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**Pain and the Politics
of Sympathy,
Historical Reflections,
1760s to 1960s**

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Inaugural Address

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In Margaret Edson's play, W;t (1999), a bald, Vivian Bearing walks on stage in her hospital gown, pushing an IV pole, and complains:

I have been asked "How are you feeling today?" while I was throwing up into a plastic washbasin. I have been asked as I was emerging from a four-hour operation with a tube in every orifice, "How are you feeling today?"

I am waiting for the moment when someone asks me this question and I am dead.

I'm a little sorry I'll miss that.¹

She laments the barrenness of metaphoric languages available to patients experiencing stage four metastatic ovarian cancer. Instead of the opulent, dramatic theatrical language of The Faerie Queene (Bearing is a professor of seventeenth century literature), her suffering elicits nothing more than a theatre replete with the "threadbare metaphor" of "sands of time slipping through the hourglass". As she acknowledges with bitter humour,

At the moment, however, I am disinclined to poetry.

I've got less than two hours. Then: curtain.

Bearing's complaint about the "feigned solicitude" of people observing pain and the "threadbare" narratives open to those experiencing it, has entered the canon of clichés about illness. Answering that question "How are you feeling today?" is a dilemma faced by pain-sufferers throughout the centuries. Most famously, literary scholar Elaine Scarry responds by stating that the question is unanswerable. Pain exists outside of language: it is essentially private, untransmissible. Scarry goes even further, stating that

Physical pain does not simply resist language but actively destroys it, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned.

Unlike other conscious states, she continues, pain

has no referential content. It is not of or for anything. It is precisely because it takes no object that it, more than any other phenomenon, resists objectification in language.²

Such an argument is deeply disconcerting to an historian of pain: it threatens to eliminate any enquiry before we even start. It is also wrong. Scarry's analysis of pain is one that is strangely monochrome: ahistorical, contextually thin, and intractable. For Scarry, the metaphoric conception of pain as an independent entity within a person ("she has a pain in her belly") is literalised. "Pain", rather than a person-in-pain, is given agency.

In contrast to Scarry's assertion that pain "actively destroys" language, the experience of pain can actually generate language. Physicians and patients alike are dependent upon figures of speech (such as metaphors and similes) for communicating sensations of discomfort, pain, or agony. Indeed, the eloquence of people when they seek to convey their afflictions to friends, family, and physicians can be striking. In her essay "On Being Ill" (1930), Virginia Woolf also lamented the "poverty of the language of pain" because "There is nothing ready made". But this could be an advantage, since the person-in-pain

is forced to coin words himself, and, taking his pain in one hand, and a lump of pure sound in the other (as perhaps the people of Babel did in the beginning), so to crush them together that a brand new word in the end drops out.³

Pain-talk is swollen with rhetorics, with metaphor, metonymy, and analogy; there are vast philosophical, theological, medical, and literary narratives that people grasp to communicate their pain and that of others. Pain is both absolutely unique and infinitely shareable. Even when suffering, people adhere to societal norms, rituals, and stories.

Crucially, these narrative traditions have complex structures and histories.

Exploring the changing languages of pain enables us to grasp the way the sensation of pain has changed over time. Some historians claim that the study of pain is nothing more than a study of representation, wholly detached, if you like, from anything that might approximate “lived experience”. Language is “about nothing other than itself” or, in another version, it “wholly constitutes experiences”. Anthropologist Thomas Csordas has a nice retort to this, reminding us that the “polarization of language and experience is itself a function of a predominantly representational theory of language”. However, it is perfectly possible – and plausible – to argue that language

gives access to a world of experience in so far as experiences comes to, or is brought to, language.... The notion that language is itself a modality of being-in-the-world... is perhaps best captured in Heidegger’s notion that language not only represents and refers, but “discloses” our being-in-the-world.⁴

In this way, the body is not only a receptacle of sensations, but also a material process that is intrinsically social and interactive.

In the next few pages, then, I will be exploring the language of pain in Anglo-American societies from the 1760s. Although the communication of pain presents difficulties, I will be arguing that painful worlds are expressed through a rich language of metaphor, simile, metonym, and analogy. Furthermore, these metaphors are based on embodied experiences, dissolving any body/mind distinction. The mind is embodied in the sense that people think via sensorimotor experiences, and the body is “mind-ful”. Although there are many consistent metaphors used by people in the past to communicate their suffering, we can also identify shifts in metaphoric use. These shifts tell us a great deal of changes in the meaning and sensation of pain. Finally, I conclude by suggesting various reasons why clinical languages of pain might have become “thinner” since the eighteenth century.

Part I: Feeling-States

One of the clichés in pain-narratives refers to the difficulty of recalling the sensation of bodily torment. In the words of social theorist Harriet Martineau, writing in the 1840s after suffering years of excruciating pain,

Where are these pains now? – Not only gone, but annihilated.... The sensations themselves cannot be retained, nor recalled, nor revived; they are the most absolutely evanescent, the most essentially and completely destructible of all things..... This pain, which I feel now as I write, I have felt innumerable times before.... And a few hours hence I shall be as unable to represent it to myself as to the healthiest person in the house.⁵

The linguistic struggle involved in attempting to communicate the sensation of pain is indisputable. But pain is not the only sensation that seems to elude language. People struggle to translate all strong sensations, including sexual *jouissance* or parental love. When people seek to convey the experience of, say, orgasm, they do so in much the same way that people do when conveying painful sensations, through the use of metaphors such as shooting, exploding, throbbing, quivering, shuddering, and spreading.

There are at least two reasons, however, why pain might be especially difficult to communicate to others. Firstly, unlike many pleasant feeling-states, painful ones can be particularly humiliating or shameful. This was what Robert Davis was alluding to when, in 1897, he described the reactions of a naval officer who had “repeatedly screamed” during an operation. Afterwards, with “haggard features and shaking frame”, the officer had admitted to his shame, apologizing to everyone present not being able to “control the expression of unendurable pain he had experienced”.⁶

The second reason refers to the potency of both the sufferers’ and the audience’s imagination. Pain narratives can resurrect the pain

for the sufferer. Eminent novelist Fanny Burney came to recognise this when, in August 1812, she underwent a mastectomy without anaesthetic. When “the dreadful steel was plunged into the breast – cutting through veins – arteries – flesh – nerves”, she wrote,

I needed no injunctions not to restrain my cries. I began a scream that lasted intermittingly during the whole time of the incident – & I almost marvel that it rings not in my Ears still! So excruciating was the agony.

Her pain was so intense that “for Months I could not speak of this terrible business without nearly again going through it!”⁷

Pain narratives do not only resurrect anguish in the breast of the original sufferer; they can also torture those listening. In 1759, political economist Adam Smith admitted that “we have no immediate experience of what other men feel” except by “conceiving what we ourselves should feel in the like situation”. Through the use of the imagination, “we then tremble and shudder at the thought of what he feels”.⁸ Whether intentionally or not, narrator-sufferers inflict this trembling and shuddering on their audiences. Face-to-face with loved relatives or friends, there is good reason for the person contorted in physical anguish to silence herself. Thus, in the Memoir of the Last Illness and Death of Rachel Betts (1834), Betts suffered “excruciating pain” and afterwards observed her sister weeping. She was mortified, admitting that “I cannot help expressing how great my pain is, it seems a relief”. However, she added that “I do not wish to distress you” and so resolved not to speak or display her agony again. A short time later, when her mother asked her if she “continued easier”, Betts simply murmured, “Quite easy”.⁹ This desire not to “alarm” loved ones – not to, literally, “bring home” ones’ own agony – represents the other side to Adam Smith’s sympathetic imagination.¹⁰

Part II: Metaphor

Whether a sufferer responds with an elaborate recitation of adjectives or a simple, disingenuous murmur of “Quite easy”, she is engaged in communicating and giving meaning to her experiences: a painful world is still a world of meaning. It is a world swollen with metaphor, simile, metonymy, and analogy. Why are such linguistic devices central to pain experiences? Linguist George Lakoff and philosopher Mark L. Johnson famously stated in Metaphors We Live By (1980) that “metaphor is not just a matter of language, that is, of mere words. . . . Human thought processes are largely metaphorical”. They also crucially argued that metaphors are based on embodied experiences.¹¹ For convenience, I will be discussing these two components separately, beginning with the role of metaphor in communicating pain, before exploring the relationship between metaphor and the body.

The term metaphor is here used in its broadest sense, as a figure of speech that employs association, comparison, or resemblance. Metaphor is not just a narrow analogy between two states (“pain gnawed at his stomach”). It also expresses similitude (“the pain felt like a rat, gnawing at his stomach”).

Etymologically, metaphor comes from the Greek words meta and pherein, “to transfer” and “to carry beyond”. Through metaphor, a concept is transferred into a context within which it is not usually found, extending its meaning. Metaphors enable people to move a subject (in this case, pain) from inchoateness to concreteness. As such, metaphor is not simply an ornament of communication but, as cognitive scientist Raymond Gibbs observed, a “specific mental mapping that influences a good deal of how people think, reason, and imagine in everyday life”.¹²

By using metaphors to bring internal sensations into a knowable, external world, sufferers attempt to impose order or logic on their experiences. As such, metaphors provide important clues about unspoken undertones. This is what critic Susan Sontag was seeking to convey in an intriguing short story she published in 1964. In it, a “Man With a Pain” experiments with various metaphors for distress, seeking

to find one that would enable him to make some kind of sense of the unassailable fact that he is hurting. He begins with the metaphor of pain as a wound. If so, someone must have wounded him. But who had inflicted this wound, he asks? Which metaphor could best translate his sensation of being wounded into language? As the “Man With a Pain” muses,

Either the wound is a contract (then there is a date of termination, when all obligations are cancelled) or it is an inheritance (then it's his until he can bequeath it to someone else) or it is a promise (then he must keep it) or it is a task (then he may refuse it, though he will be fired) or it is a gift (then he must try to cherish it before exchanging it) or it is an ornament (then he must see of it's appropriate) or it is a mistake (then he must track down the person in error, himself or another, and patiently explain matters) or it is a dream (then he must wait to wake up).

The metaphors he chooses – “whether contract, inheritance, promise, task, gift, ornament, mistake, or dream” – provide the only way he can understand, respond to, and communicate his sensation of hurting.¹³

Later, I will be examining some of the ways metaphoric languages of pain have changed in Anglo-American cultures since the eighteenth century, and speculating about what this might tell us about changes in the sensation (as well as the meaning) of pain. It is important to observe, however, that many of the metaphors used have remained constant over the past two centuries. These are eight common ones: pain is an entity within the body; a devourer of flesh, most often animalistic; a weapon; a trial; heat; an oppressive weight; a whirlwind or windmill; and finally a colour.

For instance, pain is commonly referred to as an independent entity within a person. The [Adelaide] Advertiser in 1927 expressed this well in a humorous sketched entitled “The Pain”:

Anxious Mother: "You don't look well, Johnny. Are you in pain?"
Johnny: "No, mummy. The pain's in me".¹⁴

This inner-entirety is often a destroyer of flesh. Thus, on the 4 March 1892, the day before she died, author Alice James told her companion Katharine P. Loring, "I am being ground slowly on the grim grindstone of physical pain".¹⁵ This devourer of flesh may be personified as an animal (for Jane Carlyle in 1865, it was "as if a dog were gnawing and tearing" at her arm¹⁶ and for Woolf pain was "a good deal of rat-gnawing at the back of my head"¹⁷), but it could also be a weapon. Pain "cracked like the firing of a pistol" (1869)¹⁸; was like the "stab of a knife" (1852);¹⁹ or was "like a knife stuck to the bone" (1950).²⁰ It can equally be spoken of in terms of a judgement. It was a "trial" that had to be "rightly borne" (1833)²¹ or it felt like the "stroke of the Divine rod".²² In contrast, pain can be characterised as something much more impersonal, like heat. It was fire or sun; it seared, boiled, burnt. It was a "spark of fire, shooting up the wounded finger" (1836).²³ This was the metaphor that came most readily to the pen of labourer Joseph Townend, whose wound was "smoking" and was "drenched in blood, and smoked, almost like a kiln".²⁴

The final three metaphors are wind, weight, and colour. Pain felt "as if a hundred windmills were turning round in my head" (1823),²⁵ observed one sufferer; it was a "blank whirlwind of emotion... which swept through my mind and overwhelmed my heart," (1897), according to another.²⁶ Pain was an oppressive weight that "lays low": as in the 1822 description of a dying man as "exhausted with pain and grief, and ready almost to sink into despondency".²⁷ Pain could also be a colour: it was "a well of red, flowing anguish".²⁸ Toothaches were black; rheumatic pains, grey; and the worst pains, purplish-red.²⁹ J. C. Powys described the pain of a gastric carcinoma, as "a round black iron ball of a rusty blood colour, covered with spikes".³⁰

Such metaphors are not simply attempts to describe a sensation by illuminating the unfamiliar in terms of the familiar. They contain clues to much more complex, unspoken meanings as well. They are important indications of the relationship of a person to her pain and

of the kind of pain she feels. An actively stabbing knife says something different from a less agentic description, such as a colour. Metaphors of submission (say, to the will of God) convey a different rapport with one's pain than metaphors of resistance (as in attempting to conquer the pain-inducing invader). The more mechanistic metaphors (implying a detached concern for the "dysfunctional" body that can be taken to the repair-shop) as used by Old Americans in Mark Zborowski's study in the 1950s tell us something about their image of pain, which is very different to the more holistic, future-orientated metaphors used by his Jewish patients.³¹ It makes a difference – as Sontag's "Man With a Pain" recognised – whether pain is metaphorically "a contract, inheritance, promise, task, gift, ornament, mistake, or dream". Metaphors do not just describe; they manifest pain.

Part III: Embodiment

Lakoff and Johnson did not simply argue that metaphors are central in thought processes. They claimed that metaphors are based on embodied experiences. But what is the relationship between metaphor and the body?

The mind (disembodied, rational, computational, male) and body (pre-rational, emotional, impetuous, female) distinction is a standard fare of western philosophy. Plato, Aristotle, Augustine, Descartes, and Kant, to name just a few, deployed this dualism and relegated the body to a distinctly inferior status. In the context of pain, this can be seen in the Cartesian distinction made between "bodily pain" and "psychological distress", or between "real pain" and its "psychosomatic" variety. Many writers claim that in the disciplines of the arts and the humanities as well as in philosophy and literature, the "mind has been the main concern and body sidelined".³²

This dichotomy has come under concerted attack. The nature of language, especially metaphor, is one reason for this. The body/mind distinction dissolves when looked at from the perspective of metaphors. Woolf was hinting at this in On Being Ill when she argued

that literature had sidelined the body, treating it as though it was

a sheet of plain glass through which the soul looks straight and clear, and, save for one or two passions such as desire and greed, is null, and negligible and non-existent.

On the contrary, Woolf exclaimed, it was impossible to distinguish between the body and the soul (or mind) since they were inextricably intertwined, in continuous dialogue. “All day, all night”, she wrote,

the body intervenes; blunts or sharpens, colours or discolours, turns to wax in the warmth of June, hardens to tallow in the murk of February. The creatures within can only gaze through the pane – smudged or rosy; it cannot separate off from the body like the sheath of a knife or the pod of a pea for a single instant; it must go through the whole unending procession of changes, heat and cold, comfort and discomfort, hunger and satisfaction, health and illness, until there comes the inevitable catastrophe; the body smashes itself to smithereens, and the soul (it is said) escapes.³³

This approach is at the heart of philosopher Maurice Merleau-Ponty’s theory of language. Consciousness is inherently embodied. For Merleau-Ponty, “a body is not just something we own, it is something we are”.³⁴ Furthermore, the subjective character of experience (its phenomenological content) does not simply arise from interactions in the world but is constituted by those interactions. As Lakoff and Johnson put it in *Philosophy in the Flesh* (1999), “our mind is embodied in the profound sense that the very structure of our thoughts come from the nature of our body”.³⁵ People’s “embodied experiences give rise to their metaphorical structuring of abstract concepts”, explained Gibbs, “which in turn, constrains speakers’ use and understanding of language.”³⁶

Crucially, people form image schemata out of their sensorimotor bodily experiences, which are then projected metaphorically onto the wider world. These image schemata (typically written in capital letters) are dynamic gestalt patterns that are based on recurring features in the physical interaction between the environment and the body. Take, for example, BALANCE: balancing, as Johnson explains, is an image schema that depends on bodily experiences. It is “an activity we learn with our bodies and not by grasping a set of rules or concepts”.³⁷ It is related to “equilibrium in the body, whereby we try to maintain an even state – for example, with respect to heat or cold”.³⁸ BALANCE therefore forms an image schema that can then be projected on or elaborated into other experiences, such as “pain weighed down her spirits” or “she was out of whack”. Similarly, the CONTAINMENT schema starts from the relationship between the body’s boundaries and its interiority/exteriority, and is used metaphorically in statements such as “she felt a lot of pressure”. The sensorimotor bodily experience of lying down to sleep and standing up when awake is the corporeal basis for the conceptual metaphor HAPPY IS UP; SAD IS DOWN (in the sense that “her heart soared at the sight of the doctor”, or “his spirits sank”). Similarly, the metaphor HEALTH/LIFE ARE UP; ILLNESS/DEATH ARE DOWN (as in “He was buoyant” or “He is sinking fast”) is based on the physical experience of lying down when seriously ill.³⁹ Other important, “primary” metaphors frequently encountered in pain-narratives include: DIFFICULTIES ARE BURDENS (“the pain weighed her down”); IMPORTANCE IS BIG (“the ache in her stomach grew by the minute”); MORE IS UP (“her pain soared”); STATES ARE LOCATIONS (“she was close to screaming”); CHANGE IS MOTION (“the pain went from bad to worse”); PHYSICAL AND EMOTIONAL STATES ARE ENTITIES WITHIN A PERSON (“her pain went away”); and INTENSITY IS HEAT (“the tumour burned fiercely”). In each of these instances, the “source domain of the metaphor comes from the body’s sensorimotor system”.⁴⁰ Metaphorically, these body-based schemata are transferred from one (bodily) context to another. In this way, the body is not simply the container for feeling and acting, but a way of thinking. If people think through sensorimotor experiences, the mind is embodied and the body is “mind-ful”. In Gibbs’ evocative phrase, “cognition is what happens when the body meets the world”.⁴¹

As we shall see, this cognitive embodiment model of thinking about the body and metaphor is useful, because it refuses the mind/body dualism, it is dynamic, and it allows for the possibility of investigating different bodies (male, female, pink, brown, black, petite, obese, and so on). Crucially, for historians, it opens a space for exploring change-over-time. Bodies are not simply entities awaiting social inscription (as implied in the “body as text” metaphor) but are active agents. They both create social worlds and are, in turn, created by them. Human experience, in the words of psychiatrist Laurence Kirmayer,

emerges from our bodily being-in-the-world. The bodily givens of experience described by phenomenology reflect both the physiological machinery of the body and its cultural shaping through ongoing interaction with others across the lifespan. Physiology underwrites the stories that constitute the self, even as our self-depiction remodels bodily structures and reconfigures their functions.⁴²

Part IV: Society

This emphasis on the intertwining of body and cognitive processes does not imply that these interactions take place exclusively “within” something called “the individual”. Neither does it assume that the supposed universal physiology of the human body results in linguistic universality.

Some linguists assume that assigning metaphoric meanings to pain sensations takes place within the head (mind) or inside an individual’s corporeal space (body). According to this dualistic way of thinking, people create embodied metaphorical representations of pain solely out of their individual bodily sensations in interaction with the world.⁴³

However, an individual's sensory interactions with the physical world are not the whole story. After all, the body that creates language and metaphor is a social entity. In the words of philosopher Ludwig Wittgenstein, "mental language is rendered significant not by virtue of its capacity to reveal, mark, or describe mental states, but by its function in social interaction".⁴⁴ The metaphorical representation of sensations of pain arises in the context of complex interactions within the environment, including interactions with other people from infancy onwards. Metaphor-creation is a social phenomenon.

To illustrate this point, anthropologist Thomas Csordas referred to the image schema for CONTAINMENT. CONTAINMENT is "based on one's own bodily experience of things going in and out of the body, and of our body going in and out of containers". However, containment is much more than simply a "sensori-motor act": it was sometimes

an event full of anticipation, sometimes surprise, sometimes fear, sometimes joy, each of which are shaped by the presence of other objects and people that we interact with. Image schemas are not therefore simply given by the body but reconstructed out of culturally governed interactions.⁴⁵

Thus, metaphors used to describe the pain of having one's skin cut open (a breach of the boundary of the body) may draw on CONTAINMENT metaphors linked to intense erotic pleasure or severe distress: the context (environmental, relational, and historical) matters. People choose their metaphors not as "contained", isolated, individual bodies, but in interaction with other bodies and environments. In the context of pain, for example, it makes a difference whether pain was inflicted by an infuriated deity, was due to imbalance in the ebb and flow of humours, was a result of an invasion by a germ, or emerged after a lifetime of bad habits.

It would also be wrong to assume that this cognitive embodiment approach to pain universalises the body, "flattening out" pain descriptions. Critics to the approach might claim that the

corporeal body is the same everywhere and at every period of history. If metaphors are drawn from physiological sensations, they might suggest, then the experience of pain must be transhistorical and transnational.

There are two responses to this. The first simply observes that human physiology is not, in fact, a universal given. This is clearly the case if we take a timeframe that extends across millennia. But the argument can be made in the context of the last 260 years. In Anglo-American societies from the eighteenth century onwards, the so-called universal human body has generally been predicated upon the male exemplar and a particular positioning of bone, tissue, muscle, fluids, and fat. Yet, human physiology is much more diverse in shape and function (fe/male; dis/abled; petite/obese) and has changed over historical time (life expectancy and medical advances have fundamentally altered the way bodies exist in the world). Not every body has a physiology capable of menstruation, nocturnal emissions, pregnancy, lactation, hormonal surges and plummetings, and erectile diffidence, to take just a few examples. Different bodies feel different, and we would expect to see metaphors reflecting these differences.

There is another response to the retort that if metaphors are drawn from physiological sensations, then the experience of pain must be transhistorical and transnational. This second response returns to the fundamentally social nature of the body and metaphor, as discussed earlier. People's experiences of their bodies are shaped by environmental contexts and cultural processes, including language and dialect, power relations, gender, class and cultural expectations, climate, and the weight and meaning given to religious, scientific, and other knowledges. As a consequence, there is a vast body of research showing that different cultures and languages possess profoundly different metaphors for pain. To the extent that language affects people's perceptions and cognition, it also affects the actual sensation of hurting.



Image 1: An etching of a woman suffering the torture of colic. Her pain is represented by demons tugging on a rope wound around her stomach. By George Cruikshank, 1819, after Captain Frederick Marryat.



Image 2: A seventeenth century sketch showing the agony of removing a cancerous breast prior to the invention of anesthetics.



Image 3: A drawing by Andreas Schluter showing the physiognomy of a man trying to control himself under the duress of pain.



Image 4: The human body as a machine: a doctor examining the dials inside a human machine. Pen and ink drawing by Roberts, c. 1929.



Image 5: The role of religious belief in giving meaning to pain: an oil painting of Francisco Wiedon and his wife praying for a cure for his pneumonia and pain in his side, 1864.

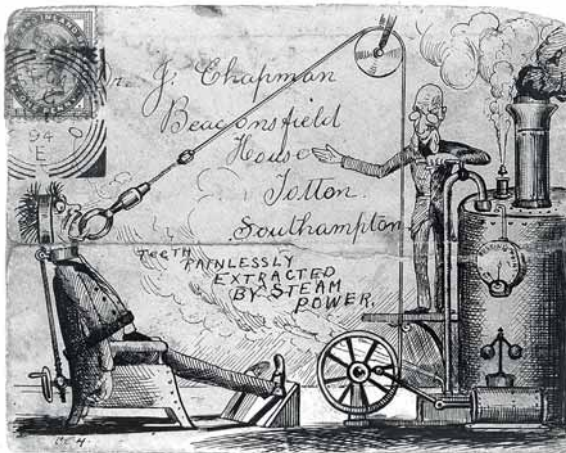


Image 6: A satire on an ingenious way of using machines to separate the physician from his patient: a scientist using a steam machine with pulley to extract a tooth from a man. Pen drawing by C.E.H., 1894.



Image 7: A watercolour showing of a man under the effect of chloroform, being attacked by little demons armed with surgical instruments. By Richard Tennant Cooper.



Image 8: The inevitability of pain: an etching of a tooth-drawer extracting a tooth from a patient who virtually falls off his chair in pain, with a servant hovers in the background.

Part V: Changes

Indeed, we can trace shifts in metaphorical usages over time within Anglo-American pain narratives. While many metaphors have remained consistent over the past three centuries, others have been quietly dropped and been replaced. The reasons for these conceptual movements can be categorised under three main headings: first, changes in the external environment (for example, industrialisation); second, ideological shifts (as in the decline of the efficacy of religious languages); and, third, developing medical knowledges.

First, changes in the environment have provided rich linguistic seams for new analogies. One example would be the introduction of metaphors based on railways, and the fascination they generated. In Britain, railway accidents inspired a series of panics from the 1860s, resulting not only in widely-reported mass deaths but also in the invention of entirely new diagnostic categories, such as “railway spine” (the predecessor for psychological trauma as understood in contemporary parlance). The concrete image of a railway accident was rapidly translated into the completely different, and much more abstract, context of pain. In the words of one physician, writing in 1862, about the pain of neuralgia:

I have seen the most heroic and stout-hearted men shed tears like a child, when enduring the agony of neuralgia. As in a powerful engine when the director turns some little key, and the monster is at once aroused, and plunges along the pathway, screaming and breathing forth flames in the majesty of his power, so the hero of a hundred battles, if perchance a filament of nerve is compressed, is seized with spasms, and struggles to escape the unendurable agony.⁴⁶

Note the masculine imagery, infused with images of industry and war. Pain is conceived of as a mechanical monster, reducing war-heroes to tears. It is a scream, like a train horn. It is the searing heat of stoked engines. As in railway accidents, it bears down upon a person at

random (fixing on any particular individual by chance), and although the cause of the disaster may be simple and small – nothing more than the compression of a “filament of nerve” – it is all-powerful and inescapable.

Railway engines offered one of many metaphorical tropes of the industrial age that were transferred into the intimate world of physical distress. Pain felt “as if a lyddite shell had hit”, according to one account of 1900, just four years after the introduction of the explosive lyddite into the British army.⁴⁷ Typically, the distressed body was spoken about as if it were a flawed machine, with the physician as a kind of mechanic whose job it was “fix” a faulty mechanism. Pain also became an electrical pulse. As one patient suffering trigeminal neuralgia put it, “My pain was caused by a short of two nerves – it’s like electricity. If you put two nerves together and they touch each other, it forms a short and that’s why I got my pain”.⁴⁸ Pain was “rust around the nerves”, “defective ball bearings”, or “twisted ligaments”.⁴⁹ It came “in a succession of short, sharp momentary burst like electric shocks or machine-gun fire”.⁵⁰ Changes in the material environment were adopted to help communicate the more inchoate sensations of pain.

The second category of change refers not to the effect of material objects but to shifts in ideology. The declining efficacy of religious metaphors was the most pronounced. In 1930, Virginia Woolf famously argued that people have the rich language of Shakespeare for love but only a thin one for pain. Lamenting the “poverty of the language” of pain, she argued that

English, which can express the thoughts of Hamlet and the tragedy of Lear, has no words for the shiver and the headache.... The merest schoolgirl, when she falls in love, has Shakespeare and 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.⁵¹

Woolf’s own anguished search for words to express her suffering makes her failure to notice a profoundly rich vein of literature

devoted to pain particularly remarkable. She was impervious to the tongues of the spirit. For Jews and Christians (whether “true” believers or not) the Bible provided rich narratives of suffering, from Job to Jonah, and from the Psalms to Jeremiah. Christians could turn to the sufferings of Christ, the mainstay of Christianity.

A typical example of religious metaphors can be found in William Shepherd’s Memoir of the Last Illness and Death of the Late William Tharp Buchanan, Esq. of Ilfracombe (1837). At the age of 21, William Buchanan tumbled down a hillside, severely injuring his spine. A visiting friend

found him in a desponding, melancholy state of mind, and harassed with much bodily suffering: like the psalmist he seemed to say, “O am weary of my groaning”: “I am troubled, I am bowed down greatly; I go mourning all the day long: my loins are filled with a loathsome disease, and there is no soundness in my flesh”.

The language of Buchanan’s suffering not only evoked the humours (including that of melancholy) with their heaviness and imbalance, and pain as an arrow and poison, but also located pain within a cosmos inhabited by a wrathful God. “Oh that my grief were thoroughly weighed”, he began (citing Job vi.2-4), and

my calamity laid in the balance together? For now it would be heavier than the sound of the sea: therefore my words are swallowed up. For the arrows of the Almighty are with me, the poison whereof drinketh up my spirit: the terrors of God do set themselves in array against me”. Job vi.2-4.⁵²

This was a world away from the secular metaphors of later periods, with the emphasis not on subjugation and submission to physical agony, but on precisely the opposite: fighting, and ultimately conquering, pain. In later descriptions, arrows were not flung by an infuriated deity but were the tools of retribution from a penetrating germ or virus.

Sufferers (more typically characterised as “patients”) were extolled to “put on the armour of battle” in order to conquer the invader.

The third and final category that helps explain shifts in rhetorical strategies refer to responses to changes in medical knowledge and the ways these shifts affected popular, as well as medical, understandings of the body. The most obvious change relates to the discrediting of humoural theory and, along with it, a series of associated metaphors. According to humoural theory, which dominated much of the period before the nineteenth century, the body consisted of four fluids – phlegm, black bile, yellow bile, and blood. Pain is the result of having too much or too little of these fluids. It is a matter of lack of balance, whether in terms of disrupted relationships or a disrupted physiology. As historian Ulinka Rublack explained, the body in this view

was not regarded as a whole and clearly delimited entity, but rather... was understood as something that was constantly changing, absorbing and excreting, flowing, sweating, being bled, cupped and purged. It was clearly situated in the continually-changing context of a relationship to the world whose precise effect was never stable or predictable, so that one simply had to submit to it – to the terror that froze the blood, [and to] the sudden trembling, bleeding, or urination.⁵³

Humoural metaphors for pain, then, were characterised by ebbs and flows: thus, Mary Brooks’ “gnawing” pains in November 1810 were described as “rolling along sluggishly or like a Wool pack”.⁵⁴ Or, take John Hervey’s description in 1731 of the pain experienced by his sister. She was

choked with phlegm, tormented with a constant cough, perpetual sickness at her stomach, most acute pains in her limbs, hysterical fits, knotted swellings about her neck and in her joints, and all sorts of disorders, consequent to a vitiated viscid

blood, which, too glutinous and weak to perform its proper circulation, stops at every narrow passage in its progress, causes exquisite pains in all the little, irritated, distended vessels of the body, produces tumours in those that stretch most easily, and keeps the stomach and bowels constantly clogged, griped, and labouring, by the perspirable matter reverting there for want of force to make its due secretions and evacuate itself through its natural channels in the habit and the pores of the skin.⁵⁵

In such accounts, pain consists of blockages of natural flows, pervading the entire body and not just particular organs. It is a force affected by everything around the patient, including her own temperament (sanguine, coleric, melancholic, or phlegmatic), her diet, the climate, and interpersonal relationships. As such, the way the very sensation of pain was experienced was fundamentally different from the mechanistic and invasive metaphors of germ theory and the “anatomy of solid parts” characteristic of later periods. It was also very different from a medical world of anaesthetics and increasingly effective analgesics, which enabled metaphors of pain to become much more aggressive. When the pharmaceutical possibilities for eradicating pain were exceptionally limited, endurance could be valorised as a virtue. The introduction of effective forms of pain relief made passive endurance perverse rather than praiseworthy. It was the duty of both patient and physician to tackle the problem of pain with “all guns blazing”.

Part VI: Empathy

Might Virginia Woolf’s lament about the “poverty of the language” of pain be more convincing if explored not from the perspective of patient’s narratives but from within the practice of medicine? There are at least three reasons why clinical languages of pain have become “thinner” since the eighteenth century. The first has to do with changes in medical technologies, effectively rendering patients’ descriptions of pain peripheral to the healing process. Anaesthetics silenced the acute pain sufferer; effective analgesics blunted the minds

of chronic sufferers. The intimacy involved in a physician pressing his ear against the sweaty or clammy skin of a person in pain was disrupted by the introduction of stethoscopes: heartbeats could be heard, literally, from a distance. Knowledges taken from microbiology, chemistry, and physiology enabled physicians to bypass patient-narratives in their search for an “objective diagnosis”. These sciences encouraged physicians to focus more on the disease than the patient, on “cases” rather than “suffering people”. This was also encouraged by medical education in universities and academic medical centres, with its time constraints, focus on specialism and “teams”, and emphasis on acute care.

Second, changing views about the nature and function of pain stripped pain of meaning, and thus lessened the coherence and function of patients’ pain narratives. When pain narratives were valued as part of the healing process, they were encouraged, elicited, and elaborated upon as signs of hope for patient and physician alike. When pain narratives became mere “noise”, serving no diagnostic or healing purpose, they were discouraged, became shameful, and might even indict both the patient and physician.

Finally, shifts within the medical profession’s appreciation of the value of clinical sympathy further sidelined patient narratives. Prior to the development of effective anaesthetics in the 1840s, surgeons and other physicians were particularly vulnerable to accusations that their job rendered them impervious to the suffering of others. Time and again, they were told that they were required to be “men of iron nerve and indomitable nerve”.⁵⁶ This was even true for doctors performing non-surgical treatments, many of which were inherently painful. In the eighteenth century, for instance, treatments based on the need to restore the balance of the humours required blood-letting, emetics, laxatives, enemas, and the application of hot irons or corrosive substances such as sulphur, caustic soda or quicklime (cautery). The intrinsically painful nature of treatments, exacerbated later in the century by the introduction of vivisection as a way of gaining knowledge’s about the body, led to accusations that physicians could only gain plaudits for their skill by jettisoning any fine-tuned inclination to feel pity. Some physicians had acquired a “taste for screams and groans” and could

“not proceed agreeably in their operations without such a musical accompaniment”, as one critic sneered in 1854.⁵⁷

Such defamations were categorically refuted, especially by gentlemen–physicians. The insistence that eminent surgeons and physicians were sympathetic men – were, indeed, gentlemen – was crucial to their identity and status. These physicians willingly embraced the idea that the “man of feeling” was innately humane (it was, literally, part of his physiology) and was swollen with intense compassion for suffering humanity. In this, they were in line with the ethical thinking of the eighteenth century, which emphasised states of feeling and encouraged the cultivation of a new sensibility of empathetic identification. Thus, in Characteristics of Men, Manners, Opinions, Times (1711), the Third Earl of Shaftesbury developed a theory of ethics that emerged not from religion but from natural affection. Imagination was the home of the “Divine Presence” in each person. Right and wrong, Shaftesbury argued, could be understood through the application of the imaginative powers of sympathy, allowing one person to experience another’s pain.

Shaftesbury’s ethics was radical. It posited a new image of the human as sympathetic and innately moral. Philosopher Adam Smith developed the idea further in his The Theory of Moral Sentiments (1759). Man may seem selfish, Smith admitted in the book’s first sentence, but there were “some principles in his nature, which interest him in the fortune of others, and render their happiness necessary to him, though he derives nothing from it except the pleasure of seeing it.” Although people had “no immediate experience if what other men feel, we can form no idea of the manner in which they are affected but by conceiving what we ourselves should feel in the like situation”. Through acts of imagination,

we place ourselves in his situation, we conceive ourselves enduring all the same torments, we enter as it were into his body, and become in some measure the same person with him, and thence form some idea of his sensations, and even feel something which, though weaker in degree, is not altogether

unlike them.

In this way, other people's "agonies" were made manifest, and the onlooker – infused with this sympathetic sensibility – could not help but "shudder" at another's suffering.⁵⁸

Crucially, when these philosophers wrote about sensibility, they fused body, mind, and emotions. This was neatly encapsulated in the Encyclopaedia Britannica's 1797 definition of sensibility as "a nice and delicate perception of pleasure or pain, beauty or deformity" that "seems to be dependent upon the organization of the nervous system".⁵⁹ Sympathy was located within physiology; it was produced by the nervous system itself.

This was the discourse that gentlemen-physicians drew upon when they sought to defend their status. In 1849, Worthington Hooker conducted one such defence. In Physician and Patient; or, A Practical View of the Mutual Duties, Relations, and Interests of the Medical Profession and the Community, Hooker maintained that a doctor had to treat his patients as though they were family members or friends. He must feel sympathy "in their seasons of suffering, anxiety, and affliction". "Familiarity with scenes of distress" would not make such a physician "incapable of sympathizing with others", Hooker insisted, unless he was only viewing patients as a "source of emolument". The good physician would not do "violence to his natural sympathies" but would allow his sympathy to "flow out, as he goes forth on his daily errands of relief and mercy to high and low". In this way, the physician's sympathies would actually "become more tender and active, instead of being blunted and repressed". Of course, Hooker went on, the physician's sympathies were not "mawkish sensibility which vents itself in tears, and sighs, and expressions of pity", but was "active sympathy". In Hooker's words, the good physician might appear to have "surrendered his humanity to the cold and stern demands of science" as he performed his duties with "an unblanched face, a cool and collected air, and a steady hand", but

there is sympathy in his bosom, but it is active....
He knows that a valuable life is hanging upon those

very exertions, which he is making with all the seeming coolness of indifference.

As such, the physician's sensibilities become "more deep and more tender".⁶⁰

These exhortations about the "natural" character of sympathy forged within the imaginations of good men – philosophers such as Smith or physicians such as Hooker – were not, however, framed in terms of an inclusive or universal mankind, let alone humanity. As already emphasized, these theories about sympathy were founded on notions of bodily sensitivity, a "sympathetic" physiology. Yet, it was taken for granted by all these commentators that not all humans possess an equal measure of bodily sympathy. At the very least, in that "great chain of feeling", vast numbers of people lagged significantly behind. Most obviously, "Negroes", the "uncivilized", and "savages" were devoid of the ability to feel pain.⁶¹ The poor and manual labourers were deficient in pain-sensitivity⁶², as were "imbeciles".⁶³ Lacking a sufficiently "sympathetic" physiology, these groups were incapable of feeling sympathy for others. Smith put it bluntly: "Before we can feel much for others we must in some measure be at ease ourselves".⁶⁴ Differences in "innate" sensibility to pain were thus directly linked to processes of civilisation and, in particular, the ability to be a "man of feeling". In the words of eminent physician Silas Weir Mitchell, writing in 1892,

Civilized man has of will ceased to torture, but in our process of being civilized we have won, I suspect, intensified capacity to suffer. The savage does not feel pain as we do.⁶⁵

Unlike "civilized" man, the "savage" could feel neither the pain in his own body, nor that in others. He was devoid of sympathy, and scarcely warranted sympathetic identification by those exemplary humans higher in that great Chain of feeling. So when Smith extolled the moral excellence of sympathy, in which onlookers "enter as it were into his [the sufferer's] body, and become in some measure the same person with him", he was oblivious to his own assumptions of power

and status. The idea that the world of the person-in-pain could be fully “entered into” and thus the onlooker could become “the same person” as him, required a “ruthless displacement and absorption of the other.... drained of its own substance before it [would] serve as an appropriate vessel”.⁶⁶

The eighteenth and early nineteenth-century insistence that physicians needed to be “men of feeling”, who approached patients with hearts swollen with compassion (albeit, infused also with a sense of superiority and power), failed to survive the biomedical revolutions of the nineteenth and early twentieth centuries. Increasingly, the perceived positive value of emotional closeness between physician and patient was disrupted. The mores of scientific medicine became increasingly hostile to emotion in medical practice, seeing it as working against scientific objectivity. The biomedical model was much more dichotomous than its predecessors, separating “mind” and “body” into rigidly different spheres. While humoural-inspired medical practice recognised and paid great attention to what Thomas Smith Rowe in 1850 called the “exquisite harmony” of the “intermingled relational & mutual dependence existing between the mind & body”,⁶⁷ the biomedical model only saw the “psychosomatic”, with all its pejorative connotations.

The famous lesson, given by Sir William Osler to graduating medical students at the University of Pennsylvania at the start of the twentieth century, neatly epitomises the distance travelled from medical forefathers who had lauded the cult of sensibility. Instead of an innate sensibility, Osler informed the young physicians that “imperturbability” was an “essential bodily virtue” and “a blessing to the possessor”. Although some physicians (“owing to congenital defects”, he lamented) may never acquire it, with education and practice, many could attain this virtue. In his words, a

certain measure of insensibility is not only an advantage, but a positive necessity in the exercise of calm judgment, and in carrying out delicate operations. Keen sensibility is doubtless a virtue of high order, when it does not interfere with

steadiness of hand or coolness of nerve; but for the practitioner in his working-day world, a callousness which thinks only of the good to be effected, and goes ahead regardless of smaller considerations, is the preferable quality.⁶⁸

Within a few decades, “imperturbability” had mutated into the concept of “detached concern”. Thus, in the Journal of the American Medical Association in 1958, Charles Aring advised physicians to remain apart from the “enervating morass of the patient’s problems, viewing the detachedly yet interestingly”.⁶⁹ Hermann Blumgart, writing in The New England Journal of Medicine in 1964, made a similar recommendation, stating that sympathy could lead doctors to grieve for their patients while “neutral empathy” was a more healthy response as it enabled to doctor to both observe carefully his patients’ response while efficiently doing the job of healing.⁷⁰ It was a view that was perfectly in line with a model of pain that had no intrinsic, positive meaning or purpose, but had to be fought according to the objective sciences of physiology, anatomy, and biochemistry. “Pain” and “suffering” were severed.

Part VII: Concluding Words

At the end of the twentieth century, Vivian Bearing, the terminally ill woman in Margaret Edson’s play W;t, struggled to answer the question “How are you feeling today?”. When she observed that her body-in-pain only solicited “feigned solicitude” from those around her, she despaired. In contrast, anthropologist Margaret Mead seemed to believe that the body-in-pain would “naturally” elicit sympathy. Mead argued that pain was

a form of human experience so sharp, so unmistakable, so immediate, that members of any culture can recognize, empathize, or identify with another human being in pain. The cry of genuine [sic] anguish knows no linguistic boundaries, and fortitude under the needle and the knife needs no

interpreters.⁷¹

Of course, Mead undermined her own argument, since she claimed that only genuine cries of anguish constituted a universal language, thus opening the door to claims that a person professing herself to be in pain might not be “genuine”. Vivian Bearing, however, recognised that people routinely failed to “hear” others in pain.

Part of the difficulty in hearing stories of people in pain is the fear that pain is an “unmaking the world”.⁷² But pain is never simply an unmediated sensation arising from some realm beyond language, culture, and history. The metaphors that move painful sensations from inchoateness to concreteness are rich, complex, and historically mutable. They open up a world of meaning, informing us of how people in the past, and today, experience everyday life. A painful world is still a world of meaning. Paradoxically, the fictive character Vivian Bearing, with her sense of alienation and loneliness in her slow and painful dying, and scholars Virginia Woolf and Elaine Scarry with their acute literary sensibilities which led them to despair about the thinness of pain-narratives, identified something profound in the nature of pain: it is by those features of pain that life is given its meaning – its unpleasant meaning.

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