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THE ALLEVIATION OF SUFFERING AS THE GOAL OF PSYCHOLOGICAL CARE

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Abstract: It would seem quite clear that what gives meaning to psychological care is the alleviation of patient suffering. But this affirmation is not so evident in some cases. In fact, some psychological care practices overlook suffering. This article explores why suffering is overlooked in some of these practices: first of all, the search for a psychological care which is free from moral judgments; secondly, the incompatibility between suffering and the prevailing psychological care models and thirdly, the professionalisation of the relief of suffering. Finally, this paper reminds that the alleviation of suffering is the goal which gives meaning to any psychological care practice.

Key words: *Psychological care, Suffering, Pain, Ethics of care.*

INTRODUCTION

Every activity is aimed at attaining a particular end, which is what gives it a meaning; a meaning in the sense of coherence between the beginning and the end of an activity. In other words, the movement which causes an activity to start must be maintained until its end, in order to achieve its goal, which is what characterises it (Aristotle, 1985, pp. 131).

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If this teleological representation is applied to psychological care, it should be clear that the meaning of psychological care practice should be deduced from why it starts in the first place and why it is maintained. In this context, psychological care practice is the human action that uses psychological knowledge to help people who suffer psychological problems. Psychological care practice (PCP) is understood here as all the care practices which deal directly with patient suffering and where psychological care has a crucial role.

We are aware of the difficulty of giving such a definition for so many manifold care practices which are aimed at providing psychological care. In fact, we understand that psychological care is mainly carried out by psychology, in the sense that psychology is not only the activity of psychologists but also of all care professionals whose work is aimed at achieving psychological care.[1] When we speak about PCP, we refer not only to clinical psychology, but also to any care profession which is orientated to offer a care relationship, such as psychotherapy, as well as certain medicine, social work and nursing practices, among others.

If we take a look at what initiates these practices, they should start because of the fact that there is a person who suffers and is in need of help (Jackson, 1999, p. 37). The starting movement of PCP is the movement which helps the sufferer. If this is its initial movement, PCP only has a meaning if its end is the relief, the management and the understanding of patient suffering.[2] In this context, the term 'suffering' is used as a psychological experience associated with a perception of a threat of self-destruction (Cassell, 1982, p. 640). The PCP guidelines should be considered as a question that tries to alleviate patient suffering. Only from this point of view is it possible to achieve a guideline for any idea of psychological care (Reich, 1989, p. 93).

Sachs has proposed that the main goal of any PCP should be the relief of suffering, but this author equates it with the search for happiness (Sachs,

[1] In addition, we are aware of the controversy implied by the concept of psychological care, which is not the objective of this paper. This work assumes that psychological care is mostly the professional action which seeks the alleviation of suffering. And although psychological care may be considered to be something more than relief, this paper assumes that psychological care is exclusively the alleviation of suffering because this should be the minimum which any psychological care practice should provide.

[2] It does not mean that there is only one way to achieve it. Actually, this goal of relieving patient suffering can be achieved by different procedures.

1989, p. 145). For us, one thing is the alleviation of suffering, which is depriving the individual of his autonomy because of some psychological problem, and another thing is the independent search for happiness. We consider a psychological problem a situation which provokes suffering in a way that it affects autonomy, autonomy being the individual's ability to freely define himself with specific criteria (Reich, 1989, p. 87).

In short, what we propose is that the PCP goal should be the relief of the autonomy-limiting suffering. The PCP intervention should be the condition of being able to search for happiness, but not something which provides it directly. So, the hypothesis defended is that the PCP goal is the alleviation, the management and the understanding of the autonomy-limiting suffering.

But before arriving at this point, a brief historical overview which could explain clearer why nowadays it is still necessary to insist on our suggestion. In this article, the brief historical overview is a study of the psychological care history and its relations with its current situation. This overview will be useful to show clearly how and why the relief of patient suffering is overlooked in some cases.

THE ALLEVIATION OF SUFFERING AND PSYCHOLOGICAL CARE

In spite of the fact that it could seem quite obvious to say that the psychological care goal is the relief of suffering, it is not clear at all among some professionals.

From the field of medicine, Cassell has pointed out that the medical technology progress has provoked an oversight of the professional obligation of relieving patient suffering (Cassell, 1982). According to this author, this oversight is due to the fact that the concept of person has lost its significance. Because of its specialisation, medicine has abandoned any notion that could be subjective and not directly linked with the body.

This assumption had as a result medicine rejecting the concept of person, which was too abstract. But at the same time, patient suffering was thrown out with the concept of person. In other words, medicine, mostly concerned with body dysfunctions, forgot patient suffering because of its subjective nature. In the cases it did pay some attention to it, it was in the quality of something associated to physical pain, something controllable by medicines and pain-killers.

Likewise in nursing, Ferrell and Coyle have recently pointed out that the medical advances in this field promote models which exclude the person and its suffering. Instead of alleviating suffering, these new medical models contribute to neglecting it (Ferrell and Coyle, 2008, p. 6).

Generally, it has been considered that the concept of person, due to its subjective nature, must be dealt with as a mental category and its study must be performed by the science of mind (Cassell, 1982, p. 640). But if psychology can be considered the science of mind, it has also neglected the concept of person (Barresi, 1999, p. 96).

Although certain humanistic psychological approaches have used this notion (Rogers, 1963, p. 18), they have done so by referring to it as a psychological category. For many authors, these humanistic points of view repeat, like other psychological schools, a theoretical ideal which conceals the real person in grief (Barresi, 1999, p. 79). From this humanistic point of view, the meaning of being a person –and therefore the meaning of the concept of person as well– depends on the success of the treatment.

To sum up, neither clinical sciences nor behavioural sciences have a procedure to deal with all the complexity of suffering (Kleinman, 1988, p. 28). Many of the psychological care theories have been developed in terms of scientific explanations, such as mechanisms of mind, symptoms, or disorders (Bray, 2010); in fact, some authors have noticed that if they do mention patient suffering, it is only indirectly. In a way, this exclusion of patient suffering puts an end to the moral purpose postulated by these type of practices at the beginning of the 20th century (Miller, 2004, X). Some authors have propounded that this exclusion of patient suffering is absolutely inadmissible in PCPs (Miller, 2004, p. 43).

Thereby, some PCPs have dealt with the alleviation of suffering as something implied within it, but, in fact, it is not clear if they provide it (Miller, 2005, p. 323). Sometimes suffering remains as a category which psychological care professionals believe to know what it is, but they neither define nor question it. In other words, as some authors have pointed out, suffering is not a priority for some PCPs and few authors have actually dared to really get into it (Goldberg, 1986; Urraca, 1995, p. 57).

This oversight of suffering in some PCPs could be explained by three reasons: first of all, because of the intention of developing a psychological care which is free from moral judgments; secondly, because of the incompatibility between the concept of suffering and the main psychological

care models; thirdly, due to the extreme difficulty and evolution of the professionalisation of the alleviation of suffering.

THE SEARCH FOR A PSYCHOLOGICAL CARE WITH NO MORAL JUDGMENTS

With the intention of preventing damage, some PCP members have avoided including moral judgments in their practice. It seems that this was a general consensus they were able to achieve. But this consensus implied neglecting other essential phenomena (Miller, 2004, p. 49).

It is true that any care practice implies many moral judgments. But these judgments are more important in psychological care. This is so because psychological suffering needs to be detected by a moral criterion which can assess it; suffering is always linked to a moral dimension which allows it to provide a meaning (Rawlinson, 1986, p. 49).

First of all, it is impossible to deal with psychological problems on a theoretical level without any kind of moral consideration. It is quite difficult to justify the statements about psychological problems due to the fact that there is no decisive empirical reality on which they can be based. The majority of the psychological statements elucidated about mental reality is not proven at all and can actually be formulated in another way.

Secondly, every explanation of suffering conceals an anthropological aspect which assumes a concrete idea of the human being. In other words, any interpretation of suffering adopts an idea about how, why and what suffering is. When someone interprets suffering, it is always from the point of view of a specific idea of good and evil, about what must be done and what not.

Thirdly, every interpretation of suffering requires a person to express it. This interpretation is proposed by an individual world view (*Weltanschauung*) which guides the whole care process. In fact, due to the asymmetric nature of the relation between the professional and the patient, this interpretation cannot avoid being moral. The patient is in a weak position when compared with the professional. The patient does not have a solid criterion with which reality can be judged and he has no other option but to accept the professional's interpretation of suffering (of his own problem). So, according to Miller (2004), a relevant moral component must be acknowledged here. On the contrary, the non-recognition of these different ethical controversies threatens its sense.

For some authors, what is currently happening with Psychology is exactly what happened with religion in the past. In an attempt to avoid the loss of credibility experienced by the theological language, psychology apparently offers a neutral language with which the human behaviour could be understood. By using the authority of science, it has proposed certain concepts which aspired to be free from ideology; concepts that, all in all, are anything but free (Hunter, 2000, p. 7).

Psychology has gained power within institutions. This power is characterised by Hunter as a psychological regime, which stands for a complex net of ideas that try to propagate a strategy to understand morality, learning and living (Hunter, 2000, pp. 7-9). At this point, one could add the fact that this psychological regime also affects the different PCPs.

In addition, the question of theodicy which was an object of study for philosophers and theologians for centuries and is now reduced to psychological categories, such as mental disorder, anxiety or stress. The concept of the evil has been transformed into psychopathology, sociopathology and personality disorders. In fact, this new psychological language minimises the problematic dimension of the human being (Spinelli, 2000, p. 562) and raises a lot of ethical questions.

Like Illouz has pointed out, psychology has replaced religion. According to psychology, suffering is to be treated as a problem of the mind which must be dealt with by experts. For this sociologist, clinical psychology is the first cultural system which discards the problem of theodicy and deals with it as if it were the result of some individual mind dysfunction. Therefore, it satisfies one of religion's objectives: it achieves explaining, rationalising and justifying individual suffering (Illouz, 2010, p. 308).

However, this relation between religion and psychology proposed by Illouz does not seem to be as clear as it should. On the one hand, in spite of the fact that psychology admits dealing with suffering, it does not make it explicit. On the other hand, unlike religion, psychology does not worry about the widow, the foreigner or the orphan, as religion did. In this context, religion is basically understood as Christianity (Borowitz, 1988, p. 568).

As Parker has noticed, psychology indirectly points out that only the individual is responsible for his own psychological problems and it refuses any kind of political or moral approach which can contribute to changing the environment conditions provoking that suffering (Parker, 2010, p. 65). Consequently, a part of suffering which is provoked by

external conditions is not attended to and some psychological care professionals forget the moral and political repercussions of their work.

And last but not least, even if we did have a scientific PCP supposedly without moral judgments, it would still have some implicit moral judgments such as a concrete value of objectivity, honesty or veracity. In short, it is impossible to offer psychological care without moral judgments. Patient suffering is always linked to the social and moral context. In order to cope with patient suffering, it is necessary to deal with the way the actual patient gives meaning to the world and this always has moral and political implications (Reich, 1989, p. 89; Rodgers and Cowles, 1997, p. 1049; Miller, 2005, p. 301).

THE INCOMPATIBILITY BETWEEN SUFFERING AND PSYCHOLOGICAL CARE MODELS

The psychological theories attempted to be useful in the comprehension of suffering, but they were not able to integrate it in their schemas. As a subjective phenomenon, suffering is extremely difficult to turn into concepts (Battenfield, 1984, p. 36). This can explain why in psychological care theories its presence is merely symbolic and trifling, as some authors have suggested (Urraca, 1995, p. 57; Modestin, 1986).

According to Kuhn (1971, p. 108), one could suggest that the problem of some PCPs with suffering has to do with the fact that they are based on a paradigm which cannot deal with it properly. Szasz (1988, p. 66) pointed out this difficulty within the framework of Freud's theory. According to this author, Freud could not integrate suffering in his theory because of his concept of mental structure. According to Freud, suffering is the result of transforming hysterical misery into ordinary misfortune (Freud, 1978, p. 309). In spite of the fact that Freud distinguished three types of unhappiness, which derived from the vulnerability of the body, natural disasters and the relationships among humans, he did not explicitly deal with it (Thompson, 2004, p. 140). It seems that suffering was something implicit in Freud's work, but it was not conceived as an explicit entity.[3]

[3] In the most reputable Spanish translation of Freud's work the concept of suffering (*sufrimiento*) is not within its conceptual index (Freud, 1985, p. 257).

Actually, as Grant (2011) has propounded, suffering is tackled neither by the psychological care models nor by the psychological scientific literature. Every psychological school deals with suffering from its own point of view, which determines what is considered beneficial or painful (Tallis, 1998, 148). There are quite a few reasons which could account for why suffering is not an easy task for the modern psychological care models.

First of all, it is not compatible with the main idea of the mind with which psychological care models work. Many of the modern psychological concepts were originated as a metaphor of technological processes. Some of them are under the effect of a mechanistic metaphor which interprets mental reality as a group of impersonal forces, such as instincts, libido, processes, cognitions, etc. By doing this, the psychological theories convert suffering into a game of impersonal forces which some authors describe as similar to ancient animism (Sarbin, 1986, p. 10).

Secondly, suffering cannot be used as a concept with the current psychological categories because of its intrinsic conceptual difficulties. In other words, suffering is a subjective phenomenon which requires a wider approach and cannot be reduced to other categories, as psychology sometimes does.

An example of this reduction is found in the DSM IV TR. The closer the DSM IV gets to suffering is when it proposes that people suffer mental disorders. It is actually suggested that people can undergo distress, disturbance, disorders, or suicide ideas, but suffering is not explicitly considered as a phenomenon (APA, 2001, XXIX).

In spite of the fact that the DSM was not created with the intention of approaching suffering, certain questions do arise. Which were the criteria for creating it? If the PCP aim was relieving people from suffering, why does this criterion not appear in the classification used to work on it? In other words, why is not suffering the criterion for hierarchically organising mental disorders? The same thing that happened with grief (Granek, 2010), uneasiness or unhappiness (Horwitz and Wakefield, 2007) and shyness (Lane, 2007), seems to be happening with suffering, which is sometimes redefined as a diagnostic category or as a mental illness (Tallis, 1998, p. 4).

Thirdly, the current hedonistic spirit of society has affected how psychological care theories have interpreted suffering. Any interpretation of suffering is related to a range of formal and informal systems that give it a meaning (Morris, 1991, p. 51). In Western societies, there is a wide-

spread belief that suffering will be eradicated thanks to scientific discoveries and technological advances.

But underneath this reliance on scientific progress, there lies an irrational belief of people's suffering being eliminated (Nietzsche, 2003, p. 253). The myth of this new era is that science will eliminate suffering from human life. From this point of view, the scientific technology is the best way to put an end to it (Urraca, 1995, p. 59) and some psychological care professionals share this faith (Bray, 2010, p. 357). But they actually forget that while there are people, there is suffering. Suffering is a phenomenon inherent to human life.

Fourthly, as Urraca (1995, p. 58) suggested, the psychological research on suffering has focused on cognitions, perceptions, sensations and behaviours related to physical pain, but not on suffering as a specific phenomenon. Sometimes suffering has been exclusively associated with a psychology focused on helping terminal patients (Bayés, 2001), as if it were only an object of this particular psychology, but in fact it is not. The clinical setting of psychology has often been concerned with specific pain problems, such as migraines, pre- and post- natal pain, traumatic pain and chronic pain, not paying enough attention to the incidence, the prevalence and the general involvement of suffering in the individual.

THE DIFFICULTIES OF PROFESSIONALISING THE ALLEVIATION OF SUFFERING

These difficulties originate from two aspects of the demanding task of dealing with people's suffering. On the one hand, the fact that the individual is really eager to professionally deal with suffering and, on the other hand, the fact that PCPs have to deal with suffering and at the same time not lose their status of scientific-based practices.

With regard to the individual's difficulties, it is not easy at all to deal with people's grief every day. The care professional must cope with a huge amount of others' suffering his whole working day. This daily contact with suffering can have as a result that some defense mechanisms, which try to avoid dealing with it directly, can appear. The case, as some authors point out (Miller, 2004, p. 44), may be that an implicit agreement between professional and patient on not dealing with patient suffering can be established.

On the one hand, the patient cannot cope with his own grief because he does not have enough resources to do it; and if he did, it would be too

painful. On the other hand, the professional does not want to be mentally disturbed and lose his comfort because of the patient's suffering (Reich, 1989, p. 88).

Moreover, some psychological care professionals make jokes of the patient's difficulties and they justify this by arguing that it is helpful (Sobel, 2006). Some of them are convinced this is a right way of taking a distance from their professional reality. But, in fact, this kind of jokes can affect the quality of the care relationship (Dharamsi et al., 2010, p. 534). As Freud proposed about the content of jokes (Freud, 1986, pp. 97-136), when a care professional makes a joke of the patient's problems, he is damaging the patient's confidence and the therapeutic alliance is transformed into something different.

As some authors have pointed out (Cabós-Teixidó, R., 2012, p. 242), may be the fact that not everybody can perform certain professions, also applies to psychological care. Perhaps not everybody is ready to be a psychological care professional; not every person can deal with other people's suffering.

With regard to the possibility of PCPs being scientific-based practices and at the same time deal with suffering, it is similar to what happens with the individual's conditions of attending to suffering. The scientific aspiration of some of these PCPs has contributed to the fact that they forget the benefits philosophy can offer them and the link between these PCPs and philosophy. But in this oversight, PCPs have lost a great range of possibilities of dealing with suffering.

Psychology, and within it the PCPs, has been assumed to be useful in clarifying psychological problems, but this must be done from a scientific point of view, without philosophical concepts or considerations, which are in fact absolutely necessary to cope with some mental realities. Specifically, most of these PCPs have forgotten the value that the history of philosophy and practical philosophy can have, in order to alleviate and cope with patient suffering and be able to work with concepts related to it.[4] The philosophical attitude, which was so essential in alleviating people's grief (Laín Entralgo, 1987; Jackson, 1999, p. 10-11), has been excluded

[4] This does not mean that we are proposing that philosophy is hierarchically superior to psychology. In fact, in the philosophical activity the psychological variables are fundamental. What we mean is that philosophy can be helpful to psychological care professionals and psychology in general to understand, question and approach some crucial issues.

from some PCPs because it is considered as a not very scientific-based practice.

Furthermore, some psychological care professionals have forgotten that what is now called psychological schools has its roots in the ancient shamans' wisdom, in some philosophers' works and in the ancient medicine and theology (Jackson, 1999, p. 10-11). As Fromm (1985, p. 114) noticed, some professionals think that psychology is a relatively modern science, because the word 'psychology' generally spread in the last 100 or 150 years. But they are forgetting that there was a psychology before this one, which lasted roughly from 500 b. C. until the seventeenth century; although it was not called 'psychology' but 'ethics' and more often 'philosophy', but it was nothing but psychology.

The philosophical tradition provides an attitude that makes suffering more bearable. Philosophy helps to cope with, elaborate and overcome suffering. Actually, philosophy was formerly justified by itself when, through reasoning, it could provide meaning to sufferers (González García, 2006, p. 16; Melley, 1998, p. 39; Nussbaum, 2003, pp. 21-22). According to it, PCPs should pay attention to the history of philosophy, recovering and developing philosophical frameworks with which psychological care professionals can handle suffering better.

However, in the last years there have already been some psychological care professionals working with philosophical approaches (Richards, 2010; Biley, 2010; Maurer, 2010; Briedis, 2011, Roberts, 2008). Part of the psychological care professionals start to realise that psychological care particularly needs philosophy (Dalen, 2010; Christopher, 2011; Rimes, 2011), if they want to cope with all the complexity of suffering.

THE ALLEVIATION OF SUFFERING AS THE GOAL OF PSYCHOLOGICAL CARE

As we have just seen, some psychological care professionals have not paid enough attention to suffering. But, as we mentioned at the beginning of this paper, the meaning of PCPs is surely the alleviation of patient suffering. The relief of suffering is the main sense any psychological care practice must have (Eriksson, 1992, p. 119; Lindholm and Eriksson, 1993, p. 1355).

But this presupposes a concealed moral judgment. As it has been just said, it is impossible to offer any kind of psychological care without

moral judgments. By stating this moral judgment one should accept that psychological problems provoke suffering which must be attended to. It entails mental problems and the individual's existence is inflicted suffering which can disable the individual's autonomy (Carnevale, 2009, p. 180; Held, 2004).

According to Pellegrino and Thomasma (1981, p. 123) the fact of being a patient with a limited autonomy sets an essential condition which cannot be ignored. The patient is the one who suffers: under the label of 'patient' there is a real person who is suffering. 'Person' stands for every individual who belongs to the human species (França, 2005, p. 23). As he cannot do it on his own, the sufferer's condition requires that someone (in this case the psychological care professional) does his best to alleviate his suffering; both in the quality of a care professional and in the quality of a human being, it ethically obliges the professional to attend to the patient's suffering, so that he can recover his autonomy (Reich, 1989, p. 87).

It is clear that there is a suffering which belongs to human life and does not deprive the individual of his autonomy. In our opinion, this kind of suffering should not be the goal of psychological care practices, because life always implies some grade of suffering. However, what determines that a suffering can be PCPs' goal is if it deprives the individual of his autonomy (Rawlinson, 1986, p. 59). Every psychological care professional must evaluate how the individual's autonomy is affected by suffering.

But this declaration of relieving the patient's suffering must also be accompanied by an intention. This intention depends on the professional and must coincide with the movement which began and maintains this kind of practice. The intention which must be the guide of different PCPs is the one which actively looks for the relief of patient's suffering. As Schopenhauer (2007, p. 250) said about morality, what gives moral and human value to PCP is considering the alleviation of patient suffering as a goal of its actions. In other words, the professional ability for taking care of patient suffering. It does not matter how, but *at the very least* the relief of suffering should be the goal of any PCP.

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