distinguishing the different experiential dimensions involved in the constitution of pain is by comparing varieties of pain. Smrdu's qualitative study refers to experiences of pain that are predominantly bodily (although lacking any identifiable direct biological cause), in the sense that the experience consists in an aching body. However, pain is not always bodily in this strict sense: some psychopathologies, such as borderline personality disorder and major depression, involve severe emotional pain, sometimes also called psychological or mental pain (Weiss 1934; Tossani 2013; Fertuck et al. 2016; Schmidt 2022). While such pain is also manifest on the bodily level, the body is not the object of the pain experience; rather, the pain experiences relate to the self as a whole and to one's relation to others, including feelings of being rejected, having low self-worth, and being socially isolated. Though these feelings are also felt in the body, they are not about the body; rather, they are about the personal as well as social cares and concerns of the individual. I suggest that distinguishing how these kinds of pain differ in terms of 5E, and demonstrating how each kind of pain shows a certain "pattern" (Gallagher 2013) of these dimensions, will help to further underscore the explanatory value of 5E.

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Pain as the Performative Body

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> Abstract • I unpack Smrdu's kaleidoscope metaphor, putting it into dialogue with enactive work on the performative body in order to cash out how it can capture the qualitative differences of the experience of chronic pain.

Handling Editor • Alexander Riegler

« 1 » How do we experience the world differently when we are in chronic pain? This is the question that Maja Smrdu confronts in her interdisciplinary investigation in the target article. Acute pain is the pain that most of us are familiar with. It is usually sudden, and a response to an injury. It typically presents clearly as a pain "of something" (even if it is difficult to describe or locate) in that the pain is the object of our experience. Chronic pain is usually defined as pain that lasts longer than six months and is often not a response to a current injury or damage. Rather than only being the object of our experience, it becomes (at least for much of the time) part of that through which we experience the world.

« 2 » Smrdu proposes that we can understand the experience of chronic pain better if we think of it as a kaleidoscope through which we experience the world. Although she does not cite the example, it seems to me that her metaphor is a development of one that enactive accounts of cognition and consciousness often use to explain how our bodily and affective changes shape how we experience the world (see, e.g., Ward & Stapleton 2012). The example runs as follows. Just as when we put on a pair of rose-tinted glasses, the colour of the glasses quickly ceases to be the object of our awareness, receding into the background and just "colouring" the way we see the world, the affective body is typically in the background of our experience, shaping our experience of the world without forcing itself into the forefront of our awareness. While we *can* take our body and affective phenomena as the object of our experience (i.e., we think "about" them), much of the time they are not the focus of our experience. Rather, they contribute to our experience by shaping (or "colouring") how we experience the world.

« 3 » Smrdu's kaleidoscope model, if I understand it correctly, seems to me to be a very helpful development of the rose-tinted glasses metaphor for capturing the specific experiences of people who experience chronic pain. It is a development because she specifies that the 5Es are analogous to the mirrors and compartments in the kaleidoscope. They contribute to the organisation of the bodily and affective processes (which in this metaphor are the beads) that, in their different configurations make up the structure of experience (the changing patterns of the beads) of those with chronic pain. The metaphor can therefore capture both how embodied and enactive dimensions contribute to the structure of our experience and the dynamic changes of the bodily and affective contributions to our experience.

« 4 » In what follows I will expand upon the ways in which I take the kaleidoscope model to be similar to and different from the rose-tinted glasses example. Like rose-tinted glasses, a kaleidoscope is something through which we look. Even though we may not see objects through it in the way that we see them through glasses, nevertheless it is crucial that, at the very least, we see light through it (otherwise we would not see the patterns). Unlike the tinted glasses, of course, it is also crucial for our kaleidoscopic experience that we do pay attention to the particular quality of the lenses. We do not go around viewing the world through kaleidoscope lenses for good reason. Even though we look "through" the kaleidoscope, the shapes and patterns do not recede into the background of our experience, their purpose is rather to be close to the forefront of our experience.

« 5 » It is the patterns' closeness to the forefront of our experience that seems to me to be crucial in capturing some of the quality of the chronic pain that Smrdu describes when she draws on the phenomenological interviews with chronic-pain patients. While the pain for chronic-pain patients is not always the object of experience, as it is pervasive and long lasting, the patients must work to make it recede to the background as much as possible. Nevertheless, it is evident from the interview extracts that this does not make it fully recede. It is not transparent except for "colouring" the way patients experience the world. They remain aware of it as very present in their consciousness.

« 6 » If this is indeed how we should understand the kaleidoscope model of pain to work, then I think it is a very helpful contribution to our understanding of the phenomenology of chronic pain as it captures a crucial aspect of the experience of chronic pain that may be missing when we focus our investigations on acute pain. Here, I would like to suggest additional resources for fleshing out this aspect of the model that may help us better capture the particular quality of the kaleidoscopic patterns of pain. In particular, I suggest that work by Dorothée Legrand on the performative body in dance may be particularly promising in this regard.

« 7 » Legrand (2007) draws upon the phenomenology of Maurice Merleau-Ponty and work by Shaun Gallagher to argue that there are (at least) two different kinds of ways of experiencing the body when dancing. She writes:

> "When a beginner learns to dance or when a dancer learns a new choreography, he often needs to control consciously the position and movements of his body. This attitude implies to take an observational stance on the body. In other words, this involves what has been called above the 'opaque body.' The situation is different with an expert dancer who knows his choreography or who improvises a skillful dance. In these cases, the expert dancer embodied the dance. Observational consciousness is not necessary to control actions and would even be counterproductive. This skillful and fully embodied dance involves what is called here a pre-reflective experience of the body. This form of experience has been adequately named 'performative awareness' [Gallagher 2005: 74]." (Legrand 2007: 501)

« 8 » Legrand argues that this pre-reflective experience of the body in dance is importantly different from our typical pre-reflective experience of our body in everyday life. Typically, my pre-reflective experience of my body is of the transparent body. I experience the world through it. Even though it may structure my experience and colour that experience (as in the example of the rose-tinted glasses above) it is not the object of my experience – rather the world is. However, the expert dancer is both experiencing the world through their body (as we normally do) and also experiencing their body "as a subject-agent" (Legrand 2007: 506). This experience of the body as "subject-agent" is not the same as taking the body as object in the way that we do when we are self-consciously dancing in front of colleagues at a work event. It is not the "opaque" body. It is experiencing the world through the body but with the body at the forefront of experience. The experience of the body for the expert dancer does not recede to the background of experience – it is present as a salient part of the experience – yet it is still "that through which" the dancer experiences the world and is not the primary object of the experience. Legrand calls this the "performative body."

« 9 » Smrdu's kaleidoscope model of chronic pain is already phenomenologically sensitive, drawing on Merleau-Ponty and others who advocate distinguishing between *Leib* and *Körper*, body as subject and body as object, pre-reflective bodily experience and the body as an intentional object of experience. I propose that adding Legrand's distinction between the performative body and the transparent body can give us a further tool to conceptualise the ways that chronic pain is described in the phenomenological interviews. Acute pain may be understood as an experience of the opaque body, where we take the bodily pain as the object of our experience and take an observational stance on the pain sensations and what is happening to our body. Chronic pain, in contrast, may be better understood as "performative." It is, by necessity, that through which people experience the world – they cannot constantly take the pain sensations as the object of their experience. However, its pre-reflective status does not mean that it is transparent, or even tinted. The pain, for significant periods, does not recede to the background of experience, merely "colouring" the world as rose-tinted glasses do. Rather, chronic pain is often at the forefront of the bodily experience of the world. As the expert dancer experiences the world through a thick experience of the body that is present to them at the foreground of their experience, both shaping their experience and feeding into it itself, the chronic-pain patient experiences the world through a thick experience of pain and related bodily sensations that both shape and colour their experience of the world and feed into that experience itself.

« 10 » Adding the concept of the performative body to the kaleidoscope model can help us see how the kaleidoscopic patterns are both interestingly similar to and importantly different from the rose-tinted glasses example described at the beginning. Both are that through which we look – they are pre-reflective contributions to experience. However, where the rose-tints recede to the background of our experience, merely colouring it, the different kaleidoscopic patterns remain at the forefront of our experience: sometimes becoming the object of our experience, and sometimes that through which we are looking, sometimes, at the forefront of our experience and sometimes receding to the background. Yet they are always thickly present to us. On this model, chronic pain is the performative body.

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Panopticon of Pain

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> Abstract • Pain remains an unintelligible mystery. Given Smrdu's efforts to expand the horizons for dealing with chronic pain, I re-present some constructivist ideas regarding communication, including commonly assumed features of communications between patients and clinicians, in particular *sharing experience* and *understanding*.

Handling Editor • Alexander Riegler

Understanding *understanding*

« 1 » Emphasising the constructivist view that there can be no direct transmission of one person's experience to another, Ernst von Glasersfeld (1995: 142) claimed that the common meaning of "understand" must be revised. Each person idiosyncratically construes ongoing interactions. One is not construing the *experience* of the other, but only one's *own* experience of the interaction. It follows that we cannot *understand* the other's experience nor can we *be understood* by others. So, if there is no *sharing* of experience (ibid: 48) nor *understanding* possible (Kenny 2011: 207f), what alternative views may be created of clinical communication?

« 2 » In §33 of her target article, Maja Smrdu speculates about the reason as to why the participants were "unable to provide additional details." Since Smrdu could not provide a definite answer, let me try to find a possible explanation. In my view, the system of medical understanding is a form of specialised *language-game* (Wittgenstein 1981) within which the patients easily lose their way in a fog of misunderstandings, particularly because it is not a *shared form of life*. Wittgenstein (1972: 6f, 52) claimed that language operates to *obscure* experiencing, and also to obscure thought. A clear example of the ways in which language obscures our thinking is found in the diagnosis of *fibromyalgia*, which, in what follows, I describe as a *dormitive diagnosis*.

« 3 » All too often a diagnosis has the same illusory status as that provided by the physician in Molière's play *The Imaginary Invalid*. When asked to explain why opium had put the patient to sleep, he replied "Because opium has *dormitive* properties." Even though the questioner is impressed and convinced by this phrase (*virtus dormitiva*) it is clear that nothing has been explained. This is a form of deception where we use "learned and significant phrases" to obscure our ignorance and conserve the illusion that we have some "insight" into the phenomena in question.

« 4 » Constructing a typical pseudo-scientific term from Latin and Greek we get the following: "fibromyalgia" is composed of "fibro" = fibrous tissue, "myo" = muscles, and "algos" = pain. Combining these together forms a *tautology* because the patient's own description of having "pain in my muscle" is diagnosed as "fibromyalgia," which is simply repeating in pseudo-scientific terms that "there is muscle pain." *It repeats with different words exactly that which needs to be explained*. The patient wants to know why they have pain and they are told in a sententious manner "because you have pain." Here the words are used simultaneously to (a) pretend that we know something, and also to (b) actively obscure our ignorance that we do not know what is going on.

« 5 » Bateson in the metalogue *What is an instinct?* shows the deception in certain forms of scientific explanations:

> "Daughter: Daddy, is an explanatory principle the same thing as an hypothesis?
> Father: Nearly, but not quite. You see, an hypothesis tries to explain some particular something but an explanatory principle – like 'gravity' or 'instinct' – really explains nothing. It's a sort of conventional agreement between scientists to stop trying to explain things at a certain point." (Bateson 1972: 39)

The *explanatory principle* is used as a *meta-communication* that says "Here we are pretending to know something, and furthermore, we agree that we are not going to investigate this area of our ignorance any further."

« 6 » Fibromyalgia is a *marker* whose meta-communication concerns the abandonment of any further efforts at under-