

Palliative Treatment for Terminally Sick Patients Experiencing Non-Somatic Pain

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Abstract

The alleviation of suffering is a mission of medicine since it is inextricably tied to the experience of sickness. Better care of the somatic component is now possible because of advancements in our understanding of terminal disease. However, there is also what is referred to as "non-somatic" suffering, which in some circumstances may predominate. In this qualitative study, we sought to comprehend the experience of non-somatic pain better in light of Paul Ricoeur's theories on human suffering. 19 patients underwent semi-structured interviews. Following a continuous comparison analysis method that was inspired by grounded theory, the data were qualitatively examined. Non-somatic pain can take many different forms, even when the patient downplays it. It is important to remember that patients might experience a "breaking point" that denotes an unmanageable level of anguish while assessing suffering. In order to manage it, we most likely need to make more space for family and friends as well as a loving attitude that places a stronger emphasis on presence and listening.

Keywords: Non-somatic; Somatic; Pain; Palliative care

Introduction

It is well acknowledged that reducing pain is one of the main goals of medicine [1-3], and this is especially true with palliative care [4,5]. Even still, study into this phenomena is still in its infancy despite the significance of pain in our lives [6,7]. There have been various efforts to define suffering in the medical literature. The definition that is most widely recognised is Cassell's [8] assertion that suffering is extreme anguish brought on by a loss of a person's integrity and cohesiveness or by an actual or perceived danger of an attack on this integrity. This definition has been supported by several authors [9-11]. However, newer publications provide criticisms. For instance, Cassell's distinction between pain and suffering is currently debatable [12,13]. The fact that Cassell's idea of pain depends on a danger to a person's integrity is also problematic because some people experience suffering without ever feeling threatened [6,14].

Instead, Beng and colleagues define four different categories of suffering: existential, psychological, social, and physical, building on the ideas of Cecily Saunders. As a result, suffering encompasses both somatic and non-somatic dimensions, which correlate to the psychological, social, and existential effects of sickness. Somatic aspects are those related to the physiological experience of illness. In other empirical investigations, the somatic vs non-somatic aspects are divided in this way. For instance, two survey studies, one conducted in Australia on 100 patients from a day oncology clinic [15] and the other in the Netherlands on 75 dying patients recruited by general practitioners [16-17], have demonstrated the significant interrelationship between physical symptoms and non-somatic impairments. Qualitative investigations conducted in the UK and Switzerland have supported these findings [18].

According to several studies, patients' non-somatic pain is more severe than their illness's purely physical misery. Krikorian and colleagues' literature assessment of 145 articles concludes that "many [patients] feel that most of their pain stems from non-physical origins," despite the fact that research by Chochinov's group in Manitoba and Australia [19,20] expand on this. Research conducted in Canada following the passage of legislation decriminalizing medical help in dying provides a particularly compelling illustration of this (MAiD). According to that study, requests for MAiD were typically driven by

non-somatic factors such as loss of dignity, not wanting to burden others, and inability to enjoy life rather than by physical concerns. Other Canadian and American research as well as investigations conducted in the United States support these findings.

However, Best and colleagues found that there was no clear definition or agreement on what non-somatic suffering is, as evidenced by the numerous synonyms used to describe it, such as depression, death anxiety, or anhedonia, among others, in a systematic review of research published between 1992 and 2012. We are aware of few research that have contributed to a clearer definition of non-somatic suffering since the publication of that review, with the exception of one study of US soldiers that found they conflated psychological anguish with physical pain. On philosophical writings, several definitions of pain are based. Van Hooft, for instance, distinguishes between vegetative life (biological processes), appetitive life (connected to desire and emotions), practical and intellectual life (agency), and contemplative life (the feeling of significance in one's existence), relying on Aristotle's concepts in the process. When one of these aspects cannot be experienced, suffering and frustration result. According to Wittgenstein, for an occurrence to be considered suffering, it must be ongoing and play a significant role in the subject's psyche. According to Frankl, loss of meaning has a bigger role in deciding suffering than loss of physical health. Last but not least, a term from Paul Ricoeur's work that is not well recognised in the biomedical world is derived from his notion of what it is to be human. He believed that man occasionally acts and occasionally suffers. According to Ricoeur, suffering isn't simply physical or even mental agony; it may also be a person's ability to act or be powerful, which is felt as an intrusion on their personal integrity. The ability for

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endurance or bearing up that humans have to be influenced by life is displayed as pain in its passive form.

Discussion

According to our findings, non-somatic pain may be seen as an oscillation between acting upon and acting, to which it is important to add the relationship to others component, which stood out as being crucial to the experience of the interviewees. This conception draws on Ricoeur's theories, who place pain in the self-other axis since, in his opinion, it isolates and separates. Several of Cassell's proposals are still included in this paradigm, although they are arranged differently. While Cassell's model's attack on integrity is similar to our model's restrictions on agency, the danger problem is represented by the worries we have now classified as part of accepting the suffering. However, the occurrence of reaching the breaking point, which is at the core of the suggested paradigm, introduces a new component of pain. Thus, the experience of pain is the realization that one cannot continue in this way (being fed up), which results in a change in temporality. The patient could start to prefer death over life as a result of this. In actuality, when one is depressed, life seems more inconceivable than death. The expression "breaking point" can also refer to a point beyond which a person reaches a state of misery that they deem unacceptable. The model proposed by Beng and colleagues, which holds that there is no pain until this barrier is reached, similarly invokes this idea of a threshold. When considering the consequences of elements connected to the sickness or the treatment that may, in some situations, drive a person past their breaking point and cause them to enter a state of suffering that requires careful management, this idea may be of utmost importance. Beng's model does not address this possibility, but it is quite possible that switching from aggressive therapy to palliative care significantly alters this threshold and that patients suffer as a result. However, compared to Cassell's model, this area's danger component is far less prominent, while being included under the title of concerns. This may be connected to the fact that numerous individuals stated that their pain was extremely effectively managed by the treatment they were receiving, at least in terms of the somatic component of suffering.

On the premise that activity averts pain, we can assume that the being who is no longer doing always relates to the being who is experiencing suffering. We could consider whether there is a more painful aspect to action, though. We specifically think of Ricoeur's view, which states that suffering "speaks or cries out, and this is not accidental, but attests to the continuation and destruction at the same time, in it [the suffering], of the active and speaking man." Thus, suffering is also expressed in action which, for Ricoeur, is a crying out to others.

The category in our suggested model that focuses on interpersonal relationships seems to be both vital and understudied. Humans suffer with and through others since they are social beings by nature. The inclusion of this category in our understanding of suffering takes us closer to the interpersonal pain that Fridh and colleagues identified as being experienced via loss, grief, and concern for one's relatives' futures. Krikorian and colleagues have proposed that three factors personality, social support, and the spiritual or religious realm are associated to the acceptance of death. According to those writers, a connection with the present moment, oneself, others, nature, or the divine is the spiritual component. The religious component was not explicitly evident in our study. However, the spiritual dimension actualized by connection to others might reflect, in our participants, some connection to a religious dimension. In any event, future studies on the behaviours and positions

people adopt in reaction to distress should look more closely at this element of our findings.

Conclusion

This study has several restrictions. We don't yet know how much the findings might apply to a more rural or ethnically diverse population. It's likely that people who weren't included in this study might define pain in a different way. Additionally, because we depended on the HBPC nurses and doctors to choose participants, the patient type may have been impacted by the fact that only "friendly" patients were chosen for recruitment. Requests to enroll patients from underrepresented groups acted as a counterweight to this genuine potential. The fact that this research is cross-sectional rather than longitudinal is another drawback. It would be intriguing to access this through longitudinal research in which individuals would be met multiple times throughout their illness. Many participants acknowledged the altering nature of their connection to suffering. In summary, this study enriches and broadens our understanding of the non-somatic distress experienced by those who are terminally sick. Every carer who is faced with pain should think about the non-somatic reasons of that suffering in order to respond to them, according to this study, which informs practise. This study makes a case for additional humanities-trained carers in palliative care teams at the policy level. Finally, future study should concentrate on the interaction between purely biological features of the diseases we treat and non-somatic sources of misery.

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Conflict of Interest

Author declares no conflict of interest.

References

1. Van Hooft S (1998) Suffering and the goals of medicine. *Med Health Care Philos* 1: 125-131.
2. Jansen L, Sulmasy D (2002) Proportionality, terminal suffering and the restorative goals of medicine. *Theor Med Bioeth* 23: 321-337.
3. Beng TS, Guan NC, Jane LE, Chin LE (2014) Health care interactional suffering in palliative care. *Am J Hosp Palliat Care* 31: 307-314.
4. Den Hartogh G (2017) Suffering and dying well: on the proper aim of palliative care. *Med Health Care Philos* 20: 413-424.
5. Abraham J (2000) The role of the clinician in palliative medicine. *JAMA* 283: 116.
6. Tate T, Pearlman R (2019) What we mean when we talk about suffering and why ERIC cassell should not have the last word. *Perspect Biol Med* 62: 95-110.
7. VanderWeele TJ (2019) Suffering and response: directions in empirical research. *Soc Sci Med* 224: 58-66.
8. Cassell EJ (1982) The nature of suffering and the goals of medicine. *N Engl J Med* 306: 639-645.
9. Ellis J, Cobb M, O'Connor T, Dunn L, Irving G, et al. (2015) The meaning of suffering in patients with advanced progressive cancer. *Chronic Illn* 11: 198-209.
10. Daneault S, Lussier V, Mongeau S, Paille P, Hudon E, et al. (2004) The nature of suffering and its relief in the terminally ill: a qualitative study. *J Palliat Care* 20: 7-11.
11. Montoya-Juarez R, Garcia-Caro MP, Campos-Calderon C, Schmidt-RioValle J, Gomez-Chica A, et al. (2013) Psychological responses of terminally ill patients who are experiencing suffering: a qualitative study. *Int J Nurs Stud* 50: 53-62.
12. Duffee CM (2021) Pain versus suffering: a distinction currently without a difference. *J Med Ethics* 47: 175-178.
13. Duffee C (2021) An intellectual history of suffering in the encyclopedia of bioethics, 1978-2014. *Med Humanit* 47: 274-282.

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14. Edwards SD (2003) Three concepts of suffering. *Med Health Care Philos* 6: 59-66.
 15. Beng TS, Yun LA, Yi LX, Yan LH, Peng NK, et al. (2019) The experiences of suffering of end-stage renal failure patients in Malaysia: a thematic analysis. *Ann Palliat Med* 8: 401-410.
 16. Lethborg C, Aranda S, Cox S, Kissane D (2007) To what extent does meaning mediate adaptation to cancer? The relationship between physical suffering, meaning in life, and connection to others in adjustment to cancer. *Palliat Support Care* 5: 377.
 17. Ruijs CD, Kerkhof AJ, van der Wal G, Onwuteaka-Philipsen BD (2013) Symptoms, unbearable and the nature of suffering in terminal cancer patients dying at home: a prospective primary care study. *BMC Fam Pract* 14: 201.
 18. Renz M, Reichmuth O, Bueche D, Traichel B, Mao MS, et al. (2018) Fear, pain, denial, and spiritual experiences in dying processes. *Am J Hosp Palliat Care* 35: 478-491.
 19. Chochinov H, Cann B (2005) Interventions to enhance the spiritual aspects of dying. *J Palliat Med* 8: 103-115.
 20. Chochinov HM, Hack T, Hassard T, Kristjanson LJ, McClement S, et al. (2005) Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. *J Clin Oncol* 23: 520-525.