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Pain as a Subjective Experience: An Integrated Approach for a Dialogue between Philosophy and Biomedical Sciences

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The aim of this article is to show how the inseparability of its objective and subjective dimensions renders pain such a complex phenomenon that it poses a challenge for both the biomedical sciences and philosophy. Neurophysiology has ascertained the variability of the relationship between damage and pain, showing that it is the result of interaction between the sensory and affective-emotional constituents of the human being. However, the process of defining the clinical concept of suffering appears comprehensively laborious and ongoing. Philosophy, while declaring the impossibility of identifying the essence of pain, makes a valuable contribution to the discovery of the singularity of the experience, thanks to the phenomenology of the *homo patiens*. Finally, we examine the debate on the possibility and the different ways of narrating and appraising suffering, a need with obvious ethical implications, perceived more and more within the field of care, also given the chronicity of many medical conditions.

Keywords: body – care ethics – phenomenology of pain – narrative – suffering

Introduction

Within the health field, more than 200 adjectives can be used to accompany the word pain: burning, acute, stinging, dull, constant, chronic, etc., yet none of them is capable of covering the complexity of the phenomenon totally, although they provide elements of use to therapy and cure. Something more is required: an understanding of the relationship existing between the sensation of pain and the personal reaction to it. Moreover, a highly medicalized context tends more and more to consider pain a residual element, an irritating reminder of our vulnerability. Buytendijk had already denounced this notion more than half a century ago: "Modern man is irritated by things, which older generations accepted with equanimity. He is irritated by old age, long illness, and even by death; above all he is irritated by pain. Pain simply must not to occur" (Buytendijk 1961, 5).

Perhaps it may be helpful to consider the fact that we are faced not so much with pain in general, as with the person in pain, the *homo patiens*, whose perception of pain is always configured as an existential experience that questions personal freedom. For this reason, pain is a privileged area where exquisitely anatomic/physiological scientific investigation encounters – or should encounter – psychological and philosophical analyses, especially if one intends to set up a therapeutic proposal properly. An authentic *phenomenology* of pain cannot, therefore, ignore this approach which is open to complexity and bent on grasping its multidimensionality: not only its neuro-physio-pathological dimension but also its emotional one, as well as its disharmonic side, the rupture it provokes in the suffering self. This perspective makes it possible to explore how pain changes the individual, but also vice versa, how the individual changes pain, that is, how s/he undergoes, narrates and interprets it.

I. The Phenomenon of Pain: A Problem for the Medical Knowledge

In dealing with pain as a subjective experience, there remains a broad range of problematic issues regarding science and philosophy alike. Undoubtedly, many steps forward have been taken compared to the rather doubtful answer provided by a well-known article dated 1887 published in *The Lancet*. Here, to the question "what is pain?," the answer was that it is "incapable of definition, or even of accurate description" ("What is Pain?" 1887, 333). Towards the mid-twentieth century, neurophysiology, with Melzack and Wall's *Gate Control Theory,* opened up a new way of explaining the variability of responses to painful stimuli (Melzack – Wall 1965, 3). Before its formulation, two fundamentally opposite theories, both of them insufficient, had confronted each other. One was the theory of specificity which held that pain was a particular modality like sight or hearing, therefore endowed with a central and peripheral apparatus of its own (Sweet 1959, 4). The second was the model theory, which argued that the nerve impulse model for pain was produced by intense stimulation of non-specific receptors, seeing that painful stimuli had no specific fibers (Sinclair 1955, 5).

The *Gate Control Theory* introduced, on the other hand, the idea of the subjectivity of an individual's experience of pain, showing that the intensity of a painful stimulus might be modulated considerably by some external conditions, so that an identical painful stimulus, applied to different people under the same conditions could provoke different responses. This theory which introduced a concept of pain that was no longer univocal but linked to the specific response of each individual has had a significant clinical impact on pain assessment and treatment. The modulation of painful stimuli at the spinal level and the dynamic role of the brain in processing pain-related information have also provided previously unexplained physiological bases for "abnormal" symptoms, for example, phantom-limb pain, believed to be of psychopathological origin. In addition, anxiety, depression, worry and other psychological phenomena, once considered mere reactions to pain, have become integral aspects of pain processing. The *Gate Control Theory* has also had a profound impact on other approaches to pain management, like that concerning the reduction of irreversible and ablative surgical procedures and has led to the adoption of new therapies like transcutaneous electrical nerve stimulation and other kinds of neuromodulation at the central and/or peripheral nervous-system level.

Although this has led to undeniable progress, pain management in healthcare remains, nevertheless, a problem that is far from being resolved, both because of the lack of homogeneity in the explanatory models adopted and the idea that acute and chronic pain have similar biological and psychological substrata and can be treated with the same analgesic strategies. This approach, while it relieves symptoms, tends to ignore all other aspects of chronic pain.

II. Towards Further Classifications: Chronic Pain and Total Pain

While it has been debated for decades whether pain is a symptom or a disease, alternately leaning towards one or the other thesis (Leriche 1940, 83),[1] the conviction that acute pain is a symptom, while chronic pain is a disease that must be treated as such, is fairly recent (Loeser 2006, 7). Paradoxically, even *Congenital Insensitivity to Pain* (CIPA), that is, the absence of the perception of pain and thermal sensations, a serious, rare disease, shows how the experience of physical pain is vital for survival (Manfredi 1981, 8). Compared to nociceptive pain, which is caused by damage to tissue and is, therefore, concrete and visible, and can be communicated without too much difficulty, the character of neuropathic pain remains problematic and, consequently,

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[1] Leriche stated that when the pain appears, the drama of the disease is already in its second act, and it is already too late. In his view, pain is for the doctor a symptom "contingent, annoying, noisy, unpleasant, difficult to suppress, but usually of little diagnostic or prognostic value."

continues to represent a challenge for its assessment with regard to appropriate care (Schott 2004, 9).

For these reasons, the need to integrate the *Gate Control Theory* too has been gradually acknowledged, because of the need to take into greater account the complexity of pain, which cannot be explained merely in terms of anatomy and sensory circuits. Proof of this is the debate that arose in 1979 in the International Association for the Study of Pain (IASP) regarding the definition of pain: "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage."[2] This definition, considered adequate for taking the emotional component into account, has, however, according to many scholars, underestimated some essential points. It has been observed, for example, that by acknowledging the sensory and emotional characteristics of pain only, one risks ignoring several clinically important aspects, such as the cognitive and social components as well as characteristics of chronic pain, thus hindering the understanding of acute and neuropathic pain (Williams 2016, 10). Furthermore, people unable to verbalize their pain are excluded. Another objection was raised against the adjective "unpleasant," judged rather weak when used to define severe pain, while "distressing" appeared more adequate to connote ranges of perception of pain: "most acute or chronic clinically problematic pain is more than "unpleasant," and the term potentially trivializes severe pain" (Williams 2016, 2421; Raja 2020).

A laborious process ensued with various discussions that led to a new definition of pain: "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (Revised IASP Definition of Pain, 2020). Although consensus has been reached, it is significant that the concept continues to require further clarification: proof of this is the subsequent addition of a series of explanatory notes, which make it clear that this is a personal experience distinct from nociception, not reducible to the activity of sensory neurons alone, but also influenced variably by psychological factors. It is neither recognizable nor evaluable exclusively through verbal description.[3] This means acknowledging, implicitly, the uniqueness of the person who suffers not only as a body but also as a person.

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[2] See https://www.iasp-pain.org/resources/terminology/#pain.

[3] Obviously, the definition and the notes did not satisfy the entire audience of scholars: according to some, tissue lesions still have a preponderant importance in the new definition, given that in chronic pain, the relationship between pain and the condition of tissue is less direct and predictable. Others argued that social damage, such as psychological trauma or abuse, should also be included in the new definition in order to consider all clinically important forms of chronic pain.

The entire debate shows how delicate the question of identifying the concept of pain is, even from a clinical point of view, and to what extent this new kind of sensitivity towards suffering pays greater attention to the complexity of individual experience (Cassell 1994). The question is, however, whether this perspective is actually incorporated into everyday healthcare where the often-dominant biomedical model still fails to provide real support and relief to what Cicely Saunders, founder of the *Hospice Movement*, called "total pain," highlighting its physical, psychological, emotional and spiritual components (Saunders 1967).

III. Thinking the Unthinkable: The Phenomenology of the *homo patiens*

Deciphering pain and making it intelligible is difficult even for philosophy. It is possible to read and interpret its signs, but it is impossible to conceive it, even if one is aware of it. When reflecting on it, as Leonardo Polo states, philosophy needs to abandon the classical issue of its essence, "what it is" and instead examine not so much what pain, but painfulness itself means for the human person (Polo 1999, 207 – 208) It is the condition of *homo patiens* that needs to be explored by reading and interpreting the signs of his suffering (Ricoeur 1994, 14).[4] Hence the distinction (accepted in reality more by philosophers than by scientists) between pain and suffering, where the latter consists in the personal and subjective way of processing physical pain. The first phenomenological datum emerges, in fact, from the notion of the person as a totality, from the "anthropological whole": the mutual involvement of the Husserlian dimensions of the human person, *Körper, Leib, Seele* (Husserl 1913, II), each one inseparable from the other two. If, at biological level, human beings suffer because they are alive and, as such, are capable of feeling physical pain, a necessary alarm bell against the presence of evil, however, they do not simply suffer physical pain, but also interpret it, wish to alleviate it and put an end to it by treating it. The link with death is also undeniable: the people who suffer bodily pain, precisely because they are capable of projecting themselves towards the future, interpret this pain as an omen of death, as a warning of their corporeality and, therefore, their mortality.

There may be, therefore, a discrepancy between the *objective dimension*, the *damage* or injury, and the *subjective dimension* of pain, which regards the personal attitude and re-elaboration of that injury, also dependent on educational and cultural factors. No physical pain can be separated from the

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[4] Paul Ricoeur emphasizes the mutual implication of the clinical, phenomenological and semiological in the understanding of the signs of suffering.

interpretational horizon, which consists of a network of meanings created by culture, education, and lifestyles. An identical pain-inducing stimulus will be experienced in a different way if experienced by the inhabitant of a highly civilized place or by a person living in a developing country, by a Christian or a Buddhist, by an unattached person or one involved in an affective relationship. The experience of that same pain, consisting of tolerance, resignation, the hope of alleviating it, will necessarily vary in proportion to the trust that the sufferers can place in medicine or in the possibility of sharing their pain, or in a religious vision. Tolerance of pain does not, therefore, indicate a threshold of perception, but rather the personal ability of the sufferer to react, also because of cultural factors (Kleinman 1995, 314). Ethnographic methods are increasingly used to show significant cultural differences in both the experience and social perception of disease. There is even talk of "local biologies" or "situated biologies" (Lock – Kaufert 2001), to indicate the unequal social and physical living conditions from one population to another, resulting in a different nosological classification of symptoms and discomforts. In this perspective, biology and culture are in a constant feedback relationship of exchange, in which both undergo variations. Informed by Margaret Lock's work on menopause in Japan this concept has been used to show the contingency and interdependency of the material and the social and underline the need to examine the embodied experience of health and illness in specific local contexts (Lock – Kaufert 2001).

Pain is, therefore, suffered, experienced, and interpreted simultaneously, that is, internalized as an intelligent perception of present or non-present physical ills considered limiting. Husserl distinguishes between "feeling pain" as sensation and "feeling pain" as act: the former (*Gefühlsempfindung*) although not intentional, is always accompanied by an emotional intentional act (*Gemütsakt*), that emerges from the awakening self, turning towards the cause of suffering (Husserl 1901, 365; 398). In this complex experience, it is undeniable that affective, cognitive, and volitional processes also intervene. Paradoxically, if humans are the only living beings capable of seeking cures to alleviate their pain, they are also the only living beings capable of increasing it, thanks, in fact, to their faculties of memory and imagination, as in the case of *psychic* pain. Anxiety, angst, and phobia, although not always triggered by organic factors, usually produce evident physical repercussions, like pallor, lack of appetite and sleep-pattern disorders. What is certain is that "pure" pain, which is neither exclusively physical nor psychic, is an extreme case and cannot be experienced. Humans are also the only beings capable of experiencing *spiritual* pain, suffering felt in the soul, like that arising from nostalgia, mourning, loneliness, remorse, and envy, for example. However, as Buytendijk observes, these experiences, even in their interrogative dimensions, possess a relative "transparency," a certain dose of reasonableness, unlike physical pain, which is, basically, the experience of conflict, explicable perhaps in its origin, though not in its meaning (Buytendijk 1961, 25).

Pain, especially chronic pain, disrupts personal unity and the harmony between the self and the body. Physical suffering reduces the twofold dimension of our corporeality, *having-a-body*, and *being-a-body*, to this ultimate, sole dimension, as Plessner states:

> To be in pain is to be thrown back defenselessly one one's body, and in such a way that one finds no further relation to it. The painful region seems excessively extended, it seems to overspread and entirely displace the remaining regions. We seem to consist of nothing but teeth, forehead, or stomach. Burning, boring, cutting, sticking, knocking, pulling, gnawing, vibrating, pain acts as an invasion, destruction, a power swirling into a bottomless deep (Plessner 1970, 132).

The organs become a kind of force that revolts against the self: the result is loss of "metaphysical lightness" (Scheler 1933, 59), of that serene oblivion of our mortality, while the center of gravity of existence shifts from the world to the suffering body. One tries, in vain, by hunching and curling up, to escape from one's body into a pain-free zone of the self, in hopes of experiencing some respite, but this at the price of renouncing oneself. In the case of transitory pain, it is also possible to resort to distraction aimed at reducing the intensity of the sensation by turning one's attention elsewhere, like when one recurs to relaxation techniques and the soothing effect of analgesics. Kant, writing to Hufeland about his nocturnal attacks of arthritis, confided that he was able to control them by turning his attention elsewhere (Kant 1798, 6 – 8).[5]

In the case of chronic pain, on the other hand, one ends up becoming the intruder of one's own existence, as if one were at the mercy of a disruptive power that upsets subjectivity, from which one seeks, in vain, to distance oneself (Jantzen 2011). The suffering that arises, during the transition from perception

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[5] Today there is now a growing emphasis on mind-body techniques for controlling chronic pain: from the cognitive behavioral therapy, to yoga, meditation, hypnosis and relaxation procedures. Most of these technics have both a cognitive component, such as attentional focus, and an emotional component. Meditation has been shown to associate with low pain sensitivity and may have a neuroprotective effect (Zeidan 2011).

to affection and from affection to emotion, always consists of moving affectivity. For this reason, Buytendijk believes that the qualification of pain exclusively as a feeling fails to express its dynamic and centrifugal character adequately, thus obliging the subject to react and experience his/her own situation as an effort (Buytendijk 1961, 113). This is what Bergson claims in *Matter and Memory*:

> Every pain, then, must consist in an effort, – an effort which is doomed to be unavailing. Every pain is a local effort, and in its very isolation lies the cause of its impotence; because the organism, by reason of the solidarity of its parts, is able to move only as a whole (Buytendijk 1911, 56).

This "effort" should be seen as a powerless reaction to a sensation or perception, as "an ineffective activity that turns, therefore, into a representative expressive movement and leads to 'living' resistance, to real suffering" (Buytendijk 1961, 115). Painfulness, as the sensation and perception of an unpleasant stimulus that provokes a tendency to flee, an aspect shared with other animals, needs to be distinguished, therefore, from the experience of one's inability to distance oneself from the feeling of impotence caused by the awareness people have of themselves. This sense of constriction and helplessness often finds expression in lamenting and screaming, even before it is described.

> Pain makes you scream, but it also makes you fall silent, drives you mad or petrifies you, makes you complain or withdraw into yourself, seek companionship and sympathy or solitude and neglect. Here the compulsion to turn towards or away corresponds to an urge to reveal or conceal (Weizsäcker 1926, 317).

Crying and groaning are the most immediate and spontaneous forms of communication triggered by a painful experience, where it is the body itself that becomes language. According to Plessner, although crying is an involuntary reaction, it is not an irrational response. The rupture with the body, manifested through crying constitutes a "reaction endowed with meaning" that is not simply endured. The fact that people lose control of themselves and permit themselves to enter into a sort of state of physical automatism, bears witness to the extraordinary nature of a situation, to which they, being rational beings, perceive no possible rational answer (Plessner 1970, 67). Human beings, as "corporeality in the body," tend to introduce a gap between themselves and what is outside of them, between themselves and their bodies: they are *eccentric* beings, who dwell in the world and govern their bodies. Faced with extreme situations, when it is impossible to provide rationally adequate responses through gestures or language, because the "normal" gap between the body or the world disappears, disorientation, a "giving up in defeat" takes place which triggers crying as a reaction. In sinking – Plessner continues – "below his level of controlled, or at least articulated, corporeality, he directly demonstrates his humanity: to be able to deal with something at the point where nothing further can be done" (Plessner 1970, 142).

The lament, unlike weeping and screaming, constitutes a transition from the body to the word, a sort of invocation; it challenges the other as a request for recognition to escape from the isolation into which pain encloses the sufferer. Although inarticulate, the lament marks the transition from the biological to the symbolic, from the somatic to language.

The lament expresses the unconscious need for confirming one's existence to oneself, even before being an unconscious demand to be heard and helped. A rift opens between the desire to say and the impotence of saying. In this fracture the will to say finds the way to lament. Those who complain express the need to continue to be, to exist, to reconstitute a subjectivity that pain risks shattering. According to Buytendjik, however, the groan is configured as a vital function, not a personal act, expressing the attempt to distance oneself from pain, "a discharge of a pathetic emotional state and, above all, an escape from oneself" (Buytendjik 1961, 128). In any case, hearing a lament is disturbing and, faced with the powerlessness of bringing immediate relief, the temptation to impart the order to be silent is nearly always the first spontaneous reflexive response. But one of the characteristics of the lament resides in the fact that it increases in the face of this demand, like a spring that releases water with greater force the more it is compressed.

Acquisition of the ability to describe and narrate suffering represents the next step. It means conducting an unthinkable object back into the order of the thinkable. If pain is a "breach of the narrative thread," an interruption of a person's biographical continuity atomized in an instant, storytelling contributes not only to reconstructing personal identity, but also to repairing the tear generated in the "internarrative warp," that is, in the stories of those of whom our story constitutes a segment (Ricoeur 1994, 60).

Leaving aside literary narrative, which has recently given rise to several "patho-autobiographies," so much so, that it has inaugurated a new literary genre (Frank 1995), it is interesting to analyze the possibility of describing painful experiences, also in view of relationships of care. Bringing pain into language is an undertaking that is so essentially complex that it is considered impossible, as held, for example, by Virginia Woolf (Woolf 1926, 32 – 35)[6] and Elaine Scarry (Scarry 1987).

In the literature of medicine and nursing, the question of understanding a patient's experience of pain, falls, therefore, within the context of the adequacy or, on the contrary, the insufficiency of language as a medium by which to describe it. If pain is to be considered a "private object," then its communicability will always be insufficient, if not downright impossible. This perplexity was expressed by Wittgenstein, when he asked whether a "private language" could exist to express intimate experiences and feelings, such as pain, that would remain incommunicable and, therefore, inaccessible to others (Wittgenstein 2009, § 243. For the philosopher, assuming the existence of a "private" language would mean destroying the possibility not only of intersubjective discourse, but also of a subject's dialogue with her/himself. However, the difficulty a patient encounters when seeking to describe the experience of pain is undeniable: it is often necessary to decode the external "signs" and contextualize them in a specific social and cultural framework. In medical literature, some consider it significant to consider chronic pain a social phenomenon, and therefore allow patients to use language of their "own" (Sullivan 1999). Others consider it important to encourage the use of figurative language, of universal metaphors, of which narrative provides a vast array, can break through the ceiling of the ineffability of pain and permit healthcare professionals to participate in it (Biro 2010).

Undoubtedly, metaphorical expressions perform a central function in the language of neuropathic pain. Some investigations have identified three fundamental metaphorical categories employed by patients: pain as physical damage, pain as physical properties of elements and pain as a transformative force, whereby patients perceive themselves in a different place, state, or entity because of their pain (Hearn 2016). Two difficulties need to be overcome when faced with modes of expression. One regards patients, who due to poor literacy may not find adequate images. To overcome this obstacle, several studies obtained from the healthcare practice have led to the development of a "metaphoric menu," a collection of quotations from patients that may prove useful to those who have been diagnosed with cancer, to facilitate verbal expression of their suffering (Semino 2014; Russo 2021). Because of the retroactive effect that language can have on thought, pain might be alleviated by

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[6] Woolf states: "The merest schoolgirl, when she falls in love, has Shakespeare, Donne, Keats to speak her mind for her; but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry. There is nothing ready made for him." (Woolf 1926, 34).

making less catastrophic images available to express one's experiences (Gallagher 2013).

A second difficulty may be represented by healthcare personnel, who, due to their reluctance to listen or their insufficient semantic competence, may be induced to ignore, minimize, or misunderstand the pain of a patient if expressed in metaphors. Some authors define "narratology distress" as the condition caused by both the physical pain itself and by its social delegitimization (Lavie-Ajayi 2012, 192 – 200). Failing to shape their own painful experience – elusive and complex – into a coherent narrative, faced with the skeptical reaction of the family or health professionals, people with chronic pain end up doubting their own feelings and bodily sensations.[7] Distinguishing the boundary between the real and the imaginary, between the sensory and the emotional, often translates, therefore, into the essential task of interpreting pain successfully. To this end, several training courses for healthcare professionals include *Medical Humanities* modules, which, among other things, favor the development of the narrative imagination, essential for an empathic understanding of patients' stories (Sanders 2009).

V. The Need for an Integrated Approach to Decoding and Interpreting Painful Experiences

Contrary to what Woolf and Scarry asserted, therefore, pain can be spoken about, although it is necessary to determine by whom and how. The multiplication of different pain-measurement scales over the years shows that it is not easy to know and interpret such a multifaceted, personal phenomenon, especially where communication is difficult, as in cases involving children or elderly people suffering from a deterioration of their cognitive faculties. It was discovered that "one-dimensional scales," like the *Numerical Rating Scale* (NRS), the *Verbal Rating Scale* (VRS) or the *Visual Analogue Scale* (VAS), used to assess the intensity of pain, are not sufficient to describe its complexity, especially in cases of chronic pain. While it is relatively easy for the patient to localize pain and indicate activities that have been reduced or interrupted due to pain, the memory of the intensity of pain can be more nuanced, even distorted (Hjermstad 2011). Hence the need to introduce "multidimensional scales," such

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[7] A patient thus confides his distress: "I was in excruciating pain, my muscles were locked and all the time like excruciating pain and the pain moves from place to place. And the doctors started to say to me 'maybe you should see a psychiatrist, maybe you take it too hard, you believe in a pain that does not exist anymore' and all kinds of stuff like that. To be honest I did start to think seriously about it. I started to think that something in my head was wrong and maybe I create the pain myself" (Lavie-Ajayi 2012, 196).

as the *McGill Pain Questionnaire* (MPQ) (Melzack 1975), which uses an abundant range of adjectives in an attempt to embrace as many aspects of pain as possible. However, these are tools that require the patient to be able to self-evaluate his/her pain, even before being able to express it. Therefore, scales for non-collaborating subjects were introduced: the Abbey Scale, which observes affective and behavioral changes; the *Pain Assessment in Advanced Dementia Scale* (Painad), for people with a cognitive impairment which focuses on the observation of body language and the *Face Pain Scale* (FPS), used with children. Of all the non-verbal signs of pain, facial expression is the indicator that has been studied most thoroughly, while more recently some attention, though still quite rare, is being paid to "vocalization," to the vocal production of sounds, noises, and words, like moaning, groaning, crying, sighing, often included generically among the behavioral indicators. However, this element is one upon which temperament, education and level of development undeniably impact and to which other significant indicators should be associated (Helmer 2020).

From what has been said so far, a new kind of sensitivity emerges which, even if not always included in the healthcare practice, is very much present nowadays in medical and nursing literature. This is the need for a relationship of care centered more on the patient's needs and on paying attention to the story of her or his experiences of pain, not only for diagnostic purposes but for an overall understanding of her or his experience. I intentionally used the term "story," because it is more than just "communication": the transmitter often expresses her/himself in an obscure or metaphorical way; at times the transmitter is the patient's own body, and the code of the messages is all that needs to be discovered and interpreted. It is necessary, therefore, that doctors renounce their claims of transparency, which might lead them to dismiss the patients' discourse or signals in haste, framing them in the light of several similar cases, thus ignoring the purely individual dimension of the patients' experience of suffering.

Pain appears paradoxical, as it is an experience that needs to be shared or at least understood if it is to be cured, without, however, ever being fully understood or shared. This paradox is a challenge for the doctor: that of being able to access the suffering individual without limiting him/herself to deal with the pain only (Hirsch 2019). It can be said, therefore, that we are faced with the duality of suffering: the suffering of the patient, who wants and needs to describe it to make it objective; the suffering of the physician who, to alleviate pain, needs to bring it closer to the boundaries of the subjectivity to which it is initially foreign.

However, these two levels of knowledge are not incommensurable. While the most appropriate explanatory model for investigating pain is an integrative pluralism, which integrates the different types of knowledge provided by the different disciplines (Mitchell 2009), it is in the caring act that we go beyond the explanation of the phenomenon to an understanding of individual experience.

In our own bodies we experience a "subjective" dimension, i.e., self-consciousness, experience, expressiveness, and at the same time an "objective" dimension, in that the body is visible, objectifiable, and manipulable. In the subject's innermost self, biology is always biography. The disequilibrium caused by pain demands to be recomposed through a relationship and a caring practice that recognizes the individual person in its complexity and unity, according to a philosophical view. An exclusively empiricist view reduces pain to its neurobiological causes, but without really reaching the suffering subject. This causal model may be an explanation, but certainly not a deeper understanding. Objectivity and subjectivity are reconciled in a therapeutic praxis capable of addressing the patient as a person and interpreting his or her narrative, more or less articulated, as a request for recognition.

In an authentic therapeutic relationship, the history of the patient's illnesses becomes a personal history, no longer part of a technical-scientific scheme that standardizes the subjectivity of the patient in a statistical anonymity. It is only by starting from the subject's experience that the physician learns to better understand the singularity of his or her fragility and suffering and can succeed in elaborating adequate and shared treatments.

VI. Conclusion

The above reflections show how necessary and fruitful the integrated approach between science and philosophy is. The former still has many goals to achieve when it comes to exploring painful phenomena, the causes of which are unknown or for which there is no adequate treatment at present. However, scientists themselves nourish reservations regarding the possibility of devising extremely powerful analgesic or genetic engineering procedures capable of producing "pain-free" subjects in the future. Pain continues to perform the biological function of preventing damage and teaching us to avoid future injuries and is a necessary part of many processes involved in recovery from injury. Therefore, commitment to the abolition of unacceptable aspects of pain needs to be integrated with the hermeneutic sensitivity required to take care of the suffering in daily healthcare practice.

The question of pain remains an exquisitely philosophical one: as an indicator of fragility, it is an invitation for sufferers to seek meaning; as a request for relief, it is addressed to carers; it is an invitation for therapists to show solicitude and compassion.

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