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Correspondence

PAIN AND THE PSYCHIATRIST

An open letter to Professor Stengel

DEAR STENGEL,

Your Maudsley Lecture on "Pain and the Psychiatrist", published in the issue of September 1965 of this Journal (111, 795–802) is of such importance and interest that I hope you will forgive me if I ask you, in the correspondence columns of this Journal, to clear up what I believe are some basic ambiguities. You offer us three definitions of "pain", and we gather that the third, Merskey's, seemed to you the most practical.

J. Z. Young's definition of a painful stimulus as something which made his octopus retreat, need not be further discussed, as it lacks generality; it would seem to be applicable only to a specific mode of response elicited in an experimental situation.

The definition proposed by Wolff and Wolf has to be taken seriously. "Pain is a specific sensory experience mediated through nerve structures which are separate from those which indicate other sensations, such as touch, pressure, heat and cold." However, you regard this definition as not helpful for the clinician and useless for the student of psychogenic pain. I am afraid that I am not fully conversant with current neurophysiological teaching, and it may be that the definition should be enlarged; perhaps the specific quality of a sensation depends not only on anatomical pathways but also on physiological characteristics, such as pattern of neuronic discharge. I believe that physiologists distinguish between at least two different kinds of painful sensation: one, the so-called cutting or pricking pain, which travels by relatively fast pathways, and the other, the slower burning or aching pain. But surely Wolff and Wolf are right in putting sensations of pain on a level with sensations of touch, pressure, heat and cold. Each of these types of sensation, on emerging into consciousness, is marked with its specific quality; and there would seem to be little doubt that this specific quality is related to anatomical and physiological aspects of the nervous system, differing from one another in the case of each type of sensation.

It is not immediately apparent that the formulation by Wolff and Wolf, perhaps slightly re-phrased, should not be helpful both to the physician and the psychiatrist. Is there any reason why we should not demand that, for acceptance as "painful", a sensation should have the quality, not of being a feeling of heat, or cold, or pressure, or tightness, or vibration, or movement, but simply of this specific quality of painfulness? We are, of course, aware that all kinds of other sensation may take on an unpleasant quality. A patient may say he has a pain, because he does not like the feeling he wishes to describe. However, there are few patients who cannot discriminate between a definite pain and say, an unpleasant sensation of tightness, when called on to do so. If we want this information, as I believe we should, we have to ask our subjects for it.

Without some degree of precision and rigidity in our definitions, it would seem to me that we run the risk of confusion. Unless we know what our fellow workers are talking about, we cannot engage with them in useful discussion. How are we to know whether our patients have anything in common with those of Spear who, you say, did not attempt a formal definition of pain, and considered it to be present when the patient reported it? We are little better off with the definition of Merskey: "Pain is an unpleasant experience that we primarily associate with tissue damage or describe in terms of tissue damage, or both." This definition would seem to include a great variety of feelings, e.g. of weakness, fainting, vertigo, etc., which, if regarded as painful by Merskey, are so regarded by him alone. And how about all the other distressing, but in my sense non-painful, feelings of which our patients complain: a tight band round the head, a pressure on the top of the head, a sick feeling in the stomach, an icy coldness in the back, a feeling as of ants crawling under the skin?

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REFERENCE

WOLFF, H. G., and WOLF, S. (1948). *Pain.* Springfield, Ill.: Chas. Thomas.

Reply from Professor Stengel

DEAR SLATER,

I am grateful to you for giving me the opportunity to clarify some aspects of pain in relation to mental disorder.

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You raise two issues in your letter. The first is the definition of pain, the second is the question what should be accepted as pain. The large majority of clinicians and physiologists who have studied pain have not attempted to define it. They implied that an individual felt pain if he reported it or, in the case of an animal, if it reacted in a certain characteristic manner. You appear to imply that unless a worker's formal definition of pain is adequate the validity of his observations is open to question. If this were so practically all studies of pain would have to be dismissed because there is no satisfactory definition of pain. Fortunately, there is no need for such drastic action. Neither of the two research workers (H. Wolff and H. Merskey) whose definitions of pain you discussed used his definition as an instrument for the ascertainment of pain. They did not try to fit pain to their definition but to devise a definition that would fit pain, which is quite a different matter. Like others, they assumed that their subjects had pain when they reported it.

Let us first deal with the question how we establish that a person has pain, and later with the problem of definition. I agree that patients should be asked whether the sensations they feel are really painful, but we cannot exclude sensations from the painful phenomena because they have other qualities in addition to that of pain. By questioning patients too closely whether what they describe as painful really deserves this adjective, we may easily distort the information they can give. They may concede that for instance migrainous pain is really only a dull though unpleasant pressure, or that herpes causes only an intense sensation of heat, etc.

You fear a patient may say he has a pain because he does not like the feeling he wishes to describe. I do not believe this fear to be justified. Many patients who complain about pain also tell us about other unpleasant sensations which they do not describe as painful. You listed several of them in your letter. However, it is quite possible for "a pressure on the top of the head" to be experienced as painful. There is no alternative than to assume that a person has pain when he says so, provided we believe him to be truthful.

Pain without physical cause presents special problems because doctors find it difficult to believe that such pain exists. There are two reasons for this difficulty. Firstly, in our medical training pain was presented as one of the most reliable indicators of physical illness. "Psychogenic" pain was hardly mentioned and if it was we were given to understand that it was not the same as real pain. The second difficulty is intrinsic to the phenomenon. Pain due to psychological causes has the same significance for the patient as pain due to physical disturbance, and therefore the former has to resemble the latter subjectively. If it were easy, for the patient and the doctor, to distinguish phenomenologically between "organic" and "psychogenic" pain, many physical examinations which often precede the diagnosis of "psychogenic" pain would not be necessary. In fact there are no reliable differences between the pain experienced as the result of tissue damage and "psychogenic" pain, although the origin of pain can often be inferred from the context of symptoms in which it occurs, and its qualitative and temporal characteristics can also give some help at times (Spear). Perhaps further research will establish reliable criteria of differentiation.

I should like to discuss briefly the definition of pain. As H. Wolff and his associates pointed out, pain has two aspects. It is a "feeling state" as well as "a specific sensation with its own structural, functional and perceptual properties". The feeling state, they say, may be the most relevant aspect of pain to the one who suffers. Ideally a definition of pain ought to do justice to both aspects. The distinction between the sensation of pain and the reaction to pain made by Wolff and his associates has not found general acceptance. You have been mainly concerned with pain as a specific sensation, and Wolff's definition quoted in my Maudsley Lecture* appeals to you because it refers to this aspect. In calling pain an experience it seems also to acknowledge the feeling state quality. However, it defines a psychic event in terms of anatomical structure and function; Hughlings Jackson long ago castigated this as impermissible. It is like defining consciousness by part of the brain stem. Wolff's definition also implies that if certain nerve structures are not involved there is no pain, i.e. it denies the existence of psychogenic pain. This is the reason why I regard it as unhelpful for the clinician. Merskey's definition, quoted in your letter, has no such implication. Although it refers, like Wolff's, to physical damage, it does not postulate that such damage must be present but only that pain is logically associated with it.

The only improvement of Merskey's definition I could suggest would be the replacement of "we" by "one", or, better still, by "people". "We" may mislead medical men into thinking that it means "we doctors", which it does not. You criticize Merskey's definition as being too broad. This may be so, but I do not think you are right in assuming that lay people

* In the definition quoted in my Maudsley Lecture it should read "mediated" instead of "indicated". In his book *Headache* Wolff defined pain, more briefly, as "a specific sensory experience with its own neural structure".

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associate weakness, fainting, vertigo, etc., primarily with tissue damage, though doctors do. I think that if lay people were asked which unpleasant experience or feeling they would expect to have as the result of physical damage, most of them will mention pain first. No such question can be formulated from Wolff's definition, which makes sense only to those familiar with physiological theory.

You suggest that Wolff's definition if re-phrased could be helpful to both the physician and the psychiatrist. I agree that this could be done, but only by the adoption of a device used by Merskey and yourself (see below). The definition would run as follows. "Pain is a specific sensory experience which physiologists associate with, etc." This would make Wolff's definition logically acceptable, but still leave its usefulness restricted to a small group of experts.

You have on another occasion proposed the following operational definition. "We accept as painful sensations those sensations which have for the subject that specifically painful quality associated with anatomico-physiological pain." This definition differs from Merskey's only in that it refers to the sensation rather than the experience. As tissue damage is the most common cause of "anatomico-physiological pain", the two terms can be regarded as exchangeable. The second part of your operational definition runs as follows. "Dysaesthesiae and unpleasant sensory experiences which have the specific quality of sensations of touch, heat, cold, etc., are not included in this definition." This part would be acceptable to me only with the proviso "unless they have also the above-mentioned painful quality". I gave the reasons for my insistence on this proviso earlier in this letter.

I am afraid my reply has been much longer than your challenge, but this is inevitable in this kind of exchange, especially if the work of others is also involved. I think we can agree that it is extremely difficult to define pain, which must be the reason why so few workers in this field have attempted to do so. Sir Thomas Lewis said in his book on pain: "Reflection tells me that I am so far from being able satisfactorily to define pain, of which I here write, that the attempt could serve no useful purpose". Yet nobody would deny that he enriched our knowledge of pain.

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