

2021

## The Lived Experience of Chronic Pain: On the Contributions of Phenomenology in Understanding Chronic Pain Disorders

Riley C. Smith  
*University of Central Florida*



Part of the [Philosophy Commons](#)

Find similar works at: <https://stars.library.ucf.edu/honorsthesis>

University of Central Florida Libraries <http://library.ucf.edu>

This Open Access is brought to you for free and open access by the UCF Theses and Dissertations at STARS. It has been accepted for inclusion in Honors Undergraduate Theses by an authorized administrator of STARS. For more information, please contact [STARS@ucf.edu](mailto:STARS@ucf.edu).

---

### Recommended Citation

Smith, Riley C., "The Lived Experience of Chronic Pain: On the Contributions of Phenomenology in Understanding Chronic Pain Disorders" (2021). *Honors Undergraduate Theses*. 1076.

<https://stars.library.ucf.edu/honorsthesis/1076>



University of  
Central  
Florida

STARS  
Showcase of Text, Archives, Research & Scholarship

THE LIVED EXPERIENCE OF CHRONIC PAIN: ON THE CONTRIBUTIONS  
OF PHENOMENOLOGY IN UNDERSTANDING CHRONIC PAIN  
DISORDERS

by

RILEY C. SMITH

A thesis submitted in partial fulfillment of the requirements  
for the Honors in the Major Program in Philosophy  
in the College of Arts and Humanities  
and in the Burnett Honors College  
at the University of Central Florida  
Orlando, Florida

Fall Term

2021

Thesis Chair: Dr. Luis H. Favela

*“Illness is the most heeded of doctors: to kindness and wisdom we make promises only; pain we obey”* (Proust, 1921/2001, pg. 135)

## ABSTRACT

Chronic pain disorders are estimated to affect a significant proportion of the global population. These disorders are often debilitating and pose a substantial challenge to the everyday life of those affected. Modern medicine has made great strides in understanding the physiological processes involved in chronic pain. However, chronic pain is more than merely a physiological process. Chronic pain is an embodied mode of being-in-the-world that manifests in multiple aspects of lived experience, from the ability to perform day-to-day tasks to the relationship between body and self. Consequently, it is essential to cultivate a rich appreciation of chronic pain as a lived experience. To rely solely on physiological knowledge in conceptualizing chronic pain precludes the development of such an appreciation. This work examines the ways that phenomenology can be leveraged to broaden the current medical understanding of chronic pain to better incorporate subjective experience. As a rigorous methodology for studying embodied consciousness, phenomenology provides the theoretical and conceptual tools to form a rich description of chronic pain's lived experience. First, a brief history of theories of pain is presented to contextualize the development of modern medical understandings of chronic pain. Following this, the writings of three classical phenomenologists—Husserl, Heidegger, and Merleau-Ponty—are presented, and key phenomenological concepts are introduced. Phenomenology is then used to examine the lived experience of chronic pain. Finally, means of integrating phenomenology into the current medical framework are explored.

*Keywords:* Phenomenology, chronic pain, lived experience, Husserl, Heidegger, Merleau-Ponty

## **DEDICATION**

To my mother, without whom, I would not be where I am today.

## **ACKNOWLEDGEMENTS**

In writing this thesis, I have received considerable support and encouragement.

I would first like to thank Dr. Luis Favela for the many hours he has invested in this project. He has inspired and guided my thinking at every point of this project, and for that, I am immensely grateful.

I would also like to thank Dr. Jonathan Beever for his considerable feedback in the writing process. He has introduced me to many new ideas and constantly challenged me to notice their connections to my research.

Finally, I would like to thank Dr. Luciana Garbayo, whose input at the beginning of this project helped to shape and refine my research topic.

## TABLE OF CONTENTS

<b>LIST OF FIGURES .....</b>	<b>viii</b>
<b>CHAPTER 1: INTRODUCTION.....</b>	<b>1</b>
<b>CHAPTER 2: A BRIEF HISTORY OF THEORIES OF PAIN .....</b>	<b>5</b>
2.1 Descartes .....	5
2.2 Specificity Theory.....	8
2.3 Gate Control Theory .....	11
2.4 The Biopsychosocial Model .....	13
<b>CHAPTER 3: PHENOMENOLOGY .....</b>	<b>16</b>
3.1 Husserl .....	16
3.2 Heidegger .....	19
3.3 Merleau-Ponty.....	24
<b>CHAPTER 4: MEDICAL PHENOMENOLOGY, ILLNESS, AND THE PHENOMENOLOGY OF CHRONIC PAIN .....</b>	<b>29</b>
4.1 Medical Phenomenology .....	29
4.2 Chronic pain is properly understood phenomenologically as an illness, not merely a disease .....	30
4.2.1 <i>Disease</i> .....	31
4.2.2 <i>Illness</i> .....	34
4.3 Chronic pain and the world.....	36
4.4 Chronic pain and the lived body .....	40
<b>CHAPTER 5: INTEGRATING PHENOMENOLOGY INTO MEDICINE: FROM THEORY TO PRACTICE.....</b>	<b>45</b>

5.1 Moving from a theory to a practice of medical phenomenology .....	45
5.2 Challenging positivism in medicine.....	47
5.2.1 <i>Positivism</i> .....	47
5.2.2 <i>Confronting positivism through medical education</i> .....	49
5.3 Addressing ambiguity and conceptual disunity in medical phenomenology.....	51
5.4 Situating phenomenology within current treatment practices for chronic pain disorders like fibromyalgia .....	53
5.4.1 <i>How fibromyalgia is currently treated</i> .....	53
5.4.2 <i>Incorporating phenomenology into chronic pain treatment</i> .....	55
5.5 Facilitating exploration of illness experience .....	56
<b>CHAPTER 6: CONCLUSION.....</b>	<b>60</b>
6.1 A thorough understanding of the first-person experience of chronic pain is crucial...60	
6.2 Understanding via phenomenology .....	61
6.3 Phenomenology can be practically utilized in realizing this goal.....	63
6.4 Final remarks .....	64
<b>REFERENCES.....</b>	<b>66</b>



## LIST OF FIGURES

Figure 1. Descartes' conception of the sensation of a flame. (Modified from Descartes (1664). Public domain).....	7
--	---

## CHAPTER 1: INTRODUCTION

Pain is one of the most ubiquitous phenomena experienced by organisms. In life, pain is continuously encountered, often daily for most. Generally, pain is beneficial for an organism in the short term. Pain signals serve a functional purpose to alert an organism of potential bodily harm. A person who accidentally places their hand on a hot stove quickly removes that hand at the sensation of pain, protecting the hand from being burned. Pain can also indicate pathological changes within the body, such as alerting a person to internal distress. For instance, a case of appendicitis may present with lower abdominal pain, encouraging the seeking of treatment to rid oneself of the pain, and by virtue of this, the pathological appendix. Pain serves a critical physiological role in the preservation of normal function, and thus, in sustaining life. Such an understanding characterizes pain as essentially motivational, commanding an imperative to protect the body (Klein, 2015).

Beyond this conceptualization of pain as a sensory response to objective, noxious stimuli, pain also has an affective dimension. This dimension is highlighted in the International Association for the Study of Pain's (IASP) recently updated definition of "pain." The IASP defines pain as, "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (Raja et al., 2020, p. 2)<sup>1</sup>. This definition underscores an important aspect of pain, specifically, the first-person experience. When including this emotional aspect, the phenomenon of pain surpasses being solely a protective

---

<sup>1</sup> I acknowledge that this definition may not apply to specific cases in which the condition of *both* unpleasant sensory and emotional experience is not met, such as those who practice forms of masochism. However, its broad applicability to most instances of painful experience is sufficient for this work.

mechanism for the body of the sufferer. Emotion confers a specific meaning to the experience of a person. For example, feelings of anger or disgust arise from worldly actions and inform subsequent actions. Thus, the emotional experience of pain is deeply connected to one's mode of interaction in the world. Pain produces an emotional meaning for the sufferer and can modulate their possibilities of engaging with the world.

Clinically, pain is generally differentiated into acute and chronic pain. Acute pain is associated with definitive, objective causative agents or damage (e.g., burns, lacerations, etc.). This type of pain usually resolves itself once the precipitating factor has been addressed. Acute pain may progress to chronic pain when normal physiological responses to noxious stimuli persist and evolve, evading suppression by control mechanisms (Carr & Goudas, 1999). When pain becomes a pathology in itself rather than serving as a signifier to an underlying pathology—as is the case in many chronic pain disorders—the potential for individual suffering is great.

In 2016, chronic pain disorders were estimated to affect 20.4% of adults in the United States alone (Dahlhamer et al., 2018). These diseases are frequently debilitating, interfering with patients' ability to work and leading to significant depression (Breivik et al., 2006). Furthermore, there is evidence that a significant overlap exists among chronic pain disorders, with many patients being affected by more than one disorder simultaneously (Maixner et al., 2016).

Clinically, there has been an effort to expand on the definition of chronic pain currently provided by the International Classification of Diseases (ICD). Proposed definitions of chronic pain have been suggested for the upcoming new edition (ICD-11), including “persistent or recurrent pain lasting longer than 3 months” (Treede et al., 2015, p. 1004). Among these proposals, chronic pain disorders have been categorized into distinct groupings, including chronic neuropathic pain,

chronic cancer pain, and chronic primary pain (Treede et al., 2015). Chronic primary pain disorders are differentiated from other chronic pain disorders by having considerable psychological and emotional distress and a notable absence of any underlying disease (Nicholas et al., 2019). Chronic primary pain comprises diseases such as irritable bowel syndrome, chronic migraine, chronic primary low back pain, and fibromyalgia. Because chronic pain is such a broad field, solely focusing on a general account would sacrifice specificity to a degree. Though there are many chronic primary pain disorders (see Nicholas et al., 2019), this work will primarily focus on fibromyalgia in discussing medical understandings.

Fibromyalgia, as a clinical disease entity, has perplexed clinicians for centuries. Reports of non-specific muscle pain have been documented as far back as the 16<sup>th</sup> century (Inanici & Yunus, 2004). Various descriptions of chronic muscular pain were published throughout the following centuries. It was not until the work of Smythe and Moldofsky (1977) that a modern description of fibromyalgia was formally published. This description contributed to the disease's legitimacy, which had often been dismissed outright due to a lack of detectable anatomical pathology. The first formal set of diagnostic criteria were published in 1990 (Wolfe et al., 1990). Since the publication of these diagnostic criteria, significant strides have been made in understanding key events leading to the onset of fibromyalgia, including central sensitization in the central nervous system, genetic predispositions, and alterations in stress response (Littlejohn & Guymer, 2020).

Chronic pain disorders are complex diseases that present a significant challenge to medical practitioners. Understanding of these disorders continues to evolve as contributions from many research fields are incorporated. In this work, I will argue that the first-hand experience of chronic pain disorders is a critical component in this understanding. I will apply research in

phenomenology to chronic pain disorders. Phenomenology provides the means to analyze the first-person experience of chronic pain disorders in a systematic way. Leveraging insights from the phenomenological tradition is valuable in understanding chronic pain disorders without reducing pain's first-hand experience.

This work is comprised of six main chapters. The following chapter discusses the evolution of medical views of chronic pain, beginning with early work in characterizing these disorders. The third chapter presents an overview of traditional phenomenology, including its major thinkers and concepts. With this foundation, the fourth chapter then presents the field of medical phenomenology, and its work is applied to chronic pain. The fifth chapter discusses ways of integrating phenomenological insights into medicine. Finally, the conclusion reiterates the importance of understanding chronic pain as a lived experience and the utility of phenomenology in this endeavor.

Importantly, this work is not intended to be explanatory in the sense of describing the genesis of these disorders. Instead, it is focused on what a thorough, phenomenological description of the first-hand experience of these disorders can add to medicine's understanding, ultimately to benefit those who live with these disorders.

## **CHAPTER 2: A BRIEF HISTORY OF THEORIES OF PAIN**

Medical understandings and treatments of disease are largely tied to the theories that inform them. Theories determine the scope of the medical field's involvement (i.e., doctors, researchers, etc.) and provide potential points of therapeutic intervention. To grasp how phenomenology may contribute to understanding chronic pain, it is first prudent to examine medical theories of pain. This section summarizes a selection of major theories of pain. These include Descartes' theory of pain, specificity theory, gate control theory, and the biopsychosocial model<sup>2</sup>. After discussing each theory's tenets, chronic pain will then be placed in the context of each theory. Emphasis is placed on the increasing role that first-person experiences of pain play in constituting theories surrounding pain. As will be seen, pain theories have increasingly needed to include more and more of pain's subjective experience. From this basis, I argue that phenomenology provides the conceptual tools and understanding to realize this integration.

### **2.1 Descartes**

Our modern understandings of pain largely owe credit to the work of René Descartes (1596-1650). Descartes' work in the fields of anatomy, mathematics, and philosophy, among others, laid the foundation for work in a diverse array of fields. In his philosophical work, Descartes is primarily remembered for his aim to form a metaphysical foundation from which scientific knowledge may be grounded. This metaphysical foundation necessitated an interrogation of what it is to be a conscious subject experiencing the world. Through

---

<sup>2</sup> These theories have been chosen in particular because of their considerable influence on medical understandings of their times as well as the continuing influence they have in current medical discourse.

methodological skepticism, Descartes arrived at the conclusion that his existence as a thinking subject was a fundamental truth, summed up in his famous conclusion, “*cogito, ergo sum,*” or “I think, therefore I am.” From this fundamental truth, Descartes could then construct his metaphysics, in the process, dividing mind and body into an immaterial mental substance and material physical substance, *res cogitans* and *res extensa*, respectively.

Descartes was an avid anatomist who frequently carried out animal dissection/vivisection and also attended displays of human dissections (Benini & DeLeo, 1999). He conceived of the body as a “machine made of earth” (Descartes, 1664/1985, p. 99), framing the functioning of the human body solely in terms of causal relations like the internal workings of a clock or an automaton (Canguilhem, 1992). His mechanistic physiology pervades his work, most explicitly in his theories surrounding sensation.

Descartes’s theory of sensation is of critical importance to developments in theories of pain. Having studied the nervous system, Descartes had carefully observed the connections between the brain and the body through peripheral nerves running throughout the body. The brain’s centrality and its many connections led him to believe that the brain must be the site at which *res cogitans* and *res extensa* interact. In examining the pineal gland within the brain, he noted it as a structure that was not paired, unlike the hemispheres of the brain, thalami, etc. Based upon this, Descartes posited the pineal gland as the site where *res cogitans* and *res extensa* interact.

Descartes explicitly lays out his understanding of pain perception in his *Treatise on Man* (1664/1985). Contained within this work, in what has become one of the most famous diagrams in the history of neuroscience, Descartes describes the transmission of a painful burn to the brain and the subsequent motor response (Figure 1). In this diagram, a person kneels with their foot

(B) next to an open flame (A). According to Descartes, the particles of the flame interact with the skin, causing the skin to move. This movement pulls on small nerve fibers (C) located in the foot. The pulling of these fibers opens a pore within the brain (de), specifically in the pineal gland, where the pain becomes conscious (Procacci & Maresca, 1994). This pore's opening allows for the flow of *animal spirit*<sup>3</sup> out of a reservoir (F). The animal spirits then cause a subsequent motor response by which the foot is moved away from the flame. Thus, the motion of the flame pulls along the length of the nerve, reaching a central center within the brain. He compares this process with the pulling of a string to ring a bell to which the string has been attached.



Figure 1. Descartes' conception of the sensation of a flame. (Modified from Descartes (1664). Public domain)

---

<sup>3</sup> For Descartes, animal spirits are a substance found in the blood that constitute a vital energy in the form of heat or wind (Rey, 1993/1998).



When the small nerve fibers are pulled with such force that they are severed, pain occurs. Because conscious perception is a property of the *mind* and not the *body*, pain is only felt by the mind (Benini & DeLeo, 1999). As such, there is a divorce between the noxious stimulus and the experience of pain, with pain becoming an epiphenomenon of an underlying physical process. Based on this, subjective experiences of pain are of secondary importance to medicine. The singular focus should be on the mechanistic process itself. To borrow Descartes' analogy, if the bell is ringing incessantly, there must be a problem with the string attached to it, and not the bell itself. This can be seen in his understanding of phantom limb pain being caused by the continual firing of nerves that once belonged to the absent limb (Sabatowski et al., 2004). Chronic pain understood in the Cartesian framework is thus a result of purely objective, mechanistic origins.

## 2.2 Specificity Theory

Descartes' theory regarding sensory transmission formed the basis for *specificity theory*. This theory grew out of many crucial neuroanatomical discoveries in the nineteenth and twentieth centuries (Perl, 2007), such as the demonstration of afferent and efferent nerves by Bell and Magendie, respectively (Bell, 1811; Perl, 2007). Specificity theory posits the existence of anatomically segregated sensory receptors that are specific for a particular sensory modality—touch is carried by touch receptors, taste by taste receptors, and so forth. These receptors then transmit sensation to a designated region of the brain via dedicated afferent nerve fibers. Each sensory modality is responsive to only a single stimulus type (Moayedi & Davis, 2013). Thus, this theory is founded on four physiological commitments: stimulus-restricted receptors, specific afferent fibers, dedicated areas of the brain for each sensory modality, and a unidirectional transmission of information from the stimulated structure to a specific area in the brain.

This theory explains pain sensation as follows: pain-specific, thinly myelinated, or free nerve endings detect noxious stimuli. The resulting signal is then carried by small-diameter A- $\delta$  and C fibers to the dorsal horn of the spinal cord. From here, the sensation is carried by the anterolateral tracts among the ascending tracts of the spinal cord. Finally, the sensation is transmitted to a pain-specific region in the thalamus. The simplicity of this theory is largely responsible for its long-lasting impact. There lies no ambiguity in the transmission of pain signals. Furthermore, it creates a clear target for treatment, the pain pathway. Neurosurgical interventions in chronic pain cases such as rhizotomy and cordotomy became increasingly common as persistent pain treatments (Sabatowski et al., 2004).

Despite its simplicity, the specificity theory of pain is highly problematic. The theory carries an implicit assumption that psychological states of pain are definitively correlated to and inseparable from peripheral noxious stimulation (Melzack & Wall, 1965). Noxious stimulation must necessarily invoke a painful psychological state. Consequently, painful psychological states must necessarily result from noxious stimulation, which is not the case in many chronic pain disorders. Pain is thus reduced to the status of a stimulus-response phenomenon, with no room for the contribution of higher-order components such as subjective meaning, past experience, or cultural background (Melzack, 1996). The personal experience of pain becomes an epiphenomenon of an underlying physiological process, much like Descartes' theory of pain.

Such a theory has profound effects on determining the purview of medicine regarding chronic pain. One effect seen is the narrowing of clinically relevant pain states. Following the tenets of specificity theory, if a patient presents to a physician complaining of pain in the absence of an objective cause, they cannot be said to be genuinely experiencing pain in the manner that an average person experiences pain. Such patients are seen as having some psychoneurotic

abnormality that warrants psychiatric evaluation (Melzack, 1993), or worse, they are seen to be malingering. Another effect of such a narrow understanding is the restriction of treatment modalities. When pain is understood in terms of solely a sensory pathway, the only treatment options for pain become those that intervene on the pathway, such as the neurosurgical methods that gained popularity.

Additionally, these theories implicitly harbor a form of dualism in understanding pain. Pain is either purely objective—as is the case in the notion of specific pain receptors and pathways being the only determinants of pain—or a manifestation of some non-physical psychopathology, and thus not *true* pain. Following this idea, there can be no genuine psychological contribution to the experience of pain (Melzack, 1996).

This notion of pain as a purely objective, organic process—one which is necessarily tied to physiological disturbance—posed a considerable obstacle to the acceptance of fibromyalgia, and beyond this, to research on the condition. Early authors proposed abandoning the classification of ‘fibrositis,’ seeing it as nonspecific and unscientific due to its lack of objective support (Halliday, 1942). Despite this, some staunchly defended its existence (Traut, 1968), albeit often endorsing the same dualism as those who denied its legitimacy. Many of those who did in fact accept the condition often attempted to reconcile their commitment to a form of medical dualism by describing the condition in psychogenic terms. Patients for whom clinical examination provided no concrete evidence were subject to explanations involving a sort of repressed psychological manifestation. Take, for example, a discussion of fibrositis patients exhibiting comorbid anxiety and depression: “In the anxiety neurotic and in the depressive, the martyrdom of pain gratifies his self-punishing tendencies which have arisen from guilt over deep-seated instinctive drives” (Ellman et al., 1936, p. 73). This stance also resulted in the

recommendation of psychological treatment over physical therapy (Boland & Corr, 1943). It took clinical trials to dispel myths that fibromyalgia was a psychosomatic condition (Yunus et al., 1981).

### **2.3 Gate Control Theory**

A landmark in pain theories came with the publication of Melzack and Wall's (1965) seminal paper on gate control theory. Recognizing the inadequacy of pain theories at the time, they sought to formulate a theory of pain that captured experimental evidence more accurately and recognized the role of higher-order neurological processes in pain. They began by refuting prevailing theories of pain at the time, namely specificity theory and pattern theory (sometimes referred to as intensity theory). Pattern theory posits the sensation of pain is caused, not by the activation of specific pain pathways, but by the coding of the stimulus itself (Melzack & Wall, 1965; Moayedil & Davis, 2013). A stimulus that reaches a specific threshold of activation in the nervous system is responsible for pain.

Gate control asserts that pain is determined by sensory-discriminative, motivational-affective, and cognitive-evaluative processes (Melzack & Casey, 1968). Small afferent nerve fibers carrying sensory information are modulated by a gate control system within the spinal cord before reaching transmission (T) cells that transmit this information to the brain via the anterolateral spinal tracts. The modulation of painful inputs can come from several sources. Large fibers transmitting sensory information simultaneously with the small fibers may dampen the small fibers' overall input. Additionally, the input may be modified by a central control function carried by descending efferent fibers. As outlined by Melzack (1996), the gate control theory relies on the following premises:

1. The transmission of nerve impulses from afferent fibers to spinal cord transmission (T) cells is modulated by a spinal gating mechanism in the dorsal horn.
2. The spinal gating mechanism is influenced by the relative amount of activity in large-diameter (L) and small-diameter (S) fibers: activity in large fibers tends to inhibit transmission (close the gate) while small-fiber activity tends to facilitate transmission (open the gate).
3. The spinal gating mechanism is influenced by nerve impulses that descend from the brain.
4. A specialized system of large-diameter, rapidly conducting fibers (the central control trigger) activates selective cognitive processes that then influence, by way of descending fibers, the modulating properties of the spinal gating mechanism.
5. When the output of the spinal cord transmission (T) cells exceeds a critical level, it activates the action system-those neural areas that underlie the complex, sequential patterns of behavior and experience characteristic of pain. (p. 131-132)

Gate control saw broad acceptance in the years following its initial publication, and today, it is one of the most widely accepted theories of pain in medicine.

This theory's impact is primarily due to its argument that higher-order processes in the CNS *can* and *do* influence the perception of pain. No longer could pain be viewed in a stimulus-response manner, as it had been historically. Furthermore, the theory overcame the problem of reducing pain to solely peripheral noxious stimulation by allowing for central determinants of pain. This proved fruitful in fostering a greater understanding of chronic pain syndromes in which peripheral nervous pathology was markedly absent. Moreover, it allowed for the CNS to modulate typical sensory inputs and to generate painful signaling, which is evident in disorders like fibromyalgia, where even normal mechanical sensation can produce severe pain. Finally, recognition was given to the influence of individual elements like cultural background and emotional meanings attached to pain.

Despite its veritable revolution in understanding pain, gate control is not without problems. Critics of the theory have critiqued its position based on the specificity of free nerve endings, the lack of differentiation between pain in different tissues, and pathological conditions

that defy the explanations of the theory (Nathan, 1976). Furthermore, elucidating the complex role of the CNS in modulating pain has necessitated a new model, that of the neuromatrix (Melzack, 1999).

## 2.4 The Biopsychosocial Model

Despite the extensive focus on biological mechanisms in chronic pain research and treatment, the past few decades have seen an increased emphasis placed on the influence of non-biological factors in persistent chronic pain syndromes. Much of this recent work has come from advocates of the biopsychosocial model of illness. As the name implies, this model incorporates biological, psychological, and social factors into medicine. This model was formulated as a reaction against the biomedical model's reductionistic tendencies and its inability to explain instances of illness that exhibited a notable absence of biological dysfunction. Engel (1977) sought to broaden the horizons of medicine to include factors beyond strictly biological mechanisms, including psychological and social factors. Explicitly drawing from work in systems theory, these constitutive factors of the biopsychosocial model are taken to constitute a whole system—one that cannot be reduced to a single factor alone. Accordingly, physicians should approach patients as a whole rather than focusing solely on biological, psychological, or sociocultural factors (Engel, 1980).

The biopsychosocial model advocates for the study of both disease and illness. *Disease* refers to objective changes that occur at the physiological or anatomical level and disturb the body's homeostatic functioning (Gatchel et al., 2007). *Illness* refers to the first-hand experience of a disease, including the emotions and judgments patients attach to it. The experience of illness is unique to a particular patient. As such, medicine must recognize the individual in the exam

room who is ill, not the disease. Illness is experienced not only by the patients themselves but also by their friends and family. It is important to note that, unlike the biomedical model, the biopsychosocial model does not require one to cause the other, or vice versa. A pathological change at the physiological level does not necessitate the phenomenon of an illness state (Engel, 1977). This model opposes the biomedical model that relegates disease to strictly bodily or psychosomatic etiology.

This model proposes that chronic pain disorders are also best understood as a combination of biological, social, and psychological factors (Turk & Monarch, 2018). A patient's experience of pain is contingent on the mutual interaction and determinacy of these factors. Moreover, an individual's experience of chronic pain is unique to them (Gatchel et al., 2007). Each patient brings with them a set of prior experience, cultural valuations, and socioeconomic status that serves to inform and modulate their subjective experience and day-to-day life with chronic pain. For example, a particular patient may hesitate to communicate their pain due to social stigmas surrounding gender norms in their culture.

There is a large push within this model to view chronic pain syndromes in a longitudinal manner rather than a static manner. Chronic pain is an ongoing process that sees periods of relief and periods of relapse. To limit the medical intervention to a static collection of symptoms would neglect the highly variable nature of chronic pain syndromes. Stressors in life can negatively influence the course of these syndromes. The course of these syndromes is very much patient-based. Advocates of the biopsychosocial model call for an active role in treatment on the patient's part (Turk & Adams, 2016).

The biopsychosocial model's acceptance has not been as widespread as some hoped (Fava & Sonino, 2007). Although this model is beneficial in approaching a broader

understanding of illness, it possibly leads to ambiguity in identifying the extent to which certain factors are involved in a specific illness. The extent to which a clinician can ascribe interactions between biological, psychological, and sociocultural factors in illness states is unclear. Furthermore, how these independent factors unify in illness is not entirely clear. The lack of theoretical concepts able to unite these factors presents a problem (Leder, 1992a). There is a theoretical gap between conceptualizing the illness and the person as a whole. Because of this, phenomenology has been drawn upon as a framework to be used in unifying these factors (Davidson & Strauss, 1995). Additionally, there have been criticisms of the biopsychosocial model that characterize certain treatments as a form of weak dualism (Duncan, 2000). In separating the biological from the psychological, it is very much possible to slip into a similar form of dualism as adherents of specificity theory.

As can be seen in the history of pain theories, there has been an ever-increasing emphasis placed on the influence of first-person experience as a contributing factor to the sensation and generation of pain. Despite this, many theories remain so tightly bound to underlying biological commitments that the first-person experience can easily be lost in translation from theory to practice. Because of this, an understanding of pain needs to be formed from the basis of the first-person experience of pain. To do so is not to deny the influence of critical biological processes at work. Rather, it is only through examining the subjective experience of pain on its own—with the understanding that it is not a sole factor—that a more integrative and cohesive understanding of chronic pain can be reached. In this work, I wish to explicate a rich first-person understanding of chronic pain grounded in patients' lived experiences. To that end, the phenomenological tradition offers valuable contributions.



## CHAPTER 3: PHENOMENOLOGY

Phenomenology is concerned with studying the first-person, subjective experiences of consciousness (Smith, 2018). Though a broad field comprised of many disparate thinkers, it can be characterized as a discipline rooted in analyzing the world through the lens of subjectivity. In doing so, it sets aside assumptions of what is ontologically real or unreal, material or immaterial, etc. The sole task is to analyze the “things themselves” (Husserl, 1913/1983, p. 35), that is, the first-person experience of a phenomenon. Before discussing the phenomenology of chronic pain, it is first necessary to introduce and define the concepts that will be drawn upon in that discussion. This section gives an overview of the significant thinkers and concepts in classical phenomenology. Three thinkers will be discussed: Edmund Husserl, Martin Heidegger, and Maurice Merleau-Ponty. For each thinker, specific concepts relevant to discussing the first-hand experience of chronic pain will be defined.

### 3.1 Husserl

Phenomenology as a distinct movement in philosophy formally began in the work of Edmund Husserl (1859-1938) in the late nineteenth and early twentieth century. Growing out of the descriptive psychology of Franz Brentano, Husserl’s phenomenology was initially concerned with understanding how knowledge is provided by conscious experience. Through an analysis of conscious experience, Husserl hoped to arrive at “an objective *theory of knowledge* and...the *pure phenomenology of the experiences of thinking and knowing*” (Husserl, 1900/2001, p. 86; emphasis in original). In this goal of pure phenomenology, Husserl hoped to derive the essential features of conscious experience, i.e., what characteristics of consciousness allow for meaning to be drawn from subjective experience. From this basis, Husserl progressively widened the scope

of phenomenology, intending to develop it into a foundational science, going so far as to call it “inferior in its methodological rigor to none of the modern sciences” (Husserl, 1917/1981, p. 10).

A key idea Husserl inherits from his teacher Brentano is the concept of *intentionality*. This concept aims to characterize how consciousness relates to the entities experienced through it. Brentano originally conceived of intentionality to distinguish between mental and physical phenomena. He saw many descriptions of mental phenomena as being solely based on negative features, for example, saying that what is mental is defined by its lack of extension in space. To Brentano, describing mental phenomena in terms of what they are *not* is inadequate. Thus, he aims to positively contribute to the definition of mental phenomena.

In Brentano’s major work, *Psychology from an Empirical Standpoint*, he notes that “Every mental phenomenon is characterized by... reference to a content, direction toward an object” (Brentano, 1874/1995, p. 68). That is, mental phenomena are predicated on specific content that forms their basis. Perception is of *something* perceived; thinking requires *something* to be thought of, and so on. There is thus a relationship between a mental phenomenon and its content, an *intentional* relationship. From this basis, Brentano defines mental phenomena as “those phenomena which contain an object intentionally within themselves” (p. 68).

For Husserl, this concept is a crucial insight in understanding conscious experience. However, he departs from Brentano’s understanding of intentionality. Primarily, he sees issues in Brentano’s terminology, especially in the distinction between mental phenomena and physical phenomena regarding intentionality. Husserl does not wish to make such a distinction. He instead utilizes the term “*intentional experience or act*” (Husserl, 1900/2001, p. 214; emphasis in original). Additionally, Husserl also believes Brentano’s characterization of intentionality leads to the conclusion that what is given in experience is both the intention of the object and the

object itself. Arguing against this, he states, “there are... not two things present in experience, we do not experience the object and beside it the intentional experience directed upon it... only one thing is present, the intentional experience” (Husserl, 1900/2001, p. 215).

To understand Husserl’s conception of the method of phenomenology, it is first necessary to understand that which he is trying to overcome through the phenomenological method he outlines. In the course of all conscious actions, people take for granted what is presented to them. The existence of the tree in the distance is of no ontological concern to a person hiking in the forest. The tree simply exists as a perceivable object. Our daily actions are filled with such presuppositions, which characterize an unspoken ontology that we presume to be true. To define these taken-for-granted assumptions, Husserl outlines the concept of a *natural attitude*. The natural attitude is the certitude with which we believe the objective world exists. Husserl does not wish to dismiss the natural attitude; he wishes to suspend it, to look past it.

Husserl strives to overcome the natural attitude to arrive at the experience of the phenomenon itself. Returning to the previous example, Husserl would ask what allows for the conscious experience of seeing the phenomenon to which we ascribe the signifier ‘tree’? To get at this understanding of the phenomenon, Husserl puts forth the concept of the *epoché*, or *bracketing*. Bracketing involves a conscious suspension of belief in the objectivity of what is perceived, a conscious suspension of the natural attitude. Instead of trying to determine the physical characteristics of the phenomenon—Husserl relegates this task to the natural sciences—the phenomenologist should allow the experience to present itself as-is: “The tree... can burn up, be resolved into its chemical elements, etc. But the sense... cannot burn up; it has no chemical elements, no forces, no real properties” (Husserl, 1913/1983, p. 216). No matter the physical state that the tree is in, there is still sensation and meaningful experience of it.

Husserl's contributions to philosophy created an entirely new research field in phenomenology. With the goal of creating a science of subjective consciousness, Husserl developed the phenomenological method. This method attempts to overcome assumptions about the nature of consciousness or the world, known as the natural attitude. By returning to the "things themselves" through the process of bracketing, conscious experience can be analyzed in a manner that sets aside presuppositions. Through these fundamental concepts and prolific lecturing, Husserl became a prominent figure in European thought.

### 3.2 Heidegger

Following the considerable influence of Husserl's work in Europe, phenomenology began to grow as a movement, amassing contributions from many thinkers. This emerging work formed the basis of many subsequent philosophical movements, including Jean-Paul Sartre and Simone De Beauvoir's existential philosophy and Jacques Derrida's deconstruction. Among these early adherents of phenomenology was Martin Heidegger (1889-1976), a student of Husserl and personal assistant to him. Heidegger became a prominent figure in 20th-century philosophy in his own right with the publication of his groundbreaking work *Being and Time* in 1927. Although fundamentally informed by the teachings of fellow thinkers within phenomenology, this work marked a significant departure from traditional phenomenology as understood by Husserl. Rather than focusing on phenomenology as a method to examine the essential features of consciousness, Heidegger shifted to an ontological focus, opting to use phenomenology as a method to formulate a radically new ontology.

In *Being and Time*, Heidegger aims to understand a fundamental concept of *being in general*, i.e., what being is in its most abstract sense. This aim stands in contrast to the analysis

of the existence of specific entities (e.g., chairs, pens, etc.), which belongs to the domain of the descriptive sciences. For Heidegger, the question of what being in general is—the ontological question—is a question that has been largely ignored in the course of philosophical thought. Implicitly, philosophy has carried with it an assumption of what it is “to be” without ever directly addressing the issue. Take, for example, Descartes’ conclusion, “I think, therefore I am.” Even if one takes Descartes’ argument and conclusion to be valid, the “am” in the conclusion is never elucidated (Heidegger, 1927/2010, p. 45). This presents a considerable problem for philosophical thought if conclusions rest on such a shaky foundation. Thus, for Heidegger, there is an urgent requirement to investigate a fundamental ontology from which philosophy and the sciences may proceed.

To arrive at the meaning of being in general, understood as the “being of beings” (Heidegger, 1927/2010, p. 5), requires an investigation of *beings* themselves. Being in general can only be encountered through the entities that are presupposed by it. Our daily interactions in the world around us are with beings. In this investigation, however, being in general cannot be grasped by analyzing just any entity encountered in the world. The question of being requires that the being to be “*interrogated*” must “have become accessible in advance as they are in themselves” (1927/2010, p. 5; emphasis in original). In other words, the being chosen must be able to be seen in itself prior to any investigation; it must be open to investigation. The being chosen by Heidegger is *Dasein*.

*Dasein* is Heidegger’s concept of a being for which being is a concern. Heidegger states, “*Dasein* is a being that does not simply occur among other beings. Rather it is ontically distinguished by the fact that in its being, this being is concerned *about* its very being” (1927/2010, p. 11; emphasis in original). In other words, the capacity for reflective thought on its

existence is a constitutive characteristic of Dasein and its mode of being. This would distinguish Dasein from other living beings such as plants and animals, who (seemingly) do not possess this capability. These entities simply exist without any reflection on the nature of their being. Human beings are a part of the concept of Dasein, but they are not the only ones. Any being that can ponder its existence, be it advanced artificial intelligence or an alien race, would also be included in Heidegger's concept of Dasein.

Furthering his characterization of Dasein, Heidegger describes the way in which Dasein "understands itself in its being... in some way and with some explicitness" (1927/2010, p. 11). That is to say, human beings possess an understanding of what it means "to be" prior to any reflection on the matter. We have no trouble in discerning that which currently exists, that which does not exist, and that which does not yet exist in the course of our everyday interaction with the world. For example, it is not difficult for the existence of a four-sided triangle or a six-sided square to be dismissed. It is intuitively known that such entities do not exist without having an explicit understanding of being in general. Thus, we possess a set of standards to determine the existential status of the thing in question (Blattner, 2006).

Unlike classical understandings of subjectivity in which consciousness is understood as separable from the world, Dasein cannot be abstracted from the world in which it exists and acts. Rather, Dasein is fundamentally rooted in the world. Heidegger's concept of *being-in-the-world* [In-der-Welt-sein] accounts for the mutual connectedness between Dasein and its world. Heidegger goes so far as to posit being-in-the-world as "an *a priori* necessary constitution of Dasein" (Heidegger, 1927/2010, p. 54; emphasis in original). Importantly, no single component of this concept is separable from the others. There can be no "being-in" without a world in which it can occur. Similarly, a world exists only by virtue of the being which inhabits it.

Heidegger formulates this being-in-the-world, not as an objective being in a precise spatial position on Earth, but as a *familiarity* with the world (Blattner, 2006). Dasein can be said to *dwell* in the world in the sense that one dwells in a home. A home is a space in which people are comfortable and able to perform most actions without a second thought. This is not to say that Dasein cannot exist objectively in the world as organisms and inanimate objects do. The ability to recognize Dasein as objectively present is only possible because of its prior state of being-in-the-world.

To understand Dasein's being-in-the-world, Heidegger focuses on the everyday interactions of Dasein with the world around it. For Heidegger, the world is characterized by a collection of meaningful<sup>4</sup> involvements that Dasein enacts in its actions. He focuses on the entities that we encounter and interact with in our daily life. Heidegger refers to these entities as *equipment* [Zeug]. He wants to show that our fundamental interaction with the world around us is not one characterized by objectively analyzing and theorizing this equipment.

Equipment is used to accomplish a task. Thus, the mode of being of equipment is as an "in order to" (Heidegger, 1927/2010, p. 65), e.g., a hammer is used *in order to* drive a nail. This usage is generally a non-reflective one. Dasein does not have to analyze the equipment before interacting with it. For example, I am writing with a keyboard on a laptop without having to ponder *how* I am able to use to use it. I do not reflect upon the material of the keys, their distance from one another, or the weight with which I push them down as I type. In fact, to do so would actively interfere with my usual interaction with the keyboard. I simply interact with the keys to

---

<sup>4</sup> By meaningful, I mean goal-oriented, purposeful engagement in the world. Dasein perceives and interprets the world through *projects* which it works towards through acting within the world.

accomplish my task of writing. This type of usage, Heidegger calls *ready-to-hand* [Zuhandenheit]. Our everyday interactions with the world usually constitute this type of usage. We are “not focused on the tools themselves, but the work” (1927/2010, p. 69) we are actively engaged in.

Not all of our interactions follow this type of usage, however. If the keyboard were to cease functioning correctly suddenly, it would halt my ability to write. The keyboard then becomes *present-at-hand*. I cease to use the keyboard non-reflectively. I examine the different parts, hoping to find what has caused a malfunction. The meaningful interaction that I had with it now presents itself to me as amiss. In Heideggerian terminology, the keyboard has now become *conspicuous* to me. Despite this malfunction, I may attempt to continue typing—maybe avoiding a particular key that is not working. At the point when all usability breaks down—say none of the keys work—I see the keyboard as merely objectively present. I can no longer accomplish my work with it, and it thus becomes an item with which I can no longer have the same meaningful interaction. The keyboard has now become *obtrusive*; the keyboard “reveals itself as something merely present, which cannot be budged without the missing element” (1927/2010, p. 73).

These breakdowns in the everyday interaction with the world around us are particularly salient to discussions of illness states. Illness (particularly chronic illness) may interfere with the skillful usage of equipment. Because Dasein understands its being in a certain way, changes in skillful usage can conflict with this understanding. When the meaningful relations that constitute the world of the sufferer are radically altered—as is the case with many chronic pain patients—their fundamental state of being-in-the-world is changed. What was once a stable understanding of being becomes alienated.



Heidegger's in-depth analysis of the world has been continually drawn on in many disciplines, including contemporary medical thought (Gullick et al., 2020). Despite his meticulous treatment of the world, Heidegger generally has little to say about the body in comparison (K. A. Aho, 2009). The body is as fundamental to conscious experience as the world. We are not immaterial minds or brains in vats. Rather, we are embodied subjects, and it is this embodiment that enables us to interact with the world. It is this importance of embodiment that inspired a considerable amount of work in phenomenology on the nature of the body and its relation to conscious experience.

### **3.3 Merleau-Ponty**

Of particular interest to medicine are the works of Maurice Merleau-Ponty (1908-1961), a French phenomenologist whose in-depth analysis of perception, the body, and the environment provides valuable insights into the ways in which a subject exists in the world. Deeply influenced by both Husserl and Heidegger as well as the Gestalt psychology movement, Merleau-Ponty rose to prominence with the publication of *Phenomenology of Perception* in 1945. Merleau-Ponty is unique among the phenomenologists in his deep interaction with work conducted in psychology and medicine. Unlike Heidegger and Husserl, he references a large amount of scientific research in his works. He often develops his positions through case studies, critiquing the predominant understandings of such cases and developing his own positions in the process. This interdisciplinary approach has contributed to the broad influence of Merleau-Ponty's work in fields outside philosophy like the cognitive sciences and psychology. In this section, I will discuss Merleau-Ponty's contribution to the corpus of phenomenology, focusing on his analysis of the body.

In *Phenomenology of Perception*, Merleau-Ponty offers an in-depth analysis of perception as the foundation of conscious experience. Perception is the means by which we grasp the world around us. Perception is not merely the transmission of sense data from an external world to an internal consciousness; neither is it merely a process by which a rational mind represents an object. Perception is direct and meaningful. The function of perception “is to establish or inaugurate knowledge” (Merleau-Ponty, 1945/2012, p. 17). Perception is not a passive process; it arises through active engagement in the world.

Merleau-Ponty sees traditional philosophy and psychology as prioritizing the objects perceived in the world rather than the actual *experience* of perceiving those objects. Even in Husserl’s concept of intentionality, he sees a bias towards the object of experience over how this experience comes about. In the traditional understanding, objects are transcendent relative to our consciousness, i.e., they go beyond the fixed point of view that we operate in. Despite only seeing a particular side of a tree at a time, for example, we know that some parts of the tree cannot be seen, parts that go beyond our point of view. These sides of the tree that cannot be seen go beyond our consciousness. For Merleau-Ponty, rather than these transcendent objects being primary and our perception of them secondary, it is actually our *perception* that is primary. Our perception forms the background upon which these objects appear. Without perception being characterized the way it is, this experience would not be possible.

Merleau-Ponty posits the lived experience of the world as primary and scientific explorations—including those of medicine—as secondary to this primary experience (Merleau-Ponty, 1945/2012, p. lxxii). Every person is situated in the world within a given first-hand perspective given to them by their body. Conscious experience is made possible by virtue of being embodied (Käufer & Chemero, 2015). He posits the body as the locus of perception and

engagement with the world. Much like the lived experience of the world, there exists a first-hand experience of the body that precedes any second-order description. This first-hand body forms the background from which all experience is made possible. As such, Merleau-Ponty was interested in understanding the experience of the body from the first-person perspective.

Merleau-Ponty begins his examination of the body through neurological case studies of his time. He focuses on mechanistic physiology as his point of departure. This view presupposes the body to be solely an object. This object is controlled and sustained by internal mechanisms that have direct causal relations and serve to dictate normal functioning. Instead of broadly focusing on this view, he delves into specific illnesses and places the mechanistic model under scrutiny. Among the case studies he considers are those of phantom limb syndrome.

Phantom limb syndrome is a condition characterized by sensation in a limb that is not objectively present. Often, this occurs following surgical amputation, with as many as three-quarters of amputees being reported to experience sensations in an amputated limb (Kooijman et al., 2000). In a large portion of patients, phantom limb presents as a chronic neuropathic pain syndrome in which the phantom limb is experienced with pain of varying characteristics and intensity (Aternali & Katz, 2019). At the time of Merleau-Ponty's work, medicine explained the phenomenon of phantom limb in strictly mechanistic terms. The sensation of the missing limb was thought to result from continual stimulation of residual nerve endings within the remaining portion of the amputated limb.

Although Merleau-Ponty acknowledges the role of physical processes in the phenomenon of phantom limb, he finds such a reductive understanding to be severely lacking. The existence of psychological factors in the phenomenon challenges such a view. For example, he notes that "[a] phantom limb appears for a subject not previously experiencing one when an emotion or a

situation evokes those of the injury” (Merleau-Ponty, 1945/2012, p. 79). The existence of both physical and psychological factors defies any explanation which would attempt to reduce the phenomenon to one or the other.

Overcoming the limitations of these two understandings requires a rethinking of the body. To do so, Merleau-Ponty turns to the first-person experience of the body. He calls this first-person experience of the body the *lived body*. This concept aims to understand the body’s subjective and objective features without falling into the trap of reducing the body to the former or latter. The lived body is said to be *intentional* in nature. It is always directed at the world around it. For instance, the act of reaching for a glass of water when thirsty presupposes a conscious act that guides its execution. A movement is an act of bodily consciousness, of *motor intentionality*, as he describes it. Additionally, drawing on Heidegger, Merleau-Ponty argues the body is “the vehicle of being in the world” (1945/2012, p. 84). It is the foundation for the meaningful relations we have with the world around us.

Returning to the example of phantom limb, Merleau-Ponty puts forth his own explanation. He understands phantom limb as the “ambivalent presence” (Merleau-Ponty, 1945/2012, p. 83) of the affected limb. Despite the limb’s absence, the body still interacts with the world as if the limb were there. The patient is not directly conscious of the absence of their limb, however, because the world presents itself in a manner that suggests the ability for meaningful engagement—there is an “appeal to a [limb] that I no longer have” (1945/2012, p. 84).

Phenomenology is a discipline that first emerged in the early 19th century with the work of Husserl. This initial work aimed to formulate a systematic methodology from which an analysis of subjective experience could occur. Husserl advocated for the study of what is given in

conscious experience before assumptions are made about its validity, realness, etc. This aim required suspending prior beliefs about the nature of this experience. While this basis proved fruitful, subsequent thinkers in phenomenology recognized its limited account of the interaction between the subject and the world, among them Heidegger. In his work, Heidegger used phenomenology as a methodology to study ontology. He focused his analysis on the existence of Dasein, a being that is concerned about its being. Heidegger argues that the world is fundamentally meaningful for Dasein. Embodiment is another prominent theme within phenomenology. Through Merleau-Ponty's work, the nature of the subjective experience of the body was analyzed. The living body is our primary mode of being-in-the-world. It is not reducible to its objective features, nor its subjective features. Through studying clinical cases, Merleau-Ponty argued for a position that resisted the reductionism present in medicine and psychology. The considerable influence of phenomenology has led to its adoption in many fields outside of philosophy, including medicine. By providing the conceptual basis to understand subjective experience, phenomenology has been used to understand the phenomenon of illness states and to interact with implicit assumptions of embodiment in medicine.

## CHAPTER 4: MEDICAL PHENOMENOLOGY, ILLNESS, AND THE PHENOMENOLOGY OF CHRONIC PAIN

### 4.1 Medical Phenomenology

As it has developed since the works of Husserl, Heidegger, and Merleau-Ponty in the early twentieth century, phenomenology has expanded both in its number of adherents and in the research areas with which it engages. This expansion has seen areas such as ethics, theology, and politics becoming prodigious areas of phenomenological inquiry from the mid-twentieth century onward (Simmons & Benson, 2013). Nevertheless, phenomenology has not remained isolated within the philosophical discipline. In fact, a wide array of disciplines outside of traditional philosophy have drawn on phenomenology, including cognitive science, computer science, and linguistics (Smith, 2018).

Among these recent expansions, work within the phenomenological tradition has been applied extensively to the discipline of medicine. Beginning in the mid to late twentieth century, research emerged from within medical academia that utilized phenomenological concepts and methodologies to explore and analyze various topics within medicine. Such topics include the essential characteristics of medical practice, the differences between lived experience and scientific accounts of such experience, the nature of embodiment, intersubjectivity in medicine, the phenomenon of empathy in medicine, and the phenomenon of the clinical encounter (Toombs, 2001). At the heart of these many issues, a foundational aim can be seen: fundamentally, *medical phenomenology* attempts to examine medicine from an unbiased perspective, *bracketing* (cf. Husserl, 1913/1983) presupposed notions of what medicine is or how

it ought to be conducted<sup>5</sup>. Through this process, it is hoped that new perspectives may be formed, and insights from these perspectives may positively impact how medicine is conceived and practiced.

In this chapter, I utilize the phenomenological framework established in the previous chapter to move beyond the solely biological descriptions of pain discussed in the second chapter. To this end, I also draw upon work in medical phenomenology to offer a descriptive analysis of the lived experience of chronic pain. The first section will situate chronic pain within the medical phenomenological literature as an illness. Next, I will examine the profound effects chronic pain can have on the relationship between an individual and the world around them. Finally, I will address the relationship between chronic pain and the lived body.

#### **4.2 Chronic pain is properly understood phenomenologically as an illness, not merely a disease**

Before examining the profound effects of chronic pain on a person's lived experience, I will first establish the sphere in which I discuss the phenomenology of chronic pain, contrasting it with that of traditional medical approaches. I will define both disease and illness. It will be demonstrated that a solely disease-based understanding does not work for chronic pain disorders.

---

<sup>5</sup> One point of distinction I would like to make here is between a phenomenological approach to medicine and a phenomenographical approach, as both approaches have appeared in medical literature. Phenomenography studies the various ways that people can understand a phenomenon (Larsson & Holmström, 2007). Unlike phenomenology, phenomenography is not concerned about a phenomenon itself so much as how that phenomenon is conceived by various people. This work largely utilizes a phenomenological approach; however, when discussing individual patients' understandings of their chronic pain, the approach discussed uses phenomenological concepts in conducting phenomenography.

#### 4.2.1 Disease

In the medical phenomenology literature, an important point of distinction is drawn between the terms *illness* and *disease* as they relate to a person experiencing malady. As used within the context of modern medicine, *disease* refers to the dysfunction of specific biological processes within the body (Carel, 2016). Essential to this conception of disease is an inherent observability, i.e., the ability for a physician to identify empirical evidence which indicates and legitimizes the presence of said disease. This empirical evidence primarily takes the form of biological description, giving an account of observed abnormalities found during the course of examination or testing. Radiology, blood pressure readings, or white blood cell counts all represent examples of such empirical evidence that can be used to diagnose a given disease. The presence of such findings allows a physician to achieve relative certainty in the presence of a disease.

Given the observable nature of such findings and the confidence they furnish on diagnosis, more often than not, a tendency in medicine emerges which privileges the discovery of such findings over any other considerations in evaluating patients. For if disease is taken to be the core of medical practice, and the discovery of objective markers provides the most efficient means of identifying disease, then the discovery of such markers ought to be privileged in clinical medicine. This tendency can be seen frequently in the firm reliance on diagnostic testing in evaluating patients, be they healthy or sick. Diagnostic testing has become the means by which physicians may uncover the underlying biological processes relevant to disease—in a sense, a means by which to visualize the disease itself (Baron, 1985).



Problems arise when such techniques become the *sole* methodology of medical practice, however. For example, a laboratory test, though clinically useful, is not the arbiter of health or sickness in itself. Attempts to use testing in such a manner works to reduce health to a quantifiable value residing in a standardized range of “healthy” values. Providing a helpful illustration, Aho & Aho (2008) write:

while after taking vitamin B12 a blood test may indicate that a patient has been cured of anemia (in that their iron level now registers within one standard deviation of a medically agreed-upon statistical norm), their level of overall health may yet remain in question. (p. 5)

Though the patient’s iron levels now occupy a predetermined healthy range, it does not necessarily follow that they are then healthy. To assume so would be to ignore a multitude of other factors contributing to health, including their ability to engage in activities or overall mental health. In this case, “health” has been reduced to the absence of objective disease findings. While such information surely informs health, to ignore a patient’s quality of life would be mistaken.

Beyond reducing health to a quantity, this tendency may also actively stifle the need for a physician to address or consider a patient’s subjective experience. To demonstrate this, Baron (1985) provides a scenario in which a doctor is listening to a patient’s heart through a stethoscope. During the examination, the patient begins to ask the doctor a question regarding their condition. Upon being asked said question, the doctor interjects, saying, “Quiet, I can’t hear you while I’m listening” (p. 606). The doctor in this situation has become so preoccupied with the detection of disease that the patient actively interferes with their intentions by expressing their subjective concerns.

When studying disease in this manner, modern medicine prioritizes objective findings over a patient's own subjective experience, often in a manner that treats such subjective experience as an epiphenomenon of an underlying physical process. The patient's experience is treated as secondary to an underlying biological malfunction. As an epiphenomenon—so this view posits—then subjective experience should not be the primary concern in treating disease. Instead, if one addresses the underlying problem of biological dysfunction, this subjective experience will be subsequently addressed as a consequence.

A significant problem arises when objective findings cannot be obtained from a patient complaining of sickness, however. The assumption that all forms of illness experience must exhibit this underlying disease process is contradicted by a patient lacking objective markers, such as fibromyalgia and other chronic pain disorders. As is seen in fibromyalgia, there are often no objective findings that would indicate that a patient is suffering from debilitating chronic pain. It was this very lack of objectivity that even led some to doubt the existence of fibromyalgia altogether, as seen in chapter two (e.g., Halliday, 1942; Ellman et al., 1936). All a physician can attend to is the patient's own experience and their verbal account of it. In trying to get at the physical events occurring in fibromyalgia, the patient is ignored. As Elaine Scarry writes in her influential work, *The Body in Pain*, “to bypass the voice is to bypass the bodily event, to bypass the patient, to bypass the person in pain” (1987, p. 7).

If biological dysfunction is considered the exclusive level of examination, then an absence of any observable or detectable dysfunction implies a lack of disease. This possibly leads to a view that a patient's complaints are merely psychological, as was the case with those who believed fibromyalgia to be “psychogenic” in nature. Thus, an over-reliance on disease

excludes such conditions and, further, may lead to opinions that discount the validity of a patient's own experience.

#### **4.2.2 Illness**

Beyond the narrow focus on objectivity and quantification that pervades a perspective based on the concept of disease, the term *illness*—as it is used in medical phenomenology—refers to the “qualitative” (Carel, 2016, p. 17) and “nonquantifiable” (Aho & Aho, 2008, p. 4) dimensions of sickness. These dimensions encompass both the symptoms *and* the life alterations experienced by a person (Leder, 1992b). Thus, in speaking of chronic pain as an illness, we may describe both the pain itself, considering how a patient experiences their pain as well as how such pain has transformed their life. For instance, a patient may no longer be able to work due to their chronic pain. It is vital that such radical changes to patients be considered in medicine.

In studying illness, medical phenomenology holds that presuppositions such as the role of biological dysfunction in the genesis of disease should be set aside. Illness should instead be investigated from how it is experienced by those affected. In doing so, medical phenomenologists do not wish to discredit the role of any physical, biological forces at work. Certainly, it would be foolish to deny the efficacy of modern medicine in treating disease. Instead, medical phenomenologists wish to set aside presuppositions in an attempt to form new perspectives. Forming new perspectives and understandings can offer improvements to how medicine is conceived and practiced.

An illness-based approach places a strong emphasis on a patient's lived experience. This emphasis proves especially crucial in accounting for the experience of those suffering from chronic pain for whom a biological cause cannot be pinpointed. Because illness need not include

biological dysfunction, one can be “ill” though clinical examination or laboratory testing cannot find anything abnormal. Being grounded in illness allows for patients in such cases to be treated in a manner that recognizes their experience and validates their concerns.

Beyond its immediate effects on the body, illness can be an ongoing experience that carries with it broad existential ramifications (Carel, 2016). Illness can be a disruptive force towards one’s life goals, place in society, or ability to engage in meaningful activities, to name a few examples. To illustrate these existential implications, consider a patient who has been diagnosed with a neurodegenerative disease such as Huntington’s disease (HD). HD is a fatal neurodegenerative disease characterized by progressive memory loss and motor abnormality, accompanied by psychiatric and cognitive symptoms (Ghosh & Tabrizi, 2013). Implicitly, an HD diagnosis carries with it the knowledge that one’s time with their health is limited. Eventually, the illness will progress, and the patient’s condition will deteriorate. Such knowledge can have drastic implications on how someone decides to live their life. The conscious prospect of eventual mortality may discourage people from engaging in some meaningful activities altogether. For instance, HD is an autosomal dominant genetic disease (MacDonald et al., 1993), meaning if a patient were to have children, there is a 50% chance that the disease will be passed down to those children. Knowing this significant risk, patients may choose to avoid having children altogether. For those that do, the anxiety of whether their children carry the disease-causing gene can be debilitating. Further, for those who have a parent or family member with the disease, the anxiety may discourage them from getting tested for the disease-causing mutation (Anderson et al., 2019).

Having established the perspective from which medical phenomenology may approach chronic pain, I will turn to a phenomenological analysis of chronic pain experience. The

following section will begin this analysis by first considering chronic pain's effects on a person and the world around them.

### 4.3 Chronic pain and the world

In this section, I explore how pain disrupts one's being-in-the-world. To do so, I will first revisit Heidegger's phenomenology to incorporate the relevant concepts for discussion. Later, I will also examine how chronic pain can isolate a person from the people around them.

As discussed in chapter three, Heideggerian phenomenology is built on the related concepts of *Dasein* and its *being-in-the-world*. *Dasein* is a being that has a concern for its very being. *Dasein* reflects on its existence and understands itself as existing in a particular way. Furthermore, *Dasein* is not a being that exists as an isolated, thinking entity; *Dasein* exists within and is intimately connected to a world that it inhabits. *Dasein* adopts a particular manner of *being-in-the-world*, a familiarity with the world that allows *Dasein* to engage with its environment meaningfully. Importantly, this mode of being-in-the-world allows *Dasein* to act in a manner that does not require stringent conscious reflection at every step of the way. An opportunity for action—such as the hammer and nail example Heidegger provides—presents itself, and instead of needing to think about every necessary step involved, *Dasein*'s conscious experience turns outward and focuses on the end goal, the “in order to,” as Heidegger writes (Heidegger, 1927/2010, p. 65).

Looking at typical day-to-day life, people become accustomed to the world around them and adopt a typical mode of being through which they act within the world. We become familiar with the environment around us, and instead of calculating our every move in this environment, we act purposefully, searching for opportunities to engage in purposeful action. As a more

concrete example of this phenomenon, consider a university student who regularly attends a lecture multiple days out of the week. For this student, the specific details of their routine and the environment they act in become second nature; driving onto the university campus, knowing where to park so as to be close to the lecture hall, navigating the shortest walking route to the classroom, and finding the classroom all become second nature. The student need not reflect on these intricacies because there is no need for them to do so to successfully engage with their world. Instead, their conscious focus is oriented towards the end goal of their actions, reaching the lecture hall on time for their course.

Chronic illness disrupts such familiarity with the world. In fact, the presence of illness works to render one's acts uncertain. Suddenly, what was once an intuitive, unconscious mode of engaging with the world can become one that must be reevaluated at every step. Recounting her experience with multiple sclerosis, the medical phenomenologist S.K. Toombs describes how her illness has changed her relationship with the space around her from one which presented the world as familiar to one which actively obstructed her movement. She writes:

The surrounding world appears (feels) different than it did prior to bodily dysfunction. In particular, the world is experienced as overtly obstructive, surprisingly non-accommodating. Actions are sensed as *effortful*, where hitherto they had been *effortless*. (Toombs, 1995, p. 15)

She describes how a "location that was formerly regarded as 'near' is now experienced as 'far'" (p. 11), and, furthermore, how "the stairs became an obstacle to be avoided, as much as possible, by using the elevator" (p. 11).

Returning to the previous example, if this same student now needed to find alternative parking, had to arrive considerably earlier than they would typically, or now needed to take an elevator instead of the stairs, it requires that student reconsider their ability to act successfully.

Their focus is no longer immediately directed at reaching the lecture hall. Instead, their immediate focus now lies in their capability to act in ways they previously could without concern. The mode in which they had once been able to engage with the world has become utterly foreign and unfamiliar.

Similarly, a patient with fibromyalgia experiences radical changes in their ability to conduct normal daily activities (Henriksson et al., 1992). For many patients, there is an ever-present threat of the onset of a painful episode. These episodes may be triggered through stress, physical exertion, etc. Even simple, mundane activities like brushing one's teeth present a possibility for the encroachment of pain. If such a minor action as brushing your teeth can lead to immense pain, there is a complete breakdown of how one usually engages with the world. Every action may now be the harbinger of pain and must be treated as such. This monumental change to daily life necessitates patients reevaluating their ability to perform everyday activities. If one wishes to avoid a painful episode, one may have to weigh the benefits of engaging in the action versus the costs of the pain associated with it. Given such a plight, some suffering from chronic pain may choose to avoid certain activities altogether to avoid the possibility of pain.

In a Heideggerian sense, this shift in one's being-in-the-world from being comprised of inherent meaningfulness to one in which relations lose their meaning changes the entire understanding of self and world for Dasein. Characterizing this phenomenon of illness, Svenaeus (2011) terms this breakdown as an *unhomelike* being-in-the-world. An unhomelike being-in-the-world renders foreign aspects which previously brought security or comfort, things that grounded a person's life. There is a profound loss of identity when the things that once stabilized you suddenly become absent or unable to be engaged with. This new mode of being-in-the-world represents an existential threat to identity and one's place in the world around them. If a person

can no longer function in the ways that typically characterize their life, there is a high chance of a particularly traumatic situation.

Beyond its immediate impacts on one's being-in-the-world, chronic pain also functions to isolate those suffering from the people around them. This isolation occurs through two means: first, through the impossibility of directly sharing painful experiences with others (Leder, 1992b). In much the same way that we cannot directly experience another person's emotions, the fundamentally private nature of painful experience means that no one, besides the sufferer, can directly experience their pain and its severity. At best, the people around the person may be able to approximate the pain that a person is in, yet it still remains an utterly foreign phenomenon to them. As witnesses to a person in pain, we rely on their speech, gestures, groans, and the like to understand that they are genuinely in pain. Consequently, the sufferer may feel as if no one can truly comprehend what is happening to them. Though they may try their best to convey their pain, it can feel as if no one "gets" it, engendering feelings of isolation. Further, because it is not directly experienced, another person's pain may be subject to suspicion. Someone may believe their pain is being exaggerated or even fabricated altogether. Thus, pain is simultaneously undeniable to the sufferer and dubitable to an observer (Scarry, 1987).

Secondly, the difficulties of sharing painful experiences are compounded by the inherent challenge of articulating painful experiences in language. Often, pain is described through metaphor in an attempt to convey the experience as well as possible (Van Hooft, 2003). Using metaphor, people may describe their pain as "like a burning needle prick" or as if they were "being stabbed." Such usage attempts to relate one's own pain to a common understanding of pain in language (Scarry, 1987; see also: Wittgenstein, 1953/2009, secs. 246, 315). These metaphors may help to articulate the painful experience to some degree; however, they can only



function as approximations at best. This can be immensely frustrating to the person trying to convey their pain to others, especially when they feel that their language fails to convey the situation's gravity.

In chronic pain, the world of the sufferer encloses as bodily pain usurps experience. For someone in pain, the only thing that can be experienced at that time is the pain itself. It is an ever-present state of suffering that resists any attempt to ignore or lessen its influence. As such, rather than having an outward focus on engaging with the world, the person in pain can only focus on their pain. A person's lived experience is turned inwards such that the world fades from the lived experience. Their ability to engage with the world is stifled by this deficit in the ability to go beyond their immediate painful experience. Perception becomes the perception of pain, and speech becomes silenced or augmented by pain, etc. Pain becomes present in all possible experiences as inescapable. The space of meaningful experience narrows to include only those bodily perceptions of pain. To use Scarry's terminology, pain is "world-destroying" (p. 29). In a sense, the person's world becomes solely pain.

#### **4.4 Chronic pain and the lived body**

Chronic pain does not only impact the relationship between self and the world. One of the most profound effects of chronic pain lies in its impacts on embodiment. To examine these impacts, I will draw upon the phenomenological concept of the *lived body*. Relying on this concept, this section will examine chronic pain within the context of embodiment. First, I will differentiate this concept of the lived body from the medical approach towards the body.

As discussed previously, within the modern medical framework, pain is understood in the context of objective, biological mechanisms which structure and determine the course of painful

experience. Even within the biopsychosocial framework (as covered in chapter two)—which purports to address the problems inherent in such a reductionist view—one sees an over-emphasis on the biological component of painful experience and a dearth of psychological or sociological analysis. Thus, the predominant view, holding mechanistic explanations as key, views the body as an assemblage of biological mechanisms. These mechanisms intertwine and feed into and out of one other, are regulated through other mechanisms, and combine to ensure the proper functioning of the body. This mechanistic view treats the body as if it were a machine comprised of mechanisms much like a clock or other complex machines (Leder, 1984, 1992a).

Rather than solely focusing on the analysis of the mechanistic body, phenomenology provides the means to examine chronic pain from the concept of the *lived body*. As discussed in chapter three, the lived body, featured prominently in the work of Merleau-Ponty, is a concept that incorporates not only the objective features of the body but also the subjective features. The concept of the lived body is theoretically rich in that it includes both the physical body and the embodied experience of a person. Irreducible to either of these, the lived body functions through the mutual interaction of each.

Contrary to mechanistic perspectives, pain is not experienced as the dysfunction of a specific physiological process; a person in pain does not experience the firing of nociceptive c-fibers nor the eventual integration of that sensory information in the brain. Likewise, vision is not experienced as the conversion of light to electrical impulses in the photoreceptors of the retina. To treat pain in a solely mechanistic manner based on physiology is to treat pain as if this were the case and thus, is to miss the experience of pain entirely. As such, an understanding of pain based within a framework such as the lived body allows for the experiential aspects of pain to be addressed as well as its physical correlates in the body.

Inherent to the concept of the lived body is its intentional nature. The lived body opens to the world and engages with it purposefully, amassing further opportunities for meaningful action. Every bodily action is intentional in that it is directed at some end. Reaching for a glass of water is directed towards satiating thirst; grasping a door handle is directed at opening a door. The lived body does not engage with the world arbitrarily. Furthermore, such actions are intuitive in that they do not require conscious planning or reflection. In reaching for the glass of water, it is not necessary to carefully plan or guide the motion of one's hand.

Pain frustrates this intentionality and purposefulness of the lived body. Intentionality is fundamentally based on the ability to direct conscious experience towards the world. It is this outward orientation that is key to successfully discovering and following through on opportunities for action. Pain disrupts intentionality by drawing the focus of conscious experience inwards towards the painful experience and away from meaningful action in the world. On this point, Leder (1990, p. 71) provides an example of a tennis player who experiences chest pain mid-match. Before the onset of pain, this player's entire conscious attention is directed towards the tennis ball. Further, their body is directed towards anticipating and responding to the motions of the ball. At the onset of pain, the player's attention immediately turns towards their body. They attempt to deduce whether the pain is from an injury and makes efforts to reduce the pain as it begins to radiate down their arm. By this point, the tennis match has already faded from their experience. The player's lived body has been effectively cut off from the world around them. The once *meaningful* game is now *meaningless* in the face of their pain and the anxiety that accompanied its sudden onset. Importantly, this case considers an isolated, singular case of painful experience. Chronic pain may perpetually turn conscious awareness away from the world and towards pain, resulting in a continual obstacle towards embodied action.

As seen in the case of this tennis player, pain turns conscious attention towards the body such that the body emerges as an object of experience. Typically, in day-to-day life, the body is not a primary concern of conscious experience like this. We do not attend to the action-oriented movements of the body. Nor do we attend to the thousands of chemical reactions going on within our body or the copious sensory information being detected and processed every second. Instead, our conscious awareness is focused outwards toward the world. As such, the body typically recedes to the background of our experience. For instance, when driving a car, the sensation of sitting in the front seat is not a prominent feature of experience. More importantly, conscious attention is dedicated to the actions of successfully operating the car. Pain, especially chronic pain, subverts this relation between the body and the world such that conscious awareness turns towards the body and away from the world.

Leder (1990) terms such a process as *dys-appearance* in which the body becomes aware to consciousness precisely because it is in an unfamiliar, abnormal state. To put this phenomenon in Heideggerian terms, the body that usually presents itself as *ready-to-hand* now becomes *present-at-hand* upon the onset of pain. In other words, there is a conscious experience of the inability to act as one would normally. For Heidegger, when a tool malfunctions, it becomes *conspicuous*. The same occurs to the body to pain. It is no longer “ready-to-hand” and may impede meaningful engagement with the world. However, unlike the conspicuous pen, the body cannot be replaced. Its conspicuousness remains ever-present, further intensifying feelings of alienation or helplessness (Carel, 2011).

Chronic pain also impacts the relationship between the mind and the body, creating rifts between the two (Leder, 1992b). One such rift occurs from a breakdown of understanding of the body. Owing to the ambiguous nature of chronic pain, a patient may lack adequate knowledge

about what is causing their pain or about the changes occurring to their body. Consider that a patient experiencing the sudden onset of idiopathic pain may not know exactly what is causing their pain. Though a person can undoubtedly sense the pain and experience the discomfort it brings, the pain brings with it an ambiguity of its origins. If a cause cannot be readily found, anxiety regarding any number of possible conditions can cause significant stress. This lack of knowledge accompanied by the ambiguity of what is wrong means that the patient can come to feel a lack of understanding of their body. Their body presents as a foreign, unfamiliar entity.

Finally, in some cases, chronic pain engenders an antagonistic relationship between self and body. To a person experiencing chronic pain, the body may be seen as an active creator of painful experience. As Scarry writes, “the person in great pain experiences his own body as the agent of his agony” (Scarry, 1987, p. 47). The body presents an inescapable and ever-present signal of pain which comes to be identified as if the body were inflicting this pain on the sufferer. Combating this, one may separate their pain from themselves, treating it as a foreign entity (Leder, 1990). In this way, one may preserve their identity against such an aversive threat.

Now that the ways in which chronic pain can be understood through a phenomenological framework have been laid out, the next chapter will propose means through which these phenomenological insights might be applied to the treatment of patients with chronic pain disorders.

## **CHAPTER 5: INTEGRATING PHENOMENOLOGY INTO MEDICINE: FROM THEORY TO PRACTICE**

### **5.1 Moving from a theory to a practice of medical phenomenology**

In the preceding chapter, a phenomenological approach to illness was distinguished from one of traditional Western medicine. As discussed, modern medicine primarily focuses on a conception of disease that privileges observable evidence of biological dysfunction and the means to find such evidence. Phenomenology, moving beyond solely considering this objective evidence, also incorporates the subjective experience of illness—the qualitative features that define the day-to-day life of living with an illness. Next, a phenomenological analysis of pain was presented, highlighting the impacts of a chronic pain disorder on both the relationship between a person and their world and between a person and their body. Having discussed this phenomenological approach, I now turn towards a more practical discussion regarding how phenomenology might be incorporated into medicine.

Though phenomenology has been appealed to by many researchers in both philosophy and medicine to better understand medicine, its incorporation into medicine proper has been to a much lesser extent. A survey of the medical phenomenology research field yields a wealth of theoretical research—embodiment, conceptions of health or illness, and intersubjectivity figure prominently into the work done in the field (see the previous chapter). However, there is a significant lack of research on how this theory-building may be concretely applied to medical practice or even how this work may be communicated to those in the medical field.

Although conceptualizing alternative understandings of how medicine might approach embodiment or illness is essential, it is equally essential to work pragmatically, conceptualizing how these findings might *actually* be put to use. Focusing solely on theory building creates a disconnect between academic research and actual medical practice. In this regard, praxis is just as crucial as theory. The goal of benefiting patients should be the guiding principle of research in medical phenomenology. Acknowledging this goal, this chapter will analyze how phenomenological insights may be applied to medical practice.

Before discussing how one might accomplish the task at hand, it is first important to recognize some of the obstacles that have hindered phenomenological perspectives from a more widespread consideration by the medical community. Recognizing these obstacles helps to understand how phenomenological perspectives should approach interacting with mainstream medicine and in what ways phenomenology might need to adapt for meaningful interaction to occur. To this end, the following two sections identify and discuss specific obstacles, namely, the positivist tendencies implicit in medicine and the conceptual troubles present in medical phenomenology. In each case, potential means of overcoming these issues are presented. The final two sections of this chapter explore means of integrating phenomenological insights into clinical practice, focusing on the integration of phenomenology into chronic pain treatment and on the use of phenomenology by patients in conceptualizing illness experience.

Before proceeding, it is important to note that there is a lack of large-scale research on integrating phenomenological techniques or methodologies in the day-to-day practice of medicine. As such, before delving into this section, I wish to emphasize that the prescriptions found herein are speculative to a certain degree. Lacking significant research to back these prescriptions, this advice will be limited in its potential efficacy. Rather than taking this advice

for a concrete fact, I recognize that these prescriptions will, at best, be jumping-off points. Consequently, I put forth possible avenues of application with the expectation that further research will be needed to evaluate the utility and efficacy of these recommendations.

## 5.2 Challenging positivism in medicine

### 5.2.1 Positivism

One significant obstacle inherent to how Western medicine is traditionally conceived and practiced is a tendency towards a *positivist* philosophy regarding medical knowledge and how this knowledge is arrived at. Positivism is a philosophical framework primarily based on the works of nineteenth-century philosopher Auguste Comte (Bourdeau, 2021). Developed throughout the nineteenth century, positivism reached its intellectual peak in the philosophical work of the Vienna Circle during the 1920s and 1930s who spearheaded the movement of *logical positivism*<sup>6</sup>.

Logical positivism holds that all true knowledge is derived exclusively from either sense experience or—if not directly observable—is formally provable, as is the case for mathematical or logical truths (Ayer, 1959). In the former, one receives sense-data from a given phenomenon, forming empirical knowledge about the said phenomenon. Consider, for instance, a simple statement: “The sky is blue.” This statement possesses a *truth value*, meaning it is either true or

---

<sup>6</sup> Though I use the term “logical positivism,” not all members of this movement described themselves as a logical positivist (Ayer, 1959, p. 3). Alternative terms have been employed to denote the movement including *logical empiricism* or *neopositivism*, though the distinction between the three terms is somewhat ambiguous (Creath, 2021).



false. For the positivist, this statement is true by virtue of our sensation of the color blue when we look at the sky. The fact that the sky is blue is empirically *verifiable* through sensation. This ability to verify the truth or falsity of a statement holds true for knowledge that is formally proven as well—that the interior angles of a triangle total 180 degrees is demonstrable through mathematical proof.

Any knowledge that is *not* arrived at through either of these means *cannot* be considered true knowledge. Among this kind of knowledge resides ethical, metaphysical, or theological knowledge, to name a few examples. The logical positivists argued that metaphysical statements, for instance, could not be empirically tested, nor could they be formally shown to be true or false (Ayer, 1959, pp. 10–17). Thus, such statements are *unverifiable* and are therefore not meaningful.

Insofar as the general positivist perspective privileges experience as a means of gaining knowledge, empiricism plays a key role in the foundation of positivist epistemology (Cruickshank, 2012). Owing to this empiricist foundation, positivism privileges the scientific method as a means to access knowledge about reality. As a systematic process through which observable phenomena are empirically verified, the scientific method allows us to make direct claims about the nature of the world.

Positivism has had widespread influence in many academic fields, particularly sociology and anthropology (Turner, 2001). Authors in the medical phenomenology field (e.g., Baron, 1992) have argued that a positivist perspective predicated on empiricism has influenced medical thought to a significant degree as well. This perspective results in hesitation among practitioners in considering approaches that pose a challenge to verification through observation. Like the

logical positivists' rejection of metaphysical propositions, practitioners may regard such approaches to medical practice as unverifiable. As Baron (1992) writes:

There is a strong current of empiricism in medical practice, a rejection of theoretical system building as being characteristic of a benighted period of medical practice in the eighteenth century when theoretical world-views competed with each other for recognition. (p. 42)

This “medical positivism” rejects knowledge not verifiable through objective observability or experimentation. Thus, approaches that rely on subjective reports, for example, may be disregarded as untrue or as unscientific. Overcoming this positivism has presented a challenge for many alternative approaches to medical practice, not just medical phenomenology.

### **5.2.2 Confronting positivism through medical education**

An ideal place to combat this positivist tendency—and to introduce an alternative framework like phenomenology—is at the educational level. Though standard medical practice relies heavily on what may be identified as a positivist epistemology, the average physician has likely never been explicitly instructed in positivism’s tenets. Positivism, instead, is mainly *implicit* in the ways medical students are educated and is further reinforced as they enter practice and begin their careers as physicians. As such, if one wishes to introduce a framework like phenomenology, medical schools would likely be a good start.

Fortunately for this goal, in recent decades, many medical schools have begun to include and promote humanities courses within their curricula. In a survey of 134 members of the American Association of Medical Colleges and the American Association of Colleges of Osteopathic Medicine, 70.8% of the schools surveyed required humanities courses in their curriculum, and 80.6% offered humanities electives (Klugman, 2018). Subjects including

anthropology, ethics, philosophy, or sociology (Schwartz et al., 2009), to name a few, have increasingly been incorporated alongside the traditional medical coursework. A guiding motivation behind this integration of the humanities is a belief that being a *good doctor* requires more than strictly medical knowledge (e.g., anatomical, clinical, or physiological facts). In addition to possessing relevant medical knowledge, a good doctor also has a developed capacity for moral reasoning, an openness when interacting with patients, and attempts to understand the perspective of a patient. All of these are examples of characteristics that are hoped to be fostered among medical students through interacting with the humanities. Though the quantitative impact of such courses is not entirely clear (Schwartz et al., 2009), there has been a strong push to expand these programs, especially in light of research highlighting trends of decreasing empathy among medical students (Hojat et al., 2009).

Given an already-existing precedent of humanities education in many medical schools, the task of implementing phenomenologically informed education is less daunting than one might initially think. To do so would be to build upon already existing curricula. Further, though not widely researched, some research has explored the impacts of phenomenologically-oriented instruction on the conception of embodiment held by physicians.

A small-scale study conducted by Jaye (2004) examined the conceptions of embodiment held by general practitioners following the completion of anthropology coursework. Participants were all currently practicing physicians who had recently completed an introductory anthropology course, a medical anthropology course, or both. Jaye conducted qualitative interviews with participants and examined common themes among their understandings of embodiment. Notably, the anthropology courses taken by the physicians had introduced the phenomenological concept of the *lived body*. Results from these interviews identified new

perspectives among participants that questioned the disembodied way in which illness is treated by mainstream medicine (p. 45). One participant even related their exposure to the concept of the lived body to the experience of a chronic pain patient they had encountered. This participant highlighted a breakdown between body and self in the patient following the onset of their pain (p. 44).

As evidenced by this research, exposure to humanities-based coursework in medical education may prove beneficial in challenging the broader trend of positivism in medicine, potentially opening the door for a broader consideration of perspectives outside the mainstream medical paradigm. This research also motivates the plausibility of directly integrating phenomenological concepts to medical understanding in a meaningful manner. Participants were able to synthesize their newfound conceptual understanding with their prior experiences as practicing physicians. Equipping medical students with this foundation allows them to critically interact with preconceived notions they may have of disease and illness. Additionally, it allows them to situate disease within the broader context of illness and the lived experience of patients (Carel, 2011).

### **5.3 Addressing ambiguity and conceptual disunity in medical phenomenology**

The difficulty of the primary literature in phenomenology has also undoubtedly hindered its acceptance in medicine. Thinkers like Husserl and Heidegger are notorious for the difficulty of their major works. So much is their difficulty that this literature presents a significant challenge even to those well-studied in philosophy. The idiosyncratic writing styles and linguistic complications of many classical phenomenologists mean that dedicated study is usually required to make sense of their works and overall philosophical projects—and all of this

is to say nothing of the lengthy nature of phenomenology's primary texts either, a factor which also contributes significantly to their understanding and acceptance.

Unfortunately, this difficulty and opaqueness persist to a degree in a large amount of secondary literature on phenomenology, including those of the medical phenomenologists themselves. A large part of this inherited difficulty is caused by an assumed familiarity with phenomenology on the reader's part. For some work in medical phenomenology, readers coming from a medical background are seemingly expected to already possess a familiarity with key thinkers of phenomenology or with foundational terms like *intentionality*, the *lived body*, or *being-in-the-world*. This expectation is unrealistic if one is hoping to interact with those in the medical field. In other cases, philosophers in the field write for an intended audience of other philosophers in the field, again assuming a prior knowledge in the reader. Both cases serve to foreclose dialogue between medical phenomenology and medicine proper.

Compounding these already existing problems, Kottow (2017) highlights a crucial problem in medical phenomenology research, namely, its broad and sometimes nebulous use of basic concepts like health, disease, or illness. For any single author, a particular concept, like health, for instance, may encompass an entirely different set of phenomena than what others may term as "health." Similarly, what constitutes illness for one author may not hold true for another author's conception of illness. This lack of conceptual consistency leads to "misunderstandings and mutual mistrust between phenomenology and medicine" (Kottow, 2017, p. 406). For the same reasons, medical phenomenology may be perceived by those on the outside as a disparate research field with few underlying foundations. If any theoretical approach, let alone medical phenomenology, aims to gain a wider acceptance—or at the very least to interact with other approaches—then the basic concepts must have broadly accepted or standard usages.

Addressing the issues raised herein will require a concerted effort from researchers in medical phenomenology hoping to interact with the medical establishment. First and foremost, medical phenomenology ought to strive to bridge the gap between the primary literature of classical phenomenology and the medical audience to which it is directed. This task entails articulating phenomenological concepts in a manner that is both intelligible and situates them in a context that is accessible to a more general audience. Further, medical phenomenology must mitigate assumptions of prior conceptual knowledge. To do otherwise undermines the ability of medical professionals to engage with the approach in a worthwhile manner. Finally, it is crucial that medical phenomenology endeavors towards a greater degree of conceptual consistency. To this end, Kottow asserts that “phenomenology in medicine ought to insist on semantic clarification” (p. 410). As the field continues to progress, researchers must engage with one another and work on clarifying and distinguishing foundational ideas.

## **5.4 Situating phenomenology within current treatment practices for chronic pain disorders like fibromyalgia**

### **5.4.1 How fibromyalgia is currently treated**

Fibromyalgia is a complex condition that presents a significant challenge to physicians attempting to treat affected patients. For one, the efficacy of pharmacological treatment for fibromyalgia is limited (Clauw, 2014). Fibromyalgia patients generally do not respond well to opioid treatments, which are typically pain-relieving (Goldenberg et al., 2016; Ngian et al., 2011). Moreover, detrimental effects of opioid use have been observed in fibromyalgia patients treated with opioid therapies when compared to untreated fibromyalgia patients (Kim et al.,

2017). Besides opioids, there are currently three drugs approved by the Food and Drug Association in the United States for specifically treating fibromyalgia: pregabalin, milnacipran, and duloxetine. However, the efficacy of these medications is obscured by ambiguity in the different measures used to evaluate their effectiveness—no standard criteria for evaluation of the medications in fibromyalgia patients exists (Arnold & Clauw, 2017). Thus, it is difficult to weigh the benefits of one of these medications as opposed to another.

Given the difficulties of a solely pharmacological treatment approach, many physicians have articulated a need for a diverse, multi-disciplinary treatment plan for fibromyalgia patients. Such a treatment plan may include patient education programs, cognitive behavioral therapy, the promotion of regular exercise routines, or addressing sleep disturbances. As an example of these proposals for broader treatment approaches, a 2017 set of guidelines on the management of fibromyalgia, published by the European League Against Rheumatism (EULAR), recommended that:

Management of fibromyalgia should aim at improving health-related quality of life balancing benefit and risk of treatment that often requires a multi-disciplinary approach with a combination of non-pharmacological and pharmacological treatment modalities tailored according to pain intensity, function, associated features (such as depression), fatigue, sleep disturbance and patient preferences and comorbidities; by shared decision-making with the patient. Initial management should focus on non-pharmacological therapies. (Macfarlane et al., 2017, p. 325)

This “multi-disciplinary approach” (p. 325) is not limited to only typical medical specialties.

Some physicians have also incorporated alternative treatment modalities such as meditation, yoga, or even acupuncture to treat fibromyalgia, though there is a lack of large-scale studies on the efficacy of such modalities (Clauw, 2014).

It is in this multi-disciplinary framework that I think phenomenology is best suited to be utilized by practitioners. As evidenced by the vast array of approaches consulted by physicians in

treating fibromyalgia patients, there is a degree of openness to drawing from alternative modalities. Following this multi-disciplinary treatment paradigm, phenomenology ought to work alongside traditional medical paradigms to maximize the benefit to the patient.

#### **5.4.2 Incorporating phenomenology into chronic pain treatment**

Having identified a potential niche phenomenology is capable of inhabiting within chronic pain treatment, I now turn to a discussion of what phenomenology can say about treating chronic pain, focusing on re-establishing a connection between body and world. As discussed in the previous chapter, in chronic pain, the orientation of the lived body becomes directed inwards as intentionality is usurped by painful experience (cf. Klein, 2015). This process limits the opportunity for meaningful engagement with the world as opportunities for action fade away from conscious experience. As a central phenomenon of painful experience, a key component of a phenomenologically informed treatment modality ought to focus on re-establishing the connection between the lived body and the world. This requires one to “approach pain as something quintessentially lived and experienced in the body” (Jackson, 1994, p. 201) as opposed to a reductionist view of pain as merely a physiological mechanism.

Bullington (2009) recommends conceptualizing treatment of chronic pain in terms of the lived body. To do so involves a process Bullington terms *articulation* (p. 107), in which patients work to rediscover their capacity for non-painful experience. This capacity has become overshadowed by the immediacy and ineluctability of chronic pain. Articulation aims for the patient to experience their body as more than a bearer of pain, experience themselves as more than someone afflicted by pain, and expand their perception to include more than just pain (p. 107). The goal of articulation is to help a patient experience themselves as more than just someone with a



chronic pain disorder. In other words, the goal is to restore a sense of “agency” (Bullington et al., 2003, p. 327) to the patient. A key part of this process is the rediscovery of possibilities for engagement with the world. Engagement encompasses a broad range of activities from communication to physical interaction with the environment. Recognizing this, Bullington writes:

Chronic pain has imprisoned the person in a tiny world dominated by pain. Rehabilitation must ultimately have as its goal the opening up of new horizons. If this is accomplished through physiotherapy, psychotherapy, dance therapy, music therapy or supportive therapy is unimportant. Even if it is not possible to eliminate pain, it is nevertheless possible to live a stimulating life, provided that the person can maintain a sense of personal self and an articulated horizon on the world pole. (Bullington, 2009, p. 107)

Thus, rather than prescribing a functional approach that targets a specific ability (e.g., ambulation) for therapy, a more general approach is required.

The use of a phenomenologically informed approach to chronic pain should aim to provide means of discovering ways that patients can open up towards and interact with their world. This form of treatment would encourage exploration and discovery of potentially meaningful activities for patients. Consequently, this process would likely be highly unique to each patient and their needs rather than following a specific formula. This process would benefit from the involvement of family and loved ones to support and encourage patients in attempting to re-establish a connection with the world around them.

### **5.5 Facilitating exploration of illness experience**

Patients may also benefit from instruction in phenomenological methods. As those who directly experience illness, patients themselves may see the most benefit from an approach like

phenomenology that encourages reflection on subjective experience<sup>7</sup>. Specifically, working with patients to explore their individual understandings of their illnesses presents an opportunity to apply phenomenological insights in a potentially therapeutic manner<sup>8</sup>.

In this realm of research, Carel (2012) has proposed a detailed “phenomenological toolkit” (p. 97), “which patients can use to develop their understanding of their illness” (p. 107). Carel was herself diagnosed with a chronic illness, lymphangiomyomatosis (LAM), and uses their experience of living with LAM to better understand how phenomenology can be used to conceptualize illness experience.

Carel’s toolkit uses a three-step phenomenological approach comprised of bracketing the natural attitude, thematizing one’s illness, and finally, an examination of one’s being in the world (p. 107). This approach is focused on cultivating a personal understanding of illness among patients that encompasses what illness means for the *individual* rather than the focus on biological factors that patients are typically exposed to.

The first step of Carel’s approach involves “[b]racketing the natural attitude toward illness” (p. 107). Patients are tasked with suspending belief in any prior notions they have of their illness—including suspending their belief in the existence of the disease they have possibly been diagnosed with. Suspension of belief in disease is not done to deny the reality of disease. Instead, the aim is to facilitate an open reflection on illness that is not burdened by any pre-

---

<sup>7</sup> Besides phenomenology, mindfulness techniques have also been turned to on this front as they encourage a similar reflection on subjective experience. Such techniques have shown benefit in chronic pain patients (e.g., Marikar Bawa et al., 2021). However, phenomenology is distinct in that it aims to cultivate an understanding of illness as a lived experience. Certainly, however, there is a possible opportunity for the use of both by patients.

<sup>8</sup> This would be an instance of using phenomenological concepts to facilitate phenomenographical analysis (see footnote 5).

existing knowledge of disease. By approaching illness from a neutral perspective, patients may attend to characteristics of their illness that had not been identified beforehand.

The second step of Carel's approach consists of the *thematization* of illness. Carel understands thematization as a process in which a person deliberately focuses conscious attention on a single aspect of a phenomenon so that specific features of that phenomenon's experience become apparent (cf. Toombs, 1987, p. 222). For instance, one may choose to focus on the color of an apple in front of them as opposed to the taste of it, and in doing so, they change their experience of the apple. Importantly, thematization is not limited to solely the sensory aspects of a given phenomenon. In looking at a work of art, for example, one can also thematize the aesthetic or emotional aspects of the experience. Likewise, illness may be thematized from multiple aspects—e.g., patients may thematize their illness cognitively, emotionally, or volitionally.

Additionally, the process of thematization is not limited to the ill person themselves. Different people in a patient's life may thematize their illness in diverse ways. Family or caregivers may thematize a patient's illness in one way, while the patient's physician may thematize their illness in an entirely different manner. Carel provides the example of a patient thematizing their illness *qua* symptoms versus a doctor thematizing illness *qua* disease or as a means of diagnosis (p. 108). Thematization allows for these many perspectives on illness experience to be explored and for a multi-faceted understanding of illness to emerge.

Finally, Carel presents a third step of examining one's being-in-the-world. By way of the preceding steps, the patient undergoing this process has gained a new perspective on their illness. This was accomplished through attending to illness as immediately experienced and through the thematization of illness experience. In this third and final step, the patient applies this new

perspective to better understand how their illness has affected their being-in-the-world. Patients come to recognize illness's effects on multiple spheres of their lives rather than just the biological dysfunction emphasized in traditional medical treatment.

Carel proposes that this procedure could possibly be implemented through single-day patient workshops. In Carel's theoretical conception of such workshops, the day begins with an overview of the three steps then proceeds through each within small groups. Participants are provided with a plethora of texts, images, and other forms of media included to help facilitate the process of attending to the many dimensions of illness experience. The selection of this material is flexible and is designed to be tailored to the goals and needs of the group rather than being a fixed curriculum. At the end of the day, this material is distributed to the participants so that they may continue to engage with the process in the future.

The challenges presented by positivism and conceptual troubles are not insurmountable. Medical education provides an opportunity to broaden the perspectives of medical practitioners. By integrating a phenomenological perspective within humanities-based courses in medical education, practitioners may be exposed to and become more familiar with the concepts of phenomenology. A crucial prerequisite to this initiative is a concerted effort towards conceptual clarification and consistency in the medical phenomenology field. On the practical side, phenomenology can be used by both practitioners and patients. For practitioners, using phenomenology allows treatment to be framed in terms of the lived body, considering the need for the discovery of opportunities for engagement in the world. Finally, phenomenology may equip patients with a method to explore their personal experience of chronic pain and with a vocabulary to articulate their experience.

## CHAPTER 6: CONCLUSION

In this work, I have argued that insights from the phenomenological tradition prove valuable in understanding chronic pain disorders in a manner that does not reduce their embodied experience. I have presented an alternative way of examining chronic pain disorders and the profound impacts such disorders can have. In doing so, I have challenged traditional views of pain in Western medicine, focusing on the lived experience of chronic pain rather than the biological processes involved. Additionally, this work has contributed to research in medical phenomenology by putting forth means of applying a phenomenologically-informed approach to medical practice.

### **6.1 A thorough understanding of the first-person experience of chronic pain is crucial**

As a complex phenomenon, chronic pain cannot be understood in its entirety with reference to a single underlying causative agent or mechanism. Traditionally, chronic pain has been understood as an instance of the body's biological processes gone awry. Consequently, the medical field has historically prioritized discovering putative mechanisms of physiological dysfunction in chronic pain. The medical field, in this effort, has made great strides in identifying and describing the underlying physiological forces at work when someone develops a chronic pain disorder. From antiquated theories of pain like those of Descartes and specificity theory to more modern theories like that of the neuromatrix, much has been learned about chronic pain *qua* biological phenomenon.

Indeed, biological knowledge is crucial in formulating a comprehensive conception of chronic pain. It would be unwise, however, to end attempts at understanding chronic pain at the biological level. Pain is not merely a sensory experience reducible to a specific neurobiological

process. Consider the IASP's starting definition of "pain:" "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (Raja et al., 2020). Crucially, pain is affective; it is intimately tied to one's subjective experience. Likewise, chronic pain is an ongoing embodied experience, a distinct mode of being-in-the-world.

Equally important as the biological conception of chronic pain is a conception of chronic pain as a lived experience. The broad, life-changing effects of these disorders require an approach that can account for their profound effects on lived experience. As it stands, medicine, in its focus on biological mechanisms, has not been able to accomplish this task. What is needed is a theoretical approach grounded in lived experience. Combining the advancements in the biological knowledge of chronic pain with such an approach creates a more comprehensive and informed understanding of chronic pain, which can benefit patients and medical practitioners alike.

## **6.2 Understanding via phenomenology**

Phenomenology presents a philosophical approach with which to investigate subjective conscious experience. Growing out of the works of Husserl, phenomenology posits the primacy of subjective conscious experience. Life is experienced through a first-person perspective prior to the formation of objective knowledge about the world. As such, phenomenology calls on us to attend to our own subjective experience in a rigorous manner. As Husserl urges, we must return to "the things themselves" (Husserl, 1913/1983, p. 35).

Phenomenology provides a conceptual structure with which to describe lived experience. Phenomenology first calls for suspension of the *natural attitude*—our preconceived notions

regarding the world and how it functions. To do so requires one to *bracket* these notions and attend solely to the experience as it is presented to consciousness. In other words, phenomenology calls on us to approach the world from a neutral perspective that avoids coloring experience with judgments founded in the natural attitude.

Subsequent thinkers in the phenomenological tradition expanded on Husserl's work and incorporated other key features. In Heidegger, an emphasis on the intimate connection between self and world is articulated. As beings fundamentally concerned with our own existence, *Dasein*, we exhibit a particular *being-in-the-world*—a familiarity with the world that allows us to engage purposefully with our environment. Through his analogy of tool usage, Heidegger gets at the unconscious nature of meaningful action in the world. We need not reflect on how to go about engaging with the world.

Though Heidegger's phenomenology takes great care to explore how one engages with the world, Heidegger notably neglects the body's role in facilitating conscious experience (K. A. Aho, 2009). Addressing this gap, Merleau-Ponty's phenomenology places a significant emphasis on the body. For Merleau-Ponty, it is not enough to merely focus on the world. One must recognize a *lived body* that predetermines the possibility of engagement in the world. Merleau-Ponty's notion of the lived body incorporates both the objective and subjective features of the body, neither privileging nor reducing the body to one or the other.

As seen in the preceding chapters, chronic pain disrupts the relationships between a person and the world around them such that their ability to engage meaningfully with the world becomes diminished. Opportunities for engaging with the world become obscured by the ever-present experience of pain. Further, pain alienates a person from those around them. At one level of this alienation, the inherently private nature of pain means that no one but the sufferer can

ever truly experience it. At another, pain resists communication, depriving a person of their ability to articulate their experience. Chronic pain also creates rifts in mind and body as well as body and self. The lived body in chronic pain is experienced as foreign and as resisting consciousness.

### **6.3 Phenomenology can be practically utilized in realizing this goal**

Despite potential challenges in its adoption, phenomenology can be concretely applied to medicine and, more specifically, to chronic pain. I argue that it is essential for the practical implementation of phenomenological concepts to occur. Though abstract inquiry certainly has its place, engaging solely in armchair research forecloses any possibility of potentially helping those affected by chronic pain. Phenomenology may be drawn from by practitioners and patients alike in their respective experiences with chronic pain.

For practitioners, phenomenology offers a means of attaining a better grasp of a patient's experience of their pain; it also offers a means of attaining a better understanding of a patient's unique needs. Building on the expanding role of humanities courses in medical education presents the most valuable opportunity to integrate phenomenological concepts. Working within an already robust initiative of humanities-based education in medical curricula lessens the difficulty of introducing a foreign philosophical framework to those who might not be well acquainted with philosophy in general. Doing so allows one to expose medical professionals to alternative perspectives on health, illness, disease, or embodiment. Incorporating these perspectives encourages reflection on one's own perspective on each concept and allows for critical interaction with traditionally held assumptions in medicine.



For patients, phenomenology may be used to better understand the illness experience. Through means like phenomenological workshops, patients may be exposed to phenomenological concepts and engage with them to help them cultivate a broader understanding of their illness. Phenomenology can also provide an increased vocabulary with which a person can articulate their lived experience of chronic pain. Doing so also potentially provides ways for a person's loved ones or their doctors to appreciate the lived experience of that person better.

Though this work has highlighted practical ways of utilizing medical phenomenology, the true test of their merit lies in the actual use of phenomenology by those in the medical field. For this to happen, subsequent work is certainly necessary to refine and expand upon the process of incorporating phenomenology into medicine. Further, a concerted effort by those in the field will be required to foster a more substantial interaction with mainstream medicine. Fostering this interaction requires an approach that presents phenomenology in a more accessible manner.

#### **6.4 Final remarks**

Merleau-Ponty once predicted that medicine would eventually need to question “whether the human body is an object, and hence the question whether its relation with exterior nature is that of function to variable” (Merleau-Ponty, 1964/1968, p. 26). Though certainly not the only case in medicine, I think that Merleau-Ponty's prediction has proven to be mostly true regarding chronic pain. In traditionally relying on a mechanistic, biological conception of disease, medicine is presented with an anomaly in chronic pain. The lack of discernible pathology in chronic pain disorders undermines this conception of disease and forces a reconsideration of how disease is approached. Further, the limited ability to investigate chronic pain through

conventional means presents a unique case where practitioners must place emphasis on a patient's experience if they are to understand that patient's morbidity. In phenomenology, medicine has an opportunity to benefit significantly in reevaluating its conception of disease and forming a more cohesive picture of chronic pain. In the end, the dilemma presented in Merleau-Ponty's prediction may be aided by drawing from his very own discipline.

## REFERENCES

- Aho, J. A., & Aho, K. A. (2008). *Body matters: A phenomenology of sickness, disease, and illness*. Lexington Books.
- Aho, K. A. (2009). *Heidegger's neglect of the body*. State University of New York Press.
- Anderson, K. E., Eberly, S., Marder, K. S., Oakes, D., Kayson, E., Young, A., & Shoulson, I. (2019). The choice not to undergo genetic testing for Huntington disease: Results from the PHAROS study. *Clinical Genetics*, *96*(1), 28–34. <https://doi.org/10.1111/cge.13529>
- Arnold, L. M., & Clauw, D. J. (2017). Challenges of implementing fibromyalgia treatment guidelines in current clinical practice. *Postgraduate Medicine*, *129*(7), 709–714. <https://doi.org/10.1080/00325481.2017.1336417>
- Aternali, A., & Katz, J. (2019). Recent advances in understanding and managing phantom limb pain. *F1000Research*, *8*, F1000 Faculty Rev-1167. <https://doi.org/10.12688/f1000research.19355.1>
- Ayer, A. J. (1959). *Logical positivism*. The Free Press.
- Baron, R. J. (1985). An introduction to medical phenomenology: I can't hear you while I'm listening. *Annals of Internal Medicine*, *103*(4), 606–611. <https://doi.org/10.7326/0003-4819-103-4-606>
- Baron, R. J. (1992). Why aren't more doctors phenomenologists? In D. Leder (Ed.), *The body in medical thought and practice* (pp. 37–47). Springer. [https://doi.org/10.1007/978-94-015-7924-7\\_3](https://doi.org/10.1007/978-94-015-7924-7_3)
- Bell, C. (1811). *An idea of a new anatomy of the brain; submitted for the observations of his friends*. Strahan and Prefton.

- Benini, A., & DeLeo, J. A. (1999). René Descartes' physiology of pain. *Spine*, *24*(20), 2115.  
<https://doi.org/10.1097/00007632-199910150-00010>
- Blattner, W. (2006). *Heidegger's "Being and Time": A reader's guide*. Continuum.
- Boland, E. W., & Corr, W. P. (1943). Psychogenic rheumatism. *JAMA*, *123*(13), 805–809.
- Bourdeau, M. (2021). Auguste Comte. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy* (Spring 2021 ed.). Stanford University.  
<https://plato.stanford.edu/archives/spr2021/entries/comte/>
- Breivik, H., Collett, B., Ventafridda, V., Cohen, R., & Gallacher, D. (2006). Survey of chronic pain in Europe: Prevalence, impact on daily life, and treatment. *European Journal of Pain*, *10*(4), 287–287. <https://doi.org/10.1016/j.ejpain.2005.06.009>
- Brentano, F. (1995). *Psychology from an empirical standpoint* (A. C. Rancurello, D. B. Terrell, & L. L. McAlister, Trans.). Routledge. (Original work published 1874)
- Bullington, J. (2009). Embodiment and chronic pain: Implications for rehabilitation practice. *Health Care Analysis: HCA: Journal of Health Philosophy and Policy*, *17*(2), 100–109.  
<https://doi.org/10.1007/s10728-008-0109-5>
- Bullington, J., Nordemar, R., Nordemar, K., & Sjöström-Flanagan, C. (2003). Meaning out of chaos: A way to understand chronic pain. *Scandinavian Journal of Caring Sciences*, *17*(4), 325–331. <https://doi.org/10.1046/j.0283-9318.2003.00244.x>
- Canguilhem, G. (1992). Machine and organism. In J. Crary & S. Kwinter (Eds.), & M. Cohen & R. Cherry (Trans.), *Incorporations* (pp. 45–69). Zone.
- Carel, H. (2011). Phenomenology and its application in medicine. *Theoretical Medicine and Bioethics*, *32*, 33–46. <https://doi.org/10.1007/s11017-010-9161-x>

- Carel, H. (2012). Phenomenology as a resource for patients. *Journal of Medicine and Philosophy*, 37(2), 96–113. <https://doi.org/10.1093/jmp/jhs008>
- Carel, H. (2016). *Phenomenology of illness*. Oxford University Press.
- Carr, D. B., & Goudas, L. C. (1999). Acute pain. *The Lancet*, 353(9169), 2051–2058. [https://doi.org/10.1016/S0140-6736\(99\)03313-9](https://doi.org/10.1016/S0140-6736(99)03313-9)
- Clauw, D. J. (2014). Fibromyalgia: A clinical review. *JAMA*, 311(15), 1547–1555. <https://doi.org/10.1001/jama.2014.3266>
- Creath, R. (2021). Logical empiricism. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy* (Fall 2021 ed.). Stanford University. <https://plato.stanford.edu/archives/fall2021/entries/logical-empiricism/>
- Cruikshank, J. (2012). Positioning positivism, critical realism and social constructionism in the health sciences: A philosophical orientation. *Nursing Inquiry*, 19(1), 71–82. <https://doi.org/10.1111/j.1440-1800.2011.00558.x>
- Dahlhamer, J., Lucas, J., Zelaya, C., Nahin, R., Mackey, S., DeBar, L., Kerns, R., Von Korff, M., Porter, L., & Helmick, C. (2018). Prevalence of chronic pain and high-impact chronic pain among adults—United States, 2016. *Morbidity and Mortality Weekly Report*, 67(36), 1001–1006. <https://doi.org/10.15585/mmwr.mm6736a2>
- Davidson, L., & Strauss, J. S. (1995). Beyond the biopsychosocial model: Integrating disorder, health, and recovery. *Psychiatry*, 58(1), 44–55. <https://doi.org/10.1080/00332747.1995.11024710>
- Descartes, R. (1985). Treatise on man. In *The philosophical writings of Descartes* (Vol. 1, pp. 99–108). Cambridge University Press. (Original work published 1664)

- Duncan, G. (2000). Mind-body dualism and the biopsychosocial model of pain: What did Descartes really say? *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, 25(4), 485–513. [https://doi.org/10.1076/0360-5310\(200008\)25:4;1-A;FT485](https://doi.org/10.1076/0360-5310(200008)25:4;1-A;FT485)
- Ellman, P., Savage, O. A., Wittkower, E., & Rodger, T. F. (1936). Fibrositis: A biographical study of fifty civilian and military cases, from the Rheumatic Unit, St. Stephen's Hospital (London County Council), and a military hospital. *Annals of the Rheumatic Diseases*, 3(1), 56–76. <https://doi.org/10.1136/ard.3.1.56>
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129–136. <https://doi.org/10.1126/science.847460>
- Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, 137(5), 535–544. <https://doi.org/10.1176/ajp.137.5.535>
- Fava, G. A., & Sonino, N. (2007). The biopsychosocial model thirty years later. *Psychotherapy and Psychosomatics*, 77(1), 1–2. <https://doi.org/10.1159/000110052>
- Gatchel, R. J., Peng, Y. B., Peters, M. L., Fuchs, P. N., & Turk, D. C. (2007). The biopsychosocial approach to chronic pain: Scientific advances and future directions. *Psychological Bulletin*, 133(4), 581–624. <https://doi.org/10.1037/0033-2909.133.4.581>
- Ghosh, R., & Tabrizi, S. J. (2013). Clinical aspects of Huntington's disease. In H. H. P. Nguyen & M. A. Cenci (Eds.), *Behavioral neurobiology of Huntington's disease and Parkinson's disease* (pp. 3–31). Springer. [https://doi.org/10.1007/7854\\_2013\\_238](https://doi.org/10.1007/7854_2013_238)
- Goldenberg, D. L., Clauw, D. J., Palmer, R. E., & Clair, A. G. (2016). Opioid use in fibromyalgia: A cautionary tale. *Mayo Clinic Proceedings*, 91(5), 640–648. <https://doi.org/10.1016/j.mayocp.2016.02.002>

- Gullick, J., Wu, J., Reid, C., Tembo, A. C., Shishehgar, S., & Conlon, L. (2020). Heideggerian structures of being-with in the nurse–patient relationship: Modelling phenomenological analysis through qualitative meta-synthesis. *Medicine, Health Care and Philosophy*, 23(4), 645–664. <https://doi.org/10.1007/s11019-020-09975-y>
- Halliday, J. L. (1942). The obsession of fibrositis. *British Medical Journal*, 1(4320), 164.
- Heidegger, M. (2010). *Being and time: A revised edition of the Stambaugh translation* (J. Stambaugh, Trans.; Revised edition). State University of New York Press. (Original work published 1927)
- Henriksson, C., Gundmark, I., Bengtsson, A., & Ek, A.-C. (1992). Living with fibromyalgia: Consequences for everyday life. *The Clinical Journal of Pain*, 8(2), 138–144. <https://doi.org/10.1097/00002508-199206000-00012>
- Hojat, M., Vergare, M. J., Maxwell, K., Brainard, G., Herrine, S. K., Isenberg, G. A., Veloski, J., & Gonnella, J. S. (2009). The devil is in the third year: A longitudinal study of erosion of empathy in medical school. *Academic Medicine*, 84(9), 1182–1191. <https://doi.org/10.1097/ACM.0b013e3181b17e55>
- Husserl, E. (1981). Husserl’s inaugural lecture at Freiburg im Breisgau. In Frederick. Elliston & P. McCormick (Eds.), *Husserl: Shorter works* (pp. 9–17). University of Notre Dame Press. (Original work published 1917)
- Husserl, E. (1983). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy: First book: General introduction to a pure phenomenology* (F. Kersten, Trans.; Vol. 2). Martinus Nijhoff. (Original work published 1913)
- Husserl, E. (2001). *The shorter logical investigations* (D. Moran, Ed.; J. N. Findlay, Trans.). Routledge. (Original work published 1900)

- Inanici, F. F., & Yunus, M. B. (2004). History of fibromyalgia: Past to present. *Current Pain and Headache Reports*, 8(5), 369–378. <https://doi.org/10.1007/s11916-996-0010-6>
- Jackson, J. (1994). Chronic pain and the tension between the body as subject and object. In T. J. Csordas (Ed.), *Embodiment and experience: The existential ground of culture and self* (pp. 201–228). Cambridge University Press.
- Jaye, C. (2004). Talking around embodiment: The views of GPs following participation in medical anthropology courses. *Medical Humanities*, 30(1), 41–48. <https://doi.org/10.1136/jmh.2003.000146>
- Käufer, S., & Chemero, A. (2015). *Phenomenology: An introduction*. Polity.
- Kim, S., Slaven, J. E., & Ang, D. C. (2017). Sustained benefits of exercise-based motivational interviewing, but only among nonusers of opioids in patients with fibromyalgia. *The Journal of Rheumatology*, 44(4), 505–511. <https://doi.org/10.3899/jrheum.161003>
- Klein, C. (2015). *What the body commands: The imperative theory of pain*. MIT Press.
- Klugman, C. M. (2018). Medical humanities teaching in North American allopathic and osteopathic medical schools. *Journal of Medical Humanities*, 39(4), 473–481. <https://doi.org/10.1007/s10912-017-9491-z>
- Kooijman, C. M., Dijkstra, P. U., Geertzen, J. H. B., Elzinga, A., & van der Schans, C. P. (2000). Phantom pain and phantom sensations in upper limb amputees: An epidemiological study. *PAIN*, 87(1), 33–41. [https://doi.org/10.1016/S0304-3959\(00\)00264-5](https://doi.org/10.1016/S0304-3959(00)00264-5)
- Kottow, M. (2017). Some thoughts on phenomenology and medicine. *Medicine, Health Care and Philosophy*, 20(3), 405–412. <https://doi.org/10.1007/s11019-017-9763-4>
- Larsson, J., & Holmström, I. (2007). Phenomenographic or phenomenological analysis: Does it matter? Examples from a study on anaesthesiologists' work. *International Journal of*



- Qualitative Studies on Health and Well-Being*, 2(1), 55–64.  
<https://doi.org/10.1080/17482620601068105>
- Leder, D. (1984). Medicine and paradigms of embodiment. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, 9(1), 29–44.  
<https://doi.org/10.1093/jmp/9.1.29>
- Leder, D. (1990). *The absent body*. University of Chicago Press.
- Leder, D. (1992a). A tale of two bodies: The Cartesian corpse and the lived body. In D. Leder (Ed.), *The body in medical thought and practice* (pp. 17–35). Springer.  
[https://doi.org/10.1007/978-94-015-7924-7\\_2](https://doi.org/10.1007/978-94-015-7924-7_2)
- Leder, D. (1992b). The experience of pain and its clinical implications. In J. L. Peset & D. Gracia (Eds.), *The ethics of diagnosis* (pp. 95–105). Springer.  
[https://doi.org/10.1007/978-0-585-28333-3\\_10](https://doi.org/10.1007/978-0-585-28333-3_10)
- Littlejohn, G., & Guymer, E. (2020). Key milestones contributing to the understanding of the mechanisms underlying fibromyalgia. *Biomedicines*, 8(7), 223.  
<https://doi.org/10.3390/biomedicines8070223>
- MacDonald, M. E., Ambrose, C. M., Duyao, M. P., Myers, R. H., Lin, C., Srinidhi, L., Barnes, G., Taylor, S. A., James, M., Groot, N., MacFarlane, H., Jenkins, B., Anderson, M. A., Wexler, N. S., Gusella, J. F., Bates, G. P., Baxendale, S., Hummerich, H., Kirby, S., ... Harper, P. S. (1993). A novel gene containing a trinucleotide repeat that is expanded and unstable on Huntington's disease chromosomes. *Cell*, 72(6), 971–983.  
[https://doi.org/10.1016/0092-8674\(93\)90585-E](https://doi.org/10.1016/0092-8674(93)90585-E)
- Macfarlane, G. J., Kronisch, C., Dean, L. E., Atzeni, F., Häuser, W., Fluß, E., Choy, E., Kosek, E., Amris, K., Branco, J., Dincer, F., Leino-Arjas, P., Longley, K., McCarthy, G. M.,

- Makri, S., Perrot, S., Sarzi-Puttini, P., Taylor, A., & Jones, G. T. (2017). EULAR revised recommendations for the management of fibromyalgia. *Annals of the Rheumatic Diseases, 76*(2), 318–328. <https://doi.org/10.1136/annrheumdis-2016-209724>
- Maixner, W., Fillingim, R. B., Williams, D. A., Smith, S. B., & Slade, G. D. (2016). Overlapping chronic pain conditions: Implications for diagnosis and classification. *The Journal of Pain, 17*(9), T93–T107. <https://doi.org/10.1016/j.jpain.2016.06.002>
- Marikar Bawa, F. L., Sutton, J. W., Mercer, S. W., & Bond, C. M. (2021). “I’m empowered to look after myself” — Mindfulness as a way to manage chronic pain: An interpretative phenomenological analysis of participant experiences in Scotland. *Social Science & Medicine, 281*, 114073. <https://doi.org/10.1016/j.socscimed.2021.114073>
- Melzack, R. (1993). Pain: Past, present and future. *Canadian Journal of Experimental Psychology, 47*(4), 615–629. <https://doi.org/10.1037/h0078871>
- Melzack, R. (1996). Gate control theory: On the evolution of pain concepts. *Pain Forum, 5*(1), 128–138. [https://doi.org/10.1016/S1082-3174\(96\)80050-X](https://doi.org/10.1016/S1082-3174(96)80050-X)
- Melzack, R. (1999). From the gate to the neuromatrix. *PAIN, 21*(4), 94–95. <https://doi.org/10.1136/eb-2018-102977>
- Melzack, R., & Casey, K. L. (1968). Sensory, motivational and central control determinants of chronic pain: A new conceptual model. In D. R. Kenshalo (Ed.), *The skin senses* (pp. 423–439). Charles C Thomas.
- Melzack, R., & Wall, P. D. (1965). Pain mechanisms: A new theory. *Science, 150*(3699), 971–979. <https://doi.org/10.1126/science.150.3699.971>
- Merleau-Ponty, M. (1968). *The visible and the invisible: Followed by working notes* (C. Lefort, Ed.; A. Lingis, Trans.). Northwestern University Press. (Original work published 1964)

- Merleau-Ponty, M. (2012). *Phenomenology of perception* (D. Landes, Trans.). Routledge.  
(Original work published 1945)
- Moayedi, M., & Davis, K. D. (2013). Theories of pain: From specificity to gate control. *Journal of Neurophysiology*, *109*(1), 5–12. <https://doi.org/10.1152/jn.00457.2012>
- Nathan, P. W. (1976). The gate-control theory of pain: A critical review. *Brain*, *99*, 123–158.  
<https://doi.org/10.1093/brain/99.1.123>
- Ngian, G.-S., Guymer, E. K., & Littlejohn, G. O. (2011). The use of opioids in fibromyalgia. *International Journal of Rheumatic Diseases*, *14*(1), 6–11. <https://doi.org/10.1111/j.1756-185X.2010.01567.x>
- Nicholas, M., Vlaeyen, J. W. S., Rief, W., Barke, A., Aziz, Q., Benoliel, R., Cohen, M., Evers, S., Giamberardino, M. A., Goebel, A., Korwisi, B., Perrot, S., Svensson, P., Wang, S.-J., Treede, R.-D., & IASP Taskforce for the Classification of Chronic Pain. (2019). The IASP classification of chronic pain for ICD-11: Chronic primary pain. *Pain*, *160*(1), 28–37. <https://doi.org/10.1097/j.pain.0000000000001390>
- Perl, E. R. (2007). Ideas about pain, a historical view. *Nature Reviews Neuroscience*, *8*(1), 71–80. <https://doi.org/10.1038/nrn2042>
- Procacci, P., & Maresca, M. (1994). Descartes' physiology of pain. *PAIN*, *58*(2), 133.  
[https://doi.org/10.1016/0304-3959\(94\)90193-7](https://doi.org/10.1016/0304-3959(94)90193-7)
- Raja, S. N., Carr, D. B., Cohen, M., Finnerup, N. B., Flor, H., Gibson, S., Keefe, F. J., Mogil, J. S., Ringkamp, M., Sluka, K. A., Song, X.-J., Stevens, B., Sullivan, M. D., Tutelman, P. R., Ushida, T., & Vader, K. (2020). The revised International Association for the Study of Pain definition of pain: Concepts, challenges, and compromises. *Pain*, *161*(9), 1976–1982. <https://doi.org/10.1097/j.pain.0000000000001939>

- Rey, R. (1998). *The history of pain* (L. E. Wallace, J. A. Cadden, & S. W. Cadden, Trans.). Harvard University Press. (Original work published 1993)
- Sabatowski, R., Schafer, D., Kasper, S. M., Brunsch, H., & Radbruch, L. (2004). Pain treatment: A historical overview. *Current Pharmaceutical Design*, *10*(7), 701–716.  
<https://doi.org/10.2174/1381612043452974>
- Scarry, E. (1987). *The body in pain: The making and unmaking of the world*. Oxford University Press.
- Schwartz, A. W., Abramson, J. S., Wojnowich, I., Accordino, R., Ronan, E. J., & Rifkin, M. R. (2009). Evaluating the impact of the humanities in medical education. *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine*, *76*(4), 372–380. <https://doi.org/10.1002/msj.20126>
- Simmons, J. A., & Benson, B. E. (2013). *The new phenomenology: A philosophical introduction*. Bloomsbury Academic.
- Smith, D. W. (2018). Phenomenology. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy* (Summer 2018 ed.). Stanford University.  
<https://plato.stanford.edu/archives/sum2018/entries/phenomenology/>
- Smythe, H. A., & Moldofsky, H. (1977). Two contributions to understanding of the “fibrositis” syndrome. *Bulletin on the Rheumatic Diseases*, *28*(1), 928–931.
- Svenaesus, F. (2011). Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine. *Medicine, Health Care and Philosophy*, *14*(3), 333–343.  
<https://doi.org/10.1007/s11019-010-9301-0>

- Toombs, S. K. (1987). The meaning of illness: A phenomenological approach to the patient-physician relationship. *Journal of Medicine and Philosophy*, *12*(3), 219–240.  
<https://doi.org/10.1093/jmp/12.3.219>
- Toombs, S. K. (1995). The lived experience of disability. *Human Studies*, *18*(1), 9–23.  
<https://doi.org/10.1007/BF01322837>
- Traut, E. F. (1968). Fibrositis. *Journal of the American Geriatrics Society*, *16*(5), 531–538.
- Treede, R.-D., Rief, W., Barke, A., Aziz, Q., Bennett, M. I., Benoliel, R., Cohen, M., Evers, S., Finnerup, N. B., First, M. B., Giamberardino, M. A., Kaasa, S., Kosek, E., Lavand'homme, P., Nicholas, M., Perrot, S., Scholz, J., Schug, S., Smith, B. H., ... Wang, S.-J. (2015). A classification of chronic pain for ICD-11. *Pain*, *156*(6), 1003–1007. <https://doi.org/10.1097/j.pain.0000000000000160>
- Turk, D. C., & Adams, L. M. (2016). Using a biopsychosocial perspective in the treatment of fibromyalgia patients. *Pain Management*, *6*(4), 357–369. <https://doi.org/10.2217/pmt-2016-0003>
- Turk, D. C., & Monarch, E. S. (2018). Biopsychosocial perspective on chronic pain. In *Psychological approaches to pain management: A practitioner's handbook* (Third edition, pp. 3–24). The Guilford Press.
- Turner, J. H. (2001). Positivism: Sociological. In N. J. Smelser & P. B. Baltes (Eds.), *International Encyclopedia of the Social & Behavioral Sciences* (pp. 11827–11831). Pergamon. <https://doi.org/10.1016/B0-08-043076-7/01941-0>
- Van Hooft, S. (2003). Pain and communication. *Medicine, Health Care and Philosophy*, *6*(3), 255–262. <https://doi.org/10.1023/a:1025956726573>

Wittgenstein, L. (2009). *Philosophical investigations* (J. Schulte, Ed.; P. M. S. Hacker, Trans.; 4th edition). Wiley-Blackwell. (Original work published 1953)

Wolfe, F., Smythe, H. A., Yunus, M. B., Bennett, R. M., Bombardier, C., Goldenberg, D. L., Tugwell, P., Campbell, S. M., Abeles, M., Clark, P., Fam, A. G., Farber, S. J., Fiechtner, J. J., Franklin, C. M., Gatter, R. A., Hamaty, D., Lessard, J., Lichtbroun, A. S., Masi, A. T., ... Sheon, R. P. (1990). The American College of Rheumatology 1990 criteria for the classification of fibromyalgia. *Arthritis & Rheumatism*, *33*(2), 160–172.  
<https://doi.org/10.1002/art.1780330203>

Yunus, M., Masi, A. T., Calabro, J. J., Miller, K. A., & Feigenbaum, S. L. (1981). Primary fibromyalgia (fibrositis): Clinical study of 50 patients with matched normal controls. *Seminars in Arthritis and Rheumatism*, *11*(1), 151–171. [https://doi.org/10.1016/0049-0172\(81\)90096-2](https://doi.org/10.1016/0049-0172(81)90096-2)