The Body in Illness: A Personal Reflection

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Abstract

Can reflection help to heal and enable a moving-on after failed surgery? We present the case of an accident that occurred while the lead author was on holiday, and the subsequent problems that were encountered. Throughout the paper an account of the patient's time in recuperative care is alternately presented and then examined in both a manner of reflection and through the lens of psychoanalytic theory. We explore the question of whether reflection, in addition to being used as a tool to present material, might also has a curative role of its own. This paper presents the symbiosis between illness and the psychoanalytic concepts of psychic retreats and containers. We discuss mourning and the debilitation of slow recovery in an unhelpful medical environment.

Keywords: medical encounter, reflection, anxiety, psychic retreats, Claustrum, container, mourning, depression

The Accident and the Aftermath

Back in August 2007, while on holiday, I fell backwards, knowing immediately that I had torn the ligament in my right knee. Following many consultations, I was fortunate to be offered care by an expert in knee surgery. During my initial appointment (April 2009) it was explained that the posterior cruciate ligament needed to be repaired and that the tibial fracture would be screwed together; after twelve weeks, I was told, I would be back to near normal.

June 2009 saw my fracture pinned and the posterior cruciate ligament relocated. Physiotherapy commenced because for nearly two years I had not been able to bend my knee; now the challenge was to get it moving again. It was a bit of an endurance test despite the physiotherapists, who were very gentle. It was made harder as my walking was restricted to 100

yards, which did not allow me to walk to the end of my garden and back or to the post box. But I felt I was making progress. However, in October I was informed that the screw was too short and needed to be replaced, but the ligament was stable. It was decided that this would be completed in December and would simply be a replacement. This did not alarm me as I know that orthopaedics cannot always be a precise art.

After the operation and post operative x-ray the Registrar explained that the screw was now too *long* and showed me the x-rays. This did not dismay me either since the next morning the Consultant said that it was a quick operation to relocate it, and explained how it could be achieved and the reason why he could undertake it on the emergency list. This was fine. So staying longer was tempered by the expectation that it would soon be over. When the Registrar visited me on the Friday evening I explained what I had been told by the Consultant, and I knew then that he was dead against any operation as he said it had been very difficult. That was the first time I felt uneasy. So when I was seen by the Consultant and he went over what he had previously said, I felt reassured but was aware that the Registrar was not present.

The Consultant requested another X-ray which was complete in the afternoon. In mid afternoon the Consultant sent up his Senior House Officer, who explained that the removal of screw would not be carried out now but after April. I was devastated, as the ward staff were aware of the pain I had and were using ice packs in conjunction with analgesia. It was at this point that it hit me that it was not finished. The was bewildered as to why I was upset, and did his best to comfort me by taking my hand, saying over and over again that all would be well in the end; then he messed even that up by saying that he was not sure how I would control the pain it would bring.

The staff were wonderful, but I could not be consoled. I had not got the closure I expected. The physiotherapist came up and applied a splint; when I explained that the hinge pressed on one of my pain points, she implied that it was too bad and that I would have to wear it for up to twelve weeks. The staff saw my knee from the surgical perspective but they failed to understand how the news would impact on me. My distress was only understood by the ward sister who had been on duty on each of my admissions. It was she who suggested I should stay for another night to come to terms with how I felt. I chose to go and go quickly, as my distress – even to me – was not rational after all my professional training.

Mourning and Moving On

After a few days at home, being unable to control the pain, all I wanted to do was cry. In six weeks' time the splint should come off, but what then? I had to consider the prospect of the screw being removed, the nerves sorting themselves out, or not having been damaged during surgery. All I could think was what might go wrong next. I seem to have lurched from one problem to the next: would it never end?

The brace rubbed against the possible nerve damage and my physiotherapist said that there was no way of modifying this pressure. I felt desolate despite having family and friends around; they did not know what I knew and kept saying it would soon be healed. It was at this point that I considered what I had read and why it felt it was like I had suffered a bereavement. Leader (2008) writes that in mourning, we grieve the dead and ourselves in them; in severe depressive illness, we *die* with them. A sense of loss engulfs them and us in a black hole; and we are forced to consider whether or not there might be a way of navigating that acute sense of deadness to emerge alive? Leader asks: 'once a mourning gets started, can it ever really end?' (p.100), going on later to clarify that mourning 'is not about giving up an object but about restoring one's links to an object as lost, as impossible' (p.134). It is apparent to me now that I was in mourning for my own past self… but often also for the selves that I had changed around me as people coped with my condition. As Leader continues: 'Mourning is not just about mourning the lost loved one, but about mourning *who we were for them*' (p.145).

I was lent two books: *Becoming a Reflective Practitioner* (Johns, 2000) and *The Good, the Wise and the Right Clinical Nursing Practice* (Delmar and Johns, 2008). Reflection provides an opportunity to make sense of an experience, and can indicate how to handle a similar situation more appropriately another time. Despite years of teaching about reflection and trying to engage many professionals in using this art in order to move their personal learning forward, could I now use it myself?

While in a state of gloom I decided (as a normally optimistic person) that I could not live under this persona. I read Hjorth's chapter entitled 'Do I hear the presence of the Other?' (Hjorth, 2008), which explores the awareness of the vulnerability of others, and this became both my starting point and my means of moving forward. Furthermore, Boud *et al* (1985) defined three key stages of reflection in learning: firstly the need to return to the experience, then to

consider one's feeling using an audit of positive and obstructive elements, then re-evaluating experiences in order to find association, integration and appropriation.

The breakthrough did not really begin until the six-week visit. I was back in Outpatients, seeing yet another Registrar, when in walked the Consultant who immediately recognized that I was really in pain and that it was not just post-op. It was nerve damage; analgesia for nerve damage was started and would prove wonderful. The downside was that a splint was to stay and my reliance on crutches to continue. However, I felt that somebody understood what I was going through, so would this turn out to be my turning point?

Commentary

I was trapped inside a condition of ill-health. Undoubtedly there was a sense of *physical* un-readiness to return to the world that I had inhabited before the accident; but might there have been a mental/emotional un-readiness as well? I was present in what Steiner (1993) called a psychic retreat and what Meltzer (1992) called the Claustrum: a self-protective psychic hideaway, from which I had no choice but to contemplate Emanuel's (2001) Void. I was locked into a depressive position and in a depressive recognition, not only of my accident and the subsequent events, but of the prospects for the future. In other words, I had been dragged into a new world and a horrifying mode of existence, my only anchor to the previous world a memory of a regretted slip and the accompanying trials of an actively punitive superego.

Steiner, meanwhile, hints at a more optimistic evaluation. 'It is in the process of mourning,' he writes, 'that projective identification is reversed and the ego is enriched and integrated' (p.59). I was exhibiting a failure to relinquish hold; also failing to allow a separation that is required before any form of psychic healing may take place. In at least one sense, I was paradoxically (and unconsciously) 'happy' in my unhappiness; I was 'comfortable' in my discomfort. Again, in Steiner's words, for many patients there exists 'the realisation of the internal disaster created by [her] sadism and the awareness that [her] love and [her] reparative wishes are insufficient to preserve [her] object' (p.60).

A state of illness infantilises some patients; there are new ways of walking to learn, for example, and methods of containing forms of madness must be explored. A spell in illness feels like a punishment, and this is partly down to the confiscation of choices. At all times on an unconscious level, there is an attempt to reduce psychic excitation to a level zero, via means of extravagant degrees of introspection, into which no non-patient is granted access or may venture.

Moving Forward

In trying to put my life back on track I needed to consider why my normal optimism had failed me. Franken (1994) reflected that when an optimist is confronted with problems which occur across life's domain they will find the positive way forward. Whereas Scott (2011) considered optimists as having a tendency to experience less stress than pessimists or realists, because they believe in themselves and their abilities, so they expect good things to happen. They see negative events as minor setbacks to be easily overcome. Boniwell (2006) speculates that optimism can be defined as a state on mind in which a person tends to think that the chances of things working in their favour are much more than the chances of things working against them. So why was my mental health not protected from the anxiety and the mental pain that I suffered?

Pompele (2011) writes: 'Mental pain is a complex phenomenon. Much as we'd like to think that it can be attacked with the same tools that rid us of physical illness, we are forced to confront the fact of its resilience. It is not that drugs don't offer much needed comfort — they often do… Inner, often invisible suffering has roots that go deeper than misfiring neurons. Comparing it to broken bones, intrusive viruses or runaway cells does not do it justice. Its roots have to do with the very nature of humanity: its finitude, its intrinsic imperfection, its weakness and fragility.' She continues by saying that this anguish can be overcome by the love and friendship of family and friends, which I had, but it did not seem be successful. Since my initial fall I have taken regular analgesic to dampen the relentless pain. The constant anxiety made me not only question why it had gone wrong again; it made me ask if it would ever be resolved, and was this fear linked to a dent in my resilience?

Thernstrom (2006) wrote: 'so what about mental pain? Does this also serve as an important warning system in the same way as physical pain? I think that the analogy holds, with mental pain alerting us to the state of our thinking. As a general rule, when thinking becomes self-centred or anxious, mental pain will occur. When thinking is compassionate, positive and relaxed, our minds are light and at peace. Just as we should be grateful for physical pain for protecting our bodies, so we should also be grateful for mental pain, for providing important signals on the path to happiness and enlightenment.' Neenan (2009) defines resilience as an intriguing yet elusive concept, which has provided us with a way of understanding why a person may crumble in the face of difficult circumstances. In that there is a link between resilience and

positive mental health, can we say that when mental health is impaired then resilience is breached? Some psychologists (e.g. Walker 2008) have described vulnerability as not being a weakness since it is recognised that nobody can have absolute resistance to adversity. Grotberg (2003) considers that resilience to adversity takes over the whole person regardless of personal strength, until a level of transformation emerges. Zautra (2003, p.5) remarks on the reminder 'that during this process there are episodes of both pain and stress which affect the level of negative emotion, but also the relationship between the negative and positive states which can lower the sustainability of a positive affect engaging, so in other words it is not a simple process'. Neenan (2009) refers to this as bouncing back, and adds that bouncing back can make for slow progress.

Communication

Leder (1984) suggested that the patient presents the lived body for treatment, while the doctor treats the objective body. More than ten years later, Laine (1996, p.125) believed that 'learning communication skills in times of change and uncertainty depends on an emotional openness to self and others. Medical educators should use knowledge of patients' perceptions of care to focus teaching on areas that will help trainees to meet patients' expectations. Teaching communication skills should be included at all levels of medical education and, even more importantly, should be a mandatory element of the medical school curriculum and programs of continuing medical education.'

Was my own experience of medical communication bad luck, or is there still a problem with communication? Before my referral to my present hospital, my encounters were with Consultants who (with one exception) had no understanding of the whole person. What have we been teaching in relation to communication over the last thirty years? The one who was interested in how the knee damage impacted on my life was in a private consultation, so should I be cynical and say that this is what you get for paying? If NHS Consultants have less time, is it hopeless to think that they can consider you holistically? If they did, would they get through their clinics?

Visits were like being on a piece of elastic. Once booked in there was about a half-hour wait, then a couple of minutes with the doctor asking why you are there, then off to the X-ray, then on average an hour wait; back to the Registrar/Consultant, who would interpret the x-ray,

and because I was not straightforward, another test or more waiting time to see if it would improve. Sometimes I was used as a teaching aid.

One Consultant said, 'I do not need to ask you any questions, I have read it all, I will add you to my operation list.' End of conversation. Apart from suffering under the hands of the medical staff, I had some encounters with clinic managers too. One caused me a great deal of embarrassment as she rung me up at work. This person's voice was so loud that the student who was with me could hear all that was being said, which was about changing my appointment: she told me that I was being inconsiderate by wanting to alter my time and date! She added that she had been in the health service for fifteen years and was sick of people making demands. After the call, I used the experience, as I knew my student had heard the whole conversation, to explore poor communication. The student will not forget this lesson!

More recently I have been frustrated as the consultation always began with either a Registrar or senior house officer, and on one occasion the Registrar was a research Registrar and he was explaining his research into post-operative knee recovery. He was in the middle of explaining findings when the Consultant came to complete the consultation, and then they left me. So the end of the conversation never occurred and this left me thwarted. On a couple of occasions I did try to get closure but was told they must leave. However, once the Consultant arrived he always treated me as a whole person and went out of his way to find how my condition was affecting my life. Did the fact that he did come to the ward as promised ignite my despair?

Where am I now?

After my immediate post-operation visit and while commencing on tablets to help the nerve pain, I was seen by the Pain Clinic. Here it was suggested that I should have my tablets changed and to use morphia patches, as the other tablets made me gain a stone in weight in eight weeks. I had three almost pain-free days, then I reacted to the morphia, with hallucinations, sickness and headaches.

Immediately following this, it became obvious that the pin had slipped further down my leg and not only could I feel it, I could also see it. So it was agreed that it had to come out and it was removed in the summer. The most marvelous thing was that after the surgery I was allowed out of my state of illness, no more crutches after nearly eighteen months! It was odd to walk free. On the first return visit I was told that all was well, however, on the second it was explained that

the fracture was not healed and I was to have a referral visit to consider the way forward. So in January of 2011, I met another Consultant who sent me for an MRI scan and at the next appointment I was informed that the ligament was not attached to the bone. The upshot of this was more surgery in August, to correct this.

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