Chapter 9
Phenomenology of Chronic Pain: De-Personalization and Re-Personalization

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Abstract This paper has four tasks. First, based on a phenomenology of personhood, it argues that the subject of chronic pain is not the body, conceived neurophysiologically, but the person, conceived phenomenologically. Secondly, it demonstrates that the processes of de-personalization and re-personalization make up the essential temporal structures of chronic pain experience. Thirdly, it offers an answer to one of the central objections raised against phenomenology of illness and pain, which suggests that phenomenology offers a solipsistic account of pain experience, which does not facilitate but impedes empathy and understanding. Fourthly, the paper maintains that the recognition of the de-personalizing and re-personalizing dimensions of chronic pain experience compel one to rethink some of the central distinctions entrenched in phenomenology of medicine, such as the distinction between organic and psychogenic pain, illness and disease or healing and curing. The paper concludes by addressing the therapeutic significance of dialogue.

1 Introduction

In what follows, I will understand phenomenology of pain as a form of pain research, which conceives of pain not as a neurological phenomenon, but as a lived-experience, and which aims to grasp the essence of this experience by following the methodological guidelines grounded in classical phenomenological principles.[1] By defining phenomenology of pain in such a manner, I depart from a widespread tendency to misidentify phenomenology as a form of introspection and

[1]Here I rely on the essential principles of Husserl's phenomenology, and especially on how they are presented in Husserl (1983), §2–§4.

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to reduce this area of research to empirical descriptions of factual experiences. With the aim of revitalizing the phenomenological ambition to be an eidetic discipline, in the following investigation, I will defend the claim that the processes of de-personalization and re-personalization make up the essential temporal structures of chronic pain experience.[2] By defending such a claim, I will depart not only from those empirical accounts, which identify phenomenology with introspective psychology, but also from the dominant penchant in phenomenological literature on pain, which invites one to focus exclusively on pain's de-personalizing consequences. Indeed, while pain's de-personalizing effects have been repeatedly addressed in phenomenological studies of pain,[3] there is, to the best of my knowledge, not a single study, which thematized chronic pain as a process of re-personalization. I will argue that, so as to overcome this limitations, besides marking the subject's withdrawal from the common world, chronic pain also resettles the subject in a new world, which one now needs to inhabit. In short, my claim is that there is no chronic pain, which is not de-personalizing and re-personalizing.

Four introductory remarks are in place. First, there are different types of pain. In what follows, I will exclusively focus on chronic pain; namely, pain which persists for months or years, which extends beyond the expected period of tissue healing, and which refuses to be explained as a mere effect that follows from tissue damage. Secondly, the notion of pain is equivocal not only because there are different types of pain, but also because there are different sciences of pain, which conceptualize pain in significantly different ways. A neuroscientist understands pain as a neurochemical phenomenon; a psychologist, as a cognitive and emotive phenomenon; an anthropologist, as a socio-historical phenomenon. In the midst of these equivocations, phenomenology invites one to keep the established conceptions at arm's length and focus instead on how pain manifests itself not in someone else's, but in one's own personal experience. One is thereby invited to concede that the pre-scientific experience of pain is the very subject matter of diverse sciences of pain and that scientific determinations are meant to be nothing other than clarifications of pain experience. In my following analysis, I will understand chronic pain as an *aversive sensory feeling, which can only be given in first-hand experience, which can be (although need not be) triggered by tissue damage, and which must have three essential qualifications: it must be temporally extended, it must be localizable within the body, and it must be experienced indubitably*. Thirdly, I will

[2]I do not claim that chronic pain is the only kind of de-personalizing and re-personalizing experience. Rather, to put the matter in those terms that Husserl employs in §3 of his *Ideas I*, chronic pain is a "particularization" (i.e., an instance) of a group of experiences (a group that also includes other experiences, such as depression and melancholia), whose *Eidos* consists of de-personalization and re-personalization.

[3]In this regard, see especially Scarry (1985). According to Scarry's central claim, while physical pain is inexpressible and "unmakes the world," the creation of verbal and material artifacts, which ultimately relies upon the powers of imagining, remakes the world.

focus only on pain as given from the first-person perspective. Fourthly, I will focus exclusively on human pain.

Within such a thematic framework, I will strive to accomplish seven goals. I will begin by subjecting the neurophysiological identification of the body as the subject of pain to a phenomenological critique. Secondly, with an eye on the phenomenological distinction between the lived-body and the physical body, I will argue that at the level of the body, chronic pain is to be conceived as the lived-body's protest against its "constitutive appropriation," i.e., the implicit and explicit sense it has been given in one's personal experience. Thirdly, I will contend that by enhancing phenomenology of the body with a phenomenology of personhood, one wins the insight that the subject of pain is not the body, conceived physiologically, but the person, conceived phenomenologically. Fourthly, I will argue that chronic pain is a de-personalizing experience in that it unsettles the fundamental relations that bind the person to his body, surroundings, others, and himself. Fifthly, I will argue that chronic pain is just as much a re-personalizing experience in that, due to its temporal nature, it forces the person to reconstitute those fundamental relations that pain disrupts. Sixthly, I will show how such a conception of chronic pain forces one to reconceptualise some entrenched distinctions in phenomenology of medicine: the distinction between psychogenic and organic pain as well as the illness/disease and healing/curing distinctions. Finally, I will conclude by addressing some further implications that are inscribed in the proposed phenomenology of chronic pain. The implications in question concern the presumably non-sharable nature of pain experience and the therapeutic significance of dialogue.

2 Can the Physiological Body be the Subject of Pain?

According to one of my claims, *the phenomenological concept of the person designates the subject of human pain, and more precisely, chronic pain*. Admittedly, this claim sounds trivial. Who else can the subject of human pain be, if not the person who has it? This claim, however, is set against one of the dominant approaches to chronic pain in medicine; namely, what Mariet Vrancken has labelled as the "somato-technical approach" (Vrancken 1989), or, what one could more appropriately call the exclusively neurophysiological approach, which identifies the brain as the location of pain, and which suggests that pain originates in the periphery, then travels through the pain pathways to the brain, until it is finally sensed in the brain as a copy of what took place in the periphery (cf. Thacker 2015). Supposedly, when a physician fails to identify an organic cause of pain, s/he must conclude that the patient's suffering is psychic, and that the patient is in need of a psychiatrist, not a physician.[4] In the framework of such an approach, to understand

[4]Besides Vrancken's study, see Szasz (1975). Both provide a telling account of the reasons that motivate physicians to suggest to their patients that they visit psychiatrists. As a rule, these reasons

and treat pain, one must turn exclusively to the body, conceived as a system of chemical, electrical and mechanical functions, one must identify the neurophysiological causes that give rise to pain, and look for ways to eliminate their effects. Thus, according to the exclusively neurophysiological approach, the subject of pain is not the person, but the body, conceived neurophysiologically.[5]

Such a neurophysiological identification of the body as the subject of pain suffers from three fundamental problems. First, this approach is incoherent. The neurophysiological approach presupposes a mechanistic conception of the body. Yet, insofar as the body is conceived exclusively mechanistically, it cannot be conceived as the subject of any feelings; and if it is incapable of feeling, it is incapable of experiencing pain. Secondly, this approach proscribes both the recognition and the treatment of the so-called psychogenic pain—pain which does not derive from organic, but rather purely psychic causes.[6] If one begins with the assumption that the subject of pain is the neurophysiologically conceived body, one inevitably loses the capacity to recognize and treat psychogenic pain. Thirdly, this approach underestimates pain's deeper effects upon the person. FJJ Buytendijk emphasized this point especially strongly. Against Max Scheler, who in his *Formalism* maintained that pain is nothing other than a feeling-state and that therefore, the subject of pain is not the self (that is, the person) but the body, Buytendijk insisted that pain has its effects on the deepest levels of personality: "The more violent a pain, the deeper it penetrates, affecting not merely the 'body-self,' but our actual personality as well" (Buytendijk 1961, p. 114). More recently, Mick Thacker reiterated the significance of this insight when he wrote: "I remain unconvinced that brains are sufficient for pain…. I believe that the only entity sufficient for the experience and perception of pain is the person" (Thacker 2015, p. 3).

(Footnote 4 continued)

derive from the physician's failure to discover an organic cause of pain. Realizing this, patients commonly interpret such referrals as signs of the physician's disbelief that they are in pain (Szasz 1975, p. 92). This view is further corroborated by Arthur Kleinman as well as RA Hilbert, who suggest that "pain patients feel biomedical practitioners routinely delegitimize the experience of their illness, pressing them to believe that it is not real or, at least, not as serious as they fear it to be" (Kleinman 1994, p. 170).

[5]In phenomenological literature, James and Kevin Aho have recently emphasized this point: "in medical science the corporeal body is both de-contextualized and de-animated. Medical science does not treat persons as such; it deals with human organisms" (Aho and Aho 2009, p. 77). This point is further echoed by Alfred I. Tauber: "…we recognize that as the body is reduced to just so many materialistic parameters of measurement, the person inhabiting that body may be de-personalized, if not lost altogether" (Tauber 2002, p. 9).

[6]See Szasz (1975), pp. 93–99.

3 Chronic Pain as a Bodily Phenomenon

To return to Buytendijk, what exactly is the "body-self?" The bodily dimensions of chronic pain experience call for a more precise determination. It is one of my claims that the experience of pain, and especially chronic pain, is to be conceived as the body's protest against the self. To clarify the meaning of this claim, it is necessary to briefly address the phenomenological distinction between *Leib* and *Körper.*

To think of the body as lived-body (*Leib*) is to thematize the body at the *pre-reflective* level of immediate experience. Following Husserl, I would like to provide this concept of the body with four fundamental determinations. First, the lived-body is the *zero point of orientation*: it is the *absolute here* to which the relative *here* and *there* relates. The lived-body is the perceptual organ of the experiencing consciousness. As Husserl puts it, "The 'far' is far from me, from my Body; the 'to the right' refers back to the right side of my Body…. I have all things over and against me; they are all 'there'—with the exception of one and only one, namely the Body, which is always 'here'" (Husserl 1989, p. 166). Secondly, the lived-body is *the organ of my will and the seat of free movement*.[7] "While extra-Bodily things are only moveable mechanically, the lived-body is "the *one and only Object* which, for the will of my pure Ego, is *moveable immediately and spontaneously*" (Husserl 1989, p. 159). A third central determination suggests that the lived-body is *the expression of the spirit*. "The Body is not only in general a thing but is indeed expression of the spirit and *is at once organ of the spirit*" (Husserl 1989, p. 102). Fourthly, Husserl also addresses the lived-body as the *bearer of localized sensations* (Husserl 1989, §36 and §40). It is the body that feels pains and pleasures, warmth and cold, tickles and irritations.

By contrast, to think of the body as physical body is to thematize it as the *reflective* level of experience. At this level, one understands the body (*Körper*) as an object extended in objective space and located in objective time. Interpreted as *Körper*, the body is a naturalistically conceived material thing and not a personalistically conceived animate organism (*Leib*). To be sure, my own physical body (*Körper*), for the simple reason that it is *mine*, is unlike any other object. Yet the *mineness* (*Jemeinigkeit*) of my physical body (*Körper*) already designates a modified (in Husserl's words, *founded*) self-relation: in contrast to the lived-body (*Leib*), the physical body (*Körper*) is no longer the body that I am; it is the body that I *have*.

Drawing on Husserl's analysis of bodily constitution, one could characterize chronic pain as the body's inner protest against its constitutive appropriation. In this regard, four points require a special emphasis. First, although we feel pain in our lived-bodies, chronic pain no longer enables one to say that the lived-body is the *zero point of orientation*. In the usual flow of experience, the lived-body, while itself remaining non-thematic and non-objective, provides the self with contact with

[7]While extra-Bodily things are only moveable mechanically, the lived-body is "the *one and only Object* which, for the will of my pure Ego, is *moveable immediately and spontaneously*" (Husserl 1989, p. 159).

all other material things. By contrast, the body-in-pain shows itself as a living wall, which blocks one's access to other objects of experience. Secondly, chronic pain brings into question the qualification of the lived-body as *the organ of my will and the seat of free movement*. Pain experience is *the lived-body's protest against the will*; it is its *resistance* that takes the form of freezing the lived-body's free movement,[8] chronic pain also renders questionable the qualification of the lived-body as the expression of the spirit. When a cancer patient asks the doctor to amputate his limb and thereby eliminate or at least alleviate his pain, it is hard to conceive of his body as an expression of what Husserl calls "the spiritual world." Fourthly, despite this threefold protest, the body-in-pain retains the sense of being the bearer of localized sensations. Such being the case, one can qualify chronic pain as the experience of the body's inner protest against the basic sense it has been given in one's personal experience.

4 A Blueprint of a Phenomenology of Personhood

Eric Cassell has argued that medical practice systematically suppresses what is specifically personal, and thus, at least in the framework that concerns health care, "we still do not know how to define a person" (Cassell 1978, p. 96). As we will soon see, without clarifying the notion of the person, one cannot determine the subject of pain. The regrettable situation of which Cassell speaks can be corrected by turning to Edmund Husserl's phenomenology; specifically, to the conception of the person he presents in *Ideas II*. According to Husserl, it is a matter of a category mistake to conceive of a person in a purely mechanistic way. To be a person is to be an embodied subject of cognitive, emotive, and practical acts. To be a person is to stand in an intentional relation to the surrounding world and in a communicative relation to others. These various acts that the person lives through build up the person's unique history, which up to a large degree determines the person's style of existence. This history, taken along with the cognitive, emotive, and practical acts, colours the subject's intentional relation to the world in a particular atmosphere, which *motivates* the person to project particular plans into the future.

It is important not to confuse motivation with causality. While causality rules over *nature*, motivation finds its place within the horizon of *understanding*. If, when I leave my apartment, I see dark clouds in the sky, I feel motivated to bring an umbrella with me, just as when I realize that I am running late for an important meeting, I feel motivated to catch a taxi. Motivation is a peculiar kind of non-mechanistic causality, which relies upon the person's capacity to discriminate between different possibilities, granting some more, others less weight. These

[8]In this regard, with a reference to Heidegger's analysis of *Zuhandenheit*, one could liken the experience of pain to the lived-body's *unreadiness-to-hand*: just as a piece of equipment becomes noticeable when it no longer functions properly, so the lived-body becomes thematic when it is no longer an obedient servant of the will.

differentiations rely upon subjective expectations, and thus exclude objective necessity. Material things cannot choose to follow or not to follow mechanistic laws. By contrast, the person always remains free to choose certain plans over others as well as to engage in these rather than other activities. No matter how dark and heavy the clouds might be, I can always choose not to bring an umbrella with me; no matter how important the meeting, I might choose not to take a taxi. In short, a person is a subject of various cognitive, emotive and practical acts, as well as the subject of a unique history, which constitutes the subject's distinctive relation to the surrounding world and a distinctive communicative relation to others.

5 Chronic Pain as De-Personalization

It is my thesis that chronic pain emerges in the field of experience as a rupture at the very core of our personal existence. To determine this notion of pain as a rupture more precisely, it is important to distinguish between four characteristics.

First, chronic pain disrupts the usual relation between the self and the body. In the normal flow of experience, this relation is marked by the body's subservience to the self, yet chronic pain destabilizes this relation. And thus, patients suffering from chronic pain often experience their bodies with what the phenomenologically oriented anthropologist, Byron Good, has so appropriately called an "irrational sense of betrayal" (Good 1994a, p. 127): "I think it's against me, that I have an enemy," as some patients with chronic pain have proclaimed.[9] The body-in-pain is experienced as *paradoxical*: it certainly retains the sense of being *my own* body; and yet (as patients struggling with chronic pain so often point out), it has also become something alien, something that resists the self.

Secondly, by disrupting the usual relation between the self and the body, chronic pain also transforms the person's *self-relation*. It does this by taking away from the person the capacity to accomplish some of the most basic activities and by robbing the person of self-confidence and self-reliance. One can no longer confidently walk down the steps, carry a cup of coffee to the table, or shake someone's hand. Having lost self-confidence and self-reliance, one feels crippled.

Thirdly, chronic pain also disrupts the person's perceptual, affective, and conceptual relation to the world. Blepharitis blinds us, the migraine makes it hard to contemplate our thoughts; an asthma attack forces us to forget our affective relation to others. Chronic pain transforms the body into a living wall that stands between

[9]Or as Brian—Byron J. Good's interviewee—puts it, "and then it goes back into my conflict about my body. Is it my body? Is it my thinking process that activates physical stresses? Or … is it the other way around?" (Good 1994b, p. 35) Consider also Gordon Stuart's, a thirty-three-year-old writer's, who is dying from cancer, observations: "The feeling there is something not me in me, an 'it, eating its way through the body. I am the creator of my own destruction. These cancer cells are me and yet not me. I am invaded by a killer…. Cancer makes us think of a lingering torture, a being eaten away from inside. And that is what it's been like for me" (Kleinman 1988, p. 148).

the self and the surrounding world: in the extreme case, the body-in-pain becomes the one and only perceptual, affective and conceptual object, whose sheer magnitude blocks the person's access to any other object.[10]

Fourthly, chronic pain unsettles the person's relation with others. First, one must stress the isolating nature of pain experience. Being in principle non-shareable, pain introduces a breach between the person in pain and everyone else. Secondly, the experience of pain lies at the limits of understanding. This point has been forcefully stressed in anthropological studies of chronic pain. As Arthur Kleinman has famously put it, "If there is a single experience shared by virtually all chronic pain patients it is that at some point those around them… come to question the authenticity of the patient's experience of pain" (Kleinman 1988, p. 57). Alternatively, in the words of Jean Jackson, "After a while, no-one believes you" (Jackson 1994, p. 138).[11] Thirdly, chronic pain renders *homo patiens* dependent upon others. Thus, the relation between the one in pain and others is fundamentally asymmetrical: the other—the very one who cannot understand me—is the only one who can help me overcome my pain.

In short, chronic pain is a rupture that unsettles four of our most fundamental relations: (1) the relation between the self and body, (2) the person's self-relation, (3) the relation between the self and the surrounding world, and (4) the relation between the self and others.[12] Pain is a de-personalizing experience, in these four fundamental ways.

[10]See Sartre (1956), and especially the section "The Body as Being-For-Itself: Facticity" (pp. 404–445) and "The Third Ontological Dimension of the Body" (pp. 460–471).

[11]These references to A. Kleinman's J. Jackson's and B. Good's studies are meant to illustrate the philosophical fruitfulness of anthropological studies of pain. It is highly regrettable that to this day, neither the phenomenologically oriented anthropologists, nor the phenomenologically minded philosophers have shown interest in each other's works. In this regard, Katherine J. Morris' recent study (Morris 2013) is a noteworthy exception. This work reconstructs the main reasons that have led medical anthropology to consider phenomenologically relevant themes. This study also spells out the main phenomenologically resonant themes that have emerged from anthropological studies of pain.

[12]I readily admit that these four kinds of disturbance are not unique to the experience of pain; they also aptly characterize other forms of affliction, such as illness. Yet chronic pain does not affect the body the way illness does. *While illness affects the whole body* (and thus we would never say that our head, or our lower back is ill), *chronic pain is always located within the body* (and thus it is always our head or our lower back that is in pain). Due to its localizability, chronic pain marks the relation between the self and the body as profoundly and irreducibly paradoxical. One the one hand, the body in pain could be characterized as both subject and object. On the other hand, the body in pain could be further said to be both subservient and insubordinate to the self.

6 The Challenge of Solipsism

At this point, I would like to briefly turn to Tania Gergel's critique of the phenomenology of medicine, which equally applies to phenomenology of pain.[13] As Gergel sees it, one of the fundamental goals of the phenomenology of medicine is "to give an account and help us understand illness as it is experienced by the ill individuals themselves" (Gergel 2012, p. 1104). Yet, as Gergel sees it, the phenomenological emphasis on the disruptive effects of illness (as well as pain), does not facilitate, but rather impedes, the capacity to understand and relate either to illness, or to ill individuals. "Far from enabling empathy and understanding, if the true conception of illness resides in the ill individual's personal experience of the phenomena, we might well ask how it can ever be truly communicated and understood by another" (Gergel 2012, p. 1104). As Gergel sees it, this is not only a methodological difficulty that hinders phenomenological studies of illness (and pain); it also impedes phenomenology's central ambition to facilitate a dialogue between patients and healthcare practitioners. If illness is confined within the boundaries of experience, then we inevitably come to confront *the challenge of solipsism*: besides the subject of experience, the experience of illness turns out to be inaccessible to anyone else.

How legitimate is this critique? Does phenomenology truly maintain that the concept of illness *resides* in the ill individual's personal experience in such a way that it would elude interpersonal understanding? This is a highly misleading qualification of the phenomenological standpoint. The suggestion that the concept of illness *resides* in the experience of the patient is an instance of *psychologism*, which was the central target of Husserl's critique in his Prolegomena to the *Logical Investigations*. It would be much more appropriate to qualify the phenomenological perspective as a standpoint, which aims to ground the concepts of illness and pain in experience, yet not to bind them within personal experience. Among other things, this means that illness and pain are not reducible to the physiological conception of the mechanisms that underlie the organism's functioning. Rather, illness and pain are rooted in experience.

Gergel's (2012) characterization of phenomenology of illness (and pain) is a good illustration of the kind of widespread misinterpretation of phenomenology of pain that I mentioned at the beginning of this paper. Supposedly, the task of phenomenology of pain is that of offering an empirical description of the experiences pain-patients live through. This is far from the truth. The task of phenomenology of pain is no different from the task characteristic of any phenomenology. The task is to provide insight into what is essential about experience (in this particular case, pain experience). My claim that the concepts of pain and illness are grounded in experience suggests that particular experiences of illness constitute the phenomenal basis that underlies an eidetic description of the essential structures characteristic of pain and illness.

[13]See Gergel (2012, pp. 1102–1109).

7 Chronic Pain as Re-Personalization

On the one hand, chronic pain de-personalizes the self in four fundamental ways. On the other hand—and this is the theme I want to address now—chronic pain is a deeply personal experience. Although Max Scheler famously called pain "death in miniature," there is a significant difference between the two. In contrast to death, chronic pain is something that one can and inevitably does respond. These responses to pain are constitutive in two different ways: they co-determine the feeling of pain; they also form the person one becomes. How shall I respond to pain? I cannot help, but must choose a way; and the way I will choose will not only co-determine my experience of pain, but also from the person I will be.

Arguably, the responses to pain are essentially of three different types: *bodily, emotive,* and *cognitive*. First, consider how our muscles tighten and our posture changes in response to both chronic and acute pain. Such bodily responses almost immediately become part of pain experience. As seen from the phenomenological standpoint, it would be a crude mistake to understand such responses only as physiological reflexes. Exclusively physiological explanations fail to take into account the role of the body's memory.[14]

Secondly, with regard to emotive responses, consider how fear, panic or anger can aggravate the experience of pain. For instance, consider the patient who interprets the pain in his chest as an impending heart attack. The emotions that accompany this interpretation significantly exacerbate his pain experience. Alternatively, consider the patient who had an expanding metastatic lesion of the femur (from cancer of the lung). "It was only when the patient was reassured that his leg was not going to be amputated … that his pain became controllable" (Cassell 2001, p. 381).

Thirdly, with regard to cognitive responses, consider a patient diagnosed with metastatic carcinoma of the prostate in the lumbar spine. This diagnosis triggered severe pain attacks, which only worsened with time and which led the doctors to diagnose the patient as chronically ill. However, the disease could not explain the reason for such severe attacks of pain. These reasons were triggered by the patient's independent discovery that survival is shortest when the metastatic disease affects young men and that metastatic disease has no cure. Clearly, the patient suffered the pain in his body; yet just as clearly, this pain was up to a large degree of cognitive rather than of physiological origin.

One could make a more general claim: If I interpret my pain as an expression of an incurable disease, as a test or punishment, my cognitive responses affect the manner in which I live my pain; in a direct way, my interpretations modify my experience of pain. This means that bodily, emotive and cognitive responses up to a large degree make up the painfulness of pain.

These diverse responses to pain are not only co-constitutive of pain experience; these responses also re-personalize the self. Recall my earlier claim that pain is de-personalizing in that it unsettles four fundamental relations: (1) the relation

[14]See Fuchs (2008, pp. 65–81).

between the self and body, (2) the person's self-relation, (3) the relation between the self and the environment, and (4) the relation between the self and others. Yet, the particular emotive and cognitive reactions to pain enable the subject of experience to form anew these four fundamental relations. Thus, if one "gives oneself up" to pain, or "pits oneself against" it; if one "endures," "tolerates," or "enjoys" pain; if one seeks pain or makes efforts to escape it; if one interprets it as a penalty or atonement, or a means of purification or correction—these diverse responses to pain enable one to establish a particular kind of relation to one's body, one's self, one's environment, and other selves. By constituting these four fundamental relations, the responses to pain form the person one becomes.

So far, I have emphasized the projective nature of pain experience: the manner in which I respond to pain, will form the person I will be. However, the responses to pain are also expressive of the person's past: these responses also rely upon the person I already am. In this regard, Thomas Fuchs' research into the bodily memory of pain (*Schmerzgedächtnis*) is informative.[15] According to Fuchs, a bodily reaction, which at first glance seems to be nothing more than a mechanical reflex, once analysed more closely proves to be a response determined by the body's prereflective memory. It is the body's past experiences that largely determine the way in which the body chooses to respond to similar experiences in the future. Our bodily, emotive and cognitive responses to pain rely upon our past experiences. Moreover, they also rely upon our interpretations of our experience, which in their own turn rely upon and incorporate the experiences of others.

In the literature on chronic pain, it was Emily Dickinson who forcefully stressed the forgetfulness of pain:

> Pain has an element of blank;
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> It cannot recollect
>
> When it began, or if there was
>
> A time when it was not.
>
> It has no future but itself,
>
> Its infinite realms contain
>
> Its past, enlightened to perceive
>
> New periods of pain.

In Dickinson's famous lines, everything is presented from pain's point of view with no reference to the person suffering pain. Although such a characterization of pain highlights pain's dominating nature, the price one thereby pays for pain's personification is the complete impersonalization of the subject of pain. However, it is undeniable that the manner in which one suffers one's pain is largely determined by one's involuntary and unconscious recollection of the past as well as involuntary and unconscious anticipation of the future. Thus, despite the overwhelming

[15]See Fuchs (2008).

timelessness of pain, which Dickinson captures so powerfully, it would be phenomenologically illegitimate to confine pain within one temporal dimension; namely, that of presence. Largely due to the temporality of pain (due to the manner in which memory and anticipation affect pain experience), the subject of pain cannot be conceived either as disembodied consciousness, or as a physiological body; rather, this subject is the person, the embodied subjectivity.

Pain, and especially chronic pain, is a highly complex phenomenon. To make sense of it, one needs to take into account not only the body's neurophysiological structure, but also the person's immersion in the lifeworld (*Lebenswelt*)—the world of everyday experience, filled with perceived, affective and practical properties. More precisely, without understanding the person's history, self-understanding, relations to others, and life-long goals, without recognizing the significance of the person's bodily, emotive, and cognitive responses to pain, one can only have a limited understanding of pain experience.

8 Psychogenic and Organic Pain

I argued earlier that one of the chief limitations of the exclusively neurophysiological approach to pain concerns its failure to recognize the existence of psychogenic pain. Such a form of resistance to the neurophysiological approach has its limits; moreover, it can also lead to misunderstandings. To be sure, chronic pain can be triggered either by organic or psychogenic causes. It is, however, crucial to add that chronic pain, which derives from organic causes, is never only organic, just as chronic pain, which derives from psychogenic causes, is never only psychic. Put otherwise, it is crucial not to misinterpret the distinction between organic and psychogenic pain as a distinction between physiological and psychological pain—a misinterpretation which would immediately re-introduce the schism between body (the subject of physiological pain) and mind (the subject of psychological pain), while leaving it unexplained how these presumed "subjects of pain" (that is, body and mind) relate to each other. The phenomenological identification of the person as the subject of pain is meant to recapture the living unity that binds the mind to the body as well as denounce the tendency to treat them as independent spheres. Thus, first, to claim that the person is the subject of pain is to suggest that this subject is also *embodied*, *ensouled* and *encultured*. However, if so, then secondly, when it comes to chronic pain, there is no such thing as purely physiological pain or purely psychological pain. Rather, purely physiological, just as purely psychological accounts address only parts of a larger whole, and this larger whole—namely, the person—is not reducible to the sum of its parts. No matter what the causes of pain might be, the concrete bodily, emotive and cognitive responses enable the person to invest the physiological tissue damage and psychological traumata with a sense or meaning through which the person's unique experience of pain is formed.

In the case of chronic pain, pain and suffering walk hand and hand. This means that for pain to become chronic, the subject of pain must either *somatise*

psychological traumata or *psychologise* tissue damage. Here somatization refers to the expression of personal and social distress in an idiom of bodily complaints, while psychologization refers to the expression of bodily distress in an idiom of psychic complaints (cf. Kleinman and Kleinman 2007).

In this regard, the work undertaken in medical anthropology is quite telling. First, I have in mind the work of Arthur Kleinman and Joan Kleinman, who conducted research on the widespread outbursts of neurasthenia in China after the Cultural Revolution, and argued that these outbursts were instances of somatization.[16] The political framework did not legitimize critical discourse on the Cultural Revolution, and thus, pain and illness provides the only safe way to express the personal meaning of this revolution. Other phenomenologists have offered studies of nerve-related illnesses in South America, especially in Brazil,[17] and analogously argued that under particular regimes, physical and mental illness provided the only safe way to express the effects of poverty. In short, due to the temporality of chronic pain, and processes of somatization and psychologization that it makes possible, just as psychogenic pain is never merely psychic, so organic pain is never merely physiological.

Phenomenologically informed anthropological studies of pain provides ample evidence to support my claim that chronic pain is neither purely physiological, nor pure psychological. Here we are faced with human experience, which is at one at the same time physiological, psychic, cultural, historical, social and personal. This is the reason why so often either purely physiological or purely psychiatric treatments of chronic pain prove ineffective. Chronic pain is a mosaic of physiological, psychic, cultural and social factors, all of which obtain their unity in the framework of the personal meaning that the patient invests in her pain.

The temporality of chronic pain, conceived as the phenomenological basis of somatization and psychologization, proscribes the possibility of explaining such a complex phenomenon as chronic pain with a reference to its origin. Just as chronic pain is not reducible to its origin, so its treatment cannot be reduced to its origin's treatment. For if it is indeed true that responses to pain—bodily, emotive, and cognitive—are part and parcel of the very experience of pain, then chronic pain is never purely physiological or purely psychological. What this established distinction conceals is nothing less than the personal meaning the subject suffering from chronic pain has invested her pain with.

9 Illness/Disease and Healing/Curing

Recall the conceptual ambiguity mentioned in the Introduction: the concept of pain means something significantly different for the physician or psychologist, historian or sociologist. One could lament this ambiguity and identify it as a cause that

[16]See Kleinman and Kleinman (2007, pp. 468–474).

[17]See Scheper-Hughes (2007, pp. 459–467).

underlies much confusion in pain research. Furthermore, one might argue that to reduce this conceptual ambiguity, one need introduce into pain research a distinction similar to the one that we come across in phenomenology of illness. Here, I have in mind the distinction between illness and disease. According to this established distinction, while the concept of disease stands for actual pathology and pathophysiology, the concept of illness refers to the patient's experience. Correlated with this distinction, there is another established distinction between healing and curing: just as one cannot cure illness, but only the disease, so one cannot heal disease, only illness.

Yet, just as my foregoing analysis invites one to give up the distinction between physiological and psychological pain, so it also brings into question the validity of the illness/disease and healing/curing distinctions, which one could characterize as the most established distinctions in the phenomenology of medicine in general. We find this distinction in the works of Edmund Pellegrino, Paul Tournier, Viktor Kestenbaum, Arthur Kleinman, Byron Good, Alfred Tauber, SK Toombs, James and Kevin Aho, among others.

Why is this distinction important? Arguably, it was introduced with the aim of providing phenomenology of illness with its *raison d'être*: While disease constitutes the subject matter of neurophysiology, illness is a distinctly phenomenological concept. Yet, I would argue that this distinction leaves phenomenology with an artificially confined domain, which it must transgress.

Consider in this regard Eric Cassell's description of how the patient personalizes the disease. A patient who develops life-threatening disease will soon know the worst that can happen. Normally, those who know the worst expect the worst. Moreover, those who expect the worst act in a way that brings the worst. We face here a self-fulfilling prophecy, brought about by the person's reaction to the disease.[18] Put differently, through the bodily, emotive, and cognitive responses, the person has an impact not only on illness, but also on the actual disease process. Just as the person's bodily, emotive and cognitive responses to pain change the course of pain experience, so these responses also affect the disease. Alternatively, as Cassell puts it, "by virtue of their behaviour—for example, the doctors they see, medications they take changes in life pattern from sleep to food—they change the expression of the pathology and the behaviour of the disease, as a result of the person they are" (Cassell 2001, p. 382). In short, if the person's bodily, emotive and cognitive responses have pathophysiological consequences, then phenomenology of medicine cannot be limited to the analysis of illness, but must also address the disease. Moreover, if the person's feelings, thoughts, and behaviour modify the behaviour of the disease, then to change the course of the disease, one must directly confront the patient's bodily, emotive, and cognitive responses to pain and illness. To do so, however, is to supplement curing with healing.

In phenomenology of illness and pain, one commonly comes across the following standpoint: "In order to heal the patient, it is not enough to cure the disease.

[18]See Cassell (2001, p. 382).

The medical establishment must also take the necessary precautions that the process of curing the disease does not have adverse consequences for the patient." Phenomenologically informed studies of illness and pain expressed this thesis and attitude with the help of the distinctions between illness and disease as well as healing and curing. When I claim that the recognition of the person as the subject of pain brings these distinctions into question, I mean that just as curing the disease constitutes a part of the process of healing the patient, so healing the patient constitutes a part of curing the disease. In this regard, Eric Cassell's late work is highly significant. As he once put it, "we are of a piece—anything that happens to one part affects the whole, what affects the whole affects every part" (Cassell 2001, p. 371).

10 Conclusion

Consider the most common claim put forth in the phenomenological literature on pain; namely, the claim concerning the fundamentally non-sharable nature of pain experience. This insight, whose phenomenological origins lead back to Carl Stumpf's account of pain as a feeling-sensation (*Gefühlsempfindung*),[19] played a central role in Scheler's reflections on pain, specifically in the context of his stratification of the emotional life.[20] According to Scheler, it is the non-sharable nature of pain that distinguishes it from similar phenomena, such as grief and despair. More recently, this insight also played a significant role in Elaine Scarry's classical study *The Body in Pain* (Scarry 1985), where she took pain's non-sharability to mean that the experience of pain shatters language and is in principle non-expressible.[21]

How exactly is one to understand pain's non-sharability? Along with Scheler (cf. Scheler 1973), I would interpret this claim as a contention that the *experience* of pain is non-sharable: I cannot live through your pain, just as you cannot live through mine. Pain introduces a breach between what is my own and what is not my own. If, impossibly, I were to experience your pain, this would prove to be the most egoistic act imaginable, for it would amount to appropriating your body and rendering it my own. The experience of pain delivers the body-in-pain as *my* body; *pain individualizes*.

However, while the *experience* of pain is non-sharable, it nonetheless is always possible (although by no means easy) to bring this experience to expression. By saying this, I am arguing against one of Elaine Scarry's claims (Scarry 1985); according to Scarry, pain's non-sharability means that the experience of pain shatters language and is in principle non-expressible. Scarry's arguments to the

[19]See Stumpf (1907, 1917)

[20]See Scheler (1973, pp. 328–344).

[21]See Scarry (1985, pp. 3–11).

contrary notwithstanding,[22] it is important to emphasize that we do have at our disposal various languages of pain—autobiographic, medical, literary and scientific, to mention the four most significant categories. In fact, Scarry's own book is one particular way of bringing pain experience to expression. Moreover, it seems to me that Gergel's critique of phenomenology of medicine, which I have addressed above, applies to Scarry's contention that the experience of pain brings about the collapse of language. If pain indeed were immune to expression, then one could legitimately qualify it as a solipsistic experience, which lies beyond empathy, sympathy, and understanding.

Yet, the experience of pain *is* expressible, and considering its diverse expressibility, I would like to conclude with some reflections on the therapeutic significance of *dialogue*. Ever since its birth in the Parisian hospitals during the French revolution, the history of clinical medicine has been a history of the decline of dialogue and the upsurge of the technically mediated "discourses on tissue." The discovery of the stethoscope in 1819, of the X-ray in 1895, of the CAT scan in the 1980s and of the MRI in the 1990s has progressively rendered direct discussions between doctors and patients obsolete. The capacity to listen to the poundings of the heart, to penetrate the patient's skin and gaze directly at the organs, to observe the one millimetre cross-sections of these organs and finally the three-dimensional pictures of organs in "real time," has certainly enabled the physician to understand the patient's body incomparably better than the patient understands it herself. Nonetheless, this unprecedented and continuously evolving technical capacity to disclose the secrets of the human body helps medical praxis at the neurophysiological level. It appears to be of little use when it comes to the medical profession's obligation to confront pain's personal dimensions.

As S. Kai Toombs has argued in her *The Meaning of Illness*, the patient and the physician experience and conceptualize the patient's affliction in fundamentally different ways. While the patient conceives of pain as a lived experience that affects her lived-body, the physician thematizes it as a collection of physical signs and symptoms that disrupt the normal functioning of the patient's physical body. For this reason, far from representing the same reality, for the patient and the physician, the phenomenon of pain represents two distinct realities. To overcome this "ontological gap," it is necessary that "the physician explicitly attend to the lived experience when devising therapeutic goals (Toombs 1993, xvi). With Gergel's critique in the background, I would like to supplement Toombs' noteworthy investigation with a suggestion that both the patient and the physician, besides inhabiting different realities, are also motivated to overcome the ontological gap that separates them. Thus, the patient, besides living through pain at the level of immediate experience, is also aware that the biomedical understanding of pain

[22]No one else has maintained as strongly as E. Scarry that pain, unlike other feelings, resists verbal objectification: "Thus Sophocles's agonized Philoctetes utters a cascade of *changing* cries and shrieks that in the original Greek are accommodated by an array of formal words (some of them twelve syllables long), but that at least one translator found could only be rendered in English by the uniform syllable 'Ah' followed by variations in punctuation (Ah! Ah!!!!)" (Scarry 1985, p. 5).

holds the promise of liberating her from affliction, and thus is motivated to trust pain's biomedical treatments. So also, the physician is motivated to understand the patient's pain not only as a symptom of disease, but also as a de-personalizing and re-personalizing experience, for the liberation of the patient from pain's dehumanizing effects constitutes one of the central goals of his professional praxis.

Only through dialogue can the patient and the physician overcome the ontological gap that separates them. Especially in the context of such afflictions as chronic pain, which typically is experienced in the absence of any detectable tissue damage, living dialogue between physician and patient obtains its preeminent therapeutic significance. What is especially called for is *listening*. What exactly is listening? It is not just a matter of hearing the patient's words, but also recognizing the meanings that inform these words, as well as the meaning with which the person has invested her pain. It is not just a matter of identifying symptoms, but also recognizing the specific meaning they have for the patient, the specific relation the person has towards her pain. It is not just a matter of understanding the person's relation to her pain. It is also a matter of how it affects the person's relation to others and to her own future plans. It is not just a matter of understanding the person's current condition, but also how her understanding of this condition is formed by her past. Without understanding the person's history, her insertion in the lifeworld, her relation to others, as well as her orientation towards her future, one cannot understand pain's personal significance. Moreover, without understanding the de-personalizing and re-personalizing dimensions of pain experience, one cannot offer chronic pain patient effective treatment.

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