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FORUM

Imagined and delusional pain*

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Abstract Extreme pain and suffering are associated with depression as well as tissue damage. The impossibility of imagining any feelings of pain and suffering intersect with two matters: the kind of imagining involved, and the nature of delusions. These two correspond to the sequence of the following discussion, in which it is contended first that feelings of pain and suffering resist being imagined in a certain, key way (defined here as proprietary imagining P *simpliciter*), and second that, given a certain analysis of delusional thought, this precludes the possibility of *delusional affections* while allowing delusions about affections (here *affective delusions*).
KEYWORDS: Pain; Imagination; Delusion; Affection; Feelings

Riassunto *Dolore immaginato e dolore illusorio* – Dolore estremo e sofferenza sono solitamente associati a depressione e danni tissutali. L'impossibilità di immaginare il provare dolore e sofferenza dipende da due fattori: il tipo di immaginazione coinvolta e la natura dell'illusione. Questi due fattori saranno trattati in parallelo nell'analisi che qui si propone, in cui si discuterà in primo luogo come il provare dolore e sofferenza oppongano resistenza all'essere immaginati in un certo modo (qui indicato come carattere proprietario dell'immaginare P *simpliciter*) e in secondo luogo come, secondo una certa analisi del pensiero illusorio, questo preclude la possibilità di affezioni illusorie mentre consente illusioni circa le affezioni (qui indicate come *illusioni affettive*).
PAROLE CHIAVE: Dolore; Immaginazione; Illusioni; Affezione; Sensazioni

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OUR MENTAL LIFE COMPRISES MORE than belief states narrowly understood. There are also affections, including states of feeling. And although many would reduce affections to their cognitive (and representational) components, a robust alternative presents itself in various feeling theories of emotion.[1] Feelings of pain resulting from tissue damage have provoked philosophical attention over whether they are intrinsically subjective and private, leaving claims about them immune from error. This idea is extended here to whether any pain experiences, including those associated with severe depression, can be *merely* imaginary, and involve misapprehensions that might, on some analyses, suggest delusional thinking.

Extreme pain and suffering are associated with depression as well as tissue damage. The impossibility of imagining any feelings of pain and suffering intersect with two matters: the kind of imagining involved, and the nature of delusions. These two correspond to the sequence of the following discussion, in which it is contended first that feelings of pain and suffering resist being imagined in a certain, key way (defined here as proprietary imagining P *simpliciter*), and second that, given a certain analysis of delusional thought, this precludes the possibility of *delusional affections* while allowing delusions about affections (here *affective delusions*).

That derived from misleading experience felt pain might also be delusional (as affective delusions) depends on the nature of delusions and the relationship between such feelings and the inferences drawn from them. Whether theorized as ideas, beliefs, imaginings or *sui generis,* delusions eventually involve doxastic states, with propositional content. Parallels with the beliefs inferred from misleading hallucinatory experience are thus at the center of this inquiry, an immediate spur for which was a group of studies contending with the idea that pain associated with tissue damage might be subject to hallucination, just as other perceptions are.[2] The same sort of parallel had been drawn long ago, in a handful of remarks by Kant about the pain and suffering endured by the depressed melancholic, it is pointed out. Described as «mere delusions of misery» which the subject «creates for himself», Kant compares them with the imaginary illnesses of the hypochondriac.[3] (As recently as 1993, moreover, the American Psychiatric Association's *Diagnostic and statistical manual* included a category (*Pain disorder associated with psychological factors* [subtype 307.80]) vulnerable to interpretation along the lines of Kant's position).[4]

Aside from the special case of proprietary imagining *simpliciter*, there is much, and perhaps much of greater significance, about pain and suffering that permits being misapprehended, and mis-imagined. Nonetheless, the analysis undertaken here may also have implications. For example, few if any doubt that our sincere reports of pain from tissue damage provide a trustworthy epistemic guide. By pointing to this additional feature regarding imaginability common to both kinds of feelings, the following discussion should serve to dispel a lingering suspicion that the pain of depression or other mood disorders might be, as Kant suggests, a mere figment of the sufferer's imagination.

1 Delusions, hallucinations, imagining and imagination: some preliminaries

Delusional and hallucinatory processes are often allied, or even confused. On one model, all hallucination reduces to delusion, since it occurs only when mistaken inferences are drawn based on flawed perceptual experience, i.e., derived from one of the outer senses. Rather than presupposed here, the analogy of hallucination with one central form of inner experience – pain feelings – is questioned.[5]

The placebo produces real effects, by way of real, if only incompletely recognized, expectations. Similarly, descriptions of psychogenic and phantom limb pain are careful to note that the pain is really felt, even if its origins cannot be linked to tissue damage.[6] The workings of the imagination are thus responsible for downstream states that, as veridical experiences, are felt. But there may also be non-veridical imaginings – (mis)apprehensions of the merely imaginary. Explored in what follows is whether feelings of pain and suffering can be merely imaginary in this way.

Imagining, in contrast to perceiving, believing or remembering some object involves forming a particular sort of mental representation or "image" of that object with a range of familiar distinguishing features (such as being able to be non-actual states of affairs).[7] The fact that the imagination *can and does* affect and effect feeling states has been most emphasized in philosophical writing about responses to works of fiction and drama.[8] Yet much ordinary mental life also involves emotionally charged relations to what is merely imaginary. We speculate on what might have been (with horror, relief) and anticipate future states of affairs (with eagerness, dread, or impatience). That the imagination produces strong feelings in most of us is *just as evident* as that fictions do, it has also been observed: «The power of fictions to move us [...] is simply a special case of the power of the imagination to do so».[9]

As Kant's «mere delusions of misery» indicates, identification of delusion as disordered, or "corrupted" imagination has a long lineage.[10] More recently, some empirical research has seemed to indicate imaginative limitations in those suffering depression, suggesting deficits in their ability to envision future possibilities and options.[11] Despite possible defects particular to the depression sufferer's imagination, however, the present inquiry explores

the hypothesis that if they cannot be imagined, then these feelings cannot be imagined by anyone.

Some beliefs about states of pain and suffering would rank as delusional. The assertion that the pain of my headache was brought about by Martians would likely be an example. So there are affective delusions, broadly understood. But this inquiry concerns whether, as well as *affective delusions*, there are also what can be called *delusional affections*. Section 2 introduces the ways the notion of imaginary pain and suffering might be understood. The contrast between (really) felt and (merely) imagined is considered in relation to today's depressive states, that share recognizable features with Kant's melancholic ones, as well as pain resulting from tissue damage. Misrepresentations about felt pain, inviting description as *affective delusions,* is placed in contrast with the hypothetical category of *delusional affections*. In section 3 Kant's "delusions of misery" are briefly reviewed. In section 4 the implications of this analysis for the idea of pain and suffering as potentially *delusional* are further assessed in light of current analyses of delusional experience.

2 Imaginary and imagined pain and suffering

There is sufficient semantic overlap to warrant accepting common usage by which the differing ways we feel pain are all described as states of pain and suffering, and the terms are used interchangeably in what follows. This usage is discussed further (see 1.4 below), but for the present we'll follow the example of depression researcher Helen Mayberg when she says of her patients' suffering:

> You can't think, but you are in pain. Now, how does your psyche hurt? What a weird choice of words. But it is not an arbitrary choice. It's there. These people are feeling a particular, indescribable kind of pain.[12]

The different forms of pain experience are allied, it is argued here, in relation to the matter of their *imaginability*. If there is a respect in which we cannot imagine our own pain and suffering, it may serve to confirm Mayberg's assertion, and clarify the relationship between seemingly different kinds of pain.

When it is proprietary, rather than another person's, the feeling of pain or suffering in what follows is designated "P". Explored here is: "*X imagines* P" – the direct referential acquaintance with P, provided by what has been described as "internal ostension",[13] and also sometimes known as "direct perception imagining".[14] By contrast with it, "X imagines *that* P is Ø" – a proposition about P, exhibits an apprehension associated with inferential knowledge by description.

Imagining is perspectival. If we adopt a spectator's perspective, proprietary feelings of pain can readily be summoned. In that imagining (i), I create an image of myself wracked and contorted through injury or disease, or frozen with depressive despair. In addition to the perspective from which the imagining is undertaken, the place of the subject in imagining, and the contrast between propositional and non-propositional imagining, have also been noted.[15] (i) above (imagining P from the perspective of a spectator), is achievable.[16] *In doubt* is that we can (ii) imagine P *from the inside,* by way of the direct referential acquaintance. (i) and (ii), each differ from (iii) imagining P propositionally: "imagining that" there is a state of P or that P is present, expressing the inference derived from the experience, or that the pain and suffering has particular properties, such as intensity or location.

2.1 Imagining (P) simpliciter, an imagining form fruste?

The imagining sought here will be achieved only if we imagine P *from the inside,* we imagine ourselves *feeling* P*,* rather than as spectators envisioning ourselves feeling P, and we imagine P *non-propositionally* (rather than imagining that we feel P – even though the inference [that we feel P] would naturally ensue from the feeling). Succeeding in imagining P in ways not captured by (i) or (iii) or some combination of them will be referred in what follows as imagining (P) *simpliciter.* Each of these features fit the "flashback" memories experienced after trauma, which are understood to be the painful *re-living* of past hurtful, alarming and painful experiences.[17] At least when identified clinically as diagnostic symptoms of trauma disorders, these are not imaginings, however. They are unsought and uncontrollable re-experiencings or re-livings of which the subject is the passive (and invariably uncomfortable) victim.[18]

The contention about imagining explored here has several parts: imagining P *simpliciter* involves a distinct alternative that cannot be conflated with other forms of imagining; and from our ability to imagine P in the ways described in (i) and (iii), it cannot be inferred that imagining P *simpliciter* is even possible. The conclusion drawn is that at least this one imaginative mode (imagining (P) *simpliciter*), *cannot be achieved*. This impossible exercise at imagining will be here distinguished as a *forme fruste* of imagining. In medicine, *formes fruste* are forms that are incomplete, although at first sight apparently possible, conditions.

Employing empirical research methods, a recent set of studies was used to challenge the hypothesis that pains associated with tissue damage, being private and subjective, could *not be hallucinated*. With research subjects offered the opportunity to opine on appropriate language and de-

scribe scenarios presented to them in a laboratory setting, it was concluded that lay people tend to hold that «pain hallucinations are possible».[19] Aspects of the research design and method, the mixed findings;[20] and the choice of research subjects are all grounds for seeking an alternative to this approach. Designed to illustrate that imagining P *simpliciter is a forme fruste of imagining*, the following examples provide attempts to imagine *without re-experiencing* pain and suffering. The lack of success of our efforts to engage in this kind of mental activity**,** it is concluded, suggest that it cannot be done. As imagining P *simpliciter*, "imagining" pain and suffering is a form *fruste* of imagining.

2.2 Flying knives and terrible news

Imagine what must be a painful experience - catching a flying knife.[21] Our minds seize on this visual image, complete with flash of metal moving through the air, a sense of bodily lurching forward, the facial feel of (actual) wince and grimace as the imagined knife makes contact, the image of its searing our outstretched hand, and the line of blood. All of these combine in an unbearable, even painful apprehension. Do we also imagine the feeling of the pain itself? It seems not. An irreducible element of pain experience, a sort of simulacra of the felt pain itself, is absent from this otherwise vivid, complex, and unpleasant imagining. Short of feeling the pain, it seems, we try in vain to imagine feeling it.

At least by those capable of visual imagery (a majority), the flying knife example demonstrates how readily some perceptual experience admits of being imagined. The visual image of the flying knife is so real it might prompt spontaneous responses: we grimace and shudder, apprehending it, just as we might flinch or gasp watching violence at the movies. It can even be said that the unpleasant, even abhorrent experience of imagining this scenario *is* likely to be *painful*. To imagine something with feeling, is not the same as to imagine having that feeling, as Moran has pointed out.[22] The experience may be painful, yet it is not an experience of pain. It doesn't hurt. If it were to hurt, it is re-experienced, not (merely) imagined**.**

For a parallel case with more emotional pain and suffering, imagine learning a piece of terrible news: the unexpected death of a beloved friend, for example. You envision yourself crumple with distress, your throat may even constrict at the thought, you see yourself try to move, reach for a phone, gasp in unbelief. All this, you can imagine. But the feeling of pain, separated from elements accompanying, causing and forming a sequel to it, does not seem to be part of the *content* of your imagining. The exercise of imagining may make you feel terrible, but as a consequence or accompaniment of your imagining. And, corresponding to the flying knife example, *feeling the pain itself,* the feeling of pain and distress will apparently be lacking, for all the indelible intensity of the image you entertain. If it is present, you are re-living, and not merely imagining the feeling experienced on receiving the news.

When we think about both cases, something is absent, and the experience is – thankfully, we might suppose – incomplete. The separation between imagining the feeling and wholly re-experiencing it is not bridged by a third element, present in imagining from the perspective of an observer. Missing is the apprehension of something, a simulacra, sharing phenomenal features with, yet distinct from, the experience itself. Instead, we have a binary: it is felt or not.

Absent with these *forme frustes* cases of imagining, the simulacra is most evident with visual or auditory imagining. Imagining a sound or color includes a qualitative component, itself possessing pitch, or color. In attempting to imagine without re-living painful experiences such as these we seem without any equivalent of the experience of qualities such as color when imagining sights, or pitch, when imagining sounds. If the painful feeling is necessarily absent the imaginative exercise is without qualitative simulacra.

In a related discussion of imagining sense experiences, Paul Noordhof recognizes the absence of the simulacra, while pointing out that sensuous imaginings usually possess not one but two elements determinative of their imaginative content: the content they share with veridical perceptual experiences and something more: a suppositional element that «characterizes the imaginative project which the image serves». In the special case of imagining pains (or other bodily feelings such as itches), however, the first element is not present. Unlike imagining other sensory experiences such as seeing, imagining pains (and itches) does not involve «presentations of sensory qualities».[23] We return to this analysis in 2.3.

Our failed attempts to imagine P simpliciter stand in contrast to imagining others' pain as well as to imagining from an observer's perspective. In describing the different process by which we imagine what happens in other minds, Goldman speaks of the creation of "pretend states". Involved in the process of "supposition imagination", these pretendings are intended to correspond to the others' mental states.[24] The effort, it is explained, enables one to «create *or try to create* in one's own mind a selected mental state, or at least a rough facsimile of such a state».[25] The other person's state thus sought illustrates, to the extent it succeeds, the element missing in the pain and suffering cases involving attempting to imagine P *simpliciter*. We may *try* to create the facsimile in one's own mind while avoiding re-experiencing, but *it cannot be done*.

There is much about feeling pain, our own and others,' that *can* be imagined, as Goldman's work

illustrates, and our examples may be of limited interest ethically. Imagining not from the inside but *from the outside* provides us with vital interpersonal knowledge, it has been explained, and grounds empathic responses to others.[26] But the kind of reproductive or recreative imagining depicted by Goldman differs fundamentally from that attempted in imagining P *simpliciter*. The ability to imagine is a variable trait, absent or relatively impoverished in some people even for outer sense, including visual and auditory, imaginings. If persuasive, the above examples illuminate an additional feature common to different kinds of pain experience. But it must be acknowledged that intuitive responses to examples cannot perhaps fully establish a defensible claim about imaginability.

2.3 Why is imagining P simpliciter a forme fruste of imagining?

In addition to the features sketched in (i)-(iii) above, imagining has been distinguished in further ways, including imagining X from imagining doing X,[27] and imagining when the imaginer is part of the imagined content.[28] Pain and suffering are affections, things we ourselves undergo or endure, however. Although we are active in our attempts to imagine P *simpliciter,* failure of which is illustrated in our examples, those efforts will necessarily include the imaginer as part of the content.[29]

More pertinent for our inquiry, propositional imagining has been separated from the non-propositional imagining variously known as imagistic, perceptual or sensory.[30] If I imagine that the moon is thousands of miles away, I imagine propositionally. If I imagine a house with six chimneys I may – it seems I need not – engage my non-propositional imagination. One way to imagistically (perceptually, sensorially) imagine is to create or be subject to "images" from one of the other sense modalities: most obviously, we imagine seeing X, or imagine X, when we see it in our mind's eye; imagine hearing Y, when we hear it internally. Its etymology suggests that this sort of imagistic (perceptual, sensorial) imagining has primacy.

The Empiricist supposition was that all imagining involves – or even reduces to – images.[31] But more commonly held today are mixed models, where imagining may be both with and without perceptual or imagistic elements, and "image" is comparably loosened to allow it.[32] That all imagining reduces to imagistic imagining has been taken as belied by the way several distinct imaginings can be captured intentionally using a single image token (the imagined figure is first my mother and, phenomenally unchanged, my aunt).[33] Recent avoidance of a strictly imagistic conception of imagining can be attributed to this argument separating imaginings through intentionality, as well as to the presence of intuitive counterexamples, where we seem to imagine without images (such as imagining the moon being thousands of miles away).

If our examples suggest that imagining P *simpliciter* affords us no image, what might this reflect? Some painful feelings present themselves as less complex than the images we associate with visual scenes or auditory sequences. Arguably, they better correspond to the perceptual qualities (colors, sounds, shapes, etc.) that make up part of such visual and auditory imaginings. But allowing that (some) pain and suffering correspond to sounds or colors, will not alone capture the way we imagine apprehending simple colors in our mind's eye or auditory tones in its ear, however. At least typically, pain hurts and is also unwelcome. And neurologically, even the simplest pain involves functionally specialized networks, with affective (emotional-cognitive) as well as sensory-discriminative components. Moreover, deprived of its affective elements, as occurs in certain dissociation syndromes, pain has been found to lose all its informational and motivational force, «with regard to the location, intensity, temporal profile and nature of harmful stimuli».[34] While some pain and suffering may be experienced as elementally simple, the affective aspects of felt bodily pain and the somatic accompaniments interwoven with emotional suffering, suggest that whatever its phenomenology, these experiences are more complicated than the experience of colors and auditory tones.

Exploring the contrast between imagistic (perceptual, sensory) imaging and propositional imagining, Bayne and Pacherie extend perceptual imaginings beyond the case of envisioning in one's mind's eye to cases of "quasi motor imagining".[35] Examples of quasi-motor imagining involve action, however. They are not, like feelings, states of which their subjects are passive recipients. They will thus be unhelpful to the analysis of feelings that resist imagining P *simpliciter*.

2.4 Possible analyses

Some partial explanation of why imagining P simpliciter seems to be a forme fruste of imagining, can be found in other discussions of imagining, one concerning structural *differences* among sense modalities; a second emphasizing the "raw feel" element of pain and a third introducing features of basic emotions. A final analysis rejecting the structural model by which imagining is to be understood is beyond the scope of the present paper.[36]

*First***,** it has been argued that optical and auditory senses alone possess a triadic structure framing, and responsible for, their distinctive phenomenology. Comprising (i) the mind's inner eye or ear, (ii) the internal field, and (iii) the visible or audible object located within it, this structure is absent, or at least different, with the senses of taste, smell, touch, and proprioception. From the

variations she finds within the sense modalities, Brann concludes that strictly speaking, taste, smell and touch are imageless, or "not imagistic".[37] Contrary to that position, dimly recognized body maps may be supposed to allow a comparable internal field and triadic structure for the other senses and for the internal sensory (or "proprio-sensorial")[38] modes including those involving apprehension of pain and suffering. Such body maps (derived from non-conscious body schemas as well as from the body images of which we are or can become aware), that provide the ongoing information allowing us to proceed on our spatiotemporal path through the material world, and might suggest revisions to this aspect of Brann's analysis. Imagined sights and sounds may only be distinguished by a triadic structure that is *relatively* more evident and precise due to the confirmation by other perceivers in the shared observable world of outer sense perception. The painfully injured toe that forms one part of this triadic structure is publicly verifiable. The intervening distances are (sometimes) public, not merely private, phenomena.

Second, Brann draws a stronger conclusion, however. Rather than delivering «the apprehension of distinct objects confronting the subject over intervening distances», even the other senses of touch, smell and taste merely deliver «immediate qualities or *feels*».[39] As well as used to explain the distinctive epistemology attributed to pain experiences, their status as immediate qualities or *raw feels,* would also account for why feelings of pain could not be imagined *simpliciter*.[40] The pain that typically emanates from tissue damage has often been judged to involve irreducibly subjective experiences associated with a limited range of phenomenal properties. There is something it is like to feel pain, but pains are private, subjective states, not amenable to the distinction between what is and what appears. Without correctness conditions, the pain is merely felt or not. An influential effort to counter mind-brain identity theory invokes imaginary pain to argue that merely imagining a pain sensation through its phenomenal properties, unaccompanied by any corresponding brain state, will be impossible because pain is *no more than* those properties.[41] Accounts of why at least some feelings lack intentionality point to a closely related feature. Not over or about anything, phenomenal "raw feels" have been described as *intransitive*, such that they are «simply present or absent».[42] If these feelings are either experienced or not, it seems to follow, then when we try to imagine them (imagining P *simpliciter*) we must fail.

Third, in their work directed towards how our human language referring to internal perception (or "proprioception") of feelings and other states is acquired and achieved, Dellantonio and Pastore hypothesize that the respective emphasis on cognitive elements and the sensory elements they call "phenomenological tone," will vary according to the feelings in question. Along with fear, anger, and disgust, in the handful of universally-occurring "basic emotions" identified by theorists, is sometimes included the distressing "sadness" that resembles depressive pain and suffering. Over such basic emotions, it is explained, cognitive, propositionally-understood elements will play a reduced role in acquiring and achieving language capabilities, while sensory (phenomenological tone) elements, will be relatively important, even sufficient, for identifying such feelings. In contrast, linguistic competence over non-basic emotions (regret or nostalgia, for example) will rest on recognition of the conditions that typically cause and situations that accompany them, learned inferentially. Thus, while apprehension of the phenomenal tone is sufficient for identifying basic emotions such as (at least some) sadness, the greater the complexity of non-basic emotions, the more their identification and classification rest on propositional and inferential knowledge.[43] Understood to be a basic emotion, the pain and suffering described as extreme sadness can be expected to correspond to more apparently somatic pain in this respect.

Understood as pain and suffering, much sadness involves more complex, intentional feelings and cognitive elements, allowing us to imagine it – as spectators – in rich and complex detail likely exceeding that in the pain associated with tissue damage. Yet if not only the pain typically associated with tissue damage, but also those other feelings of pain and suffering share alike this feature of being identified, at least primarily, through their more somatic components, then we can apparently explain why our examples seem to show the same imagining *fruste*. Phenomenal elements of each kind will be experienced or not, in the manner of raw feels – explaining why, trying to imagine them (P *simpliciter* imagining), without re-experiencing them, we fail.

Feeling theories, as we saw earlier, divide between those emphasizing the cognitive element associated with feelings and those, following James and Lange's analyses of emotion, stressing their sensory and somatic qualities. By bifurcating the class of emotions, Dellantonio and Pastore's work illustrates, it is possible to recognize a way towards reconciling these two models that may further explain why, when P is pain and suffering, imagining P *simpliciter* will not succeed.

2.5 Different feelings of pain and suffering compared

Used naturally, "feelings" include both the states typically caused by tissue damage and experienced as painful, and the distress associated with

states identified as emotions. The category of feelings is even broader, including what are commonly separated as emotional states (both moods and more enduring attitudes), localized pain sensations, and tactile sensations, as well as whole bodily experiences.[44] Terms such as "pain" and "suffering" are better seen as broad concepts sharing overlapping (family) resemblances, since the pain associated with tissue damage is distinct from the activation of physiological pain centers or nociceptive pathways that bring it to conscious awareness, and are extensively influenced by higher-order cognitive states of expectation and belief with respect to both stimulus intensity and subjective unpleasantness.[45]

That pain and suffering may possess the same sort of irreducibly phenomenal properties as experiencing localized bodily pain from tissue damage apparently authorizes us to extend the analysis above to the pain and suffering of the depression sufferer, the example of terrible news was used to suggest. Support for this position comes from a range of sources.

(i) There is phenomenological report. For example: «There is something it is like to *feel* sad, both psychically and physically – perhaps for some it is a kind of feeling of vulnerability and melancholy weariness accompanied by bodily fatigue».[46] And the phenomenology of such feelings has been recognized to sometimes include indissoluble mixtures of more and less somatically-experienced states.[47] Similarly, while somehow localized, feelings are described as distinct from a given bodily organ or area: «not the felt body, but the feeling body – the resonant field through which we are affectively aware of something else [that] discloses the significance of something and thereby functions as the prime channel of affective experience».[48]

(ii) Clinical data indicates that somatically-experienced pain regularly accompanies the feelings and mood states making up diagnosed depression.[49]

(iii) Recent analyses of internal perception emphasize the range of ongoing somatic information that accompanies emotional feelings while being confined "recessively" to the margins of conscious awareness or attention.[50]

(iv) From neuroscience evidence emerges of overlap and intermingling between more and less somatically-experienced pain in the brain structures that accompany them.[51] (Because such affective elements influence pain from tissue damage at every level, pain scientists have increasingly moved toward seeing such pains as ineluctably affective, and thus as emotions, even as many philosophers have increasingly analogized them, and such localized bodily feelings, to perceptual experience. More sensorially-experienced pains, at least, are then construed as representations of particular, damaged bodily states in the same way that perceptions are seen to represent the non-bodily world around us).[52]

(v) Cultural historians have shown that rather than the brute, unchanging aspects of human experience that they often seem to us, pain and suffering are best seen as constructions, mediated by cultural ideas and expectations.[53]

The commonalities between more and less somatically-experienced pain are striking. Stimulus intensity and unpleasantness are characteristic of the range of experiences described as pain and suffering; important forms of behavioral expression are common to both (gasps, cries, grimaces, and tears); synonyms are shared: "anguish," "suffering," and "hurt" for example, in addition to every cognate of "pain"). The relationship between more and less somatically and sensorially experienced pain feelings has been contested since William James's famous discussion. When we speak of experiencing "emotional" pain, some suggest, we employ metaphor only: a painful depression is closer to a painful decision, or encounter, on this view, than to my splitting headache or twinge of back pain.[54] Other discussions separate what can loosely be called somatic pain and emotional pain as parallel, but distinct, senses of "pain" (and "suffering"), or else allow that the term is broad enough and the commonalities sufficiently numerous to accommodate each of these several core cases of pain – the *heartache* of despair, as much as the *chest pain* of angina.[55]

In support of the view that all are core cases of pain is that more and less localized and somatic or sensorial pains each reflect hybrid classes. "Emotional" pain may seem distinct, but "emotions" range from intense anger and rage to calm passions such as nostalgia, and enduring attitudinal states, such as envy; what may be true for some, may not for other emotions. Paralleling this range, moreover, "pain" similarly lacks a unitary characterization, it has been pointed out. No qualitative content, even including "painful feelings," is consistently present in cases persuasively described, by observers and sufferers alike, as pain.[56]

2.6 Can't or Won't: Feelings of pain and imaginative resistance

Our seeming inability to imagine some things has been explored by Gendler. Her work on imaginative resistance, emphasizes that in some cases it seems we can't, while in others we don't want to, imagine – not wanting, as she puts it, to take on points of view we would not reflectively endorse as authentically our own.[57] Gendler's taxonomy actually separates four cases: *pure won't* cases that evoke feelings of imaginative impropriety without imaginative barriers; *pure can't* cases that evoke imaginative barriers without feelings of imaginative impropriety; *wont – couldn't* cases, that evoke both feelings of imaginative impropriety and imaginative barriers but when the felt imaginative

impropriety eclipses the imaginative barrier; and *can't – wouldn't* cases, which are the contrary, where it is the imaginative barrier that explains our failure to explain the world, eclipsing the motivating force of the imaginative impropriety.[58]

If the position developed thus far is viable, then imaginative resistence over feelings of pain and suffering are *can't* cases, they exhibit an imaginative barrier. Conceptual features of those feelings render them unimaginable in this one particular way, even though much about and over them *can* be imagined. The question of whether there is also imaginative impropriety, thus making our inability to imagine feelings of misery an instance of *can't-wouldn't,* is not so easy to resolve.[59] Attitudes towards suffering are too complex to be easily fitted into Gendler's rubric.

3 Kant's melancholic's "mere delusions of misery"

Brief remarks in the *Anthropologie* indicate that Kant understands melancholia as delusional misery, pain, or suffering.[60] Just as the hypochondriac suffers imaginary illnesses, Kant asserts, the melancholic may suffer «a mere delusion of misery».[61] Of this delusion, he adds that «the low-spirited self-tormenter (inclined towards feeling wretched) creates for himself».[62] "Wahnsinn" in these passages from the *Anthropologie* might equally and perhaps more closely be rendered something like "deluded meaning," rather than "delusion." Yet neither "delusion" nor "melancholia" was as sharply defined in Kant's time as to prevent our employing the more natural, and also loose, English "delusion" and "deluded".[63]

Kant was an astute observer of mental disorder; moreover, the conditions he describes here (hypochondria and melancholia) are reflected in today's nosology and symptom descriptions. Despite the risk of confusion in changes of usage between Kant's time and ours, "delusion" and "deluded" or "delusional" remain imprecise enough to warrant their inclusion in the analysis undertaken here.[64]

Kant's passage above seems to admit of two interpretations. One is that some at least of the melancholic's feelings (of misery), like the imaginary illness of the hypochondriac, are not actually felt, or *imaginary*. Alternatively, and although a causal outcome of nothing more than the person's imagination combined with an inclination towards feeling wretched, the person experiencing feelings of misery really feels wretched. The analogy between hypochondria and melancholia lies at the center of the ambiguity. And Kant's further comments fail to resolve it. The downstream causal products of no more than imagination can still be either felt, *or* merely imaginary, and not felt. The placebo produces real effects, by way of real, if only incompletely recognized, expectations. Similarly, descriptions of psychogenic and phantom limb pain are careful to note that the pain is really felt, even if its origins cannot be linked to tissue damage.[65]

Kant's remarks on how to go about treating defects of reason further explain his reasoning in the above passage.[66] Speaking of ways to remedy hypochondria, rather than melancholia, Kant extolls the power of the mind to heal itself, remarking that a reasonable person can prevent the tendency toward hypochondria from becoming a more serious illness by distracting himself, redirecting his attention and engaging in a close analysis of his misapprehensions.[67]

> [...] averting attention from certain painful sensations, and concentrating on some other object voluntarily grasped in thought, can ward off the painful sensations so completely that they are unable to break out into an illness.[68]

Using distraction this way, he asserts, has worked with his personal efforts to counter the tendency towards hypochondria. Because melancholia is allied to hypochondria in Kant's discussion, these passages suggest that he supposed feelings of misery, too, might be extinguished, augmented, or otherwise changed by controlling attention.

4 Feelings of pain, suffering and misery as delusions

Certain traits have long been proposed as characteristic, if not definitive, of clinical delusions, several relying on the doxastic assumption that delusions are beliefs, or belief-like. These characteristics of delusions are four:

> (i) Delusions are false or implausible beliefs;
>
> (ii) they seem often to have been acquired in irregular ways – through an inferential process that eludes the surrounding epistemic community, for example;
>
> (iii) they are accepted and clung to with unwarranted insistence in the face of seemingly irrefutable countervailing evidence;
>
> (iv) they fail to cohere with the rest of the person's beliefs, other mental states, or expressive and other behavioral responses.[69]

The kinds of rationality constraints tied to belief ascription have been divided into three.[70] *Epistemic* rationality governs the way beliefs are acquired and maintained in relation to evidence, thus applying to the deficiencies captured in (ii)-(iii) above; *procedural* and *agential* rationality concern the consistency and integration within the individual's be-

lief set, and beliefs and behavior, respectively, thus corresponding to the irrationalities noted in (iv).[71]

4.1 Epistemic rationality

If we accept these traditional characterizations of delusion, can feelings such as those of pain and suffering be delusional? Only (iv), we'll see, is fully applicable to depressive pain. The question raised by the present discussion challenges, rather than accepting, the assumption about epistemic rationality embodied in (i) (that delusions are false beliefs). Mistakes or infelicities involving their belief elements are part of (many) affective states.[72] The person may be mistaken over why he feels pain and suffering, what he is suffering over or about, even over how relatively miserable he is, in addition to what he might do about it. The feeling's object may be obscure, as in mood states without any clearly defined or definable object, as well as those whose apparent "object" is all-encompassing. In these and other ways, painful feelings are often accompanied by judgements about oneself and one's feelings that are inaccurate. Depending on context, they might qualify for our broad category of *affective delusions*.

On doxastic accounts of delusion, they comprise erroneous and mistaken belief states.[73] This takes us to what sometimes appears to be delusional thinking associated with depression. Delusional thought is somehow mediated by mysterious imaginative processes, as when the person comes to believe that her suffering was wrought by Martians. However, the imagination may enter in different ways, as we saw earlier. We can imagine some things directly, as when we imagine ourselves taking actions, or imagine others experiencing pain. And we come to imagine certain states of affairs indirectly, through the mediation of expectations. The delusional thought that her pain is brought about by Martians will have been brought about by efforts of the imagination. But her feeling pain cannot be because she inaccurately believes she feels pain. If she experiences pain and suffering, brought about by imagination indirectly. then at least on a doxastic or belief-based account of delusions her belief that she is in pain may be *accurate* – apparently failing to explain why she should be seen as delusional. And on a non-doxastic, meta-cognitive account, we'll see, feelings of pain and suffering (or misery) fare little better as instances of delusion.

While they are accompanied by, or comprise erroneous belief elements when regarded as affective wholes, feelings of pain do not reduce to those elements, as even the most committed cognitivist and appraisal theorists admit.[74] Part 1 of this discussion attempted to show that there remains a phenomenal residue, a way it is to feel in feeling pain and suffering which resists characterization in terms beyond itself at the same time as it also resists reduction to the cognitive elements with which it is associated. Feelings are often quixotic and random; they affect us in ways we can neither understand nor control. And (ii) above (acquired in irregular ways), since it captures much of what has traditionally been regarded as distinguishing affective states, is not a characteristic applicable to whether there can be delusional feelings. Similarly, and related, our feelings are often tenaciously maintained, even in the face of counter-evidence (see (iii)). We do not expect them to be entirely constrained by what might be supposed to support, explain, or warrant, them.[75]

4.2 Procedural rationality

By contrast with these other characteristics of delusional responses, the incoherence captured in (iv) that violates Bortolotti's agential rationality *does* seem to get traction with the thesis that we may be deluded about feeling miserable. Yet, clinical evidence indicates that such inconsistency is not commonly associated with melancholia and depression, which typically exhibit *consistency* such as to account for systematically biased cognitive habits. Inconsistencies between feelings and their outward expression in action, behavior, gesture, or demeanor might be expected to represent a stronger case here, assessed as they are by social norms.[76] However, mood disorders such as depression are commonly identified by their overall coherence, or *congruence,* rather than incongruence.[77] His suicidal preoccupations and self-neglect seem appropriate to the despair and self-loathing voiced by the depression sufferer. [78] Because incongruence is not characteristic of depressive disorders, we cannot easily appeal to this feature to confirm the delusional status of our melancholic's feelings of misery.

In sum, the usual characteristics of delusions only very imperfectly capture the feelings we are interested in deemed by Kant to be delusional. Criteria (i)-(iii) are inapplicable to feeling states because of their status as affections; those in (iv), while applicable, are not strongly associated with the melancholic or the pain and suffering of depression.

4.3 Imagination and Currie-style meta-cognitivism

In the metacognitive account offered by Gregory Currie and associates the deluded person imagines, rather than believing, P while at the same time mistakenly believing that he believes P.[79] The delusional person thus portrayed entertains a false belief about his own cognitive states.[80] He seems to believe P, but actually only imagines P, while mistakenly believing he believes P. This apparently fits Kant's account of some of the hypochondriac's ideas: he imagines he is ill, is not ill, but (mistakenly) believes he believes he is ill. A person's

being ill (in the sense intended), however, is usually understood to be an independently verifiable bodily state.

In application to all delusions, the metacognitive account has been criticized.[81] Even with regard to *pain and suffering*, it proves problematic, requiring that the depressed person is not miserable, *imagines feeling pain and suffering*, and mistakenly believes that he believes that he is (suffering), confusing what he imagines with what he believes. Certainly, as we saw, the depressed person might hold mistaken beliefs over aspects of his state that would in turn distort affective responses to it. He may judge himself to deserve to die because of some *imagined* crime (an example not uncommon within the annals of delusional depression). He can be *loosely* said to imagine himself feeling pain – when that refers to what his feeling is over or about, its origins, or how intense it is in comparison with other painful feelings. But if the reasoning in the first part of this discussion is persuasive, one side of the metacognitive formulation – the person's imagining feeling pain (without actually being in pain) – will be precluded. To *successfully* imagine feeling P *simpliciter* can only be to *actually feel pain*.

Other forms of imagining may be sufficient for some minimal meta-cognitive account, inasmuch as the depressed person is able to (propositionally) imagine that he is in pain; or imagine his feeling by envisioning it from the outside. The impossibility of imagining P *simpliciter* would seem to render the meta-cognitive account significantly incomplete. Without any imagined feelings to provide the prompt for additional propositional and imagistic imaginings, there would be less reason for such subsequent imaginings to arise in the first place. Other triggers there would be, certainly, including the mere, and perhaps mistaken, inferred *belief that he feels pain* derived from others' observations, or his own, imagining as a spectator. But feelings must be an important goad and occasion for many subsequent elaborations and inferences.

As a response to, and result of, feeling pain, the person would *conclude that* he feels pain; *attend to* what he feels pain over or about; or, from an observer's perspective – and mistakenly, even delusionally, or not – *imagine his own suffering*. Perhaps not wholly, but still undeniably, this impediment to imagining pain and suffering will diminish the force of the meta-cognitive analysis.

5 Conclusions

If the hindrances to imagining oneself feeling pain identified here are persuasively argued for, the depressed person's feelings of pain will not be entirely imaginary. And so regarded, *contra* Kant, they are not delusional, either as false beliefs, or as imaginings mistaken for believings. Nor does the imagining *forme fruste* identified here reflect barriers involving authenticity: it will be conceptually impossible to imagine feelings of pain and suffering this way. Rather, what has been shown is that expectation and feedback effects can alter and engender painful feelings such as those associated with depression. Although these feelings may be accompanied by, and the subject of, any number of mistaken beliefs, including some ranking as delusional, the feelings themselves are not misapprehended. The depression sufferer believes he feels pain, and does.

In relation to issues of imaginability, just as we cannot have delusional somatic pain, we cannot have other delusional feelings of pain and suffering. The broader implications of this analysis may be insignificant: there is much about pain and suffering that does permit being misapprehended (and mis-imagined). But by pointing to this additional feature regarding imaginability common to both kinds of feelings, the preceding discussion aimed to dispel a lingering suspicion that reported pain may be a mere figment of the sufferer's imagination.

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Notes

[1] Emphasis on feelings includes work that is primarily critical of cognitivist and appraisal theories (cf. P. GOLDIE, *The emotions: A philosophical exploration*; J. DEIGH, *Cognitivism in the theory of emotions*; M. STOCKER, *Psychic feelings: Their importance and irreducibility*; M. STOCKER, E. HEGEMAN, *Valuing emotions*); descendants of James' famous account of emotion (cf. P. GRIFFITHS, *What emotions really are: The problem of psychological categories*; J.J. PRINZ, *Gut reactions: A perceptual theory of emotion*; J.J. PRINZ, *Are emotions feelings?*; S. DELLANTONIO, L. PASTORE, *Internal perception. The role of bodily information in concepts and word mastery*), and analyses influenced by phenomenological traditions (cf. J. SLABY, *Affective intentionality and the feeling body*; M. RATCLIFFE, *Feeling of being: Phenomenology, psychiatry and the sense of reality*; M. RATCLIFFE, *The phenomenology of mood and the meaning of life*). For reviews of the limitations of cognitivism and the strengths of feeling theories, cf. S. GRANT, *Emotion, cognition and feeling*; D. WHITING, *The feeling theory of emotion and the object-directed*

emotions. See also essays J. CORNS (ed.), *The Routledge handbook of philosophy of pain*.

[2] Cf. K. REUTER, D. PHILLIPS, J. SYTSMA, *Hallucinating pain*.

[3] I. KANT, *Anthropology from a pragmatic point of view*, p. 109.

[4] In this subtype a medical (organic) condition was said to «play either *no role or a minimal role* in the onset and maintainance of the pain» (AMERICAN PSYCHIATRIC ASSOCIATION, *Diagnostic and statistical manual of mental disorders*, Fourth Edition (DSM-IV, APA Press, Washington (DC) 1994, p. 458 – emphasis added); with recent revisions in 2013, Kant's implication that the melancholic's suffering may be imaginary has now been expunged from the DSM (AMERICAN PSYCHIATRIC ASSOCIATION, *Diagnostic and statistical manual of mental disorders*, Fifth Edition (DSM-V), APA Press, Washington (DC) 2013).

[5] We return later to the view that pain is a form of perception, from which reference to phantom limb pain as "experiential misrepresentation" apparently analogizes it to *hallucination* (M. TYE, *The experience of emotion: An intentionalist theory*, p. 32).

[6] A much-quoted earlier definition from the *International Association for the Study of Pain* states that pain is «an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage». This brief definition is followed by a note insisting that «pain is always subjective [...] Activity induced in the nociceptor and nociceptive pathways by a noxious stimulus is not pain, which is *always a psychological state*, even though we may well appreciate that pain most often has a proximate physical cause» (INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN, *Pain terms: A list with definitions and notes on pain*, p. 250 – emphasis added).

[7] T. GENDLER, *Imagination*: «[...] imagining *S* does not require (that the subject consider) *S* to be or have been the case, whereas the contrasting states do. It is distinguished from mental states such as *desiring* or *anticipating* in that imagining *S* does not require that the subject wish or expect *S* to be the case, whereas the contrasting states do. It is also sometimes distinguished from mental states such as *conceiving* and *supposing*, on the grounds that imagining *S* requires some sort of quasi-sensory or positive representation of *S*, whereas the contrasting states do not».

[8] Cf. K. WALTON, *Mimesis as make believe*; E. BRANN, *The world of imagination: Sum and substance*.

[9] T. SCHROEDER, C. MATHESON, *Imagination and emotion*, p. 22. Explaining how the imagination works on our affections and whether covert beliefs might be implicated, has stimulated a range of explanatory hypotheses.

[10] It actually traces to Hippocratic medicine, cf. S. JACKSON, *Melancholia and depression*.

[11] Cf. T. FUCHS, *Melancholia as desynchronization: Towards a psychopathology of interpersonal time*; S. GALLAGHER, *Time, emotion, and depression*; M. RATCLIFFE, *Feeling of being: Phenomenology, psychiatry and the sense of reality*; M. RATCLIFFE, *The phenomenology of mood and the meaning of life*; M. RATCLIFFE, A. STEPHAN (eds.), *Depression, emotion and the self: Philosophical and interdisciplinary perspectives*.

[12] Mayberg's words have been quoted according to D. DOBBS, *A depression switch*.

[13] S. DELLANTONIO, L. PASTORE, *Internal perception*.

[14] Cf. D. ZAHAVI, *Simulation, projection and empathy*. Such internal ostension apparently adheres to the position that sensuously imagining something is imagining an experience of that thing, known as the "Dependency Thesis" (cf. P. NOORDHOF, *Imaginative content*, p. 100).

[15] There is also in-his-shoes imagining (cf. P. GOLDIE, *The emotions: A philosophical exploration*, pp. 198-205) and Goldman's enactment imagining, which involves trying to create in one's own mind a mental state or a facsimile of another's (cf. A.I. GOLDMAN, *Précis of Simulating minds: The philosophy, psychology, and neuroscience of mindreading*).

[16] Cf. B. WILLIAMS, *Imagination and the self*; R. MORAN, *The expression of feeling in imagination*; K. WALTON, *Mimesis as make believe*; C. PEACOCKE, *Imagination, experience, and possibility: A Berkeleian view defended*; F. DE VIGNERMONT, P. JACOB, *What is it like to feel another's pain?*. Illness, injury and depression memoirs are made up of such efforts when, imagining as a spectator, the author re-envisions her past suffering just this way.

[17] Cf. L.A. DUKE, D.N. ALLEN, P.D. ROZEE, M. BOMMARITTO, *The sensitivity and specificity of flashbacks and nightmares to trauma*; J.F. LIPINSKI JR, H.G. POPE JR., *Do "flashbacks" represent obsessional imagery?*; C.R. HIRSCH, E.A. HOLMES, *Mental imagery in anxiety disorders*; AMERICAN PSYCHIATRIC ASSOCIATION, *Diagnostic Statistical Manual of Mental Disorders*, Fifth edition.

[18] DSM-5 (*ibid.*, p. 271-280) notes that they are recurrent, involuntary, intrusive and distressing memories of the traumatic event(s). Such re-experiencings of the initial trauma event are also known as re-traumatization.

[19] K. REUTER, D. PHILLIPS, J. SYTSMA, *Hallucinating pain*, p. 95.

[20] 64.5% of subjects endorsed the possibility of pain hallucinations (in contrast to 84.3% endorsing the possibility of auditory hallucinations, for example), suggesting a significant disparity and an unresounding confidence.

[21] I owe the example to Peter Goldie, with appreciation.

[22] R. MORAN, *The expression of feeling in imagination*, p. 93.

[23] P. NOORDHOF, *Imaginative content*, p. 99 and p. 111.

[24] Cf. A.I. GOLDMAN, *Précis of Simulating mind*, p. 431. Others speak of this, or closely related forms as "recreative" imagining (cf. G. CURRIE, I. RAVENSCROFT, *Recreative minds: Imagination in philosophy and psychology*).

[25] A.I. GOLDMAN, *Imagination and simulation in audience responses to fiction*, p. 42 – emphasis added.

[26] Third person ascription, some think, employs imaginative projection: an attributor «creates pretend states intended to correspond to those of the target, feeds them into his own cognitive equipment, and lets it produce an output state, e.g., a belief, decision, or emotion» (A.I. GOLDMAN, *Précis of Simulating mind*, p. 431). See also J. HEAL, *Replication and functionalism*; F. DE VIGNEMONT, P. JACOB, *What is it like to feel another's pain?*, who distinguish among the ways we are able to imagine others' pain vicariously, as contagious and empathic pain, supporting their case by a range of studies employing visual awareness of others' pain.

[27] Cf. B. WILLIAMS, *Imagination and the self*; C. PEACOCKE, *Imagination, experience, and possibility*; A. WHITE, *Visualizing and imaginative seeing*; R. MORAN, *The expression of feeling in imagination*; K. WALTON, *Mimesis as make believe*. Disputes also arise over whether imagining is necessarily a voluntary process (F.

DE VIGNEMONT, P. JACOB, *What is it like to feel another's pain?*).

[28] Richard Moran insists that making an aspect of one's psychological state of imagining part of what can be imagined is a mistake, since, as he puts it: «many or most exercises of the imagination need not include any part of the person's mental life as part of their content» (R. MORAN, *The expression of feeling in imagination*, p. 90). Cf. also Williams: «I as a perceiver do not necessarily belong inside the world that I visualize, *any more than I necessarily do so in the world that I imagine*; or the painter in the scene that he paints» (B. WILLIAMS, *Imagination and the self*, pp. 34-35 – emphasis added).

[29] It has been argued that being active is an essential feature of imagining (cf. A. KIND, *Putting the image back in imagination*). Yet some experiences very like imagining often comes unbidden (for example, a tune or remembered conversation fragment might float into our mind). Of unbidden imaginings, even those that are unwanted, Amy Kind remarks that «imagining is nonetheless *something that I do*» (A. KIND, *Putting the image back in imagination*, p. 91 – emphasis added). Although it leaves unbidden "imaginings" a puzzlingly anomalous case, the distinction between imaginings and flashbacks noted earlier requires adherence to this analysis.

[30] Cf. G. CURRIE, I. RAVENSCROFT, *Recreative minds*; G. CURRIE, J. JUREIDINI, *Delusion, rationality, empathy*; T. BAYNE, E. PACHERIE, *In defence of the doxastic conception of delusions*; E. BRANN, *The world of imagination*; S. NICHOLS (ed.), *The architecture of the imagination*; K. WALTON, *Mimesis as make believe*.

[31] Hobbes speaks of the form taken by our imaginings as "more obscure" than sense impressions; for Hume, imaginings are less vivid versions of those impressions. Attempts to reinstate the centrality of imaging to imagining can be found in E. BRANN, *The world of imagination*; A. KIND, *Putting the image back in imagination*.

[32] For such mixed models of imagining cf., for example, K. WALTON, *Mimesis as make believe*; A. WHITE, *The language of imagination*; S. NICHOLS (ed.), *The architecture of the imagination: New essays on pretence, possibility, and fiction*.

[33] This is the "Multiple Use Thesis" defined as being able to serve more than one imaginative project (P. NOORDHOF, *Imaginative content*, p. 100). See also A. WHITE, *The language of imagination*.

[34] N. GRAHEK, *Feeling pain and being in pain*, p. 2.

[35] One example is «what it is like to imagine raising one's hand» (T. BAYNE, E. PACHERIE, *In defence of the doxastic conception of delusions*, p. 167). Another is reported from patients suffering the frozen gait of Parkinson's Disease, who when asked to imagine themselves bicycling have been found to improve the flow of the interrupted (frozen) activity (A. KUKUCHI, T. BABA, T. HASEGAWA, N. SUGENO, M. KONNO, E. MIURA, R. OSHIMA, M. AOKI, A. TAKEDA, *Improvement of freezing of gait in patients with Parkinson's disease by imagining bicycling*).

[36] In the model of sensorial imagining employed in our discussion, sensuously imagining something is imagining the experience of that feeling. For a representationalist, our inability to imagine pain and suffering calls for further explanation, as Paul Noordhof recognizes when he invokes the suppositional element that «characterizes the imaginative project which the image serves» to deal with the case of imagined feelings (pains and itches) lacking a «presentation of sensory qualities»), or *simulacra* (P. NOORDHOF, *Imaginative content*, p. 99). Noordhof's particular focus is imagining perceptual experiences such as sight and sounds. The suppositional element plays a larger role when we speak of imagining pain (or itches). It serves other tasks as well, including interpretive ones, when we imagine sights and sounds. But with pain, it serves to frame the exercise of imagining intentionally – *as* imagining. That is, as the «*intention behind a piece of active [...] imagining*» (*ibid*., p. 111). In contrast to imagining other experiences, «almost invariably, we are aware of our mental activity» in imagining pain (*ibid*., p. 121), and with its lack of presentational features, this awareness of imagining explains the part played by the suppositional element – it is necessary to allow us to know we are imagining.

[37] They are powerful triggers or releasers of visual imagery, it is added. Given our ability to readily imagine pain and misery by adopting an external or onlooker's perspective, in ourselves and others, this role played by non-imagistic imagining as an inciter of further feelings is unquestionably significant.

[38] For Dellantonio and Pastore "proprioception" covers the apprehension of any internal body states. Continuous mapping based on information provided by both external perception and proprioception that is available to conscious awareness provides the essential *basso continuo* underlying all experience and necessary for understanding (cf. S. DELLANTONIO, L. PASTORE, *Internal perception*, pp. 211-222).

[39] E. BRANN, *The world of imagination*, p. 13 – emphasis added.

[40] Cf. M. BAIN, *The location of pains*; K. REUTER, D. PHILLIPS, J. SYTSMA, *Hallucinating pain*.

[41] Cf. S. KRIPKE, *Naming and necessity*, p. 153.

[42] Cf. E. PACHERIE, *Self-Agency*, p. 455. Intentionality or its absence is a contested here, since emphasis on the analogies between such feelings and other perceptual modalities also have objects. Cf. A. HATZIMOYSIS, *Emotional feelings and intentionalism*, in: A. HATZIMOYSIS (ed.) *Philosophy and the emotions*, pp. 105-111; M. AYDEDE, *Pain: New essays on its nature and the methodology of its study*; S. DELLANTONIO, L. PASTORE, *Internal perception*.

[43] S. DELLANTONIO, L. PASTORE, *Internal perception*, pp. 234-251.

[44] Cf. also R. FURTAK, *Emotion, the bodily, and the cognitive*.

[45] Cf. D.D. PRICE, *Central neural mechanisms that interrelate sensory and affective dimensions of pain*; N. GRAHEK, *Feeling pain and being in pain*; A. ELSNER, *The story of pain: From prayers to painkillers/pain and suffering*.

[46] M. MONTAGUE, *The logic, intentionality, and phenomenology of emotion*, p. 183.

[47] Cf. M. RATCLIFFE, A. STEPHAN (eds.), *Depression, emotion and the self: Philosophical and interdisciplinary perspectives*, cit. That it is a mistake to think of all bodily feelings as states that have an exclusively bodily phenomenology, has been demonstrated with the disorienting sense of bodily imbalance: «A feeling such as disorientation is a bodily feeling but it is not just an experience of the body» (M. RATCLIFFE, *The phenomenology of mood and the meaning of life*, p. 363).

[48] Cf. J. SLABY, *Affective intentionality and the feeling body*, p. 440-441; cf. also M. RATCLIFFE, *The phenome-*

nology of mood and the meaning of life.

[49] L.J. WILLIAMS, F.N. JACKA, J.A. PASCO, S. DOOD, M. BERK, *Depression and pain: An overview*.

[50] S. DELLANTONIO, L. PASTORE, *Internal perception*.

[51] The variant known as "social pain" (suffered over rejection by one's social group), results from some of the same neural mechanisms as somatic pain (N. EISENBERGER, M. LIEBERMAN, *Why rejection hurts: A common neural alarm system for physical and social pain*), and is similarly alleviated by opiates (J. PANKSEPP, *The neuroevolutionary and neuroaffective psychobiology of the prosocial brain*).

[52] P. GRIFFITHS, *What emotions really are: The problem of psychological categories*; M. BAIN, *Intentionalism and pain*. Cf. also M. AYDEDE, *Pain*. Whether the representational approach is applicable to more apparently emotional suffering, with its inherent complexity and intentionality, is debated, although not an issue discussed here (cf. A. HATZIMOYSIS, *Emotional feelings and intentionalism*).

[53] J. VAN DIJKHUIZEN, K.A.E. ENENKEL (eds.), *The sense of suffering: Constructions of physical pain in early modern culture*.

[54] J. CORNS, *Are emotions ever painful feelings?*, talk given at the *Pain and Emotion conference*, Pain Project, University of Glasgow, October 2012, unpublished manuscript.

[55] For an exploration of these different positions, cf. J. RADDEN, *Emotional pain and psychiatry*; J. CORNS, *The social pain posit*.

[56] Cf. J. CORNS, *The inadequacy of unitary characterizations of pain*.

[57] Cf. T. GENDLER, *Imaginative resistance revisited*.

[58] *Ibid.*, p. 156.

[59] To be able to merely *imagine* rather than re-experiencing misery could sometimes be useful or adaptive. It might temper unwarranted euphoria, or serve as a warning against imprudent action ("Remember how upset you were last time that happened").

[60] "pain," "suffering" and "misery" are used interchangeably in the present discussion.

[61] Hypochondria is a term with a long history, during some of which it was used as an equivalent or, as in Kant's discussion, a sub-form of melancholia (cf. S. JACKSON, *Melancholia and depression*). Kant accepts that hypochondriacs complain of non-existent organic disorder. For a more thorough exploration of Kant's account of mental illness, cf. P. FRIERSON, *Kant on mental disorder. Part 1: An overview*.

[62] I. KANT, *Anthropology from a pragmatic point of view*, p. 109.

[63] The perceptual errors we would call illusions, Kant speaks of as optical delusions (*praestigiae*).

[64] On that imprecision, cf. L. BORTOLOTTI, *Delusions and other irrational beliefs*; J. RADDEN, *On delusion*; P. MCKENNA, *Delusions: Understanding the un-understandable*.

[65] Cf. *supra*, fn. 6.

[66] They also foreshadow today's cognitive therapy, where practitioners describe a method focused on the eponymous cognitions that are components and causes of the patient's depressed frame of mind: challenging faulty inference patterns, especially about attribution (that is, causal explanation) (cf. A.T. BECK, B.A. ALFORD, *Depression, causes and treatment*).

[67] I. KANT, *The conflict of faculties*, p. 104: «[the hypochondriac] asks himself whether his anxiety has an object. If he finds nothing that could furnish a valid reason for his anxiety, or if he sees that, were there really such a reason, nothing could be done to prevent its effect, he goes on, despite this claim of his inner feeling, to his agenda for the day – in other words, he leaves his oppression (which is then merely local) in its proper place (as if it had nothing to do with him), and turns his attention to the business at hand».

[68] I. KANT, *Anthropology from a pragmatic point of view*, p. 109, fn.

[69] Although solely comprised of beliefs, even common clinical delusions such as those about religious and spiritual matters, only imperfectly fit the notion of accuracy associated with empirical beliefs, it should be noted, so these criteria are not unproblematic even with (alleged) delusions involving doxastic states. Nor do (ii)-(iv) find traction with allied and more belief-like states, such as hoping, wishing and imagining. We may hope against hope; our imagination is limited by what is possible, not what is actual; hopes and imaginings are both free of inferential constraints of the kind that attach to belief; we can also wish for incompatible things.

[70] Cf. L. BORTOLOTTI, *Delusions and other irrational beliefs*.

[71] Whether delusions can be captured in the set of necessary and sufficient conditions assembled by combining (i)-(iv), or Bortolotti's three factors, is a contested question, the answer to which is not attempted here.

[72] For a thorough catalogue of these mistakes we make over our emotions, cf. R. DE SOUSA, *The rationality of emotion*.

[73] The only general characteristic of true insanity, says Kant, is a lack of intersubjective agreement. The madman, because of his failure to check for agreement with others in reaching his judgements, remains trapped in an understanding that is merely "subjective", isolated within his own experience (cf. I. KANT, *Anthropology from a pragmatic point of view*, p. 117).

[74] Cf. R. SOLOMON, *Emotions, thoughts and feelings: What is a "cognitive theory" of the emotions and does it neglect affectivity?*.

[75] There are norms for assessing affections. But none of these norms concern the degree of tenacity with which they are held. Only if being clung to with tenacity were to transgress the constraints governing epistemic or procedural rationality would such tenacity be judged as wanting in some way (perhaps obsessive, or unreasonable, or unwarranted).

[76] *Displays* of feeling out of proportion to their occasion; *acts* taken on feelings deemed insignificant or unwarranted; *outer responses* apparently belied by voiced feelings or inferred inner states: each are judged inappropriate, unwarranted, irrational, or even as indicative of mental disorder.

[77] See, for example, R. ELLIOTT, J. RUBENZSTEIN, B.J.SAHAKIAN, R.J. DOLAN, *The neural basis of mood congruent processing biases in depression*.

[78] Mood disorders such as depression usually fall short of delusional, to be sure. Yet fundamental classificatory and terminological questions about psychotic affective conditions remain unresolved, apparently in part because mood *incongruence* is so strongly associated with psychosis. On some analyses delusional affective disorders are a subtype of affective illness, while on others they are a separate schizoaffective disorder (cf. K.S.

KENDLER, *Mood-incongruent psychotic affective illness*; T. KUMAZAKI, *What is a "mood-congruent" delusion? History and conceptual problems*). In the face of this confusion we can perhaps safely say only that were there consistent incongruence between inner states inferred from the melancholic's assertion that she feels miserable (together with other outer responses she displays), it might encourage us to attribute delusional feelings, on the grounds that such incongruence is a strong marker of psychotic or delusional status.

[79] Cf. G. CURRIE, *Imagination, delusion, and hallucinations*; G. CURRIE, J. JUREIDINI, *Delusion, rationality, empathy*.

[80] This is in contrast to the view of delusions that depicts them as false beliefs about some
state of affairs in the world. The influential definition of delusions found in the American Psychiatric Association's *Diagnostic and statistical manuals*, has long spoken of them as false beliefs based on *incorrect inference about external reality*.

[81] Cf. T. BAYNE, E. PACHERIE, *In defence of the doxastic conception of delusions*.

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