive pain process tells the brain very clearly what is happening and is intended to protect people from further structural harm. The classical treatment with pain killers right up to and including morphine is usually effective here. As an experienced mountain climber and a mountain rescue worker this seemed nothing particularly dramatic to Walter.

- ***Neuropathic component***

The second component in the quartet concerns the damage to the transmitters, that is, the nerves. Every injury or infection leads also more or less to nerve damage, whether in the periphery or in the central nervous system, that is, the spinal cord or the brain. The pains from such injuries have characteristics quite different from the nociceptive ones. They are falsely projected in the

brain onto the spot that is *supplied* by the fibres in question. For example, we perceive an injury of the sciatic nerve, which usually arises through a slipped disk in the bottommost part of the spinal column, as a pain in the leg reaching down into the toes, although these are not even damaged. Nor does the nature of the pain correspond to what is happening in the spinal column, i.e. the pressure on a tissue; rather it is comparable to a burning knife that stabs all the way from the back down to the feet.

Patients have similar experiences of so-called neuropathic pains with trigeminal neuralgia or following shingles. In Walter's case, such a pain arose at the moment of the spinal anaesthesia, as the needle obviously damaged nerve fibres in the spinal canal. He experienced severe pains in his back and legs. As you may be aware, neuropathic pains respond only poorly to standard pain-killers, not even morphine. They can be alleviated with antidepressants or epilepsy medications. It is more important of course to eliminate the cause of, for example, a slipped disk, a neuroma, or a compression of the wrist in carpal tunnel syndrome.

Here, the pain-therapeutic technique or neurosurgery is occasionally also required. So one can dull the sensitive filaments of a nerve fibre with pulsed radio frequencies, or completely destroy it with cold or heat. These are therefore somewhat crude measures. In extreme cases, the pain stimulus can be drowned out by means of an electrical stimulation on the spinal cord, the so-called dorsal column stimulation, so that only an easily bearable “humming” is perceived. The stimulator, similar in size to a pace maker, is installed beneath the skin and has to be replaced every few years, according to load. In the case of pains that respond to morphine, there is another possibility: the installation of a pump that releases dosed morphine into the spinal canal and in this way achieves alleviation.

Thus far the first two mechanisms that can lead to pain. They affect the structure of the body and stem from visible injuries or infections of the tissue. We may therefore define them, through analogy with computer technology as “hardware disturbances”. Generally, they also have to be treated with technical measures (surgery, medications, physiotherapy or pain-technical procedures, as mentioned above, or at least cortisone injections in the place of injury). It is therefore important to look for them carefully and to distinguish between them.

- ***Autonomous component***

So what other kinds of mechanisms are there? As we all know, many people suffer from pains that cannot be explained through the physical symptoms. Here, we must be dealing with pains that are not caused purely by tissue damage or wear and tear, yet in part they burden patients very heavily indeed. We only have to think of the many headache patients, or people with post-operative pains in spite of flawless healing of the wound.

Are all of these psychological pains? What we can observe is that pains of this kind in part respond well to autonomous stimuli such as cold, heat, electrical stimulation, massage or diet changes, as well as injections of local anaesthetics at the site of the pain or vegetative nerve ganglia. The autonomous nervous system has a crucial influence on the origin and progress of certain pains without a physical cause. Hence someone with a predisposition to migraine can benefit immensely from injections in the autonomous ganglia of the head. If the migraine attacks appear mostly with impaired evacuation of the bowels, then a regulation of the bowel function can virtually bring miracles to pass.

A single measure is often not enough to correct a malfunction. The autonomous nervous system, which maintains and guides practically all the unconsciously occurring life processes, is networked all over the body. Every disruption in the network puts strain on the system and ultimately allows the outbreak of malfunctions such as headache, migraine, muscular pains and many other symptoms, depending on where the person affected has his or her weak points. For the sake of simplicity, we call this part of the emergence of pain the “autonomous component”. Since it is not concerned with tissue damage or a chemical imbalance, but rather with a malfunction, I class it among the “software disturbances”.

Like neuropathic pains, autonomous pains also often react poorly to pain-killers; they are more likely to react to tranquillisers such as benzodiazepine. People who suffer predominantly from autonomous pains have often already been to many specialists when they come to me. Likewise, the psychiatrist or psychologist has often already been involved, because a psychological cause is suspected. So occasionally I see women with abdominal pains, who have tested completely normal in gynaecological tests, with no causes being evident in the spinal column either, and yet something is still not right. An inspection then brings the focus to rest, for example, on a scar following a caesarean section or episiotomy, which healed badly at the time and sometimes has remained painful even years later. As a neural therapist, I am left with no other option but to anaesthetise the scar with procaine. As a rule, one to three treatments suffice to render the scar pain free.

- ***Psychological component***

The fourth component in the tetralogy is, as you suppose, the emotional element of pain. Just as there are pains having a mostly nociceptive or almost purely neuropathic cause, there are situations in which we assume that the cause is for all practical purposes purely psychological. Such pains, which previously were considered as psychosomatic and therefore often as “imagined“, are today recognised as an illness in their own right and classed as “somatoform pain disorders“. In the case of a somatoform pain disorder, we are concerned with a *severe and agonising* pain that has existed for *at least six months*, which cannot or cannot wholly be explained by a physiological process or a bodily disorder.

The pain *appeared in connection with emotional conflicts or psycho-social factors* (e.g. stress, hassle in private and professional contexts). These ought to be more than enough to count as decisive, causative influences. *A considerable support* (through relatives, friends and medical establishments) is at first (!) a consequence of these pains.

It is estimated that approximately 25% of the patients in pain surgeries suffer from somatoform pain disorders. My experience is somewhat different. I rarely see patients with purely psychogenic pains without any physical or autonomous foundation. The ICD 10 from 2009 takes this into account through the second diagnosis of *chronic pain disorders with somatic and psychological factors*.

Likewise in the foreground of this clinical picture there are pains that have existed for at least six months in one or several anatomical regions, having their *point of origin in a physiological process or a bodily disorder. An important role is attached to psychical factors for the severity, exacerbation or preservation of the pains, though not the causative role of their beginning.* In a clinically meaningful way, the pain causes suffering and impairments in social, occupational or

other important areas of functioning. The pain is not deliberately generated or feigned (as in the feigned disorder or simulation).

This form of pain is, in my experience, essentially more frequent, though is often put on a level with the somatoform disorder, most notably in the context of insurances.

Clinical practice

I never cease to be amazed by the life stories of people with chronic physical pain. I told you that Walter was a sturdy, well built man with a great deal of experience in hill climbing. Following his operation, he was also sent to the psychiatrist with his inexplicable pains. The psychiatrist attempted to treat him using behavioural therapy, as his impression was that of an otherwise healthy man, experienced in life. He tried, for example, to get Walter to improve the circulation in his feet by way of his breathing. So he told him that he should breathe out through his feet. This proved too much for the mountain climber, accustomed as he was to understanding things in a technical way. After six years of being examined by various doctors and unsuccessfully treated with painkillers of all kinds and psychotropic drugs, he requested a specific treatment for pain. He was therefore directed to our clinic, although he had to travel for more than three hours to get there, which in Switzerland counts as a long time. I have already told you about the treatment of the nociceptive, neuropathic and autonomous aspects of his pains. But what happened on the psychological plane?

To begin with, Walter was hospitalised in our inpatient ward during 3 weeks and was treated for the neuropathic pain with blockades and cortisone injections. To modulate the autonomous disorder, I was supposed to contribute with neural therapy. During the examination, I was struck by the frustration of this strong man who was hardly able anymore to stand on his own two feet and could not keep his balance without sticks. Nothing could be found in physical terms to explain the desensitisation of his feet and the extreme pains when walking except a slightly slowed neurological conductivity of the foot nerves. In the magnetic resonance imaging, no trace of damage to neural structures could be found in the location of the spinal anaesthesia that had been so painful. The neurologist therefore decided on an acute neuropathic event via the spinal anaesthesia, though its actual cause remained unclear. Unfortunately, no lasting improvement could be reached through a blockade with anaesthesia. On the other hand, as I mentioned previously, Walter always sensed an improvement through injections in the leg arteries. Admittedly only for a matter of hours.

This gave me the certainty that there was no structurally definitive lesion, but rather a functional disorder, which was essentially reversible. I informed Walter of this clearly as follows: “I know what you've got. It just remains for us to find the key to it“. Personally, I do not remember having said these words, but Walter has again and again confronted me with them when I seemed somewhat disheartened about his slow progress. Obviously time and again it gave him courage and support. To begin with, following his dismissal – being only slightly improved – he travelled to Basel every two weeks, and then every three to four weeks, to have me inject him in the arteries, leg nerves and feet. For the tinnitus he received injections in the occipital nerves, because the symptom had arisen at the injury of the dura mater during the spinal anaesthesia. Each time, he could sense a clear improvement.

However, I had the feeling that there was more to this that lay much deeper than this painful anaesthesia. I tried therefore to penetrate more deeply into his story. At first, he was sceptical, but then he became increasingly open. He had apparently never previously told this to a doctor. Not even the psychiatrist, because he was afraid he would again be labelled as a psychopath and a fake.

It had to do with his childhood. They were six siblings, his father was an alcoholic and his mother was obviously not in a fit state to look after them all. Therefore when he was four years old, he, like his siblings, was sent away for adoption. Between 1800 and 1950, this was a commonly applied procedure in Switzerland, especially in rural areas, to provide for destitute children. Usually they would be taken to live with a farmer, after the wages owed to him by the parish had been handed over. In the Canton of Bern, it is said that, before the First World War, approximately ten percent and in the whole of Switzerland more than four percent of all children were sent away for adoption. They were mostly exploited, abused, also raped, and hence they often bore psychiatric damages or committed suicide.

Walter, too, was placed on a farmstead. His sleeping spot was a hollow under the wooden staircase with a straw mattress. He would be woken by the farmer and his wife, who came clattering down the stairs and expected him to go and fetch and kindle firewood for breakfast and later to help out in the stables. He was only allowed to eat in the kitchen, while the family dined in the parlour with their only son, who was slightly older than Walter. Of course, the son of the family had many toys, an electric railway and a bicycle, whereas Walter had to toil in the stables and the fields, was beaten regularly and scarcely had time for school work. A peculiar circumstance was Walter's stroke of luck. The farmer was an elder in a church. To the outside world, everything must therefore appear in perfect order. And so, on Sundays, Walter had to attend Sunday School and later the sermon. He also had a claim to the worn out Sunday best clothes of the farmer's son. However, because he had grown faster, they were always too small for him. But at least still in one piece.

When he was twelve, the farmstead was sold and Walter was placed on a different farm. This was his salvation. The foster parents were childless and pleased to gain a helper on cheap terms. He was now strong and tall and was more readily able to stand in his own defense. The farmer's wife was firm but fair and the farmer was hardworking. But here, too, Walter never received one good word too many and felt no personal affection.

At seventeen, he received a written notice from the parish that his mother had died and that he must report to his official guardian by the name of XY to deal with official problems. He hardly remembered his mother, except that she was often unhappy and sent him away when he wanted something from her. His father had died at some earlier point, without Walter having been officially informed of this. And so he felt suddenly very alone. The farmer's wife, who had handed him the letter, watched him and saw how he became lost in thought. In any case, she suddenly embraced him and pressed him to her own breast. For the first time in his life, Walter felt accepted. The farmer's wife said that he was after all, in a small way, her son.

This was what Walter told me in several episodes about two years ago. Together we have tried to achieve some sort of reconciliation with the various people. This was most difficult with the first farmer and his wife, because of their falsehood. But somehow or other it worked after all.

Walter now refers to me as his friend and the clinic as “our home“. Since about two years ago, we have been on first name terms. It took a very long period of treatment, including injections and

physiotherapy, before he could come to terms with this story and process it. But ever since then it has been going gradually uphill.

Walter completed an apprenticeship as a machine mechanic and later on worked in various locations, got married and has a 30 year old son. But the Alpine world was more important to him than his relationship with his wife and son. He told me time and again of earlier ascents and hikes, which he would now resume. I will tell you the rest at the end.

Just some theoretical thoughts about this problem. You see how complicated the analysis can be, particularly of a chronic pain occurrence. The psychical background always plays an important part in the perception of pain. The significance of childhood in terms of the risk of chronic pain development is well attested.

The following factors have been specifically investigated and raised as predictors:

- emotional neglect (unwantedness)
- work stress of both parents from infancy onwards
- chronic family disharmony/violence
- age gap to siblings less than 18 months
- often being beaten/abused
- serious sexual abuse
- scanty/unstable financial situation, little formal education
- separation/divorce of parents
- bodily or emotional disability or illness of the parents, addiction problems
- death of one of the parents

(© 2011 B. Vill Universitätsklinikum Erlangen)

We can easily recognize our chronic pain patients and many others. Of course, there are also people who have a heavy past and yet develop no chronic pain.

It is impressive to see the number of studies published in recent times in the medical journals on the theme of pain and psyche, psycho-social situation, pain-coping, psychological pain treatment. In itself, this is very good news, but through this the doctors are being made aware that pain is not in itself a physical disorder but rather a psychical phenomenon. Hence, it was possible to show that fear in connection with an experimental painful injury worsened the average pain level by two to three grades of the 0 – 10 scale, whereas a pleasant distraction diminished the perceived pain. Similar findings could be made with light depressions. So it is crucial to promote healing with the correct measures: we may convey fear to injured children, or on the contrary we may convey swift courage. A good parent-child relationship seems to be quite crucial.

Mrs Hefti

One of my patients, whom I will refer to as Mrs Hefti, a young lady, in 2003 met with a serious accident, likewise during a mountain tour. Her right lower leg was crushed by a rock boulder falling on it. Considering the extensive injuries, the team of surgeons decided to recommend her to have an amputation, since it was inconceivable to surgically save her foot. The lady, who was 22 years

old at the time, successfully resisted this decision, and an operation lasting approximately ten hours was carried out to save her leg. In total, the patient has gone through 13 operations on her lower leg. The technical miracle came to pass and her foot has remained full of life until today. But the most terrible chronic neuropathic pains arose in her lower leg, which initially only responded to morphine. In the case of such a severe injury with the cutting through of several nerves and their supplying vessels and the subsequent surgical injuries, chronic pains are absolutely by no means unusual.

Many sensitisation mechanisms are well known, though equally many are not. The patient then also received morphine in high doses, until she was dependant and one was forced to acknowledge that the 16 daily pethidine injections did not significantly relieve the pain. The withdrawal was carried out in a psychiatric clinic. In this way, using neural therapy, a clear pain reduction could be achieved. Mrs Hefti was therefore referred to me for post-operative treatment. For more than five years now, I have been treating her with neural therapy, with moderate success. It struck me that she had increasing pains when under stress or in discussions with her parents. And then she told me that, as the second of twins, she had never been considered her sister's equal. Her sister was always preferred, both by the mother and above all by the father for being more beautiful, more intelligent, more successful, and indeed not disabled like her.

Whereas in Walter's case, his Sunday School faith has always had and even today continues to have a very stabilising effect and arguably saved his legs from the chainsaw, this support is entirely lacking in Mrs Hefti's case. I attempt to raise her missing sense of self-worth by pointing out her thriving marriage, her dealing so well with the pain, her activities in the garden and the house, and above all to mitigate her attitude towards her parents and her sister. Since the conference in Willersley, the work of forgiveness has become important for me and my patient. Even in Mrs Hefti's case, this seems to bring about a reduction in the relationship stress and a diminishment of the pain.

Time and again, this approach is important. Just recently, I saw a patient who had grown up in 12 different foster homes. She will never be able to forgive everything.

Mrs Melanie Weiss

By way of a third example, I want to show you how far we actually need to search in order to be able to help a person to let go of burdens. In 2004, I had treated Mrs Melanie Weiss, then 21 years old, a young Indian lady who had been adopted into Switzerland, because of a painful shoulder after falling down the stairs. The treatment with neural therapy had lasted an exceptionally long time, even though nothing was visibly injured. At last, however, it was successful and the patient was able to continue working after a change of apprenticeship position from geriatric nurse to activation therapist.

Three years later, she came back, because her asthma, which she had had as a child and had left her at 15, had once again become manifest. Because Mrs Weiss also suffers of a food intolerance, I thought of an allergic component and had her examined by the respirologist. The negative result surprised me somewhat. But more surprising was the fact that the asthma attacks responded sometimes well, but sometimes not at all to the neural therapy. Additionally, they had become

atypical and Mrs Weiss often complained of pressure in the throat area. Sometimes she came to see me with her adoptive mother.

We spoke about the circumstances of her early youth, as we had done previously in connection with the delayed healing of her shoulder, so now because of her asthma. She had been adopted when she was three years old by her Swiss foster parents from a children's care home in Delhi. Little Melanie had been found as a baby of three months or so beside a garbage bin in one of the quarters that we know from the film *Slumdog Millionaire,* and brought into the children's home. There she remained until her adoption. In Switzerland she grew up together with a boy who was two years older than her in a really very pleasant atmosphere. She was able to develop well and has a lovely relationship with her parents. She soon had her origin explained to her, and visited the children's home in Delhi. And yet we had to accept that a psychical burden might be the hidden cause of the breathing disorder. A colleague and friend of mine, a children's doctor, examined the patient kinesiologically and realised that an emotional block exists, but it was not permitted to investigate it more deeply. After lengthy hesitation, the patient consented after all to a psychosomatic treatment with a correspondingly qualified colleague.

I lost sight of her after that, until she reappeared three months ago with the painful shoulder. On the subject of the asthma, she told me the following: for a whole year, she had gone for a monthly discussion. After a lengthy search, they had come to her birth and apparent abandonment. She had watched the film *Slumdog Millionaire,* and in doing so had sensed severe pains and breathlessness in her throat. Subsequently, she had talked through several times with her therapist how, as an unwanted girl, she must presumably have been not simply abandoned but probably choked to begin with and perhaps even almost strangled and left to die, until by chance she was discovered. It had been a very difficult task, but it had been worth it. Since then, the supposed asthma had disappeared.

You guess correctly. In this situation, too, part of the process had to cross paths with forgiveness. This time towards a person whom Melanie had never known or consciously encountered, but who must have been a man, as had emerged from her dream analysis work. Concerning the shoulder pains, psychotherapy has so far not been able to offer any clarity.

Conclusion

What did I want to show you with these three people? A chronic pain is not an isolated illness. A careful analysis must comprehend the various components as cleanly as possible in order to be able to treat the structural and autonomous functional parts with the corresponding means. Here we work on the principle of as much as necessary, or as little as necessary. Sometimes, even in the case of strong pains of structural origin, medications and invasive measures have to be dropped and replaced with methods such as bio feedback, relaxation measures, or hypnosis. The move to actual psychotherapy and psychological support, even via a non-psychiatrist is not an *either-or* option, but both-*and* one.

Chronic pain often burdens patients and their milieu very heavily. Mrs Hefti for example is an orthoptist, but because of the pains in her leg, she can neither practise her profession nor gather

the courage to have children. She has difficulty with her identity and therefore also not uncommonly has problems with her husband. We have often spoken about this and as of recently she is being regularly supported in a more relaxed fashion by one of our psychologists. The repercussions on work, experience of free time, relationships with family and friends, quality of life, sleep and many other things in addition must be formulated. To discuss all of this with the patient means to take him seriously as a human being and a person, and to help him to rediscover his place and dignity. This is sometimes more important than to search in vain for a psychical cause, which is often many-faceted and very difficult to come to terms with. The patient very often begins to doubt himself if everywhere he goes he encounters lack of understanding and even disbelief at his suffering.

To finish with, here's the end of Walter's story: Two years ago he separated from his wife. He confessed to me that he had never experienced a really intimate, loving relationship with her. Since last summer, he now has a girlfriend and it seems to us both that since then he has made great progress and was better able to train. With this woman, he could for the first time live for and share his feelings. His feet also suddenly became warm again.

Time and again, what leaves a lasting impression in my work with chronic pain patients is the serious wound caused by lack of love and breach of trust during childhood. And here lies also the secret of the Medicine of the Person. In our mode of approaching people, showing them appreciation and bringing them love, we can help many people – sometimes with a reference towards the love of God – to accept their past and themselves. As was mentioned at the start, there lies an opportunity in the mode of our encounter with the patient, which can have a direct influence even on the effectiveness of the technique.

Many thanks for listening.