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THE CONCEPTION OF "PAIN" BETWEEN RHEUMATOLOGY AND MEDICAL ANTHROPOLOGY: A NEW WAY OF CONCEIVING PAIN

R. LEONE

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Medical Anthropology, Fondazione di Noopolis, Rome, Italy

Corresponding Author
Raimondo Leone, MD; e-mail: raimondoleone90@gmail.com

ABSTRACT – ***Objective:*** In this brief article we have to start looking at the patient as a person and at the complexity of the situation he or she is handing over to us. After setting some coordinates on medical anthropology, we will try to understand how it can be of help to the rheumatologist, what new perspectives arise from the dialogue between these two disciplines. Medical Anthropology shows how every individual in every social context perceives, interprets, and deals with illness and health in a manner closely linked to personal experience and the socio-cultural environment of which he or she is a part; it recovers the old holistic paradigm of ancient and primitive and folk medicine, the reunification of soul and body, the global study of the person. In this perspective, the issue of pain emerges, particularly in rheumatology (we have to consider that in Italy there are about 4 million patients with arthrosis, the most widespread chronic degenerative rheumatic disease, about 400,000 those with rheumatoid arthritis, and at least 600,000 who are affected by other diseases of great clinical relevance, such as psoriatic arthritis, ankylosing spondylitis, lupus and scleroderma). Starting from the assumption that man is not a machine, nor is his pain the result of a series of mechanisms, we could assume that between man and his pain there is the ambivalence of the relationship that unites man to the world. Pain affects man's identity, often shattering it, thus becoming the disease to be cured. In this perspective, it can never be considered as something good, something that adds to a person's life. Pain, therefore, being a multiple reality, needs to be inserted in the relationship that the subject has with himself, the socio-cultural uses that he has assimilated, elements from which the physician cannot prescind.

KEYWORDS: Pain, Rheumatologist, Medical anthropology.

INTRODUCTION

We might begin by saying that treatment passes through the angle from which one looks at the patient as a person and at the complexity of the situation he or she is handing over to us, in the knowledge that the administration of drugs is not always enough to respond to the request that is made. Therefore, we must start precisely from the patient's request itself and its decoding, looking at the doctor as the one who is called upon each time to decipher the language of each patient by drawing on the integrity of his or her person. After setting some coordinates on medical anthropology, we will try to understand how it can be of help to the rheumatologist, what new perspectives arise from the dialogue between these two disciplines.

MEDICAL ANTHROPOLOGY

According to the SIAM (Italian Society of Medical Anthropology), medical anthropology encompasses the definitions and interpretations of health and illness; of the conditionings of the socio-cultural set-up on health-disease states, of the representations and values associated with these states; the conceptions of the body and, finally, the responses that derive from them at the level of individual and collective behaviour and "the institutional structures in which these responses are expressed". Where does the need to combine the clinical and biological aspect with the socio-cultural data come from? According to Lanternari[1], medical anthropology, as well as other disciplines (Ethnomedicine, History of Folk Medicine, Ethnopsychiatry, Transcultural Psychiatry, etc.), arise from the crisis of science and medical practice in Western societies and from the emergence of a widespread social malaise towards a medicine that is increasingly detached from the patient (one wonders today who would visit a patient if not after obtaining a package of examinations, which very often become the only element that speaks for the patient). With Volpini[2] (2005) we share that medical anthropology has shown how every individual in every social context perceives, interprets, and deals with illness and health in a manner closely linked to personal experience and the socio-cultural environment of which he or she is a part. In the light of this approach, which I would dare to define as different rather than new, it is essential to reflect on the concept of health, given that it is a concept in continuous evolution. As early as 1946, the WHO recognized the need for a new health culture, based on the concept of 'health' understood not only as the absence of disease, but as a "state of complete physical, mental and social well-being" (Table 1).

Table 1. Medical Anthropology's Aims[5].

Improve the ability of the doctor, nurse, health worker, health manager, to communicate with patients and, more generally, with users of health services.
Penetrate deepxer into the patient's experience of discomfort or illness.
Better understand the patient's experience, especially in the case of chronic diseases.
Improve diagnosis skills.
Seeking different pathways to promote well-being and reduce the impact of illness or disability on the patient's quality of life.
Avoid the risk of an overly prescriptive medical practice (not only from a pharmacological point of view).

The doctor, consequently, no longer has to treat only the disease but the person, abandoning the Cartesian concept of the split between res cogitans and res extensa, and looking at a dynamic concept of health[3], that is, as a balance between the individual and the environment. The biologistic dimension now dominant in current medical practice neglects that space between individuality and universality dear to anthropology. This distance between the two approaches renders the anthropological dimension useless in the doctor's curriculum, relegating it to exoticism, abstractness, and practical uselessness. Medical anthropology, as mentioned above, recovers the old holistic paradigm of ancient and primitive and folk medicine, the reunification of soul and body, the global study of the person. Medical anthropology, therefore, comes to be constituted as a discipline-hinge between the world of the physician and medicine and that of the patient[4]; the latter subtracted from the objectification of a pathological case to be solved and reintegrated into a network of aspects of which pain becomes a manifestation of a broken knit.

A NEW DISEASE: PAIN

Regarding "pain" in the rheumatology field, we must start from an objective fact that we take directly from the Observatory for Rare Diseases, according to which "Rheumatic diseases are very widespread in Italy; consider that more than 10% of the Italian population is affected, about 6

million subjects. Of which, there are about 4 million patients with arthrosis, the most widespread chronic degenerative rheumatic disease, about 400,000 those with rheumatoid arthritis, and at least 600,000 who are affected by other diseases of great clinical relevance, such as psoriatic arthritis, ankylosing spondylitis, lupus, and scleroderma". Prof. Minisola himself states that "pain is a common denominator of these pathologies. Rheumatoid arthritis, the most frequent immune-inflammatory rheumatic disease, is a highly invalidating condition that can also affect children; the highest frequency is between the ages of 35 and 50, with a clear prevalence in the female sex, causing progressive loss of joint function. There is a high percentage of those who develop a severe form of disability a few years after the first symptoms appear, which can force them to stop working". Added to this is the WHO figure that defines "rheumatic diseases as the leading cause of pain and disability in Europe". Pain becomes the element on which to focus in order to try to understand its complexity and function, especially in the economy of the patient's life and not only its symptomatology[6]. Pain in rheumatology can arise from various causes: inflammatory, as in the case of arthritis, arthrosis or lumbago; neuropathic, as in carpal tunnel syndrome or due to a herniated disc compressing a nerve root; or it can have a mixed genesis, as happens for example when several problems are associated, not only rheumatological, or even nociplastic, which presents an alteration of nociception (the neurobiological systems involved in pain perception), characteristic of those suffering from fibromyalgia. The study of pain falls within the field of semeiotics, i.e., the discipline that detects signs on the basis of clinical observation[6]; it is a psycho-somatic experience, characterized by biological, affective, relational, spiritual and cultural elements that are inseparably linked[8]. Each person learns to express pain with categories derived from their own personal experience. Although pain is an experience shared by everyone, there is no exhaustive definition of it, even more so because it is not a simple neurophysiological response to a stimulus, but the result of the interaction of multiple factors: physiological, physiopathological, psychological, social, cultural, environmental, and memory (which inevitably plays a decisive role in modifying the algic sensation). In clinical practice, therefore, one cannot ignore the affective-emotional-experiential sphere, to which the person's behavioral and psychological responses are due (Table 2).

Table 2. A new anamnestic approach.

Clinical approach	Understanding of pain
Pain characteristics	Site of pain, mode of onset (sharp, acute, gradual, burning, constrictive, lacerating, cramp-like, dagger-like), intensity, which is related to the algogenic receptivity of the affected structure, duration, frequency (episodic, recurrent).
Pain triggering factors	Mechanical, chemical, thermal stimulation.
Pain-modifying factors	Family, religious, social upbringing, pain memory, patient's age, physical constitution, gender, subject's psychology etc. must be considered among these parameters.
Psychological assessment of pain	Cognitive, affective, and relational factors. The interview with the patient is indispensable, paying attention to three levels: the ability to listen, the acceptance of the patient's personality, the ability to confront the patient with his own contradictions.
The measurement of pain	Ordinal scales (verbal and numerical), magnitude scales, visual analogue, graphic and chromatic scales. The most used ordinal scale is the verbal rating scale (Verbal Rating Scale VRS), very widespread is the visual-analogue scale (VAS), the chromatic ones use the progressive increase in intensity of color along a segment. More complex is the McGill Pain Questionnaire, which uses 102 words divided into three classes based on sensory, affective, and global intensity qualities. Finally, there are pain maps based on the use of colors that patients have to apply to human figures or diagrams.

We could subdivide pain into[9]:

- **Acute pain**: such as that resulting from arthritis (rheumatoid arthritis, psoriatic, gouty, microcystic). It can be considered a physiological response to an organic alteration, which produces psycho-affective effects such as mood alteration (depression, anxiety, fear); clinical attitudes, postural, verbal expressions; changes in the Autonomic Nervous System. From a therapeutic point of view, it is of limited duration, because it responds to drug therapy.
- **Chronic pain**: such as that resulting from arthrosis, fibromyalgia, chronic back pain, which varies in intensity and tends to increase over time. It often presents itself as being of unpredictable duration, sometimes unfortunately coinciding with the patient's life. Chronic pain does not always have a single cause, which makes it problematic from a therapeutic point of view because it requires a customized treatment plan, with pharmacological dosages that vary in intensity over time. This type of pain can itself become the disease because it correlates with the worsening of the patient's life, his social dimension, his personality, the degree of frustration. All this also aggravates the perception of pain itself, which reaches such levels of intolerability that the patient cannot tolerate intramuscular analgesic injections. The treatment plan, therefore, widens the circle of specialists (doctor, nurse, physiotherapist, pharmacist) to obtain the best result in terms of rehabilitation to social life. Analgesic therapy aims to treat the 'disease of pain', meaning pain as a dominant symptom to such an extent that it becomes a disease, capable of compromising the patient's quality of life. Given that in the human person, as we have already mentioned, the psychic component (res cogitans) lives in very close symbiosis with the physical dimension (res extensa) and with the rest of the universe. The holistic approach allows us to place the question of pain in a broader horizon, different from the one that often drags medicine into a hedonistic decline of life, which would obscure the healthy value of pain. The question arises spontaneously in the listener, whether pain can ever take on a healthy dimension, whether it can ever play a significant role in man's life that is not tied to a bundle of feelings, emotions, sensations that deserve to be banished as far as possible. The real interest in the question of pain lies in the relationship between the body and the identity of the person, the primary object of study in anthropology.

A NEW WAY OF CONCEIVING "PAIN"

We must start from the assumption that man is not a machine, nor is his pain the result of a series of mechanisms, but between man and his pain there is the ambivalence of the relationship that unites man to the world. Pain affects man's identity, often shattering it, thus becoming the disease to be cured. In this perspective, it can never be considered as something good, something that adds to a person's life. In this regard, Renè Leriche's[10] consideration is pertinent, who states that "we must abandon the false idea that pain has beneficial effects. Pain is always a sinister gift that lowers man, that makes him sicker than he would be without it". But if it always has the connotations of an event, reality, experience, a negative entity, there is no escaping the fact that it is a constitutive part of the person. This is why man cannot always shy away from pain, no matter how much modernity sees it as an archaic enemy that medicine has a duty to eradicate (cf. "Pain therapy: ethical guidelines" of 30 March 2001 of the CNB). Pain, in the words of Le Breton[11], is "an incision of the sacred, in the sense that it tears man away from himself and confronts him with his limits [...] it widens his gaze, it reminds him of the price of existence, the taste of the instant that passes [...] it is that memento mori that brings us back to the essential". All this clashes with that idea of progress inaugurated in the 19th century, in which the fight against pain becomes the prerogative of the doctor, who is called upon to treat its causes, to attribute meaning to it, and then reduce it to silence[12]. And in the case of chronic pain? We must take a step back then, looking at pain as an anthropological experience, as a threat to a person's identity, as an invitation to the inevitable renunciation of a part of oneself. Those who suffer are called upon to reshape their relationships with others, to assume unusual behavior (swearing, moaning, grimacing); it seems almost akin to a kind of erosion of identity, a form of possession that bends the individual, forcing him or her into a new way of life. Every pain, beyond its intensity induces and produces at the same time a metamorphosis that implies a new relational paradigm with oneself and with the world around us. This metamorphosis takes on different levels, depending on the type of pain: acute pain, for example, has the flavor of 'almost always transitory, capable of educating the subject to prudence, to prevention. When it is perceived as a symptom that preludes to a pathological aspect, it generates in the subject the hope that it can be alleviated, only to be removed along with its cause. For this reason, the physician is often reduced to one who reduces/removes pain. Chronic pain, on the other hand, is an enormous obstacle to existence, because it assumes

varying intensities, prevents the performance of certain daily activities, and very often excludes the possibility of improvement. This second type of pain, in a society where longevity is increasing, is the most widespread. The patient suffering from chronic pain slowly loses confidence in his body, increases his sense of loneliness, and slowly withdraws into himself, not only by his own will, but also because of the difficulty it generates in relationships. All this shows us that pain is not a physiological fact, because it is not the body that suffers, but the person. The very geography of the body shows us how much the body refers to unconscious, social, individual meanings that escape simple physiological causality. Pain, therefore, being a multiple reality, needs to be inserted in the relationship that the subject has with himself, the socio-cultural uses that he has assimilated, elements from which the physician cannot prescind[13]. Beyond the immediate therapeutic response, the physician must be aware that pain belongs first to the life and then to the body of the patient. An awareness that avoids the patient's fragmentation[14]; through the time that the physician himself dedicates to listening and questioning the meaning of the pain's expression, he allows the patient to see the evil that grips him recognized. This simple but good habit prevents fossilization on organic causes alone, placing the physician in a relationship with the patient, which in turn is configured (the relationship itself) as a shared journey that leads to touching the heart of suffering and the drama of the crumbling of identity. It is wrongly assumed that pain is a matter of the individual patient because the physician also integrates the patient's pain into his or her own specific worldview. Inevitably, the physician projects his moral and cultural categories onto the symptoms; he is not a machine that delivers services, but a man who possesses a package of practical-cognitive knowledge in front of another man who speaks of his pain. What Sgreccia[15] calls in his handbook the "relational dimension of medicine" re-emerges here. The anamnesis then becomes a kind of informal deliberation in which a doctor who strives to make his own categories fit with those of the patient and the patient himself, who does not understand why he quibbles so minutely over matters that appear obvious to him, participate. "A sense of the relativity of values and actions, a good knowledge of one's own cultural orientations, a sufficient perception of the other's culture, a certain ability to distance what hitherto appeared to be self-evident, are necessary tools for the healer" (Le Breton).

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