

On pain – Virginia Woolf and the language of poets and patients

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Abstract

Influenced by Virginia Woolf pain is traditionally believed to be a private object that defies language. However, our analysis of classical and contemporary works of British and American poets, in addition to our own clinical experiences, leads us to challenge this notion. In accordance with Wittgenstein we instead view pain as a concept and objective experience that should encourage interaction. Reasons why patients and healthcare providers often assume language to be insufficient to grasp the complexity of pain are manifold. Based on neuro-cognitive mechanisms we propose an important contributor might be that patients in pain speak a different language than their pain-free peers and doctors.

Keywords

Pain, pain measurement, language of pain, fiction, poets

John 1:1: In the beginning was the Word, and the Word was with God, and the Word was God.

‘The merest schoolgirl, when she falls in love, has Shakespeare, Donne, Keats to speak her mind for her; but let a sufferer try to describe a pain [. . .] and language at once runs dry’.¹ Virginia Woolf’s apodictic statement in ‘On Being Ill’ summarizes an influential argument in the philosophy of pain. It was later not only advanced by Elaine Scarry in her book ‘The Body in Pain’ where she famously claimed that ‘pain defies language’, but also directed the way scholars and clinicians think about pain.² In 2011 Katz and Melzack,³ for instance, wrote ‘anyone who has suffered severe pain [. . .] finds him-/herself at loss for words’ because ‘[. . .] there are no external objective references for [. . .] pain’. Following this line of thought the former president of the International Association for the Study of Pain (IASP), R.-D. Treede re-emphasized in 2018 the status of pain as ‘private object’ when he specified ‘pain [. . .] as a subjective experience that [. . .] exists only in the person that feels it’.⁴

The hypothesis of pain as a ‘private object’ is currently widely accepted possibly because it fits well into a philosophical framework that is partly based on Wittgenstein and which assumes private (subjective)

objects cannot be expressed with sensible language.^{4–6} However, despite the persuasiveness of this idea, authors have recently started to challenge it. McDougall,⁷ for instance, noted that viewing pain as purely ‘subjective’ might lead to its dismissal by healthcare providers and subsequently undertreatment. Furthermore, McIntyre⁸ even questioned whether the hypothesis could indeed explain pain sufficiently. His notion was based on Sullivan⁹ who highlighted the dualistic nature of pain – as a private sensation and as a concept. To be able to identify pain and distinguish it from other sensations he stressed, people must be able to conceptualize it. As a

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concept, he inferred, pain is a social phenomenon, which – contrary to the beliefs of Woolf and Scarry – *can be talked about*. We therefore think, if pain can be talked about, it should frequently appear in works of fiction and consequently be part of the language of poets. In addition to the description of physical and mental pain, poets should hence use words of pain and suffering also figuratively (metaphorically) or idiomatically as part of the ordinary language of their heroes.

To test this notion, we determined the frequency of pain words and their contextual function in works of contemporary and classical English and American writers such as William Shakespeare, John Donne, John Milton, Sir Walter Scott, Oscar Wilde, Ford Madox Ford, Virginia Woolf, James Fenimore Cooper, Nathaniel Hawthorne, Edgar Allen Poe, Mark Twain, F. Scott Fitzgerald; J.D. Salinger, Jack Kerouac and all Pulitzer and Man Booker Prize awardees from 2000 to 2016 as well randomly chosen winners of the Romantic Novelists' Association Award and the Crime Writers' Association Gold Dagger Award (please see Supplementary Table for a complete list of texts).

We found pain words in every book we analysed and were thus able to refute Virginia Woolf and the private object theory.^{10,11} Furthermore, we discovered in a third of their appearance, pain words were used linguistically to describe or illustrate things that were not typically related to painful conditions. They were also frequently employed idiomatically as part of the ordinary language of the stories' heroes. Some of the most vivid examples are listed below: 'One pain is lessened by another's anguish', 'here is for thy pains [hassle]', 'pain of death' (*Shakespeare*); 'stings of jest', 'ease my pains [sorrows]', 'all the hurt which ever gold hath wrought', 'love dulled with pain' (*Donne*); 'trammels of pain', 'should ever unhappy love my bosom pain' (*Keats*); 'why am I mocked with death and lengthened out to deathless pain?', 'long were to tell what have I done, what suffered, with what pain voyaged the unreal, vast unbounded deep of horrible confusion', 'to whom thus Adam sore beset replied', 'the pain of absence', 'what can your knowledge hurt Him', 'hell [. . .] the house of woe and pain', 'no pain can equal anger infinite provoked', 'painful superstition' (*Milton*); 'we take pains to over-educate ourselves', 'life's sores', 'you pain me [I am concerned about you]', 'painful precision', 'the woodwork creaked [. . .] as if in pain' (*Wilde*); '[a boat] crept painfully to anchor', 'it hurt him to say it', 'many people [. . .] have been at great pains to prove [. . .]' (*Woolf*); 'I didn't think he would ever hurt me', 'the headache red of flowers', 'what you don't know won't hurt you', 'he was dowdy to the point of pain', 'it does give men such migraines, doesn't it, shopping', 'aching happiness', 'achingly sweet' (*Atwood*); 'his large dark eyes had a world of pain [. . .]', 'there was a look

of pain in her face', 'the gnawing and poisonous tooth of bodily pain', 'painful efficacy', 'sting of remorse', 'his conscience [. . .] painfully sensitive [. . .]', 'painfully embarrassed' (*Hawthorne*); 'linen so white it hurt your eyes', '[. . .] hurt Harvey's feelings', '[. . .] till I wore my head sore, but I couldn't see no way out of the trouble', 'he looked kind of hurt', 'painful music' (*Twain*); '[. . .] pains taken to secure the shifting-boards [. . .]' (*Poe*); 'he laboured painfully over the simple form [. . .]', 'I ached [longed] all over for her', 'he was pained to hear me say', 'burning thirst' (*Kerouac*); 'I didn't want to hurt his feelings', 'pain in the ass', 'something else that gives me a royal pain [annoys me]', 'she was sore [angry]' (*Salinger*); 'a blackness to hurt your ears with listening', 'the sky was aching blue' (*McCarthy*).

Therefore, poets can not only talk about pain, but they can also use it creatively to illustrate what otherwise might be difficult to describe. Subsequently, authors *and* their readers must have a considerable understanding of pain and what it means. But what about patients? Our own clinical experience and, for instance, the study by Munday et al.¹² show they too can talk about their pain. If we are willing to listen carefully, patients will tell about their pain in sometimes great detail, from its onset, its time course, intensity and impact on their lives to even a full description of its characteristics. Thus, Scarry's long-held belief that 'pain defies language' is not only refuted, but instead it is supplanted by evidence in support for Wittgenstein's and Sullivan's idea of pain as a concept and social phenomenon. This, of course, has consequences for clinicians as well, because if pain is not private, it also is not subjective. Patients' descriptions of their suffering can hence not be dismissed and should instead be regarded as objective and true and therefore elicit a therapeutic response by its mere mentioning. This is echoed in Eula Biss's¹³ outcry 'I had not realized that the fact that I believed myself to be in pain was not reason enough [to be trusted]'.

So far, so good. However, in reality, we as healthcare providers but also our patients themselves still work under the assumption language is not enough to grasp the complexity of pain. Interestingly, there might be several reasons to explain this.

First, *social habit*: in daily life, it is not necessary for people in acute pain to describe their sensation in great detail. In concert with bodily expressions minimalistic verbal language, such as 'I have a headache', 'my belly hurts' and 'my back is sore', is normally enough for them to elicit a response by others, such as compassion and care. Or have you ever heard a child with a bruise on its knee needing to tell her mom after a fall she is having a constant sharp, stinging pain that does not radiate and that responds well to a hug?

This social habit on part of the sender (patient) to use simple language to describe pain unfortunately might also fall onto less sympathetic ears of a more or less disinterested receiver (e.g. healthcare provider). Especially chronic pain patients often complain about the inability or unwillingness of others to make an effort to listen and understand their sorrows.¹²

Second, *expectations*: in their quest to differentiate painful conditions and hence to be able to apply personalized treatments, scientists and healthcare professionals were traditionally searching for verbal cues in the history and narratives of patients that might be disease specific.^{14,15} Melzack and Torgerson were the first to systematically search for single adjectives that would serve as pain descriptors. Four years later, Melzack and colleagues^{16,17} would build on this work to include those adjectives into his now famous McGill Pain Questionnaire. Others followed suit so that there are now several questionnaire-based tools that employ plain descriptors to help diagnose, for instance, neuropathic pain.¹⁴

What is often overlooked in this regard is the fact that these descriptors are nothing else but metaphors and as such linguistic tools. Not only is this highlighted by Bourke¹⁸ in her carefully researched book ‘The Story of Pain’, she further went on to clarify that pain metaphors change over time and are hence dependent on politics, culture and zeitgeist. They therefore are not as widely accessible by patients and healthcare professionals as usually claimed. Dancygier and Sweetser illustrate this by explaining that even the idea of ‘pain as (private) object’ is itself a metaphor.¹¹

Critics have claimed the employment of pre-chosen pain descriptors in questionnaires and using them as diagnostic means might not represent the pain of individuals accurately, it might furthermore also force an expectation on patients to describe their experience with words (in a language) that is not their own.¹⁹ We further propose that the extensive use of figurative language to describe pain might even help its chronification. This notion is also based on Wittgenstein⁶ who stated in §19 of his *Philosophical Investigations*: ‘To imagine a language means to imagine a form of life’. Hence, the more patients use metaphors to describe their pain, the more they might create their own kind of language and subsequently a form of life which separates them even further from the healthy. Therefore, contrary to Biro’s²⁰ recommendation, patients should not be purposely encouraged to express pain in metaphorical language but should be left to use their own.

Finally, *neuro-cognition*: the invention and use of metaphors is likely not only dependent on a person’s imagination or verbal intelligence but probably also on her ability to observe, self-reflect and integrate information.

This is highlighted by James²¹ who stressed that despite the fact that Shakespeare, who is regarded by many as the greatest author of all times, created 1501 new words and Virginia Woolf only 8, Woolf nevertheless was able to simply modifying existing words to create new sense.

Based on our own findings, patients with chronic pain may be disadvantaged in this respect as they frequently have lower verbal IQs compared to matched healthy controls.²² This is possibly due to morphological and functional changes in the brains of patients.²³ Consequently, their ability to describe their symptoms and thus meet the expectations of their doctors might be hampered from the start. Furthermore, either because of neuro-anatomical and neuro-functional changes or because they are forced to use words that are not their own, patients might literally speak a different language than their peers. Surprisingly, so far, this has not been addressed by research. It also remains unclear, if the use of a certain type of language does indeed contribute to the chronification of pain. However, if true, it might open up yet another therapeutic avenue.

In conclusion, as pain is being expressed in detail in the clinical setting as well as numerous times in works of literature, it is not a private object that defies language. On the contrary, as a social phenomenon, it is also something that – as Bourke¹⁸ put it – ‘could encourage interaction’. Therefore, borrowing from Woolf, we can state ‘the merest schoolgirl, when she falls in pain, has Shakespeare, Donne, Milton, Keats, Hawthorne, Twain, Kerouac and many others as well as even Woolf herself to speak her mind’. However, it is up to us to listen.

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Supplemental material

Supplemental material for this article is available online.

References

1. Woolf V. On Being Ill. In: Eliot TS (ed.) *The new criterion – a quarterly review*. London: Faber & Gwyer, Ltd, 1926.
2. Scarry E. *The body in pain – the making and unmaking of the World*. New York: Oxford University Press, 1985.
3. Katz J and Melzack R. The McGill pain questionnaire. In: Turk DC and Melzack R (eds) *Handbook of pain assessment*. 3rd ed. New York: Guilford Press, 2011.
4. Treede RD. The International Association for the Study of Pain definition of pain: as valid in 2018 as in 1979, but in need of regularly updated footnotes. *Pain Rep* 2018; 3(2): e643.
5. Cohen M, Quintner J and van Rysewyk S. Reconsidering the international association for the Study of Pain definition of pain. *Pain Rep* 2018; 3(2): e634.
6. Wittgenstein L. *Philosophische Untersuchungen*. 8th ed. Frankfurt: Suhrkamp, 2017, p. 300.
7. McDougall DA. Is Wittgenstein presenting a reductio ad absurdum argument in the ‘Private Language’ sections of philosophical investigations §§ 243–315? *Philos Quart* 2017; 67: 552–570.
8. McIntyre M. Rethinking the body in pain. *Subjectivity* 2016; 9: 381–398.
9. Sullivan MD. Pain in language – from sentience to sapience. *Pain Forum* 1995; 4: 3–14.
10. James H. *The Art of Fiction*. Britannica, 1884, <https://www.britannica.com/topic/The-Art-of-Fiction-essay-by-James>
11. Dancygier B and Sweetser E. *Figurative language*. Cambridge: Cambridge University Press, 2014.
12. Munday I, Kneebone I and Newton-John T. The language of chronic pain. *Disabil Rehabil* 2021; 43: 354–361.
13. Biss E. *The Pain Scale*. *Harper's Magazine*, 2005, <https://harpers.org/archive/2005/06/the-pain-scale/>
14. Colloca L, Ludman T, Bouhassira D, et al. Neuropathic pain. *Nat Rev Dis Primers* 2017; 3: 17002.
15. Woolf CJ and Mannion RJ. Neuropathic pain: aetiology, symptoms, mechanisms, and management. *Lancet* 1999; 353: 1959–1964.
16. Melzack R and Torgerson WS. On the language of pain. *Anesthesiology* 1971; 34: 50–59.
17. Melzack R. The McGill Pain Questionnaire: major properties and scoring methods. *Pain* 1975; 1(3): 277–299.
18. Bourke J. *The story of pain – from prayer to painkillers*. Oxford: Oxford University Press, 2014, p. 396.
19. Main CJ. Pain assessment in context: a state of the science review of the McGill pain questionnaire 40 years on. *Pain* 2016; 157(7): 1387–1399.
20. Biro D. *The Language of Pain: Finding words, compassion, and relief*. New York: W. W. Norton & Company, 2010, p. 256.
21. James E. A Lexicon for the sick room: Virginia Woolf’s narrative medicine. *Lit Med* 2019; 37(1): 1–25.
22. Spindler M, Koch K, Borisov E, et al. The influence of chronic pain and cognitive function on spatial-numerical processing. *Front Behav Neurosci* 2018; 12: 165.
23. Martucci KT and Mackey SC. Neuroimaging of pain: human evidence and clinical relevance of central nervous system processes and modulation. *Anesthesiology* 2018; 128(6): 1241–1254.