**Penultimate Draft**

**The World of Chronic Pain: A Dialogue**

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**Abstract**: This chapter investigates the phenomenology of chronic pain, with an emphasis on the relationship between a bodily feeling of pain and interpersonal / social experience. We focus on the first author’s experience of chronic pain, and on his increasingly desperate search for a clear diagnosis and effective medical treatment. In so doing, we argue that how one experiences chronic pain is bound up with what one anticipates from other people. To be more specific, erosion of a form of interpersonal *trust* is inseparable from an all-enveloping feeling of distress and helplessness, a feeling that is itself integral to the experience of pain. We further argue that certain pains challenge a commonplace philosophical assumption about intentionality: that an intentional experience is *either* directed at something specific *or* more diffuse in character. Kusch’s pain was both: a feeling in a part of his body was at the same time a change in his overall relationship with the world. In considering the implications of this, we turn to Heidegger’s discussion of ‘attunement’ [*Befindlichkeit*] in *Being and Time*.

**Introduction**

This chapter is a dialogue in more than one sense. To begin with, it results from several face-to-face discussions between the two co-authors, who are colleagues in the same philosophy department. But what divides them is more important: only Kusch (subsequently ‘MK’) is a chronic-pain patient, and only Ratcliffe has a background in the philosophy of illness. This paper is the result of our attempt to bring these two forms of ‘expertise’ together. The starting point for our dialogue was a document entitled ‘Pain’, which was the basis for a talk given by MK. His experience with chronic pain had become known to the organizers of a conference on ‘Philosophy and Medicine’, held in early 2017 in Vienna, and they invited him there to speak ‘bluntly’ and ‘directly’ about pain. He decided to focus on the year 2014, when chronic pain -and the treatments he received- brought him close to madness and death. The talk came as a shock to the audience of medical professionals, but it has since opened up something of a dialogue between MK and some German and Austrian pain therapists. In the interest of authenticity, and in order to anchor our dialogue in a first-hand experiential account, we decided to reproduce the whole document here (in English translation).

Our subsequent discussion starts from some key elements of ‘Pain’, rather than attempting to cover all aspects of MK’s account. We focus on the *phenomenology* of chronic pain and emphasize two interrelated points: (a) an experience of chronic pain is inextricable from how one relates to other people and, more specifically, what one anticipates from them; and (b) certain experiences of pain are both concretely focused and yet, at the same time, all-encompassing, thus challenging commonplace assumptions about the nature of intentionality.

One might question the reliability of our somewhat undisciplined philosophical approach. Can we generalize about the nature of chronic pain by reflecting on one single case? Almost certainly not. Are a philosopher’s first-person reflections on the experience of chronic pain, mediated by occasional, informal conversations with another philosopher, likely to be reliable? Possibly not. Nevertheless, such exercises can draw attention to aspects of human experience that are more usually not so conspicuous. What we gain are philosophical possibilities that might otherwise have evaded explicit consideration. Once these possibilities have been brought to light and developed into explicit philosophical claims, they can then be defended on independent grounds, as they are here. Our conclusions do not concern ‘the experience of pain’ or even ‘the experience of chronic pain’. After all, pain experiences are highly diverse. Rather, we reflect upon *an* *experience of pain* in order to develop and defend claims about human experience and interpersonal relations that have much broader applicability.

**Pain**

*Patient file:* Patient (male, married, three children under 12 years old, Professor for Philosophy of Science at the University of Cambridge); since Spring 2008 frequently suffers from pain in the right upper jaw. On the ‘numerical rating scale’ (NRS) for pain intensity (from 1 to 10): 5-6. Dull pain. In early 2008 root-canal treatment of the penultimate tooth (in the right upper jaw). The tooth is capped with a dental crown. Pain returns irregularly. Since 2009 patient lives in Vienna (and works for the University of Vienna). In 2012 dentist A diagnoses malocclusion (bad bite), which she seeks to correct by fitting fixed braces. NRS 7. Dull and stinging pain. The third-to-last tooth is extracted in the summer of 2013. Increased pain in the area of fourth-to-last tooth. Extracted in February 2014. Subsequently increased pain in the fifth-to-last tooth as well as in the areas of previous extractions. Increasing distress.

January 2014: Dentist A presents the case of the patient at an international conference as a success-story of orthodontics. She declares the pain situation to be ‘beyond the realm of dentistry’. Transferral to kinesiologist (practitioner of a form of alternative therapy focused on bodily movement).

March 2014: Patient changes dentist and begins treatment in dental clinic X. Dentist B extracts the fifth-to-last tooth. NRS 8 in the resulting gap and around the sixth-to-last tooth. Patient continues to work. Insomnia, nausea. Patient begins treatment with pain therapist 1. Prescription of antidepressant and neuropathic drugs.

April 2014: Oral surgeon α of dental clinic X diagnoses putrescent nerve material in the jawbone. First jawbone operation.

May-June 2014: Three further jawbone operations to remove putrescent nerve material. NRS 8-9. Patient unable to work. Weight loss from 85 to under 70 kilograms.

July 2014: Dizzy spells and nausea. Admission to the oral surgery division of Vienna’s Central Hospital against the will of the head of department, oral surgeon β. Extraction of samples from the jawbone. β wants to cut the facial nerve to reduce pain level. Patient resists.

August 2014: MRI of the head; diagnosis: ‘unremarkable’. Negative side effects of the neuropathic drugs. Frequent spells of dizziness and disorientation. Feelings of loss of control. Depression. Diagnoses based on analysis of the jawbone samples: chronic jawbone infection. Patient is prescribed high doses of antibiotics. Start of an acupuncture treatment. No improvement.

September 2014: Patient put on waiting list for pain therapy in Vienna’s Central Hospital. On his way home, patient prevents the suicide of a psychiatric patient who had just been released. The specialist for infectious diseases refers patient back to the oral surgery division. Patient begins private treatment with pain therapist 2. The latter prescribes opiates, neuropathic and other pain killers. Patient takes about 25 different pills per day. Pain therapist 2 prescribes increasing doses of opiates. Depression and suicidal thoughts.

October 2014: Patient begins treatment with dentist C and oral surgeon γ. C wants to do a further jawbone operation. γ is unsure. Pain therapist 2 is opposed.

November 2014: Patient is admitted to the psychiatric ward of Vienna’s Central Hospital. Against medical advice he leaves again the next day in order to discuss relativism with the philosopher Paul Boghossian. – Patient decides to start afresh. He changes to pain therapist 3, and is helped by a psychiatrist, a psychologist and a physiotherapist. He stops taking drugs that can cause suicidal thoughts. He attempts to start living positively with pain. NRS recedes slowly to 5-6. Clear improvement of mental balance.

December 2014: Admission to Vienna’s Central Hospital with (life-threatening) epiglottitis. No connection with the jawbone problems. Discharge one week later.

Since that time, a chronic pain patient. NRS 3-8; the type of pain varies. Causes of the pain still unknown. Mentally stable. Since 2015, able to work. Positive attitude. Frequently happy.

*Images of Pain:* The medical taxonomy of pain is crude: On the NRS scale from 1 to 10, what is the intensity of pain? Is the pain drilling, dull or stabbing? And how often does it occur? Someone who knows the answers to these questions does not yet understand the first thing about strong chronic pains.

In my ‘annus horribilis’, 2014, I experienced my chronic jawbone pains as both extremely concrete and highly abstract. ‘Extremely concrete’ since I could always tell, with great accuracy, where exactly it hurt the most. ‘Highly abstract’ since my whole self-image and *Weltbild* had acquired the modality of pain. I was shackled inside my pain as if it were a straitjacket; and I was unable to relate cognitively or emotionally to anything without at the same time experiencing and thinking of myself as a sufferer. This applied first and foremost to my relationships with others. I categorized them into two groups: those who supported me, and those who weren’t interested. (Strangely enough, this dichotomy did not coincide with the distinction between ‘friends’ and ‘mere acquaintances’.) Put differently, the world of the chronic pain patient differs from the world of the person free of pain. Many certainties of the healthy world are suspended. And there are new, terrible, certainties: ‘I will not be able to stand this for much longer’; ‘I will never be free of this pain again’; ‘I am desperate’; ‘Life continues without me’.

Psychologically, pain is most gruelling when, in addition to being chronic and strong, it is also *undiagnosed* or perhaps even *undiagnosable.* (The medical euphemism for ‘undiagnosable’ is ‘atypical’. This semantic shift would be worth a separate investigation.) The undiagnosed and atypical pain is an invisible opponent whose next step is unpredictable. And all is possible: perhaps it is a sign of deadly disease, perhaps ‘merely’ psychosomatic. Dentist B thought a cancer diagnosis was a near-certainty; a ‘life-coach’ suspected it was either the pain of parting (from Cambridge), or due to facial tension caused by excessive ‘wearing of masks’ in social interactions; a psychotherapist saw as the cause the love towards my father - in World War Two, shrapnel wounded him in the exact same spot. Who knows, maybe all of these causes are relevant. Perhaps the wisest course of action would be to give up all hope of a definitive diagnosis. But hope springs eternal: even today there is a naïve voice inside me that counts on, one day, getting the liberating truth: ‘the mother of a diagnoses’, the diagnosis that brings the end to the sheer endless diagnostic efforts.

Pain is painful not least because, from childhood onwards, we associate it with punishment. In 2014, this association led me to see my pain frequently in the context of guilt and failure. Did I wait too long before I went to the dentist? Did I properly follow the advice of the doctors? Was the pain the punishment for more general wrongdoing? What or who was the punishing authority? Perhaps even a god? – There are no limits to the feelings of guilt of the patient with atypical, chronic, and strong pains.

*Images of medical doctors:* Before the onset of my jawbone pains, I spontaneously perceived medical doctors as specialists whose time one ‘rents’ for them to repair – efficiently and without personal attachment – breakdowns in one’s body. I trusted doctors when I had reason to assume that they would be the most suitable ‘craftsmen’ for the given damage.

The distress of strong, chronic pain changed my relationship with, and trust in, doctors completely. This had different causes. To begin with, I spontaneously conceived of the relationship in terms of moral categories. In situations of acute and serious plight, we normally assume that any person who (alone) is able to help will do so immediately and fully. Imagine, for example, that you have medical knowledge and witness a traffic accident with seriously injured people. There would be no question concerning your moral obligation to help. And this obligation would overrule whatever else you had planned to do with your time. In 2014, I initially saw my relationships with dentists, oral surgeons and pain therapist in analogous fashion.

Compared with the seriously injured in a traffic accident, a further consideration also seemed pressing: to wit, the fact that I had entrusted myself to the doctor and that I had told them about my distress and worries. In everyday life, we do this only with our spouses or partners, with close friends and relatives. Indeed, it is often precisely the entrusting of such plights that constitutes and reconstitutes the intimacy of a relationship. Alas, this too was a problematic analogy. It seduced me into thinking my openness towards the doctors had gained me the entitlement to receive attention beyond the minimum level of medical treatment – 2 to 5 minutes in the surgery of the jawbone specialists at Vienna’s Central Hospital.

But there was also a third mistake, and it was the worst. The first two were in any case part of the third. I am referring to what one might call ‘self-infantilization’. When the distress peaked, I tended to fall back into infantile forms of feeling and thinking. Demoralizing long-term pain and increasing doses of opiates made it impossible for me to think clearly: my higher – self-reflective and self-corrective – functions became more and more restricted. This created an area for archaic, primitive, infantile cognitive and emotional patterns. It led me to see the medical doctor as a father figure, and to build up expectations that only a father could possibly have fulfilled. The fear of losing the doctor – what will I do if he refuses to treat me any longer? – also had irrational elements that are best explained on the basis of the equation of the doctor with a parent. (Note in passing that this fear is nourished by the ways in which all too many doctors signal their impatience with patients who suffer from complicated, hard-to-diagnose, and hard-to-treat illnesses.)

I doubt that I alone suffered from the cognitive and emotional patterns relating to these projections. At least I see many parallels in the texts of pain patients on the Internet. At the same time, it has become increasingly clear to me – now that the *annus horribilis* has passed – that no doctor can fulfil the expectations I had built up. Given dozens of distressed patients with similar entitlements to help, the doctor cannot give any one of them the amount of time they demand in their depressive moods. Not to forget that the doctor has a life of their own, whatever our chronic pains might happen to be.

The doctor thus needs strategies and tactics in order to block or therapeutically use the mentioned projections. Unfortunately, my experiences of 2014 have led me to suspect that many doctors approach this difficult task no less unreflectively and no less inappropriately than I approached my role as a chronic pain patient. In what follows, I shall propose – *sine ira et studio* – the sketch of an analysis of medical defence tactics. I shall be as direct and blunt as I was when writing about myself.

The first common way in which doctors block patients’ projections is by using a strictly ritualised form of communication that leaves no space for suffering and despair. Pain therapist 2 confined the communication to checking the pain table: Where is the pain on the scale from 1 to 10? Is it dull, stabbing or drilling? And are there variations in these two dimensions? That was it. In order to nevertheless fill the time slot of 45 minutes, and thus to justify the price of €220, he then needed thirty minutes for issuing the prescription and the bill. He did this with an expensive, thick and shiny fountain pen. And he wrote so slowly and calligraphically that producing the two documents took forever. During this important work one was not allowed to speak. Whatever time remained was then used for the complex search for a new appointment.

The above already identifies the main motif in all strategies for preventing patient projections: establishing a clear difference in authority between patient and doctor. (It does not make a difference if the patient is a university professor.) The doctor forces the patient into the role of a subordinate or supplicant. This connects with, and re-enforces, the begging attitude of the self-infantilised patient. It is not difficult to establish the claim to authority vis-à-vis a distressed pain patient: whatever ability to resist the patient might have had, it has been reduced to a minimum by high doses of drugs – opiates, neuro- and psychopathic medications – as well as the fear of losing the doctor.

The methods for establishing the power differential are sometimes rough. For instance, one does not shake hands when the patient comes in; one does not talk *with* the patient, one talks *about* the patient with the nurse; one interrupts the patient or forbids the patient to speak; one shouts at the patient or declares the therapies of other doctors to be useless. In the surgery of the oral surgeons in Vienna’s Central Hospital, such methods are the norm. Especially degrading was the order to walk on my own from the oral-surgery ward to the operating theatre, dressed only in a much-too-short nightdress. To cover my genitals I had to pull the gown down with both hands and lean forward. Or, when I arrived at the Central Hospital with epiglottitis, I learnt only from the phone call between the doctor and the ward that my condition was life-threatening. Or, when I told pain therapist 2, despite his unwillingness to listen, that I was suffering from suicidal thoughts, and when I asked him about psychological help, he replied: ‘Listen man: you have to get over it. Without that psychological nonsense. Don’t be a chicken.’ It was the first and only time since my childhood that I let anyone talk to me in this way.

I don’t want to be misunderstood: I do not regard these patterns of behaviour as individual, personal, moral failures. We know from the classic social-psychological studies by Milgram and Zimbardo how easy it is for all of us to suppress and humiliate others when the situation invites this behaviour, and when there are no controls. And we should not forget either that the role of the unrestricted authority makes it easy for the doctors to convince the patient to accept uncomfortable but potentially effective forms of therapy.

*The Escape:* It is the essence of authority not to tolerate too much competition. This rule also applies to doctors: hence the many negative remarks about their colleagues and other specialities. And yet, since almost all doctors engage in this practice, and since even the pharmacists act likewise, the long-suffering patient sooner or later confronts a massive cognitive, emotional and social dissonance. Since the patient usually needs more than one doctor – in my case for instance a dentist, an oral surgeon, and a pain therapist – and since they offer different, incompatible diagnoses and therapies, the patient eventually no longer knows whom to believe and trust.[[1]](#footnote-1)

This is not a positive development for the patient. The self-infantilization, the transfer of responsibility and decision-making to the doctor, also has a calming and consoling side to it. Once one is confronted with more and more competing medical claims to authority, one suddenly has to make his one’s own decisions again. And this – at least in my case – at a point in time when my thinking had been shackled by many years of strong pains and by opiates; at a point in time when I could not tell whether my attempt to think would result in rational plans or in illusions. I was ‘condemned to be free’; I had to choose. Even a patient with thirty years of work in the philosophy of science can be overwhelmed by this situation. I can easily imagine patients unable to meet this challenge, and despairing.

I came close to this hell. But at least I still had the inner strength to go voluntarily to the psychiatric ward in the Central Hospital in order to gain control over my depression and suicidal thoughts. And then I got lucky: that sleepless night in the four-bed room on the psychiatric ward, surrounded by loudly snoring, crying and groaning men, men whom I could still somehow help with consoling words. This night generated in me a feeling of defiance, a last great rearing up of my desire to determine my own fate. All the better that on the next day I had the chance to discuss relativism with Paul Boghossian.

I fired all my doctors and put together a new team according to my own criteria. It helped me to escape the role of the victim and learn how to live with pain. The pain is still there, chronically; but it no longer stands between me and a good life; it is a hurdle that I have to surpass as part of my daily duties. But only a part of my daily duties. And, fortunately, my life consists of a lot more than just duties.

I have here confined myself to speaking about the phenomenology of pain and my interactions with doctors. But, of course, there is so much more to talk about. Especially about my wife and children who were reason enough not to give up, even in greatest despair, and who helped me, over many months, in endless ways. And about the friends and colleagues whose encouragement and support was so important. But they know what they have meant to me and will mean to me in the future. Even without a talk.

**The Unpleasantness of Pain**

We now turn from MK’s first-person report to our more systematic attempts to make sense of some of its details. We will begin by asking what, exactly, it is about (chronic) pain that makes it so unpleasant.

To understand the nature of chronic pain, one approach is to start by formulating a more general account of pain, which can then be refined. Pain either *is* or at least *includes* a kind of sensory experience: a pain in one’s jaw involves a distinctive type of sensation, emanating from a bodily location. Philosophers have offered various conflicting accounts of what this sensation consists of. There is disagreement over whether it is representational and, if so, what it represents; whether its nature is exhausted by representational properties; whether it is partly or wholly perceptual in nature; and which theory of perception might be best placed to accommodate it (e.g. Aydede, ed., 2005). Although one could get dragged into these debates, perhaps never to return, they can be avoided for current purposes. While we accept that pain has a sensory component, we will remain agnostic about its specific nature. Of more interest to us are distinctions that have been drawn between the sensory, affective, and motivational constituents of pain. There is compelling evidence that these can come apart in various ways. For instance, a condition called ‘pain asymbolia’ is said to involve pain-sensation but without any sense of unpleasantness or any motivation to avoid or seek relief from pain. Conversely, the characteristic feeling of unpleasantness and associated behavioural tendencies can occur without pain-sensation (Grahek, 2007; Corns, 2014b).

Note, moreover, that the unpleasantness of pain is not reducible to an inclination to avoid or escape something, and that pain need not have motivational force. As Bain (2013) observes, the unpleasantness of pain ‘rationalizes’ action, whereas behavioural tendencies do not, suggesting that the two are distinct. Complementary empirical evidence seems to show that one can dislike one’s pain without seeking avoidance or relief. According to Grahek (2007, p.39), only pain asymbolia involves complete retention of pain-sensation with complete loss of affective response and motivational tendencies. Certain other cases that are described in terms of ‘pain without unpleasantness’ actually involve finding the pain disagreeable but not feeling inclined to act upon it in any way.

It is doubtful that any one ingredient is *sufficient* for pain. Grahek refers to sensation without affect / motivation as ‘pain without painfulness’ and to affect / motivation without pain-sensation as ‘painfulness without pain’. Given this terminological choice, one might take it that sensation alone suffices for ‘pain’. However, he also emphasizes that it bears little resemblance to what we would ordinarily call pain: it ‘becomes a blunt, inert sensation, with no power to galvanize the mind and body for fight or flight’ (Grahek, 2007, p.73). Perhaps pain-sensation is at least *necessary*, but even that much is debatable. Corns (2015) considers what is sometimes referred to as ‘social pain’, where emotional distress arises due to a change of interpersonal circumstances, without any pain-sensation. There are, she suggests, insufficient grounds for maintaining that this really does constitute *pain*. After all, unpleasantness without pain-sensation does not, in other contexts, add up to pain. For instance, a horrible taste in one’s mouth is not literally ‘painful’. In contrast, Radden (2009, p.111) does allow for ‘pain and suffering that is nonlocalized and nonsensory’. One option is to endorse a pluralistic account, according to which pain can involve various different components, none of which are necessary or sufficient (Corns, 2014a). Here, we take it that what is referred to as ‘pain’, in everyday, scientific, and medical contexts, ordinarily encompasses sensory, affective, and motivational aspects of experience, and that this applies equally to chronic pain. Consistent with this, we adopt an inclusive conception of chronic pain.

Of course, chronic pain also has more specific properties. Defined minimally, it is a pain that endures for a prolonged period. In addition to this, it is often taken to have no identifiable biological cause or a biologically inappropriate cause. Chronic pain is also likely to have distinctive affective and motivational properties, given the uncertainty over when or even whether it will end, along with an inability to find long-term relief. In what follows, we seek to show how these properties are inextricable from one’s expectations concerning other people.

One interesting feature of MK’s experience is that, over time, he learned not to expect that the pain-sensation would ever change. Indeed, the first words of his most recent (extremely helpful) pain therapist were: ‘Let us start from the premise that you will always have this pain; and now let us see how we can find a way for you to live happily.’ What the therapist was proposing involved separating the pain-sensation from the affective-motivational dimensions to which it had previously been tightly linked. Consistent with this, MK’s coping strategy now is not to ‘care’ too much about the pain sensation. Learning this strategy meant of course unlearning a web of associations that comes naturally to all of us, which link pain to depressive moods, withdrawal, (self-)pity, and anger.

All of this suggests that the painfulness or distress of pain can be manipulated, at least to some extent, by explicit strategies involving reappraisal and / or by indirect manipulation of emotional feeling (e.g. by listening to music and playing musical instruments, in MK’s case). Hence an experience of suffering is not insulated from one’s wider cognitive repertoire. That view is consistent with empirical research on pain. As Jennifer Radden (2009, p.115) observes, pain research has increasingly come to recognize that ‘all pain is less simple, more cognitively mediated, and thus more *like an emotion* than had previously been supposed’. Pain-experiences, she adds, are thus shaped by ‘memory, personal and social attitudes, role expectations, and life experience, as well as mental and emotional health and bodily traits’. The inclusion of such factors further indicates that experiences of pain are susceptible to *social* and *cultural* influences.[[2]](#footnote-2)

Regardless of how pain might be socially shaped, regulated, and interpreted, some of our readers might still think of its unpleasantness as an experiential quality that is *constitutively* independent of interpersonal and social relations. However, MK’s experience suggests otherwise. Recall from ‘Pain’, above, how MK ran from dentist to dentist, oral surgeon to oral surgeon, pain therapist to pain therapist, and life coach to psychiatrist in order to get help; and how the level of his suffering grew steadily in parallel to the number of disappointed promises, false diagnoses, and mistaken therapies and interventions.

As this sequence of events illustrates, the distress of chronic pain is tied up with a non-localized feeling of helplessness. Central to this feeling is what we might call a *style of anticipation* – one expects more pain; one expects no relief from it; and this impacts on what one expects from the world more generally. The phenomenologist and psychiatrist Eugène Minkowski (1933/1970, pp.87-9) remarks that, in the realm of human experience, activity is not opposed to mere passivity but to expectation, to waiting. In our goal-directed interactions with the world, we are solicited to act by our surroundings and drawn in by them. When we wait for something to happen, our activities are suspended, something that he associates with a form of ‘anguish’. Instead of actively engaging with the future, moving towards it, ‘I feel, in an immediate way, the future come toward me in all its impetuousness’. Minkowski also observes that this form of expectation is structurally similar to an experience of ‘sensory pain’. Elsewhere, he further suggests that a shift from active engagement towards passive expectation is inseparable from the phenomenology of sensory pain:

….intrinsically bound up in pain is the feeling of some external force acting upon us to which we are compelled to submit. Seen in this light, pain evidently opposes the expansive tendency of our personal impetus; we can no longer turn ourselves outward, nor do we try to leave our personal stamp on the external world. Instead, we let the world, in all its impetuousness, come to us, making us suffer. Thus, pain is also an attitude toward the environment. (Minkowski, 1958, p.134)

The interesting point here is not simply that pain is often attributed to a specific physical cause, one that acts upon us. Rather, it is that pain-experience includes the predominance of a certain kind of passive expectation. This aspect of pain is not localized - pain alters an overarching orientation towards the future; it tips the balance from activity towards expectation. The unpleasantness of pain is thus constituted, at least in part, by a certain way of anticipating.

Of course, pain’s unpleasantness varies considerably (both quantitatively and qualitatively), as does the extent to which it includes feelings of helplessness and anxiety. Nevertheless, as MK’s experience suggests, this kind of anticipatory structure is a conspicuous feature of at least some pain-experiences. Remember his ‘certainties’: ‘I will not be able to stand this for much longer’; ‘I will never be free of this pain again’; ‘I am desperate’; ‘Life continues without me’.

Consider also the effects of prefrontal lobotomy, when used as a treatment for chronic pain. Although it is sometimes said that the outcome is pain without distress, closer scrutiny suggests that lobotomized patients still find pain stimuli noxious and still seek relief from episodic pain. Their indifference is specific to enduring forms of pain. But, even here, the pain still feels unpleasant. What is lacking is any distress over what is coming next - a kind of anxious anticipation and associated helplessness that more usually characterizes chronic pain. In contrast to the experiences of these patients, the distressing quality of chronic pain more usually includes a sense of ‘its lasting meaning or significance’ (Grahek, 2007, pp.135-7).[[3]](#footnote-3) What Kusch’s coping strategy seeks to achieve is similar in one important respect: it also involves decoupling pain-sensations from a certain kind of anticipatory structure.

Once it is acknowledged that chronic pain can have a certain kind of anticipatory structure, one that is inseparable from the experience of distress, we can come to see why the phenomenology of chronic pain *must* be bound up to some extent with interpersonal relations and expectations.

**Trust, Doubt, and Helplessness**

Havi Carel (2013) has proposed that experiences of serious illness centrally involve a loss of ‘bodily certainty’, something that is replaced by ‘bodily doubt’. This, we suggest, provides a helpful way of thinking about the interpersonal and social dimensions of chronic pain. Ordinarily, Carel says, people go about their business with a sense of pre-reflective certainty regarding their bodily abilities and the continuation of their bodily functions. It is not a matter of reflectively or pre-reflectively endorsing however many propositions about what one’s body does, can do, and will continue to do. Rather, it consists in a habitual, bodily, practical confidence that could equally be described as a kind of *feeling*: a ‘feeling of possibility, openness, and ability that characterizes routine and familiar actions’ (2013, p.181). What Carel calls ‘bodily doubt’ involves losing this habitual certainty, in a way that can vary in degree and scope. With a loss of bodily certainty, one’s body becomes conspicuous, problematic, and one’s practical performances are monitored carefully, their outcomes no longer taken for granted. Felt doubt of this kind thus involves a pervasive sense of anxious uncertainty and helplessness: ‘The natural confidence in her bodily abilities is displaced by a feeling of helplessness, alarm, and distrust in her body’ (Carel, 2013, p.184).[[4]](#footnote-4) Although bodily doubt need not be associated specifically with pain, what we have said so far implies that, where there is both bodily doubt and pain, the former can contribute to the latter. Chronic pain, as we have seen, can similarly include a sense of anxiety and helplessness - a style of anticipation that interferes with habitual, practical, bodily immersion in one’s surroundings.

The concepts of certainty, doubt, and distrust are helpful to us here because they make salient the affinity between bodily experience and our relations with other people. Indeed, we suggest that the predominance of bodily doubt is dependent, to some degree, on one’s trusting relations with other people. The style of anticipation that permeates chronic pain can be characterized in terms of propositions such as ‘this will never cease’; ‘nothing can be done to stop this’; ‘there is nowhere else to turn’; ‘the world offers nothing else’; ‘there is even worse to come’. While this amounts to an erosion of trust in one’s own body, it equally implies an erosion of trust within the interpersonal sphere. More usually, we depend on others to diagnose and treat medical conditions, to manage pain, to sustain a sense that there remain alternative possibilities, that something can be done, that there is something or someone to fall back on. Propositions such as ‘nothing can be done to stop this’ are incompatible with propositions such as ‘someone can help me’. Only when the latter is negated can the former be accepted.

The point applies equally to modes of non-propositional, affective anticipation. Trust in another person need not involve explicitly entertaining various propositions. Interpersonal encounters are also shaped and regulated by more inchoate sets of expectations, embedded in one’s various practices, which involve taking for granted that others are well-meaning, capable, qualified, and so forth. When interacting with a given individual, there might be a general feeling of discomfort and suspicion. Alternatively, and more usually, interactions are permeated by a sense of confidence or ease, which might relate to a specific problem / subject matter or apply more generally. This contrast can apply not only to our relations with specific individuals but also to our relations with those in certain professions or roles, to whole institutions, and even to other people in general.

As with bodily trust or ‘certainty’, a sense of what other people have to offer is, in many circumstances, pre-reflective and taken for granted. Thus, when it is lost, there is similarly a kind of bewilderment. What is overturned is not one or more contestable propositions but something presupposed by all of one’s experiences, thoughts, and activities, something that one took as given. It is difficult to find a philosophical terminology that allows us to speak about this thick and multifaceted layer of ‘certainties’. One possible source is Ludwig Wittgenstein’s posthumously published *On Certainty* (1975), assembled from his last notebooks. Here, Wittgenstein distinguishes between various such certainties: some are propositional; some are “animal” or pre-propositional; some concern other people; some concern oneself and one’s body. These certainties are closely connected; sometimes the removal of one of them can bring down the whole structure. Successful communication presupposes that most of the certainties are shared. Accordingly, Kusch (2017) has analyzed the “Sprachnot” (linguistic despair) of Holocaust survivors in reporting their horrendous experiences as due to the difficulty of communicating a situation in which so many of our ordinary certainties are destroyed. Although the situation of the chronic-pain patient in no way compares to the horrors these people struggle to describe, communicating one’s predicament can sometimes feel difficult for (distantly) similar reasons.

The sudden destruction of ‘trust in the world’ has been captured with unforgettable precision by Jean Améry (1999, p.28), in his account of his arrest and torture by the Gestapo. He remarks on how, with the ‘very first blow’, one loses ‘trust in the world’. This loss is attributable in part, to others failing to respect one’s bodily integrity in a way that can never be taken for granted again. More importantly, though, there is a subversion of something more usually assumed. Ordinarily, when we are injured, we cry out to others for help. In so doing, we anticipate that they will help. We do not ordinarily have to think about this; we reach out without thinking, without doubting. The torture victim is faced with something that runs contrary to an engrained system of anticipation. The other person is herself the agent of harm and there is nobody else one can call to:

Even on the battlefield, the Red Cross ambulances find their way to the wounded man. In almost all situations in life where there is bodily injury there is also the expectation of help; the former is compensated by the latter. But with the first blow from a policeman’s fist, against which there can be no defence and which no helping hand will ward off, a part of our life ends and it can never be revived. (Améry, 1999, p.29)

To reiterate, we do not mean to compare the doctor-patient relationship with the torturer-prisoner interaction. Instead, we draw on Améry’s example to further illustrate how interpersonal encounters usually involve certain kinds of expectation, of a kind that we might call ‘trusting’. Loss of these expectations, in various different contexts, can be disorientating and profoundly challenging. Furthermore, the effects inevitably extend beyond the interpersonal domain. In MK’s case, loss of trust in the medical profession was inextricable from loss of bodily trust and thus from the unpleasantness of chronic pain. The relevant process can occur gradually, as when one is faced with conflicting opinions and diagnoses, unhelpful attitudes, and lack of empathy, or it might occur more quickly. But, regardless of the precise trajectory, we maintain that a sense of one’s pain as inescapable, a sense of dread and helplessness, and an inability to effectively act upon one’s situation are all inseparable from a loss of certain interpersonal possibilities: ‘they’ are not to be trusted; nothing they can do will help; I cannot call on anyone else and so there is nothing to be done.[[5]](#footnote-5)

Loss of interpersonal trust (of a kind that varies in degree and scope) is thus inseparable from the distressing nature of one’s pain, from a sense of helplessness and anxiety. This aspect of pain is non-localized - it permeates every aspect of the experienced world. To return to Minkowski, we ordinarily experience our surroundings in terms of various kinds of significant possibility, some of which solicit activities and draw us in. This kind of engagement is balanced by expectation, waiting. Chronic pain involves a pervasive disengagement from the social world and, with it, an alteration of the balance between engagement and expectation. Instead of anticipating the practically significant possibilities offered by one’s meaningful surroundings, one anticipates more pain and, with this, one’s continuing helplessness.

Our reflections on the loss of trust perhaps also help to make sense of MK’s onetime strategy of ‘self-infantilization’. After all, this centrally involved a sense of having lost control of his life. One might think that it originated in a loss of trust in his *own* previously taken-for-granted ability to reason clearly and make reasonable decisions, rather than in a loss of interpersonal trust. But such abilities cannot be extricated from their wider, interpersonal context. What MK also lost (at least when it came to understanding and managing his chronic pain) was a way of engaging with and relying on the judgments of others that confident practical decision-making more usually presupposes. However, self-infantilization is not just a *loss* of ordinary certainties. It is also the attempt to fall back on something else, perhaps on the vaguely-remembered certainties of one’s childhood. The certainty ‘I am a reasonable person, able to make the right decisions for my own life’ is partially overwritten by the child(ish) certainty ‘I am a helpless creature but there are good people, parents, who will do everything they can go protect me from misfortunes’. The transition between them is perhaps not unlike the scenario where someone eventually falls to the floor and begs a tormentor for mercy, having exhausted all other avenues of persuasion and been left with no other resources to draw on. Of course, the attempt is unlikely to succeed, since reality does not readily comply; although doctors might sometimes intentionally or unwittingly encourage the childish attitude (say, by chastising or consoling the patient in parent-like manner), they do not ultimately act like good parents. The failure of self-infantilization then further exacerbates the sense of distrust, helplessness, and abandonment in which it originated – ‘even now you can’t -or won’t- help me’.

**The Two-sidedness of Emotional Intentionality**

To conclude, we want to offer a Heideggerian vocabulary to explicate the following passage from ‘Pain’:

I experienced my chronic jawbone pains as both extremely concrete and highly abstract. ‘Extremely concrete’ since I could always tell, with great accuracy, where exactly it hurt the most. ‘Highly abstract’ since my whole self-image and *Weltbild* had acquired the modality of pain. I was shackled inside my pain as if it were a straitjacket; and I was unable to relate cognitively or emotionally to anything without, at the same time, experiencing and thinking of myself as a sufferer.

The all-enveloping character of certain pain-experiences is philosophically puzzling. We have attributed it to the manner in which pain alters the significance of the surrounding world, including the interpersonal domain, something that involves a pervasive sense of disengagement. Pain, or at least the affective-motivational aspect of pain, can thus resemble what Heidegger, in *Being and Time*, refers to as a ‘mood’ (*Simmung*). According to Heidegger, we do not first of all find ourselves situated in a world and only afterwards impose a superficial, subjective colouring upon it in the guise of a mood. Instead, he claims, it is only through one or another mood that we find ourselves situated in a world at all: ‘*The mood has already disclosed, in every case, Being-in-the-world as a whole, and makes it possible first of all to direct oneself towards something*’ (Heidegger, 1927/1962, §29, p.176). In other words, a mood -in this sense of the term- is presupposed by intentionally directed experiences and thoughts with one or another content, such as thinking about *p* or seeing *q*. And it is not simply an intentional experience with a very wide-ranging content, such as being in a bad mood about one’s life. Rather, moods constitute a sense of the kinds of significant possibilities that the world incorporates, something that intentional states with whatever content take for granted. For instance, in order to find something threatening, one must be open to the possibility of threat and, in order to hope for something, one must be open to the possibility of things changing in a good way. A mood constitutes an openness to certain kinds of possibilities and not others. For instance, a mood of profound despair involves lacking any sense that anything could ever change for the better; the world is bereft of that kind of possibility (Ratcliffe, 2013). Heidegger refers to ‘finding oneself in the world through one or another mood’as *Befindlichkeit*. Following Joan Stambaugh, we translate this as ‘attunement’ (Heidegger, 1927/1996).

One could thus say that chronic pain consists of, or is at least integral to, a Heideggerian ‘mood’ or ‘mode of attunement’. However, it is here that we encounter a problem. Heidegger appears to endorse a distinction between intentionally directed experiences and the more enveloping phenomenological role of moods. And many other philosophers assume a similar distinction. Even those who construe moods as intentional states with very general objects endorse a distinction between specifically focused emotions and more encompassing moods. However, chronic pain -it seems- is both at the same time. MK’s pain was (and still is) located quite specifically in his jaw. Regardless of which ingredients of pain are admitted as intentional and which are not, the object of distress was clearly an apparent condition *of the jaw*. At the same time, however, this amounted to a way of Being-in-the-world, characterized by helplessness, anxious anticipation, and practical disengagement.[[6]](#footnote-6)

Others have also emphasized how pain can come to engulf a world. In an influential discussion, Elaine Scarry (1985, p.35) writes that intense pain ‘destroys a person’s self and world, a destruction experienced spatially as either the contraction of the universe down to the immediate vicinity of the body or as the body swelling to fill the entire universe’.[[7]](#footnote-7) Now, it could be that the kind of pain she is addressing is non-localized - one does not feel it as arising in a specific part of one’s body. However, this does not apply to MK’s jaw pain. It seems plausible to us that many other pain-experiences (and not just experiences of chronic pain) share this same two-sidedness; they are experienced as located in a particular part of one’s body but also permeate the world in which one’s body is situated. For instance, Jonathan Cole (2004) offers an intriguing description of what he experienced after being injected in the arm with pepper extract under experimental conditions, having been told (correctly) that the ensuing pain would only last for around 16 minutes:

….I could think of little but the pain….my pain was difficult to localize; it was out there and below me, though I was no longer sure quite what that meant. It filled my arm, my body, and my sense of self. Pain destroyed my perspective and even my perception of me…..In an existential way, the pain removed my feeling of being embodied; I just had pain. My perception of a shaped arm and hand was absent, overwhelmed and driven from me by the pain. I could think of nothing. (Cole, 2004, pp.7-8)

Although Cole writes that the pain was ‘difficult to localize’, he does not mean by this that it was distributed evenly throughout his body. What he is saying is that the pain in his arm was so intense that it eroded a wider sense of localization, changing -albeit briefly- how he experienced his arm, his body as a whole, and his relationship to the surrounding world. Again, it seems that a pain can have a felt location and yet be diffuse and all-pervasive.

A simple response is to reiterate that pain has different components. While the sensation is localized, the associated affective-motivational tendencies are more diffuse. Now, one cannot infer, on the basis that two physiological processes are dissociable, that an associated experience itself has ‘components’, however an ‘experiential component’ might be conceived of. And, even if one could, it is not merely the pain-sensation that has an apparent location. The associated distress has the jaw as its *object*: the jaw is experienced *as* the source of distress. And this same experience of emotional distress also amounts to an altered way of inhabiting the world. It can be added that the same applies to certain profound and sometimes long-term emotions, thus ruling out an explanation in terms of contingently associated, localized sensations. For instance, the object of profound grief is the loss of something quite specific (a particular person and / or particular relationship). But it also amounts to a profound disturbance of one’s wider experiential world (Ratcliffe, 2017-in press). Nevertheless, the two-sidedness of affective intentionality is especially salient in the case of pain. The pain is *right there*, in the jaw, but it is also the shape of the world one inhabits, within which one has a jaw.

What might Heidegger say about this? His discussion of the ‘mood’ of fear is of particular interest. Even though Heidegger appears to insist that moods do not have specific objects, he is also adamant that fear is a mood. And he is not just referring to *fear of nothing in particular*. He explicitly distinguishes between ‘that in the face of which we fear’, ‘fearing’, and ‘that about which we fear’ (1927/1962, §30, p.179).[[8]](#footnote-8) The first of these is the intentional object - whatever we are afraid of; the second is the attitude of fearing that object; and the third is what we are afraid for (ourselves). So how are we to reconcile the specificity of fear with the all-enveloping role of mood? Consider the following remark:

Fearing, as a slumbering possibility of attuned Being-in-the-world (we call this possibility ‘fearfulness’ [‘Furchtsamkeit’]), has already disclosed the world, in that out of it something like the fearsome may come close. (Heidegger, 1927/1962, §30, p.180)[[9]](#footnote-9)

One way of interpreting this is to identify fear with a specifically directed intentional state and ‘fearfulness’ with the ‘mood of fear’. So fearfulness is an all-enveloping mood of a kind that incorporates the possibility of being threatened (amongst other types of possibility) and thus of fearing something. It is therefore a condition of possibility for an intentional attitude of fear (of the kind that arises within a pre-given world). This was the approach adopted by Ratcliffe (2013). However, we now want to consider an alternative interpretation, inspired by the reflections of this chapter. Instead of identifying fearfulness with a particular mood, we can conceive of fearfulness as *having the potential to enter into a mood of fear.* That potential is integral to our attunement, to our *being mooded at all* rather than to our being in a particular mood. And, when we actually *are* in a mood of fear, we do indeed encounter a specific intentional object as threatening. At the same time, however, we encounter it as threatening to ourselves and, by implication, to our world as a whole. Hence fear is at the same time both specifically directed and all-enveloping. This interpretation is consistent with the following:

Whether privatively or positively, fearing about something, as being-afraid in the face of something, always discloses equiprimordially entities within-the-world and Being-in – the former as threatening and the latter as threatened. (1927/1962, §30, p.181)

So perhaps what Heidegger is trying to get at in appealing to ‘mood’ is not something presupposed by intentionally directed emotion but, rather, an aspect of it that is often overlooked or misinterpreted: encountering something in an emotional way is at the same time an experience of its destabilizing a wider system of salient possibilities - one’s world. Similarly, when we suffer from chronic pain, what *pains us* might be a part of the body, but our *pain* is also the shape of our world; we are *in* pain.

It is doubtful, however, that this interpretation serves to accommodate all aspects of Heidegger’s discussion. For instance, he writes that even what seems to be a mundane lack of mood is in fact a certain kind of inconspicuous mood (1927/1962, §29, p.173). And this is not something that can be ascribed a specific intentional object. There is also the question of what we say about ‘moods’ such as *Angst*, which do not have an object *within* the world, even if we allow that they do have an ‘object’ in the guise of Being-in-the-world itself.

Nevertheless, we suggest that one of the things Heidegger is trying to convey, at certain points in the text, is not something *underlying* emotional intentionality but something *integral* to it, something that passes unnoticed when we interpret intentionally directed emotional experience as arising against the backdrop of a stable world. In so doing, we fail to acknowledge the manner in which these experiences are also episodic or sustained disruptions of world. This, we have argued, applies to some forms of pain as well. It can be added that such experiences can therefore be very difficult to convey to others. The pain is located here, but it is also everywhere. It is a disturbance of the shared world that you continue to obliviously accept as a backdrop to your interpretation of my experience. We encounter here, once more, the ‘linguistic despair’ of the pain patient.

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1. We should emphasize that, in this chapter, we do not wish to make any claims concerning ‘how medical doctors in general behave’, even if the scope of these generalizations is restricted to a particular cultural or social environment. What we present in this section is an account written by MK in a very different context. The various patterns of behaviour he was faced with are likely to reflect wider practice to varying degrees. [↑](#footnote-ref-1)
2. See also Morris (2013) for a discussion of the cultural anthropology of chronic pain. [↑](#footnote-ref-2)
3. The claim that chronic pain incorporates a type of affective anticipation is consistent with various other discussions. For instance, Price (2000, p.1769) identifies both “pain affect” (defined as the “moment-by-moment unpleasantness of pain, made up of emotional feelings that pertain to the present or short-term future, such as distress or fear”) and also “secondary pain affect” (involving “emotional feelings directed toward long-term implications of having pain”). Complementing an emphasis on anticipation, Loeser and Melzack (1999, p.1609) remark that “because chronic pain is unrelenting, it is likely that stress, environmental, and affective factors” are integral to the “intensity and persistence of the pain”. And, from a phenomenological perspective, Geniušas (2015) suggests that chronic pain involves a way of experiencing time - an anticipatory structure that offers only *more of the same*. This cuts one off from a meaningful past and a meaningful future, thus amounting to a sense of being stuck in an expansive present. [↑](#footnote-ref-3)
4. Various others have offered complementary descriptions of bodily conspicuousness. See, for example, Leder (1990). However, it should not be assumed that all experiences of bodily conspicuousness take this form. [↑](#footnote-ref-4)
5. While we have emphasized diffuse sets of expectations concerning other people, of a kind that could be expressed in terms of various different propositions, we acknowledge that more specific, explicit attitudes of trust and distrust also have an important role to play. In turning to the contents of these attitudes, we face difficult philosophical questions concerning (a) when, where, and why trust, distrust, or neither are appropriate or inappropriate, and (b) which criteria should be employed to assess appropriateness (see, e.g., Hawley, 2015). As acknowledged in “Pain”, some of MK’s initial expectations concerning the medical profession were misguided, as was the conduct of some of his doctors. The kind of pervasive, affective distrust that we have emphasized here could thus arise through various kinds of interpersonal and social process, involving –among other things- more localized attitudes of trust and distrust. [↑](#footnote-ref-5)
6. See Morris (2013) and Svenaeus (2015) for complementary accounts of how chronic pain can reshape what is offered by the surrounding world, in such a way that nothing is left undisturbed. As Svenaeus writes, “pain is in everything, in the things one does, in the things one sees, hears, thinks, says, and so on. In this way pain, at least intense and chronic pain, is a *total* experience” (p.117). [↑](#footnote-ref-6)
7. Scarry’s discussion is confused by the fact that she describes the effects of pain while at the same time focusing on the effects of pain inflicted under torture. So it is unclear what should be attributed to the pain and what is specific to torture. If what we have said about interpersonal experience, pain, and anticipation is correct, then it is not possible to separate the experience of pain from an experience of the interpersonal situation in which it arises. [↑](#footnote-ref-7)
8. The original German terms are “das Wovor der Furcht”, “das Fürchten”, and “das Worum der Furcht” (1927/1993, §30, p.140). [↑](#footnote-ref-8)
9. We have altered the Macquarrie and Robinson translation from “Being-in-the-world in a state-of-mind” to “attuned Being-in-the-world”, so as to better reflect the original German “schlummernde Möglichkeit des befindlichen In-der-Welt-seins” (1927/1993, §30, p.141). [↑](#footnote-ref-9)