

# Dynamic Autonomy in Chronic Pain Management: Frida Kahlo Illustrates

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## Abstract

The opioid epidemic has brought attention to the difficulty inherent in the medical treatment of chronic pain, a complex and multi-faceted health problem. However, chronic pain also raises questions of autonomy, an important concept in healthcare ethics. Chronic pain management programs that are multidisciplinary and utilize a biopsychosocial model with a strong emphasis on non-pharmacological therapies have become more prevalent as an alternative treatment option. These programs have a strong rehabilitative composition and espouse rehabilitative goals of empowering, guiding, and motivating patients toward involvement and responsibility in their care. The current bioethical conception of autonomy is insufficient in these programs because it presumes a static, stable self-knowledge.

Patients participating in chronic pain management programs are experiencing a dynamic, transformative process that needs a relational-creative-narrative conception of autonomy. By including expressive therapies in chronic pain management programs, patients explore and develop their self-knowledge in order to make the decisions and choices that tell their

life stories. Frida Kahlo's autobiographical art work illustrates how people living with chronic pain can understand themselves and integrate their chronic pain experiences into their lives through an expressive creative process.

Multidisciplinary programs utilizing a biopsychosocial model with a strong emphasis on non-pharmacological therapies are today more prevalent in the treatment of chronic pain because of the opioid epidemic. While medical care has its role in multidisciplinary approaches, rehabilitation offered by physical therapy, occupational therapy, psychology, and addiction counseling is the core of these programs.<sup>1</sup> The strong rehabilitative nature of these programs supports goals of empowering, guiding, and motivating patients toward involvement and responsibility in their care. Within these programs, respect for patient autonomy—a dominant principle in healthcare ethics—is enacted through informed consent that assumes a static, stable autonomy. Yet, patients in multidisciplinary programs are experiencing a life transition full of varying amounts of discontinuity and disorientation. Patients in chronic pain management programs must be able to exercise their autonomy in a meaningful way in order for these programs to be

consistent with the moral commitments of healthcare ethics. The rehabilitative nature of chronic pain management warrants a reframing of autonomy and a reconsideration of healthcare professionals' enactment of respect for autonomy.

This article reframes autonomy as a relational-creative-narrative concept that enables people living with chronic pain and the disability, mental health issues, and addiction that may be associated with it to untangle and interpret their lived experiences within their life stories. I explain the complexity of chronic pain and outline the multidisciplinary programs with a rehabilitation focus that are a response to the multifaceted and complex problem of chronic pain. My claim is that autonomy conceived and enacted as a medico-legal process is insufficient for people living with chronic pain who choose to participate in chronic pain management programs. Rather, autonomy in rehabilitation requires a situated conception that considers the dynamic self-knowledge patients need in order to make the autonomous decisions and choices that integrate their lived experiences of chronic pain into their life stories.

Multidisciplinary programs support and promote such a conception of autonomy by including the use of expressive therapies, such as art therapy, music therapy, dance/movement therapy, drama therapy, and play therapy, as a treatment option. Through expressive therapies, patients have the time, space, and attention requisite to explore and develop their self-knowledge. Healthcare professionals respect their patients' autonomy by providing a means for patients to creatively paint, write, move, enact, or play their lived experience. Consequently, patients are able to exercise their autonomy in ways that make sense of their experiences and tell a meaningful life story.<sup>2</sup> That is, patients creatively express their autonomy as

autobiography.

## Frida Kahlo and Chronic Pain

The medical imagery of Frida Kahlo's art work portraying her experiences of chronic pain has been influential in understanding patients' experiences of chronic pain.<sup>3,4</sup> Although engaging with the medical imagery in Kahlo's art work may generate valuable insights for healthcare professionals, previous authors have missed an important contribution that she brings to the lives of patients themselves. People living with chronic pain and its consequences benefit from understanding their experiences within the context of their lives. Engaging in creative expression helps people explore their sense of self, make sense of their pain experiences, and meaningfully exercise their autonomy in the narrative of their lives. Kahlo's body of artwork threads throughout this article to illustrate how she expressed a lifelong relational-creative-narrative conception of autonomy in telling her story. After all, storytelling, like pain, is as old as humanity.

Kahlo (1907–1954), a Mexican artist in the first half of the twentieth century, struggled with disability and chronic pain from her young childhood. At the age of six, she contracted polio and spent a year convalescing to recover her strength and health. As an active, vibrant child, she worked hard throughout her childhood to regain her strength—although her right leg never fully recovered. In her teenage years, Kahlo was an exceptional student and wanted to study medicine. But she also dabbled in photography and painting, because she was close to her father who was a professional photographer and amateur painter. Unfortunately, her student days ended abruptly when she was involved in a catastrophic streetcar accident at the age of 17 and spent a year recuperating and convalescing. There is no record that she participated in rehabilitation, a new

healthcare field at that time; however, she received a considerable amount of medical care to address her illnesses, injuries, and chronic pain and spent lengthy parts of the last 10 years of her life recuperating and convalescing in hospitals.

## Chronic Pain and Multidisciplinary Rehabilitation Programs

Chronic pain is currently entangled in the opioid epidemic—a public health crisis of opioid abuse, addiction, and overdose deaths that has become one of the biggest social problems in the United States. People living with chronic pain became involved in the opioid epidemic subsequent to the public health crisis of undertreatment of pain.

Because relief of pain and suffering is a core goal for medical practice, pain was declared the fifth vital sign in 1995 and became a key focus of medical care under the auspices of the medical model.<sup>5</sup> Physicians were expected to treat all pain aggressively with pain medications. Aggressive pain management encompassed chronic pain as well as acute pain and pain in active cancer, palliative, and end-of-life care. Opioids, strongly and fraudulently marketed by pharmaceutical companies, became the pain medication of choice for physicians to prescribe. Due to the misinformation disseminated with little actual guidance, physicians, thinking that opioids were effective and safe in the long-term management of chronic pain, misprescribed and overprescribed opioids, with a false sense of security, for people living with chronic pain.<sup>6</sup> The “dual public health crises of undertreated pain and opioid misuse/abuse”<sup>7</sup> have since been problematic in the treatment of chronic

pain—a complex and multi-faceted health problem.

### THE COMPLEXITY AND SUBJECTIVITY OF CHRONIC PAIN

The medical treatment of chronic pain is complex because of its etiology, its pathophysiology, and its psychosocial effects on those living with chronic pain. First, chronic pain “arises from a complex web of heterogeneous illnesses and injuries.”<sup>7</sup> It may occur singularly, as a group of co-morbidities, or as a series of co-morbidities. Consider the story of Jim, a healthy 43-year old, who sustains a knee injury that either does not heal well or does not recover well from surgery, which leads Jim to suffer from chronic knee pain. To make Jim’s story more complicated, he also has diabetes and is physically deconditioned as a result of working many years at a sedentary job. His comorbidities negatively affect the tissue healing in his knee leading to chronic knee pain and adding to his other health problems. Adding yet another, even more complex, layer to this medical story, Jim, with comorbidities of diabetes and deconditioning has knee surgery and develops Complex Regional Pain Syndrome, a chronic pain condition with systemic ramifications.

Next, chronic pain is defined pathophysiologically as pain lasting more than three months or as longer than what medical science understands to be the normal healing time for the affected tissue.<sup>8</sup> However, the character of chronic pain is more complex than this definition, because it occurs at varying intensities, frequencies, and durations. As with all pain, chronic pain is a subjective report by patients that is assessed by healthcare professionals using a variety of pain scales and questionnaires. The frequency and duration of pain is also subjectively reported by patients and

fluctuates with their physical activity, emotional states, and psychosocial circumstances. However, chronic pain does not necessarily follow explainable biological patterns of pathology and impairments. While all pain is held suspect because of its subjective nature, chronic pain that is disassociated from physical pathology is even more highly suspect.<sup>9</sup> The distinct subjectivity of chronic pain makes it difficult for medical science to particularly locate the source of the pain in order to recommend, and treat with, effective medical interventions.

Last, not only does chronic pain *arise* from a complex web, it *creates* a complex web. In summarizing the psychosocial effects of chronic pain, the American Academy of Family Physicians (AAFP) states that “in addition to the physical discomfort, chronic pain causes significant work absenteeism, family disruption, and impairment of normal activities of daily living, resulting in secondary depression, social isolation, and low self-esteem among other consequences.”<sup>9</sup> Chronic pain is a debilitating health condition experienced by people in a holistic way involving their physical, emotional, and psychosocial selves.<sup>10,11</sup> Daniel Goldberg<sup>9</sup> summarizes the social experience of chronic pain as silencing, stigmatizing, self-isolating, and socially alienating. The experience of chronic pain can leave people triply disabled: first by their pain, then by mental health issues of depression and anxiety, and, if opioids are prescribed inappropriately or used inappropriately, by drug addiction. The medical model grapples with adequately treating all the aspects of chronic pain.

## THE MULTIDISCIPLINARY TREATMENT APPROACH

Recognizing the complex, multi-factorial nature of chronic pain and its medical assessment and treatment,

pain researchers and government agencies have more recently emphasized treatment within a biopsychosocial model<sup>8,11</sup> with a strong emphasis on non-pharmacological therapies.<sup>12</sup> Professionals develop multidisciplinary programs from an ethical orientation of utilizing healthcare sciences to improve the well-being of people living with chronic pain. The biopsychosocial model is enacted through multidisciplinary programs whose overarching goal is to promote patients’ active self-care and self-management.<sup>12</sup> Typical strategies include patient-professional goal setting, patient education on the science and mechanisms of pain and chronic pain, and physical and psychological self-care. Teams of healthcare professionals from multiple disciplines work to execute the strategies of these programs.

Within the multidisciplinary teams,<sup>13</sup> physicians provide medical evaluations and recommendations including the selection and dosing of pain medication—primarily non-opioid. If necessary, outpatient medication-assisted treatment for addiction is also provided. Nurse practitioners can also provide these medical services, and as a part of multi-interdisciplinary teams addressing chronic pain, they often regularly assess and monitor drug usage plans with patients including dosing, effectiveness, and side effects. Physical therapists provide instruction and training focused on aerobic exercise and strengthening while occupational therapists provide instruction and training focused on daily functional activities. Psychologists, counselors, and social workers provide emotional and mental health care using a variety of approaches and techniques such as cognitive behavioral therapy (CBT), stress and/or anger management, coping and problem-solving skills,<sup>13,14</sup> and, if needed, addiction counseling. All healthcare providers integrate patient education into their care. This variety of healthcare providers represents the

biopsychosocial model that provides the multidimensional care people in chronic pain need.

The structure and content of a multidisciplinary program's protocols are developed by its healthcare professionals and based on a scientific approach to chronic pain. Through the evidence-based practice of their disciplines, various healthcare professionals delineate the specific treatment options available to patients. Programs offer inpatient and outpatient services with defined requirements of frequency and duration of attendance including a set number of weeks with specific hours each day that the patient is required to attend. Additionally, each patient follows a structured protocol of treatment interventions and activities within specific time frames, such as 30 minutes of aerobic exercise or an hour of CBT. Interventions and activities may be group-based or have both group and individual components, and are inclusive of families.<sup>11,14,15</sup> In this manner, healthcare professionals decide what treatment options are best for and available to patients. Although care may be individualized by giving a patient the choice to ride a stationary bike or walk on a treadmill for aerobic exercise, a patient entering a multidisciplinary program agrees to follow the established protocol of the program within the limits created by the healthcare professionals through evidence-based practice.

The scientifically-established protocols of multidisciplinary approaches are rooted in the healthcare ethics principle of beneficence—which can often be, despite good intentions, paternalistic. The protocols are beneficent because healthcare professionals are acting both in accordance with, and in a manner that, contributes to the welfare of patients in their programs. At the same time, they are paternalistic because they assume healthcare science and its professionals know best how to treat chronic

pain and its associated mental health conditions and addiction. Certainly, people living with chronic pain who may also be experiencing disability, depression, anxiety, or addiction are vulnerable and seek the help of healthcare professionals, hopeful that their pain can be relieved and that their lives will change in positive ways. However, paternalistic beneficence must be balanced with the moral principle of respecting patient autonomy.<sup>16</sup>

## Relational Autonomy in Rehabilitation

In healthcare ethics, respect for patient autonomy is a concept that places an obligation on the healthcare professional to respect patients' choices regarding their treatments. In multidisciplinary programs for chronic pain, once a patient is believed to have decision-making capacity, they exercise their autonomy legally through informed consent when entering a program. Through their informed consent, a patient agrees to follow the established protocol of the program. Their choices are thereby limited to the established structure, time frames, and treatment interventions offered within the protocol.

A medico-legal operation of respecting autonomy as informed consent is a “minimalist interpretation of individual and personal autonomy”<sup>17(p39)</sup> and does not adequately reflect the complexities and uncertainties of a vulnerable patient's autonomy.<sup>17</sup> It is also contrary to the rehabilitative goals of empowering, guiding, and motivating patients toward involvement and responsibility that are espoused by multidisciplinary programs for chronic pain.<sup>18</sup>

## A DIFFERENT CONCEPTION OF AUTONOMY

Rehabilitation, as a practice of helping people recover from disabling illnesses and injuries, requires a different conception of autonomy and enactment of respect for autonomy than medicine because patients' experiences of their autonomy are situated differently during rehabilitation. In medical contexts, the conception of autonomy is based on an either-or proposition judged by a healthcare professional about a patient's decision-making capacity; the patient either has decision-making capacity, and thus autonomy, or they don't. Respecting autonomy, then, is "generally no more than informed consent requirements...[which] amounts simply to a right to choose or refuse treatments on offer and the corresponding obligations of practitioners not to proceed without patients' consent."<sup>17(p37)</sup> Rachel Haliburton's<sup>2</sup> conception of autonomy that situates the person and their decision-making "within practices, narratives and tradition"<sup>2(p287)</sup> is more fitting for rehabilitation contexts. In rehabilitation, respecting autonomy involves healthcare professionals supporting the dynamic autonomy of a situated person as they adapt and adjust their value judgments and choices in the narrative of their recovery. Understanding patients' lived experiences of chronic pain and their autonomy in rehabilitation is essential for an understanding of autonomy and of respecting autonomy in rehabilitation.

## RECOGNIZING EXISTENTIAL CRISES

People living with chronic pain who seek multidisciplinary healthcare services are often experiencing an existential crisis.<sup>19-22</sup> Elaine Scarry

claims that pain has the "power to end all aspects of self and world."<sup>23(p34)</sup> Not only are people in pain; their life as they have known it is lost.<sup>23</sup> They are disoriented because every aspect of their lives—their physical and mental health, their relationships and roles, their economic welfare, and their life aspirations—is disrupted.<sup>1</sup> They are vulnerable and seek help to learn adapting and coping strategies in order to improve their quality of life. Any disabling injury or disease disorients a person, throwing into question one's knowledge of who they are and what values and beliefs they are enacting in their decisions and choices.<sup>2,17</sup> For Haliburton,<sup>2</sup> self-knowledge is needed not only to be able and free to make choices; self-knowledge encompasses knowing what values, beliefs, relationships, and aspirations underpin and determine those choices. During the disabling experience of chronic pain, self-knowledge is dynamic—devolving and evolving as people attempt to accept and adjust within their unsettling, changing life course.<sup>24</sup>

In identifying unique characteristics of autonomy in rehabilitation care, Caplan et al<sup>25</sup> state that coping with disabling injuries and illness during rehabilitation "leaves some patients emotionally unwilling to try and make decisions for themselves even though they retain the cognitive capacities to do so."<sup>25(p11)</sup> These authors support "an infringement of autonomy [by rehabilitation professionals] in the short run...during the initial stages of rehabilitation" as a justified harm because patients may be "depressed and demoralized by the severity of their impairments"<sup>25(p11)</sup> to the point of not being able to participate in decision-making for themselves. Although Caplan et al<sup>25</sup> also support the return of decision-making to patients as they adapt to disabilities, the transference of authority is still framed in the medical conception of respecting autonomy that assumes a stable self-knowledge underlying autonomous decision-making.

## Supporting Patients’ Dynamic Self-Knowledge

During the rehabilitative process, a stable self-knowledge is not lost and found; self-knowledge changes and develops as patients learn new information and skills and have time for personal reflection and observation.<sup>22,24</sup> Dynamic self-knowledge can complicate or thwart a patient’s everyday autonomous decision-making concerning their quality of life, self-care, and self-management that rehabilitation requires. For professionals, the moral challenge to respect patient autonomy during rehabilitation is not simply allowing and granting the transfer of decision-making authority as patients recover. Their moral responsibility lies in supporting the dynamic self-knowledge of patients that empowers autonomous decision-making in consideration of the values, beliefs, relationships, and aspirations within their lives.

Nancy K. Schlossberg’s transitional model in adult development theory helps clarify the concept of dynamic self-knowledge and elucidates how autonomy is a process that takes time and may occur in an ebb-and-flow manner.<sup>26</sup> Schlossberg’s model incorporates both anticipated and unanticipated transitions in a person’s life course. Life transitions, whether positive or negative, change the “individual’s roles, relationships, routines and assumptions,”<sup>26(p38)</sup> leaving them confused and “adjusting to discontinuity.”<sup>26(p3)</sup> According to Frederick Hudson, transitions are “a natural process of disorientation and reorientation that alters the perception of self and world and demands changes in assumptions and behavior.”<sup>27(p96)</sup>

## LIFE TRANSITIONS

People living with chronic pain experience several life transitions:

- Because the experience of chronic pain begins with an unanticipated bodily insult through illness or injury, a person first encounters a life transition to that of a person in pain.
- When they turn to healthcare professionals, hopeful that medical science will relieve their pain, they transition to being a patient.
- When medical science is not able to cure their pain, they face another unanticipated transition struggling to cope and adapt to the disabling experience of chronic pain, often without adequate and timely help from healthcare professionals.<sup>28</sup>
- They learn and adopt strategies that are often maladaptive, negatively impacting their relationships and life plans.
- Additionally, mental health issues and addiction may become factors in their disabling experience of chronic pain.

When the experience of chronic pain continues to be a struggle without positive results, multidisciplinary programs are an important treatment option for people to consider.

Entering a multidisciplinary program, people living with chronic pain begin the rehabilitation process as an anticipated transition in their life. Although the transition to acceptance and self-management of their pain is positive and anticipated, it is still another

evolution in their life course that will require “adjusting to discontinuity ... [because] old strategies no longer work.”<sup>26(p3)</sup> The unsuccessful strategies they developed transitioning first to a person in pain and then to a person living with chronic pain must change. The patient is challenged to “uncover their own sources of strength and adaptation”<sup>26(p3)</sup> in order to learn more about their self and the values and beliefs that make sense in their life and contribute to living a meaningful life.

## EVOLVING RELATIONSHIPS

As the patient’s physical and psychological capabilities change with time and with the progress they make in rehabilitation care, autonomy as situated and relational involves evolving relationships between patients, caregivers, and healthcare professionals.<sup>2,27,29</sup> Harold Braswell<sup>29</sup> asks, “What kind of relationships cultivate autonomy?”<sup>(p86)</sup> While this is an important question in the lives of patients progressing through a rehabilitation program, the more pointed and necessary question is, “What is the patient’s relationship with their self?” Their relationship with self grounds their relationships with others and guides their autonomous decisions and choices about their roles, relationships, and life plans. Developing new self-knowledge during rehabilitation, a patient’s relationship with self changes, empowering them in making their autonomous decisions and choices about how to live in the world in new ways.

A conception of autonomy as relational and dynamic is more robust and better suited for enacting respect for patient autonomy in the complex and multi-faceted nature of chronic pain management programs. Within the disorientation and reorientation of transitioning during experiences of chronic pain and its consequences, patients seek help “to perceive and

organize their life stories, learn to use and make sense of their experiences, and reconstruct their narratives during a life transition.”<sup>26(p55)</sup> For patients in rehabilitation, they, and their autonomy, are transforming and growing as they gain self-knowledge and clarity regarding their values and beliefs and reorient the construal of their life.

## Frida Kahlo and Dynamic Self-Knowledge

Frida Kahlo illustrates how a person’s self-knowledge and relationships change as they transition through recovering from a major health crisis and cope with disability and chronic pain. While Kahlo was recuperating from the streetcar accident, her parents brought her art supplies to her hospital room and an apparatus was built so that she could draw and paint while lying down.<sup>30</sup> A friend remarked that, through painting, Kahlo formed a new identity.<sup>31</sup> Interpreting her work, art historian Frank Milner<sup>32</sup> notes that she reinvented herself and that her paintings, rather than conveying meaning, are emblematic, “speak[ing] most clearly of herself.”<sup>31(p86)</sup>

Explaining her multitude of self-portraits, Kahlo claimed, “I am the person I know best.”<sup>30(p3)</sup> Kahlo painted several early self-portraits against a blank background, but starting with “Self-Portrait - Time Flies,” 1929, she contextualized and situated her remaining self-portraits. In “My Grandparents My Parents and Me,” 1936, Kahlo painted herself within her family as an infant. In her unfinished family painting, 1949-1950, she paints herself as an adult within her family tree. She represented her changing relationship with her husband, Diego Rivera, a prominent Mexican painter. In “Frida and Diego



Rivera,” 1931, which was painted around the time of their wedding, they hold hands, but stand apart. In “Diego and Kahlo,” 1944, Kahlo painted them sharing a face, conjoined and inseparable from each other.

Kahlo’s art work, however, expresses more than her relationships with the people in her life. In many self-portraits, she painted backgrounds of vines, leaves, and roots, both literally and metaphorically representing her relationship with nature. She also included her pet birds, monkeys, and dogs in many self-portraits. By creatively symbolizing and depicting her Mexican culture and heritage and her political affiliation with the Communist Party, Kahlo also painted her relationships with landscapes and her socio-political environment.<sup>30,42</sup>

Through her art, Kahlo conveys her relationship with herself and her relationships with the people, circumstances, and contexts that formed her and influenced her life. She represents her whole person over time making sense of her experiences, decisions, and choices within the “practices, narratives, and tradition”<sup>2(p287)</sup> of her time and culture, which Rachel Haliburton claims is the basis for situated autonomy.<sup>2</sup>

## Creative Autonomy Through Expressive Therapies

In order to employ a conception of autonomy that is relational, dynamic, and reliant on patient self-knowledge, patients need opportunities to explore, communicate, and integrate their lived experiences of chronic pain and its consequences. Expressive therapies (also called expressive arts therapies or creative arts in counseling) are treatment interventions that use the arts to foster potentiality and possibility.

According to Cathy Malchiodi,<sup>33</sup> the use of arts for healing and health has a long history and has developed into a psychotherapy and counseling treatment modality. Natalie Rogers, a pioneer in the field of expressive therapies, describes expressive therapy as “non-verbal and/or metaphoric expression [with the ability] to facilitate growth and healing.”<sup>34(p2)</sup>

Malchiodi defines expressive therapies as “the use of art, music, dance/movement, drama, poetry/creative writing, play, and sandtray within the context of psychotherapy, counseling, rehabilitation, or health care.”<sup>33(p2)</sup> Each of these creative mediums can be used separately or in conjunction with other mediums as a therapeutic technique. However, collectively they constitute their own distinctive domain as a means of “self-expression and...as a language”<sup>35(p122)</sup> between the patient and the therapist. Although the unique therapies have similar and different goals,<sup>33</sup> they all are active processes that reflect a dynamic, therapeutic style that promotes personal change, which is essential for patients caught in the web of the experience of chronic pain and its consequences.

### ACTION AND VERBAL EXPRESSION

The therapeutic basis of expressive therapies is a synthesis of action expression and verbal expression. The patient engages in a non-verbal process of active self-expression via their imagination to create a project. The creative project furnishes “access to whatever might be in the vast reservoir of the unconscious so that [patients] can break through habitual patterns of perception, thought, and behavior, a goal central to all therapy.”<sup>36(p81)</sup> Using “verbal reflection about the product or experience,”<sup>33(p10)</sup> the expressive therapist works to guide patients “toward understanding, respecting, and integrating as much of themselves as

possible.”<sup>36(p81)</sup> The active engagement of creative practices enables patients who are negatively affected by the daily sensory experiences and limitations of chronic pain to perceive their potential for making new, positive, and meaningful changes in their lives.

## FIVE STAGES OF CHANGE

Expressive therapies can be used to intervene at any of the five stages of change—outlined by Kerns et al<sup>37</sup> as precontemplation, contemplation, preparation, action, and maintenance. Holt and Kaiser have studied the benefits of expressive therapies particularly on patient motivation in the early stages of change.<sup>38</sup> By gaining self-knowledge about their behaviors and how those behaviors conflict with their values and goals, a patient comes to understand how their behaviors affect others and their social environment. Moreover, patients can recognize alternative behaviors available in their social environment. In addition, the action-verbal synthesis of expressive therapies that leads “to insight and the discovery of new or repressed parts of the self”<sup>39(p402)</sup> is beneficial during all the stages of change during rehabilitation.

Because expressive therapies promote “thinking in a flexible and exploratory manner,”<sup>40(p432)</sup> patients reveal and assert their lived experiences differently in each stage of change. Someone in the precontemplation stage of change, where their interest in changing is limited, will express their lived experience differently in a creative project than if they were in the action stage of change where they are actively working to change their behavior. Assisting patients “to recognize the voices from the inside, so they can find their way clearly and negotiate successfully through the hazards and alternate routes along their separate pathways”<sup>36(p81)</sup> supports self-knowledge and promotes a robust, dynamic conception of autonomy in

rehabilitation.

Including expressive therapies in healthcare to foster self-knowledge would be especially fruitful for people living with chronic pain.<sup>22,33,41</sup> Providing patients with the access and the means to use a creative, intuitive, and imaginative process to express their lived experiences, chronic pain management programs give patients the opportunity for deeper reflection and meaning-making about their experiences of chronic pain and its consequences. Developing flexible and open-ended thinking skills is “associated with coping skills and positive mental health, as well as resiliency and even happiness.”<sup>40(p432)</sup> Finding a deeper sense of oneself and a better understanding of oneself through expressive therapies allows patients to develop their autonomy by expressing their chronic pain narratives in their own chosen creative way—by, perhaps, writing poetry or identifying songs that connect to their lived experiences, or choosing to perform a dance practice.

## Frida Kahlo and Creative Autonomy

Illustrating creative autonomy, Frida Kahlo firmly knew that she was using her visual art to express her lived experience of chronic pain, declaring: “My art is not from my imagination, but from my reality.”<sup>42(p266)</sup> Andrea Kettenmann<sup>31</sup> remarks that Kahlo’s “works should be viewed as metaphorical summaries of concrete experiences” where “fact and fiction fuse in her works...as two components of one and the same reality.”<sup>(p20)</sup> Kahlo juxtaposed the harsh medical nature of her spinal surgery against the background of her native Mexico in “The Broken Column,” 1944. She painted herself standing with one foot in Mexico and one in the United States in “Self-Portrait Along the

Border Line Between Mexico and the United States,” 1932. Two paintings, “The Two Fridas,” 1939, and “Tree of Hope,” 1946, are each double self-portraits representing, in the former, her feelings surrounding her divorce and, in the latter, her hopes for recovering from a spinal surgery.

While painting was Kahlo’s primary creative expression, she also used many other expressive arts during her life. Recovering from polio when she was a child, Kahlo participated in masculine sporting activities such as bicycling, boxing, and wrestling, expressing her physical exuberance and rebellious personality.<sup>42</sup> As an adult she dressed in traditional Mexican dresses and costumes, making a spectacular, dramatic sight on the streets of major cities such as New York, Paris, San Francisco, and Detroit. She also loved singing and leading sing-alongs of traditional Mexican songs and political songs. One story of Kahlo describes her engaging in dramatic/performance arts. While ill and bedridden after spinal surgery, she contrived puppet shows using her feet. Through all of these creative expressions, she narrated her life in meaningful ways.

## Narrative Autonomy as Autobiography

A patient’s story of chronic pain and its consequences may be told in two ways: as biography or autobiography. The medical chart is the patient’s biography as told by the healthcare professionals who treat them.<sup>43</sup> The chart records the facts and events of the medical story that professionals identify as significant in rehabilitation care, constructing the patient as the object of the medical chart with their illness as the topic of the story.<sup>44</sup> Reflecting the

biopsychosocial model, multidisciplinary chronic pain management programs consider and chart many aspects of patients’ lives such as familial relationships, daily living functions and adaptations, the patient’s willingness and compliance with program protocols, and insurance funding and limits. Because of its importance for treatment decisions about healthcare, the medical chart’s focus remains on the story of the patient as told by the healthcare professionals rather than on the patient’s lived experiences of chronic pain.

As a biography, the medical chart is meant to be a valid interpretation of the patient in order to address the patient’s chronic pain with appropriate interventions.<sup>45</sup> Yet, it separates the illness from the person and their life story. This separation may be useful for scientific evaluation and determination of interventions; however, a medical chart cannot encompass a patient’s lived experiences.<sup>44</sup> It contextualizes the patient’s experiences to specific medical times and places, thus limiting the patient’s story to the medical chart. Chronic pain, along with its associated mental health conditions and possible addiction, is “embodied in a particular life trajectory, envired in a concrete life world.”<sup>45(p31)</sup> Not only does a patient have a life that holds their story of chronic pain; their story of chronic pain holds their life. Healthcare providers, as biographers, have limited knowledge of this intricate and interdependent connection within a patient’s lived experiences. This limited contextualization is not enough to understand a patient’s autonomous decisions and choices. Professionals in chronic pain management programs need autobiographies to meaningfully interpret and respect a patient’s autonomy.

## THE PATIENT’S VOICE

One critique of current chronic pain management

guidelines by the American Association of Family Practice is that “the patient voice and preferences were not explicitly included.”<sup>46</sup> This is problematic because patients are “wounded not just in body, but in voice.”<sup>37(pxii)</sup> Yet, to improve their physical and mental health, patients who become disabled from an injury or illness that causes chronic pain, and its possible mental health conditions and addiction, need to find their voices and tell their own stories.<sup>47</sup> As an autobiographer, “the patient’s attention is focused on [their] self.”<sup>48(p5)</sup> Professionals need patient autobiographies to meaningfully interpret and respect a patient’s autonomy. According to Roy Pascal, autobiography is both historical and cultural as “an interplay, a collusion, between past and present; its significance is indeed more the revelation of the present situation than the uncovering of the past.”<sup>48(p11)</sup> Jerome Bruner sees the self in autobiography as both narrator and protagonist, with the protagonist “always...pointing to the future.”<sup>49(p121)</sup>

## AUTOBIOGRAPHY IN REHABILITATION

In rehabilitation, patients can take time to review their life, both past and present, in an effort to understand their experiences of coping with their pain and disabilities. From their unique position, patients relate and interpret their interactions with the facts, events, and circumstances of their life, especially their chronic pain experience.<sup>48</sup> By choosing the events to highlight and to relate in telling their own story, patients make meaning of their current life experience. By making autonomous decisions and choices, patients tell their own story, moving forward to transform their relationships to themselves, to others, and to their own life.

“In response to a rupture or turning point in the course of [their] life,”<sup>50(p33)</sup> patients tell stories as a part of their experience of chronic pain. Telling their stories, patients can make judgments and choices about how to cope in both small and large ways, and how to live with the disorientation of their experiences.<sup>45</sup> Telling a story that explains past and present, patients reveal their life’s threads of relationships, emotions, personality, and personal ethics. They try to find meaning in past experiences, make meaning of present experiences, and envision meaning for future experiences.

To tell their stories of chronic pain, patients reconnect their bodies to their selves and their selves to their world, then portray their story “through the body.”<sup>37(p2)</sup> Using expressive therapies as a transformative therapeutic engagement of the patient with their imagination and creativity, patients tell their stories through the body in a multitude of ways that may or may not require the voice, yet represent the voice. Because expressive therapies “involve the [patient] in the invention of his or her own world”<sup>28(p75)</sup> and in the development of their internal voice, they are able to re-examine, re-imagine, and re-tell their chronic pain narrative within their life story. Developing knowledge about one’s self and one’s values and beliefs empowers patients in their autonomous decision-making that engenders a narrative voice telling their stories.

## Frida Kahlo and Autobiography

Through her lifelong artwork, Frida Kahlo portrayed her autobiography, finding ways to live a life that was meaningful to her and to the world. Although Kahlo’s paintings representing her chronic pain and health

problems have received particular attention in healthcare fields,<sup>3,4</sup> they are only a small part of her body of work. Through personal creative expression, Kahlo made sense not only of her chronic pain experiences, but also of her life, which has led to her legacy as an autobiographical painter.<sup>42</sup> Her body of work tells us her story. She contextualizes and represents her life from her birth scene to her death. She understood herself and creatively expressed her experiences, feelings, and ideas<sup>31,42</sup> regarding her relationships, socio-political world, and her connections to nature. Milner<sup>32</sup> notes that her “symbolism is...straightforwardly intelligible, usually representing specific autobiographical problems and anxieties.”<sup>(p17)</sup> From her creative expressions, we are able to know her and better understand the decisions and choices she made in her life.

In her last signed painting, “Viva la Vida,” 1954, Kahlo ends her artistic career with a painting of watermelons symbolizing both the vitality of life and the certainty of death in Mexican culture.<sup>42</sup> The watermelons are set against a setting of blue skies and rich, brown earth. One watermelon is depicted as a whole in smooth, deep greens while another is depicted from its roughened stem-end in exploding greens and yellows. The remaining ones are cut and arranged in assorted positions showing their brilliant red flesh and their vital black seeds. In this celebratory completion of her autobiography, Kahlo portrays life as vibrant and abundant and, with the painting’s inscription, invokes us all to “live life.”<sup>42</sup> An autobiography that all patients living with chronic pain should have a chance to tell.

## Conclusion

Advancements in pain science will continue to guide treatment interventions in multidisciplinary

rehabilitation programs for chronic pain; however, patients in life transitions need time, space, and attention to tell their life stories in creatively transforming ways.<sup>2</sup> Hudson<sup>27</sup> describes living creatively during transitions as “collaging your way through time and space. You arrange and rearrange your colors and shapes as you move along. You pick and choose, search and find, wander and get lost, cut and paste—assembling and disassembling yourself and the universe around you.”<sup>(p202-203)</sup> Reframing autonomy as a relational-creative-narrative conception allows for situated and dynamic selves that are changing, growing, transforming. By participating in a creative process during their life transitions in rehabilitation, patients gain new knowledge about themselves and their values and beliefs that informs their autonomous decisions and choices as they express and integrate their chronic pain experiences within their life story.

A relational-creative-narrative conception of autonomy also opens the way for healthcare professionals to fulfill their moral responsibility regarding their patients’ autonomy. By encouraging and supporting their patients’ narratives of chronic pain experiences within their life stories, they promote, rather than simply respect, patient autonomy. Chronic pain management programs meet the moral dimensions of their patients’ care by including expressive therapies interventions as an opportunity for people living with chronic pain to make sense of their experiences, develop new self-knowledge, and to tell their life stories.

The meaningful exercise of autonomy is an important goal of healthcare ethics. Examining autonomy in a rehabilitative setting allows for a reframing that can be expanded to all healthcare settings. A relational-creative-narrative conception of autonomy throughout healthcare promotes a more robust consideration of

patients' changing relationships, their creative responses to life transitions, and their life stories, that is, their dynamic autonomy.

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