



Introduction

Over the past few years an area that I've become increasingly interested in has been the relationship between illness - in particular chronic illness and pain - and art. In year 2000 I was diagnosed with a chronic illness. Whilst learning to live with my disease, I've discovered that there is a vast gap between what objective medical science can observe, diagnose and treat, and what the patient actually feels and experiences. In my earlier works I have explored the wider experience of my illness and how it has affected me psychologically and physically. My research for the installation, *McGill Pain Questionnaire* 2012 focuses specifically on the expression of pain. Through the process of making art, I tried to express my private pain and to make sense of the experience. I was also interested in more objective methods for describing pain, in particular clinical studies and methods that try to quantify what is essentially a very subjective experience.

Throughout the course the more I researched my topic, the more I have found pain to be an enigmatic concept. Pain is something that at one time or another affects almost everyone, yet it is also highly subjective in that its expressions and responses differ between individuals. It is obscurely wrapped up in an intricate web of physical sensations, emotions, memories and cognition. It is not only difficult to describe the experience of pain through language, but also the actual word *pain* has never been adequately defined. One may think of pain only in terms of a physiological sensory experience that is exclusively linked with tissue damage or injury. However recent research shows that pain is an illness in its own right and that it may not only be caused by physical damage to bodily organs and tissue. Pain can in fact exist when there is no apparent cause, or long after a physical cause has been remedied. Some definitions loosely attempt to explain the psychological aspects of pain, but without the experience of misery, anxiety and desperation. To date there has not been a satisfactory interpretation that draws the various dimensions together. Partly this is because one person's pain is confined within his or her

body and cannot be shared nor clearly understood by another. This fact has given rise to a range of clinical methods that aim to define pain in various ways. In art it has inspired different approaches to expressing pain. For this project I have researched selected works by Bob Flanagan and Hannah Wilke who were both compelled to create, define and express the experience of their own illness and pain. In Doris Salcedo's *Untitled* furniture series (1990 -), references to wounding and pain are used as a metaphor to express the physical, psychological and political damage inflicted on a generation of civilians as a result of the Civil War in Colombia.

This paper begins by exploring Hegel's definition of illness in his book, *Philosophy of Nature*¹. Hegel describes illness as a loss of vitality in the organism. He argues that illness can become incorporated into the life of the sufferer and it is then necessary to treat the person as a whole rather than focusing on the individual symptoms of illness. This more holistic view of pain is supported by recent research into the psychology of pain management which shows how the physical, emotional and psychological aspects of pain are interlinked. Works by the three artists I have previously mentioned - Bob Flanagan, Hannah Wilke and Doris Salcedo - will be analysed to show how they have managed to externalise such a subjective experience. One of my past works, *Taint* (2008), is also brought in to demonstrate the relationship between an illness, in this case Obsessive Compulsive Disorder, and an artwork.² Like Salcedo, I often use furniture in my work. In his book *The Poetics of Space*³, Gaston Bachelard describes furniture as an object that both stores one's psychological life as well as transforms one's personal experience into a reliable and orderly structure. This concept of the role of furniture has led me to construct filing cabinets in *McGill Pain Questionnaire*

¹ See Chapt 3C, section 3. Georg Wilhelm Friedrich Hegel, "Medical Science (The genius and the individual)",

² Although I do not have Obsessive Compulsive Disorder, it is something I got interested in as part of my ongoing exploration of the relationship between illness and art. This work was a particularly significant experiment because one of the primary aims was to draw my attention away from my own illness/story. However during the process I discovered that it was not possible for me to detach my thoughts, memories, emotions – all the things that makes me a unique person and an artist- completely from the artwork. Once I realised this I was more at peace with my practice, drive and artistic concepts, and this has allowed me to better balance the objective and subjective natures of my works ever since.

³ Gaston Bachelard, *The Poetics of Space: The classic Look at How We Experience Intimate Places* (Boston: Beacon Press, 1994).

as a means to express the way that medical science tries to measure and record one's personal experience of pain.

Chronic Illness and Pain

According to Hegel, a diseased state, or loss of vitality, manifests when a part of the system or organs become stimulated into something unnatural.⁴ Its cause could be anything from age to congenital defects. Outside influences, which Hegel does not go into details about, could trigger a potentially disease-causing substance to build up its own autonomy against the normal flow of the organism within the body. This substance then becomes isolated within the organism, imposing obstructions on the natural activities of the whole. It transforms itself into an abnormality that takes on a life of its own. Hegel analyses this process by comparing the organism to an inanimate object like a stone. He states that a stone can not get sick, because it is not able to take within its structural body a *separate* being with a different chemical composition than its own. On the other hand, a living body can cope with external influences and still manage to function as a whole; thus the body's capacity to operate despite the condition or action that hinders the natural process of the system differs from the example of a rock. The presence or the cause of illness is to actively oppose the harmonious functioning of the body; an illness means to undertake itself to cause varying degrees of hindrance to the natural flow of the healthy body. Yet the sufferer will manage to live with obtrusive illness as an incorporated part of their life. Hegel also calls disease "irritation"⁵, and argues that our body can still maintain its balance in the presence of irritation - for example the excess of heat constituting fever - without being subject to the entire destruction of the body.⁶ But when this equilibrium is overwhelmed by either excessive irritation or an inability to maintain the natural flow, the organism loses its balance. This can then lead to prolonged disease and potentially even death. The body can

⁴ Hegel, *Philosophy of Nature*, 194-5.

⁵ Ibid.

⁶ Ibid.

only return to a healthy state if equilibrium is restored. Chronic illness, as Hegel defines it, occurs when the system no longer has the ability to overcome the excessive irritation;⁷ the body loses the capability to fight the disease and bring it back to the healthy state. Instead, the abnormality continues to stay isolated and imposes limitations on the activities of the entire body. The affected body, fluid and free in its healthy state, instead becomes fixed and dominated by the illness. Disease is no longer isolated inside a particular organ, nor acts like a separate being to the rest of the body. Because the organism has lost the ability to maintain its equilibrium by this stage, the abnormality extends its negativity towards the weakened centre of the whole body. The system is eventually consumed by the disease, which not only causes dysfunction, but also becomes part of the general life of the individual person.⁸ This statement by Hegel implies a modern outlook, ahead of his time. In dealing with chronic illness, he suggests, *all* aspects associated with it must be taken into consideration, not just the visible elements of irritations; because it is not about the irritation any more. Since the centre of a whole person is affected by the chronic illness, the treatment must therefore deal with this whole person rather than focusing on only the symptoms. A person as a sentient being is more than just a living body with anatomical composites – taking into account mental and social factors, all matters towards chronic illness and pain must be considered to treat the person. This holistic approach has been adopted by current psychologists and pain specialists, and is central to my next argument, however it has taken a long time for it to gain full acceptance with general medical practitioners outside of these specialist fields and is still not fully developed and understood.

⁷ Ibid. 198.

⁸ Hegel, *Philosophy of Nature*, 198.



[Figure 1]

L'homme de René Descartes (reproduced by permission of René Descartes Paris: Charles Angot, 1664)

One of the best-known classical theories of pain is Descartes' pain pathway of 1664.⁹ In the drawing [Figure 1], an external influence such as fire (A) on a person's foot (B) triggers a signal which travels through the leg (C), back (D), and finally into the brain (E) to cause an *alarm* which the person then feels as pain. Descartes claims it is much like the mechanism of a bell-ringing in a church tower - a person pulls a rope near the ground, and the rope attached to the bell on the belfry makes it ring.¹⁰ The bell in the belfry is like the brain that signals pain to the sufferer; the person pulling the rope is like the instigator or cause of the pain. Descartes' pain analogy is purely based on the sensory aspect. It is a logical and causal description in that pain is seen as the direct result of a physical action or injury. This assumption has been the primary view of pain held by medical professionals until recently. According to the psychologist Robert Kugelmann, clinical treatment for pain until 1950s had addressed only the biological, noxious sensations, and ignored anything other than the mechanical processes of the body in terms of disease and pain.¹¹ The technical investigation of pain since Descartes' time goes like this: the spinal cord acts like a bridge from the mechanics of the body to the pineal gland in the brain. Pain was believed to send noxious signals to the brain through the nerves in the spinal cord. Thus in order to eliminate pain, all that was considered necessary was to simply perform an

⁹ Ronald Melzack & Patrick Wall (eds), *The Challenge of Pain*, (London: Penguin, 1988), 150.

¹⁰ Ibid.

¹¹ Robert Kugelmann, "The psychology and management of pain: Gate Control as Theory and Symbol", in *The Body and Psychology*, ed. Henderikus J. Stam, (London, Thousand Oaks, New Delhi: Sage Publications, 1998), 184-5.

excision of the associated nerve by a surgeon, so that the sensory-processing brain could be disconnected and freed from the pain. Since the 1950s however, the medical theory and treatment of pain has undergone a dramatic change with the emergence of new studies. They show that the structure of chronic illness and pain is much more complex than what was once believed. The perplexing structure of pain does not necessarily correspond solely to tissue damage. Recent studies acknowledge the fact that pain is a subjective experience in which the expressions and responses vary between individuals.

Although Hegel's scope of illness in *Philosophy of Nature* was also limited to physiology,¹² his in-depth analogy of illness and how it affects our entire body parallels the current holistic management of pain. These new theses about the causes and treatment of pain were based on practical research which discredited the Cartesian way of thinking about the body. They advocated a two-pronged approach to treating pain. According to these theories biomedical science should be accompanied by the better understanding of the influences of psychological and social determinants – including the sufferer's past experiences, emotions, and the support or distrust of third parties. In these theories pain is interpreted as multi-dimensional, as having both physical and psychological aspects. Dennis Turk, a professor and researcher with special interests in the assessment and treatment of pain, stresses pain is not exclusively confined to the sensory experience; it cannot be presumed that all physical causes of chronic pain must be detectable otherwise they are psychiatric complaints.¹³ Instead, Turk asserts, pain is an intense, individual experience of discomfort derived from complex composites of biological, psychological, and social phenomena. As a result of these views it is now recommended that the objective and somatic view of the body in pain for medical treatment be replaced by a holistic approach; in other words, the body in pain is to be seen as a *person* in pain. This approach mirrors Hegel's statement on the need to view chronic illness as an integrated part of a whole person. However, despite these recent

¹² *Philosophy of Nature* by Hegel was written in the early 19th century and it predates the understanding of the subjective aspect of pain.

¹³ D. C. Turk, "Chronic Pain: Models and Treatment Approaches," in *International Encyclopedia of the Social & Behavioral Sciences*, ed. Neil Smelser, J. and Paul B. Baltes, (Oxford: Pergamon, 2001). Accessed May 24, 2012. Doi: 10.1016/B0-08-043076-7/03897-3.

developments, the Cartesian outlook of pain - narrowly based on only the sensory aspect - is still accepted by many professionals in the field of medicine today. Furthermore, the intensity of pain, until recently, was the only facet to measuring the quality of the experience. The most used method was quantitative measurement - ranging from 0 to 10, with 0 being no pain, to 10 being unbearable pain. Despite the slow acceptance of the new theses, many important studies were directed towards better assessment of pain. For example, the McGill Pain Questionnaire, designed by the psychologist Ronald Melzack, has changed the way that pain is measured. Researching this new approach has been an important aspect of my Honours studio project, which aims to show how art can help to visualise abstract concepts and private experiences that are difficult to communicate otherwise.

For her book *The Body in Pain*, Elaine Scarry researched how the medical profession finds objective ways to measure and record pain. She claims that pain carries a peculiar dichotomy.¹⁴ Because pain is experienced as absolute and undoubtable agony for the sufferer it can be seen as one of the fundamental definitions of certainty. Yet it can also epitomise the very meaning of uncertainty for someone who does not feel the pain. The depth of someone else's pain is difficult to grasp as an observer. There is often doubt in the mind of the person who is witnessing the other's pain even if they are both in the same room. This very quality is what Scarry calls the "unsharability" of pain.¹⁵ Because it is so difficult to communicate pain through language, finding the precise words to convey such subjective and private agony is problematic for the sufferer. Scarry says pain resists the aid of language;¹⁶ that the difficulty of expressing pain through words, whether physiological or psychological, is constantly in battle against a rudimentary scream or moan. However, there are ways to mediate this incommunicability via art, music, or metaphorical descriptions – 'it feels like...', 'it feels as if ...';¹⁷ these 'as if' sentences are often the most appropriate communication in

¹⁴ Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York, Oxford: Oxford University Press, 1985), 4.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Elaine Scarry, "The Poetics of Anesthesia", in *Pain and Its Transformations: The Interface of Biology and Culture*, Sarah Coakley and Kay K. Shelemay, eds., (Cambridge, Massachusetts, London: Harvard University Press, 2007), 281-2.

language to express the pain experience. By presenting comparable connections through metaphorical description, it gives pain material features like shape, weight and colour. An example would be – “it feels like red hot coal searing onto my knees.”

The same effect can be achieved through art; by transforming the original incommunicable and ineffable pain into an object it becomes communicable to others.¹⁸ Rather than pain being a confined internal experience, art allows the private agony of pain to be objectified, externalised, and ultimately become sharable.¹⁹

Other Artists' Works

In order to show how this takes place I have researched the work of three artists who have found a way to transform and share voiceless pain with the audience in their own ways. Artists Bob Flanagan in his *Auto-Erotic SM* (1989) and Hannah Wilke in *Intra-Venus* (1994) have both used their medical conditions as the subject matter for art. The artistic aspect that I can particularly relate to here is the fact that grappling with chronic pain became an unwilling obsession that they were impelled to express through art works. I will also look at Doris Salcedo who has adopted the broader term of pain with a humanitarian outlook in her *Untitled* furniture series. Her pain expression covers the effects of the psychological residues on the daily lives of the families and friends of civil war victims in Colombia. Using domestic furniture in place of human bodies, Salcedo represents pain by altering and disfiguring the original function of the objects.

¹⁸ Ibid.

¹⁹ Ibid. 282.



[Figure 2]
Bob Flanagan
Auto-Erotic SM 1989
Los Angeles

Bob Flanagan was a life-long sufferer of cystic fibrosis, an incurable disease inevitably causing slow and painful premature death. Rather than giving in to the disease Flanagan externalises the private experience of pain into a series of confronting performances. *Auto-Erotic SM* (1989) [Figure 2] begins with graphic slides showing the symptoms of Flanagan's disease and his gruesome medical treatments. This is followed by Flanagan staging several S&M acts with his partner Sheree Rose and then finishes with Flanagan nailing his penis to a small timber panel.²⁰ Through these self-mutilating, extreme performances Flanagan not only aimed to explore and express his masochistic sexual desires, but also to divert his attention away from the degrading routine of dealing with his illness – away from maddening obsession on his sick body and the pain that demand his attention everyday. This channelling of pain into a ritualistic performance becomes for Flanagan a self-prescribed homeopathic medicine that confronts uncontrollable pain with self-willed pain.²¹ Flanagan justifies his extreme performances by saying "I've learned to fight sickness with sickness."²² In doing so he distances himself from the habitual pain involved with the disease and its atrocious medical treatments. Instead he turns his paranoiac and obsessive attention to his penis, as it is one of the only body parts he could still control. Due to the arbitrary nature of the disease and the side effects from the medical treatments, his body has become unmanageable with severe symptoms. The

²⁰ Tracey Warr(ed.), Amelia Jones (survey), *The Artist's Body*, (London, New York: Phaidon Press Limited, 2000) 109.

²¹ Meiling Cheng, *Bob Flanagan's Body Double*, in *The Artist's Body*, Tracey Warr(ed.), Amelia Jones (survey), (London, New York: Phaidon Press Limited, 2000) 229.

²² *Bob Flanagan: Supermasochist*, ed. M. Andrea Juno and V. Vale (San Francisco: Re/Search, 1993) 3.

fear and frustration he feels over the loss of ownership of his own body seems compensated by and proxy for mutilating his sexual organ through the performance. The enactment of bondage and self-torture presents two kinds of pain: the first mimics the brutal medical treatments and their effects; the second demonstrates the release of one's will - in the form of appropriating his daily pain.²³ He thus takes ownership of the pain and *chooses* to share it metaphorically by parodying his loss of control and integrity over his own body due to the illness.



[Figure 3]
Hannah Wilke
Intra-Venus Series No. 5
June 10, 1992
Photography

Unlike Flanagan who objectified his own body to reach out to the audience to communicate his private agony, Hannah Wilke used photography and watercolour drawings to objectify her body *for herself*, by illustrating symptoms of her cancer and invasive medical treatments. Her work *Intra-Venus* [Figure 3] was the very last project completed before her premature death by Lymphoma in 1993. The work documented the final stages of her physical decline and death, and was shown posthumously. It comprises a series of photographic records of the artist's body placed alongside self-portrait watercolours, medical objects, and her hair lost during chemotherapy. By meticulously collecting abject materials from her hospital treatments like used bandages soaked with her blood, syringes, and fallen hair, etc., it seems

²³ Cheng, *Bob Flanagan's Body Double*, in *The Artist's Body*, 229.

as if Wilke aimed to make every effort to understand her impending death. Yet this work is not solely about death. With her frank manner and a hint of humour, it bares all aspects of her cancer-ridden body and soul openly to the viewers. There is a sense of quiet yet iron-willed resistance behind the artist's fragile and swollen body in the confronting images. In every image, like Flanagan, Wilke was not just a simple subject in front of the camera. She maintained tight control over all aspects of the project. Compensating with a sense of control when there is only little control left for the sick person is an important factor in the work. In Wilke's case, this involved obsessively documenting her body under the grip of cancer and the treatments that destructively transformed her into a bloated, bruised and bald figure. For Flanagan, it was the obsessive focus on his penis every hour of every day²⁴ that leads to the mutilation of this organ during the performance. Because of my own experience of extreme pain and illness, I empathise with their self-depictions as ones who have nothing to lose, who have neither options nor time left for them to protect their dignity. It is their final attempt to leave their trace behind in an honest and true form. For me they are heartbreakingly poignant images. Perhaps because I know the routine of my recovery of health after each bout of extreme pain, I feel rather hesitant to place myself exposed in such a vulnerable and private situation in the very moment of agony for all to witness. That is the defining boundary or difference between theirs and my work. I have life to live, thus my pride and dignity still lingers which I inadvertently wish to protect. This attitude is reflected onto the process of my art making, but they did not have this luxury. Both artists have set aside their shame and grief and have instead in different ways pushed themselves to the very limits in the pursuit of their art practice.

²⁴ Bob Flanagan, *The Pain Journal: Bob Flanagan*, (Cambridge, Massachusetts, and London, England: Semiotext(e)/Smart Art Press, Distributed by MIT Press, 2000).



[Figure 4]
Doris Salcedo
Untitled 1992
Mixed media
114.5 x 187 x 51cm

Doris Salcedo's series of *Untitled* works [Figure 4] have also inspired my project in terms of her choice of materials and use of metaphors. Although her works do not directly deal with chronic illness from a medical perspective, the metaphor of pain apparent through her use of furniture parallels my work. In both, furniture is used to symbolise the pained bodies of suffering individuals. Salcedo's works speak of the impact of the civil war on those whose lives have permanently become fractured through physical and psychological pain, torture, loss and grief. The wardrobes and cabinets used by the victims of this war are exhibited as a surrogate for their bodies, memories and the traces of everyday habits left behind. Salcedo transforms the material of the furniture – which is usually mute and rigid – into something quite human. The artist does this by subverting the normally intended functions of the furniture. Rather than storing and organising mundane household objects and such, which once were taken for granted, she paralyses them by pouring wet concrete into or conjoining them with delicate materials like human hair and frail cloth. She comments on the vulnerability of human lives through her metaphorical treatment of humble, domestic furniture. By highlighting the violated function of these objects, Salcedo confronts the audience with an analogy for the pained and traumatised bodies and psyches of individuals who are otherwise voiceless and invisible.



[Figure 5]
Eugenie Lee
Taint 2008
Mixed media
120 x 120 x 60cm



Taint (detail)

The link between domestic furniture and the human body has been a great source of inspiration and led me to produce *Taint* (2008) [Figure 5]. It is based on the various symptoms of obsessive-compulsive disorder (OCD) and is presented in the form of a wunderkammer. In this work, eight selected symptoms were arranged in the top drawer of the cabinet, which was compartmentalised into eight miniature dioramas. The individual scenes within the small cubicles are detailed and compulsively executed. The front doors of the cabinet have two oval shaped panels covered with human hair. Each strain of hair was neatly attached one by one until the panels were fully covered. The repetitive act of placing each hair reflects the fetishising nature of obsessive compulsive disorder. This idea of an obsessive collection is also addressed in my current project in the form of filing cabinets - the physical construction on the outside is like a shell with numerous drawers into which can be stored a myriad of aspects of chronic pain.

In his *The Poetics of Space*, Gaston Bachelard claims various architectural structures that deal with inside and outside such as wardrobes

and cabinets are metaphors for the complex human psyche – our intimate ideas, memories, thoughts and feelings are stored and organised inside of these constructions.²⁵ He also states that drawers in a filing cabinet, shelves in a wardrobe and other purposeful furniture to contain and store objects are symbols for the organs of one's psychological life²⁶ – the outer shell of the cabinets contain objects that conjure up our memories, thoughts, feelings, ideas and knowledge in its drawers and shelves. This idea of Bachelard has informed many of my past works in which I have used the cabinet form. In my current work I also use a cabinet in order to show how pain is measured and assessed.

My Project

McGill Pain Questionnaire explores an artistic way to communicate the unsharable and highly private nature of pain. By finding a method to objectify the subjective experience with an undercurrent of Hegel's definition of chronic illness - the holistic outlook on the pain and illness which incorporates psychological, social, cognitive as well as physiological factors - I hope to reach out to the audience with renewed understanding on this subject. It takes the form of two large sized filing cabinets (360x200x50cm) facing each other. The viewer walks between the two white painted cabinets in a claustrophobic space created by the towering structures and the narrow gap between them. Uniform drawers cover the faces of both cabinets, each labelled with selected adjectives drawn from the McGill Pain Questionnaire – which I will explain later in more detail – and following its 'as if/as though' pain descriptor methodology. There are also viewing windows on both sides showing selected visual manifestations of my own chronic pain.

²⁵ Bachelard, *The Poetics of Space: The classic Look at How We Experience Intimate Places*.

²⁶ Ibid. 78.

If the outside of cabinets and wardrobes are the shell structure for concepts, then the meaning of each concept is the actual contents, classified into each of its drawers. Keeping order of one's psychological life just like administrative materials, a filing cabinet can be used to organise everything in a systematic manner - including abstract concepts which can also be categorised within it.²⁷ Thus irrational ideas or intangible memories may be rationally filed away inside the drawers of the cabinet. Once done, there is no need to rely on memory, which can often be shiftable, to recollect past ideas or events - objectively archiving them in a filing cabinet is more reliable.²⁸ These characteristics of filing cabinets are incorporated into my current project in combination with the medical pain assessment method, the McGill Pain Questionnaire, for clinically cataloguing and measuring pain sufferers' private experiences. [see below]

²⁷ Bachelard, *The Poetics of Space: The classic Look at How We Experience Intimate Places*, 77.

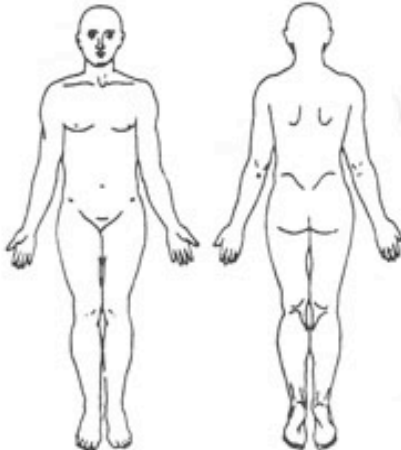
²⁸ Ibid.

[Figure 6]

McGill Pain Questionnaire

Patient's Name _____ Date _____ Time _____ am/pm

PRI: S _____ A _____ E _____ M _____ PRI(T) _____ PPI _____
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The McGill Pain Questionnaire

The McGill Pain Questionnaire [Figure 6] is essentially composed of patients' subjective experiences and metaphorical word descriptions – 'as if/as though' - that are used as a measuring tool for the patients' clinical pain assessment. This method gives sufferers the ability to communicate their pain to their physicians, and is one of the most effective mediators for pain in the

field of current medicine. Once thought doubtable perceptions such as pain can now be clinically diagnosed through this questionnaire, and it has become an important tool for externalising an inherently internal experience. It enables private experiences to be sharable and presents a significant insight into the precise characteristics of an individual's pain, as there are many different forms of it. The questionnaire acknowledges and examines the multi-dimensionality of pain rather than simplifying it wholly into the quantitative intensity of pain – that is, measuring severity of pain based solely on numerical values.²⁹ There are two components to the questionnaire – the Pain Rating Index (PRI) and the Present Pain Intensity (PPI).³⁰ The Pain Rating Index (PRI) is a scoring system which is composed of four major pain descriptors with twenty subclasses – sensory, affective, evaluative and miscellaneous. The *sensory* descriptor refers to the physical sensations; it includes a collection of pain adjectives in subclasses for temporal, spatial, pressure and thermal, such as 'pulsing', 'shooting', 'tugging' and 'burning'. The second major descriptor describes the *affective* qualities of emotional arousal, in terms of tension and fear - lists of adjectives such as 'punishing' and 'terrifying'. The third major class is *evaluative* and is comprised of words that express the intensity of the overall pain experience, for example, 'troublesome' or 'unbearable'. The *miscellaneous* category is a group of words that does not particularly fit into the first three major descriptors, like 'nauseating' or 'torturing'. Each word in the subclasses has numerical ranking values that keep the score. The second component, the Present Pain Intensity (PPI) is a part of *evaluative* category that has a scale from 0 to 5 - from 'no pain' to 'excruciating'; it is used to measure *how much* a person is hurting. Not only has the McGill Questionnaire provided much needed opportunities for pain sufferers to coherently express their experiences but it has also helped researchers to realise a groundbreaking fact - that each type of pain has a unique set of adjectives that belongs to the qualities of that pain disorder.³¹ For instance, as inflammatory pain differs from cancer pain or acute migraine, the collection of words used to describe it would be likely to

²⁹ Melzack, *The McGill Pain Questionnaire*, 277.

³⁰ Melzack & Wall (eds.), *The Challenge of Pain*, 39-41.

³¹ Ibid. 41.

include 'throbbing', 'dull', 'hot', rather than 'stabbing', 'pulling', or 'cold'. Studies of data show an astonishing consistency in the chosen adjectives that sufferers of similar disorders have used to describe their pain.³² These selected words have since become an important language tool for clinical diagnosis. A few adjectives brought up by a patient could give the physician a better chance of determining an appropriate treatment to improve the life of the sufferer. Through this remarkable finding of the consistency of verbal descriptors, pain has become more communicable and also better measured, recorded and referenced.



[Figure 7]

Eugenie Lee

McGill Pain Questionnaire 2012

drawer front (Detail)

These studies have informed my decision to use the filing cabinet format as the verbal descriptions were collected, filed and catalogued for the clinical assessment. Furthermore, the multitude of closed drawers in the installation signifies private information which can only be accessed by a suitable party, and also represents how one's private experiences can never be fully exposed nor conveyed directly, despite the latest methods of medical research. Like pain, which is so difficult to express openly, the drawers are always closed in this work and can not be opened by the viewer. Bachelard highlights the mystery of information behind a closed door:

³² Melzack & Wall (eds.), *The Challenge of Pain*, 43.

*...there will always be more things in a closed, than in an open, box. To verify images kills them, and it is always more enriching to imagine than to experience.*³³

Although I have labelled the drawer fronts with pain descriptive adjectives, the word itself is just as good as a closed door, for there is no adequate substitute for the actual sensation of the pain. The listener, in this case the viewer, can only imagine but not directly experience it. On either side of the filing cabinet structure, however, are window views of scenes suggesting what might lie behind the closed drawers. The windows on the left-hand side cabinet show one particular experience which I feel regularly: “it feels as though strings of barbed wire are scraping against my organs”. To visually implement this effect, I have employed barbed wire painted in black with a moving mechanism behind the viewing window.

As the barbed wire rotates, it scrapes, digs and tears everything within its vicinity. Accompanying this is the eerie noise of scratching. The barbed wire slowly eats away on the inner surface of the Perspex whilst the outside texture maintains the seemingly unblemished smooth texture. It symbolises an experience that is imperceptible, yet it certainly exists for the person feeling it. The right-hand side windows show another pain experience via three video screens: “it feels as if it is pulsing, shooting and stabbing through my organs and muscles”. Each screen shows visual interpretations of these three descriptors. The materials used to illustrate this experience are seaweed and thickened milk. Sensitive to the quality of the ocean environment, seaweed absorbs everything from the water’s mineral contents, also including toxic chemicals leaked into the ocean. As my illness is closely contributed to by environmental factors such as dioxin, I chose to employ seaweed as metaphor for my affected organs.

³³ Bachelard, *The Poetics of Space: The classic Look at How We Experience Intimate Places*, 88.



[Figure 8]

Eugenie Lee

McGill Pain Questionnaire 2012

video 'stabbing' (Detail)

Milk on the other hand represents the hereditary factor of my illness. Although the clear cause of this particular illness is yet to be found, medical practitioners believe there is a strong link to the female family line. My illness is also highly active during child bearing years, so for both these reasons I have used milk. Bachelard's idea, which suggests the humanness of storage furniture like cabinets is thus exemplified in my installation, which combines both the subjective experience and an objectively collected method.

Conclusion

Pain affects most of us at sometime in our lives in one way or another to varying degrees. It brings attention to the fact that the body is not perfect, that our body is vulnerable. The experience of pain, either through illness or injury, is very much a part of our living experience and is also a sign that we are alive. Pain is one of the most undoubtable ways for the body to tell us that something is not right. However, it often creates tension between what one feels and what medical practitioners believe based on the sufferer's description. The objective evidence – for example X-rays or scans – that medical practitioners seek does not necessarily coincide with the patient's felt experience. The internal and subjective nature of pain makes it difficult for a third party to understand its degree and type. Pain is often simply invisible,

and directly trying to communicate this ambiguous yet basic perception can often add to the burden for the sufferer. The negative effects of illness span all aspects of the sufferer's life, not just the physical. In order to treat chronic illness and pain it becomes necessary to address this multi-layered trait. Thus, Hegel's position on the importance of treating *people* with illness as a whole is still relevant today. Fortunately, pain specialists in recent years have started to acknowledge the fact that each pain has unique qualities. Perception of pain is no longer believed to be always symptomatic of a physiological disease or injury that can be traced and seen. However, pain often still leaves medical practitioners baffled. It is even more difficult for the general public to understand the complex nature of pain. I do not propose that the new theories and praxis of pain can answer all the challenges for communicating a sufferer's pain – and this is pointed out in my installation through the closed doors and smooth façade of the Perspex. However in terms of the communicability of pain, the McGill Pain Questionnaire is one of the most appropriate mediators currently available to medical science.

In a similar way art also has a role to play, both as a tool for the sufferer to communicate their pain to others, and in allowing that audience to create meaningful interpretations of what to them is essentially an abstract concept. In fact, pain and art have something in common. They both need metaphorical or visual forms or treatments to be able to communicate and share with others. Through this work I hope to generate a better understanding of the complexities of pain for myself and for the wider audience.

- Written by Eugenie Lee

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