RIVISTA INTERNAZIONALE DI FILOSOFIA E PSICOLOGIA
DOI: 10.4453/rifp.2021.0017
ISSN 2039-4667; E-ISSN 2239-2629
Vol. 12 (2021), n. 2, pp. 190-199

FORUM

Psychogenic pain as imaginary pain*

Elisa Arnaudo(α)

Ricevuto: 3 aprile 2021; accettato: 12 maggio 2021

Abstract Psychogenic pain is considered to be pain that has a psychological origin. In this paper, I provide a brief history of the ways in which such pain has been interpreted and classified, highlighting the problem that psychogenic pain is typically defined by excluding organic evidence that could account for the sufferer's experience. This has led to ambiguous disease classifications, which challenges the authenticity of the patient's suffering. Today psychogenic pain is no longer considered a valid diagnosis, because it is deemed to stigmatize the patient by implying that their pain is imaginary. But such stigmatization continues in the modern approach to chronic pain. Addressing this issue requires us to understand the relationship between "emotional" and "physical" pain and acknowledge the reality of all suffering. Radden tackles these issues by showing that even though pain and suffering can be accompanied by mistaken beliefs, such experiences cannot be delusional.
KEYWORDS: Psychogenic Pain; Imaginary Pain; Chronic Pain; IASP; DSM

Riassunto *Il dolore psicogeno come dolore immaginario* – Con dolore psicogeno si intende un dolore di origine psicologica. In questo lavoro presento una breve storia delle interpretazioni e classificazioni di questa forma di sofferenza, evidenziando che queste si sono fondate perlopiù sull'esclusione di evidenze organiche a giustificazione dell'esperienza del sofferente. Ciò ha portato ad ambigue classificazioni di malattia che mettono in discussione l'autenticità della sofferenza del paziente. Oggi, quella di dolore psicogeno non è più considerata una diagnosi valida perché ritenuta stigmatizzante, implicando che il dolore del paziente sia immaginario. Ciononostante, la stigmatizzazione persiste nell'approccio odierno al dolore cronico. Affrontare questo problema comporta la comprensione della relazione tra dolore "emozionale" e dolore "fisico" ed il riconoscimento della realtà di tutte le forme di sofferenza. Nel suo lavoro, Radden esamina queste tematiche mostrando che, sebbene esperienze di dolore e sofferenza possano essere accompagnate da credenze errate, le esperienze stesse non possono essere illusorie.
PAROLE CHIAVE: Dolore psicogeno; dolore immaginario; dolore cronico; IASP; DSM

*Comment on J. RADDEN, *Imagined and delusional pain*, Forum on *Imagining pain*, in: «Rivista internazionale di Filosofia e Psicologia», vol. XII, n. 2, 2021, pp. 151-206.

(α)Independent researcher

E-mail: elisa.arnaudo@gmail.com (✉)

IN HER WELL-KNOWN STUDY on pain and suffering, Scarry writes: «Pain enters into our midst as at once something that cannot be denied and something that cannot be confirmed [...] To have pain is to have *certainty*; to hear about pain is to have *doubt*». [1] Even if everyone knows what it means to feel pain, hearing about someone else's pain immediately plunges us into a situation of absolute not-knowing. This is due to the peculiar nature of pain: while it is recognized to be a bodily sensation, pain is also subjective and private, an intimate experience directly available only to the sufferer. The epistemic status of pain's is so peculiar that, as Aydede puts it, «the existence of this object seems to literally depend on my epistemic access to it: it seems to go out of existence when I cease to *feel* it (perceive it)».[2]

As Radden notes, the intrinsic subjectivity and privacy of pain has attracted philosophical attention, especially with regard to the supposed incorrigibility of the sufferer in relation to her own experience of pain. Clinical conditions such as phantom limb pain clearly show that it is possible to have misrepresentations of pain, i.e., inaccurate perceptions of features of pain, such as the location where the damage is experienced to be. But even in such cases, the sufferer's epistemic authority in relation to the presence of pain should not be questioned since pain, by definition, is either felt or not.[3] Scientific research is, in fact, careful to note that pain – whether associated with tissue damage or not – is always *real*. But at the same time, pain reports that cannot be related to detectable tissue damage are usually seen as less reliable, and patients suffering these conditions often feel stigmatized. This is because their experiences are interpreted as psychogenic; their *reality* is still challenged because *in the mind* becomes equated with *imaginary*. Radden traces this idea – that a suffering experience can be hallucinatory, thereby linking it to hypochondriac or imaginary illness – back to Kant's description of melancholic suffering; in the *Anthropologie*, Kant describes this condition as a «mere delusion of misery which the gloomy self-tormentor creates for himself»[4]. As Radden notes, a similar conception of delusional suffering might be found in the DSM-IV classification of psychogenic pain.

In her work, Radden investigates whether it is possible to have imaginary experiences of pain and suffering and shows that such feelings resist being imagined in a certain key way, whether or not they are associated with tissue damage. According to the author, just as there cannot be delusional "somatic pain" neither can there be delusional "emotional pain". The idea that these different forms of suffering might (and should) be related in terms of their imaginability represents an original approach, particularly given the disjunctive view of the phenomenon of pain assumed in scientific classifications. This medical perspective, which discriminates between "organic" (somatogenic) and psychogenic pain, is based on the idea that when reported pain is not accounted for by the presence of detectable tissue damage, it has to be of psychological origin.

In this work, I present a history of psychogenic pain, focusing on the ways in which it has been interpreted as a pathological entity and classified as a mental disorder. The principal troublesome issue is that such pain is identified by excluding any organic cause for the pain that the patient has reported. This is clear both from the DSM classification as well as from the first definition of pain provided by the International Association for the Study of Pain (IASP). Notwithstanding several attempts to identify psychogenic pain as a specific disorder, it is now considered to be an artificial construct, lacking positive criteria and, as a result, clinically useless. A particularly troublesome issue is the stigmatizing implication that psychogenic means *imaginary,* i.e., *unreal* pain.

Today psychogenic pain is rejected as an outdated concept, deemed to be a residue of Cartesian mind/body dualism. It is also recognized that the distinction between somatogenic and psychogenic pain makes no sense in relation to current scientific knowledge. At the same time, crucial issues underlying the notion of psychogenic pain must be tackled, especially those that relate to complex types of suffering such as chronic pain. In this context, acknowledging the *reality* of all experiences of pain and suffering is not merely tautological, but a task that requires careful attention: crucial issues remain to be clarified. This is what Radden achieves with her inquiry: Is it possible to have imaginary experiences of pain? And, if so, what does this mean? Is it possible for an individual to have *unreal* experiences of pain and suffering, i.e., to believe they are in pain when they are not? How can psychiatric conditions such as depression act on feelings of pain and suffering? Might it generate them? What is the relationship between pain related to tissue damage and pain not associated with any detectable tissue damage?
In her study, Radden shows that (i) feelings of pain and suffering resist being imagined and (ii) this is valid for any kind of pain and suffering experience, whether it is associated with tissue damage or not; therefore, instead of distinguishing these experiences on the basis of imaginability, they can be allied on this ground: (iii) psychogenic, like somatogenic pain and suffering, cannot be imaginary (*unreal*), even if (iv) it is possible to have delusions about these afflictions.

1 Pain and medicine

Medicine has historically resisted acknowledging the opacity of pain experience,[5] mainly be-

cause pain has always been recognized as a valuable symptom and therefore a pivotal tool in the diagnostic process. According to this standard view, the physician's question "Where does it hurt?" is the prologue to the clinical encounter. In an ideal scenario, an accurate description of the patient's pain will allow the doctor to make a diagnosis, discover the pathological entity causing the pain and, finally, bring about healing and the cessation of pain. In this perspective, pain is a physiological warning signal, a bell that rings, loudly and precisely indicating where the pathological process lies. In the second half of the 20th century, this paradigmatic view of pain (largely underpinned by a neurophysiological theory that dates back to Descartes) began to be challenged, especially in the wake of several clinical studies. Phantom limb pain and other pathological manifestations of pain clearly showed the inconsistency of the view that pain was a trustworthy marker of disease and led to the notion that pain could itself constitute a disease. In his 1940 work, *The surgery of pain*, Leriche states: «physical pain is not a simple question of nerve impulses moving at a fixed speed along a nerve. It is the result of the conflict between a stimulant and the individual as a whole».[6] As Canguilhem remarks, Leriche conceives of pain as something that, far from just happening to the individual, involves and is always shaped by the sufferer in their complexity.[7] This conception of pain as an experience led to the definition of *douleur-maladie* (pain-disease), for Leriche sees pain as «a monstruous individual phenomenon and not a law of the species. A fact of disease».[8] Leriche's view was aimed at forcing physicians to abandon their fatalistic conception of pain as a natural (therefore somehow acceptable) disease-related fact; about 10 years later, John J. Bonica, the founding father of pain medicine, echoed this view, defining chronic pain as a pathological entity.[9]

The idea that pain was not solely a physiological sensation underpinned by direct transmission from the skin to the brain was acknowledged by the scientific community in the second half of the 20th century. In 1965, Ronald Melzack and Patrick D. Wall put forward their Gate Control theory, a neurophysiological theory of pain mechanisms. They presented pain as the final outcome of a complex system of modulations of the original stimulus involving different factors, both physiological (i.e., fibre activity) as well as psychological (anxiety, attention, prior experience). This ground-breaking view of the phenomenon led to the scientific definition of pain formulated in 1979 by the IASP. The statement reads as follows: «Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in the terms of such a damage».[10] In the accompanying note, it is added:

> Pain is always subjective [...] Many people report pain in the absence of tissue damage or any likely pathophysiological cause; usually this happens for psychological reasons. There is usually no way to distinguish their experience from that due to tissue damage if we take the subjective report. If they regard their experience as pain, and if they report it in the same ways as pain caused by tissue damage, it should be accepted as pain. This definition avoids tying pain to the stimulus. Activity induced in the nociceptor and nociceptive pathways by a noxious stimulus is not pain, which is always a psychological state, even though we may well appreciate that pain most often has a proximate physical cause.[11]

This statement was undeniably revolutionary. For the first time, it offered a scientific definition of pain as an experience, a subjective phenomenon. As the proponents clarified, this implied that if an individual claimed to be in pain, their report must be accepted as *true* – whether or not detectable tissue damage was present. The definition was, in fact, careful to note that nociception (the detection of a noxious stimulus) is not pain, which is always a psychological state. At the same time, the professed aim of the IASP – to recognize the *reality* of all pains by defining pain as an experience – was strongly challenged by the classification of those pains with no detectable pathophysiological cause as psychogenic. While it is explicitly stated that the sufferer should be given epistemic authority in pain experience, in fact, this authority is limited: if the sufferer claims to be in pain, the physician must believe this assertion to be true. Yet, the reason for the patient's pain has already been determined: if the patient's report does not match the organic evidence, the patient's pain is identified as different from "organic pain", as psychogenic. The IASP definition acknowledges the *reality* of all pain experiences, but at the same time fits them into an etiology-grounded model which dichotomizes the mind and body, leaving some suspicion as to the *reality* of "non-organic" painful experiences. This is due to the definition of the psychogenic pain experience which, unlike "organic pain", is characterized by the absence of any pathophysiological explanation, pointing, therefore, to a psychological cause. At the same time, the nature of the psychological basis for the pain is left unspecified, adding additional uncertainty to the acknowledgment of these pain experiences. Further, identification of such conditions is based on the exclusion of organic causes rather than precise description. This leads to equivocal definitions of pain experiences that do not relate to detectable tissue damage as something different from "somatogenic pain" and, eventually, to downplaying the authority of sufferers who report their own suffering experiences.

After discussion by experts in the field, the IASP definition was updated in 2020. The phrase, «or described in the terms of such a damage»,[12] in the main statement was replaced with «or resembling that associated with, actual or potential tissue damage»[13] in order to put, as the proponents claim, «the onus for perceiving pain on the *experiencer of that pain* whereas in the old definition, part of that responsibility would lie with whomever *heard* the description».[14] According to the IASP authors, the emphasis on the primacy of the sufferer's authority in pain experience was related to an issue that becomes critical in clinical practice, i.e. «believing pain patients when they assert that they're in pain».[15] Furthermore, the sentence regarding the psychological etiology of pain being an absence of tissue damage was eliminated to reflect our current scientific understanding of pain. In the updated definition, the statement concerning psychogenic pain is described as "outdated". This assertion is clarified in a 2018 work quoted in the IASP paper, in which the concept of psychogenic pain is defined as "clinically untenable"; according to the authors, it reflects an unacceptable form of mind/body dualism, entailing the perpetuation of «the erroneous belief that pain is either "real", implying that it exists "in the body", or "imagined", implying that it exists "in the mind"».[16]

The IASP's updated definition reflects fundamental advances in the understanding of pain. Among these, is the acknowledgment that many painful conditions do not have any clearly detectable organic etiology, and psychological and physiological factors are often deeply intertwined, especially in chronic pain. This change of perspective is also reflected by the introduction of a specific classification for chronic pain as a disease in the ICD-11. Here, *chronic primary pain* is defined as a condition characterized by the presence of persistent pain, emotional distress, and significant functional disability.[17] As the proponents of this new definition claim, this is «a new phenomenological definition, created because the etiology is unknown for many forms of chronic pain».[18]

Philosophers Aydede and Güzeldere claim that in the IASP statement, and more generally in scientific studies of pain, there is a «fundamental tension between pain as subjectively understood versus pain as objectively characterized».[19] According to the authors, this is due to the inherent complexity of the phenomenon and is probably unavoidable. In the first version of the IASP definition, one of the major points of tension was the case of psychogenic pain, defined as an experience reported by the patient for which no organic damage was found. The *reality* of pain emerged from the clash between sufferers' (unequivocally *real*) experience of pain and the presence of a dualistic etiological framework identifying pain not associated to tissue damage as (at least) *less real* than "somatogenic" pain. In the updated version of the IASP definition, there is an epistemological shift, characterized by eliminating the notion of psychogenic pain and placing greater emphasis on the sufferer's experience. However, the tension between pain as experience and pain as objectively characterized remains: the authors remark on the importance of validating patients' experiences of suffering (whether or not there is organic evidence) in clinical practice.[20]

2 Psychogenic pain

Etymologically, psychogenic pain refers to all those pains caused (or supposed to be caused) by psychological mechanisms. In the history of psychology, these forms of suffering have gained visibility since the work of Freud and Breuer on hysteria, where pain often appears as a conversion symptom, a somatic manifestation of an internal dynamic conflict.[21] The idea that unexpressed emotional processes are at the basis of psychogenic pain characterizes psychological speculation on "non-organic pain" in the first half of the 20th century.

In 1959, Engel presented his study on the *pain-prone patient*, describing a category of individuals particularly prone to suffer lesionless pain; according to the psychiatrist, these people have a tendency to use pain as a psychic regulator to deal with psychologically untenable issues such as a sense of guilt or aggressive behaviour and as a response to real or imagined loss. According to Engel, pain can be experienced «just as visual and auditory sensations (hallucinations) may occur without sense organ input».[22] These experiences are indistinguishable for the patient, but not for the physician, who must rely on detecting an organic lesion.

In the 1980s, Blumer and Heilbronn elaborated on the notion of pain-proneness, explaining that chronic pain could mask depression. According to the authors, given the absence of any plausible theories to explain chronic pain, one could conclude that such patients experience psychological suffering in a physical way. On the basis of a psychological study involving 900 chronic pain patients, the authors claimed that these individuals could be considered to form a homogeneous group with common features such as hypochondriacal preoccupations with painful body parts, reported feelings of tiredness, anhedonia, and helplessness, all symptoms that the patients tended to ascribe to pain rather than depression. In a series of critical works,[23] Gamsa criticized Blumer and Heilbronn's work, reviewing results from the main contemporary psychological studies on the relationship between psychopathological factors and chronic pain. The author stresses that the majority of these works suffer from important methodological issues (such as the lack of control groups). She also points out some epistemological

problems, importantly, the tendency to draw causal inferences from correlational data, such as the presence of high rates of pain and depression in the same patients.[24]

In 1961, Walters presented the first large review of "psychiatric pain". In his work, the author identifies three main psychopathological factors that can cause pain: psychogenic magnification of physical pain, psychogenic muscular pain, and psychogenic regional pain, a label that he suggests as a replacement for hysterical pain. This last category refers to regionally located «pains patients feel in their bodies, and for which the clinician finds no physical lesion or peripheral cause».[25] In the author's view, these pains are a «behavioural expression of a personal state of danger or injury»[26] where the patient's pain is an hallucination (a sensory perception without peripheral stimulation) triggered by mental activity. In Walters' perspective, the origin of this pathological process is organic, since it is located in the nervous system, more precisely, in the brain.

In a 2004 review of the literature on psychogenic pain, psychiatrist Merskey claims that the nineteenth century solution to the problem of *pain without lesion* was a diagnosis of hysteria. Merskey argues that category of *Somatoform Disorders* in the DSM-III constitutes a refashioning of this hysteria diagnosis; here, conditions characterized by hysterical symptoms without pain are classified as *Conversion Disorders*, whereas those that only present pain symptoms are categorized as *Psychogenic Pain Disorders*.[27] To receive the latter diagnosis, the patient has to have experienced severe and prolonged pain that can't be attributed to any organic pathology or pathophysiological mechanisms, and the patient's complaint has to be grossly excessive in relation to the physical findings. Evidence that psychological factors play a role in the production of pain includes: (i) a temporal relationship between the onset of pain and environmental factors that produced psychological conflict; (ii) the pain appears to enable the patient to avoid "noxious" activities; and (iii) the presence of pain somehow enables the patient to receive emotional support or attention otherwise unobtainable. Furthermore, the pain must not be due to any other mental disorder. Associated features include the tendency to frequently seek medical help.

In the DSM-III revised edition, *Psychogenic Pain Disorder* becomes *Somatoform Pain Disorder*, whose diagnostic criteria are reformulated to eliminate the need to prove the presence of psychological factors in pain etiology. Moreover, a new criterion is introduced: the patient must have demonstrated preoccupation with pain for at least six months. This places the emphasis on the patient's pathological reaction to pain and not the severity of pain itself. Again, there must be either physiopathological processes that can account for the pain or the patient's pain must be excessive with respect to physical findings.

In the DSM-IV, psychogenic pain is classified as *Pain Disorder*. Diagnostic criteria to define it are the presence of severe pain in one or more anatomical sites, where «psychological factors are judged to have an important role in the onset, severity, exacerbation or maintenance of the pain.»[28] Furthermore, the pain has to cause significant impairment to the individual's functioning, and the presence of other disorders has to be excluded. The pain may also be either associated solely with psychological factors [subtype 307.80] or with both psychological factors and a general medical condition [307.89]. If the pain is associated solely with a general medical condition, it is not considered to be a mental disorder.

In *Pain Disorder*, the focus is on the pain, which must be «of sufficient severity to warrant clinical attention».[29] The authors of the DSM-IV Sourcebook, King and Strain, stress several reasons why the previous diagnosis (*Somatoform Pain Disorder*) has rarely been employed. Among these are the difficulty of defining a patient's preoccupation with pain or demonstrating that pain is in excess of what would be expected given the physiological conditions. Another troublesome issue is the dualistic view of pain underlying the diagnostic category, implying that the condition is somehow different from "organic pain". These issues, alongside the risk of stigmatizing patients whose pain is deemed to be psychogenic, have led to a narrow use of *Somatoform Pain Disorder* in research projects and in clinical practice. To obviate this problem, in the DSM-IV the clinician can specify subtypes of the disorder, assessing the influence of the factors involved. The "Psychological subtype" is defined as pain with a largely psychosocial etiology; if a non-psychiatric condition is present, its role is minimal.

The Pain Disorder classification acknowledges that it is often not possible to make a clear-cut distinction between psychological and non-psychiatric factors, especially in chronic pain syndromes. At the same time, the status of the psychological issues underlying pain is blurred and no guidance is given on when to diagnose the psychological *Pain Disorder* subtype instead of that including also a medical condition. In addition, as Aigner and Bach remark, the presence of two specifications for the category seems to (again) introduce a distinction between «"pure" psychosocially mediated pain and 'mixed' psychosomatic pain disorders».[30] The supposedly discarded dualistic approach to pain therefore returns in a more subtle way. Furthermore, it been criticized as a nosological entity that lacks positive criteria. The nature of psychopathological factors which might engender, worsen, or maintain such pain are unknown, running the risk that the classification re-

mains an empty concept.[31] *Pain Disorder* seems to be a "pure" psychogenic pain identified by the absence of a medical (non-psychological) etiology, leading to the conclusion that psychological factors must be causing the pain, even if their nature is not specified. But this excludes conditions characterized by an interplay of psychological and physiological factors, which might well describe chronic pain conditions. Thus, as has been highlighted, the *Pain Disorder* diagnosis is rarely applied in clinical settings, mainly because the second subtype has been considered a troublesome diagnosis for chronic pain conditions. As Sullivan argues, discussions about psychiatric disorders in chronic pain patients are «haunted by the concept of psychogenic pain»[32] – this concept should account for conditions that cannot be explained merely in terms of physical damage, but it lacks positive criteria and specific therapies, and is therefore useless. According to Sullivan in such cases this diagnosis should be avoided; it would be better to employ mood disorder classifications such as depression or anxiety for which, at least, effective treatments exist.

In a 2002 paper, psychiatrist Boland remarks that a *Pain Disorder* diagnosis is rarely made in pain clinics, where typically psychiatry does not play a major role. According to the author, *Pain Disorder* associated with psychological factors and a general medical condition may well describe most chronic pain conditions, but its over-inclusiveness risks making this categorization useless: in encompassing all pain patients, there seems to be no clear way to distinguish the cases that are of particular psychological concern, and the decision to use a psychiatric diagnosis appears to be a subjective one, that depends on the philosophy of the diagnostician.

Pain Disorder (again) to appears be a classification grounded on exclusive criteria (the absence of organic evidence accounting for reported pain). The lack of any positive description makes it look more like an artificial construct used to account for poorly understood painful conditions than a nosological entity in its own right. As Sullivan argues, «perhaps the most serious problem with *Pain Disorder* is the implication that pain is a mental disorder»[33] and, even though in the DSM-IV there has clearly been an effort to minimize this aspect of the conception of pain, «the very inclusion of the diagnosis in the manual of mental disorders undermines this effort».[34] In the DSM-V revised edition of APA's Manual, psychogenic pain is subsumed under the more general category of *Somatic Symptom Disorder*. Beside *Pain Disorder*, this category also includes *Combined Somatization Disorder, Hypochondriasis*, and *Undifferentiated Somatoform Disorder*.

Here, psychogenic pain occurs as a particular specification of a broader condition in which distressing somatic symptoms are related to the patient's maladaptive behaviour or to exaggerated health concerns related to it. Psychogenic pain thus loses its autonomy, but seems to fit better with scientific findings indicating frequent overlap between somatoform conditions. This approach is grounded in the identification of a chronic somatic symptom that causes the patient distress, but their disproportionate concern with this symptom is judged pathological in relation to the organic evidence.

In the note accompanying the classification, APA claims that reconceptualization of the somatoform disorders category is emphasized by a desire to move away from the DSM-IV view of mental disorders, a classification grounded on the absence of medically explainable symptoms that therefore emphasized mind/body dualism. In DSM-V, positive criteria are preferred instead, such as «distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms».[35]

The classification of psychogenic pain as somatic symptom disorder has been criticized mainly because this categorization appears too loose, entailing the risk of an over-medicalization of patients with painful symptomatology.[36] As has been highlighted, this diagnosis might be particularly harmful for chronic pain patients, whose condition is far more complex, characterized by the constant interplay of physiological and psychological factors. *SSD*'s criteria might apply to most chronic pain conditions, especially those without clear etiology. As a matter of fact, the presence of persistent pain of unknown origin might make these patients particularly vulnerable to the development of distressing thoughts, feelings, and behaviours. As has been highlighted,[37] it remains unclear who should determine the level of distress and impairment or whether the patient's reactions or concerns are excessive (rather than an appropriate response to relentless unexplained pain) in order to diagnose the disorder. Chronic pain is characterized by several psychopathological issues but, in many cases, these are not the source of the pain itself or of its persistence, but pathological manifestations of the condition itself. Any assessment that relies on only one perspective (psychological or physiological) will fail to address the complex interplay of pathological issues that characterize chronic pain, which instead demands an integrated approach.

3 Pain and stigmatization

Since the second half of the last century, scientific knowledge of pain mechanisms has grown enormously supporting better understanding and approaches to pain and suffering; the IASP definition of pain as well as the recognition of chronic

pain as a disease in its own right bears witness to what can be defined as a change of paradigm in pain knowledge. Nevertheless, we still lack a definitive account of this complex phenomenon, especially its pathological manifestations. The global burden of pain is huge and growing: according to the IASP, 1 in 5 patients experience pain and 1 in 10 are diagnosed with chronic pain every year. Pain is the most common reason patients seek medical care; moreover, it has been estimated that 34 % of individuals living in low- and middle-income countries have persistent pain without a clear etiology.[38] Finally, there is abundant evidence for the stigma affecting people living with pain,[39] especially when this condition is not directly associated with detectable tissue damage.

According to the standard definition, stigma consists in "devaluing and discrediting responses of observers towards individuals" possessing features that deviate from societal norms.[40]

In two pivotal works,[41] anthropologist Jackson tackles the issue of pain *reality* and investigates the stigmatization affecting chronic pain sufferers. The author underscores that while pain presents some intrinsic challenges due to its nature (its invisibility, its subjectivity, its position across mind and body), the source of stigma is related to the troublesome identification of this form of suffering in biomedicine. Pain, especially in its chronic form, occupies in a *liminal*[42] position in our scientific understanding; it has long been identified as pain felt in absence of detectable tissue damage. Moreover, persistent pain transgresses the traditional view of pain as something that at a certain point ceases, leading to uncertainty over why it persists. As has been remarked, this uncertainty might lead to ambiguous psychopathological interpretations of a sufferer's condition. As has also been remarked, delegitimization of pain sufferers occurs when psychological factors are involved because conceptions of psychogenicity entail questioning the reality of the suffering. As Jackson notes, in clinical practice, the contrast between *real* and *unreal* pain does not entail a clear-cut distinction between conditions, but it has a precise meaning. *Real* pain is «organic, physical in origin and maintenance»[43] and the «patient is not seen as responsible for pain»[44] while «any pain with inputs from psychological factors is to some degree unreal because of the non-physical nature of these causes and the problematic nature of responsibility for them».[45] As Kirmayer highlights, even if Cartesian dualism no longer represents an issue for modern science, biology leaves the ethical aspect of mind/body dualism unexplored; in this regard, suffers are stigmatized «because mind and body symbolize contrasting poles in human experience: the voluntary or intentional and the involuntary or accidental».[46] The *reality* of any condition whose origin is not directly attributable to damage in the "body-machine" is questioned, since it involves individual responsibility; «"real" sickness in Western culture is an exemplar of the kind of misfortune that just happens to us».[47] People suffering from complex conditions such as chronic pain without lesion are therefore seen as «either rational but morally suspect in choosing to be sick, or irrational and thus morally blameless, but mentally incompetent».[48]

During my research on medicine and pain, I have investigated fibromyalgic patients' experiences of suffering. Fibromyalgic syndrome is one of the most controversial chronic pain conditions, with a troublesome disease status,[49] mainly due to the multiple interactions between psychopathological and physiopathological factors and its unknown etiopathology. As part of this research, I have analyzed the relationship between so-called mental pain and physical pain in sufferers' lived experiences, eliciting patient input through focused interviews and by observing clinical encounters in a Rheumatological Clinic. According to the interviewees, "mental" and "physical" pain differ: physical pain is something that hits the body from the outside, whereas mental pain involves emotional aspects of the pain experience, it is a kind of general distress, that results from the difficulty of bearing physical pain. As a consequence, for sufferers, the possibility of healing chronic pain would also entail ending their emotional suffering. If in these patients' experiences the distinction between mental and physical pain appears very clear, the definition of the *reality* of their suffering turns out to be grounded in the ways in which their condition is approached in clinical practice. In this context, patients are not so much concerned with how fibromyalgia is defined as in avoiding psychological care, even if antidepressants are widely employed to treat the condition. This, far from being due to the stigma implied by a psychological labelling of their condition *per se*, has to do with the fear of therapeutic abandonment, for in our medical system you do not see a psychologist if you have *real* pain.

4 Conclusion

Pain is perhaps one of the most complex and fundamental human experiences. While pain has always played a role in medical diagnosis and theory, in the last fifty years, it has become the focus of dedicated attention, as evidenced by the creation of a specific branch of medicine devoted to the study and management of pain. Important pillars in this endeavour have been the formulation of a scientific definition of pain and the acknowledgment of chronic pain as a disease in its own right. A crucial issue underlying these questions has been the conceptualization of pain of a psychological origin.

In this work, I have retraced the history of psychogenic pain, highlighting that this diagnosis has represented an attempt to describe forms of suffering that could not be accounted for in a medical framework characterized by a dualistic etiological view of the mind/body relationship. Diagnostic classifications of psychogenic pain have been troublesome, because they have failed to define clinical entities, i.e., pain as a mental disorder, and for their stigmatizing implications. As a result, today, the notion of psychogenic pain is deemed to be a residue of outdated Cartesian dualism and has been rejected as clinically useless. Nevertheless, rejection of this notion has not succeeded in eliminating troublesome issues that underpin the concept, which instead have resurfaced in approaches to complex pain conditions such as chronic pain of unknown etiology. As has been argued, this is because scientific conceptions of pain and suffering have consequences: they emerge at the intersection of epistemological tensions and entail moral issues. From this perspective, understanding the relationship between "emotional" and "physical" pain (underlying the more general definition of pain itself) and acknowledging the *authenticity* of pain experiences and suffering becomes crucial. In her work, Radden has outlined these experiences, showing that pain and suffering cannot be imagined, i.e. they are always *real*. The impossibility of having delusional experiences of pain applies to any kind of suffering experience and therefore allows for an association between seemingly different feelings of pain and suffering, as those resulting from tissue damage and those associated with mood disorders. As the author has stressed, even if such experiences might be accompanied by several mistaken (even delusional) beliefs, the experiences themselves cannot be delusional.

Notes

[1] E. SCARRY, *The body in pain*, p. 13.

[2] M. AYDEDE, *Pain*.

[3] As Radden notes, the recognition that pain is more than the stimulation of nocioceptors allows us to say that «in the case of pain, to be is to be experienced or perceived (*esse est percipi*)» (cf. J. RADDEN, *Emotional pain and psychiatry*, p. 114).

[4] P. FRIERSON, *Kant on mental disorders: An overview*, p. 10.

[5] According to Foucault, this approach became common practice with the rise of the novel clinical method around 1800, when the medical gaze acquired greater importance than symptoms of disease in medical diagnostics, and hence pain was related to a localized lesion. Cf. M. FOUCAULT, *The birth of the clinic*.

[6] R. LERICHE, *La chirurgie da la douleur*, Masson, Paris 1940, p. 488 - translation mine.

[7] Canguilhem defines it therefore as a type of behaviour (cf. G. CANGUILHEM, *On the normal and the pathological*).

[8] R. LERICHE, *La chirurgie da la couleur*, p. 490.

[9] J.J. BONICA, *The management of pain*, p. 76. For a detailed history of the rise of pain medicine, cf. I. BASZANGER, *Inventing pain medicine: From the laboratory to the clinic*. For a history of the concept of pain as a disease, cf. E. ARNAUDO, *Dolore e medicina*; E. ARNAUDO, *Biomedicine and pain*

[10] INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN, *Classification of Chronic Pain Syndromes and definitions of pain*.

[11] *Ibidem*.

[12] Cf. S.N. RAJA, D.B. CARR, M. COHEN, N.B. FINNERUP, H. FLOR, S. GIBSON, F.J. KEEFE, J.S. MOGIL, M. RINGKAMP, K.A. SLUKA, X.J. SONG, B. STEVENS, M.D. SULLIVAN, P.R. TUTELMAN, T. USHIDA, K. VADER, *The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises*.

[13] *Ibidem*.

[14] Cf. A. DRAKULICH, *Pain redefined: Inside the IASP's Updated Definition*.

[15] *Ibidem*.

[16] M. COHEN, J. QUINTNER, S. V. RYSEWYK, *Reconsidering the International Association for the Study of Pain definition of pain*.

[17] WHO, *Chronic primary pain*, in: «International Classification of Diseases 11th version».

[18] R.D. TREEDE, W. RIEF, A. BARKE, Q. AZIZ, M.I. BENNETT, R. BENOLIEL, M. COHEN, S. EVERS, N.B. FINNERUP, M.B. FIRST, M.A. GIAMBERARDINO, S. KAASA, E. KOSEK, P. LAVAND'HOMME, M. NICHOLAS, S. PERROT, J. SCHOLZ, S. SCHUG, B.H. SMITH, P. SVENSSON, J.W.S. VLAEYEN, S.-J. WANG, *A classification of chronic pain for ICD-11*.

[19] M. AYDEDE, G. GÜZELDERE, *Some foundational problems in the scientific study of pain*, p. 266.

[20] This issue has been tackled from the sufferers' perspective in relation to the notion of epistemic injustice. See I. J. KIDD, H. CAREL, *Epistemic injustice in healthcare: A philosophical analysis*.

[21] Breuer and Freud's interpretations of the origin of these pains diverged remarkably. Breuer not only rejected Freud's contention that conversion symptoms had their root in repressed traumatic sexual memories but also disagreed on the role played by physiological and psychological factors in pain production. While Freud conceived of these as the result of purely psychological mechanisms, Breuer instead thought that the overexcited, diseased nerves of hysterics were central to the phenomenon, stimulating traumatic reminiscence. Cf. A. HODGKISS, *From lesion to metaphor: Chronic pain in British, French and German medical writings: 1800-1914*.

[22] G.L. ENGEL, *Psychogenic pain and the pain-prone patient*, p. 912.

[23] Cf. A. GAMSA, *Is emotional disturbance a consequence or a precipitator of chronic pain?*; A. GAMSA, *Psychological events are both risk factors in, and consequence of, chronic pain*; A. GAMSA, *The role of psychological factors in chronic pain I. A Half century of studies*; A. GAMSA, *The role of psychological factors in chronic pain II. A critical appraisal*.

[24] The association of depression and pain is widely recognized. It has been estimated that up to 65% of clinically depressed patients have unexplained pain, and 37% of pain patients manifest clinically significant depression, cf. D.M. DOLEYS, *Pain. Dynamics and complexities*, p. 117.

[25] A. WALTERS, *Psychogenic regional pain alias hysterical pain*, p. 2.

[26] *Ibid.*, p. 17.

[27] Micale indicates a wider redistribution of hysterical features in the DSM-III categories: *Facticious illness behaviour, Dissociative Disorder- conversion type, Histrionic Personality Disorder, Undifferentiated Somatoform Disorder* and, finally, *Psychogenic Pain Disorder*. Cf. M.S. MICALE, *Approaching hysteria. Disease and its interpretations*.
[28] AMERICAN PSYCHIATRIC ASSOCIATION, *Diagnostic and statistic manual of mental disorders*, 4th edition, p. 458.
[29] *Ibid.*, p. 459.
[30] M. AIGNER, M. BACH, *Clinical utility of DSM-IV Pain Disorder*, p. 356.
[31] As Hardcastle notes, since, as of July 1997, no one has published a single article that makes use of these criteria for Pain Disorder (V.G. HARDCASTLE, *The myth of pain*, p. 20). Cf. also M.D. SULLIVAN, *Pain disorder: A case against the diagnosis*.
[32] M. SULLIVAN, *Pain disorder*, p. 91.
[33] *Ivi*, p. 92.
[34] *Ibidem*.
[35] A. DICKERMAN, J. W. BARNHILL, J.A. BOURGEOIS, J.L. LEVENSON, R. BOLAND, J.P. CAPLAN, T. A. STERN, J. F. MURRAY, J.GORDON-ELLIOTT, *Somatic symptom and related disorders*.
[36] Cf. J. KATZ, B. N. ROSENBLOOM, S. FASHLER, *Chronic pain, psychopathology, and DSM-V Somatic Symptom Disorder*.
[37] D.M. DOLEYS, *Pain*, pp. 123-124.
[38] Cf. A. ENRIGHT, R. GOUCKE, *The global burden of pain: The tip of the iceberg?*.
[39] Cf. W. SCOTT W, L. YU, S. PATEL, L. M. MCCRACKEN, *Measuring stigma in chronic pain: Preliminary investigation of instrument psychometrics, correlates, and magnitude of change in a prospective cohort attending interdisciplinary treatment*.
[40] Cf. L. DE RUDDERE, K. D. CRAIG, *Understanding stigma and chronic pain: A state-of-the-art review*.
[41] Cf. J. JACKSON, *After a while none believes you*; J. JACKSON, *Stigma, liminality and chronic pain: Mind-body borderlands*.
[42] In anthropology, liminality refers to two distinct albeit connected notions, both employed by Jackson with reference to chronic pain. These are "betwixt and between" and "matter out of place". Cf. J. JACKSON, *Stigma, liminality and chronic pain*, p. 333.
[43] J. JACKSON, *After a while no one believes you*, p. 143.
[44] *Ibidem*.
[45] *Ibid.*, pp. 143-144.
[46] L.J. KIRMAYER, *Mind and body as metaphors: Hidden values in biomedicine*, p. 57.
[47] *Ibid.*, p. 75.
[48] *Ibid.,* p. 83.
[49] Cf. E. ARNAUDO, *Dolore e medicina*; E. ARNAUDO, *Biomedicine and pain*.

References

AIGNER, M., BACH, M. (1999). *Clinical utility of DSM-IV pain disorder*. In: «Comprehensive Psychiatry», vol. XL, n. 5, pp. 353-357.

AMERICAN PSYCHIATRIC ASSOCIATION (1994). *Diagnostic and statistic manual of mental disorders*, Fourth edition (DSM-IV), APA Press, Washington (DC).

ARNAUDO, E. (2013). *Biomedicine and pain*, Ph.D. dissertation, Università di Bologna – doi: 10.6092/unibo/amsdottorato/5876.

ARNAUDO, E. (2017). *Dolore e medicina*. Edizioni ETS, Pisa.

AYDEDE, M. (2005) *Pain*. In: E.N. ZALTA (ed.), *Stanford encyclopedia of philosophy*, 2005 edition, substantive revision 2019 – URL: https://plato.stanford.edu/entries/pain/.

AYDEDE, M., GÜZELDERE, G. (2000). *Some foundational problems in the scientific study of pain*. In: «Philosophy of Science», vol. LXIX, Supplement, pp. 265-283.

BASZANGER, I. (1998). *Inventing pain medicine: From the laboratory to the clinic*, Rutgers University Press, London/New York

BONICA, J.J. (1953). *The management of pain*, Kimpton, London.

CANGUILHEM, G. (1978). *On the normal and the pathological* (1943), translated by C.R. FAWCETT, Reidal, Dordrecht.

COHEN, M., QUINTNER, J., RYSEWYK, S.V. (2018). *Reconsidering the International Association for the Study of Pain definition of pain*. In: «PAIN Reports», vol. III, n. 2, Art.Nr. e634 – doi: 10.1097/PR9.0000000000000634.

DE RUDDERE, L., CRAIG, K.D. (2016). *Understanding stigma and chronic pain: a-state-of-the-art review*. In: «Pain», vol. CLVII, n. 8, pp. 1607-1610.

DICKERMAN, A., BARNHILL, J.W., BOURGEOIS, J.A., LEVENSON, J.L., BOLAND, R., CAPLAN, J.P., STERN, T.A., MURRAY, J.F., GORDON-ELLIOTT, J. (2013). *Somatic symptom and related disorders*. In: J.W. BARNHILL (ed.), DSM-5 clinical cases, chap. 9, doi: 10.1176/appi.books.9781585624836.jb09.

DOLEYS, D.M. (2014). *Pain. Dynamics and complexities,* Oxford University Press, Oxford/New York.

DRAKULICH, A. (2020), *Pain redefined: Inside the IASP's updated definition* – URL: https://www.practicalpainmanagement.com/resources/news-and-research/pain-redefined-inside-iasp-updated-definition.

ENGEL, G.L. (1959). *Psychogenic pain and the pain-prone patient*. In: «The American Journal of Medicine», vol. XXVI, n. 6, pp. 899-918.

ENRIGHT, A., GOUCKE, R. (2016). *The global burden of pain: The tip of the iceberg?*. In: «Anesthesia and Analgesia», vol. CXXIII, n. 3, pp. 529-530.

FOUCAULT, M. (1973). *The birth of the clinic* (1963), translated by A.M. SHERIDAN-SMITH, Pantheon Books, New York.

FRIERSON, P. (2009). *Kant on mental disorders. Part 1: An overview*. In: «History of Psychiatry», vol. XX, n. 3, pp. 267-289.

GAMSA, A. (1990). *Is emotional disturbance a consequence or a precipitator of chronic pain?*. In: «Pain», vol. XLII, n. 2, 1990, pp. 183-195.

GAMSA, A. (1991). *Psychological events are both risk factors in, and consequence of chronic pain*. In: «Pain», vol. XLIV, n. 3, pp. 271-277.

GAMSA, A. (1994). *The role of psychological factors in chronic pain I. A Half century of studies*. In: «Pain», vol. LVII, n. 1, pp. 5-15.

GAMSA, A. (1994). *The role of psychological factors in chronic pain II. A critical appraisal*. In: «Pain», vol. LVII, n. 1, pp. 17-29.

HARDCASTLE, V.G. (1999). *The myth of pain*, MIT Press, Cambridge (MA)/London.

HODGKISS, A. (2000). *From lesion to metaphor: Chronic pain in British, French and German medical writings: 1800-1914*, Rodopi, Amsterdam.

INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN (1994). *Classification of chronic pain syndromes and definitions of pain*, Second Edition (Revised), IASP Press, Seattle.

JACKSON, J. (1992). *After a while none believes you*. In: M.-J. DELVECCHIO GOOD, P.E. BRODWIN, B.J. GOOD, A. KLEINMANN (eds), *Pain as a human experience: An anthropological perspective*, University of California Press, Berkley/Los Angeles, pp. 138-168.

JACKSON, J. (2005). *Stigma, liminality and chronic pain: Mind-body borderlands*. In: «American Ethnologist», vol. XXXII, n. 3, pp. 332-353.

KATZ, J., ROSENBLOOM, B.N., FASHLER, S. (2015). *Chronic pain, psychopathology, and DSM-V somatic symptom disorder*. In: «The Canadian Journal of Psychiatry», vol. LX, n. 4, pp. 160-167.

KIDD, I.J., CAREL, H. (2014). *Epistemic injustice in healthcare: A philosophical analysis*. In: «Medicine, Health Care and Philosophy», vol. XVII, n. 4, pp. 529-540.

KIRMAYER, L.K. (1988). *Mind and body as metaphors: Hidden values in biomedicine*. In: M.M. LOCK, D.R. GORDON (eds.), *Biomedicine examined,* Kluwer, Dordrecht/Boston/London, pp. 57-93.

LERICHE, R. (1940). *La chirurgie da la douleur*, Masson, Paris.

MICALE, M.S. (1995). *Approaching hysteria. Disease and its interpretations*, Princeton University Press, Princeton (NJ).

RADDEN, J. (2009). *Emotional pain and psychiatry*. In: J. RADDEN, *Moody minds distempered. Essays on melancholy and depression*, Oxford University Press, Oxford/New York, pp. 111-129.

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*. In: «Pain», vol. CLXI, n. 9, pp. 976-1982.

SCARRY, E. (1985). *The body in pain*, Oxford University Press, Oxford/New York.

SCOTT, W., YU, L., PATEL, S., MCCRACKEN, L.M. (2019). *Measuring stigma in chronic pain: Preliminary investigation of instrument psychometrics, correlates, and magnitude of change in a prospective cohort attending interdisciplinary treatment*. In: «The Journal of Pain», vol. XX, n. 10, pp. 1164-1175.

SULLIVAN, M.D. (2000). *Pain disorder: A case against the diagnosis*. In: «International Review of Psychiatry», vol. XII, n. 2, pp. 91-98.

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., SVENSSON, P., VLAEYEN, J.W.S., WANG, S.-J. (2015). *A classification of chronic pain for ICD-11*. In: «Pain», vol. CLVI, n. 6, pp. 1003-1007.

WALTERS, A. (1961). *Psychogenic regional pain alias hysterical pain*. In: «Brain», vol. LXXXIV, pp. 1-18.

WHO, *Chronic primary pain*. In: «International Classification of Diseases - 11th version».