

NOV 19 | Rockefeller 106

Early-Career Workshop on Philosophy of Pain

10 AM - 10:50 AM



Tiina Rosenqvist, Dartmouth College

“Engineering the Concept of Pain for Clinical Practice”

11 AM - 11:50 AM



Sara Purinton, Princeton University

“Responsibility in Contexts of Injustice: Medically Unexplained Chronic Pain and Symptom Management”

{ 12 PM - 2 PM | LUNCH BREAK }

2 PM - 2:50 PM



Laurenz Casser, University of Sheffield

“The Mismeasure of Pain”

3 PM - 3:50 PM



Jada Wiggleton-Little, Ohio State University

“‘But Hurt Feelings Really Hurt:’ A Response to Jennifer Corns’ The Social Pain Posit”

Laurenz Casser: “The Mismeasure of Pain”

A persistent claim throughout the history of modern medicine has been that human beings differ in their sensitivity to pain: that when afflicted with comparable conditions, certain individuals, and especially certain groups of individuals, ‘hurt more’ than others. Differences in pain sensitivity have traditionally been linked to the sex, race, age, and socioeconomic status of the patient, and first became subject to experimental testing with the invention of psychophysics in the late 19th century. While the results and interpretations of their experiments have varied over time, medical scientists have almost universally maintained that their findings vindicate the longstanding assumption that the capacities to detect and endure pain are systematically related to differences between sociobiological groups. In this paper, I wish to question scientific orthodoxy. I argue not that there couldn’t plausibly be variation in pain sensitivity between individuals, but that such variation, if it exists, has never been shown to be systematically influenced by an individual’s sex, race, age, or socioeconomic status. Moreover, I argue that, contrary to popular medical opinion, continued research into pain variation is unlikely to aid the development of improved treatment methods, but instead causes significant harm by legitimising differential medical treatment on the basis of perceived patient identity.

Jada Wiggleton-Little: “‘But Hurt Feelings Really Hurt:’ A Response to Jennifer Corns’ The Social Pain Posit”

Philosophers have been relatively silent as to whether social pain is a genuine pain type. Social pain is defined as an unpleasant experience associated with actual or potential damage to one’s sense of social connection or social value (Riva et al 2014). Examples of social pain include ostracization, grief, jealousy, and heartbreak. Jennifer Corns (2020) suggests that philosophers ought not to endorse the social pain posit, claiming that, despite the overlap observed in neurology, evolutionary history, linguistic reports, and psychological roles, social pain does not have enough of the paradigmatic features of pain. I echo Corns in arguing that present evidence shows that social pains are paradigmatically negative, affective experiences, though unlike Corns, I cite this as an affirming reason to think that social pain is a pain type. First, I highlight the limits of Corns’ critiques against the observed commonalities between social and physical pain. Then I argue that aversive valence is a paradigmatic feature of pain even if it not a sufficient criterion for pain. By appealing to relational imperativist accounts of affective experiences (see Prinz 2004, 2010; Barlassina & Hayward 2019; Kauppinen 2021), I conclude that paradigmatic social and physical pains share an unpleasant feeling that inherently signals ‘Less of this!’ I briefly consider upshots and potential objections.

Tiina Rosenqvist: “Engineering the Concept of Pain for Clinical Practice”

Conceptual engineering involves assessing and improving our concepts (Cappelen 2018). The ongoing efforts of the International Association for the Study of Pain (IASP) to provide a useful definition of pain serve as a paradigmatic example of this process: the IASP states on its website that its definition has been carefully reviewed and its utility in both clinical and basic science contexts assessed. In this paper, I aim to contribute to the conceptual engineering of pain, with a particular focus on the challenges pertaining to clinical practice. I discuss the general process of conceptual engineering before outlining the desiderata for a definition of pain in clinical practice. I categorize these desiderata under three main headings—*Accuracy*, *(Clinical) Guidance*, and *Justice*—and explore tensions among them. For example, *Accuracy* requires that the definition of pain adequately reflect its complex, multifactorial nature as revealed by our best science, while *Guidance* requires that the definition be simple and straightforward enough to guide effective diagnosis and treatment. Balancing these requirements is important. *Justice* requires that the definition contribute to both distributive and epistemic justice in clinical practice, helping to address identity-prejudicial credibility deficits and treatment disparities. This requires a nuanced understanding of the scope, nature, and causes of the inequalities at play. I then evaluate the recent revision of the IASP definition (from 2020) against these desiderata, and propose that further engineering work is needed.

Sara Purinton: “Responsibility in Contexts of Injustice: Medically Unexplained Chronic Pain and Symptom Management”

Individuals living with medically unexplained chronic pain are routinely unjustly blamed for mismanaging their symptoms. In particular, medical providers and members of the general public frequently over estimate the degree of control that patients have over their symptoms by assuming that there is always something patients are in a position to do to mitigate their symptoms (e.g., breathing techniques, meditation, exercise, supplements, massages, therapy, not ruminating on the symptoms, etc.), and further, that if the patient has not tried all treatments/ if they fail to work, then they are to some extent criticizable for the severity of the symptoms and how distressing they find them. This practice of patient-blaming is often paired with under estimating, if not leaving out entirely, the structural reasons why patients can have difficulty managing their symptoms. For example, many techniques require money, time, and energy— all resources that individuals with chronic pain often lack.

These practices— both overplaying individual responsibility for managing symptoms and downplaying structural barriers to such management— are obviously harmful. Not only do they perpetuate damaging stereotypes about those with unexplained pain (as attention-seeking, uninterested in getting better, etc.), they also serve as an excuse to not make the structural changes required to give all chronic pain patients the resources needed to, when possible, manage their symptoms.

In this presentation, I argue that these pernicious practices also lead to less obvious harms. First, these practices make it difficult for patients to talk openly and honestly about trying to find techniques to manage their symptoms. More precisely, discussing symptom mitigating/ managing techniques often risks reinforcing these pernicious practices, especially in cases where the techniques involve psychological training. For example, ruminating on one's pain has been shown to increase the intensity and duration of painful episodes. Cognitive behavior therapy can help reduce ruminating and so can serve as a useful tool for managing pain. While this is a genuinely helpful technique for some, the fact that it is helpful for some is frequently used to blame patients for whom cognitive behavioral therapy is an ineffective tool.

Second, in cases where there are things individuals can do to manage their symptoms, these pernicious practices make it difficult for individuals to figure out whether/ to what extent they are responsible for engaging in those managing activities. This is because of how easy it is for discussions of responsibility to over-reach and, again, end up reinforcing pernicious practices like those outlined above. To be clear, I bring up the idea of responsibility for managing symptoms not out of a desire to blame individuals when they fail to do so. Rather, I am focused on how those with chronic pain sometimes have an interest in figuring out what their role should be in managing their symptoms, and further whether/ how they should hold themselves accountable to those mitigating activities (in cases, again, where there are things that would help and that one is in a position to do). Put another way, I am focused on how individuals are sometimes interested in determining whether/ how to hold themselves accountable, not on whether/ how others should hold them accountable. The prevalence of pernicious practices like those discussed above, and the threat of reinforcing those practices, present barriers to thinking through questions like these.