UNIVERSITY OF CALIFORNIA SAN DIEGO

Let Me Have Your Attention! Taking Pain Utterances Seriously

A Dissertation submitted in partial satisfaction of the requirements
for the degree Doctor of Philosophy

in

Philosophy

by

Jada Wiggleton-Little

Committee in charge:

Professor Matthew Fulkerson, Chair
Professor Cathy Gere
Professor Susanna Siegel
Professor Briana Toole
Professor Manuel Vargas
Professor Monique Wonderly

2023

The Dissertation of Jada Wiggleton-Little is approved, and it is acceptable in quality and form for publication on microfilm and electronically.

University of California San Diego

2023

DEDICATION

To those who have had their pain downplayed, denied, or ignored.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

One cannot do this life, nor write a dissertation, alone. To start, I want to thank my advisor, Matthew Fulkerson, for your guidance. Working together have caused my research and philosophical approach to evolve in so many ways. I know I came to UCSD with some very ambiguous goals, but you supported me at every step, and for that, I truly thank you.

I also want to thank my other committee members for their wisdom and feedback. Monique Wonderly, your endless confidence in helped me to be more confident in myself and in my work. Thank you for always reminding me to keep a list of all that I've done, and to not just list the things I have yet to do. Manuel Vargas, I am indebted to the many conversations we have had on navigating academic spaces. Your ability to be a critical yet charitable reader pushed me to be a more precise writer. Susanne Siegel, I have always been a great admirer of your work so your early interest in this project motivated me. Thank you for challenging me to sit in the various nuances of this project. Briana Toole, we crossed paths at the 2019 APA Pacific Conference, where you opened my eyes to feminist epistemology. I am beyond grateful to have you on my committee; the last two chapters were largely shaped by our discussions. Lastly, I am grateful to Cathy Gere. You kept me attune to the social implications of my work and encouraged me to give voice to the forms of injustice that most inspired this project. I am a better philosopher because of each of you.

I am especially indebted to the number of other mentors whose advice greatly shaped the trajectory of this project and my career. I owe a great debt of gratitude to Nneka Sederstrom. Since my first day as your clinical ethics intern, you have continuously supported me in my pursuit of a career in clinical ethics—even when others said it couldn't be done. I am also

grateful to Quill Kukla, your work on discursive injustice and speech act theory greatly inspired this project. Thank you for allowing me to work with you at Georgetown, for your feedback was truly immensurable. I would also like to thank Craig Callender and the opportunities afforded to me by the Institute of Practical Ethics. It has been a privilege to collaborate with you.

Lastly, I would not be where I am today if it was not for the love and support of my friends and family. Thank you to the Black Graduate & Professional Student Association for providing me with such a vital community. I want to especially thank my best friends Mariah Clarke and Melissa Hayban for keeping me grounded. Melissa Hayban, I don't know if I could have finished this dissertation if not for our many virtual work sessions. To my family, thank you for your continued prayers and for being my biggest cheerleaders. Most of all, I want to thank my mother. Mom, I know I inherited my work ethic and heat of service from you.

VITA

2017	Bachelor of Arts, Davidson College
2022-23	Visiting Researcher, Georgetown University
2023	Doctor of Philosophy in Philosophy, University of California San Diego

PUBLICATIONS

Forthcoming	Sharing Pain: A Hybrid Expressivist Account, *Australasian Journal of Philosophy*.
	Screening Out Neurodiversity (with Craig Callender), *Kennedy Institute of Ethics Journal*
2022	MPQ Descriptors as a Pain Pidgin Language, *Journal of Hospital Ethics* 8(2).
2021	Acknowledging the Burdens of 'Blackness' (with Nneka Sederstrom), *Healthcare Ethics Committee Forum* 33.

FIELD OF STUDY

Major Field: Philosophy

Areas: Bioethics, Philosophy of Mind, Philosophy of Language, Social Epistemology

ABSTRACT OF THE DISSERTATION

Let Me Have Your Attention! Taking Pain Utterances Seriously

by

Jada Wiggleton-Little

Doctor of Philosophy in Philosophy

University of California San Diego, 2023

Professor Matthew Fulkerson, Chair

In this project, I have two aims. First, I take seriously the imperativist idea that pain commands its audience and the potential normative implications this idea can have for the clinic. More specifically, I appeal to the nature of pain to determine what it is we are doing when we communicate our pains to others. I characterize pain utterances as having both indicative and

imperative content, in virtue of expressing pain beliefs and the pain experience, respectively. I contend that, *be concerned!,* is the imperative issued by both felt pains and pain utterances. I refer to a notion of concern that configures itself to comply with pain's demand for (1) attention, (2) a beholdenness towards restoring well-being, and (3) action when otherwise appropriate. The second aim of this project is to explain the societal mechanisms that can cause the sharing of one's pain to fail to motivate. My thesis considers how ideologies can distort features of the speaker, i.e., the body, or distort the kind of pain expressed, i.e., menstrual pain, such that a *pain-related motivational deficit* occurs. A pain-related motivational deficit occurs when ideology systematically distorts certain pain utterances such that there is a defective uptake of the pain utterance's motivational contribution, or imperative content, without disturbing the proper uptake of its epistemic contribution, or indicative content. As a result, a pain utterance that would otherwise motivate concern is believed but is responded to with a lack of concern.

INTRODUCTION

Kelly Coffey was experiencing nausea-inducing, life-stopping cramps. At a gynecology appointment, Kelly said, "My cramps are so bad that I cry and get sick to my stomach. I can't stand up straight. I need help." However, after hearing Kelly's complaints, the gynecologist failed to be concerned. Rather, the gynecologist looked bored and vaguely annoyed. She did not touch Kelly or run any tests; she simply told Kelly to lose weight. Reflecting on the encounter in the Self Magazine article, *The Shocking Ways Large Women are Mistreated by Health-Care Providers*, Kelly Coffey (2017) wrote, “Wasn’t she curious about what was going on inside of me? Wasn’t she worried it might be something serious? Nothing that hurts that bad can be nothing, can it?”. It would take nearly 20 years for Kelly to receive a diagnosis: *endometriosis.*

Kelly’s pain was not taken seriously. It was dismissed. Pain dismissal is often characterized as ignoring or denying another's pain. Many pain sufferers, especially those who identify as a woman or a person of color, are dismissed as complainers, drug seekers, or told that their pain is "all in their heads." However, some forms of pain dismissal are caused not by denial or disbelief but by minimizing the pain’s import. When the pain is minimized, the reason to be concerned becomes less salient. I am particularly interested in cases where the clinician believes the sufferer is in pain, but due to the influence of pejorative ideologies, the clinician fails to be moved by the particular pain expression. By pejorative ideologies, I mean systemic, interconnected webs of distortive meanings, symbols, social practices, and norms that work to produce and sustain unjust social relations. I take it that this is the kind of pain dismissal that Kelly experienced. Unfortunately, Kelly’s experience is not uncommon.

Pain dismissal is a significant barrier to effective pain management. It can lead to frustration, depression, delayed or missed diagnoses, and inadequate or ineffective pain treatment

(Chen, Draucker, & Carpenter, 2019). Failing to treat pain reasonably is physically and psychologically harmful, violating the bioethical principle of non-maleficence. The principle of non-maleficence prohibits the infliction of harm. Access to pain management has also been identified as a human right implied from the fundamental right to health (Brennan et al., 2007; Lohman, Schleifer, & Amon, 2010). The World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity." Failing to be moved by another's pain violates these principles because one must first recognize the expressed pain as being worthy of attention and care to then respond with proper pain management.

Importantly, pain dismissal can also cause disparities in pain. The systemic denial of women's pain has resulted in gender disparities in diagnosis and treatment for various clinical conditions. For example, middle-aged women with chest pain and other symptoms of heart disease are twice as likely to be diagnosed with a mental illness compared to men with the same symptoms (Maserejian et al., 2009). Women with knee pain are 22 times less likely to be referred for a knee replacement compared to men (Borkhoff et al., 2008). While women's pains are generally more likely to be dismissed compared to men, certain *kinds* of pain experiences are more likely to be dismissed as well. For example, the pain associated with inserting an intrauterine device (IUD) is rarely responded to with treatment and has received little to no attention from the medical community.[1] Many IUD users describe the insertion process as painful, while many OB/GYNs will warn patients that the IUD insertion procedure might simply be 'uncomfortable.' A Swedish study found that among 224 women who had not given birth, 89 percent reported moderate or severe pain (Marions et al., 2011). Most health professionals do not

[1] One theory as to why clinicians dismiss pains related to IUD insertion and use is that IUDs are one of the most effective forms of birth control. For this reason, clinicians may be reluctant to remove the device.

routinely use local anesthetics during an IUD placement, and there is no consensus on how to effectively alleviate pain during the procedure (Akintomide, Sewell, & Stephenson, 2013). "There are enough tales of discomfort that goes beyond just taking an Advil or Tylenol that I think there should be more information available," said Danielle Petermann (2021), a 48-year-old IUD user from Cincinnati. She described her first insertion process as “harrowing;” it left her in constant pain for a month and a half.[2]

Elaine Scarry said it best in her influential work The Body in Pain: "To have great pain is to have certainty; to hear that another person has pain is to have doubt" (1985, p.13). In recent bioethics literature, there has been much discussion on pain dismissal characterized as doubt and skepticism regarding the existence, scope, and legitimacy of another's pain. Daniel Buchman, Anita Ho, and Daniel Goldberg (2017) describe this form of pain dismissal as an example of *testimonial injustice.* According to Miranda Fricker (2007), the central case of testimonial injustice is an *identity-prejudicial credibility deficit,* which occurs when a hearer unfairly downgrades the credibility of a speaker's testimony due to prejudice at the end of the hearer. The problem of pain disparities and ineffective pain management can, in huge part, be because pain testimonies are often not believed. Pain sufferers are considered systemically less credible in clinical encounters compared to clinicians, with the credibility of a patient's pain report being more likely to be questioned when they are also members of socially marginalized populations (Buchman, Ho, & Goldberg, 2017).

However, sharing beliefs is only one of the communicative aims of communicating our pains. Communicating pain also functions to share or express pain as a way of eliciting care and concern. Moreover, eliciting concern seems to be the more primitive social-normative function

[2] Danielle Petermann’s quote was retrieved from an article on thelily.com entitled "Patients are warned that IUDs can be 'uncomfortable.' But many say the pain is excruciating."

of sharing pain. Infants instinctively cry out in pain as a means of eliciting care. Because expressing pain was reliably met with aid and protection, psychologists have noted that the ability to express and communicate pain was likely naturally selected (see Williams 2001). If communicating one's pains does more than sharing one's beliefs, as recipients of these communicative acts, is simply believing the person in pain enough of a response?

Given the imperatival nature of a pain experience, a failure to be moved by a shared pain is an important form of pain dismissal to highlight. There are two fundamental features of pain: (1) pains are typically unpleasant, and (2) unpleasant pains, independent of further beliefs and desires, will motivate certain behaviors—e.g., removing our hand from a hot stove, applying pressure on a cramping muscle, seeking medical intervention, etc.—not in the sense that those in pain will always perform those behaviors, but in the sense that those in pain will always at least be moved to act (Bain, 2011). In other words, pain has a robust motivational profile. Moreover, pain acts as an inherent signal to avoid actions that have evolutionarily led to bodily injury or death and does so with such a motivating force that it often feels as if such actions are required —e.g., keeping weight off an injured body part or pulling a body part away from extreme heat. These directives aid in our survival. For example, individuals born with Congenital Insensitivity to Pain and Anhidrosis (CIPA) do not experience pain and, consequently, do not feel required to tend to bodily injuries. As a result, they are subjected to repeated injuries that often lead to a reduced life expectancy. For these reasons, *imperativists* identify pain as an imperatival state (e.g., Hall, 2008; Klein, 2007, 2015a; Martínez, 2011, 2015; Barlassina & Hayward, 2019).

In this project, I have two aims. First, I take seriously the imperativist idea that pain *commands* its audience and the potential normative implications this idea can have for the clinic. More specifically, I appeal to the nature of pain to determine what it is we are doing when we

communicate our pains to others. J.L. Austin (1962) famously noted how we could use speech to do certain actions; he called these acts *speech acts*. A speech act has three parts: the *locutionary act,* or the utterance's surface grammar; the *illocutionary act,* or the action done by the utterance; and the *perlocutionary act,* which is the effects brought about by the utterance. I will focus on two kinds of speech acts: *assertions* and *directives*. Assertions are the type of act we typically perform by uttering a declarative sentence, e.g., *It is raining.* Often, an assertion's illocutionary point, or purpose, is to transfer information. On the other hand, commands are a type of directive. Directives are the type of act we typically perform by uttering an imperative sentence, e.g., *Go to bed!* Often the illocutionary point of a directive is to modify an addressee's behavior.

Determining which speech act was performed is normatively significant. Normatively, assertions warrant that an addressee treats what was said as true and holds the speaker accountable for such. Directives warrant that an addressee does as they are told. If sharing pain is a directive—which I will argue it is—then it introduces a normative output of placing a pro tanto responsibility onto the addressee to comply with the issued imperative. A failure to be motivated by a self-reported pain would then indicate a failure to give uptake to the utterance in its function as a directive.

The second aim of this project is to explain the societal mechanisms that can cause the sharing of one's pain to fail to motivate. My thesis considers how ideologies can distort the kinds of pain expressed, i.e., menstrual pain, such that the expression of that pain fails to motivate others. Not all pains are created equal. Ideologies dictate who we think is entitled to complain about pains and what kinds of pains are worthy of our attention and care. We are socialized to appraise and respond to certain pains with concern and to others with no concern. Ideology produces pain-specific myths shared by both clinicians and patients, and such myths include but

are not limited to notions that certain pains are necessary, natural, and hence, beneficial; that pain is essential for diagnosis; that "good patients" do not complain and never challenge clinicians; that undertreated pain has insignificant economic (and psychological) consequences; that severe pain associated with cancer or after surgery is unavoidable; and that many patients with chronic, noncancerous pains are malingerers or have purely psychological problems (Brennan et al., 2007).

More specifically, I utilize Patricia Collin's (1990) notion of *controlling images* to show how ideology can create or exploit symbols to control the normative yardstick used to evaluate self-reported pains. Controlling images of pain are a systemic tool that can explain collective and individual uptake failures of certain shared pains. For example, systemically, menstrual pains are dismissed as a normal, natural, inevitable consequence of having a female reproductive system (see Cleghorn, 2021); and pains expressed by Black speakers are systemically minimized because Black people are misinterpreted as having a higher pain tolerance compared to their white counterparts (see Hoffman, 2016). I used individual cases, like Kelly's, to show how individual uptake failures can be explained by controlling images of pain. Although individual prejudice or error can result in a speaker's pain being dismissed, I am particularly interested in cases in which the addressee's evaluation of the shared pain has been disrupted by a society-held distortive representation of the speaker in pain or of the pain expressed. For now, I am tabling any questions surrounding individually held prejudices and individual culpability regarding the failure to respond to a particular pain with concern.

In the first chapter, "Sharing Pain," I characterize the kind of content found in a self-reported pain (hereafter referred to as a *pain utterance*). Until now, the communicative content of a pain utterance has never been explicitly analyzed by philosophers. I will show that pain

utterances express both a speaker's pain belief and the pain experience itself. Felt pains have been characterized as imperatival in nature; they function as action-guiding signals. For this reason, I propose that pain utterances have both indicative and imperative content. If it is plausible that felt pains function as commands, pain utterances then function as *secondary commands.* A secondary command is when a speaker, subjected to the primary command—pain—reports that they have been subjected to an imperative and then re-issues the imperative to an addressee as a means of satisfying the primary command the speaker was subjected to. In this chapter, I also stipulate that pain, whether felt or expressed, is an imperative to, *Be concerned!*

In the second chapter, "Being Concerned," I argue that pain utterances demand us to 'fire up' an *other-oriented concern*. By *other-oriented concern,* I refer to a notion of concern that configures itself as a sustained, prioritized commitment toward the speaker's well-being. I show that *other-oriented concern* differs from *empathic concern* in that the latter aims to validate another's pain while the former aims to validate *and* actively prioritize another's pain. I then show that the other-oriented concern commanded by a pain utterance shares the same proprieties and is a derivative of the *self-oriented concern* commanded by a felt pain. *Self-oriented concern* is a concern with respect to one's own well-being. I argue that because other-oriented concern is a derivative of self-oriented concern, this explains how, like a felt pain demands one's attention, commitment, and action, we, too, expect addressees of our pain utterances to be attuned, committed, and prepared to act in a way that aims to relieve *our* pain as the speaker.

Everyone has the capacity and authority to demand concern in virtue of expressing a pain experience. However, there are clear limitations to my account. In the third chapter, "Limits to the Pain Imperative," I spell out a few of these limitations. Because a pain utterance can only successfully command when it is pragmatically well-formed, an obligation to respond with

concern is not imputed if the pain utterance is performed insincerely or under inappropriate conditions. In other cases, if an addressee has overriding reasons *not* to be concerned, it can be morally permissible for the addressee to not comply with the command. However, a failure to comply is not morally permitted if the overriding reasons are ill-formed or if the addressee's reasoning utilizes a social logic tainted by ideology.

In the fourth chapter, "Dismissal as a Motivational Deficit," I aim to identify and explain a phenomenon I call *pain-related motivational deficit.* A pain-related motivational deficit occurs when ideology systemically distorts certain pain utterances such that there is a defective uptake of the pain utterance's motivational contribution, or imperative content, without disturbing the proper uptake of its epistemic contribution, or indicative content. As a result, a pain utterance that would otherwise motivate concern is believed but is responded to with a lack of concern. In this chapter, I examine controlling images of menstrual pains, labor pains, pain expressed by Black speakers, and pains expressed by obese speakers. I argue that these controlling images can prevent an addressee from recognizing the import of a speaker's pain experience, which in turn disrupts the uptake given to the imperatival content of a pain utterance.

In the final chapter, "Pain Dismissal and the Limits of Epistemic Injustice," I show how my account of pain-related motivational deficit differs from popular accounts of epistemic injustice because (1) the deficit I identify is one of motivation, not credibility or competency, and (2) pain-related motivational deficits identifies as the driving force of the deficit a societal prejudice against the communicative content—or in this case, against the expressed pain. Popular accounts of epistemic injustice identify an individually held prejudice against the speaker's social identity as what drives a pain dismissal. I also shed light on several ways pain-related

motivational deficits can be harmful in the clinic, warranting such a discussion of this phenomenon.

This project draws from bioethics, analytic philosophy of mind, philosophy of language, moral psychology, social epistemology, and black feminist theory. Moreover, I use memoirs, case studies, news articles, and documentaries featuring pain sufferers' experiences from marginalized communities to inform my views. I will return to Kelly's case throughout this project. Lastly, I would be remiss if I did not mention the project's scope. My account is limited to those pain utterances a patient provides to a healthcare professional within the clinical setting. One, this provides the clearest example of a social context in which it is reasonable to interpret the pain utterances as having imperatival content and functioning as a command. In the future, my account could be applied to cases outside the clinic, e.g., a pain utterance provided by a child to a parent, or a pain utterance provided by an unhoused person to a stranger. However, for now, I table these more complicated cases. Two, my account is intended to respond to the numerous instances of pain dismissal observed in the clinic. My primary aim is to identify impediments to our pursuit of just and equitable healthcare.

CHAPTER 1
SHARING PAIN

> If your body is telling you something, you've got to listen to it, and then you've got to get other people to listen to you.
>
> Adrienne Moore, *a Sickle Cell Advocate*

A baby in pain will instinctively cry out. The cry signals a need that the baby alone cannot meet, eliciting care and assistance from those around them. As babies develop, they gain new communicative tools—*pain utterances*—to express their pain. Pain utterances are any act that a speaker provides to communicate to another that they, the speaker, are undergoing a pain experience. A pain utterance includes but is not limited to the exclamation "ow," grimacing, moaning, gesturing to an injured body part, and uttering phrases like, "My arm hurts" or "I have a headache." Although language allows us to expand how we 'cry out' and share our pain with those around us, our communicative aim remains the same as in our infantile days.

Consider the following utterance:

I am in pain.

Sentential pain utterances like this clearly are reporting something; these utterances can express what a speaker takes as experiential facts about the pain they feel, the pain's location, and even the intensity or duration of that pain experience. Intentionalists interpret utterances like, *I am in pain*, as asserting indicative content about the said experience (e.g., Aydede, 2009; Tye, 1995; Armstrong, 1968). However, in doing so, intentionalist views about pain often assume a *cognitivist stance*—the stance that sentential pain utterances express a speaker's introspective belief about their pain and nothing else—which ignores the fact that pain 'reports' fall in the same

behavior kind as crying or grimacing. Sentential pain utterances are a complex pain behavior, culturally learned to be an expansion of the more primitive “ow,” wince, or cry. Wittgenstein makes a similar observation:

> … words are connected with the primitive, the natural, expressions of the sensation and used in their place. A child had hurt himself and he cries; and then adults talk to him and teach him exclamations and, later, sentences. They teach the child new pain-behavior… the verbal expression of pain replaces crying and does not describe it. (1953, para. 244)

Crying can be used to expresses pain. A normal addressee would not reasonably take crying to be reporting or testifying pain. The exclamation, “ow,” also expresses pain. A normal addressee would not reasonably take it to be reporting or testifying. Nevertheless, when we develop more verbally sophisticated statements such as "I am in pain" or "my chest is burning," suddenly, it is assumed that these sentential pain utterances solely express a belief. In virtue of this, it is reasonable to take these utterances as only functioning as a report. If it is plausible that a cry, an "ow," and a sentential utterance in which a speaker tells someone they are in pain are all members of the same behavior-kind, that is, pain utterances, and if we acknowledge that a cry and an "ow" have a communicative content of expressing pain, then it is plausible that pain utterances in the form of sentential utterances have a communicative content of expressing pain as well.

In this chapter, I propose and argue for a *Hybrid Expressivist Stance.* I do not deny that sentential pain utterances report. Rather, in addition to reporting, I propose that it is reasonable to interpret sentential pain utterances as expressing the pain experience itself. Just as a sincere smile expresses happiness, to claim a sincere pain utterance *expresses* pain is to suggest that one is disposed to perform a pain utterance when in pain. Along with recognizing the pain utterance as a report or act of testimony, a normal addressee can reasonably take the pain utterance as having

a unique communicative content derived from expressing the pain state itself. This content consists of an *imperative,* or an action-guiding signal. According to imperativists, a sub-class of intentionalists, pain is an *internal,* experiential imperatival state (Hall, 2008; Martínez, 2011, 2015; Barlassina & Hayward, 2019). Only the person in pain has direct access to the action-guiding signal pain conveys. However, language allows us, as speakers, to share our pain. When a person shares that they are in pain, in virtue of expressing their pain, I will argue that the imperative of pain gets expressed as well, making it available for uptake by the addressee.

This chapter proceeds as follows: In § 1, I will say more about the *Cognitivist Stance* and its limits. In § 2, I introduce *Hybrid Expressivism about Pain*, showing the causal relationship between what pain conveys when felt and what pain conveys when shared via a pain utterance. Here, I make the case that pain utterances function as secondary commands because of their unique communicative content. In §3, I address a few objections.

1 Cognitivism and its Limits

First, let me distinguish between sentential pain utterances and sentential utterances about pain. Consider the following statements:

(1) If you touch the hot stove, you will hurt yourself.
(2) David said he had a stomachache.
(3) Are you in any pain?
(4) Will the vaccine hurt?
(5) My head is throbbing.

By pain utterances, I am explicitly referring to statements like (5), sentential utterances in which the speaker attributes a pain experience to themselves. Although they are utterances *about* pain, statements (1)-(4) do not classify as pain utterances according to my definition.

Intentionalists have provided a few brief analyses of pain utterances, most often for the sole purpose of determining the intentional content of a pain experience (e.g., see Aydede 2009). However, these analyses have yet to go in the opposite direction; philosophers have yet to analyze the nature of a pain experience to determine the communicative content of pain utterances. In this brief analysis, intentionalists compare pain utterances to other reporting sentences, like visual reports. For example, Murat Aydede claims the only difference between pain utterances and visual reports is the source of their truth conditions. In describing pain utterances, he writes, "their truth conditions are determined not by the presence or absence of tissue damage, but by the presence or absence of a certain kind of experience" (2009, p. 54). However, this comparison reveals the widespread assumption that pain utterances express only *one's thoughts* about a pain experience and that, in virtue of this, it is reasonable to take pain utterances as asserting or reporting. I call this the *Cognitivist Stance* of pain utterances.

Some might find the cognitivist stance of pain utterances intuitive. First, pain utterances often have an assertive syntax, inviting a normal addressee to give them the same semantic treatment as other assertive utterances. When a person utters a statement like (5), an addressee reasonably takes the speaker to be conveying indicative information on a pain experience. Secondly, it seems reasonable to derive indicative information from a pain utterance, given that it communicates similarly to other perceptual reports. To say one is in pain conveys that one "feels" pain. This seems equivalent to conveying that one "sees" a red apple or "hears" loud music, where such verbs reliably signal a perceptual-based or introspective-based belief. In virtue of expressing an introspective-based belief, a normal addressee can reasonably take the pain utterance to be reporting or testifying.

On the surface, the cognitivist stance provides a good enough explanation for why pain utterances typically move addressees. Generating a belief in the addressee that conforms to the speaker's expressed belief is often the perlocutionary effect of a report; it is the effect that the utterance is intended to have on its audience. However, being motivated by an utterance dissociates from believing the utterance, albeit the former often follows from the latter. An utterance will not move an addressee one way or another if the addressee fails to find either the speaker credible or the utterance veridical. Nevertheless, being motivated by an utterance and finding the utterance veridical is not a bi-directional relationship. Believing an utterance can only motivate action in an addressee if the addressee also desires to act according to the newly formed belief.[3] In Chapter 4, I highlight cases where an addressee believes the speaker's pain utterance but fails to see the import of the expressed pain or is unmotivated by what the speaker is sharing. Vice versa, one could imagine cases in which the addressee does not believe the speaker's pain utterance—for example, they think the speaker is malingering or drug-seeking—but the addressee is still moved by the speaker's expression of a painful, aversive experience.

Moreover, the cognitivist stance overintellectualizes the relationship between a pain experience and a pain utterance. Under a cognitivist stance, one must have a concept of pain and the cognitive ability to appropriately apply it to an unpleasant, painful sensation to qualify as providing a pain utterance. Yet, one does not need a concept of pain to express pain or a concept of pain to elicit concern from an addressee. Infants can express pain via crying, and as clinical psychologist Amanda C de C Williams (2001) notes, it is likely that the ability to express pain was naturally selected, given that crying and other forms of pain expressions were reliably followed with acts of protection and aid from others.

[3] Here, I am appealing to the Humean claim that motivation always requires a desire.

2 Hybrid Expressivism About Pain

2.1 Expressing Pain

Conventionally, pain utterances convey that a speaker, if sincere, would perform a pain utterance only if they have a pain experience. This communicative norm is most apparent with regards to the simple exclamation, "ow": it would be contradictory to what we take "ow" to convey if a speaker sincerely uttered "ow" and was not experiencing any pain. While taking pain utterances to report and testify is reasonable, conventionally, we also consider pain utterances to be a reliable performance tool for pain since providing pain utterances requires the speaker to be in a pain state.

Moreover, like the homeostatic sensations, hunger, and thirst, restoring one's well-being is the communicative purpose of a felt pain experience. Under ordinary conditions, homeostatic sensations are strongly and directly motivating and are relatively uninformative about their causes (Klein, 2015a). If informing was the communicative purpose of feeling pain, then there would be a tight link between a pain experience and the presence of a disordered or damaged bodily state. Nevertheless, there are countless examples of the dissociation between a pain experience and a bodily injury (Wall, 1979; Grahek, 2001). The claim that pain's primary purpose is to inform can also be challenged epistemically. Often when we experience pain, we may be able to localize it, but rarely if ever, are we informed of the cause of pain via the pain experience itself (Klein, 2015a).

There is a non-cognitive, imperative quality essential to being in pain.[4] Pain represents a negative appraisal that inherently moves us. For example, Bennett Helm (2002) and Hila

[4] This is a simplistic picture of pain. Elsewhere, pain is characterized as a multidimensional complex that includes a cognitive-evaluative component (e.g., see Melzack & Wall, 1965). The cognitive-evaluative component of pain

Jacobsen (2013) speak of pains as having intrinsically motivating evaluative content like that found in a desire. Desire is an imperatival state. Helm (2002) claims that in a desire, the evaluation and motivation are inseparable such that to be motivated in a way characteristic of a desire is just to be motivated by a recognition that the object of the desire has *import:*

> to have import is to be a worthy object of attention and action insofar as something has import for one, one ought to pay attention to it and so be prepared to act on its behalf when otherwise appropriate. (2002, p.7)

The object of pain, too, has import. Pains are feelings in which the negative import, or badness, of what is going on in our bodies impresses on us, getting us to attend to it and be motivated by it. Our bodies have import in virtue of our background concerns regarding our bodies' proper function. Because of these background concerns, we evaluate the bodily damage that gives rise to a painful feeling as unpleasant or bad *for us.*

However, Helm's evaluativism paints pain as merely a messenger of bad news, suggesting pains only have import in virtue of our bodies' import. However, pain seems bad *for us* for its own sake. There are cases in which we are attuned and moved by pain even when no bodily damage is present (e.g., phantom limb pains). Moreover, if pains only had import in virtue of our bodies having import, then pains will only motivate and justify body-directed behaviors. Yet, it does not seem unjustified to "kill the messenger." We are often moved to perform pain-directed behaviors like taking painkillers (Jacobson, 2013; Brady, 2015). Later, Murat Aydede and Matthew Fulkerson (2019) distinguish between a *body-directed desire* inherent to pain and an *experiential desire* inherent to pain. Under their psychofunctionalist account, pain can also

---

refers to the *secondary* cognitive effect of pain, including the negative value one often assigns to a pain experience. To say pain is essentially non-cognitive is to say pain is *primarily* not a belief.

function as an experiential desire where the painfulness itself has the import or is the object of the desire inherent to having a pain experience.

Two, pain moves with the authority of a command. Commands are imperatives issued by an authoritative source, and it is because of this authority that a command alone can give us a sufficient, motivating reason to act. Colin Klein (2015a) famously claimed that pains have imperative content, or sensory content that tells us what to do. Because of their content, pain experiences are *bodily commands* that do not indicate a particular bodily damage but rather demand that subjects act in a particular way. Other philosophers have expressed similar views (e.g., Hall, 2008; Martínez, 2011, 2015; Barlassina & Hayward, 2019). According to Klein, pains are commands issued by the body, and the body has *minimal practical authority*: its commands give us motivating reasons to act solely because the command was issued, and we take these reasons seriously in our deliberations (2015a, p. 80). For example, when I twist my ankle and suddenly feel a sharp pain, I am moved to stop putting weight on my ankle for no other reason than the pain I felt. It is a reason I cannot simply ignore.

If pain is a command, then this still leaves the question, what is it that pain demands us to do? What is the type of imperative content that is both sufficient and necessary for an experience to be a pain experience? Various imperatives have been proposed. Initially, Hall (2008) proposed that pain demands the subject *to stop what they are doing with respect to a certain body part at a particular moment.* However, this imperative would not apply to certain chronic pain experiences, like migraines or irritable bowel syndrome (IBS). Manolo Martínez (2011) later proposed the imperative, *That this bodily disturbance is no more!*, but this cannot apply to pain experiences in which there is no known bodily disturbance, i.e., phantom limb pains or complex regional pain syndrome (CRPS). Klein (2015a) proposed *Protect X part of your body!* is the pain

imperative, but this proposal cannot apply to everyday pain experiences like menstrual pains or most abdominal pains. Most recently, Luca Barlassina and Max Khan Hayward (2019) proposed that pain is a self-reflexive imperative, *Less of Me!* This is the most applicable of the imperatives proposed; however, it fails to explain pain experiences that we form a desire to have more, e.g., eating spicy foods.

While it is unclear if there is a specific action type that all pains call for, it is well-agreed that pain's motivational character is linked to its phenomenal character—the unpleasant painfulness of pain. It is pain's unpleasantness that causes pain to consume our attention in such a way that our *concerns* are first directed to where the pain is felt (Klein, 2015a). According to Helms (2002), because pain is a negative import, it focuses our concerns. Pain achieves this by eliciting an immediate dislike or concern for itself, along with a concern for the state of the bodily region where the disturbance feels located (Tye, 1996). From this place of concern—from this disposition to desire a particular outcome— we are then moved to act in a way that brings about said outcome. In this case, because pain directs our concern to itself and to the bodily region where it is felt, we typically are moved to act in a way that attempts to relieve the unpleasantness of the pain experience, the bodily disturbance, or both. Given pain motivates various action types via eliciting concern, I will stipulate that the pain imperative is to *be concerned.* I will elaborate on this claim in the next chapter.

To be clear, I am not suggesting that pain utterances are a unique kind of utterance. Instead, I claim that pain utterances feature unique communicative content, given that pain is one of the mental states such utterances express. Pain is unique because it is an inherently motivating sensory state that is often aversive for the subject. Moreover, pain is a *homeostatic sensation.* Like hunger or thirst, pain is intimately connected with health-promoting actions. For example, a

motivation to eat is inherent to one being hungry. Hunger is so associated with a motivation to eat that it is hard to imagine someone claiming to be hungry but not being at least motivated to eat. Klein (2015a) makes a similar observation about pain. He argues that motivation is so tightly connected to pain that it is hard to imagine someone claiming to feel pain but being utterly unmoved by it. Hall (2008) goes a bit further, claiming we would ordinarily doubt that a person who is in pain but not unmoved by that pain is in pain at all. When someone says, "I am hungry," it is plausible that the utterance goes beyond reporting the sensation they have.[5] It is plausible that given the kind of state hunger, the utterance also expresses an imperative, the speaker's occurrent desire to eat. Similarly, when someone says, "I am in pain," it is plausible that the utterance, given the kind of state pain is, both reports what the speaker takes to be their sensational experience and expresses an imperative attitude: the speaker's state of concern manifested as an occurrent desire to have that pain relieved.

2.2 Hybrid Expressivism About Pain

For these reasons, I propose the following view:

> Hybrid Expressivist Stance of Pain Utterances: Pain utterances typically express two mental states, the speaker's belief about a pain experience and the pain experience itself. The pain experience is a non-cognitive imperative.[6]

One can break up this view into two sub-claims:

> (SC 1) Expressing the Pain Belief: In virtue of expressing a pain belief, the pain utterance has indicative content.

[5] Thus, a hybrid expressivist account could apply to the expression of any motivational sensory (i.e., ones that can be captured in terms of an imperative). The account most plausibly applies to the expression of homeostatic states, like pain and hunger, whose aversiveness gives the subject an inherent motivation to no longer be in that state.

[6] This project presents the first account of a hybrid expressivist view of pain utterances, but the notion of hybrid expressivism has roots in ethical expressivism. See R. M. Hare (1952) and Ridge (2006) for examples of hybrid expressivist views in metaethics. While I do not take a stance on the plausibility of ethical expressivism, these approaches influence hybrid expressivism about pain.

(SC 2) Expressing the Pain Experience: In virtue of expressing the pain experience, the pain utterance expresses the pain imperative, *Be Concerned!* Thus, the pain utterance has imperative content. If the right discursive conditions are invoked, then the pain utterance re-issues, or commands, the pain imperative.

SC 1 makes it reasonable that a normal addressee treats the pain utterance as a testimony or report. Thus, the addressee correctly uptakes the indicative content by forming a belief. SC 2 makes it reasonable that a normal addressee treats the pain utterance as a command. Thus, the addressee correctly uptakes the imperative content by forming a motivation to be concerned. I propose the following definitions of testimony and command:

Testimony: An utterance testifies if and only if a speaker's addressee reasonably takes the utterance as conveying indicative information in virtue of expressing an endorsed belief.

Command: An utterance commands if and only if a speaker's addressee recognizes the speaker as speaking from an authoritative position and the addressee reasonably takes the utterance as conveying imperative information in virtue of expressing a speaker's desire.

Hybrid Expressivism is a meta-theory of the communicative content of pain utterances. One can understand communicative content in terms of semantic content and pragmatic content. I will entertain these two potential approaches before ultimately defining communicative content more broadly in terms of a content that is reasonable to derive from the utterance.

The semantic content considers the 'denotations' and 'extensions' of a sentence's terms to determine the sentence's literal meaning. In other words, the meaning of a sentential utterance can be reduced to the meaning of its terms, which can then be explained by the mental states expressed by those terms. Sentential pain utterances feature "pain terms"—*ow, pain, hurt(s), -ache(s), burns, throbs, stabbing*—although this is not an exhaustive list. One plausible explanation for how pain utterances can covey both indicative and imperative content is that pain

terms are polysemous, where one sense refers to pain as an indicative state and another as an imperative state.[7] Recently, Borg et al. proposed that our everyday concept of pain is polyeidic, or multidimensional, "containing a number of different strands or elements (with the bodily/mental dimension being just one strand among others)" (2019, p. 30-31); the motivational/non-motivational being another dimension (Borg et al., 2019, p. 43). As a result, pain terms can have a hybrid meaning inherited from the various dimensions of the pain state.

Consider the following reported pain and compatible interpretations that are available:

(6)

a. This box is heavy! My arm *hurts*.
b. This box is heavy! My arm *is feeling painful.*
c. This box is heavy! My arm, *make it stop.*
d. This boxy is heavy! My arm*!*

(6b), (6c) and (6d) each show a different meaning that is available to the term *hurt* but is still compatible with how *hurt* is being used in (6a). (6b) refers to the sensory dimension of pain. (6c) features an imperative and (6d) an imperative mood, but both refer to the motivational dimension of pain. All three interpretations are compatible with the meaning of (6a) because they each refer to a notion of pain found in the broader concept of pain that the term *hurts* in (6a) refers to. Moreover, (6a) can be simultaneously interpreted as (6b), (6c), and (6d); the interpretations do not contradict. If it works, reducing pain's hybrid communicative content to semantic content would directly explain how one can take pain utterances to report and express an imperative.

[7] Michelle Liu (2021) proposes a similar view, suggesting pain terms are polysemous in that one sense refers to a mental state and another a bodily state. Our proposals are similar in that polysemy is used to explain how pain terms can reflect two distinct but related concepts of pain. However, our proposals differ in that Liu's view attempts to address the paradox of pain, a metaphysical issue, while I am not concerned with the metaphysical nature of pain. Instead, I attempt to capture two distinct pieces of information we can get from pain. Also, Liu explicitly argues that pain terms refer to two different folk concepts of pain rather than two different dimensions of a singular concept. I take no stake in that debate.

However, a semantic account requires complicated semantic machinery and falls victim to the embedding problem that plagues similar meta-semantic expressivist views (e.g., see Geach, 1965; Schroder, 2008). The problem is that pain utterances can form parts of more semantically complex sentences. Frege and Geach noted that terms and simple sentences should have the same meaning even when placed in these complex sentences. Suppose pain terms mean a combination of expressing a pain belief and expressing a pain experience. In that case, it should sustain that meaning even when placed in a hypothetical like the following:

(7)
If I touch the stove, then my hand will hurt.

It is unclear in (7) how "my hand will *hurt*" refers to either the speaker's endorsed belief that they are in pain or an occurrent desire to have the pain be relieved, let alone both. My definition of a pain utterance allows me to bypass this problem, but this problem is very much alive for those interested in *Hybrid Expressivism* as a meta-semantic account.

Pragmatic, or extra-semantic content, considers the meanings a speaker can convey in an utterance without literally saying that meaning. Thus, another plausible explanation for how pain utterances have a hybrid communicative content is that pain utterances have an indicative semantic content but pragmatically convey imperative content. For example, it seems the imperative of a pain utterance is cancelable and reinforceable.[8] One could utter (6) and cancel the interpretation in (6c) without contradicting the literal meaning of the utterance:

(8)
This box is heavy! My arm hurts, *but don't worry about it.*

[8] The cancelability test and reinforceability tests are standard tests to determine if the content is extra-semantic. See Grice (1975).

The “but don’t worry about it” cancels the conveyed imperative, *be concerned* or *be worried about it*. One could also utter (6) and reinforce the interpretation in (6c) without changing what the utterance (6) was being used to do:

(9)
This box is heavy! My arm hurts; *can you help me?*

The "can you help me?" reinforces the speaker's attempt to motivate the addressee to direct the addressee to a state of concern by making the implicit content more explicit.

Reducing the imperative content of a pain utterance to pragmatic content is more parsimonious and intuitive than the semantic approach. However, a pragmatic approach suggests that there is nothing special about the communicative content of a pain utterance; plenty of assertive utterances can be used to convey an imperative. However, there is something unique about the communicative content of a pain utterance. Pain utterances have pain as their content, and pains inherently have import, unlike many other states or objects. What has import, according to Charles Taylor, "cannot be neutral, cannot be something to which we are indifferent" (1985, p.48). Thus, in talking about our pains, given the imperative quality of pain, *it just is* the case that we are also talking about something that is concerning or concern-generating.

Suppose, instead, one was talking about oat milk. I tell you, "I ran out of oat milk." Suppose you have the means and opportunity to replace it; you may even have a societal role of providing oat milk. Given these conditions, by telling you, "I ran out of oat milk," it is reasonable that you, as my addressee, take me to be issuing the imperative, to *replace my oat milk.* However, being in a state of not having oat milk is not inherently a concerning state. I have the freedom to be indifferent to my own lack of milk. It is not inherent to me telling you that I have no milk that I am also expressing a desire to have that milk replaced. Instead, the desire or

imperative is secondary; it is ‘extra.’ In telling someone, "I ran out of milk," any imperative would have to be added by my intentions or use of the utterance. This is unlike telling someone, "I'm in pain," where I do not have the freedom to be indifferent to my pain. As a result, the imperative is inherent to pain being reported; my intention to use the pain utterance as a command only reinforces the already present imperative.

Although I have entertained the possibility of either a semantic or pragmatic approach to *Hybrid Expressivism*, we do not need to determine which reductive explanation of pain's communicative content is the most appropriate. Instead, for our purposes, it is enough to define communicative content as any content that a normal addressee would *reasonably* derive from that act of communication.[9] This definition of communicative content abstracts from and leaves open whether that communicative content is determined by semantic or pragmatic content.

I include the clause *reasonably* to denote that the communicative content has a reasonably obvious connection between the content the addressee derives from the utterance and what is stated in the utterance. "Reasonableness" ensures that an addressee is not expected to recognize content irrelevant to what was uttered. Jennifer Lackey (2006) gives a helpful example: It is reasonable to take the utterance "there are umbrellas in the closet" to convey that it is raining outside. However, it is unreasonable to take the utterance "bananas are yellow" to convey that grass is green. The fact that grass is green is too distinctly related to the fact that bananas are yellow. A speaker could not expect a normal addressee to derive the former from the latter.

However, there is a reasonably obvious connection between the utterance "I am in pain" and a conveyed concern or desire for the pain to be relieved. Linguistic conventions dictate that

[9] My reasonable clause is similar to that used in Jennifer Lackey's (2006) account of a hearer testimony.

someone who says they are in pain or expresses an endorsed belief that they are in pain is also liable for being in a pain state. Telling someone "I am in pain," or any other variant of this utterance reliably expresses the speaker's pain. Pain is an inherently concerning state. To be in a pain state is to be subject to the imperative, *be concerned,* and again, this imperative is so connected to pain that it is hard to imagine someone being in pain and not being concerned by it. Therefore, there is an apparent connection between someone being in pain and someone being concerned by that pain, which often manifests as an occurrent desire for the pain to be relieved. Thus, when describing or reporting pain, a speaker cannot but help to convey the import of that experience and their concern. In telling someone, "I am in pain," a speaker reliably expresses an endorsed belief that they, the speaker, are in pain, *and* they reliably expresses an inherently concerning state, pain. The desire to relieve the pain is inherent to, not distant from, the expressed pain.It is then clearly reasonable to also take the utterance "I am in pain" as conveying a desire to have that pain be relieved.

2.3 Secondary Commands

When the proper discursive conventions are deployed by the speaker—i.e., the speaker is entitled to provide a pain utterance given they have been subjected to a pain experience, and the circumstances are such that it is appropriate to use a pain utterance to elicit concern from others—then the pain utterance can be characterized as a *secondary command.*

> *Secondary Command:* An utterance is a secondary command if and only if a speaker, subjected to a primary command, testifies that have been subjected to a command and then re-issues the initial imperative to an addressee as a means of satisfying with the primary command the speaker was subject to.

Before tackling pain utterances as secondary commands, let us first consider a more straightforward example. Suppose a CEO of a grocery chain directs a local manager to change

the layout of a store. Thus, the imperative is, *to change the store layout.* With help from the local store clerks, the imperative can be satisfied. Subjected to the CEO's imperative, the manager may utter the following to the store clerks:

(10)
The CEO directed that the store layout be changed.

In virtue of testifying that the manager has been subjected to a command, utterance (10) can be interpreted as having two communicative contents: (a) In virtue of expressing the speaker's endorsed belief, the utterance reports the speaker's experience. In this case, the manager experienced being subject to a directive issued by the CEO. (b) In virtue of expressing the imperative itself, the utterance can be taken as an action-guiding signal that a world in which the imperative is satisfied is preferred. In this case, a world in which the store layout has been changed is preferred. Let us call (a) the utterance's *testimonial content* and (b) the utterance's *imperatival content*.

Imperatives have a *requiring* illocutionary force; they add the action denoted by the imperative to the addressee's To-Do List (Porter, 2004; Martínez, 2015). The imperative gives the addressee a restricted set of possible worlds, or satisfaction worlds, that consists of reasonable steps the addressee can take such that the addressee, if they so choose, brings about the denoted world in the actual world, thus, satisfying the imperative. When the CEO, from an authoritative position, commands that the store layout be changed, the imperative denotes that all worlds in which the store layout is changed are satisfaction worlds. Moreover, suppose it was part of the imperative that the store layout is *urgently* changed. In that case, all the worlds in which the addressee changes the store layout expediently are preferable to those in which the addressee changes the store layout leisurely, which are still preferable to the worlds in which the

store layout is not changed at all. The manager's secondary command inherits the imperative issued by the CEO's primary command. By this, I mean the manager's secondary command inherits the same satisfaction worlds denoted by the original command. If the store clerks were to change the store layout, their actions would satisfy the imperative expressed in both the CEO's and the manager's utterances.

The speaker re-issues or commands the initial imperative when the speaker testifies that they have been subject to a command and does so as a means of providing the addressee a *pro-tanto obligation* to act. By *pro-tanto obligation*, I mean the utterance gives a sufficient reason to act that, all things considered, the addressee is obligated to adhere to. To the extent that it is right for the addressee to comply with the imperative, then the addressee has an obligation to do so. The fact that the manager expressed an imperative, and given the legitimate authority the manager has over the store clerks, the store clerks now have a sufficient, obligatory reason to change the store's layout that they did not have before. Moreover, as a pro-tanto obligation, the store clerks are only required to act on the utterance if no other overriding or *defeating* reasons exist. If changing the store layout would put the store clerks in grave danger or have to be put off to another day (say) because the store is too crowded with customers, then the store clerks would be permitted to not comply with the manager's utterance at this time.

Secondly, the manager's utterance is a command because the utterance has two authoritative sources: The utterance has residual authority given the CEO, who is over both the manager and the store clerks, initially issued the imperative. However, the primary source of authority comes from the manager. The secondary command will only give the store clerks a pro-tanto obligation to act if the manager, too, has the relevant authority to re-issue the CEO’s

command. For example, the secondary command would be less motivating if the imperative was re-issued from, say, a child or a clerk of another store.

Pain is analogous to the CEO, and the speaker in pain is analogous to the manager. Pain experiences foster our survival by reliably directing us toward appropriate actions for sustaining our physiological well-being (Klein & Martínez, 2018; Coninx, 2020). Pain experiences perform this biological role by acting as an experiential command. When we are limited in complying with this imperative ourselves, we often turn to others for help. Providing a pain utterance is one means by which we comply with the pain imperative. By telling someone, "I am in pain," a speaker attempts to elicit care and concern from others. Pain utterances are secondary commands in that, subject to the experiential command of a pain experience, a speaker expresses the pain and re-issues the pain imperative as a way of complying with the pain imperative, *Be Concerned!*

Subjected to pain as an experiential command, a speaker may utter to another:

(11)
My head really hurts.

In virtue of expressing an endorsed pain belief, the utterance reports the speaker as vouching for the presence of a painful feeling in their head. This is the testimonial content. In virtue of expressing the pain experience itself, the utterance is an action-guiding signal that a world in which the speaker is relieved of the pain is preferred. The reported intensity—It does not just hurt, it *really* hurts—suggests a world in which one attempts to relieve the pain expediently is what is ultimately preferred.[10] This is the imperatival content. Both contents are available for uptake. However, only under certain discursive conventions is it reasonable to expect that the

[10] Imperativists spell out a pain's intensity in terms of restricting the satisfaction worlds to preferring worlds with a particular action to preferring worlds with that particular action being done expediently. See Klein (2015a); Klein & Martínez (2018).

addressee appropriately recognizes both the testimonial and the imperatival content of the pain utterance. When this occurs, the pain utterance counts as a secondary command.

The manager was the only audience when the CEO first issued the imperative. Similarly, only the person in pain has access to the pain imperative, given that pain is a *private,* experiential imperative-like state. The person in pain is the only one moved to be concerned. However, when the person in pain expresses that pain outwardly, the initial imperative also gets outwardly expressed, making it available to be recognized by an external addressee. Like the manager's utterance, the pain utterance inherits the imperative of the pain experience because the pain utterance inherits the original satisfaction worlds denoted by the pain experience. These satisfaction worlds are the same despite the person in pain and the addressee of the pain utterance being oriented differently toward the same pain experience. By this, I mean the person in pain is moved to be concerned by *their* pain while the addressee is moved to be concerned by *the speaker's* pain.

Moreover, the pain utterance gives a pro-tanto obligation to be concerned. It gives an addressee a sufficient yet obligatory reason to be concerned by the speaker's pain solely because the pain was expressed. However, like the manager's utterance, the addressee is only obligated to be concerned for the speaker's pain to the extent that no other defeating reasons exist. If, given contextual factors, the addressee has an overriding reason *not to* be concerned, then they would be morally permitted to not comply with the pain imperative. In Chapter 3, I consider cases in which an addressee is morally permitted to not comply with the pain imperative because their conflicting reason qualifies as a defeating reason.

Lastly, pain utterance has two authoritative sources: the body in pain and the speaker. The body is a source of authority for both the person in pain and the addressee of a pain

utterance. When in pain, one's body has minimal practical authority over them because one cannot simply ignore their own pain, or the imperatives issued by their own body (Klein, 2015a). Similarly, as Kate Manne (2017) has noted, any subject's bodily imperative can make moral claims on others. Manne argues that pain as a moral imperative is parasitic on pain's metaphysical imperative structure. The unpleasantness of a pain experience gives pain the authority alone to impute a moral obligation over us not to cause pain and to alleviate pain and suffering when present in others.

However, this universal moral obligation issued by the body in pain is not enough to explain why we are motivated by some people's expressions of pain and not by others. While the pain utterance has residual moral authority, given the body in pain initially issued the imperative, the pain utterance will only give the addressee a compelling, motivating reason to relieve *this* particular pain experience if the speaker, too, has the relevant authority. The speaker must also be recognized as entitled to re-issue the pain imperative and as having the authority to impute an obligation onto another. What determines entitlement is simple: a speaker is entitled to re-issue the pain imperative if they have a pain experience. What determines whether the speaker then has the authority to impute an obligation onto a particular addressee is tricky. There are various notions of authority that one can consider—e.g., epistemic authority (they have authority on this subject matter), relational authority (like a parent to a child), social authority (authority granted by one's position on the social hierarchy), or legitimate authority (authority granted by their legal or professional position). In sum, pain's moral authority may give a normative reason to lessen another's pain, but only by recognizing the speaker's authority to re-issue the pain imperative does an addressee take that normative reason as a justifying reason to be concerned by the particular pain experience of this specific speaker.

3 Objections

One may think that I am appealing to the imperative qualities of a pain state and simply re-packaging them as the imperative properties of an utterance.

Neuroscientific studies suggest that just simply being aware of another person's pain can trigger concern in others *as if* those aware of the person's pain had been subjected to the pain imperative themselves, i.e., *as if* they, themselves, had the pain experience (Vignemont & Jacob, 2016). For example, one study showed that the affective component of the brain responsible for the unpleasantness of pain (the anterior insula, anterior cingulated cortex, thalamus, and brain stem) could be activated when participants saw an arrow indicating that a pain stimulus was inflicting their partner or when they saw a facial expression of pain (Singer et al., 2004). By activating the affective component, observers shared the affective state, i.e., pain. However, in sharing the affective state, the observer and the person in pain also share the emotional and motivational significance relevant to the affective state (Vignemont & Singer, 2006). To put it in terms of the language I have been utilizing: In sharing the affective state, the observer and the person in pain also share in the pain's *import.* These studies suggest that a pain utterance is unnecessary to "share" pain or concern with others. To be moved to concern, a person does not necessarily have to be the addressee of a pain utterance.

I agree that the person in pain does not need an intended recipient for the pain expression to still be considered a pain utterance or communicative act. Pain expressions have evolved to function as a signal that one is in pain and as a cue for assistance, and they convey this information independent of the expressive individual's intentions or awareness of this communication (Williams, 2002). Even if a speaker does not direct their pain utterance to a particular audience and does not intentionally re-issue the imperative, a pain utterance can still

express the pain imperative, making it available to be recognized by any bystanders. A speaker does not have to be aware of their audience to express the imperative, *be concerned.* Just as we can recognize indicative information from 'eavesdropping', so, too, can we take in and comply with imperative information from 'eavesdropping' or from observing a pain expression.

However, what explains why it is reasonable for the addressee to be moved to concern is the fact that the speaker is in pain *and* is invoking conventions that give the pain utterance the effect of functioning as a secondary command. There is no denying there are instances in which a speaker does not intend to provide a pain utterance, yet, a pain imperative was still expressed via a pain expression, and the observer had a psychological reason to be concerned. However, an utterance only counts as re-issuing the pain imperative when the appropriate discursive conventions are invoked. [11] When the appropriate discursive conventions are invoked, the pain utterance acts as a secondary-address, or *call*, shifting the normative status between the speaker and an addressee. If a mere observer or hearer of a pain utterance fails to recognize and be moved by the pain imperative expressed, they will not violate communicative expectations. On the other hand, an addressee of a pain utterance does not have this same freedom. If an addressee (due to bias, not a cognitive error) fails to recognize and be moved by the expressed imperative, they would be committing a communicative wrong. I will say more about *calls* in the next chapter.

4 Conclusion

[11] Some may argue that the imperative, to *be concerned*, is derived from either (1) pain as a moral imperative or (2) from a clinician's occupational duty; that the motivation to be concerned is not derived from pain's metaphysical imperative structure. I respond by noting the plausibility that pain's moral imperative and a clinician's occupational duty to relieve pain stem from the fact that we consider pain unpleasant. The connection between the unpleasant badness of pain and the imperative to be concerned is regarded as a brute fact in many ethical theories. One explanation is that the moral imperative is parasitic on pain's metaphysical imperative structure. Our ethics may be informed by pain's nature, just like our pain language. Kate Manne [2017] argues such a view.

Philosophers have long noted a parallel between pain experiences and commands. Both produce in their addressee a motivating reason to act. However, these theories have only used command speech acts to explain the strong motivational force of a pain experience. This chapter aims to bring the discussion full circle by claiming, that in virtue of expressing pain, which functions as an experiential command, pain utterances uniquely function as secondary commands. Moreover, as I will show in upcoming chapters, my account has normative implications, especially within the clinic. Clinicians have a professional duty to relieve pain and suffering, making them uniquely obligated to pick up on the saliency of the imperative expressed in patient-provided pain utterances. Given the unique content of a pain utterance, this invites the question of whether an addressee's belief in a pain utterance is really all that is required for the pain to be successfully communicated. But for now, I will table this question and, instead, delve deep into what it means to be concerned.

CHAPTER 2
BEING CONCERNED

> Pain is meant to make us pay attention, to warn us like flares being shot up into the night sky. At first, it's brief: a cry for help that, if it goes unanswered, will only get louder, a flame that, if left unattended, will burn brighter and longer.
>
> Abby Norman, Author of *Ask Me About My Uterus*

An utterance's content contributes to its normative function. For example, an assertion is often characterized as having indicative content; what an assertion often aims to do, or what it often has as its normative output, is an entitlement for both the speaker and addressee to form certain beliefs or make certain inferences. On the other hand, an order or command is often characterized as having imperative content; what a command often has as its normative output is a pro tanto responsibility placed on the addressee to comply with the imperative that was issued. In Chapter 1, I identify the communicative content found in a pain utterance. This chapter examines a pain utterance's typical normative function given its unique imperative content.

In the last chapter, I stipulated that pain, whether felt or expressed, is an imperative to, *Be concerned!* This chapter aims to expand and defend that claim. Fundamentally, concern is a disposition to act in accordance with a particular desire or aversion. A person can have background concerns about their own well-being or the well-being of others, and given the right input, these concerns dispose one to act in a caring way. A command to, *Be concerned!*, is then that input. When pain is felt, it is a demand to 'fire up' *self-oriented concern,* a concern with respect to one's *own* well-being. When pain is expressed as a pain utterance, it is a demand to 'fire-up' *other-oriented concern,* a concern with respect to the *speaker's* well-being.

We are easily motivated by our own well-being; we often act in a way that promotes our own interests, goals, or survival. However, humans are social beings who behave altruistically towards strangers with no chance of reciprocation. This non-kin, non-reciprocated altruistic behavior is nearly universal among humans—psychopaths excluded—and has not been observed in any other species on such a broad scale (Vlerick, 2021). This suggests that, as humans, we are disposed to act in a caring way toward others. We are the kind of creatures who are also motivated by others' welfare.[12] Given these dispositions, we have prima facie reasons to respond to the deprivations of others' well-being and are sensitive to demands to 'fire up' *other-oriented* concern. This is especially the case for clinicians.

However, recent discussions in clinical ethics blur two distinct but interrelated responses to another's pain. The first response is an *empathic concern* and the second response I call an *other-oriented concern.* Colloquially, empathy is defined as the ability to 'feel with' another person or to put oneself into someone else's shoes. More specifically, Clarissa Guidi and Chiara Traversa define *empathic concern* as a notion of concern that "configures itself as a genuine interest towards the other" and is an "attitude that gives value to the act of welcoming and acknowledging the complexity in the experience of those suffering "(Halpern, 2011; Guidi & Traversa, 2021, p. 575). Regarding pain, empathic concern is often characterized by an addressee's attempt to share in what it is like for the speaker to experience the particular pain being expressed. On the other hand, *other-oriented concern* often takes the form of (1) attention, (2) a beholdenness to the restoration of the speaker's well-being, and (3) action when otherwise appropriate. I argue that empathic concern is an insufficient response to another's pain utterance

[12] Peter Singer (1981) makes a similar point in his book *The Expanding Circle.* Here he argues that, throughout human history, we have expanded our circle of moral concern. We have evolved from valuing only our interests to valuing the interests of our family, our tribe, our nation, our race, and of humankind more broadly.

because, with empathic concern, the aim is to validate another's pain. Other-oriented concern goes a step further; other-oriented concern aims to validate *and* actively prioritize another's pain.

I characterize pain as a command for concern, and as a command for concern, pain typically demands attention and action from both the person in pain and the addressee of the pain utterance. Empathic concern alone suggests that one is responding to a pain experience as if it is worthy of attention. However, other-oriented concern suggests that one is responding to a pain experience as if it is worthy of attention *and* action. After showing the limits of empathic concern, I will show that the other-oriented concern commanded by a pain utterance shares the same properties and is a derivative of the *self-oriented concern* commanded by a felt pain. This can explain how, like a person in pain responds with attention, commitment, and action to their own pain, we, too, expect addressees of our pain utterances to be attuned, committed, and prepared to act in a way that restores our wellbeing when we share our pain. In the last section, I will establish a normative floor for clinical encounters by providing a few recommendations on what other-oriented concern could look like in the clinic.

1 Why Not Empathy?

Clinicians have recognized that responding to patients with empathy has its benefits. Empathy improves clinicians' collection of patients' medical history, patient adherence to treatment, patients' capacity to cope with bad news, clinicians' ability to resolve difficult conflicts with patients, and lowers physician-reported error rates (Anzaldua & Halpern, 2021, p. 23). Furthermore, empathy is generally believed to be a driver for helping and caregiving behaviors. On the surface, empathic concern is a sufficient response to another's pain.

Let us start with a simple picture of how an addressee can respond to a pain utterance with empathy. Jennette Fulda told her acupuncturist, "I've had a headache for over nine months

now.” In her book, Chocolate & Vicodin: My Quest for Relief from the Headache that Wouldn’t Go Away, Jennette reflects on her acupuncturist’s response:

> She winced like I had pinched her. "Oh, so, so sorry," she said genuinely, as if we actually had been hooked into each other's nervous systems…Her empathy had made me feel validated. I had a witness to my pain, someone who acknowledge that it was real and that it was a true burden (Fulda, 2011, p. 137).

By wincing, the acupuncturist responded as if she was *feeling with* Jennette, or affectively sharing Jennette’s pain. Many scholars refer to this form of empathy as *affective empathy.* Affective empathy results from *affective resonance,* or feeling what others feel. Often affective resonance is a spontaneous process, the 'catching' of a feeling from another, like suddenly feeling tense when one walks up on a couple who just finished having a heated discussion. However, empathy would be highly problematic if it only equated to affective empathy. Affective resonance is vulnerable to 'similarity bias,' or the tendency to resonate better and deeper with those who resemble and are near and dear to the addressee (Stefanello, 2022). Furthermore, affective resonance or affective sharing alone can cause personal distress, compassion fatigue, and burnout, which in turn can actually cause a long-term decrease in empathic concern and helping behavior (Stefanello, 2022; Guidi-Traversa, 2021).

That said, the acupuncturist's response also indicated an *understanding* of Jennette’s experience. She believed that Jennette was in pain, but she also put herself in Jennette’s shoes. Many scholars refer to this form of empathy as *cognitive empathy.* Imagining how hard it must have been to be in ceaseless pain for nine months and struggling to find a treatment that works, the acupuncturist expresses her cognitive empathy with an apology. Cognitive empathy results from *perspective-taking or* seeing another's lived experiences from their point of view. Perspective-taking often occurs through perceiving and attributing mental states to others, then

mentally simulating those mental states so that we can understand others' perspectives of the world (Guidi &Traversa, 2021).

However, like affective empathy, it would be problematic to reduce empathy to just cognitive empathy. Because cognitive empathy can result from a simulation process, an addressee's understanding of another's pain is limited to what an addressee can imagine about that pain experience (Guidi &Traversa, 2021).[13] For example, it may be difficult to imagine what excruciating menstrual pain truly feels like for a speaker if the addressee has never shared that experience. As a result, cognitive empathy may risk obscuring rather than shedding light on patients' experiences of pain. Secondly, cognitive empathy can also look like a *detached concern* from which the person in pain is treated "as an *object* for observation and judgment, rather than a *subject* with whom physicians interact" (Guidi& Traversa, 2021, p. 577).[14] Lastly, whether perspective-taking leads to an empathic concern greatly depends on why one is interested in the other's perspective. For this reason, cognitive empathy can also be consistent with the cruelty of sadism (Darwall, 1998).

In order to avoid the potential pitfalls of privileging one form of empathy over another, scholars like Jodi Halpern have pushed for a more inclusive and holistic definition of what empathy entails from a clinician. *Clinical empathy* is defined as the affective capacity to 'feel with' the suffering of the patient *and* the cognitive ability to put oneself in the patient's shoes. According to Halpern, clinical empathy results from an *emotionally engaged curiosity,* or a

[13] Cognitive empathy can also result from invoking a folk psychological theory about others' minds; this is a theory-theory account of cognitive empathy. However, it would be problematic to reduce empathy to just cognitive empathy qua theory-theory because it requires us to understand all the main factors that influence another's behavior/mental states. Such a task may be too computationally demanding to actually be achieved. (see Spaulding, 2017).

[14] In fact, Halpern proposed her notion of clinical empathy as a response to mainstream medical culture's privileging of cognitive empathy. She worried that emphasizing cognitive empathy while simultaneously suppressing one's emotions mistakenly makes a cold, detached concern the professional ideal (see Halpern, 2001).

“genuine, emotionally engaged interest in learning more about the complexity of the patient’s (and our responsive) emotional points of views” (2011, p. 308). When a clinician’s curiosity is emotionally engaged, the clinician responds to a patient’s pain by allowing their *feeling with* the patient to guide how the clinician *imagines* what the patient is experiencing. On Halpern’s account, feeling pain or discomfort with the patient helps guide one's curiosity toward the source of the patient's concerns.

Clarissa Guidi and Chiara Traversa (2021) suggest that Halpern's emotionally engaged curiosity is a precondition for empathic concern. I can now specify what I mean by “empathic concern.” Empathic concern *is a genuine interest in the lived experience of the speaker such that the addressee forms a detailed experiential and cognitive understanding of the expressed pain experience.* I take empathic concern to be an interest in the import of the expressed pain, an acknowledgement that the speaker "feels like something is wrong" or experiences their own pain as a bad state for them to be in. Instead of a generalized empathy, empathic concern is a recognition and acknowledgment that individuals may experience the same kind of pain, i.e., a headache or an abdominal cramp, differently. For example, while many may assign little to no import to their own headaches, Jennette expressed a headache she experienced as having grave negative import. Suppose, instead, the acupuncturist said, "Oh a little headache? That's all?" Clearly, this would indicate a lack of experiential understanding of how Jennette was feeling.

Importantly, this account of empathic concern translates to a commitment to *validate* the speaker's expressed pain, as articulated in Jennette's reflections. However, this commitment only partially complies with a pain utterance's imperative. The specific actions commonly demanded by a pain utterance are those aimed at relieving or lessening the speaker’s unpleasant pain experience for the purpose of restoring the speaker’s well-being. Empathic concern typically

motivates behaviors that communicate an attunement and emotional engagement with the speaker in pain. The clinical empathy that generates an empathic concern is action-oriented in that it motivates non-verbal resonance behaviors, i.e., one's tone of voice or facial expression, that communicates to the patient that the clinician is attuned (see Anzaldua & Halpern, 2021, p. 24). The addressee or clinician may also ‘check back' with the patient to confirm or to correct their shared understanding ("Do I have this right?") (Garden, 2009, p.123). Although the reception of this attunement can be healing for the patient, affective resonance and the validation of another’s experiences are not aimed at restoring another's well-being, although they serve as a helpful starting point. Empathic concern mediates caring and helping behaviors only when an attunement and sensitivity to another's pain is paired with a sustained commitment toward the wellbeing of that speaker (Decety et al., 2016).

Before I move on, one may also think that given empathic concern involves affective empathy or presumably some vicarious pain experience, it can be action-oriented in the sense that it also motivates behaviors aimed at the self. For example, an addressee responds with vicarious pain if they, in some sense, *feel* the speaker's pain, and this vicarious pain is caused by the speaker's pain (Vignemont & Jacob, 2016). However, not all vicarious pain experiences are empathic. According to Frédérique de Vignemont and Pierre Jacob (2012; 2016), some vicarious pains are contagious pains, and contagious pain experiences are self-centered in that one mistakenly takes themselves to be the one subjected to the unpleasantness of the physical pain. An addressee has a contagious response to another's pain when they tense or wince as if anticipating the pain in their own body. This could motivate behaviors aimed at alleviating the addressee's own discomfort, i.e., removing themselves from the situation, or helping in so far as it makes the addressee feel better. Clearly, such actions do not comply with the imperative issued

by the pain utterance as they do not attend to or actively prioritize the *speaker's* pain. Moreover, for Vignemont and Jacob (2012), contagious pain can never equate to empathic pain. The former is self-directed, the latter other-directed. Empathic pains are other-directed in that the addressee has a pain experience similar to the speaker, *and* the addressee is aware that the speaker is the one subjected to the unpleasant pain.[15] Self-directed and other-directed are inconsistent properties of an experience (Vignemont & Jacob, 2012, p. 304). Thus, empathic pain or empathic concern will likely not motivate self-directed behaviors; such motivations likely indicate the presence of a contagious pain or concern instead.

2 Self-Oriented and Other-Oriented Concern

I propose that a felt pain typically demands from the person in pain (1) attention, (2) a beholdenness towards restoring well-being, and (3) action when otherwise appropriate. Given the demands expressed by a felt pain, a person complies with the pain imperative when they respond with *self-oriented concern*: *attention and a sustained commitment to the restoration of one's own well-being.* Self-oriented concern often manifests as an occurrent desire to relieve the pain or relieve the deprivation of one's well-being.

In Chapter 1, I argued that, given pain utterances share the same imperative as felt pain experiences, pain utterances, too, share the satisfaction worlds denoted by a pain experience. The satisfaction worlds consist of the reasonable steps an addressee of pain can take to satisfy the imperative, *Be concerned!* Thus, pain utterances also typically demand from their addressees (1) attention, (2) a beholdenness towards restoring well-being, and (3) action when otherwise

[15] Interestingly, Vignemont and Jacob (2012) claim that what distinguishes empathic pain from contagious pain is an *ascription condition*—X is aware of Y's being in s—and a *caring condition*—X must care about Y's affective life. Although I am hesitant to call it empathy, I see these two conditions as compatible with my proposal that proper uptake of a pain utterance's indicative content will generate knowledge in the addressee and proper uptake of a pain utterance's imperative content will 'fire up' the background concerns they have regarding the speaker's well-being.

appropriate. Given the demands expressed by a pain utterance, an addressee complies with the pain imperative when they respond with *other-oriented concern: a genuine interest in the lived experience of the speaker and a beholdenness to the speaker's welfare such that the addressee is prepared to relieve the deprivation to the speaker's well-being when appropriate.* An other-oriented concern is a derivative of and has similar properties to a self-oriented concern.

In this section, I will unpack each of these demands by combining real pain sufferers' testimonials with recent insights from philosophers and experimental psychologists studying pain's effects.

2.1 Demanding Attention

People in pain often report feeling consumed by their pains, that the pain 'grips' their attention, and that they are unable to focus on anything else. As Jennette Fulda writes,

> 604,800 seconds of pain. Constant pain…Worst of all, it was a shiny object distracting my attention, a small child screaming, "Look at me! Look at me!" There was no room for thoughts about the plans for the weekend and what to eat for dinner. The headache was all there was now (2011, p. 20).

Pain demands our attention but does so such that its relief becomes our priority. On all theories of pain, pain's effect is to orient one toward not-being-in pain (Reynolds, 2022).

Attention can be defined as a dynamic mechanism for the selection of action. Experimental psychologists suggest pain's perceived threat value, novelty, and intensity capture or give access to our focal attention (Eccleston & Crombez, 1999; Moore, Keogh, & Eccleston, 2012). To understand how pain interrupts one's attention, Chris Eccleston & Geert Crombez give the following example:

> … imagine again that while you have been listening to the fascinating story, you eat hot food. Suddenly, the current attentional engagement with the story is interrupted as your burnt tongue produces pain. Also interrupted are other ongoing actions: For example, you make a sharp intake of breath as regular respiration is interrupted. Action programs that enable a focus on the story are halted, and new action programs are prioritized aimed at escaping from the noxious input. Current engagement switches to the pain and its threat value: Escape is urged (1999, p. 362).

This example shows pain's ability to disrupt attentional (and actional) engagement and impose a new behavioral priority of escape; pain can also impose a behavioral priority of avoidance or social alarm. Moreover, this example shows that when multiple things are competing for our attention—i.e., continue to listen to the interesting story or attune to the pain—pain will typically override other attentional demands. A tendency to selectively attend to pain over competing material is observed in both acute and chronic pain states (e.g., Pearce & Morley, 1989; Van Damme, Crombez, & Lorenz, 2007; Moore, Keogh, & Eccleston' 2011).

There are also philosophical explanations as to why pain grabs our attention. As mentioned in Chapter 1, Helm characterizes painful feelings as feelings of negative *import.* He defines import as a kind of worth imparted by an individual's concern for a thing (Helm, 2001, p.32). For example, because of my own background concern or interest in the proper function of my ankle, the state of twisting my ankle is something that has (negative) import for me. My painful feeling is a feeling of this negative, or bad, state. It grabs and consumes my attention because I assign this state import. What it is like to feel pain is to have one's attention gripped by the badness of something in such a way that one thereby feels the pull to act appropriately. What it is like to feel pain is to be "enthralled" by import: "the import of a state impresses itself on us, exerting a basic attraction upon our minds, foremost with respect to our attention, but in consequence with respect to our motivation "(Helm, 2001, p. 79; Monteleone, 2017, p. 185). In

other words, to be enthralled by import is to be moved by it. Thus, the feeling of pain I have not only grabs my attention, but it also moves me to, say, stop putting weight on my ankle.

Similarly, pain utterances often have as a perlocutionary effect, or normative output, a demand for an addressee's attention and consideration. Empirical studies on attentional allocation to pain expressions show evidence of this. Research has shown we have an attentional bias toward others' pains. Using eye-tracking technology, studies suggest that others are more likely to fixate on pain facial expressions when both pain and neutral facial expressions are presented (Pilch et al., 2020). These studies also showed that greater pain expressiveness would induce faster detection and longer gaze duration. In an unsophisticated, primitive way, people are simply more likely to respond to others' pain with attention.

Moreover, the fact that pain utterances often elicit attention and a reaction from their addressee is a communicative norm shared by addressees and speakers alike. In one qualitative study, researchers examine the intentions behind pain behaviors from both the perspective of the patient in pain and their romantic partner. Patients voiced an awareness that their pain utterances elicit a reaction they would not otherwise get: "When I am in a severe pain, I express it verbally. If I do not directly mention that 'I am in pain', he would not have any reactions" (Akbari et al., 2020, p. 753). Partners voiced a similar awareness: "When she verbally discloses her pain, the pain might not be that severe, but she expresses it in order to make me understand that she is in pain because I do not show any reaction to other behaviors that she shows" (Akbari et al., 2020, p. 753). It is because pain utterances have this conventional effect, speakers may perform pain utterances insincerely or catastrophically as a way of “seeking attention.” In the next chapter, I will say more about how the conventions of pain utterances can be misused in this way.

2.2 Beholden Towards Restoring Well-Being

Some obligations are discharged as soon as you comply with the command. If I ask you to shut the door, once the door is closed, you are no longer under that obligation. Other obligations remain in force on an addressee even as one complies with the command. If I tell you to watch after my dog, you are obligated to watch and then keep watching my dog until I tell you to stop. Klein claims that felt pains issue the second kind of obligation. More specifically, he claims that felt pains issue a *standing imperative: "*It is an imperative that remains in force as long as it continues to be issued and until it stops. In that sense, pain is like a fire alarm. The fire alarm gets you to evacuate, and stay evacuated, for as long as it rings" (2015a, p.16). Klein gives the example of pain in one's ankle. The pain orders that one protects one's ankle, keep weight off one's ankle, etc., and does so until the pain ceases. Because pain is a standing imperative, it imposes a behavioral priority for both the present and future. The important takeaway is that pain typically demands *continuous* action. It typically demands a commitment or dedication to comply and continuously comply when pain calls.

Pain also typically demands that we be 'on call.' Joel Reynolds (2022) implies as much in his characterization of the *beholdenness* of pain. For those with chronic pain, one is beholden by their pain or obligated to act when called. As Reynolds notes, "At any point, pain may call for one's services, for being retained means that one is obligated to jump at such a call" (2022, p. 46). While Klein describes pain as demanding a commitment to comply when such a call is made, for Reynolds, pain also demands a commitment to be *vigilant* for such a call. By *vigilance* here, I mean to claim that pain demands habitual alertness, a readiness to selectively attend to and act on a pain when present. Again, this demand for vigilance falls from the fact that pain involves negative import. For example, Chapman (1978) was one of the first researchers to apply

the concept of (hyper)vigilance to pain. He considered hypervigilance to be an emergent property of the threat value, or negative import, of pain. For individuals who appraise pain as dangerous or appraise pain as a state that is bad for them to be in, they were more likely to develop a perceptual habit of scanning the body for pain; in the clinic, these individuals may contemplate the ineffectiveness of past medical interventions and continue to seek ways to control their pain (Crombez, Van Damme, & Eccleston 2005).[16]

Felt pains can *call* for the person in pain to be beholden to the body's claims for attention and action. Similarly, pain utterances can *call* for their addressees to be beholden to a speaker's claims for attention and action via a pain expression. In Chapter 1, I showed that pain utterances have, in part, imperative content and they function as secondary commands. Imperatives are a type of second-person address, or *call.* Second-person addresses are speech acts that "call upon 'you' to give uptake to specific normative statuses by acting in some range of ways" (Lance & Kukla, 2013, p. 457). When an addressee gives uptake to the fact that the speaker occupies the proper authoritative position to make such demands, the addressee can gain a pro tanto reason to act that they did not have before, i.e., a speaker's pain utterance can create a pro tanto reason to, say, grab the speaker a Tylenol.

However, to properly respond to a pain utterance as a *call,* it is not enough to coincidentally hand the speaker a Tylenol (i.e., the addressee was already handing the speaker a Tylenol before the pain utterance was issued), nor is it enough that the pain utterance causes the

[16] While pain may demand vigilance, hypervigilance may be an ineffective and, arguably, inappropriate way to respond to pain. Clinicians have long noted that a hypervigilance to pain can cause, or at least significantly contribute to persistent, distressing, and preoccupying chronic pain. To continue the parallel between felt pains and pain utterances, one can think that pain utterances demand only a certain level of vigilance, such that it is inappropriate to respond with hypervigilance. The hypervigilance exhibited by those with Factitious Disorder Imposed by Another (FDIA), formerly known as Munchausen syndrome by proxy, might be such an example. That being said, it is difficult to draw a sharp line between vigilance and hypervigilance (see, Eccleston & Crombez, 1999).

addressee to hand the speaker a Tylenol (i.e., the pain utterance triggered a mechanical response in the addressee. The addressee is simply following a protocol). To properly respond to a pain utterance as a *call*, the addressee must give uptake to the relational reason to act by recognizing that the pain utterance *calls* for a normative shift in the relationship between the speaker and the addressee. The pain utterance functions to impute a normative burden, or to bind, the addressee to what is being commanded. The speaker now also has the right to hold the addressee accountable for those actions or the lack thereof. Tylenol ought to be given out of a recognition of this normative shift.

A quick caveat: While pain typically demands a beholdenness from both the person in pain and the addressee, the addressee's beholdenness significantly differs from that experienced by the person-in-pain. As Adam Smith notes in *The Theory of Moral Sentiments,*

> When I suffer some misfortune or am done some injury, my companion doesn't *naturally* take the same view of this as I do. It affects me much more nearly. He and I don't see it from the same vantage-point, as we do a picture, a poem, or a scientific theory, so we are apt to be differently affected by it (Bennett, 2017, p. 9).

A pain utterance's addressee is free to ignore or 'walk away' from the demands of the pain imperative in a way that the person in pain is not. In virtue of having direct access to pain's insistent demands for attention and response, the person in pain cannot simply choose to forgo pain's attempt to impute a sustained commitment to one's well-being. Because we are deeply invested in and dependent on our own well-being, we cannot simply choose to 'walk away' from the obligation to act when pain calls. Although the person in pain may be able to ignore or override individual pain experiences to a certain extent, an addressee is free to actively choose how invested they are in a speaker's well-being; they can actively choose not to accept the responsibility of being beholden or retained to another's pain. This difference in freedom makes

the dismissal of others' pains normatively significant. Just because we *can* ignore pain's demand to be committed to restoring another's well-being, *should* we?

For this reason, when clinicians do initially attune and act on a pain utterance but fail to attune or act on that pain utterance continuously, pain sufferers often voice frustration and disappointment at the clinician's failure to respond to their pain utterance as a 'call for alarm.' In *The Atlantic* article, "How Doctors Take Women's Pain Less Seriously," Joe Fassler describes the lack of sustained action and urgency given to his wife's, Rachel's, pain utterance. On a scale of one to ten, Rachel was asked, with ten being the worst, how bad was her pain? Rachel answered, "Eleven." Her husband described Rachel as being nearly crucified with pain, arms gripping the metal rails blanched-knuckle tight. Her husband, re-enforcing the pain utterance, says to the nurse: "My wife, I've never seen her like this. Something's wrong; you have to see her." The nurse responded, "She'll have to wait her turn." Joe voiced his frustration:

> From an early age, we're taught to observe basic social codes: *Be polite. Ask nicely. Wait your turn.* But during an emergency, established codes evaporate—this is why ambulances can run red lights and drive on the wrong side of the road. I found myself pleading, uselessly, for that kind of special treatment (Fassler, 2015, Oct 15).

Rachel and her husband expected that the nurse would recognize and acknowledge the claim that Rachel's pain utterance had made on the nurse. The pain utterance called upon the nurse to give uptake to the expressed pain as a standing imperative. Like the "special" treatment given to an ambulance, it was expected that the pain utterance be met with a range of actions, and that the nurse continues to act for as long as Rachel's pain persists. When precisely an addressee can be said to have done their best to fulfill this persisting standing obligation is a difficult question that I will attempt to address in the next chapter.

Secondly, pain sufferers typically hold addressees of their pain utterances to a certain level of vigilance. By vigilance here, I mean to claim that pain utterances typically demand a readiness to investigate the pain when present. A vigilant addressee is habitually curious, engaging with the speaker in such a way that the addressee establishes a cognitive, experiential, and clinical understanding of the pain. These are the same characteristics of an addressee who is empathically concerned. When clinicians fail to respond with this vigilance, pain sufferers feel as if their pain utterance was "dismissed," as if their claims received no uptake. This has especially been the case for obese pain sufferers. To briefly return to Kelly's case, when Kelly told her gynecologist about her excruciating cramps, she expected the gynecologists to run further exams. This expectation is reflected when Kelly writes, "My mom had told me how horrible internal exams were. I hated getting blood drawn. I braced for which would come first" (2017). However, when her gynecologist simply looked Kelly up and down and told her to lose weight, Kelly expressed confusion at the gynecologist's lack of vigilance in response to her pain: "Wasn't she curious about what was inside me? Wasn't she worried it might be something serious? Nothing that hurts that bad can be nothing, can it?" (2017). Kelly recognized the claim for vigilance made by her pain utterance, which now made the gynecologist's *lack* of vigilance normatively significant.

Both a felt pain and a pain utterance are demands for a sustained commitment and a certain level of vigilance, but this still leaves the question, committed and vigilant to what? If pain, whether felt or expressed, is an imperative to *Be concerned!*, what is it that pain calls us to be concerned about?

On the surface, the answer seems simple. Pain calls us to be concerned about and care for one's bodily integrity. Many philosophers suggest just this (e.g., Helm, 2001; Hall, 2008;

Martínez, 2011; Bain, 2014; Vignemont, 2015; Klein, 2007, 2015b). Klein goes as far as to claim that the only plausible common motivational force behind a pain experience is the concern and care we have towards the fate of our bodies; that this is the immediate import of pain:

> Pains motivate because we care about our bodies. Were we to stop caring, something that's nearly impossible, for good biological reasons, then pains wouldn't matter (2015b, p. 500).

He argues that this is the case for those with *pain asymbolia*, a rare condition caused by lesions to the posterior insula. Patients with *pain asymbolia* can recognize their experiences as pain, but in some important sense, it has ceased to be something worth caring about (Klein, 2015b, p. 511). According to Klein, this is because the pain asymbolic experiences a certain detachment from that pain. The pain asymbolic is indifferent to their body, and their body becomes just another object in the world: "An object, perhaps, that still commands you to care for it—but not an object that you have any deeper reason to care for than anything else around you"(Klein, 2015b, p. 510).[17] Notably, Klein stipulates here that only when we care about our body, *and* we identify that body as our own, are we given a strong pro-tanto reason to be moved by pain.

Klein's claim that pain calls us to be concerned about one's *own* body overly restricts the target of concern. For example, patients with somatoparaphrenia (a condition where patients deny ownership of a limb) reported feeling painful sensations in their 'alien' limb. They also displayed normal pain behaviors, including aversive reactions to the pain in the 'alien' limb (Vignemont, 2015). Somatoparaphrenia challenges the notion that a sense of bodily ownership is required to be motivated by a pain experience. Moreover, the same brain area is activated (i.e.,

[17] Klein (2015b) further argues that this phenomenology resembles the DSM IV definition of *depersonalization,* 'a feeling of detachment or estrangement from oneself.' This feeling of depersonalization is potentially caused by damage to the insula.

ACC and bilateral anterior insula) when one feels a motivating, unpleasant pain for oneself and when one observes another person suffering (Singer et al., 2004; Vignemont & Jacob, 2012; Vignemont, 2015). Thus, the motivational force of a pain experience can also be activated by *others'* bodies. For this reason, Frederique de Vignemont suggests the target of concern is "*the body,* no matter whose body it is" (2015, p. 549).

Vignemont's weaker claim that pain calls us to be concerned about *the* body does explain how we can be motivated by others' bodies in pain. However, it still fails to address why pain moves us to take experiential-directed actions, like taking painkillers, with either ourselves or another as the target. Luca Barlassina and Max Hayward note that often we only take steps to protect our bodies because this seems to be the best way to avoid or lessen the pain (2019, p. 1024).

On the surface, it looks like pain calls us to be concerned about bodies, but given the limitations mentioned above, I propose that pain is typically calling us to be concerned about *well-being,* no matter whose well-being it is. Hedonists considered pains to be basic welfare *bads.* Welfare theorist, Shelly Kagan, goes as far as to say that pain is a plausible candidate for a *robust bad*: states of affairs that directly constitute a life going badly (2014, p. 262). Generally, the presence of pain makes life worse off; persistent, unrelieved pains can lower one's overall level of well-being. Well-being describes what is non-instrumentally or ultimately good for a person. Bodily integrity is good for a person, but so is one's quality of life, including how one experiences their life, mental health, or the ability to pursue one's life goals. Pain impedes each of these things, which all fall neatly under the umbrella of "well-being." Thus, forming a self-oriented or other-oriented concern prompts actions that relieve the deprivation of one's well-

being, actions aimed at relieving the source of the well-fare deprivation or the pain experience itself.

This then raises the following question: As persons in pain and as pain utterances' addressees, is it that we are beholden to alleviating the deprivation of one's well-being, or are we beholden to alleviating the unpleasant pain experience? What are we committed to acting on in cases in which the deprivation of welfare is not accompanied by pain (e.g., having a spinal fracture but feeling no pain because of shock), when there is a feeling of unpleasant pain accompanied with a boast of well-fare (e.g., feeling pain while running), or even in overdetermined cases (e.g., a person is in pain because they are having a heart attack)? To be clear, I am not stipulating that pain *necessarily* demands a beholdenness to remove the deprivation of one's well-being. However, typically, the two are one and the same. Being subjected to an unpleasant pain experience *is* a deprivation of one's well-being in and of itself, and a commitment to restoring well-being would require attempts to relieve the pain. Moreover, an unpleasant pain experience typically also acts as a *signal* of an additional deprivation of one's well-being, i.e., a person is in pain because they twisted their ankle. In such cases, being committed to restoring one's well-being may require attempts to relieve the initial source of the welfare deprivation. There will, of course, be counterexamples in which a commitment to alleviating the pain experience and a commitment to alleviating a deprivation of one's well-being is at odds.

2.3 Demanding Action When Otherwise Appropriate

Pain is quite flexible as far as when and what particular action one can choose to relieve the deprivation of one's well-being. For the person in pain, self-oriented concern can prompt a diverse set of actions: drink a cup of coffee, drink a cup of water, take ibuprofen, seek a

clinician, provide a pain utterance, etc. Similarly, for a pain utterance's addressee, other-oriented concern can also prompt a diverse set of actions: offer comfort, soothe, provide ibuprofen, run diagnostics, treat the pain's source, etc. Intentional action is sufficient for a person to be self-oriented concerned or other-oriented concerned, but it is not necessary. This is because pain only demands intentional action when it is appropriate to do so.

Thus, a *lack* of these intentional acts does not entail a lack of concern. A person can be moved to concern by a pain but may have incompatible goals or more pressing concerns they need to act on. Suppose you were running from a lion. You may be concerned by the sharp pain you suddenly feel in your foot, but at the moment, you are too busy running for your life. Or a more modern example. A woman is concerned by the persistent pain in her lower back, but there is nothing she can do about it now; she has too much work to do. Moreover, a person can be moved to concern by another's pain but not be in the (best) position to act on that concern. For example, a mother who is concerned by her child's stomach pains but at the moment does not act. She knows the clinician currently examining the child is more qualified to take actions aimed at relieving her child's pain. In these circumstances, an addressee of a pain utterance can still have concern about another's well-being, even if the target of this concern is being realized through the actions of others. If the circumstances were different, and the mother was equally qualified to act, then it is reasonable to think that the mother would act on her own concern. Lastly, the circumstances can be such that the addressee is in no position to act on their self-oriented concern, like being told via text that my friend's at home with a headache. If the barrier of space were removed, I would presumably relieve my friend's pain (Presumably, comforting my friend with an "I hope you feel soon!" text could also be sufficient.)

To summarize: Pain requires attention and a response that indicates a commitment to well-being. A person can still be self-oriented or other-oriented concerned and not necessarily take intentional actions at that time. Concern only requires that you act when otherwise appropriate.

3 Other-Oriented Concern in the Clinic

When Kelly told her gynecologist of the nausea-inducing, life-stopping cramps that she had been experiencing, the gynecologist responded with boredom and annoyance. The gynecologist did not touch Kelly, nor did she run any tests. After hearing Kelly's pain utterance, the gynecologist simply told Kelly to lose weight. Clearly, the gynecologist was unconcerned by Kelly's pains. But what would it have looked like if the gynecologist was adequately moved to an other-oriented concern? More broadly, what does other-oriented concern entail from clinicians when they are the addressees of a pain utterance?

First, other-oriented concern requires responding with attention. In one sense, attention in the clinic can look like responding to the pain utterance with non-verbal attunement behaviors, i.e., maintaining eye contact or nodding. However, in a deeper sense, to give attention to a patient's shared pain is to be *interested* in that expressed pain. Again, Guidi & Traversa's notion of empathic concern is helpful here. Empathic concern is a genuine interest in the lived experience of pain for the patient speaking. This genuine interest can look like a clinician actively listening to the patient, i.e., following the patient's narrative, recognizing the meaning and value the patient is assigning to their pain, and when appropriate, asking follow-up questions to help identify how that pain experience has impacted the patient's quality of life or life

narrative.[18] In Kelly's case, the gynecologist's boredom signals a lack of interest. If the gynecologist was interested in Kelly's cramps, the gynecologist would have presumably asked Kelly to "say more," e.g., How long has this been going on?

Second, other-oriented concern requires responding vigilantly to the patient's pain. Just like a vigilant person in pain habitually scans their body for pain, a vigilant clinician uses the diagnostic tools at their disposal to be habitually alerted to the pain's source. Vigilance requires that a clinician, in good faith, investigate the shared pain to the best of their ability. A lack of vigilance can result in a missed or delayed diagnosis. However, a lack of a proper, accurate diagnosis does not entail that a clinician failed to be vigilant. Clearly some expressed pains require little to no investigation. If a patient with a broken femur comes into the ER complaining of leg pain, a clinician does not have to go deep into their diagnostic toolbox to be alerted to the source of that pain. However, when a diagnosis or treatment plan stems from bias-induced reasoning and has been provided without entertaining other possible explanations, we can question whether the clinician investigated the shared pain in good faith. Some cases I have in mind include telling a patient to lose weight as part of a treatment plan for an ear infection or identifying that a woman does not have kids as the reason they are bedridden.[19] Kelly's weight was identified as the source of Kelly's pains, and because no further tests nor evaluations were done to generate other possible explanations, we have reason to doubt that the diagnosis was provided in good faith. Vigilance in Kelly's case would have involved conducting exams (i.e., blood exam, vaginal exam, applying pressure to the abdominal) before writing off the pain as an

[18] Such an approach is also highlighted in the notion of *narrative medicine*: to practice medicine with narrative competence as a way of enabling empathy. *Narrative competence* is the ability to listen to the patient's narratives, grasp and honor their meanings, and be moved to act on the patient's behalf. For more, see Charon, 2001.
[19] Both are real statements that were said by clinicians. The former was reported in a 2018 Self Magazine article entitled "Weight Stigma Kept Me Out of Doctors' Offices for Almost a Decade," and the latter was reported in a survey conducted by TODAY News.

'obesity pain.' It is possible that if the gynecologist was more vigilant, Kelly's endometriosis would not have taken twenty years to be diagnosed.

Lastly, other-oriented concern requires a standing commitment and beholdenness to the patient's pain. In the clinic, this standing commitment and beholdennness is often aimed at managing a patient's pain. An individual clinician is on call and continues to be on call to manage a patient's pain as long as the pain persists.

Simply telling Kelly to lose weight without explaining *how* she could lose weight and how the weight loss will directly address the pain signals a lack of sustained commitment with regards to Kelly's pain management. A nonchalant, "lose weight," is dismissive in a wave of the hand kind of way. It signals a lack of stake in the outcome of Kelly's pain. In a sense, the gynecologist complied but indicated no interest in further complying with the pain utterance. If the gynecologist had a standing, sustained commitment to Kelly's pain, further pain management options would have been offered *along with* the recommendation to lose weight. Such a recommendation would have consisted of practical steps Kelly could take to make the desire to manage her pain feasible.

That being said, this standing commitment looks at odds with persistent pains, like those that constitute most chronic pain conditions or those found in the dying process. However, palliative care embodies this standing commitment on the institutional level by being a specialty dedicated to managing a patient's pain and suffering, even when a condition is chronic or terminal. It is harder to say for how long and to what extent an individual clinician ought to be committed to managing a patient's pain. More specifically, if the relief of the pain does not indicate the removal of the standing imperative, what does, if anything? These are tough questions that I will attempt to address in the next chapter.

4 Conclusion

As secondary commands, pain utterances share pain's demand for one's attention, commitment, and action when otherwise appropriate. This is important because although empathy often fosters caregiving behaviors and serves a valuable role in the clinic, pain demands more than an empathic response. When providing a pain utterance, the speaker in pain is making claims for not just validation but also that one makes a behavioral priority relieving or managing the speaker's pain. Every speaker in pain has the capacity and authority to demand another's attention and action. However, in the next chapter, I will identify a few pragmatic and normative limitations to this claim.

CHAPTER 3
LIMITS TO THE PAIN IMPERATIVE

> Unfortunately, this is one of the earliest lessons in masculinity and it starts the first time a boy hurts himself or suffers disappointment. He'll begin to cry and someone, whether it's a father or a mother, will tell him "boys don't cry." The scolding is bad enough in that it tells the boy he's not allowed to show his emotions and that crying, a perfectly natural coping mechanism, is not appropriate and serves to differentiate the sexes.
>
> Jared Yates Sexton, Author of *The Man They Wanted Me to Be*

Thus far, I propose that everyone in pain has the capacity and authority to demand concern from others in virtue of expressing that pain. Because a pain utterance functions, in part, as a command, when a pain is shared with an addressee, the addressee is now obligated to respond with concern. Notably, a pain expression conveys a demand for concern independent of the expressive individual's intentions or awareness of this communication. Because the ability to demand concern does not rely on intentions or awareness, infants and animals, too, can re-issue this demand. On the surface, this seems like a big bullet to bite. Can I really suggest that whenever we are the recipients of a pain utterance, we are now, in some sense, bound to attune to and act on that pain? I am.

That being said, there are clearly limits to this claim. Here are what I take to be common exceptions to the view:

1. **A pain utterance performed insincerely.** A soccer player suddenly rolls around in the grass, dramatically holding his ankle. There are 30 seconds left in the game.

2. **Local conventions deem it inappropriate to elicit concern.** A teenage girl participates in the ritual of female genital cutting (FGC). The point of the ritual is to experience pain; in this context, invoking concern may not be allowed.

3. **An overriding reason *not* to be concerned.** The clinician is worried that the speaker will develop an opioid addiction, which gives the clinician reason to withhold (pharmaceutical) care.

In the first two scenarios, the pain utterance does not 'count' as a secondary command because the pain utterance was not satisfactorily performed. In the first scenario, the pain utterance was performed insincerely. In the second scenario, the universal conventions that give a pain utterance the effect of a secondary command were disallowed in that particular context. Whether or not a pain utterance 'counts' as demanding concern is deeply influenced by local or cultural conventions. In the third scenario, the pain utterance counts as a secondary command, but the clinician may be morally permitted to not comply with the pain imperative. However, if the addressee's reasoning is a by-product of or tainted by pejorative ideologies, a failure to comply with the pain imperative is not permitted. Moreover, if the addressee fails to comply with the pain imperative and this failure results from ideology-induced reasoning, then the speaker has been communicatively wronged, and the lack of concern is the wrong result. I will refrain from saying anything about whether the individual addressee is blameworthy in these cases. I am more interested in the systemic structures that allow these wrongdoings to occur.

In this chapter, I will consider each exception to my account in turn before briefly considering the limits of the pain imperative with regard to chronic pain. Chronic pain raises interesting yet challenging questions as to when it is morally permissible to *stop complying* with the pain imperative.

1 Performed Insincerely

A pain utterance can only successfully command if the pain utterance is *felicitous* or pragmatically well-formed. Like other speech acts, pain utterances, too, have felicity conditions.

Felicity conditions must be fulfilled for a speech act to 'count,' or be satisfactorily performed (Austin, 1962; Searle, 1969).[20] If the pain utterance is performed insincerely or, given the circumstances, the speech act is inappropriately performed, then the pain utterance is *infelicitous.* An *infelicitous* pain utterance fails to act as a command, and as a result, a demand for other-oriented concern is not issued. Thus, the addressee is not given a pro tanto obligatory reason to respond with concern.

An insincere pain utterance is provided by a person who is not in pain, often with the intent of deceiving their addressee. To clarify, a speaker can be *presently* pain-free and still provide a sincere pain utterance that 'counts' as a command for concern. For example, suppose a patient shares with their primary care physician the headache they had yesterday, or the knee pain they experienced last week. It just happens to be the case, as they are presently communicating with their doctor, the pain has temporarily subsided. Clearly, the pain utterance is still sincere in that the speaker *was* in pain and did not intend to deceive the addressee. However, intuitively, one would think that the pain utterance still imputes an obligation for the physician to respond with concern. The following explanation is available. Often, the patient takes themselves to be expressing a *recurring* pain. Although the pain has temporarily subsided, the speaker is still beholden to the initial standing imperative to be concerned. When the patient communicates about the headache they had yesterday, they are re-issuing the standing imperative they have been subjected to. As long as the pain will (potentially) continue or re-occur, even if

[20] Searle (1969), a student of J.L. Austin, identified four rules concerning felicity conditions: *sincerity condition,* which requires that the speaker be performed sincerely and seriously; *preparatory condition,* which requires that the circumstances and the authority of the speaker be appropriate to provide the utterance; *propositional content,* which requires that the content of the utterance be plausible or coherent; and *essential condition,* which requires that the speaker intend that the utterance be acted upon.

the patient is presently pain-free, the demand to be concerned remains in force for the addressee, just as it remains in force for the person in pain.

Moreover, one might immediately worry that there is no way of knowing whether a speaker is intentionally deceptive. We do not have epistemic access to others' intentions. Secondly, writing off another's pain utterance as insincere is a prominent form of pain dismissal; a form of pain dismissal that is particularly unjust when the evaluation of insincerity is made under the guise of ideology (i.e., a Black speaker in pain being misperceived as insincere or drug-seeking due to anti-black racism). If an addressee does not know if the pain utterance is insincere, then the addressee ought to operate as if the pain utterance 'counts.' Without evidence of insincerity, the default position holds: the pain utterance places the addressee under an obligation to respond to the speaker's pain with other-oriented concern. However, can we ever have evidence of insincerity with respect to pain utterances? Pain is unique in that it is inherently action-guiding but is also unique in that it is a subjective, private state. Like intentions, we do not have epistemic access to others' pain. No objective tests exist to assess pain, so we must rely on a speaker's pain utterance.[21] Acknowledging these worries, I contend that there can still be insincerity in the speech act itself. Insincerity can be found in the plausibility of the performance of the speech act, given the context and associated conventions of expressing pain.

For example, soccer (or football) players are notoriously known for dramatically feigning pain or 'playing up' an injury. In soccer, once halted, a play cannot continue if a player is injured or in pain (Derbyshire, Angel, & Bushell, 2016). To abuse this rule and others, soccer players will often perform an implausible pain utterance: A player who is barely touched falls to the ground, flopping around, grabbing his ankle; a player who is tackled takes another two strides,

[21] Although there currently does not exist an objective test for assessment pain, scientists claim to be making progress (see, e.g., Elster, 16 Apr 2023).

and when he is entirely in control finally falls over; a tackled player displays additional rolls that could not plausibly be part of the momentum of the fall; a player is hit by an elbow in the chest but instead, falls to the ground clutching his face (Morris & Lewis, 2010). Their behaviors suggest a deliberate strategy to feign pain as a way of eliciting a response, i.e., an attempt to get the referee, their addressee, to halt the game. However, FIFA, the organization that governs international soccer, recommends that referees issue a yellow card, or a warning if an implausible performance of pain is detected. The rationale: exaggerated performances during a game should be met with a penalty rather than concern.

To clarify, a speaker can be overly expressive while providing a pain utterance and the pain utterance still 'counts' as a command for concern. When a pain utterance seems to express a more intense pain than the speaker is actually in, the speaker is often accused of catastrophizing, and the performance is often interpreted as implausible. Because of this, there is a tendency to discount overly expressive pain utterances.[22] However, a speaker's cultural background can influence how expressive a speaker may be while sharing their pain.[23] A cultural difference in *display rules of pain*—or the socially learned standards that regulate the expression of pain—does not equate to a difference in the plausibility of the pain utterances.[24] For example, one study found that Arab Americans tend to be overly expressive with pain by emphasizing and exaggerating the pain (Sobralske & Katz, 2005).

[22] For example, a study by the University of Miami (2021, 6 Apr) suggests that women's pain is discounted because of the stereotype that women are overly expressive.

[23] A speaker's cultural background can also make them more likely to be stoic or under express their pain. Whether stoic pain utterances still 'count' as a command for concern is a tricky case. In some scenarios, speakers are intentionally stoic or suppressing their pain expression, potentially to cancel the pain imperative—i.e., *Don't worry, I'm fine!* In other scenarios, what is interpreted as an under-expression of pain is not intentional. Arguably, in those scenarios, the pain utterance still 'counts' as a command for concern.

[24] Cases in which patients from marginalized backgrounds must 'perform' or exaggerate their pain utterances to account for the systemic discounting or diminishing of their pains still count as sincere pain utterances for my account.

How then do we distinguish implausible, deceptive pain utterances like those performed by soccer players from pain utterances that appear overly expressive given cultural differences? That is a tricky question. Again, all things considered, the default should be to respond to a pain utterance with concern. However, if the pain utterance clearly violates conventions or display rules of pain such that the pain utterance is implausible given the circumstances, it is likely the pain utterance is insincere and fails to issue any obligation to the addressee. Importantly, ideology can, too, distort the interpretation of a pain utterance's plausibility by invoking and sustaining non-representative, illegitimate display rules of pain. I will say more about this in the next section.

2 Local Conventions & Inappropriateness

According to Austin, for a speech act to be pragmatically well-formed,

> There must exist an accepted conventional procedure having a certain conventional effect, that procedure to include the uttering of certain words by certain persons in certain circumstances (1962, p. 14).

Such a conventional procedure exists when it comes to pain. Display rules of pain are culturally held conventions about the plausibility and appropriateness of a pain utterance. Not only do we consider the appropriateness of the intensity of the pain utterance, but we also consider whether the circumstances are ones in which a speaker's pain expression has the conventional effect of eliciting concern in their addressee.

A pain utterance is infelicitous if it is provided under circumstances in which it is conventionally inappropriate to express pain. Austin would say the pain utterance then *misfires*, or "the procedure which we purport to invoke is disallowed or is botched" (1962, p. 167). An example of a speech act misfiring can be found in Donald Davidson's example of an actor

unsuccessfully warning the audience about a fire. The actor is performing a scene that includes a fire. However, the actor really sees a fire in the back of the theatre. The actor screams, "Fire! I mean it!" The actor genuinely attempts to warn the audience but to no avail. It can be argued that something about the conventions of the theatre constrains the speech acts the actor can make—i.e., "the act of warning has been made unspeakable for him" (Langton, 1993, p. 317). Similarly, social conventions can make a pain utterance in its function as a secondary command 'unspeakable' for a person in pain.

2.1 Establishing Local Conventions of Pain

We are all taught display rules of pain, and we are taught these rules as early as infancy. Infants engage in social referencing or look to their caregivers for cues about how they should react to a pain-inducing situation. For example, if an infant or child sees their caregiver expressing concern after they fall, then they, too, learn that falling or getting hurt is concerning. On the other hand, if they see that their caregiver is not panicking, then the infant learns that they do not need to panic.

When infants learn to walk, they fall an average of 17 times an hour. In a study of 563 spontaneous falls, researchers found that caregivers expressed concern only 7.64% of the time (Adolph et al., 2012). Instead, much of the caregivers' language demonstrated encouragement (i.e., "You're fine. It's fine.) or redirection (i.e., "There's a ball, can you go get the ball?). The caregivers' lack of concern teaches the infant that spontaneously falling while learning to walk is trivial; although falling leads to discomfort, that it is 'not that bad.' The babies in the study would not only fall and immediately get back up, but they also only fussed or expressed pain 4.26% of the time. Thus, the baby and the caregiver now share the societal procedure that trivial falls do

not need to be attended to, and as such, one should not express pain, or demand attention, after a trivial fall.

However, because of this socially established procedure, and others, certain attempts at providing a pain utterance can misfire. Our normative expectations about how much pain one is in after a fall make it so that certain sincere attempts to demand attention and care are disallowed.[25] Consider what I take to be a common scenario:

> It is the middle of a little league baseball game. David is rounding second and heading to third when he suddenly trips over his own feet and falls. David clutches his scrapped knee and begins to cry. The coach runs to assess the situation. "It hurts," says David. The coach tells David "You are a big boy. Walk it off." David limps off the field.

Although David attempts to elicit concern, display rules of pain prevent David's pain utterance from 'counting' as a command. Again, this notion that trivial falls do not need to be attended to prevents the resulting pain utterance from having the conventional effect of demanding concern. Some identity-based display rules are at play here as well. Mantras like "boys don't cry" or "take it like a man" indicate an acceptable range of feelings or emotions that a young boy can express. Masculine norms dictate that a boy ought to be strong, and self-reliant; absent of grave injury or distress, a young boy does not get to be the kind of person that can make claims for aid or comfort. As a result, our social practices around masculinity and falling are such that the pain utterance is unsuccessful in imputing an obligation onto the coach.

Some display rules of pain are legitimate in that they capture and reinforce relatively accurate perceptions of threat value or injury. Teaching children not to overreact to trivial falls or

[25] An interesting yet complex example of how a pain utterance can be disallowed is when a perpetrator of harm (or even a provider of charity) inappropriately attempts to redirect attention and care to themselves by expressing pain. Examples include a person crying and expressing being offended after causing pain in another person or a person expressing pain after carrying a box of donated canned food to the recipient. Thank you to Quill Kukla for bringing this case to my attention.

injuries is such an example. However, other conventions or display rules of pains fail to track perceptions of threat or injury but, instead, can function to reinforce pejorative ideological messages about who is entitled to make claims for attention and care. Masculine norms about pain fall into this camp. Gendered rules of pain utterances are harmful when used to systemically make pain utterances unspeakable for men and make pain utterances unbelieved for women.

We are socialized with both legitimate and illegitimate display rules of pain. Unfortunately, the violation of both can nullified the conventional effects that make a pain utterance a secondary command.

2.2 Deemed Inappropriate

Rituals are a helpful example of situations where expressing pain is typically considered inappropriate. Often pain is the point of a ritual. For certain religious rituals, like self-flagellation, enduring pain is supposed to strengthen one's faith or bring one closer to God (Glucklich, 2001). For other painful rituals, like certain tribal rituals, enduring pain is an act of group affiliation and fosters belongingness to a particular community. In situations such as these, participants often express little to no pain.[26] Commanding concern from others via a pain utterance would not only be inappropriate given the goals of the rituals, but it would also be counterproductive.

Consider the highly contested ritual of female genital cutting (FGC). Practiced in certain regions of Africa and the Middle East, FGC is a painful ritual conducted around the time that a woman reaches puberty. In one study, Somali-Canadian women who were interviewed acknowledged that it was the most painful experience they ever had but also described it as

[26] Some studies suggest that participants of painful religious rituals express little to no pain because they positively appraise the pain and so do not suffer or find the pain unpleasant or because they have dissociative experiences during the painful ritual (e.g., see Glucklich, 2001).

"something you have to pass" —a gateway to womanhood (Jacobson et al., 2018, p.6). Anthropologist Bettina Shell-Duncan (2015) witnessed an FGC ceremony during her time in Kenya and made the following observation,

> No, no, she was proud. She sat there stoic and looked up at a focal point. She didn't flinch, and that's apparently a really important part of showing your maturity: Can you withstand the pain? It shows that you have the maturity to face the hardship that is coming as a woman.[27]

An expression of pain would bring shame upon the girl and her family. In other words, it is vital to the FGC ritual that the girls endure their pains 'like the grown-up woman' they are about to become (Schultz & Lien, 2022).

The local conventions associated with FGC constrain the pain utterances made during the ritual and about the ritual. R. Elise B. Johansen (2008) describes FGC as a *muted experience* of pain. During the ritual, pain utterances in their function as a secondary command for concern are disallowed and even silenced. When a girl screams out, conventions are such that the elder women in the ceremony are cued to sing even louder to drown out the girl's cries (Khazan, 8 Apr 2015). Moreover, pain utterances about FGC are largely undiscussed in the communities where the ritual is practiced. The conventional practice is to talk about FGC just enough to prompt acceptance of the ritual and carry on the tradition without (openly) questioning it (Shultz & Lien, 2022). The local social discourse causes some to feel as if they cannot speak about the pain they had during the ritual (Johansen, 2008). The threat of stigma or exile results in a smothering or silencing of their own pain utterances. The worry is that if women did speak on the pain

[27] This quote was retrieved from an interview Shell-Duncan captured in The Atlantic article entitled "Why Some Women Choose to Get Circumcised."

experienced during FGC, it would be counterproductive to keeping the tradition alive as collective attention would shift to the short- and long-term harms associated with the practice.

3 Morally Permitted Not to Comply

There are also cases in which, even if the felicity conditions are met, and the pain utterance successfully issues a demand for concern, it is *morally permissible to not comply* with the pain imperative. Often such cases can be explained by the presence of *overriding defeaters*.[28]

I define an *overriding defeater* as a stronger reason or concern that overrides or cancels the demand for concern issued by a pain utterance. Although the pain utterance may initially provide an addressee with a pro tanto obligatory reason to be concerned, that reason can be overridden by other pressing reasons that would temporarily 'excused' the addressee from being bound to attune and act on the expressed pain. Because it is rational to engage in intentional actions that are responsive to reasons, one is justified in responding to a stronger reason for inaction *even if* that means one fails to comply with a particular obligatory reason for action.

Pain utterances provide sufficient, obligatory reasons to be concerned that the addressee did not priorly have. Sometimes these reasons to be concerned conflict with other things the addressee has going on or other imperatives the addressee is subjected to. As mentioned in Chapter 2, felt pains will typically override other attentional demands, and we typically expect our shared pains to have a similar effect. Nevertheless, it is important to consider the ranking induced by a particular pain utterance and how it compares to the ranking of other held reasons.

Both imperatives and pains can differ in intensity or force. Klein and Martínez (2019) usefully cash out intensity or force in terms of a ranking function in which more intense, urgent

[28] The notion of an overriding defeater was initially proposed by John L. Pollock (1974: 42-43) in discussing evidence and justified belief. According to Pollock, if a subject previously believed a justified proposition, *P*, but *S* gives the subject a reason to believe not *P*, then *S* is an overriding defeater.

imperatives will, all things considered, rank their own satisfaction worlds higher than the satisfaction worlds denoted by less intense imperatives. Moreover, conflicting reasons for action typically have mutually inconsistent rankings. Take, for example, Peter Singer's Drowning Child thought experiment. One has a reason to save the child drowning in the pond, but one also has a reason to keep their new suit dry (i.e., they are on their way to an important philosophy conference). The ranking corresponding to saving the child places worlds in which the person's suit gets wet higher up than worlds in which the suit stays dry; the ranking corresponding to keeping the suit dry has these preferences reversed. Arguably, the imperative to save the drowning child has more force than the imperative to attend the philosophy conference, given that the former is a moral imperative and the latter a mere professional one. The moral imperative *defeats* the reasons one has to attend the conference. Satisfying the higher-ranked worlds induced by a more intense imperative will, if necessary, trump satisfying the ranked worlds induced by the less intense imperative.

Although an addressee *ought* to respond to a pain utterance with an other-oriented concern, when an addressee responds to stronger reasons not to be concerned, such a failure to comply with the pain imperative is morally permitted—however, the source of the overriding defeater matters. As I will show, when the demand for concern is overridden by ill-formed reasons or reasons rooted in society-wide, pejorative, ideological practices, then not complying with the pain imperative produces the wrong result.

3.1 Inducing Pain in the Clinic

Clinicians must routinely inflict pain on patients to improve their well-being in the long run. Whether a clinician is administering a vaccine, drawing blood, or setting up an IV, patients

often communicate pain or discomfort. Rarely does this sharing of pain move the clinician to cease inflicting pain.

It can be argued that because a patient previously consented to be inflicted with pain, their consent 'cancels' the pain imperative. Such an argument is too quick. I can initially consent to a procedure, but if it becomes unbearable and I express such, it would be wrong to remain unmoved by my pain utterance just because I initially consented to *some* pain. A patient being pricked by a needle can plausibly and appropriately provide a pain utterance as a means of eliciting care and concern. Although the clinician recognize that this pain utterance alone provides them a pro tanto reason to alleviate the pain, the clinician can fail to comply with the re-issued pain imperative.[29] However, in a case like this, we would not describe the continued inflicting of pain as the wrong response, nor would we describe the patient as being communicatively wronged. Instead, regarding the routine use of needles in the clinic, the clinician is temporarily excused from being beholden to removing the pain.

In fact, studies suggest that physicians will often suppress the attention they give to others' pain to free up the information processing resources used to make higher-level cognitive responses necessary for clinical problem-solving. In one experiment, physicians who practice acupuncture were asked to watch videos of needles being inserted into another person's hands, feet, and areas around their mouth (Cheng et al., 2007). These physicians showed significantly less response in the brain regions involved in empathetic pain and showed significantly greater activation in areas of the brain involved in executive control, self-regulation, and theory of mind

[29] Of course, it can be said that clinicians, while inflicting pain, still respond with other-oriented concern by showing comfort, i.e., "*I am sorry, this is going to hurt a little."* However, if one has the means and opportunity to relieve a speaker's pain, this would typically be the way an addressee would respond with other-oriented concern. For the sake of discussion, I assume that a pain utterance is calling for relief of the pain.

compared to non-physicians.[30] The researchers conducted another experiment tracking the brain's event-related potential (ERP). They showed that physicians who practiced acupuncture did not even show an early empathetic response to pain (Cheng et al., 2007). These physicians were able to be more effective in practicing acupuncture, by overriding the pain imperative to be concerned.

Suppose a clinician is placing an IV in a patient's arm. The IV will be used to administer a life-saving drug. While placing the IV, suppose the patient says, "Ow! That hurts!" All things considered, if the speaker does not intentionally cancel the pain imperative the pain utterance counts as a secondary command in that it has the conventional effect of subjecting the clinician to the imperative, *be concerned!* The clinician has a reason to inflict pain on the patient (i.e., they want the patient to receive the necessary medication). However, after being a recipient of the pain utterance, the clinician now has a new reason to stop inflicting the pain (i.e., the patient has demanded that the clinician makes as a behavioral priority the relief of this new impediment to the patient's well-being).[31] The ranking corresponding to saving the patient's life places worlds in which the patient continues to experience pain higher up than worlds in which the clinician relieves the pain by prematurely stopping the IV placement; the ranking corresponding to attending to and immediately relieving the pain has these preferences reversed. Clearly, the gravity of what is at stake if the clinician *does not* place the IV (i.e., death) is more 'intense' than

[30] Increased activity in the area of the brain responsible for the Theory of Mind is not the same as being affectively empathic or affectively motivated by another's pain. The Theory of Mind is a complicated concept that is most associated with the notion of cognitive empathy.

[31] One could think that clinicians routinely inflicting pain on patients with needles is an interesting case because, on the surface, it looks like the conflicting reasons the clinicians have to both inflict pain and to relieve pain are actually derivatives of the same reason: concern for the patient's well-being. Depending on the context, concern can manifest as a variety of different occurrent desires, i.e., a desire that the patient be protected from certain diseases, a desire that the patient receives necessary intravenous medication, or a desire that the patient be relieved from pain. Thus, the clinician could have a reason to be concerned for the patient's well-being in the long run but fail to have a reason to be concerned now manifests as a motivating reason to stop inflicting pain on the patient.

the pain typically expressed after being pricked by a needle. Thus, it is reasonable and morally permitted that the clinician act on the overriding, more 'intense' reason to temporarily inflict pain rather than act on the reason to be concerned provided by the patient's pain utterance.

Suppose the patient sincerely communicates an excruciating, torturous pain during the IV placement. Suppose the patient is particularly sensitive to needle pricks. The intravenous drug would still be life-saving, but now, the more intense pain expression equates to the clinician being subjected to a more intense imperative to be concerned. Can we still conclude that the reason to inflict pain overrides the pain imperative in this case? Can we still say the clinician is temporarily excused from attending to and acting on the expressed pain? It would be dangerous to operate as if the seriousness of saving the speaker's life always cancels an expressed pain imperative; such a governing principle quickly leads to a slippery slope. Regardless of other reasons the addressee has or other imperatives the addressee is subjected to, it does seem like certain pain experiences are so intense—and thus when expressed, the pain imperative is so intense—that it becomes morally *impermissible* to not attend to them. A prime example would be tortuous pains. As Scarry demonstrates, torture, or intense pain, is world-destroying:

> It is the intense pain that destroys a person's self and world, a destruction experienced spatially as either the contraction of the universe down to the immediate vicinity of the body or as the body swelling to fill the entire universe. Intense pain is also language-destroying: as the content of one's world disintegrates, so the content of one's language disintegrates; as the self disintegrates, so that which would express and project the self is robbed of its source and its subject (1985, p. 35).[32]

[32] Some might read this as meaning that torturous pains can never be communicated. Scarry claims intense pains destroy language and causes a revision to pre-language, i.e., cries and groans (1985, p. 6). Cries and groans can count as pain utterances under my account.

Imitating the pattern of death, a torturous pain destroys the very conditions for a subject to exist (Reynolds, 2022, p. 55). A torturous pain does not just impede one's well-being, it destroys it. The conflicting reason not to relieve the speaker of a torturous pain must be of the utmost importance to override the demand for concern toward a condition that *actively destroys* the speaker's well-being. It is not apparent to me, all things considered, that prolonging death—if not demanded by the speaker/patient—necessarily cancels the intense imperative re-issued by the expression of a torturous pain.

3.2 The Case of Opioids

Clinicians also face conflicting obligations with regards to pain utterances and opioid therapy. Many clinicians face a daily conundrum: Do I attend and act on the expressed pain utterance by prescribing opioids, or do I respond to the societal crisis and patient risk of addiction by withholding (pharmaceutical) care?

In 2014 alone, 245 million prescriptions were written for opioid pain relievers (Volkow & McLellan, 2016). In 2017, approximately 12 million Americans misused opioids, and more than 47,000 people died of opioid overdose (Jalali et al., 2020). The growing issue of opioid misuse has been deemed a national public health emergency. Many societal trends led to the American opioid crisis, but one unintended cause was the pain advocacy movement of the 1990s (Jalali et al., 2020). During this time, pain advocates like Kathleen Foley were urging fellow clinicians to take patients' pain more seriously and to abandon concerns surrounding opioid pain analgesics; her statement, "inadequate pain care constitutes 'torture by omission'" became something like a slogan for the movement (Rieder, 2019, p. 30). However, after the opioid overdose fatality rate increased by 345% between 2001 and 2016, the CDC restricted access to certain opioids (i.e., Oxycontin and Vicodin) and recommended that clinicians carefully weigh

the potential benefits against the potential risks when deciding whether to initiate or continue opioid therapy (see, "CDC Guideline for Prescribing Opioids for Chronic Pain"*).* As a result, the pendulum has swung in the opposite direction. The stigma associated with opioid use, the restrictive prescribing policies, and clinicians' widespread fear of prescribing opioids have caused many pain patients to feel as if their pains are not being heard or properly responded to.

A quick caveat: The demand for other-oriented concern does not equate to a demand for pills or an opioid prescription. Pain utterances are action-guiding in that they call for empathic curiosity, vigilance, and action. Pain utterances do not call for a particular treatment plan; pain utterances are flexible in the kinds of actions or treatments available to the clinician when complying with the pain imperative. To reduce compliance to a pain utterance to access to opioids is to force a dichotomy where one is not present. Bioethicist Travis Rieder put it well when he said, "it can be true *both* that prescription opioids play a role in a deadly epidemic, and that pain patients asking to have their suffering addressed deserve respectful, dignified care" (2018, p. 226).

That being said, for the remainder of this section, I will focus on cases in which clinicians feel as if responding with other-oriented concern entails prescribing opioids to the speaker. These are cases in which the speaker is expressing pain, and if the addressee thoroughly investigated the cause of the pain and has a genuine interest in the speaker being relieved of that pain, it would be clinically appropriate to write an opioid prescription. In such cases, it is challenging to say precisely under what conditions a clinician's concern about opioid misuse can override the pain imperative.

A clinician may have legal reasons for not prescribing opioids to a speaker (i.e., it violates recent regulatory policies or protocols). Secondly, several social and biological factors

can make a person in pain more vulnerable to developing Opioid Use Disorder (e.g., genetic susceptibility, prior substance abuse, or a family history of substance abuse). A clinician would then be morally permitted to withhold opioid pain analgesics if the risks of prescribing the opioids clearly outweigh the clinical benefits. What determines how much risk is too much to prescribe opioids when otherwise appropriate is not a problem I attempt to solve here. Rather, I examine clinicians' concerns about opioid misuse to illuminate the importance of considering the source of what is being identified as the overriding defeater. If the conflicting reason *not* to be concerned is ill-formed or has roots in society-wide, pejorative ideological practices, then it is not a proper overriding defeater. Moreover, the addressee is not morally permitted to withhold other-oriented concern, and by doing so, the addressee would be acting wrongly by not complying with the pain imperative.

Consider Amy Mason-Cooley's story:

> Amy Mason-Cooley has sickle cell disease and regularly experiences excruciating pain as a result. In June 2020, Amy went to the hospital because she was in so much pain that she could not walk. She describes feeling like she was "being sliced open with a rusty hand saw." However, after 24 hours at the hospital, Amy's doctor decided to take her off the medications despite her pleas that she was still experiencing a sickle cell crisis. In another pain crisis the year before, Amy was left in a hospital waiting room for 10 hours until she passed out from the pain. A nurse woke her up and said, "This isn't a pain clinic," implying that Amy was seeking an opioid prescription.[33]

Tensions have arisen between a societal desire to slow the opioid crisis and protect patients from the harms of opioid addiction and a societal desire to adequately respond to sickle cell patients during crisis. Sickle cell disease (SCD) is a life-threatening, inherited blood disorder that features painful vaso-occlusive crises as one of its defining symptoms. A sickle cell crisis is a state in

[33] Amy Mason-Cooley's story was taken from a Yahoo News article entitled, "'You are not listening to me': Black women on pain and implicit bias in medicine."

which prescribing opioids would be a clinically appropriate response. However, sickle cell is also a *racialized* disease. Globally, SCD affects people of all races, but due to the SCD mutation primarily arising on the African continent and the effects of the transatlantic slave trade, nearly all SCD patients in the US are Black (Power-Hays & McGann, 2020). SCD is then treated as a 'Black disease,' and SCD patients often face barriers created by structural racism and interpersonal racism when seeking care. Presumably, a concern that Amy is misusing opioids was the clinicians' justifying reason for explicitly withholding medication in the last encounter and for generally withholding clinical attention in the former encounter. However, because this reasoning is a by-product of pejorative social practices that generate and reinforce distorted public mental representations of "drug-seeking," the reason to withhold opioids and clinical attention was ill-formed. Thus, the clinicians were wrong in acting as if their fears that Amy would misuse opioids overrode or cancelled Amy's expression of the pain imperative.

In one study, 63 percent of nurses surveyed said many patients with sickle cell are addicted to opioids (Pack-Mabien et al., 2001). In fact, the estimated prevalence of opioid addiction in the sickle cell population is about 10 percent, a rate of addiction that is no higher than in members of the general population who have received an opioid prescription (Ruta & Ballas, 2016). The popular assumption that SCD patients are more likely to develop drug addiction or abuse drugs is a false narrative that results from what Alisia Bierria (2020) describes as the ongoing conflation of "blackness" and "criminality." Bierria writes,

> This persistent yoking of “blackness” to “criminality” does not merely reflect unjust, uncharitable, or untrue characterizations of black people, but is a matter of the structure of concepts themselves…As part of the structure of the concepts themselves, the relationship primes others before the fact—and *before the act*—in how to understand intention, curb potential for doubt, “logically” draw conclusions, and accept those conclusions as a non-controversial reality (2020, p.5).

The routine and systemic criminalization of Black people—and therefore, Black action—then trickles down into clinical practice. Even when an SCD patient has a genuine claim to an opioid prescription, the conflation of Blackness and criminality makes the reason to withhold pain pills appear to have higher precedence. The clinician now (falsely) reasons that this particular speaker is more likely to abuse opioids. Given the grave consequences of opioid misuse, the clinician then feels justified in not complying with the pain imperative. How clinicians are trained to identify drug-seeking can also make it difficult to distinguish between addiction and *pseudoaddiction*, a phenomenon that can occur in SCD patients with untreated or under-treated pain. Seeking pain treatment at a hospital, asking for opioid medications by name, making multiple visits for the same complaint, and having symptoms that seem 'out of proportion' to what an examination shows are all identified as signs of drug-seeking or drug addiction. SCD patients attempting to elicit care during an acute sickle crisis in an ER are likely to exhibit similar behaviors. SCD patients can build up a tolerance to medication, so they will often ask for higher doses of medications as well.

To summarize: The opioid crisis has heightened clinicians' fears about addictive pain medications. These concerns do not necessarily trump the pain imperative, given that the demand for other-oriented concern does not equate to a demand for pain pills. However, fears about drug addiction can conflict with adequately responding to pain utterances provided by SCD patients. In some cases, these fears are treated as an overriding defeater with regards to the pain imperative. If a fear about a particular speaker's risk of opioid misuse is a by-product of ideological practices, like the systemic criminalization of Black people, then the fear does not

qualify as a proper defeater. The pain utterance still 'counts' as a secondary command, and the addressee is still beholden to the patient's pain.

4 The Case of Chronic Pain

Thus far, I focused on *external* limits to the pain imperative by considering circumstances in which it would be inappropriate to provide a pain utterance and by considering overriding reasons an addressee can have that permits them to *not* comply with the pain imperative. I will now briefly consider *temporal* limits to the pain imperative.

The most obvious example is chronic or persistent pains. Chronic pain are pains that persists past normal healing time, and are usually defined as a pain that lasts for at least 3 to 6 months. Chronic pains can be a consistent pain or a series of recurring pains. Regarding responding to a pain utterance about chronic pain, how long and to what extent is an individual clinician expected to comply with the pain imperative? As I mentioned in Chapter 2, on the institutional level, there is no temporal limit to complying with the pain imperative. Palliative care is a branch of medicine dedicated to responding to pain as a standing imperative, even when the expressed pain results from a chronic or terminal condition. However, on the individual level, there are many factors that contribute to our expectation of how long a clinician can reasonably respond to a patient's chronic pain. Some chronic pain conditions can be successfully managed. A speaker may be justified in expecting, all things considered, that a clinician continues to provide a therapeutic regime that knowingly manages their chronic pain for as long as the clinician has the means and ability to do so.

But what if a pain utterance is about an *intractable pain*—a chronic pain that is challenging to manage or cannot be controlled with standard medical care (e.g., chronic regional pain syndrome CRPS)—would it be morally permissible for a clinician to cease complying with

the pain imperative after some time? Would we say the individual clinician is acting wrongly if they 'throw in the towel,' or if they cease attending to and responding to a patient with intractable pain by (say) referring the patient to another healthcare provider? Again, it is a slippery slope to suggest that once a clinician receives a pain utterance, they are forever beholden to the relief (or management) of the speaker's expressed pain. Moreover, a clinician or addressee should not be expected to be so beholden to a pain experience that they *burnout* or internalize the speaker's suffering and as a result, experience *concern* or *compassion fatigue.* On the other hand, it is reasonable to feel as if one's pain utterance is not 'taken seriously' if a clinician ceases to comply with the pain imperative after the suggestion of one medical intervention or therapeutic regime fails to yield a successful alleviation of the pain immediately. It is not morally permissible for a clinician to wipe their hands of a patient if the patient continues to express pain after taking a Tylenol as directed. How we draw a line between these two extremes is nuanced and agent-specific and, unfortunately, outside this project's scope. I acknowledge that there must exist a point at which a clinician or addressee can determine that they have done all that they, as individuals, are willing and capable of doing. Once this point has been reached, the clinician can rightly excuse themselves from any further obligation to attend to the speaker's pain.

5 Conclusion

Not all pain utterances provided 'count' as a secondary command. Like other speech acts, pain utterances must be felicitous to have the conventional effect of eliciting other-oriented concern from an addressee. Even when a pain utterance 'counts' as a secondary command, overriding defeaters can make it morally permissible that an addressee does not comply with a particular re-issuing of the pain imperative. However, if the conflicting reason is a by-product of reasoning distorted by systemic, pejorative ideological practices—like the criminalization of

Black people—then it would be wrong to respond *as if* the conflicting reason overrides or cancels the pain imperative.

Importantly, ideological social practices can cause a pain utterance to misfire. Ideology shapes display rules of pain, has the power to distort the conflicting reasons an addressee may have, *and* can distort the interpretation of the expressed pain such that the addressee fails to grasp the import of that pain experience. This disrupts the uptake given to the pain utterance. For example, there is also a false assumption that a sickle cell crisis is *just* pain despite the fact that many SCD patients describe sickle cell crisis as the worst pain one can experience. This sentiment is expressed in the words of Amy Mason-Cooley (2020) who writes:

> …I know people with sickle cell that have actually died from a heart attack because the pain was so excruciating. No one took it seriously and they passed away. So, it's gotta stop. We're asking you to listen to us. We just want to be treated the way you would want your own family treated.[34]

Thus, our society's ideologies can not only cause an addressee to prioritize a distorted perception of an individual's risk of drug addiction, but an address can also fail to respond with other-oriented concern because of ideological distortions of SCD patients' pain experiences. Distortions of the pain experience can cause an addressee to wrongly interpret the pain as 'not that bad" and to deprioritize the pain imperative in that communicative exchange. I will say more about this process in the next chapter.

[34] Quote retrieved from a news article entitled "'You are not listening to me': Black women on pain and implicit bias in medicine" published in Today.

CHAPTER 4
DISMISSAL AS A MOTIVATIONAL DEFICIT

> Women's illnesses were easily interpreted—and dismissed—according to blanket assumptions about the weakness and inferiority of the female body and mind. Hysteria then became whatever male physicians and medical writers wanted it to be. The only definitive diagnostic sign was being a woman.
>
> Elinor Cleghorn, Author of *Unwell Women*

Given their communicative content, pain utterances typically can demand other-oriented concern from their addressees as part of their social-normative function. As shown in the last chapter, the capacity and authority to demand concern is not simply a given but has pragmatic and normative limits. In this chapter, I further complicate the story. I consider how *ideology*—a systemic, interconnected web of distortive meanings, symbols, social practices, and norms—scaffolds and hinders a speaker's ability to provide a pain utterance successfully. More specifically, I consider how ideology can disrupt a pain utterance's basic social-normative function by disrupting the uptake given to the pain utterance's imperatival content.

Our practical commitments constitute the uptake given to a pain utterance. As Quill Kukla has noted: "The uptake of the speech act is recognized and responded to in practice" (2014 p. 453); "again, uptake involves responsive action that mobilizes various norms and conventions, and this action forms an integral part of the entire material and conventional context that enables speech acts to have particular performative forces" (2014, p. 454). Kukla adds that we often only know which conventions and rituals determined the uptake of the speech act after the speech act occurred, because a speech act is literally not finished until people respond. Moreover, ideology can shape our practical commitments by shaping what we perceive as reasons. An addressee can

fail to appropriately respond to a pain utterance because they either do not have the capacity to recognize the relevant normative reasons (i.e., they lack a disposition for altruism) or because ideological tools mask the pro tanto motivating reasons a pain utterance gives to be concerned. I take it that the latter is primarily driving pain dismissals along race and gender lines.

In her book, Black Feminist Thought, Patricia Collins (1990) argues that stereotypes of Black women, which she refers to as *controlling images*, are used to control the ideological landscape against which the behavior of Black women is judged and against which society's marginalized treatment of Black women is justified. Collins' notion of controlling images sheds light on how ideology can control social interactions by using distortive representations of others and their lived experiences to make certain morally relevant reasons for action more salient (or more concealed). I will show that in our society, controlling images with respect to pain also exist. Examples I consider are the controlling images of obese people, Black people, menstrual pains, and labor pains. By no means is this an exhaustive list. These controlling images disrupt the uptake given to the imperatival content by distorting either features of the speaker in pain or the kind of pain being expressed—i.e., the imperatival content of the pain utterance—causing the addressee to be unable to recognize the pain utterance as functioning as a secondary command.

This chapter aims to identify and explain a phenomenon I call *pain-related motivational deficit,* in which ideology systemically distorts certain pain utterances such that there is proper uptake of the pain utterance's indicative content, or epistemic contribution, but a defective uptake of the pain utterance's imperatival content, or motivational contribution. Note that there are other ways a speaker can be prevented from successfully providing a pain utterance. Sexist ideology can produce a social habit that makes it stigmatizing to talk about certain pain experiences, like menstrual pains. This can make it too costly to provide certain pain utterances

and can incentive speakers to remain silent. Most notably, individual addressees can have a prejudicial bias against the speaker, which can cause the addressee to fail to give uptake to the pain utterance's indicative content, imperative content, or both. However, what has yet to be discussed in the literature, and what is the focal point of this project, is how systemic structures 'silence' the imperative content of a pain utterance such that the pain utterance fails to motivate concern from others.

I will first say more about what I intend to capture by the terms, *ideology* and *controlling images.* I will then give some examples of controlling images of pain before finally introducing the conditions that characterize a pain-related motivational deficit and will unpack each in turn.

1 Ideology and Controlling Images

Like Sally Haslanger, I use the term *ideology* to refer to an interconnected web of meanings, symbols, scripts, norms, and social practices that produce or sustain unjust social relations (2017, p. 16).[35] These symbols, scripts, and such generate the mental representations we have of the kind of person who is (or is not) entitled to demand concern and the kinds of pains that we would deem (or would not deem) 'concerning.'

In particular, dominant groups can create new symbols or exploit existing symbols to distort important facts about those belonging to subordinated communities. The use of *controlling images* is a prime example. Stereotypical images of Black women as mammies, matriarchs, welfare recipients, and jezebels aim to control their behavior and justify their oppressive treatment. Moreover, these controlling images are created to mask certain social-normative facts, like the effects that social power differentials have on Black women and their

[35] More specifically, Haslanger argues that ideology is a cultural techn**ē**, **a** social structure constituted by an interconnected web of practices that relies on a network of semiotic relations (2017, p. 16).

lived experiences, "making racism, sexism, poverty, and other forms of injustice appear to be natural, normal, and inevitable parts of everyday life" (Collins, 1990, p. 69). An example of how these controlling images dictate how Black women's behavior is judged can be in the representation of Black women as mammies. The controlling image of the mammy symbolizes the Black woman as a "faithful, obedient domestic servant" (Collins, 1990, p. 72). This image can mask Black women's discontent with being economically exploited, distorting the Black woman into someone who desires to be obedient and complacent. However, analysis of Black slave narratives revealed that "unlike the white southern image of mammy, she is cunning, prone to poisoning her master, and not all content with her lot" (Christian, 1985, p. 5; Collins, 1990, p. 74). Collins also notes,

> Created to justify the economic exploitation of house slaves and sustained to explain Black women's longstanding restriction to domestic service, the mammy image represents the *normative yardstick used to evaluate all Black women's behavior* (1990, p. 74).72; italics added).

The mammy image instilled an expectation of deferential behavior from Black women. The actions available to Black women became restricted as they are penalized in various contexts if they do not appear warm and nurturing.

Importantly, in controlling the normative landscape against which Black women's behavior is judged, controlling images also dictate what counts as good reasons to oppress Black women. For example, there has been a longstanding mental representation of Black women as promiscuous and well-suited to bear children. This mental representation is captured in the controlling image of the welfare queen. The image of the welfare queen directs one's attention to Black women's fertility and its negative impact on the U.S. economy, giving society a reason to intrude and control Black women's decisions about fertility (Collins, 1990). Again, the

controlling image of the welfare queen has a masking effect. By painting the Black women's fertility as the cause of her own poverty, societal attention is directed away from the structural causes of poverty and blames the Black woman for her subordinate position. One is then provided with a good reason to withhold welfare, i.e., "she is undeserving because she brought it on herself."

While Collins uses the idea of controlling images to show how ideological symbols can control the normative landscape against which Black women's behavior is judged and responded to, I extend the use of the term. *Controlling images can be usefully applied to distorted representations of pain that control the normative landscape used to evaluate and respond to pain utterances.* While antiblack ideology is a systemic misrepresentation of Black people as the inferior race and patriarchal ideology is a systemic misrepresentation of women as the inferior gender, controlling images of pain show how these ideologies, and others, can control the value we assign to another's pain utterance, the pain concepts that we invoke when hearing a pain utterance, and our societal response as a result.

One might wonder why I frame this discussion in terms of controlling images and not in terms of, say, stereotypes. Stereotypes are typically defined as cognitive schemas; as quick, often negative, generalizations about the characteristics or qualities of members of a particular group. Stereotypes, too, influence how we perceive and evaluate others and their actions. However, note that controlling images *are* stereotypical images. Talk of stereotypes typically places the spotlight on attitudes and habits of mind, i.e., prejudice, hasty generalization, fundamental attribution errors, etc. By shifting to controlling images, I aim to emphasize stereotypical images' role in orchestrating our norms, values, and social practices. By doing so, we can see how stereotypical images control the normative landscape against which both a particular pain

utterance's indicative and imperative content is evaluated. More specifically, by shifting to controlling images, we gain insight into the structural causes for the lack of uptake given to the imperatival content of certain pain utterances.

2 Controlling Images of Pain

Pains typically fall into two camps: *concerning* pains and *non-concerning pains.* By *concerning* here, I mean any pain experience that is socially assigned negative import—a pain that we appraised as a state that is bad for an individual to be in, and as a result, responding to this pain with concern (rather it be self or other-oriented) becomes conventional practice. On the surface, this distinction is obvious and common sense. Pains conceived as 'unnatural,' often pathological in nature, are readily recognized as concerning pains; pains conceived as a 'normal' or 'natural' consequence of a particular embodied identity or activity are readily recognized as non-concerning pains.

How a pain experience is categorized can influence the uptake given to a pain utterance. For example, a pain utterance that expresses a ‘normal’ pain is unlikely to motivate an addressee to be concerned. Suppose a person was in the gym, lifting weights. After a set, they turn to their trainer and tell them that their arms hurt. A little pain is treated as a ‘normal,’ inevitable consequence of working out—as the idiom says, no pain, no gain—because of this, the trainer will likely be unmoved by the person’s complaints. The trainer believes that the speaker is in pain but fails to give uptake to the imperatival content of the pain utterance because the preparatory condition of felicity was not met. Given that the goal of lifting weights is to generate tension in the muscle, which makes a little pain a 'normal' consequence, the social conventions invoked were not appropriate for providing a pain utterance that would have the effect of demanding concern for the trainer. The social logic is that a normal, natural pain warrants no

need for special attention or care; a normal, natural pain does not socially generate a behavioral priority in others. That being said, a normal, natural pain can still demand self-oriented concern and establish a behavioral priority in the person feeling the pain. However, if the person in pain internalizes the societal appraisal of a pain experience and conceives their *own* pain as non-concerning, the person may de-prioritize the pro tanto reasons their pain gives them to be concerned and direct their attention elsewhere. E.g., the person lifting weights starts to feel pain, but knowing the pain is 'normal,' proceeds to 'push' through the pain.

Controlling images of pain can justify a systemic dismissal of marginalized speakers in pain or pain experiences associated with a marginalized identity by masking pains that are *felt* as concerning—or pains the speaker experiences and attempts to express as a demand for concern—and misrepresent them as a normal or non-concerning. The controlling images of pain I consider are those depicting obese people, Black people, menstrual pains, and labor pains. Again, this is by no means an exhaustive list. These controlling images distort features of the speaker in pain (i.e., the speaker's body or lifestyle) or the kinds of pain being expressed (i.e., menstrual or labor pains) such that the pro tanto reason a pain utterance gives to be concerned becomes less salient.

2.1 Distorting Features of The Speaker in Pain

One way by which a controlling image can disrupt the uptake given to a pain utterance is by distorting the speaker's features. These distorted features often include bodily features of the speaker or the speaker's observed or imagined lifestyle. By distorting the speaker's features, controlling images of pain can misrepresent the speaker as being deserving of their pain or as incapable of experiencing a concerning pain. The former applies to controlling images of obese people, and the latter applies to controlling images of Black people.

Controlling images of obesity distort the speaker in pain such that nearly any pain they express is unfairly interpreted as a pain that is deserved. Stereotypical images of obese individuals depict them as constantly overeating, sedentary, unhealthy, and lazy. A great example of this depiction is in the Pixar movie *Wall-E*. After destroying their own planet, the humans in the film lived in outer space, drinking oversized sodas and being transported everywhere in a hoovering chair. All the humans were obese. The movie implied that the adults were overweight because they overconsumed and were unwilling to move their bodies. Such stereotypical images of obese individuals direct societal attention to one's lifestyle—whether that lifestyle is observed or imagined—and mask genetic or structural causes of someone's weight. Of course, certain lifestyles can put a person at a greater risk of developing chronic pain, heart disease, insulin-resistant diabetes, high blood pressure, etc. However, this data, at best, apply to populations, not individuals; we cannot say with certainty—or even with a high degree of confidence—whether a particular obese individual will develop an illness or pain.

However, pain is considered an inevitable consequence of a high body fat percentage, and this is insinuated in the label of "obesity pain." Additional weight can put added stress on a person's joints, especially a person's knees, hips, and spine. When this occurs, clinicians might categorize the pain as "obesity pain." Yet, "obesity pain" can be overly applied to any pain expressed by an obese speaker because controlling images can cause an addressee to be overly attuned to the speaker's weight and less attuned to the particularities of the speaker's expressed pain. Controlling images of obese people as constantly overeating or lazy can control the normative landscape against which we perceive pains expressed by obese speakers by taking pains that the speaker feels as concerning, that often have a non-obesity related pathological cause, and misrepresent them as inevitable consequences of the speaker’s lifestyle qua the

speaker's weight. As a result, in virtue of speaking as an obese person, a pain utterance's imperative content may fail to gain proper uptake because the speaker is seen as not entitled to demand concern as they 'brought it upon themselves.'

Ideology can use stereotypical images to cast obese individuals as deserving of their pain experiences and thus, justify a social habit of being unmoved by their pain utterances. Typically, we are not moved to concern when we perceive another's pain as deserving. For example, male participants in a study had reduced activity in the affective component of pain, i.e., the ACC and bilateral anterior insula, when the person in pain was previously unfair to them (Singer et al., 2006; De Vignemont & Jacob, 2012). The participants were less likely to affectively resonate with the person in pain if that person was perceived as deserving of punishment.[36] In other words, when we focus on the perceived vices of a person, this can cause us to interpret their expressed pains as earned. Pains seen as earned are less likely to be met with other-oriented concern.[37] A similar process occurs in the systemic lack of concern given to pains expressed by obese patients.

On the other hand, various controlling images of Black people exist that control the normative landscape against which their pain utterances are evaluated. In Chapter 3, I allude to the controlling image of Black people as criminal and drug-seeking. This controlling image can distort the perceived credibility of a Black speaker in pain and, as a result, disrupt the uptake given to the pain utterance's indicative content. The drug-seeking, criminal depiction of Black people works to discredit the pain utterance in its testimonial function. However, there also exist

[36] In fact, the term 'pain' is derived from the Latin *poena,* which is the precursor of, and translatable as *penalty* and *punishment* (Duncan, 2017).

[37] To further illustrate this point, imagine a person is subjected to a round of electric shocks. The person is screaming out in immense pain. Suppose we knew nothing about this person. I assume, all things considered, we would be motivated to be concerned. Now suppose we learn that this person committed heinous acts, including multiple assaults, kidnapping, and murder. I assume that for many people, this new information will make it more difficult for us to respond with the same care we would have shown before learning of his behavior.

controlling images that dehumanize Black people. More specifically, controlling images of Black people in pain distort them into beings whose 'strong' bodies allow them to experience pains that are naturally less concerning or intense than their White counterparts. For example, gynecologist Marion Sims famously perfected his medical procedures on enslaved women, subjecting them to countless experiments without anesthetics. Sims saw the enslaved Black women as "not human beings but medical specimens;" and as analyzed by historian Elinor Cleghorn, "he felt justified in his actions by the dehumanized perceptions of Black women's diminished sensitivity to pain" (2021, p. 115).

This dehumanized, distorted perception of Black people in pain still exists in present-day medicine. A study conducted by Kelly Hoffman et al (2016) showed that a substantial number of white medical students and residents believed that there are biological differences between Black people and white people. These supposed 'biological' differences—e.g., Black people's skin is thicker; Black people's blood coagulate more quickly—generate a social logic that Black people have lower pain sensitivities compared to white people. Given that our society is structured by white normativity, i.e., Whiteness serves as the normative standard, beliefs that Black people have a diminished sensitivity to pain convey a social meaning that a pain expressed by a Black speaker is less concerning, analogous to pains expressed by non-humans. The dehumanizing perception of Black bodies as naturally strong and resilient makes the import of pains felt by Black speakers less salient, which makes it more difficult to perceive their pains as (equally) worthy of attention and care.[38] Thus, these controlling images can justify the social habit of taking pains expressed by Black patients less seriously.

[38] Importantly, Hoffman et al. (2016) results also showed that these dehumanizing beliefs operated independently of individual prejudicial bias.

2.2 Distorting the Expressed Pain

Controlling images can also distort certain *kinds* of pain expressed such that, even when experienced as concerning by a speaker, addressees can misinterpret the pain as an inevitable, natural consequence of a particular embodiment. By distorting the perception of the *kind* of pain expressed, these controlling images uniquely derail the uptake given to the pain utterance's imperative content which causes the pain utterance to fail in its function as a secondary command to be concerned. Such examples I have in mind are the controlling images of menstrual pains and labor pains.

Menstrual pains and labor pains are treated as inevitable consequences of having a female reproductive system. Their imports are often minimized, given the interpretation that they are 'natural' for those who experience them. In the 19th century, physicians hand-selected and exploited a few cases of women who were, in reality, experiencing *pathological* menstrual pains and used them to produce the highly influential medical idea that all with a female reproductive system are terribly impaired by their periods. At this time, the idea that periods caused "disability and suffering" was so ingrained that those who experienced easy enough periods feared they were somehow "abnormal" (Cleghorn, 2021, p. 277). The controlling image of menstrual pains then depicted 'normal' pains as natural, albeit unbearable, excruciating pains that interfere with one's daily activities. This controlling image can disrupt a speaker's attempt to express a menstrual pain that the *speaker* feels as concerning. An addressee can misinterpret excruciating pains during a speaker's period as being *just* a bad period or as the expression of a pain experience that conventionally fails to invoke responding with concern. The social and medical practice being that normal menstrual pain does not demand attention or action. Even our society is structured so that one rarely calls out of school or work for what is perceived as normal menstrual pains.

On the other hand, labor pains are described as the most challenging and intense pain experience someone may go through, yet these pains are often caused by normal tissue changes that occur during the birth of a baby (Whitburn et al., 2019). However, controlling images of labor pains disrupt the uptake of a pain utterance's imperative content by depicting labor pains not only as normal and natural but also as a pain experience with a positive rather than negative import. Historically, many (male) obstetric physicians saw labor pains as valuable and necessary for child birthing. In 1848, obstetrician Charles Meigs declared labor pain "the most desirable, salutary, and conservative manifestation of life-force" (Cleghorn, 2021, p. 117). As a result, he objected to the use of chloroform in the, then, popularized pain-free labor. The pervasive idea that labor pains are not only natural but also good for one to feel still exists.[39] For those who seek pain relief during and after labor, many internalized the (false) societal message that, by not *feeling* the full intensity of labor pains, they somehow failed as women and mothers (Cleghorn, 2021).

By also assigning a positive import to labor pains, controlling images can make it difficult to interpret an expressed labor pain as having negative import for the speaker or as an impediment to the speaker's well-being that is worthy of attention and action. This can cause clinicians to discount excruciating pains and other symptoms during or after childbirth as *just* labor pains, resulting in a failure to investigate other potential pathological causes. This was the case for Tara Hanson who died from an infection six days after giving birth because, according to her husband, “her symptoms didn't ring alarms with her doctors…her complaints just kept falling on deaf ears.” "Everyone assumed that the pain she described was to be expected because she just had a baby" (Dunn, Carroll, & Weaver, 2018, May 13).

[39] One theory is that labor pains evolutionarily function to capture the expecting mother's attention and motivate her to seek safety and help (Whitubrn et al., 2019).

On the surface, controlling images of menstrual pains and labor pains looks like a distortion of the speaker's features and not a distortion of the kind of pain being communicated or expressed. To show why this is not the case, consider the following: A pain utterance about menstrual pains can be interpreted as expressing a pain that is an inevitable consequence of having a female reproductive system. But can we say the same about a pain utterance that has a headache as its content? What about a pain utterance that has a backache as its content? A chest pain? We do not have the social habit of responding to these pains as a natural, normal, inevitable consequence of a particular embodied identity. Whether speaking as an obese person, Black person, tall, or short person, a speaker's features do not somehow trigger the interpretation of a chest pain or headache as a normal, inevitable consequence of their particular embodied identity.

I say particular embodied identity because although the embodied identity associated with the kind of pain being communicated is often the same as the speaker's embodied identity, it does not have to be. Because the failure to motivate is due to *what* the utterance is about and not the identity of the speaker, the two can dissociate and the utterance still fails to motivate concern. Suppose a husband had to speak on behalf of his wife; suppose the wife was so debilitated by pain that she could not speak for herself. The husband tells the nurses and doctors that his wife is experiencing excruciating and unusual pains post-labor and that he is concerned. The nurse and doctors acknowledge that the wife is in pain, i.e., *of course, we can see she's in pain! She just had a baby.* However, despite the husband being the one to 'share' the pain, the content of the utterance is still distorted in such a way that the post-labor pains as interpreted as natural and normal for the wife to feel. As a result, the nurses and doctors still fail to be concerned by the wife's pain.

3 Pain-Related Motivational Deficit

I highlight the distorting mechanisms utilized in controlling images of pain because they explain how a *pain-related motivational deficit* can be assigned to a particular pain utterance.

The phrase "motivational deficit" can describe a broader range of communicative wrongs than those highlighted in this project. Motivational deficit describes all instances in which an utterance would otherwise be motivating, but due to misrepresentations in our society, the addressee's interpretation of the utterance is distorted such that the addressee is unable to see the pro tanto reason to act. As a result, the addressee fails to be motivated by the utterance. A report of domestic violence from a man could be given a motivational deficit from the attending police officers. The orders issued by a woman CEO could be given a motivational deficit from her predominantly male employees. Pain-related motivational deficit is just one kind of motivational deficit. In an ideal world, one void of oppressive social structures, addressees can correctly recognize when a pain utterance does or does not demand concern and respond accordingly.

A pain-related motivational deficit occurs when there is proper uptake of the pain utterance's indicative content, or epistemic contribution, but a defective uptake of the pain utterance's imperatival content, or motivational contribution. It can be characterized by the following conditions:

(i) The speaker provides a pain utterance and,
(ii) The addressee believes the speaker is in pain and acknowledges that the pain exists, yet,
(iii) The addressee is improperly moved to concern by the speaker's pain utterance and,
(iv) This motivational failure is explained by ideologies distorting features of the speaker in pain or the communicative content of the pain utterance.

I set the stage for condition (i) at the beginning of this project. As I mentioned in Chapter 1, pain utterances can express what a speaker takes to be the experiential facts about their pain experience. Call this a pain utterance's *indicative* content. However, in virtue of expressing pain, an imperatival state, a pain utterance also has *imperative* content. Thus, when the speaker provides a pain utterance, in virtue of its content, it functions as a testimony and a command, respectively. More specifically, the pain utterance functions as a secondary command to be concerned. This section will unpack the remaining conditions (ii)-(iv).

3.1 Condition (ii): Believes and Acknowledges the Pain

What is it to believe a speaker when they say they are in pain and acknowledge the existence of that pain?

The belief that the speaker is in pain must be a testimonially-based belief, resulting from the addressee accepting the testimony and based on the information the speaker conveyed. A belief is testimonially based if the testimony causes the addressee's belief, if the propositional content of the addressee's belief is causally related to the propositional content of the speaker's belief, and if that propositional content is conveyed to the addressee by the testimony (Shieber, 2015). To clarify, I am not equating a testimony to an assertion. A testimony is any act of communication performed by a speaker that intends to convey the information *that p* or is any act of communication that a recipient can reasonably take as conveying the information *that p* (in part) in virtue of the act's communicable content (Lackey, 2008). Thus, when a speaker in pain clutches their chest to convey that they have a pain experience, and the addressee comes to know that the speaker is in pain because of that gesture, then the addressee forms a testimonially based belief that the speaker is in pain. On the other hand, if a speaker in pain clutches their chest without the intention of conveying a belief that they are in pain, yet if it is still reasonable that

the observer perceives that act as conveying such information, we can say the observer has formed a testimonially based belief as well.

If the addressee believes the speaker to be in pain, their response will then indicate an acknowledgment that the pain exists. When the addressee doubts the pain utterance, denies that the pain is real, or quite simply ignores what the speaker said, the speaker's pain is not acknowledged. Moreover, the speaker's pain is not acknowledged if the addressee refers to what the speaker expressed as hysteria or 'just in their head'. Stipulating that the addressee does believe and acknowledge the speaker's pain excludes cases of pain dismissal in which there is improper uptake of the indicative content.

3.2 Condition (iii): Improperly Moved to Concern

When proper uptake is given to both the indicative and imperative content of a pain utterance, an addressee believes what was said *and* is moved to act in a way that indicates they are concerned. However, when there is improper uptake given to the imperative content or to the command attempting to be re-issued, an addressee will fail to interpret the pain utterance as a sufficient reason to be concerned.

A speaker cannot successfully perform a speech act without the addressee giving the utterance proper *uptake*. Austin defines uptake as “the understanding of the meaning and force of the locution” (1962, p. 116-117). The understanding of the locution can be read as either securing the recognition of the illocutionary intentions of the speaker or securing the recognition of the convention invoked by the speaker (Bianchi, 2020). Searle notably ascribes to the first reading, and so do many others. E.g., Hornsby and Langton: “A speaker’s illocutionary acts depend on the fulfillment of her intentions, and such fulfillment is uptake” (1998, p. 31); Mikkola: “Illocutionary force hinges on… whether the speaker achieves *uptake*: the hearer

recognizes the particular intended illocution being performed." (2019, p. 26); McDonald: "Uptake is most typically understood as the hearer's perception of or inference about the speaker's communicative intention" (2021, p. 3509). However, I ascribe to the second reading along with Lance and Kukla (2013) and Kukla (2014). I define uptake as recognizing the convention invoked by a particular utterance and the concrete social response that follows. I do so because pain utterances can still function and be recognized as a secondary command to be concerned even if the speaker did not intend for the pain utterance to have this social-normative function.

An addressee's uptake is considered improper when there is no uptake given at all or when the given uptake is of the wrong kind. The command fails when the imperative content of the pain utterance receives no uptake. By not receiving uptake, the illocutionary force that pain utterances have as a command is neutralized and the motivational contributions are nullified. In other words, even though the utterance is believed, it is as if the command had not been issued. What occurs fits well with what Hornsby and Langton (1998) call illocutionary silencing. They argue that women's sexual refusals may be silenced by way of uptake failure:

> A woman says "No" to a man, when she is trying to refuse sex; she uses the right locution for an act of refusal, but somehow her speech act goes wrong […]. She says "No", intends to refuse, but there is no uptake in her hearer. She is therefore not fully successful in refusing (1998, p. 27).

In a similar vein, we could say that when a speaker says, "I am in pain," but due to ideological distortions there is no uptake of the expressed imperative qua the expressed pain, then the speaker has been silenced in their capacity to re-issue the pain imperative. They cannot be understood as conveying a "Be concerned!" with their pain utterances and meaning it. When the

addressee fails to grasp the pain utterance as a command, they fail to recognize it as giving an obligatory, pro tanto reason to attend to and act on the pain.

In other cases, there is uptake of the imperative content—it was not as if no command occurred at all—but rather, the imperative was given a defective uptake or an uptake of the wrong kind. In these cases, the speaker attempts for the pain utterance to act as a command, but instead, the addressee interprets the pain utterance as, say, a request. When this occurs, the motivational contribution of the pain utterance is recognized, but the force of the contribution is downgraded. For an addressee to recognize the force of an utterance, they must recognize how it changes the normative situation— "what kinds of rights, duties, entitlements, and the like, it imputes on people" (Caponetto, 2021, p. 197). Commands impute an obligation to act a certain way, while requests leave the requested party free to grant or refuse them (Kukla, 2014; McDonald, 2021). In fact, Kukla argues that the pragmatic structure of a request is such that "the output of a successful request is that the target now has a specific sort of reason to do what was requested, but it is essential to the notion of a request that this reason is *not* [italics added] an obligation "(2014, p. 445-446).

When a pain utterance is responded to as a request rather than a command, an uptake distortion most likely occurred. Uptake distortion occurs when the alternative uptake an utterance receives, in fact, constitutes it as some other kind of speech act of type B, with an unconventional output, given its input (Kukla, 2014, p. 445).[40] There are cases of a pain-related motivational deficit in which the pain utterance, despite having been produced using similar pain descriptors, in the same clinical context, and with the same conventional entitlements to speak—i.e., the speaker is in pain— the uptake given makes the utterance's imperative content weaker in

[40] Here, Kukla can be interpreted as defending what McDonald (2021) calls a *constitution* theory of uptake. According to this view, an addressee's uptake can determine *which* speech act was performed.

force than what would have otherwise been produced. More specifically, the uptake distorts the pain utterance from a prioritized obligation, or command, to be concerned to a de-prioritized, non-obligation, or request, to be concerned. By this I mean, the addressee grasps that the speaker, in expressing their pain is attempting to elicit concern, but the addressee fails to grasp the import of the particular pain expressed. As a result, the addressee acknowledges that the speaker is in pain, but the communicated pain is improperly interpreted as not that bad or concerning. When this occurs, the addressee may develop a pro tanto reason to be concerned by the speaker's pain, but the reason is assigned little motivational weight. The reason is surely not seen as obligatory. In these cases, the addressee may fail to respond like being concerned is something they must do and something that they must do now.

Again, uptake distortion and uptake failure are not mutually exclusive. As Kukla notes, uptake distortions occur because of a "queering of the path between performance and uptake" (2014, p. 444). In cases of uptake failure, the disruption is so strong that, according to Langton, we cannot say there is uptake at all: the speech act has become unspeakable (Bianchi, 2020). As I have shown, controlling images distort features of the speaker in pain or of the communicative content of the pain utterance, disrupting the path between the speaker providing the pain utterance and the addressee's uptake of the pain utterance. As a result, the disrupted uptake can cause the pain utterance to be improperly assigned little motivational weight. The expressed pain is seen as not that concerning. In some cases, the disruption is so strong that the expressed pain via the pain utterance is assigned no motivational weight at all. It is as if the command to be concerned was never issued.

It is also important to note that both Hornsby and Langton (1998) and Kukla (2014) refer to improper uptake given to utterances as a whole. What I am suggesting here is that similar

forms of improper uptake can be given to a part of an utterance, i.e., proper uptake is given to an utterance's indicative content, while improper uptake is given to an utterance's imperative content.

3.3 Condition (iv): Motivational Failure Explained by Ideologies

Consider some different possible ways that a 'motivational deficit' can be assigned to a pain utterance:

> **MD_1**: Steve has Crohn's disease. In the grips of intense abdominal pain, Steve sits in front of his doctor, hunched over, with tears in his eyes. "The cramps keep me up at night, doc! I need drugs!" The doctor thinks about their other patients with Crohn's disease. Other patients have consistently only reported mild pain that is manageable with lifestyle changes. For this reason, the doctor is not that concerned. The doctor tells Steve, "The pain is not that bad," and does not see a reason to write Steve a prescription.
>
> **MD_2**: Adrienne complained of irregular periods and excruciating pelvic pain for nine months. At one doctor's visit, Adrienne, in reference to her pelvic pains, says, "It still hurts!" Adrienne is worried that the pain may be a sign that something is wrong; Adrienne is concerned. The doctor shrugs Adrienne off and says, "You're a Black Woman, you get fibroids."[41]
>
> **MD_3:** Patients lined the emergency room hall. Rachel comes into the ER. On a scale of one-to-ten, she is asked, with ten being the worst, how bad is her pain? Rachel answered, "Eleven." Rachel is told to wait. Rachel is nearly crippled with pain. Rachel tries to get the attention of the overworked nurses. With 30 other beds pushed up against the walls, a nurse tells Rachel she must wait her turn, that "you're just feeling a little pain, honey."[42] The nurse keeps on walking.
>
> **MD_4:** Patty's hip hurts so badly she could barely walk from her car to work. She went to an orthopedist and began to describe the pain. Patty spoke two sentences before the orthopedist cut her off and said, "Let me cut to the chase—you need to lose weight."

[41] This is an adaption of a true story. Adrienne Moore insisted for nine months that her doctors take her list of health concerns, including her pelvic pain, seriously. The doctors did not share her concern, providing the response I articulated above. By the time Adrienne was taken seriously, she was diagnosed with advanced stage 3 endometrial cancer. More of her story can be found in the Health.com article, "Women of Color Die of Cancer at Higher Rates Than White Women—Here's What Experts Say We Should Do About It."

[42] I first introduced Rachel's story in Chapter 2. Rachel, the wife of *The Atlantic* contributor Joe Fassler, was labeled a non-urgent case despite being rushed to the hospital in an ambulance and reporting debilitating abdominal pains. Rachel waited two hours before receiving any pain medication. It was later discovered that Rachel was having an ovarian torsion.

> Patty had recently lost 70 pounds, so why would it be happening now if the pain was weight-related? The orthopedist did not consider any other cause for the pain or any other means to relieve the pain. Patty started to cry. The doctor said, "See you are even crying because of your pain." In the report to the primary care physician, the orthopedist wrote 'obesity pain.'[43]

The pain utterance fails to properly motivate the addressee in all four cases. The odd-numbered cases can be characterized by the pain utterance's imperative content receiving a defective uptake. The even-numbered cases can be characterized by the pain utterance's imperative content receiving no uptake at all. Moreover, the even-numbered cases provide clear examples of a motivational deficit caused by ideology-based distortions. MD_2 is an example of a disrupted uptake caused by a distortion of the kind of pain expressed, and MD_4 is an example of a disrupted uptake caused by a distortion of the speaker's bodily features.

MD_1 is an example of how an innocent error can cause a motivational deficit to be assigned to a pain utterance. Relying on their prior experiences with patients with Crohn's Disease, the doctor judged Steve's pain as having lower import, or motivational weight, than what Steve had assigned to his own pain experience. We can interpret from the doctor's response, "The pain's not that bad," that the illocutionary force of the pain utterance has been downgraded. Steve's pain utterance was not given the uptake that indicates the pain utterance was functioning as a command. However, there will always be cases where a motivational deficit follows from an innocent error because human judgment, even human clinical judgment, is fallible. Condition (iv) eliminates these kinds of cases since an innocent error is not a systematic issue and it does not qualify as a communicative wrong.

[43] This is an adaption of a true story. Patty Nece recounts the experience in the Self article, "The Shocking Ways Large Women Are Mistreated by Health-care Providers."

MD_3 is an example of how an utterance fails to motivate because the addressee has higher priorities or is already pursuing another end. Like MD_1, the addressee, in this case, assigns little import to Rachel's pain. This is evident by the nurse's claim that Rachel was only experiencing a little pain despite Rachel ranking her own pain an eleven. However, given the stressful conditions of the emergency room—i.e., the influx of patients waiting to be seen and the likely nursing shortage—it is plausible the nurse failed to recognize Rachel's pain utterance as demanding concern because the nurse's attentional and motivational capacities were already inundated with (say) concern toward other patients, managing the emergency room, performing orders from the doctors, institutional pressures, etc. The nurse quite literally had no concern left to give. There will always be cases in which a motivational deficit follows from a person's selective attention because, as humans, we are limited in our attentional and motivational capacities, which means we often must be selective in what we attend to. Sometimes a person innocently misses what they should have recognized because their attention is elsewhere. Again, condition (iv) eliminates these kinds of cases since this, too, does not constitute a communicative wrong.

MD_2 illustrates well that even when the pain is known to be pathological in cause, the pain utterance can fail to motivate because the influence of ill-formed social ideas about Black women's embodiment distort the utterance's communicative content. In this case, the addressee fails to grasp the motivational weight of Adrienne's expressed pain to such a strong degree that the addressee does not recognize the reason that Adrienne's pain utterance gives to be concern. The comment, "you're a Black Woman, you get fibroids," makes explicit the ideology-induced societal message that fibroid pains are normal for Black women. The pain utterance would have otherwise motivated concern if not for the effects of the dominant ideology in our society.

Lastly, MD_4 also illustrates well how stereotypical depictions and ideas about obesity can disrupt an addressee's ability to give proper uptake to a pain utterance's imperative content. Patty's pain utterance failed to move the doctor because Patty was re-issuing the pain imperative as an obese speaker. Patty later told the doctor, "You're not even listening to me. The only thing you're seeing is my weight." Patty was correct. Controlling images about obesity can distort a speaker's weight until it is all that an addressee can see. Controlling images can also reinforce the ideological message that obesity indicates a blameworthy lifestyle. As a result, any pains expressed by an obese speaker are attributed to the lifestyle and, thus, are perceived as self-inflicted and deserving. We can assume a similar social logic occurred in MD_4. The fact that the doctor cut Patty off while she was speaking is a strong indicator that the doctor was not, and could not, recognize a reason to be concerned by Patty's expressed pain, regardless of the *kind* of pain Patty was expressing. The doctor could not hear her command because Patty's weight was the only thing the doctor could perceive. Because of ideological distortions, it is as if Patty was not commanding concern at all.

In analyzing these cases, I do not want to suggest that ideology only explains cases in which a pain utterance's imperative content receives no uptake at all. Ideology can also explain cases where a pain utterance's imperative content receives defective uptake. Moreover, I also do not want to suggest that motivational failings caused by human error or limited attentional capacities are necessarily void of ideological influences. In a non-ideal world, the borders that define these common examples of motivational failing are not as neat. For example, an overwhelmed addressee can be influenced by ideology when they wrongly misjudge the pain of an obese person as a dessert pain and, thus, a non-priority. Thus, the influence of ideology can disguise itself as a case of innocent error or the effects of being overwhelmed.

4 Conclusion

Before I conclude, let us circle back to the case of Kelly Coffey. Kelly provided a pain utterance about menstrual pains as an obese speaker. Ideology can disrupt the uptake given to pain utterances about menstrual pains by producing controlling images that distort excruciating menstrual pains as natural, normal, or *just* a menstrual pain. These controlling images downgrade the import of the expressed pain such that the addressee fails to recognize that the pain is concerning for the speaker. Ideology can also disrupt the uptake given to pain utterances provided by obese speakers by producing controlling images that distort the speaker's weight such that the speaker is perceived as someone who instigated their own pain. Both distortions could have played a role in the dismissal of Kelly's pain.

It would be too strong of a claim to stipulate that controlling images off the speaker's features or o the communicative content thoroughly explains the motivational failing of a pain utterance. For example, Kelly also provider her pain utterance as a woman. Many display rules of pain are gendered, including those that negatively impact the perception of women's pain complaints. Because we stereotype women as being more expressive than men, even 'overly' expressive, there is a tendency to discount women's pain behaviors (University of Miami, 2021). In some studies, despite reporting and exhibiting pain of the same intensity, participants judged women patients as higher in catastrophizing and exaggerating their pains compared to men patients (Zhang et al., 2021). Social norms dictate that men be stoic, so when they express intense pain, the audience assumes the pain expressed must be appropriate to the situation—that man must be in excruciating pain! These gender stereotypes about pain expression convey a message that women's pain complaints are complaining—the unvalued venting and dwelling on negative feelings—while men's pain complaints are merely expressions of a concerning pain.

Although we can theoretically pull apart the various ways in which a communicative exchange goes wrong, these lines may be difficult to draw in practice—especially clinical practice. However, if we do not finely define each barrier to effective pain communication, we risk proposing solutions that only partially address the problem of pain dismissal.

CHAPTER 5
PAIN DISMISSAL AND THE LIMITS OF EPISTEMIC INJUSTICE

> So, we've been enduring this pain for years and just going to work, buttoning up, because we are trained that way. And I think these tampon commercials are detrimental. They're always like "oh, you're on your period? Don't let that stop you, girl! Get out there! Go surfing! Go play a sport! Get on a horse!" …if you saw a man bleeding uncontrollably and having a four-day-long heart attack you wouldn't be like, "Don't let that stop you, get on a horse!"
>
> Sasheer Zamata, *Comedian*

Menstrual pains have been scientifically proven to be as painful as a heart attack, yet, systemically, pain utterances about menstrual pains are not taken as seriously as pain utterances about chest pains.[44,45] Menstrual pains, labor pains, and the vague, catch-all diagnosis of "obesity pains" are examples of pain utterances more likely to be dismissed by clinicians. So far, in the clinical ethics literature, discussions around pain dismissal have been limited to what I call *identity-based pain dismissal,* where a pain utterance is denied or disbelieved due to an addressee's prejudicial bias against the social identity of the speaker. This kind of pain dismissal is often characterized by the addressee being unwilling or unable to give uptake of the epistemic contribution of the pain utterance.

In Chapter 4, I introduced a phenomenon I call *pain-related motivational deficit.* A *pain-related motivational deficit* occurs when ideology distorts either the features of the speakers or

[44] Menstrual cramping can cause ischemia or a lack of blood flow in the endometrium (Deligeoroglou, 2000). A lack of blood flow causes a similar pain mechanism to that found in a heart attack because heart attacks are also caused by ischemia.

[45] One may immediately object to this and think that it is obvious why chest pains are taken more seriously than menstrual pains: chest pains often signal heart attacks, and heart attacks, left untreated, can lead to death. Menstrual pains left untreated will *rarely* lead to death. To this, I say we can easily swap out chest pains with other pain experiences, say headaches or back aches. Backaches are recognized as debilitating in a way that menstrual pains are not, and backaches rarely lead to death.

the communicative content of the pain utterance such that there is a defective uptake of the pain utterance's motivational contribution, or imperative content, without disturbing the proper uptake of its epistemic contribution, or indicative content. In this final chapter, I will show how my account of pain-related motivational deficit differs from popular accounts of epistemic injustice in that the deficit I identify is one of motivation rather than competency or credibility. It also differs in that I identify societal prejudice against the communicative content rather than the speaker's social identity as the primary driver of the pain dismissal. My account of pain-related motivational deficit can capture cases of pain dismissal that get excluded from identity-based explanations like those provided under the concepts of *testimonial injustice, discursive injustice,* and *hermeneutical injustice*.

In the first section, I will discuss several ways pain-related motivational deficits are harmful in the clinic. I will then provide a case in which a pain utterance's failure to motivate is due, in huge part, to ideological distortions about the kind of pain being expressed. I will show why various accounts of epistemic injustice—testimonial injustice (Fricker, 2007), discursive injustice (Kukla, 2014), and hermeneutical injustice (Fricker, 2007; Falbo, 2022)—provide inadequate explanations for this case. Finally, I will conclude with a brief overview of how the topics raised in this project can be extended outside of healthcare. Here I will also give a few recommendations for addressing pain-related motivational deficits in the clinic.

1 Pain-Related Motivational Deficits in the Clinic

Pain-related motivational deficits are particularly harmful within the clinical setting. A clinician's ability to diagnose and treat a patient's pain often rests on the pain utterance, requiring that the epistemic contributions of the utterance be factored into the pain assessment but also requiring that the motivational contributions grab the clinician's attention in such a way that there

is a desire to consider the epistemic contributions and that there is a sustained, prioritizing interest in the patient's pain being relieved or managed. Thus, pain-related motivational deficits constitute a serious threat to providing adequate clinical care.

Kelly's story is not uncommon. Endometriosis is one of the most common gynecological diseases, affecting at least 11% of people assigned female at birth worldwide. However, it often goes undetected for years because the abdominal pain associated with the condition is mistaken for menstrual cramps (Ellis, 2022). Because of the controlling image that bad abdominal and pelvic pain are 'just what having a period is,' once a clinician interprets the pain as menstrual-related, as something associated with the female reproductive system, the expressed pain no longer grabs the clinician's attention. They are not moved to consider other possible conditions that could be causing the pain (Pettersson & Berterö, 2020). Consequently, on average, women wait between seven to nine years to be correctly diagnosed with endometriosis (Frankel, 2022). During this delay, the underlying condition can progress, placing the patient at great physical harm. For example, it took Lexi Frankel ten years to be diagnosed with endometriosis. It took ten physicians, 50+ office visits, and surgery for her to arrive at a diagnosis. During that time, she suffered with iron-deficiency anemia and intermittent constipation, and diarrhea with rectal bleeding.

Second, a provider responding to menstrual pains with a lack of concern reinforces the societal message that what the patient is experiencing *is* non-concerning. Because of their authoritative position, a provider's lack of concern helps constitute the message that bad menstrual pains are not a legitimate health issue. This message can be particularly harmful when internalized in such a way that the patient still believes they are in pain but begin to de-prioritize and dismiss their own concerns about their pain experiences. For example, participants in one

study reported that they thought of their pain symptoms as "part of life" or "going along with being a woman" (Chen, Draucker, & Carpenter, 2018). Several participants expressed surprise that the painful cramps they had been experiencing "actually had a name"—dysmenorrhea—and some participants were unaware there was even treatment available that could provide relief. The societal message that pains and discomfort are normal during one's period causes many females to just grin and bear it; seeing their own pains as an illegitimate health issue can cause them to fail to search for relief or an alternative source of the pain. As Nutritional Therapist and founder of The Female Health Hub, Jodie Brandman, notes, our response should be the opposite: "our period is actually a window into our health and if something is difficult then we need to explore it and give our bodies a bit of TLC, digging deeper to find out what's going on."[46] In other words, it is fitting to be concerned when one experiences excruciating menstrual pains. A lack of concern from others can silence and replace our own concerns.

Excruciating menstrual pains also fail to motivate on the institutional level. It has been estimated that between 50-84% of those who have periods experience pain and cramping; up to 40% of those who experience symptoms during their period say their pain is so severe they have had to miss school or work (Broster 2020, 9 Jun). However, in a survey asking women to share their experiences with menstruation, one participant made the following claim,

> I think that more women experience these symptoms than [they] will admit, because we don't want to be seen as the weaker sex. The truth is that menstruation (as well as childbearing) has a significant effect on our bodies…but there is not enough empathy or understanding for the physical price we pay (Chen, Draucker, & Carpenter, 2018, p.5).

[46] Quote retrieved from Forbes article entitled "You Shouldn't Accept Pain & Discomfort as Normal, Explains Expert."

Despite the prevalence of excruciating period pains and their negative impact on one's life, there has been little to no scientific research on menstruation. Only ~0.1% of pain papers deal with menstrual pains (Berkely & McAllister, 2011). Scientific research is steeped in andronormativity, meaning masculine values and male presentation of symptoms are prioritized and often cast as the clinical standard (Samulowitz, 2018). As a result, research into female conditions, like menstruation, has been de-prioritized. Elinor Cleghorn, author of Unwell Women: Misdiagnosis and Myth in a Man-Made World, claims it is the historic mythologizing of women's blood and pain that has gotten in the way of proper science being done. Whatever the cause, a lack of substantial scientific data on dysmenorrhea symptoms has resulted in a broad ignorance around experiences of menstrual pains and this ignorance contributes to the minimizing and dismissal of these kinds of pain utterances. Having substantial scientific data available would validate the concern felt by those experiencing severe dysmenorrhea but also indicate an institutional interest in these kinds of pains.

The lack of concern towards excruciating menstrual pains provides us with a clear example of the harm that can ensue when a pain utterance fails to motivate its addressee. However, the harms that follow from a pain-related motivational deficit are not unique to pain utterances about menstrual pains. I suspect similar harms can be found with a lack of clinical concern given to other pain experiences like labor pains, obesity-associated pains, and addiction withdrawals. Again, I suspect this list is non-exhaustive. Whether or not this suspicion is correct, it is important and informative to consider the impact a pain-related motivational deficit can have on individual patients and scientific research more broadly.

2 Dismissal of Menstrual Pains

Consider the following case.

> Alma has had extremely painful periods since the age of 14. Every time she told a gynecologist about her pain, they told her it was *just* a painful period. They would inform her that her pain was normal, despite Alma having cramps so bad that she would experience visual hallucinations and vomit to the point of fainting. None of her gynecologists seemed to consider the pain worthy of further investigation, nor did they consider it something worthy of treatment. Once, when the pain was too unbearable to function, Alma asked her family doctor for a doctor's note. The doctor responded: "you want a doctor's note …for period pain. A doctor's note …for… period pain" as if the request was inconceivable. At the age of 30, Alma finally received a formal diagnosis: Endometriosis.[47]

There are key features of the case that are important to highlight. First, it is important to note that Alma communicated to her physicians that she was in pain. Second, the physicians acknowledged the existence of Alma's pain, suggesting that they took what Alma was reporting to be true and credible information. This is demonstrated by the fact that the physicians told her, 'It was *just* a painful period;' their response does not indicate disbelief or denial of Alma's complaints. However, despite acknowledging that Alma is, in fact, in pain, the physicians are unmoved by Alma's pain utterances. We can see this feature in many of the physicians' actions, or lack thereof. Despite believing Alma, they did not engage in any actions that would indicate the physicians were *concerned* by what Alma was expressing, i.e., no further diagnostic or treatment steps were taken. The doctors' language suggests they interpreted menstrual pains as low in import. Colloquially, adding 'just' in front of a noun negates its significance, e.g., it's *just* an ant, it's *just* a cough, or they're *just* a friend. Moreover, doctor's notes are a legal document affirming the existence of a state that warranted medical attention. The family doctor's confusion is a sign that Alma's expressed menstrual pains are not being interpreted as being *warranted* of concern. Finally, we can assume that the pain utterance's failure to motivate is due, in huge part,

[47] This vignette is based on a real story in the Medical News Today article, *Endometriosis experiences: The long, painful road to diagnosis,* published on March 30, 2021.

to distortions of menstrual pains such that excruciating menstrual pains are habitually interpreted as normal and natural. The influence of this concept can be seen in the physicians informing Alma that her hallucination-inducing pains were 'normal.'

If proper uptake were given to both the indicative and imperative content of Alma's pain utterances, then the physicians would have believed that Alma was in pain *and* would have responded with other-oriented concern. As discussed in Chapter 2, they were expected to act in a way that indicated a sustained attention and commitment to alleviating this deprivation of Alma's well-being. Such behaviors would have included showing empathetic curiosity and interest by asking follow-up questions, being vigilant by further investigating alternative diagnoses, and by offering up any treatment or pain management techniques that best alleviate the unpleasantness of Alma's menstrual pains. Notably, the pain is a *standing* imperative. Seeing as the misinterpretation of Alma's menstrual pains as *normal* menstrual pains resulted in no further investigation or diagnostics, we can deduce that the imperative content was not given proper uptake. Presumably, Alma's pain utterances met the appropriate discursive conventions, and the physicians had no overriding reasons that would morally permit them to no respond to Alma's pain with attention and care. If not for the existence of controlling images of menstrual pains, a normal addressee could reasonably recognize Alma's pain utterances as functioning as secondary commands.

3 Limits of Epistemic Injustice

A pain-related motivational deficit can be characterized as a type of *epistemic violence.* Epistemic violence occurs when an audience fails to communicatively reciprocate—or fails to recognize how an utterance was meant to be taken—in a linguistic exchange due to (pernicious)

ignorance (Dotson, 2011).[48] When there is no reciprocity among individuals, the speaker is *not heard.*

Controlling images of menstrual pains can produce ignorance in a society by making *unimaginable* the idea that an excruciating menstrual pain is worthy of attention and a prioritized commitment to care. Symbols, images, and scripts that are collectively shared form our *social imagination*; the social imagination acts as the representational background against which people communicate (Medina, 2013). However, if constituted by ideology, the social imagination can be an obstacle to 'hearing' pain utterances by providing "an easily imaginable, ready-made scenario" (Medina, 2013, p. 68). Those under the influence of controlling images of menstrual pains are likely to develop the mental and social habits that help sustain the imaginable idea that all menstrual pains, even excruciating menstrual pains, are natural and normal. As Medina notes,

> Those under the sway of this social imaginary are likely to develop epistemic habits that protect established cultural expectations and make them relatively blind and deaf to those things that seem to defy those expectations. In the first place, they will lack the motivation and intellectual curiosity to probe the evidence more fully, to ask about alternative explanations and to find out more. In other words, the social imaginary produces a strong form of epistemic laziness that blocks evidentiary explorations. This laziness becomes an epistemic obstacle in the pursuit of knowledge that can easily lead to epistemic injustices (Medina, 2013, p. 68).

Although, in our pursuit for communicative reciprocity, controlling images of menstrual pains can hinder both our ability to epistemically appraise the speaker in pain and to motivational appraise the pain being shared, present accounts of epistemic injustice can only accommodate the former.

[48] I put pernicious in parentheses because Dotson defines pernicious ignorance as any reliable ignorance that consistently follows from a predictable epistemic gap in cognitive resources that harms another person (2011, p. 238). I take it that epistemic violence can also be due to a broader notion of ignorance, one in which a lack of knowledge or motivation is due to what is imaginable (or is not imaginable).

Epistemic injustice has been partitioned into many forms since Fricker first introduced the label (e.g., Hookway, 2010). As I will show in this section, concepts like testimonial injustice and discursive injustice are limited to explaining cases of identity-based pain dismissal. Hermeneutical injustice is limited to explaining cases in which the pain cannot even be acknowledged. Cases like Alma's fall in neither bucket.

3.1 Testimonial Injustice

A pain utterance can be dismissed and fail to motivate if the speaker's credibility is unfairly downgraded. This kind of pain dismissal is an identity-based pain dismissal and is best characterized as an act of *testimonial injustice.* As Fricker (2007) notes, testimonial injustice in its most common form is an *identity-prejudicial credibility deficit,* in which prejudice on the hearer's end causes the speaker to be given less credibility than what would have otherwise been given. As a result of prejudicial beliefs about the speaker's group membership, the speaker is misperceived as unreliable or untrustworthy.

A well-discussed example of testimonial injustice as pain dismissal can be found in Dr. Damon Tweedy's book, Black Doctor in a White Coat. Here Dr. Tweedy recounts telling his doctor about his knee pain while wearing a fleece pullover, sweatpants, and slightly mismatched socks. The doctor asked Dr. Tweedy to stand, and he grimaced in pain. After seeing the grimace, the doctor told Dr. Tweedy he was fine; that it was probably just a bruise or sprain, despite not having even touched Tweedy's knee. The doctor offered no explanation as to what part of the knee was bruised or sprained and did not mention pain management or any type of knee bracing. From the doctor's actions or lack thereof, it is clear the doctor was not concerned by Dr. Tweedy's pain. Dr. Tweedy's pain utterance failed to motivate because, as a black man, he was initially interpreted as an unreliable reporter of his pain experience. This is apparent when

Tweedy later signaled his medical credentials, disclosing that he had a "left third metacarpal fracture" the summer before, and the doctor's interpretation of Tweedy shifted (2015, p. 214). Instead of seeing Tweedy as an unreliable Black man, the doctor now saw Tweedy as a trustworthy physician, and as a result, he was suddenly moved to concern: "let me take a close look at your knee" (Tweedy, 2015, p. 214). In this case, it is clear that a credibility deficit primarily explains the pain utterance's failure to motivate.

Dr. Tweedy's case is like Alma's in that the import of their pain was not given proper uptake, and thus, their doctors failed to recognize the imperative to be concerned. But note how the *cause* of the failure to be concerned differs in Tweedy's case compared to Alma's. For Alma, the doctor's response was determined mainly by the interpretation of the kind of pain she was communicating, i.e., menstrual pains. In contrast, for Tweedy, the doctor's response was determined by the interpretation of Tweedy's group membership. As Tweedy notes,

> But I couldn't get out of my mind how I'd been treated as two entirely different patients. Damon Tweedy, the unknown black man, dressed like he was about to mow the lawn, couldn't get the doctor to look him in the eye or touch him; Damon Tweedy, M.D. was worthy of personal, first-class service (2015, p. 215).

Testimonial injustice suggests it was the physician's own prejudicial bias against Black Americans that prevented the physician from being able to interpret Dr. Tweedy as a competent, credible reporter of a pain experience. On the other hand, suppose Alma was complaining about chest pains instead. Although women's chest pains, in general, are not taken as seriously as men's (Lewis et al., 2018), I think it is safe to assume that a woman complaining of chest pains will be taken more seriously (e.g., be prioritized and the clinician more vigilant) than if that same woman was complaining of menstrual pains.[49] This suggests that the dismissal of menstrual

[49] Although there exist no empirical data on this. More research could be done here.

pains is not the same as having a prejudicial bias against the speaker's group membership; for if the two were one and the same, it wouldn't matter what kind of pain Alma complained about it, yet in Alma's case, the kind of pain expressed clearly matters. By only appealing to a speaker's group membership and perceived credibility, we miss the causal influence that *what was communicated* can have on the uptake given to a pain utterance.

One could think I have not entirely taken an appeal to testimonial injustice off the table. It seems like Alma's case can still be explained by the following:

> In telling her doctors about her excruciating menstrual pains, Alma attempts to testify *that she is experiencing a pathological pain*. However, because Alma lacks medical credentials, training, or experience, her physicians do not trust or believe her to be a reliable or credible reporter of *pathological pains.* The pain utterance fails to motivate concern because the doctors do not trust or believe Alma to be experiencing a pathological pain. They acknowledge that Alma is experiencing pain, but not one that warrants further investigation or treatment.[50]

Such an explanation can equate Alma's case to Dr. Tweedy's case (supposing Dr. Tweedy, too, was perceived as uncredible in reporting a pathological pain until he provided his medical credentials) and provides a more parsimonious explanation than the one I provided—it does not postulate that pain utterances have a unique, hybrid communicative content. One may think, why then be persuaded by an account of pain-related motivational deficit?

I think such an appeal to testimonial injustice relies on a faulty starting condition. It assumes that the speaker, when providing their pain utterance *knows* that their pain is pathological. Such a starting condition is rarely met when first providing a pain utterance within a clinical setting. Often, unless the associated bodily damage is visible from the outside, the speaker does not know the cause of their pain. Thus, the speaker is not and should not be on the

[50] Thank you to Emma Duncan for this counterexample.

hook for knowing if the source of the pain is pathological. The speaker just knows that they are in pain and that the pain *feels* bad to them. As I mentioned in the previous chapter, pain is concerning if it first generates concern in the speaker, regardless of if that pain has a pathological cause.

To avoid this starting assumption, the previously mentioned scenario could be reformulated such that Alma is attempting to provide a testimony *that she is experiencing a concerning pain.* In this scenario, the doctors can be interpreted as not trusting or believing Alma to be a reliable or credible reporter of pains that are bad for her. Such an explanation could equate Alma's case to Dr. Tweedy's case (this time supposing Dr. Tweedy, too, was initially perceived as uncredible in reporting concerning pains as a Black man) and maintains parsimony while avoiding the flaws of the prior explanation. However, this reformulation still fails to capture the fact that the kind of pain expressed matters. Such an explanation would suggest that Alma's pain utterance would have been responded to with the same lack of concern rather it be a chest pain, headache, or backache that she expressed since she can't be trusted to report *any* concerning pains. Given that none of these kinds of pains are associated with a particular embodiment, it seems unlikely that a different expressed pain would have been responded to as 'normal' and unworthy of even a doctor's note.

Although perceiving Tweedy as credible ultimately moved his doctor to act, it is also important to note that credibility is not a necessary condition for concern. Finding a speaker credible or competent are necessary conditions for *trusting* an utterance. Trust in an utterance only provides a recipient with good reason to *believe* the propositional content of that utterance (Fricker, 1995; 2006). However, beliefs have a mind-to-world direction of fit. They function to provide us with internal representations of the world, but beliefs, alone, are not motivational

states.[51] Desires, on the other hand, have a world-to-mind direction of fit; to have a desire is to have a disposition to act. As mentioned in Chapter 1, believing a propositional content can only motivate action if the addressee also desires to act according to the newly formed belief. Thus, epistemic trust and volition come apart.

3.2 Discursive injustice

According to Fricker, telling is the parent case of testimonial injustice given the basic wrong of testimonial injustice is that the speaker is undermined in their role as a knower (2014). In telling, conveying knowledge is the *illocutionary point,* or the most basic and immediate point of the utterance. Testimonial injustice may be limited in explaining what goes wrong in some instances of pain dismissal because appealing to testimonial injustice assumes that the illocutionary point of a pain utterance is a *telling,* i.e., telling another that they are in pain.

A speaker can utter a sentence in the appropriate context with certain intentions and perform one or more illocutionary acts (Searle & Vanderveken, 1985).[52] Sentences can be used to tell but also to exclaim, promise, command, request, warn, etc. This is important because although epistemic trust may be necessary for a telling to have appropriate uptake, it is not necessary for, say, an imperative. Imperatives are illocutionary acts that motivate action, but their proper uptake does not require an evaluation of credibility or veridicality. Because imperatives express how a speaker wants the world to be and not how the world is, their ability to motivate is not determined by the speaker's credibility as a reporter or by the content's conformity to the truth. But rather, imperatives motivate and act as an inducement for intentional

[51] I acknowledge that this is a potentially controversial claim. Some have argued that there are cases in which beliefs can themselves be motivational states (e.g., see Plats, 1980). Rationalists have argued that beliefs may not inherently be motivationally but that they can directly produce a motivational state (e.g., see Smith 1994 and Wallace 2006).
[52] Note, I take illocutionary acts and speech acts as referring to the same thing, and thus, take it that the two concepts are interchangeable.

action when the addressee properly recognizes that the speaker is entitled to issue the imperative (Kukla, 2014).

If pain utterances are, in a sense, secondary commands, then one may think cases like Alma's are best characterized as acts of *discursive injustice,* given that the basic wrong of discursive injustice is not limited to assertions or tellings. Quill Kukla defines *discursive injustice* as the following,

> When members of any disadvantaged group face a systematic inability to produce certain kinds of speech acts that they ought, but for their social identity, to be able to produce—in particular when their attempts result in their actually producing a different kind of speech act that further weakens or problematizes their social position—then we can say they suffer a "*discursive injustice*" … (2014, p. 441)[53]

Despite being entitled to perform that speech act in that context and using the appropriate words, tones, and gestures, because of the speaker's group membership, the performative force of the utterance, or the normative output it introduces, can be radically distorted. The impact the speech act was intended to have on social space can be misrecognized (or not recognized at all). An example Kukla provides is that of a floor manager of a heavy machinery factory who is entitled to issue orders to her majority male workers, but despite following the conventions that typically would make it such that her speech acts are recognized as orders, her gender makes it such that her workers recognize her as issuing a request instead. A request has a weaker performative force, making it difficult for the floor manager to elicit compliance from her employees—something that is necessary for her to do her job.

A pain utterance can fail to motivate because of a discursive injustice. Discursive injustice of pain utterances occurs when ideologies distort pain utterances from speakers of an

[53] To clarify, discursive injustice was named as an analogy to epistemic injustice, although in the endnotes, Kukla (2014) identifies some forms of epistemic injustice as being subspecies of discursive injustice.

already disadvantaged social group such that the pain utterance is given the uptake of an entirely different kind of act. This distortion further exacerbates the suffering of the speaker in pain. A prime example is the systemic distorting of women's acts of pain expression into acts of emotional expression due to a patriarchal society that paints women as 'hysterical.' In cases like this, the ideological depiction of women as overtly emotional and sensitive to stress disrupts the uptake of the pain utterance and constitutes it as an emotional utterance. Often, the women's pain is not acknowledged *as pain.* Instead, women's pains are socially authored to hysteria, or more modernly, somatization, the physical expression of stress (Cleghorn, 2021). This distortion of their pain utterances undermines what women intend to do with their pain utterances to elicit concern. Presumably, the expression of emotions either lacks the imperative to be concerned or the imperative has a downgraded motivational force.[54] Consequently, once doctors have settled on the idea that the pain is 'all in their head,' they remain unmoved. They do not search for another explanation which delays proper diagnosis and treatment. Moreover, taking a women's pain utterances as acts of depression can actually induce depressive reactions in women patients (Dusenbery, 2018), which can be used as evidence to support physicians' misjudgment of the intention and content of the utterance.

Note how Alma's case significantly differs from the general distortion that turns women's pain utterances into emotional utterances. When a woman's pain utterance is distorted into an emotional utterance, an addressee will fail to acknowledge the existence of the speaker's pain because the utterance is not being interpreted as a pain expression. In Alma's case, the

[54] One may think that emotions, especially emotional pain caused by depression, too, issue an imperative to be concerned. Thus, even if women's pain utterances are distorted into expressions of stress or depression, others should still be moved to be interested in what women are expressing. Maybe what explains the 'weaker performative force' of an expression of emotion is that the emotional imperative, to be concerned, is less of a priority than the pain imperative, to be concerned. More could be said on this topic, but unfortunately, it is out of this project's scope.

import of her pain was downgraded, but her pain *was* acknowledged. The doctors would not have acknowledged her pain if the improper uptake given to Alma's pain utterance matched the improper uptake often given to women's pain utterances, in virtue of them speaking as women.

Second, like testimonial injustice, discursive injustice can only provide us with an identity-based explanation as to why a pain utterance would fail to move an addressee. Discursive injustice does not distinguish between interpreting someone as being entitled to issue an imperative and interpreting what was communicated as functioning as an imperative. For example, although it might be the case that women face a systematic inability to issue orders to men, given the import of what is being communicated, a particular order could still 'break through' and have an intended impact on the addressee. To return to Kukla's floor manager, the male workers will likely dismiss the manager's orders to, say, *move the equipment* or *check the inventory*, but presumably, it is unlikely that they would just as easily dismiss the manager's utterances if she was, instead, ordering them to *put out that fire* or *call 911*. Why? Talking about fire or calling 911 is more attention-grabbing; we often prioritize our physical well-being over doing our jobs. Despite the speaker being a member of a disadvantaged group, the import of what is being ordered is so high that the imperative's authority relies less on *who* is doing the issuing and is, instead, relying more on what is being said.

To further illustrate this point, consider the opposite scenario: Suppose the floor manager is male. As a floor manager, he has the legitimate authority to issue orders to his employees. However, as a cis-gendered male, he is also a member of an advantaged group that usually has the discursive freedom to issue orders. Nevertheless, whenever he orders his employees to touch their noses, his order is taken as issuing a request instead. Even though he is entitled to issue orders in this context, as a male, he is often afforded the discursive freedom to have his

utterances appropriately recognized as orders. However, because there is so little import in what is being ordered, the performative force is too low to give the utterance proper uptake.[55] Not only is touching one's nose often not a priority, but unless the discursive players are playing a game of Simon Says, it seems unusual to think touching one's nose can be obligatory. Again, whether the speaker is entitled to issue an imperative and whether what is communicated functions as an imperative comes apart. The import of what is being ordered can be so low that despite the speaker being entitled to issue the order, there will be a low performative force and the utterance will fail to induce action.

Yes, Alma is a member of an already disadvantaged group, but because of ideological-based images of excruciating period pains as normal, the *kind of pain* Alma is communicating also faces a systematic inability to elicit concern from others. Although those with already restricted discursive freedoms are more likely to be improperly interpreted as expressing a non-concerning pain—or no pain at all—it is still valuable to treat these two features of an oppressive society as distinct, albeit closely related, phenomena.

3.3 Hermeneutical Injustice

Lastly, a pain utterance can fail to motivate if the speaker cannot articulate the pain experience they are attempting to share. This can stem from a conceptual impoverishment within a particular culture that prevents a person in pain from having the hermeneutical resources to clearly conceive and articulate their own pain experiences (Carel & Kidd, 2014). As a result, the pain utterance is judged to be irrelevant or insufficiently articulated. Because the speaker's

[55] To clarify, Kukla (2014) does not see discursive injustice as a phenomenon that can only occur to those who lack social power; they argue that even the socially advantaged, in virtue of their social identity, can have their utterances distorted. Yet, even in these reverse cases, the speaker's identity is doing all the explanatory work.

experiences are left unintelligible to the addressee, the addressee dismisses the pain utterance. This kind of pain-dismissal is best described as an act of *hermeneutical injustice.*

A hermeneutical injustice occurs when a gap in collective interpretive resources puts a speaker at a disadvantage when trying to make sense of their social experience (Fricker, 2007). The stock example of hermeneutical injustice is the emergence of the concept of *sexual harassment* in the early 1970s. When Carmita Wood quit her job at Cornell University's Nuclear Physics Department, she could not articulate her experiences of persistent and unwanted sexual advances from her boss. Wood experienced sexual harassment, but because such a concept was not available in the collective interpretive resources, Wood could not articulate her experiences as such (Fricker, 2007). Instead, when applying for unemployment insurance, she cited quitting for "personal reasons." Her request for insurance was ultimately denied. "Personal reasons" insufficiently articulated what Wood experienced; the subsequent denial of unemployment insurance was a consequence of Wood being unable to make communicatively intelligible something which was in her interest to be able to articulate (Falbo, 2022*;* Fricker, 2007).

In one sense, people frequently find it difficult to communicate their pain experiences in an intelligible way. Many aspects of being in pain are difficult to understand and articulate, and this is owed, in part, to pain's enormous capacity to destroy language and silence it (Scarry, 1985). In another sense, as Carel & Kidd (2014) suggests, the structures of contemporary healthcare practices encourage the unintelligibility of a patient's pain experience—e.g., privileging certain styles of articulating testimonies, i.e., pain scales and short questionnaires, and privileging impersonal third-person reports over patient's first-person report in a way that disables the patient's contributions to the collective assortment of knowledge. Patients occupy a marginalized group *qua* patients relative to healthcare professionals because of vulnerabilities

with respect to their illness; their general servility to healthcare providers' demands; their overall lack of institutional power and epistemic authority; and their general lack of medical expertise relative to healthcare professionals within the clinical space (Freeman & Steward, 2019). In virtue of being a patient, a speaker in pain is hermeneutically marginalized; there is unequal hermeneutical participation with respect to conceptualizing pain experiences (Fricker, 2007). As a result, there exists a hermeneutical gap, or hermeneutical lacuna, within the culture of medicine that cognitively handicaps both the clinician and patient when it comes to comprehending a subjective pain experience. This conceptual impoverishment is most apparent when the patient's first-person report is incompatible with the privileged impersonal report. The patient's insistence that they are in pain is then unintelligible, making the patient's entitlement to elicit concern unintelligible as well. As a result, a clinician can remain unmoved.

However, I take it that hermeneutical injustice provides a *global* explanation behind pain dismissals and not the immediate explanation behind cases like Alma's. If all pains have an inarticulable quality and all persons in pain qua patients are hermeneutically marginalized, then all pain utterances provided within the clinical setting are, in some sense, unintelligible. This may be the right conclusion. But even if there is a broad unintelligibility regarding pain utterances, this fact doesn't explain how some pain utterances successfully elicit concern while others do not. One could argue that along with the unintelligibility attributed to pain experiences more broadly, there are also narrower hermeneutical resources missing from our collective conceptual repertoire—resources that would make experiences like excruciating menstrual pains or labor pains intelligible. Pain utterances that express these kinds of pains fail to motivate because such concepts, like excruciating menstrual pain, are collectively unavailable. Note how this explanation is at odds with the fact that we *do* have a shared interpretive resource about

excruciating menstrual pains: that they are a normal, natural consequence of having a female reproductive system. It is a *pejorative,* shared resource. There is no hermeneutical lacuna that needs to be filled.

Instead, maybe cases like Alma's could be better explained by an appeal to *positive hermeneutical injustice.* Ariana Falbo (2022) draws a distinction between Fricker's *negative* hermeneutical injustice and Ariana's proposed, *positive* hermeneutical injustice. Cases of negative hermeneutical injustice are those in which important social experiences are rendered unintelligible because of a lack of hermeneutical resources; cases of positive hermeneutical injustice are those in which the application of an available and more accurate concept is prevented due to the presence of oppressive and distorting concepts, i.e., a controlling image, limiting or altogether blocking the accurate application of a concept (Falbo, 2022). What often results is a *hermeneutical clash.* Falbo gives the example of attempting to apply the concept *rapist* to someone who seamlessly fits the profile of a *golden boy*—a white, cis, heterosexual, popular athlete. Because the concept of rapist is distortedly portrayed as a creepy stranger, monster, animal—or a black man—its application is severely constrained when the speaker attempts to apply *rapist* to someone who matches the *golden boy* profile. Falbo claims what is going wrong here is not a lack of conceptual competency with the concept *rapist,* but rather one fails to identify an *actual* rapist in particular instances owing to hermeneutical pre-emption or defeat (Falbo, 2022).

Similarly, one could argue that there is a hermeneutical clash between the concepts, *normal menstrual pains and pathological menstrual pains.* Normal menstrual pains, clinically referred to as *primary dysmenorrhea,* occurs in the absence of underlying pathological findings; pathological menstrual pains, or *secondary dysmenorrhea* are menstrual pains that are related to

other conditions such as endometriosis, fibroids, or pelvic inflammatory diseases (Chen, Draucker, & Carpenter, 2018). An appeal to positive hermeneutical injustice would suggest that the existence of controlling images about normal menstrual pains prevents a speaker from successfully applying the concept, *pathological menstrual pains,* while providing a pain utterance. Because the more accurate concept, *pathological menstrual pains,* cannot be applied, the utterance is not met with the responses such a concept would invoke, i.e., further investigation and care. An appeal to positive hermeneutical injustice is plausible given that this approach considers the impact that the utterance's communicative content, or what is being communicated, can have on whether that utterance is given proper uptake.

However, positive hermeneutical injustice requires that the dismissal of the pain utterance be owed to a hermeneutical clash. As I have already shown, a speaker does not necessarily have to be attempting to apply the *pathological menstrual pain* concept, and their pain utterance still fails to motivate. Suppose we stipulate that there is a hermeneutical clash between the concepts *concerning* and *non-concerning menstrual pains.* Even then, the concept of positive hermeneutical injustice seems to suggest that, in virtue of this clash, the speaker's pain cannot be acknowledged. This is not what happened in Alma's case. The doctors acknowledged that Alma's excruciating menstrual pains were real. Moreover, it is not farfetched to think that they even acknowledge that Alma was applying a *concerning pain* concept, i.e., they recognize that she was reporting a pain that was *concerning* to her. However, what is likely an explanation, is that the controlling image of normal menstrual pain constrained the doctors' ability to *interpret* the obligation that Alma's attempting to impute on them to be concerned.

By recognizing a speaker is expressing a concerning pain, an addressee may receive a normative pro tanto reason to be concerned, i.e., that recognize that there exist social norms that

broadly dictate that, all things considered, we ought to respond with concern to this kind of pain. However, a distortion of the pain, a distortion of the imperative content, prevents the addressee from receiving a *psychological pro tanto reason* to be concerned, i.e., they are unable to recognize the utterance as imputing an obligation that they be concerned by *this* expressed pain.

3.4 Silencing

It is worth quickly addressing why explanations that appeal to silencing also fall short. Analysis of utterances is usually broken down into the *locutionary act,* or the utterance's surface grammar; the *illocutionary act*, or the action done by the utterance; and the *perlocutionary act*, or the effects brought about by the utterance. Philosophers have then proposed two kinds of silencing: *illocutionary silencing* (Langton & Hornsby, 1998) and *perlocutionary silencing* (Medina, 2021).

According to Langton and Hornsby (1998), illocutionary silencing occurs when the illocutionary force of an utterance is nullified or silenced, rendering the speech act void. The illocution is short-circuited, or as Hornsby and Langton describe it, *disabled,* causing the utterance to be silenced by a lack of uptake given to the utterance. They give the example of how women's communicative capacity to refuse sexual advances are disabled in a sexist culture such that their addressees treat their saying 'No!' as "pure noise with no communicative force at all" (Medina, 2021, p. 188). In a similar vein, illocutionary silencing could provide the following explanation: Patients like Alma, i.e., women patients, are disabled in their capacity to produce pain utterances by the systemic disregard of women's pain. This causes the doctors to be unable to register women's utterances *as* pain utterances. However, this explanation clearly does not apply to cases like Alma's. One, it provides another identity-based explanation of pain dismissal. Two, if her pain utterance failed to motivate due to an illocutionary silencing or disablement,

then the doctors would fail to give Alma's utterance *any* uptake. They would treat Alma's pain utterance as "pure noise." However, the doctors responding to Alma's pain as *just* menstrual pains suggest *some* uptake was given to Alma's pain utterance. They can register that Alma is reporting pain, but they are not able to register that Alma is expressing and re-issuing a directive. To use Langton & Hornsby's language, in cases like Alma's, only the imperative content is registered as "pure noise;" the indicative content still maintains its communicative or illocutionary force.[56]

Medina (2021) later identifies a form of silencing that disables not the illocutionary act of the utterance, but the perlocutionary act. Perlocutionary silencing occurs when the intended effects of a speech are blocked or short-circuited by the kind of uptake received (or lack thereof) (Medina, 2021, p. 190). In cases like this, the utterance is not entirely unheard (or heard as mere noise) and the utterance is not entirely distorted, but the perlocutionary consequences (or lack thereof) still render the utterance ineffective and self-undermining. As an example, Medina considers the grievances of detained subjects:

> …detainee's speech acts of grieving typically make no difference (they are looked down upon by the guards and the institution and those who voice them are perceived as trouble-makers engaging in bad or questionable conduct). In this way, detainees are discouraged from their communicative attempts; they are incentivized to remain quiet and refrain from grieving (2021, p. 190).

Perlocutionary silencing would suggest that the intended effects of a pain utterance, i.e., to believe *and* be concerned by the pain, are blocked by the defective uptake they receive. In cases like this, the perlocutionary effects are blocked despite the pain utterance being recognized as an act of pain expression and the pain utterance receiving *some* uptake. This is very compatible with

[56] Kukla (2014) argues illocutionary silencing is a subset of discursive injustice. If this is true, then the same arguments against an appeal to discursive injustice can be extended to illocutionary silencing as well.

my account of pain-related motivational deficit. In this project, I have argued that one of the conventional effects, to elicit concern, is blocked by an overall defective uptake characterized as proper uptake given to the indicative content with an improper uptake given to the imperative content. I do not deny that perlocutionary silencing may have occurred in Alma's case. However, an appeal to perlocutionary silencing just pushes the question back. Why are the intended effects of certain pain utterances, like pain utterances about menstrual pains, systemically blocked or short-circuited? This is the question that this project sought to answer.

4 Conclusion

In this project, I proposed that pain utterances have two kinds of communicative content: indicative content in virtue of expressing the speaker's pain belief(s) and imperative content in virtue of expressing the pain itself. However, in this account, I only examined utterances about physical pains provided by adults. However, because my account does not rely on speaker's intentions, there is room to think that animals' pain utterances can have imperative content and function as a secondary command as well. A whimpering dog can, too, by expressing pain (or a similar imperatival state), demand other-oriented concern from its addressee. More would need to be said regarding the conventions that give animals' pain utterances the effect of acting as a secondary command, but overall, such a conclusion could provide insights into ongoing discussions on our potential moral obligations to animals and the wrongs of animal testing.

Moreover, I expect that it is not just physical pains that are an imperatival state. Humans also often experience *social pains*, or "the painful experience of actual or potential psychological distance from other people or social groups" (Eisenberger & Lieberman, 2005; Zhang, Zhang, & Kong, 2019, p. 265). Given that the processing of social pains and the processing of physical pains overlap in neural circuitry and behaviors (see Zhang, Zhang, Kong, 2019), I expect that

social pains also express an imperative to *be concerned.* A question worth exploring is in what sense is the self-oriented or other-oriented concern demanded by social pain isomorphic to that demanded by physical pain. After the wake of George Floyd's killing and the rise in anti-Asian hate crimes, I am specifically interested in how sharing racial trauma can also function as a secondary command in our society. What are the addressees of shared racial trauma being called to do?

Lastly, in this project, I solely focus on pain-related motivational deficits that occur in the clinic, but pain-related motivational deficits also occur outside the clinic. A teacher fails to excuse a student expressing severe menstrual pains. A parent fails to take their child's complaints seriously. Policymakers fail to recognize chronic pain in and of itself as debilitating (see Moore, 2021). Each of these can be characterized as a pain-related motivational deficit. We expect non-clinicians and clinicians alike, to be moved to concern by our pains. Of course, the nature of, say, the attention and beholdenness we expect from non-clinicians differ from that we expect from clinicians. Still, to some relevant extent, I take it that our pain utterances to non-clinicians are also demands for attention, a beholdenness to restore the speaker's well-being, and action when otherwise appropriate.

However, medical practice *is* an important site for the reproduction of controlling images of pain. How menstrual pains are described and depicted in medical archives, medical school curricula, and current research (or the lack thereof) could contribute to the systemic dismissal of various pain experiences, including the dismissal of fibroid pains. On an institutional level, pain-related motivational deficits can be alleviated by producing a medical discourse that creates an interpretative landscape in which pain utterances to be appropriately recognized as ‘concerning.’ As Medina notes,

> Properly addressing these instances of active ignorance—these forms of insensitivity requires deep transformations of the social imagination and the cognitive and emotive restructuring of attitudes and habits… (2013, p. 70)

Moving beyond a single narrative of menstrual pains—that they are natural and normal—to a medical practice that embraces a more pluralistic picture of menstrual pains can make more salient the reasons that a particular pain utterance about menstrual pains ought to be met with attention and care.

On a policy level, hospitals can address pain-related motivational deficits by promoting and sustaining a work environment in which clinicians have the capacity to give pain utterances proper uptake. One, stressful situations can exacerbate decision bias as we are more likely to lean on society-wide mental habits or fast and effortless heuristics when making a decision (see Yu, 2016). In an overwhelming, high-paced environment, clinicians are more likely to fall back on the ready-made scenarios found in the social imagination; ready-made scenarios that often justify not responding with other-oriented concern. Two, overwhelming working conditions (i.e., staffing shortages, limited resources, limited time allocations with patients) can produce an environment in which clinicians cannot be concerned due to burnout. As I showed in Chapter 4, motivational deficits can occur when clinicians have maxed out their attentional and motivational capacities.

Individual clinicians can, too, take actions to address pain-related motivational deficits. Just as we have implicit bias training to address prejudices that a clinician may have toward a speaker's social identity, so, too, can we offer implicit bias training to address prejudices that a clinician may have toward certain kinds of pain experiences or diagnoses. A clinician can be aware of their biases toward a particular race or gender but be blinded to how they unknowingly

discriminate against or dismissed certain pain complaints in virtue of what is being complained about. Addressing both the biases we have towards particular identities and towards particular pains can provide a more cohesive solution to the problem of pain dismissal.

In sum, this project takes pain utterances seriously. Pain utterances are a unique communicative act in which believing the speaker or finding the speaker credible is not enough. To hear another's pain is to be moved to concern. In this project, I aimed to start a conversation on how speakers in pain can communicatively be wronged by an addressee's lack of attention or action. Such a conversation is needed to pursue what can be characterized as motivationally-just healthcare.

REFERENCES

Adolph, K. E., Cole, W. G., Komati, M., Garciaguirre, J.S., Badaly, D., Lingement, J. M., Chan, G. L. Y., & Sotsky, R. B. (2012). How do you learn to walk? Thousands of steps and dozens of falls per day. *Psychological Science, 23*(11), 1387-1394.

Akbari, F., Mohammadi, S., Dehghani, M., Sanderman, R., & Hagedoorn, M. (2020). Interpretations of partners' responses to pain behaviours: Perspectives of patients and partners. *British Journal of Health Psychology, 26*(2), 401-418.

Akintomide, H., Sewell, R. D. E., & Stephenson, J. M. (2013). The use of local anaesthesia for intrauterine device insertion by health professionals in the UK. *Family Planning and Reproductive Healthcare, 39,* 276-280.

Anzaldua, A., & Halpern, J. (2021). Can clinical empathy survive? Distress, burnout, and malignant duty in the age of Covid-19. *Hastings Center Report, 51*(1), 22-27.

Armstrong, D. M. (1968). *A Materialist Theory of the Mind.* Humanities Press.

Austin, J. L. (1962). *How to do Things with Words.* Harvard University Press

Aydede, M. (2009). Is feeling pain the perception of something? *Philosophy, 61*(10), 531-567.

Aydede, M., & Fulkerson, M. (2019). Reasons and theories of sensory affect. In D. Bain, M. Brady, & J. Corns (Eds.), *The Philosophy of Pain: Unpleasantness, Emotion, and Deviance.* Routledge.

Bain, D. (2011). The imperative view of pain. *Consciousness Studies, 18*(9-10), 164-185.

Bain, D. (2014). Pains that don't hurt. *Australasian Journal of Philosophy, 92*(2), 305-320.

Barlassina, L., Hayward, M. K. (2019). More of me! Less of me!: Reflexive imperativism about affective phenomenal character. *Mind, 128*(512), 1013-1044.

Bierria, A. (2020). Racial conflation: Agency, black action, and criminal intent. *Social Philosophy, 4,* 575-594.

Berkley, K. J., & McAllister, S. L. (2011). Don't dismiss dysmenorrhea! *Pain, 152*(9), 1940-1941.

Borg, E., Harrison, R., Stazicker, J., & Salomons, T. (2019). Is the folk concept of pain polyeidic? *Mind & Language, 35*(1), 29-47.

Borkhoff, C. M., Hawker, G. A., Kreder, H. J., Glazier, R. H., Mahomed, N. N., and Wright, J. G. (2008). The effect of patients' sex on physicians' recommendations for total knee arthroplasty. *Canadian Medial Association Journal, 178*(6), 681-687.

Brady, M. S. (2015). Feeling bad and seeing bad. *Dialectica, 69*(3), 403-416.

Brennan, F., Carr, D. B., & Cousins, M. (2007). Pain management: A fundamental health right. *Anesthesia & Analgesia, 105*(1), 205-221.

Broster, A. (2020, Jun 9). *You shouldn't accept period pain & discomfort as normal, explains expert.* Forbes. https://www.forbes.com/sites/alicebroster/2020/06/09/you-shouldnt-accept-period-pain--discomfort-as-normal-explains-expert/?sh=451bdbbe4900

Buchman, D. Z., Ho, A., Goldberg, D. S. (2017). Investigating trust, expertise, and epistemic injustice in chronic pain. *Bioethical Inquiry, 14*, 31-42.

Byrd, A. (2021, Apr 3). *Women of color die of cancer at higher rates than white women—Here's what experts say we should do about it.* Health.com. https://www.health.com/condition/cancer/cancer-death-rates-white-black-women

Caponetto, L. (2021). A comprehensive definition of illocutionary silencing. *Topoi, 40*, 191-202.

Carel, H., & Kidd., I. J. (2014). Epistemic injustice in healthcare. *Medicine, Health Care, and Philosophy, 17*(4), 529-540.

Centers for Disease Control and Prevention. (n.d.). *CDC guideline for prescribing opioids for chronic pain.* U.S. Department of Health and Human Services. https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf

Chapman, C. R. (1978). Pain: The perception of noxious events. In R. A. Sternbach (ed), *The Psychology of Pain.* Raven Press.

Charon, R. (2001). Narrative medicine: A model for empathy, reflection, profession, and trust. *JAMA, 286*(15), 1897-1902.

Chen, C. X., Draucker, C. B., & Carpenter, J. S. (2018). Reasons women do not seek health care for dysmenorrhea. *Clinical Nursing, 27*(1-2), e301-e308.

Cheng, Y., Lin, C-P., Lin, H-L., Hsu, Y-Y., Lim, K-E., Hung, D., & Decety, J. (2007). Expertise modulates the perception of pain in others. *Current Biology, 17*(19), 1708-1713.

Cleghorn, E. (2021). *Unwell Women: Misdiagnosis and Myth in a Man-Mande World.* Dutton.

Coffey, K. (2017, Jul 18). *The shocking ways large women are mistreated by health-care providers.* Self. https://www.self.com/story/weight-bias-and-health-care

Cohut, M. (2021 Mar 30). *Endometriosis experiences: The long, painful road to diagnosis.* Medical News Today. https://www.medicalnewstoday.com/articles/endometriosis-experiences-the-long-painful-road-to-diagnosis

Collins, P. H. (1990). *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment, 2nd Edition.* Routledge.

Coninx, S. (2020). Pain experiences and their link to action: Challenging imperative theories. *Consciousness Studies, 27*(9-10), 104-126.

Crombez, G., Van Damme, S., & Eccleston, C. (2005). Hypervigilance to pain: An experimental and clinical analysis. *Pain, 116*(1-2), 4-7.

Darwall, S. (1998). Empathy, sympathy, care. *Philosophical Studies, 89,* 261-282.

Decety, J., Bartal, I, B-A., Uzefovsky, F., & Knafo-Noam, A. (2016). Empathy as a driver of prosocial behaviour: Highly conserved neurobehavioural mechanisms across species. *Philosophical Transactions Royal Society B, 371*(1686), 20150077.

Deligeoroglou, E. (2000). Dysmenorrhea. *Annals of the New York Academy of Sciences, 900,* 237-244.

Derbyshire, S.W.G., Angel, I., & Bushell, R. (2016). When pain brings gain: Soccer players behavior and admissions suggest feigning injury to maintain a favorable scoreline. *Frontiers in Psychology*, 7, 1-6.

Dotson, K. (2011). Tracking epistemic violence, tracking practices of silencing. *Hypatia, 26*(2), 236-257.

Dunn, L., Carroll, L., & Weaver, J. (2018, May 13). *Too many mothers are dying after childbirth. A hospital hopes to save them.* NBC News. https://www.nbcnews.com/health/womens-health/too-many-mothers-are-dying-after-childbirth-hospital-hopes-save-n873531

Dusenbery, M. (2018). *Doing Harm: The Truth About How Medicine and Lazy Science Leave Women Dismissed, Misdiagnosed, and Sick.* HarperOne.

Eccleston, C., & Crombez, G. (1999). Pain demands attention: A cognitive–affective model of the interruptive function of pain. *Psychological Bulletin, 125*(3), 356-366.

Ellis, K., Munro, D., & Clarke, J. (2022). Endometriosis is undervalued: A call to action. *Frontiers in Global Women's Health, 3,* 902371.

Elster, N. (16 Apr 2023). *How an object measure of pain could counter bias in medicine.* BBC. https://www.bbc.com/future/article/20230414-the-search-for-an-objective-measure-of-pain

Falbo, A. (2022). Hermeneutical injustice: Distortion and conceptual aptness. *Hypatia, 37*(2), 343-363.

Fassler, J. (2015, Oct 15). *How doctors take women's pain less seriously.* The Atlantic. https://www.theatlantic.com/health/archive/2015/10/emergency-room-wait-times-sexism/410515/

Frankel, L.R. (2022). A 10-year journey to diagnosis with endometriosis: An autobiographical case report. *Cureus, 14*(1), e21329.

Freeman, L., & Steward, H. (2018). Microaggressions in clinical medicine. *Kennedy Institute Ethics Journal, 28*(4), 411-449.

Fricker, E. (1995). Critical notice: Telling and trusting: Reductionism and anti-reductionism in the epistemology of testimony. *Mind, 104*(414), 393-411.

Fricker, E. (2006). Second-hand knowledge. *Philosophy and Phenomenological Research, 73*(3), 592-618.

Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing.* Oxford University Press.

Fulda, J. (2011). *Chocolate & Vicodin: My Quest for Relief from the Headache that Wouldn't Go Away.* Gallery Books.

Garden, R. (2009). Expanding clinical empathy: An activist perspective. *General Internal Medicine, 24*(1), 122-125.

Geach, P. (1965). Assertion. *Philosophical Review, 74,* 449-465.

Glucklich, A. (2001). *Sacred Pain: Hurting the Body for the Sake of the Soul*. Oxford University Press.

Gordon, A. (2018 Jun 26). *Weight stigma kept me out of doctors' offices for almost a decade.* Self. https://www.self.com/story/weight-stigma-kept-me-out-of-doctors-offices

Grahek, N. (2001). *Feeling Pain and Being in Pain.* MIT Press.

Grice, H. P. (1975). Logic and conversation. In P. Cole & J. Morgan (eds), *Speech Acts [Syntax and Semantics 3].* Academic Press.

Guidi, C., & Traversa, C. (2021). Empathy in patient care: From 'clinical empathy' to empathic concern.' *Medicine, Health Care, and Philosophy, 24,* 573-585.

Hall, R. J. (2008). If it itches, scratch! *Australasian Journal of Philosophy, 86*(4), 525-535.

Halpern, J. (2011). *From Detached Concern to Empathy: Humanizing Medical Practice.* Oxford University Press.

Hare, R. M. (1952). *The Language of Morals.* Clarendon.

Haslanger, S. (2017). Racism, ideology, and social movements. *Res Philosophica, 94*(1), 1-22.

Helm, B. W. (2001). *Emotional Reason: Deliberation, Motivation, and the Nature of Value.* Cambridge University Press.

Helm, B. W. (2002). Felt evaluations: A theory of pleasure and pain. *American Philosophical Quarterly, 39*(1), 13-30.

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *PNAS, 113*(6), 4396-4301.

Hookway, C. (2010). Some varieties of epistemic injustice: Reflections on Fricker. *Episteme, 7*(2), 151-163.

Hornsby, J. (1995). Disempowered speech. *Philosophical topics, 23*(2), 127-147.

It's not all in our heads. (n.a.) Today. https://www.today.com/health/women-speak-out-about-feeling-dismissed-doctors-t153701

Jacobson, D., Glazer, E., Mason, R., Duplessis, D., Blom, K., Mont, J. D., & Jassal, N. (2018). The lived experience of female genital cutting (FGC) in Somali-Canadian women's daily lives. *PLoS ONE, 13*(11), e0206886.

Jacobson, H. (2013). Killing the messenger: Representationalism and the painfulness of pain. *Philosophical Quarterly, 63*(252), 509-519.

Jalali, M. S., Botticelli, M., Hwang, R. C., Koh, H. K., & McHugh, R. K. (2020). The opioid crisis: A contextual, social-ecological framework. *Health Research Policy and Systems, 18*:87.

Johansen, R. E. B. (2002). Pain as a counterpoint to culture: Toward an analysis of pain associated with infibulation among Somali immigrants in Norway. *Medical Anthropology Quarterly, 16*(2), 312-340.

Kagan, S. (2014). An introduction to ill-being. In M. Timmons (ed), *Oxford Studies in Normative Ethics, Vol. 4.* Oxford University Press.

Khazan, O. (2015 Apr 8). *Why some women choose to get circumcised.* The Atlantic. https://www.theatlantic.com/international/archive/2015/04/female-genital-mutilation-cutting-anthropologist/389640/

Klein, C. (2007). An imperative theory of pain. *Philosophy, 104*(10), 517-532.

Klein, C. (2015a). *What the Body Commands: The Imperative Theory of Pain.* MIT Press.

Klein, C. (2015b). 'What pain asymbolia really shows.' *Mind, 124*(494), 493-516.

Klein, C., & Martínez, M. (2018). Imperativism and pain intensity. In D. Bain, M. Brady, J. Corns (eds), *Philosophy of Pain: Unpleasantness, Emotion, and Deviance.* Routledge.

Kukla, R. (2014). Performative force, convention, and discursive injustice. *Hypatia, 29*(2), 440-457.

Kukla, R., & Lance, M. (2009). *'Yo!' and 'Lo!': The Pragmatic Topography of the Space of Reasons.* Harvard University Press.

Lance, M., & Kukla, R. (2013). Leave the gun; take the cannoli! The pragmatic topographic of second-person calls. *Ethics, 123*(3), 3456-478.

Lackey, J. (2006). The nature of testimony. *Pacific Philosophical Quarterly, 87,* 177-197.

Lackey, J. (2008). *Learning From Words: Testimony as a Source of Knowledge.*

Langton, R. (1993). Speech acts and unspeakable acts. *Philosophy & Public Affairs, 22*(4), 293-330.

Langton, R., & Hornsby, J. (1998). Free speech and illocution. *Legal Theory, 4*(1), 21-37.

Lewis, J. F., Zeger, S. C., Li, X., Mann, N. C., Newgard, C. D., Haynes, S., Wood, S. F., Dai, M., Simon, A. E., & McCarthy, M. (2019). Gender differences in the quality of EMS care nationwide for chest pain and out-of-hospital cardiac arrest. *Womens Health Issues, 29*(2), 116-124.

Liu, M. (2021). The polysemy view of pain. *Mind & Language, 38*(1), 198-217.

Lohman, D., Schleifer, R., & Amon, J. J. (2010). Access to pain treatment as a human right. *BMC Med, 8*:8.

Manne, K. (2017). Locating Morality: Moral imperatives as bodily imperatives. In R. Shafer-Landau (ed), *Oxford Studies in Metaethics* (12th ed). Oxford University Press.

Marions, L., Lövkvist, L, Taube, A., Johansson, M., Dalvik, H., and Øverlie, I. (2011). use of the levonorgestrel releasing—intrauterine system in nulliparous women—a non-

interventional study in Sweden. *European Journal of Contraceptive Reproductive Health Care, 16*(2), 126-134.

Martínez, M. (2011). Imperative content and the painfulness of pain. *Phenomenology and the Cognitive Sciences, 10*(1), 67-90.

Martínez, M. (2015). Pain as reasons. *Philosophical Studies, 172*(9), 2261-2274.

Maserejian, N. N., Link, C. L., Lutfey, K. L., Marceau, L. D., & McKinlay, J. B. (2009). Disparities in physicians' interpretations of heart disease symptoms by patient gender: results of a video vignette factorial experiment. *Women's Health, 18*(10), 1661-1667.

McDonald, L. (2021). Please like this paper. *Philosophy, 96*(3), 335-358.

Medina, J. (2013). *The Epistemology of Resistance: Gender and Racial Oppression, Epistemic Injustice, and Resistant Imaginations (Studies in feminist Philosophy).* Oxford University Press.

Medina, J. (2021). Agential epistemic injustice and collective epistemic resistance in the criminal justice system. *Social Epistemology, 35*(2), 185-196.

Melzack, R., & Wall, P. D. (1965). Pain mechanisms: A new theory. *Science, 50,* 971-979.

Mikkola, M. (2019). *Pornography: A Philosophical Introduction.* Oxford University Press.

Monteleone, J. M. (2017). Concerns and the seriousness of emotion. *Dialectica, 71*(2), 181-207.

Moore, D. J., Keogh, E., & Eccleston, C. (2012). The interruptive effect of pain on attention. *Quarterly Journal of Experimental Psychology, 65*(3), 565-586.

Moore, K. L. (2021). Pain is enough: Chronic pain as disability. *Buffalo Law Review 69*(5), 1471-1540.

Morris, P. H., & Lewis, D. (2010). Tackling diving: The perception of deceptive intentions in association football (soccer). *Nonverbal Behavior, 34,* 1-13.

Norman, Abby. (2018). *Ask Me About My Uterus: A Quest to Make Doctors Believe in Women's Pain.* Nation Books.

Pack-Mabien, A., Labbe, E., Herbert, D., & Haynes, J. (2001). Nurses' attitudes and practices in sickle cell pain management. *Applied Nursing Research, 14*(4), 187-192.

Pearce, J., & Morely, S. (1989). An experimental investigation of the construct validity of the McGill Pain Questionnaire. *Pain, 39,* 115-121.

Pettersson, A., & Berterö, C. M. (2020). How women with endometriosis experience health care encounters, *1*(1), 529-542.

Pilch, M., O'Hora, D., Jennings, C., Caes, L., McGuire, B. E., Kainz, V., & Vervoot, T. (2020). Perspective-taking influences attentional deployment towards facial expressions of pain: An eye-tracking study. *Pain, 161*(6), 1286-1296.

Platts, M. (1980). Moral reality and the end of desire. In M Platts (ed.), *Reference, Truth, and Reality.* Routledge.

Pollock, J. L. (1974). *Knowledge and Justification.* Princeton University Press.

Porter, P. (2004). The semantics of imperatives within a theory of clause types. *Semantics and Linguistic Theory, 14,* 235-252.

Power-Hays, A., & McGann, P. T. (2020). When actions speak louder than words—Racism and sickle cell disease. *New England Journal of Medicine, 383,* 1902-1903.

Rao, V. (2020, Jul 27). *'You are not listening to me': Black women on pain and implicit bias in medicine.* Yahoo. https://www.yahoo.com/now/not-listening-black-women-pain-164426358.html

Reynolds, J. M. (2022). *The Life Worth Living: Disability, Pain, and Morality.* University of Minnesota Press.

Ridge, M. (2006). Ecumenical expressivism: Finessing Frege. *Ethics, 116*(2), 302-336.

Rieder, T. (2019). *In Pain: A Bioethicist's Personal Struggle with Opioids.* Harper.

Ruta, N. S., & Ballas, S. K. (2016). The opioid drug epidemic and sickle cell disease: Guilt by association. *Pain Medicine, 17*(10), 1793-1798.

Samulowitz, A., Gremyr, I., Eriksson, E., & Hensing, G. (2018). "Brave men" and "emotional women": A theory-guided literature review on gender bias in health care and gendered norms towards patients with chronic pain. *Pain Research and Management:* 6358624.

Scarry, E. (1985). *The Body in Pain: The Making and Unmaking of the World.* Oxford University Press.

Schroeder, M. (2008). How expressivists can and should solve their problem with negation. *Noûs, 42*(4), 573-599.

Schultz, J-H, & Lien, I-L. (2022). Meaning-making of female genital cutting: Children's perception and acquired knowledge of the ritual. *International Journal of Women's Health, 5,* 165-175.

Searle, J. R. (1969). *Expression and Meaning: Studies in the Theory of Speech Acts.* Cambridge University Press.

Searle, J. R., & Vanderveken, D. (1985). *Foundations of Illocutionary Logic.* Cambridge University Press.

Sexton, J. Y. (2019). *The Man They Wanted Me to Be: Toxic Masculinity and a Crisis of Our Own Making.* Counterpoint.

Shaw, G. (2018, Jun 8). *Why women struggle to get the right diagnosis.* WebMD. https://www.webmd.com/women/news/20180607/why-women-are-getting-misdiagnosed

Shieber, J. (2015). *Testimony: A Philosophical Introduction.* Routledge.

Singer, P. (1981). *The Expanding Circle: Ethics and Sociobiology.* Clarendon Press.

Singer, T., Seymour, B., O'Dohetry, J., Kaube, H., Dolan, R. J., Frith, C. D. (2004). Empathy for pain involves the affective but not sensory components of pain. *Science, 303*(5661), 1157-1162.

Singer, T., Seymour, B., O'Dohetry, J., Stephan, K., Dolan, R., & Frith, C. D. (2006). Empathic neural responses are modulated by the perceived fairness of others. *Nature, 439,* 466-369.

Smith, M. (1994). *The Moral Problem.* Basil Blackwell.

Sobralske, M., & Katz, J. (2005). Culturally competent care of patients with chest pain. *American Academy of Nurse Practitioners, 17*(9), 343-349.

Spaulding, S. (2017). Cognitive empathy. In H. L. Maibom (Ed.), *The Routledge Handbook of Philosophy of Empathy.* Routledge/Taylor & Francis Group.

Stefanello, E. (2022). Your pain is not mine: A critique of clinical empathy. *Bioethics, 36*(5), 486-493.

Taylor, C. (1985). *Philosophical Papers: Volume 2, Philosophy and the Human Sciences.* McGill University Press.

Tweedy, D. (2015). *Black Man in a White Coat.* Picdor.

Tye, M. (1995). A representational theory of pains and their philosophical character. *Philosophical Perspectives, 9,* 223-239.

Tye, M. (1996). *Ten Problems of Consciousness: A Representational Theory of Mind.* MIT Press.

University of Miami. (2021, Apr 6). *Women's pain not taken as seriously as men's pain.* Science Daily. https://www.sciencedaily.com/releases/2021/04/210406164124.htm#:~:text=Cite%20This%20Page%3A-,University%20of%20Miami.,ScienceDaily%2C%206%20April%202021.

Van Damme, S., Crombez, G., & Lorenz, J. (2007). Pain draws attention to its location: Experimental evidence for a threat related bias. *The Journal of Pain, 8,* 976-982.

Vignemont, F. (2015). Pain and bodily care: Whose body matters? *Australasian Journal of Philosophy, 93*(3), 542-460.

Vignemont, F., & Jacob, P. (2012). What is it like to feel another's pain? *Philosophy of Science, 79*(2), 295-316.

Vignemont, F., & Jacob, P. (2016). Beyond empathy for pain. *Philosophy of Science, 83*(3), 434-445.

Vignemont, F. & Singer, T. (2006). The empathic brain: How, when, and why? *Trends Cognitive Science, 10*(10), 435-441.

Vlerick, M. (2021). Explaining human altruism. *Synthese, 199,* 2395-2413.

Volkow, N. D., & McLellan, A. T. (2016). Opioid abuse in Chronic pain—Misconceptions and mitigation strategies. *New England Journal of Medicine, 374,* 1253-1263.

Wall, P.D. (1979). On the relation of injury to pain the John J. Bonica Lecture. *Pain, 6*(3), 253-264.

Wallace, R. J. (2006). Moral motivation. In J. Dreier (ed.), *Contemporary Debates in Moral Theory.* Blackwell.

Whitburn, L. Y., Jones, L. E., Davey, M-A., & McDonald, S. (2019). The nature of labour pain: An updated review of the literature. *Women and Birth, 32*(1), 28-38.

Williams, A. C. (2002). Facial expressions of pain: An evolutionary account. *Behavioral and Brain Sciences 25,* 439-488.

Wittgenstein, L. (1953). *The Philosophical Investigations.* Blackwell.

Yu, R. (2016). Stress potentiates decision biases: A stress induced deliberation-to-intuition model. *Neurobiology of Stress, 3,* 83-95.

Zhang, L., Reynolds Losin, E. A., Ashar, Y. K., Koban, L., & Wager, T. D. (2021). Gender biases in estimation of other's pain. *Pain, 22*(9), 1048-1059.