PITCHER AND AYDEDE: IS PAIN A PERCEPTION?

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In "Pain Perception" (1970), George Pitcher defends his influential theory that to feel pain is to perceive tissue damage, or a "disordered state" of a part of one's body. This argument for a perceptual view of pain is Pitcher's attempt to bring pain—a subjective experience—under the purview of objective science. Pain can be studied scientifically, he argues, because *what is felt* when one feels pain, is objective. Because pains seem, prima facie, entirely unlike anything physical, many theorists conclude that pains are non-physical or mental phenomena. Their argument, based on three features of our ordinary concept of pain, can be laid out as follows (Pitcher 370):

1. Pains are *private*: a particular pain can be experienced or felt by only one person.
2. Pains are metaphysically *subjective*: pains exist only when they are felt; there are no unfelt pains.
3. Pain experiences and reports are *incorrigible*: a person cannot be mistaken in her belief that she is in pain. In other words, there is no appearance/reality distinction with regard to pain; the appearance of pain *is* the reality of pain.
4. By contrast, physical objects or states of affairs are characterized in ways that are irreconcilable with these features: physical objects are public and intersubjectively verifiable, their existence is independent of our experiencing them, or our existence at all, and our reports about them may be mistaken.
5. Therefore pains cannot be physical and must instead be mental.

Pitcher defends his perceptual theory against this argument. If one denied 1-3, it would be questionable that his argument was really about *pain* at all. Similarly, if one granted 1-3 but denied 4, it would seem that he is simply redefining what we normally mean by *physical*. Pitcher's aim, then, is to show that 1-4 do not in fact lead to the conclusion that pains are non-physical. He does this by addressing three main objections to the perceptual view.

Objection 1

The first objection he considers involves the privacy and metaphysical subjectivity of pains, or premises 1 and 2 above. According to this objection, if what one feels when he has a pain is the disordered state of a part of his body, then the pain must be identical with the disordered state. But the pain is subjective and private, while the disordered state is objective and public. Thus, the pain and the disordered state are not identical, and what one feels when he has a pain is not the disordered state of his body (Pitcher 373).

Pitcher argues that although it is part of our concept of pain that it is subjective and private, this does not imply that *what one feels* when he has a pain is not something objective and public. To demonstrate this, he draws an analogy between feeling a pain and catching a glimpse. Just like our concept of a pain, our concept of a glimpse involves the same kind of subjectivity and privacy. Glimpses are private: a particular glimpse can be caught by only one person. And glimpses only exist when they are caught; it makes no

sense to discuss uncaught glimpses. Yet *what* is glimpsed, the object of a glimpse, is objective. Additionally, the concept GLIMPSE applies to the act of glimpsing, rather than to the object glimpsed, and likewise, the concept PAIN applies to the act of feeling a pain. So, Pitcher argues, no special difficulty arises from the fact that a pain and the disordered state are not identical (Pitcher 374-379).

More directly, this objection rests on a critical misunderstanding of Pitcher's thesis. His thesis is not that pain *is* tissue damage or a disordered bodily state, but rather that pain is the perception *of* such a disordered state. In other words, pain is a subjective, private experience which, at least under certain conditions, *represents* an objective, public, disordered bodily state. Once this misunderstanding is clarified, Objection 1 loses all its force. Vision is a subjective, private experience that represents objective, public properties of one's environment. The situation is parallel in the case of pain.

Objection 2

The second objection Pitcher confronts is simply that pain cannot be a perception because perception is never, in itself, unpleasant. Pitcher dismisses the premise of this objection, arguing simply that "animals usually just do not like to feel, via their pain receptors, disordered parts of their body: when they do happen to engage in that form of sense perception, they want to stop doing so. . .. To have some spontaneous inclination of this general 'anti'-kind is to experience the perceptual act (or state) as unpleasant or worse" (Pitcher 380). Additionally, there is now evidence that pain need not always be unpleasant. As we will discuss in the next section, this possibility raises further difficulties for Pitcher's theory, but it further weakens this specific objection.

Even if it is true that ordinary modes of perception are never, in themselves, unpleasant, Objection 2 is further weakened by pointing out that it is hardly an *essential* feature of our concept of perception that it is not unpleasant in itself, such that we would refuse to count something as a genuine form of perception simply because it was unpleasant. Pitcher acknowledges that pain may be unique among forms of perception in carrying a strong negative affective aspect, but this in no way condemns his perceptual theory. In fact it seems reasonable that our perception of such an urgent bodily threat would carry just the kind of negative affective aspect that pain does. Pitcher suggests that the evolutionary importance of pain as an unpleasant experience provides an adequate account of why pain might be uniquely unpleasant (Pitcher 381). In addition, if pain is a mode perception, its object is unique. The object of pain—i.e., a disordered bodily state—is always, prima facie, a threat to its subject's survival. Objects of other modes of perception, on the other hand, can be threatening, beneficial, or neutral. We would expect, then, that pain would involve a negative affective component, while other modes of perception would not.

Objection 3

The third objection, involving premise 3 in the initial argument, is the most serious of the three that Pitcher addresses. The argument is as follows: All modes of perception allow

for the possibility of *mis*perception, but our concept of pain does not allow for this possibility. Hallucinations and illusions are possible in ordinary modes of perception, but not in the case of pain. When a person believes he is in pain, even in the case of phantom limbs, we do not say he is hallucinating or mistaken; we say he is genuinely feeling pain. Simply put, all modes of perception admit of an appearance/reality distinction, but there is no appearance/reality distinction with regard to pain. Therefore, pain is not a mode of perception (Pitcher 382-383).

Pitcher begins his response to Objection 3 by giving an account of why, in agreement with the objection, pain is still pain even when there is no disordered bodily state for it to represent. He modifies his original thesis to say that in *standard cases*, to have a pain is to perceive a disordered bodily state via one's pain receptors. Standard cases, then, are those in which we could say pain experiences are veridical: the pain accurately represents the state of the relevant body part or region. Pitcher then defines *nonstandard cases* as those in which pain *mis*represents the state of the relevant body part or region. Nonstandard cases, then, include even dramatic examples like phantom pain and also referred pain (Pitcher 383-384).

But, as Objection 3 states and Pitcher agrees, misrepresenting pain is still pain. Why do we combine standard and nonstandard cases under the single concept of pain? Pitcher's answer is that they are sufficiently similar in certain crucial respects. First, there is no first-person difference between a standard and a nonstandard case; to the person having a misrepresenting pain, it feels just as though it were an accurately-representing pain. Furthermore, the same affective response accompanies both standard and nonstandard cases; misrepresenting pain is just as unpleasant. Pitcher argues that it is this affective aspect, shared by both standard and nonstandard cases, that is of primary importance. Because this aspect of pain is shared by both standard and nonstandard cases, we combine them under the single concept of pain (Pitcher 384-385). In short, we do not call misrepresenting pain hallucinatory or illusory because it still *hurts*.

Recent findings in pain research have revealed that the pain landscape is far more complex than Pitcher realized, raising serious questions about his characterization of nonstandard cases. For one thing, although Pitcher thought that so-called nonstandard cases were rare, they now appear to be very common. Aydede reports that up to 40% of Americans experience chronic pain, or pain with no stimuli (Aydede "Introduction" 31). More troubling for Pitcher's theory is the mounting scientific evidence that the sensory and affective aspects of pain can be disassociated. Some degree of sensory-affect disassociation can be brought about by procedures such as prefrontal lobotomy and cingulotomy, drugs such as nitrous oxide and morphine, and even hypnosis. The most severe disassociation is found in patients suffering from pain asymbolia. These patients show no affective response whatsoever to painful stimuli. Their pain experiences lack negative affect entirely, yet they identify and describe these experiences as *painful* (Aydede "Introduction" 32). These are obviously not standard cases of pain, but they do not fall under Pitcher's definition of nonstandard cases either. Clearly, there is a difference from the first-person perspective, and the negative affect is diminished or even

absent. It would seem that Pitcher would have to argue that these disassociation cases are not pain at all, and that the pain reports of these patients are mistaken.

Indeed, although he does not foresee these disassociation cases, Pitcher argues that pain awareness is not infallible for all persons in all cases; infallibility requires that the person has the correct concept of pain and is applying it correctly. Pitcher would likely question whether the patients in these disassociation cases have the correct concept of pain. This is not entirely implausible, especially for people who have *never* felt pain as unpleasant. Such people would learn to apply the concept PAIN to experiences that *would be* unpleasant to others. But because what they call painful is not unpleasant, it seems reasonable to suppose that they have a different concept of pain. Furthermore, Pitcher suggests that there are cases in which we may conclude that a person is not genuinely feeling pain, even if he has the correct concept of pain, ". . . if, for example, there is good evidence that the relevant bodily part is perfectly healthy and/or if the person behaves in a way that we think, for one reason or another, is incompatible with his feeling a pain where he says he does" (Pitcher 387). It seems, then, that Pitcher would be comfortable with the conclusion that the pain reports of disassociation patients are mistaken. And while it may seem counterintuitive and even ethically risky to accept this conclusion, it does not necessarily condemn Pitcher's perceptual theory.

Aydede's Argument from Focus

Aydede raises an objection that is far more damaging that any Pitcher addresses in "Pain Perception." Aydede argues that all genuine forms of perception are "transparent": the perceptual experience gives rise to concepts that apply to the features represented by the experience, not to the experience itself (Aydede 2008 15). For example, when I see a red cup, the concepts I apply—RED and CUP—are applied to the object represented by my visual experience, i.e., the red cup in front of me. If pain is a perception representing a disordered bodily state, we would expect pain to give rise to concepts that apply to a disordered state. But this is not the case. As mentioned above, Pitcher acknowledges that the concept PAIN applies to the *experience* of perceiving a disordered state, not to the disordered state itself (Pitcher 378-379). When I feel pain in my foot, I apply the concept PAIN to my experience, not to my foot or to any possible or actual tissue damage in my foot. So, if pain is a perception, it is uniquely non-transparent. A successful perceptual theory of pain must account for this asymmetry. Why is our conceptual focus the *experience* of pain, rather than the tissue damage it supposedly represents?

To put the problem a different way, the accuracy of all other perceptual reports depends on the accuracy of the representation. If I say, "I see a red cup on the table," my report is false if there is no red cup on the table, that is, if my visual experience does not accurately represent the features of my environment. However, if I say, "I feel a pain in my foot," this report is not false even if what my experience represents, i.e., a disordered state in my foot, is absent. It is not false even if my foot *itself* is absent, as in the case of phantom-limb pain. So, as Aydede puts it, "A pain report is a report of an experience whose representational accuracy is of no relevance to whether the report itself is accurate" (Aydede "Pain"). Pain is clearly quite strange if it is a mode of perception.

Aydede says that the standard response, which he attributes to Pitcher, is quite similar to Pitcher's response to Objection 3. The urgent, negative affective aspect of pain forces our attention to the experience, rather than what it represents. The experience itself, because of its negative affect, is of primary importance, while the tissue damage it represents is secondary (Aydede "The Main Difficulty" 129). Aydede is rightly suspicious of this account. He points out that even gustatory experiences, which can have strong affective components, are transparent; gustatory experiences induce us to apply concepts like SWEET and BITTER to the foods we eat, not the experience of eating them (Aydede "Pain"). Furthermore, if we take seriously the reports of patients in the disassociation cases discussed above, these patients are still conceptually focused on the experience, which is affectively neutral for them, rather than the disordered bodily state.

I argue that Pitcher has a stronger, more subtle response available. Although he does not anticipate Aydede's objection specifically, he ends "Pain Perception" with a potential answer. First he elaborates on the necessary privacy of pain. To feel pain, according to his thesis, is to perceive via one's pain receptors. It is no surprise then that pain is private, because only my pain receptors are connected to my tissue. Any perception you have of my tissue damage is not going to be via my (or your) pain receptors, and so it will not be pain; it will simply be some other perceptual representation of my tissue damage. Thus, I have special epistemic access to my pain. Pitcher then points out that, much of the time, pain experience is the most reliable indicator of a disordered bodily state. Certainly there are times when tissue damage can be verified with other senses, or even intersubjectively, and medical science is increasing this possibility. But more often than not, the experience of pain is the *only* reliable source of information regarding injury or illness. We can verify our pain perceptions in the case of surface injuries, such as cuts and burns, but internal injuries and illnesses are often entirely inaccessible to other modes of perception. Pain is unique in this respect. If I see a red cup on the table, but other people tell me they do not, I can safely conclude that my visual experience misrepresents and that there is no red cup. But if I say that I feel a pain in my stomach, and others tell me they perceive no disordered state there, it would be very risky indeed for me to conclude that there is nothing wrong with my stomach. It is precisely because our awareness of pain is often our only access to reliable information about the status our bodies that our conceptual focus is on the experience itself.

So the non-transparency on which Aydede's objection rests can be accounted for by the pain experience's epistemic authority. It is an evolutionary advantage to focus on the experience of pain, not because of the experience's negative affective aspect, but because the experience of pain is our most—sometimes our *only*—reliable source of information on the condition of our bodies. This distinguishes pain from other intransitive sensations and explains why a perceptual account may not hold for them.

I conclude then that Pitcher's argument stands as a successful perceptual theory of pain. Questions remain about representationalism in general and whether the phenomenology of pain can be entirely accounted for representationally. Michael Tye has argued that pain experience represents tissue damage *as bad*, thus explaining how the negative affective aspect can be representational (Tye 107). But Aydede rejects this, asking simply, "What

is the quality of the tissue damage itself that is detected or tracked by the experience so that we can say the experience carries information about it?" (Aydede "The Main Difficulty" 131). In light of these questions, a strong representational thesis, claiming that pain is entirely representational, may be inappropriate. However, Pitcher's perceptual theory provides a plausible argument that pain is at least *weakly* representational.

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