„Analiza i Egzystencja" 70 (2025), 73–91
ISSN (print): 1734-9923
ISSN (online): 2300-7621
DOI: 10.18276/aie.2025.70-03

ARTYKUŁY

ADRIANA JOANNA MICKIEWICZ
Jagiellonian University
ORCID: 0000-0002-7090-9987
email: adriana.mickiewicz@wp.pl

Wounded Body: A Phenomenological Attempt to Define Physical Pain

Keywords: pain, nociception, suffering, philosophy of medicine, phenomenology
Słowa kluczowe: ból, nocycepcja, cierpienie, filozofia medycyny, fenomenologia

Abstract

The article proposes a definition of pain, starting from the analysis and critique of existing definitions in the literature, including those from medical science and philosophy. The author then offers her own proposals, focusing on distinguishing pain from nociception and suffering.

Introduction

The ongoing debate among medical science, cognitive science, and philosophy regarding the definition of physical pain, which began in the second half of the 20th century, remains unresolved. This is partly due to the varying goals and assumptions of these disciplines, but primarily because of the phenomenon's complexity. Pain manifests in numerous forms (e.g., acute, chronic, mild, localized, whole-body, throbbing, stabbing, radiating), and is perceived by individuals in diverse ways. Additionally, pain comprises multiple components, including anatomical, emotional, cognitive, and social aspects.

The establishment of a comprehensive definition of pain is not merely a theoretical exercise: it is imperative for comprehending its profound therapeutic implications. A comprehensive definition aids not only in classifying patients' varied experiences, but also in delineating treatment and therapeutic procedures. Proposals for definitions reflect researchers' underlying assumptions regarding, for example, their conceptualization of corporeality, particularly regarding the body-mind relationship.

In this article, I aim to define physical pain from a phenomenological perspective. Pain is to be understood primarily as the complex lived experience of the subject. Within the phenomenological tradition, the subject is regarded as embodied and as being-in-the-world, inherently relational and interconnected with other human and non-human beings. Phenomenology is particularly well-suited as a philosophical method for studying the subjective experiences of the subject. Through methods such as phenomenological reduction, it allows for the exploration and analysis of the structures underlying these experiences. In the case of pain, this complex phenomenon encompasses biological, psychological, and social factors. Starting from vivid, subjective experiences is especially relevant for describing physical pain, which, as I will demonstrate later in the article, resists the medical perspective that treats pain exclusively as a biological process.

Pain is a phenomenon that has interested phenomenology virtually from the very beginnings of the movement. Considerations of it already appear in the precursory writings of Husserl's immediate teachers Franz Brentano (2009, pp. 63–65; 1907, pp. 119–125) and Carl Strumf (1917). These authors, however, did not analyze pain *per se*, but used it as an example for considering the nature of mind and intentional relations. When discussing Brentana's theses on the example of physical pain, Strumf tried to show that not all mental states are intentional. In a similar context, pain also functions in the writings of Husserl, who, following in the footsteps of his teacher, presented further arguments for the non-intentionality of physical pain (2001, especially pp. 109–112). The main goal, however, was not to analyze pain, but intentionality.

Physical pain also appears as a significant theme in French phenomenology, particularly in the works of Sartre (1993, pp. 331–339) and Henry (2015) as part of their explorations of corporeality. However, in their writings, pain functions more as an illustrative example or a peripheral topic; the authors do not focus on defining pain itself. Addressing this gap is therefore crucial.

Contemporary phenomenological methods are occasionally used to describe patients' experiences of chronic pain (e.g., Svenaeus, 2015), to analyze verbal and non-verbal expressions of pain (Miglio & Stanier, 2022), and to explore intersubjective components of pain (Stanier & Miglio, 2021; Kono, 2023). However, phenomenologically grounded definitions of physical pain remain rare. A notable exception is the study by Saulius Geniusas (2015), which I will examine critically later in this article. His proposed definition, while insightful, contains significant gaps. For this reason, I propose my own definition, drawing on both the IASP framework and Geniusas's contributions. It is important to note that the considerations I propose are not confined to philosophy. Phenomenology can engage in interdisciplinary dialogues with various philosophical perspectives and fields, including psychology, medicine or sociology.

This article begins with a review of the main definitional proposals in the literature, with particular attention to terminologies adopted by leading research institutions and independent scholars. I will organize the concepts along two axes that delineate key areas of dispute. The first addresses the transition from understanding pain as a physiological mechanism to viewing it as a personal, subjective experience. This debate is closely linked to the broader discussion on biological reductionism versus anti-reductionism. A central question is the extent to which pain can be reduced to a purely physiological mechanism. Most contemporary scholars agree that pain transcends anatomy. However, in resisting reductionism, some authors take equally extreme positions, seeking to completely dissociate pain from its physiological basis (e.g., Henry, 2000/2015). I argue that both extremes should be balanced.

The second axis addresses the distinction between physical pain and suffering. Some researchers attempt to separate these phenomena by associating physical pain with the material body and suffering with the disintegration of identity or personality (see Cassell, 1991, pp. 32–37; Charmaz, 1983; Fishman, 1992; Ricoeur, 2013) or negative affects (Bueno-Gomez, 2017; Devish et al., 2017; Dillane, O'Sullivan, Di Blasi & Murphy, 2021; Yager, 2021). Others contend that such a separation should be abandoned (e.g., Shapiro, 1999), emphasizing the interplay between the two: psychological suffering often manifests somatically, while tissue damage can induce psychological discomfort. In this article, I argue for

the usefulness of distinguishing suffering from physical pain while acknowledging that in most cases they are interconnected.

I will begin by addressing these two issues, which will form the foundation for my own proposed definition of pain, designed to address both challenges.

From Nociception to Lived Experience

The understanding of pain in medical discourse typically focuses on its physiological aspects, such as the timing of tissue damage and the complex process of nociception. Nociception refers to the neuronal processes involved in encoding and processing noxious stimuli (see Kendroud, Fitzgerald, Murray & Hanna, 2022). These stimuli can have both physiological and psychological dimensions; for example, a traumatic experience can result in physiological tissue damage.

While I do not intend to diminish the importance of medical science in understanding and addressing the physiological mechanisms of pain, contemporary researchers, including those affiliated with medical institutions, often point out the limitations of this approach. By reducing pain to nociception, medical discourse confines its understanding to an objectified, third-person perspective. Consequently, it fails to capture pain as a subjective experience lived by the individual.[1]

Moreover, nociception does not account for instances in which individuals experience pain in the absence of any discernible tissue damage or external stimulus, as is often the case in chronic pain patients. These limitations have led many researchers to describe pain as a first-person feeling, sensation, or lived experience (e.g., Scarry, 1985; Geniusas, 2020). Despite subtle differences among these terms, they collectively stress the need to incorporate a first-person perspective into the study and understanding of pain. This is consistent with the widespread belief that pain is an inherently subjective and private experience (e.g., Aydede, 2005; Scarry, 1985; Geniusas, 2020).

[1] An analogous argument can be made here for Thomas Nagel's famous thesis in his article *What is it like to be a bat?* (1974) Nagel argues that even a complete understanding of the bat brain will not provide us with the phenomenological experience of a bat or the way the bat experiences reality. Similarly, knowledge of anatomical mechanisms is insufficient to capture the way pain is experienced.

No amount of physiological knowledge can enable one to fully comprehend another person's experience of pain.

The most widely accepted definition of pain, especially in the medical field, was provided by the International Association for the Study of Pain (IASP) in 1979. Pain was defined as "an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (Merskey & Bogduk, 1994, p. 209). This definition is practical in clinical settings because it allows clinicians to identify pain based on two criteria: observed tissue damage or the patient's verbal communication of pain. The patient can be assumed to be in pain either at the time of observed tissue damage or at the time the pain is communicated. The 1979 definition also acknowledges the role of both somatic and emotional factors in the experience of pain. Additionally, it introduces the concept of anticipatory pain by referring to potential tissue damage. For instance, a patient in a dentist's chair might feel pain at the mere sight of an approaching drill, even before any actual damage occurs.

However, this definition was subject to considerable criticism, particularly since the 1990s. The main objection was its alleged Cartesianism. Critics argued that the definition implicitly upheld a strict separation between physical and mental elements (Shapiro, 1999, pp. 101–102). Secondly, researchers criticized the emphasis on verbal description, which excludes those unable to communicate their pain, such as newborns or animals. (Anand & Craig, 1996, p. 3; Shapiro, 1999, p. 100). Moreover, some researchers argued that the IASP definition failed to address the cognitive and social dimensions of pain (Williams & Craig, 2016, p. 2421). Critics also argued that the term "unpleasant" trivialized the severe and traumatic nature of many pain experiences (Williams & Craig, 2016, p. 2421).[2] Another objection addressed the words "associated with." The phrase implied a statistical rather than causal relationship, prompting Aydede to suggest replacing it with "paradigmatically results from" (2019, pp. 4–5).

In 2020, the IASP introduced a revised definition: "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (Raja et al., 2020). This update marked a shift away from verbal descriptions and incorporated the term "resembling," acknowledging that pain caused by tissue

[2] The above allegations are dealt with very effectively by Aydede (2019).

damage serves as a paradigmatic example rather than the sole form of pain. According to the IASP, pain can occur in the absence of tissue damage. The patient then recognizes their sensation as pain because of its similarity to other experiences that were clearly related to tissue damage. The revised definition also included six complementary notes, highlighting the subjectivity of pain, its distinction from nociception, and the role of non-verbal communication.

While the updated definition addressed some criticisms, it was only a modest revision. For a fuller understanding, it is worth exploring alternative definitions.

Alternative Definitions

Another proposal for understanding pain was put forward by Milton Cohen (Cohen, Quinter & Rysewyk, 2018, pp. 5–6), who understood pain as "a mutually recognizable somatic experience that reflects a person's apprehension of threat to their bodily or existential integrity." This definition, however, has significant shortcomings. The phrase "mutually recognizable" implies that pain can be understood from a third-person perspective, which is problematic given the subjective nature of pain. While pain can be described and communicated, empathic recognition of another's pain remains incomplete, as one cannot directly feel another's somatic experience.

Increasingly, research is highlighting the interpersonal and even social dimensions of physical pain (Stanier & Miglio, 2021; Kono, 2023). Pain can be both described and communicated to others through a variety of verbal and non-verbal methods—ranging from verbal descriptions and medical questionnaires to facial expressions and bodily gestures (see, for example, Dubuisson & Melzack, 1976; Miglio & Stanier, 2022). This is especially relevant in medical practice, where an accurate description of pain is often critical for effective diagnosis and treatment. However, empathic recognition and understanding of another person's pain remains inherently limited. One cannot fully experience another's somatic sensations; at best, one can imagine them. At its core, pain is a deeply private and subjective experience. This fundamental subjectivity can, at times, hinder mutual understanding. For instance, people with chronic pain may learn to suppress or mask their expressions of discomfort, making their pain effectively invisible

to others. This lack of visibility poses a challenge to mutual recognition, especially when the observer is unaware of the underlying condition. As a result, the term "mutual recognition" may not adequately capture the nuances of these interactions.

Moreover, Cohen's definition does not account for cases in which pain is not clearly related to bodily harm, such as chronic pain. Thus, the other conditions of Cohen's definition are also questionable. Such an example would be, for example, chronic pain, which often occurs in people who are not physically harmed. It also fails to differentiate between pain and suffering, particularly in cases involving the somatization of mental health issues.

French phenomenologist Michel Henry's perspective on pain is diametrically opposed. The author offers a phenomenological account of pain, placing it in the context of embodiment and incarnation. He distinguishes between the *corps* (the objective body) and the *chair* (the flesh). While the *corps* is accessible from a third-person perspective, the *chair* represents the subjective, lived experience of the body, immune to thematization. Flesh is always lived and can never become an object of experience. (Henry, 2000, pp. 2–3). According to Henry, pain is rooted in the *chair*, experienced as a pure immanence without external reference. This due to the luck of clear separation between the subject of an experience and the object of their encounter. Henry acknowledges that pain has no object, is not about anything, and represents nothing. Pain refers only to itself. In pain, the subject experiences pure immanence (Henry, 2000, pp. 84–85).

While Henry's perspective highlights the subjective nature of pain, his strict distinction between the *corps* and the *chair* and his reduction of pain to a purely immanent sensation overlook the multifaceted nature of pain, which includes social and material dimensions. Linking pain exclusively to an immanent sensation limits the potential for reflecting on its causes, which are often rooted in material factors. Although pain cannot be reduced to nociception alone, nociception is frequently a significant aspect of pain, and effective pain management relies on understanding its physiological mechanisms. In addition, non-subjective factors, such as social influences, play a substantial role in shaping how people experience pain. Menstrual pain is a pertinent example: in this context, pain can be exacerbated by an internalized sense of shame stemming from societal taboos surrounding female physiology (see, e.g., Wiggleton-Little, 2024). These examples demonstrate that pain is more than an isolated, immanent sensation existing

independently of external factors. Both reducing pain to a physiological mechanism and confining it to the subjective experience of the individual are oversimplifications.

Saulius Geniusas offers a more nuanced perspective, distancing himself from the necessarily universalistic framework of medical discourse. He argues that understanding pain must be grounded in first-hand experience, adopting a phenomenological approach. In his work *Phenomenology of Pain*, Geniusas defines pain as "an aversive bodily feeling with a distinct experiential quality, which can only be given in original firsthand experience, either as a feeling-sensation or as an emotion" (Geniusas, 2020, p. 42). The last part of this definition warrants further discussion.

Geniusas conceptualizes pain as a stratified phenomenon. At its most fundamental level, pain manifests as a pure, immanent feeling-sensation: a subjective, undeniable, and directly given experience. At this level, pain is not an object of consciousness but a pervasive mood through which consciousness operates. Pain here is experienced rather than known. However, pain can ascend to a higher level of awareness, becoming the content of consciousness. When this occurs, the individual begins to conceptualize their experience in an affective-cognitive way. Pain transitions from being a simple, immanent sensation to a complex emotion. At this stage, the individual may reflect on the causes of their pain, its social dimensions, or its broader existential significance. Geniusas asserts that pain as a feeling-sensation is its most fundamental dimension. While additional layers are not strictly necessary—pain can exist solely as a feeling-sensation—they complement and enrich the experience, providing a fuller understanding of pain (see Geniusas, 2020, pp. 42–67).

Geniusas extends his definitions to explore forms of pain that go beyond typical, everyday experiences. For instance, he examines the phenomenon of asymbolia, in which individuals recognize a sensation as pain but do not associate it with unpleasantness. In such cases, pain is experienced as a neutral sensation, devoid of suffering. Geniusas views this as an example of pain limited to its most basic layer of feeling-sensation, without constituting a complete experience of pain (Geniusas, 2020, pp. 85–93). Other examples of incomplete pain experiences discussed by Geniusas include unconscious pain, congenital insensitivity to pain, and the experiences of lobotomy patients. Extreme pain experiences, such as those described by Elaine Scarry, could also be understood in this context.

Scarry's study of torture victims' memories revealed that, under extreme suffering, consciousness is reduced to the sensation of pain itself, with the external world fading into irrelevance (1985). In such cases, pain is reduced to its most basic feeling-sensation layer, preventing the full experience of pain. For for the vast majority of people, however, pain is a multifaceted experience encompassing emotional, cognitive, and, although Geniusas underemphasizes this point, social components.

There are several advantages to discussing pain as a stratified phenomenon. This perspective situates pain not only as an immanent, individual sensation but also within broader emotional, social, existential, and therapeutic contexts. Stratification explains the diverse ways in which pain is experienced, from immanent bodily sensations to intersubjectively communicable pain described to a medical professional; from unconscious pain (e.g., back pain unnoticed while engrossed in work) to pain analyzed in self-reflection. This layered understanding facilitates a more comprehensive approach to management that includes both individual and social dimensions.

The stratification of pain also enables a clearer structuring of its components. Simply stating that pain is complex adds little to contemporary discourse, as psychological and medical research already emphasizes its biopsychosocial nature, combining biological, psychological, and social elements. Geniusas's concept, however, identifies the essential elements of pain and their hierarchical relationships. Through a phenomenological reduction, he isolates the fundamental properties of pain: it is primarily a subjective, immanent feeling-sensation that is necessary to classify an experience as pain. A fuller, holistic experience of pain, however, unfolds within the subject's lived world, encompassing social, cognitive, and emotional dimensions that remain secondary to the core sensation.

Geniusas's definition centers on first-hand experience, transcending strictly medical frameworks that view the body and pain from an external perspective, as mere symptoms of disease. It places greater emphasis on the individual's subjective experience of physical pain. The main drawback of his approach is its lack of precision. While Geniusas highlights the importance of distinguishing pain from other unpleasant bodily sensations, his use of the phrase "distinct experiential quality" as a defining characteristic is ultimately unsatisfactory. The failure to specify what the characteristic is that distinguishes pain from other experiences actually weakens the validity of the definition.

Pain and Suffering

Distinguishing physical pain from psychological suffering presents a significant challenge because these experiences often overlap and resist clear delineation. Consequently, any attempt to separate them is inherently somewhat artificial. Mental suffering, for instance, can somatize and manifest physically, leading to symptoms such as muscle pain, stomach cramps, or migraines, among others. At the same time, physical pain is deeply intertwined with emotional responses. Pain can cause irritability, exhaustion, and feelings of isolation because no one else can fully share the subjective and private experience of another's pain. Prolonged exposure to pain often leads to serious mental health issues.

Psychological research highlights the bidirectional influence of emotions on the somatic experience of pain. For example, tension and the anxious anticipation of pain can amplify its unpleasantness when it finally occurs (Suchocka, 2008, p. 78). Additionally, depressive moods and psychological distress increase the likelihood of acute pain evolving into chronic pain (Pincus, Burton, Vogel, & Field, 2002). Studies indicate that positive emotions, such as gratitude and a sense of agency, can enhance pain tolerance (Di Blasi, Dillane, & Murphy, 2021). These interactions underscore the need to move beyond Cartesian dualism to acknowledge the human being as a psychophysical whole (Craig, 1984; Craig, 2011).

Barbara Schapiro also questions the validity of strictly separating physical pain from psychological pain (1999). In her view, any form of pain can be described in both physiological and psychological terms, although the relevance of each perspective may vary depending on the clinical context.

That said, it is essential to recognize that some forms of physical pain neither stem from psychological problems nor have significant psychological consequences. For instance, if someone accidentally bumps my elbow, I may feel pain. This sensation arises solely from the other person's inattention, not from my mental state. The pain will be brief and mild, possibly momentarily distracting, but it will not lead to lasting emotional distress.While I undoubtedly experienced pain in this scenario, describing it as suffering would be an exaggeration. This example illustrates the importance of maintaining a conceptual distinction between the two.

Suffering is often defined in relation to the individual as a psychophysical whole, whereas pain is typically understood as a localized sensation within the body. Nevertheless, these spheres are interconnected. Polish psychiatrist Krystyna Walden-Galuszko (2007) proposed a model of pain as a multistage experience. She identified four stages: (1) the initial sensory perception of the pain stimulus, followed by (2) an affective response, the feeling of unpleasantness, then (3) suffering—characterized by complex emotional reactions such as anger, anxiety, or depression—and, finally, (4) the behavioral expression of pain. This model illustrates how suffering can emerge as part of the pain experience, yet remain distinct from the initial bodily sensation.

One of the most significant theoretical attempts to differentiate between pain (*douleur*) and suffering (*souffrance*) comes from Paul Ricoeur (2013). Ricoeur acknowledges that his distinction is primarily conceptual and that in practice, pain and suffering often overlap. Nevertheless, he emphasizes the importance of maintaining a theoretical separation. In his framework, pain refers to sensations localized in specific parts of the body or experienced throughout it. Suffering, on the other hand, involves a disruption of introspection, language, self-understanding, and one's relationship to meaning. Ricoeur defines suffering as a disintegration of the subject's integrity, affecting fundamental aspects of identity such as one's sense of belonging in the world, capacity for intentional action, relationships with others, and linguistic expression. Put simply, pain impacts the body, while suffering disrupts the self.

Eric J. Cassel, a key figure in humanistic medicine theory, proposed a similar perspective on pain and suffering. Cassel's work critiqued traditional evidence-based medicine for upholding a Cartesian distinction between body and mind. This dualism often overlooked the psychological dimensions of pain and rendered the patient's mental suffering invisible within medical practice. Cassel acknowledged that pain involves, but is not limited to, nociception. The physiological mechanisms of pain are invariably accompanied by a process of individuation, in which individuals ascribe meaning to their sensations. Nonetheless, pain remains closely tied to anatomical factors.

Cassel also observed that suffering can often be somatized. He defined suffering as "the state of severe distress associated with events that threaten the intactness of the person" (Cassel, 1991, p. 33). The distinction between

pain and suffering, according to Cassel, lies in the latter's capacity to disrupt a person's sense of self. Suffering negatively affects relationships with both others and with oneself. In the face of suffering, a person's perspective can shift dramatically: what once seemed important may lose its value, and prior goals may dissolve into a sense of overwhelming hopelessness. Pain, by contrast, only leads to suffering in extreme circumstances, such as unrelenting pain or pain perceived as having no hope of relief. In most cases, pain does not necessarily result in a disruption of identity. For this reason, Cassel argued that pain and suffering are qualitatively distinct phenomena.

However, defining suffering as a disruption of the subject's integrity poses several challenges. First, this concept rests on questionable anthropological assumptions, particularly regarding the nature of personhood. It presumes coherence and completeness as defining characteristics of identity. Yet, as some scholars argue, personality is not a static or unified entity. Instead, it is a dynamic, ever-changing web of experiences, beliefs, and unconscious influences. If integrity itself is unstable and fluid, how can suffering be consistently defined as its disruption? (Svenaeus, 2014; Bueno Gómez, 2017).

Second, suffering does not always result in a loss of identity. While suffering is often associated with alienation or a loss of meaning, it can also enable individuals to discover new meaning in their lives. For some, suffering prompts a re-evaluation of values, fostering new insights and a deeper understanding of oneself (Bueno Gómez, 2017). Hence, it may be more appropriate to speak of the effect of suffering on the transformation of self-understanding.

A New Proposal

In conclusion, definitions of pain face two major challenges. First, is it possible to reduce the experience of pain to a physiological mechanism? Second, is there a qualitative difference between pain and suffering?
Most authors agree on some fundamental aspects of physical pain, such as:

- Subjectivity (pain is only experienced in a first-person perspective, I cannot experience someone else's pain)

- Locating in the body (whereby there is no consensus on the understanding of the category of body as well as the relationship between body and subject)
- Pain has an important emotional dimension
- Unpleasantness, aversiveness

These characteristics include essential and necessary aspects of pain; however, they remain insufficient. Phenomena distinct from pain—such as suffering, disgust, fatigue, or anxiety—may share some of the characteristics outlined above. For this reason, I propose my own definition of pain, building on previous concepts. My primary point of reference is Geniusas's stratified concept of pain, which acknowledges the various dimensions of this complex experience. However, unlike the author of *The Phenomenology of Pain*, I aim to incorporate the physiological dimension, specifically the phenomenon of nociception. I believe that excluding this process from our understanding of physical pain results in an overly narrow perspective. Pain focuses our attention on the body as a network of material organs subject to biological processes and external threats. However, this does not imply that pain is reducible to nociception. My definition, therefore, is as follows:

Pain—a repulsive and discomforting sensory and somatic experience that can only be experienced in the first person and usually results from actual or potential tissue damage. Pain is a stratified experience, encompassing both fundamental, intra-corporeal and immanent sensations, and emotional--cognitive ways of grasping these sensations.

Let us analyze this definition in detail.

Repulsive and discomforting: I deliberately avoid the term "unpleasant" because there are contexts in which pain can be perceived as pleasant. In most cases, pain is both an unpleasant and undesirable experience. This unpleasantness serves one of pain's primary functions: signaling threats to the body or indicating a state of disease. The subsidence of pain can also signify the effectiveness of treatment. Thus, the unpleasantness of pain contributes to its warning and informational functions (Trachsel & Cascella, 2019). However, there are instances in which pain is not perceived as unpleasant. For example, masochistic practices, intense exercise, or deep tissue massage

can induce pain that is either neutral or even pleasurable. A definition that treats "unpleasantness" as a necessary aspect of pain fails in such cases and is, therefore, inadequate. Instead, I use the broader and less judgmental term "repulsive."

For example, during an intense massage, I might experience pain that feels repulsive, which I might express through physical reactions (e.g., wincing, flinching, or gritting my teeth). Yet, I can simultaneously derive pleasure from the experience. By using "repulsive," we risk the accusation of trivializing pain. While severe pain can be life-altering, not all pain is intense. Some pain produces only a brief and harmless sensation of discomfort. Thus, the terms "repulsive" and "discomforting" are intended to encompass the full spectrum of pain, from mild and fleeting sensations to extreme, severe cases—and even those perceived as pleasurable.

Experience: By using the term "experience" (rather than nociception or bodily reaction), I emphasize that pain is inherently subjective and mediated by the individual. This framing recognizes that a person's unique characteristics—worldview, social positioning, knowledge, and past experiences—influence how pain is perceived. Pain does not exist in a vacuum; it is an experience shaped by context and individual interpretation. This experience is also multi-layered, encompassing both immediate sensations and emotional responses.

Sensory-somatic: Pain is both sensorial and emotional. These elements form a unified experience perceived by the same psychophysical subject. While bodily and emotional sensations are inherent to pain, the sensory-somatic aspects tend to dominate the subject's attention. This is particularly evident in cases such as pain asymbolia, where individuals recognize pain sensations but lack the associated emotional distress.

Given only in first-person perspective: Pain is private and subjective, but it can be communicated and expressed to some extent.

It usually results from tissue damage: Although there are instances of pain without any tissue damage, these are exceptions rather than the norm. Pain is a psychophysical phenomenon, making its physical and medical components integral to its study. Pain cannot be reduced to nociception alone, but nociception remains a fundamental aspect of it.

Actual or potential: Pain often arises from actual tissue damage but can also result from anticipated harm, as in the case of a dentist's drill approaching a tooth.

Stratified experience: Here, I adopt Geniusas's concept of pain as a stratified phenomenon. At its most fundamental level, pain involves immanent feeling-sensations. Building upon this, additional layers of emotional and cognitive perception are added. These cognitive-emotional experiences often incorporate a social dimension, influenced by internalized norms and cultural factors.

Unlike pain, suffering can be understood as a radical shift in self-understanding. I argue that while pain does not necessarily evoke negative emotions in the subject and does not always affect identity transformation, suffering represents a far more aversive and totalizing category. Whereas pain can be brief and mild, suffering always leaves an irreversible mark on the subject, fundamentally altering their perception of the world. Thus, suffering can be defined as a strongly aversive emotional and sensory-somatic experience, accessible only through first-person experience, that affects a significant transformation in the subject's self-understanding and their relationship to the external world. Let us examine this definition in more detail.

Strongly aversive: If pain can be perceived as pleasurable in some circumstances, suffering cannot. For example, while "sweet melancholy" might appear to counter this claim, the source of pleasure in such cases is not the suffering itself but rather the reflective state that suffering enables. Moreover, suffering is distinct in its intensity: mild sadness or disappointment does not qualify as suffering. Suffering is always intense and deeply impactful.

Experience: Like pain, suffering is primarily experienced by the subject, making it essential to study suffering from a first-person perspective.

Emotional and sensory-somatic: Suffering includes both bodily and emotional aspects, but this time it is the emotional components that primarily occupy the subject.

A first-person experience: As with pain, suffering is inherently subjective and private, accessible only through the individual's perspective.

Influence: Even if suffering does not necessarily disrupt the sense of an integral identity, it remains an experience that profoundly influences the subject's self-understanding, their view of the world, and their relationships with others. Whether one adopts an essentialist conception of identity or a more fluid, dynamic view of self-definition, the transformative influence of suffering is undeniable. Suffering is totalizing, dominating the subject's consciousness and shaping their other experiences.

Conclusions

In this article, I have attempted to define pain in terms of nociception and suffering. I contend that pain cannot be reduced to either nociception or suffering, as demonstrated by scenarios in which a subject experiences pain without suffering, or pain that lacks a physiological cause. At the same time, in most cases, pain remains conditioned by nociceptive processes and is closely related to the subject's psychological state. The need to establish the relationship between these concepts has led me to define pain as a repulsive and discomforting sensory-somatic and emotional experience, accessible only through first-person experience, that usually results from actual or potential tissue damage. Pain is a stratified phenomenon, encompassing both intrapersonal sensations and the emotional-cognitive interpretations of those sensations.

This definition reflects a holistic approach. In crafting it, I sought to integrate the sensory, emotional, and physiological dimensions of pain to account for the complexity and diversity of pain experiences. To this end, I drew on Geniusas's stratified understanding of pain as well as the IASP definition, which highlights its multi-dimensional nature. Additionally, the definition emphasizes the first-person perspective, which is particularly relevant in the context of pain therapy and medicine. By linking pain to clinical practice, the definition also underscores the relationship between pain and nociception.

References

Anand, K. J. S., & Craig, K. D. (1996). New perspectives on the definition of pain [Editorial]. *Pain, 67* (1), 3–6. https://doi.org/10.1016/0304-3959(96)03135-1

Aydede, M. (2005). Introduction: Critical and quasi-historical essay on theories of pain. In M. Aydede (Ed.), *Pain: New essays on its nature and the methodology of its study* (pp. 1–59). The MIT Press.

Aydede, M. (2019). Does the IASP definition of pain need updating?. *Pain Reports*, *4* (5), e777. https://doi.org/10.1097/PR9.0000000000000777

Bueno-Gómez, N. (2017). Conceptualizing suffering and pain. *Philosophy, Ethics and Humanities in Medicine: PEHM*, *12* (1), 7. https://doi.org/10.1186/s13010-017-0049-5.

Cassel, E. J. (1991). *The nature of suffering and the goals of medicine.* Oxford University Press.

Charmaz, K. (1983). Loss of self: A fundamental form of suffering in the chronically ill. *Sociology of Health and Illness*, *5*, 168–195. https://doi.org/10.1111/1467-9566.ep10491512

Cohen, M., Quintner, J., & van Rysewyk, S. (2018). Reconsidering the International Association for the Study of Pain definition of pain. *Pain Reports*, *3* (2), e634. https://doi.org/10.1097/PR9.0000000000000634

Craig, K. D. (1984). Psychology of pain. *Postgraduate Medical Journal*, *60* (710), 835–384. https://doi.org/10.1136/pgmj.60.710.835

Devisch, I., Vanheule, S., Deveugele, M., Nola, I., Civaner, M., & Pype, P. (2017). Victims of disaster: Can ethical debriefings be of help to care for their suffering?. *Medicine, Health Care, and Philosophy*, *20* (2), 257–267. https://doi.org/10.1007/s11019-016-9742-1

Dillane, M., Murphy, M., O'Sullivan, D., & Di Blasi, Z. (2021). Pain is inevitable, but suffering is optional: A cross-sectional study of positive psychology variables in chronic back pain. *European Journal of Applied Positive Psychology*, *5* (16), 1–14. https://www.nationalwellbeingservice.org/volumes/volume-5-2021/volume-5-article-16/

Dubuisson, D., & Melzack, R. (1976). Classification of clinical pain descriptions by multiple group discriminant analysis. *Experimental Neurology*, *51* (2), 480–487. https://doi.org/10.1016/0014-4886(76)90271-5

Fischman, B. (1992). The cognitive behavioral perspective on pain management in terminal illness. *The Hospice Journal*, *8*, 73–88.

Geniusas, S. (2015). *The phenomenology of pain.* Ohio University Press.

Henry, M. (2015). *Incarnation: A philosophy of flesh* (K. Hefty, Trans.). Northwestern University Press. (Original work published 2000)

Henry, M. (2000). *Incarnation. Une philosophie de la chair*. Éditions du Seuil.

Husserl, E. (2001). *Logical Investigations, vol. II.* (J. N. Findlay, Trans.). Routledge. (Original work published 1900/1901)

Kendroud, S., Fitzgerald, L. A., Murray, I. V., & Hanna, A. (2022, September 26). *Physiology, nociceptive pathways*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK470255/

Kono, T. (2023). Intersubjective intentionality of pain. *Philosophy & Cultural Embodiment*, *3*, 10–20. https://doi.org/10.14992/0002000105

Krueger, R. B., Reed, G. M., First, M. B., Marais, A., Kismodi, E., & Briken, P. (2017). Proposals for paraphilic disorders in the international classification of diseases and related health problems, eleventh revision (ICD-11). *Archives of Sexual Behavior*, *46* (5), 1529–1545. https://doi.org/10.1007/s10508-017-0944-2

Merskey, H., & Bogduk, N. (1994). *Classification of chronic pain: Descriptions of chronic pain syndromes and definitions of pain terms* (2nd ed.). IASP Press.

Miglio, N., & Stanier, J. (2022). Beyond pain scales: A critical phenomenology of the expression of pain. *Frontiers in Pain Research*, *3*. https://doi.org/10.3389/fpain.2022.895443

Nagel, T. (1974). What is it like to be a bat? *The Philosophical Review*, *83* (4), 435–450.

Raja, S. N., Carr, D. B., Cohen, M., Finnerup, N. B., Flor, H., Gibson, S., Keefe, F. J., Mogil, J. S., Ringkamp, M., Sluka, K. A., Song, X. J., Stevens, B., Sullivan, M. D., Tutelman, P. R., Ushida, T., & Vader, K. (2020). The revised International Association for the Study of Pain definition of pain: Concepts, challenges, and compromises. *Pain*, *161* (9), 1976–1982. https://doi.org/10.1097/j.pain.0000000000001939

Ricoeur, P. (2013). La souffrance n'est pas la douleur. In C. Marin, & N. Zaccaï-Reyners (Eds.), *Souffrance et douleur. Autour de Paul Ricoeur* (pp. 13–34). Presses Universitaries de France.

Sartre, J-P. (1993). *Being and nothingness: An essay on phenomenological ontology* (H. E. Barnes, Trans.). Methuen Publishing. (Original work published 1943)

Scarry, E. (1985). *The body in pain. The making and unmaking of the world*. Oxford University Press.

Shapiro, B. S. (1999). Implications for our definition of pain. *Pain Forum*, *8* (2), 100–102.

Stanier, J., & Miglio, N. (2021). Painful experience and constitution of the intersubjective self: A critical-phenomenolozical analysis. In S. Ferrarello (Ed.), *Phenomenology of Bioethics: Technoethics and Lived-Experience* (pp. 101–114). Springer. https://doi.org/10.1007/978-3-030-65613-3_8

Stumpf, C. (1917). Apologie der Gefühlsempfindungen. *Zeitschrift für Psychologie und Physiologie der Sinnesorgane*, *75*, 330–350.

Svenaeus, F. (2014). The phenomenology of suffering in medicine and bioethics. *Theoretical medicine and bioethics*, *35* (6), 407–420. https://doi.org/10.1007/s11017-014-9315-3

Svenaeus, F. (2015). The phenomenology of chronic pain: embodiment and alienation. *Continental Philosophy Review*, *48* (2), 107–122. https://doi.org/10.1007/s11007-015-9325-5

Suchocka, L. (2008). *Psychologia bólu*. Centrum Doradztwa i Informacji DIFIN.

Wiggleton-Little, J. (2024). "Just" a painful period: A philosophical perspective review of the dismissal of menstrual pain. *Women's Health*, *20*, 1–6. https://doi.org/10.1177/17455057241255646

Walden-Gałuszko, K. (2007). Psychologiczne aspekty bólu i jego leczenia. *Medycyna Paliatywna w Praktyce*, *1*, 66–70.

Williams, A. C. C., & Craig, K. D. (2016). Updating the definition of pain. *Pain*, *157* (11), 2420–2423. https://doi.org/10.1097/j.pain.0000000000000613

Yager, J. (2021). Addressing suffering in patients with psychiatric disorders. *The Journal of Nervous and Mental Disease, 9*, 615–621.

Author note

Adriana Joanna Mickiewicz is a PhD student in Philosophy at Jagiellonian University, winner of the Ministerial Diamond Grant competition, and the Minister of Science and Higher Education Scholarship. She is author of a number of scientific publications on ethics and hermeneutic philosophy, as well as popular philosophical texts. Her research interests include contemporary ethics, feminist theory, and the problem of suffering. She is currently conducting research on the category of vulnerability and the phenomenology of physical pain, and is working on the moral philosophy of John D. Caputo. She is the author of the podcast *Mówi Muger*, dedicated to promoting the philosophy of women.

Address for correspondence: Uniwersytet Jagielloński Instytut Filozofii ul. Grodzka 52, 31-044 Kraków, Poland.

Citation

Mickiewicz, A. J. (2025). Wounded Body: A Phenomenological Attempt to Define Physical Pain. *Analiza i Egzystencja*, *70* (2), 73–91. https://doi.org/10.18276/aie.2025.70-03.