Expanding Evaluativism: Valence as the Evaluative Component of Pain States

Ampliando o avaliacionismo: a valência como componente avaliativo dos estados de dor

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ABSTRACT

Within the philosophy of pain, evaluativist theory maintains that pain experiences exhibit a dual structure comprising both sensory and affective dimensions. The sensory aspect, which concerns phenomenological features, is intrinsically connected to an affective element through which pain presents itself as bad for the subject. This dual structure grounds the subject's evaluative stance toward their own pain. According to evaluativists such as David Bain, this structure provides reasons which, from the subject's perspective, rationalize actions undertaken to cope with pain. Such a position entails a commitment to cognitivism, insofar as it presupposes that the subject exercises cognitive control over their painful experience. We argue, however, that this commitment narrows the explanatory scope of evaluativism, limiting it primarily to straightforward cases of acute pain. To address this limitation, we propose reconceiving the affective dimension in terms of valence, thereby overcoming its dependence on cognition. Such a proposal could broaden the explanatory scope of evaluativism, so as to encompass not only straightforward cases of acute pain, but also more complex cases in which the agent, despite lacking cognitive control over their pain, still evaluates it as bad for them.

Keywords:

Pain. Evaluativism. Valence. Affects. Cognitive control.

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RESUMO
No domínio da filosofia da dor, a teoria avaliacionista postula que estados de dor possuem uma dupla estrutura, a saber, sensorial e afetiva. O componente sensorial, que aponta para aspectos fenomenológicos, carrega um elemento afetivo pelo qual estados mentais de dor representam algo ruim para o sujeito. Essa dupla-estrutura, por sua vez, está na base das avaliações que o sujeito faz sobre a sua própria dor. Avaliacionistas como David Bain entendem que essa dupla estrutura remete a razões que, do ponto de vista do sujeito, justificam ações que possam contornar a dor. Isso mostra um comprometimento com o cognitivismo que, entre outras coisas, pressupõe um controle cognitivo do sujeito sobre a sua própria dor. Argumentaremos que esse comprometimento restringe o escopo explicativo do avaliacionismo a casos simples de dor aguda. Para contornar esse problema, argumentaremos que é possível ampliar tal escopo explicativo se pensarmos o componente afetivo como valência que, por sua vez, desfaz a dependência da cognição. Tal proposta poderá ampliar a explicação da teoria avaliacionista, de modo a não somente incluir casos simples de dor aguda, mas também casos mais complexos, nos quais o sujeito, embora não possua controle cognitivo sobre a sua dor, ainda assim a avalia como algo ruim para ele.
Palavras-chave:
Dor. Avaliacionismo. Valência. Afetos. Controle cognitivo.

Introduction

A central challenge for explanatory theories of pain, one that affects not only philosophy but also several other fields of research, is that pain is a multidimensional phenomenon. The most recent definition of pain proposed by the International Association for the Study of Pain (IASP) defines pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage", and adds that pain "is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors"[3]. This definition highlights the multidimensional character of pain. It is influenced by emotional, cognitive, and motor aspects. Neuroscience has also proposed a tripartite typology of pain, namely nociceptive, nociplastic, and neuropathic pain[4]. Moreover, pains are enormously varied. There are potential pains, that is, pains without evident physical damage, such as phantom limb pain; acute pains, which are localized; chronic pains, which manifest in a diffuse and persistent manner; and, furthermore, the notion of "total pain" commonly observed in terminal patients (CASTRO et. al. 2024). From an adaptive

[3] See IASP's website, available at https://www.iasp-pain.org/publications/iasp-news/iasp-announces-revised-definition-of-pain/.
[4] Nociceptive pain is pain that is caused by actual or threatened tissue damage. Neuropathic pain is pain that is caused by a lesion or disease of the nervous system. And nociplastic pain is pain that arises from altered nociception in the absence damage to tissue or the nervous system. For more one this distinctions, see Hoegh & Hodges (2025).

standpoint, pain does not seem to serve a single function either. In addition to signaling actual damage, it may also prevent potential harm (ROSENQVIST, 2024).

Since pain is not a unitary phenomenon, anti-essentialist positions have gained prominence in philosophy. In a recent book, Jennifer Corns argued that pain is not a natural kind (2020, p.26). Similarly, Colin Klein (2007) argues that we should embrace explanatory pluralism. In this regard, clarifying which kind of pain is to be explained, along with its mechanisms and specific phenomenological dimensions, should constitute a starting point for philosophical theories of pain. Such pluralism does not, however, preclude a comparative analysis of the explanatory scope of philosophical theories of pain. Moreover, different types of pain may bear similarities to one another, at least with respect to the mechanisms underlying the experience. Certainly, the broader the range of *explananda* that a theory encompasses, the greater its explanatory power. It should therefore be preferable to more restrictive theories.

Our article seeks to explore one such occasion. The aim is to expand the explanatory scope of the evaluativist position in the philosophy of pain. We think that evaluativism, as proposed by Bain, is correct in its general aspects. However, we think that its commitment to cognitivism is problematic. Although this cognitivism presents itself as moderate, the problem is that it restricts the theory's explanatory power to a hand full of textbook cases of acute pain. These are cases in which the experience of pain does not affect the sense of agency, i.e., cognitive control, on the part of the subject. However, we shall argue that it is possible to broaden the explanatory scope of evaluativism if one abandons such commitment to cognitivism. We will defend what we shall call here a basic or primitive evaluativism. As we will see, this evaluativism can account for more complex cases in which the subject loses the sense of agency over his or her pain because it conceives the evaluative component of pain states as valence. This applies not only to acute pain but also to chronic pain, which is the main focus of this article.

The argumentative path unfolds as follows: in the first section, we present traditional evaluativism, as proposed by David Bain. In this exposition, the theory's commitment to cognitivism should become clear, particularly with regard to the idea that the evaluative component of pain can be explained by affects understood as representational mental states. The second section explores cases of chronic pain that appear to resist an evaluative-cognitivist approach. This is due to the fact that chronic

pain states are markedly non-conceptual and fall outside the subject's control. Finally, the third section seeks to dissolve evaluativism's commitment to cognitivism so that it may adequately account not only for chronic pain, but also for acute pain. We shall see that the affect constituting evaluations (appraisals)[5] in cases of pain can be conceived as valence**,** which marks with negativity the physiological alterations constitutive of pain. In the case of chronic pain**,** valence functions as a marker of the physiological alterations constitutive of pain without reliance on the agent's rational capacities. Although the regulatory function of the valence of pain states does not depend on agents' rational capacities, it is connected to the organization of different kinds of actions aimed at maintaining the integrity of the body, such that it permeates cognitive processes related to pain in general. Understanding the affective component as valence, what we will call here "primitive evaluativism", thus allows us to expand traditional evaluativism. All things considered, it should become clear that our aim is not to reject Bain's account, but rather to show that it depends on a more primitive layer.

1. The Cognitivist Conception of Evaluativism

Evaluativism maintains that mental states of pain are both representational and evaluative. Here is how traditional evaluativism has been defined:

> "Evaluativism attempts to update representationalist theories of pain to capture the unpleasant character of paradigmatic pain. According to such views, in addition to (putatively) representing bodily damage, pain experiences represent that same bodily damage as *bad for you*; and arguably it is in virtue of doing so, in being evaluative representations of bodily damage, that we account for their unpleasantness." (MITCHEL, 2019, p. 786)

One of the most vocal proponents of traditional evaluativism is David Bain. Here is how he conceives of the relationship between unpleasantness and the being-bad-for-you quality of pain: "It is by dint of representing the badness-for-you of some bodily damage (…) that your pain is unpleasant, and it is in turn by dint of your pains' being unpleasant that your pain is bad-for-you" (BAIN, 2019, p. 463). So, according to traditional evaluativism, pain experience represents a bodily injury of a certain kind; that

[5] For a detailed account, see Moors et al., 2013

same experience also represents this injury as something bad for the subject, and these two features of pain always go hand in hand, because they entail each other.

To further clarify this dual dimension, we may take into account the interoceptive capacity through which subjects experience their pain. Interoception concerns the capacity for self-monitoring one's physiological changes, such as body temperature, heartbeat, digestion, and pain. In the case of the pain experience, the interoceptive content consists of the manner in which it presents itself to the subject. In this regard, a series of descriptive terms are well known, which present pain as intense, in waves, as a band, as a stabbing sensation, and so forth (cf. MELZACK, 1975). Evaluativists argue that pain representations carry a phenomenology, that is, they are determined by their representational content.

In this way, the theory maintains that mental representations of pain are not evaluatively neutral. Typically, such representations carry a negative value, since pain reveals some bodily problem. They express the property of something harmful to the subject, a property such as "badness" (CUTTER; TYE, 2011). Therefore, in addition to a phenomenal component, they also carry an evaluative component, which is expressed through the subject's evaluations of their own pain (BAIN, 2013; CUTTER; TYE, 2011). We shall have more to say about pain evaluations later. For now, it is important to note that, apart from cases of asymbolia and other atypicalities (GERRANS, 2020) mental representations of pain possess two closely associated aspects: sensory and evaluative.

How is the cognitive component of the evaluation of pain to be understood? Evaluativists such as Bain (2013) argue that evaluations are first-order states because they constitute the representational state of pain. This means that evaluations are embedded in the way the subject experiences their pain. In other words, evaluations do not necessarily result from judgments constructed through conceptual articulation. Certainly, they can be expressed as judgments that arise from self-reflection on the agent's pain experience. In this case, the agent may mobilize evaluative concepts to refer to the negative value corresponding to the pain experience. Yet note that the judgment here would derive from reflection on the experience, that is, from a second-order activity. The judgment does not belong to the experience itself, in which evaluations are already at work, even if only implicitly. Nor is the construction of judgments a necessary activity for the agent to experience pain as something bad for him.

Certainly, this more basic understanding of evaluations is useful for considering cases of pain. But in what way could they be incorporated into the cognitivist framework defended by Bain? The answer is that, by virtue of their representational character (both phenomenal and evaluative), mental states of pain possess truth conditions. They contain descriptive reasons insofar as they involve accuracy regarding the physical damage they represent. In addition, they contain motivational reasons related to actions that may interrupt the causal process of pain (BAIN, 2013; HELM, 2002). These are reasons embedded in the very content of the evaluation, namely, that pain is bad for the agent. Here, then, a commitment emerges to a moderate cognitivism which, at first sight, appears desirable for thinking about pain evaluations. Let us now examine in detail what this cognitivist commitment consists of.

Following an example given by Bain (2013), consider an agent standing before a rock that appears to him as large and broad. The mere perception of the rock is not, in itself, motivational, i.e., the mere presence of the rock does not provide the agent with a reason either for climbing it or for going around it. The agent will be impelled to act only if he has a desire to go around it in order to move forward. Compare this with a situation in which a subject submerges his hands in a jar of water hot enough to burn. In this case, unlike the former, the perception of the burning sensation (i.e., the pain) is itself motivational. That is, the action of withdrawing the hands from the water does not depend on a desire that might be posited beyond the representation of pain or independent of it. There is no need for a second-order desire to interrupt the process of pain that could be added to the very representation of the pain. As we have stated, according to Bain, evaluative representations of pain possess truth conditions and, therefore, point to a set of motivating reasons that justify the agent's behavior. According to Bain, such representations of pain play a role similar to that of beliefs and desires in the rationalization of action:

> "Like belief-desire explanations of action, pain explanations are perspectival and normative. An explanation of your hand-lifting in terms of your pain allows me to put myself in your shoes and see from your perspective why your action should have seemed reasonable to you. In short, pains figure in rationalizations; and crucially, evaluativists argue, they do so courtesy of their evaluative content. In particular, they are motivating reasons by dint of representing justifying reasons: you are moved to lift your hand because your pain represents a good reason for doing so, namely your hand's bad state." (BAIN, 2013, p.78)

Bain distinguishes this role of rationalizing pain behavior from merely causal explanations. He maintains that, apart from mere reflex reactions, pain states do not play a merely causal role in behavior. The point is not only which actions unpleasant pain motivates, but how it motivates them. This *how* is absent from merely causal explanations, which, for example, point to the heating of magma as the cause of a volcanic eruption.

What is missing from merely causal explanations? Bain is quite explicit in stating that what is missing is the agent's point of view. In the above quoted excerpt, it is clear that, in the explanation of actions, the interpreter places himself in the position of the other and considers the reasons that he (the subject) might have had for acting as he did. Understanding an action is, therefore, a matter of reconstructing the agent's point of view in a given interaction with the world. The expression "point of view" here means a stance taken by the agent toward his experience. This stance does not necessarily mean a reflective attitude taken by the agent on his experience through which he could describe it. It is enough that the world presents itself to the agent in a certain way. From there, he is able to consider what it is reasonable to do in view of the goals he seeks to achieve. To have a point of view is to be capable of taking a step back in relation to perceived stimuli, whatever the perceptual modality at play, and to act in a flexible manner. In other words, to have a point of view on the world is to be able to act intentionally, to go beyond mere immediate reactions. Along these lines, depending on what is perceived and evaluated in his own experience of pain, the agent may act in different ways - seeking medical care, taking an analgesic, or intervening directly in the sore region.

Up to this point we have, in broad terms, the foundations of the moderate cognitivist conception of traditional evaluativism. But it is important to note that evaluations concern values (in this case, positive or negative). For this reason, they involve an affective component through which the unpleasant character of the pain experience is expressed. How, then, can we explain this affective component? As we have seen, traditional evaluativists claim that affects permeate pain representations. Since the concept of affect admits diverse interpretations within the philosophy of emotions, it is crucial to clarify its meaning in the evaluativist framework. Nevertheless, it is surprising that this is not an issue developed in any great detail in their work (PRINZ, 2018). In what follows, we shall attempt to uncover the conception of affects present in traditional evaluativism.

What matters to us is to understand the concept of affect present in pain states. It should be observed that affects can evidently influence pain states, intensifying or alleviating them, for example. Furthermore, it would be important to investigate whether there is a specific affect for pain, or whether this affect, if it exists, also constitutes other mental states. However, the point we want to investigate does not concern the causal relations between affects and pain, nor whether there is a specific affect for pain or whether it could be present in other mental states. As we have stated, our point is more basic: namely, what is the concept of affect which, according to evaluativists, constitutes the nature of pain states on which the evaluative dimension is grounded.

The first point to be noted is that, at least for an important strand of the philosophy of emotions, there is a distinction between emotion and affect (TAPPOLET, 2004). Emotions are conceptually structured mental states that possess the property of being directed toward objects with which agents are in interaction (NUSSBAUM, 2001, p. 23-31). Affects, on the other hand, are more basic, non-conceptual mental states, and they account for the way in which we react to the world more directly. However, judging from the cognitivism present in evaluativist theory, this distinction is not evident. In fact, insofar as pain states refer to reasons that justify behaviors, we may say, according to traditional evaluativism, that affects track physical phenomena, which, in this case, are bodily damages, attributing to them negative value. Thus, affects are not mental states devoid of directedness. This highlights an important assumption, often implicit in the evaluativist framework: namely, that affects are directed toward bodily damage in the same way as the sensory aspects of pain. It seems that only in this way can affects figure in the process of rationalizing action. Therefore, for traditional evaluativism, affects are mental states as structured as emotions.

The considerations above allow us to point to an explanatory restriction of traditional evaluativism. Given its commitment to cognitivism, we may affirm that traditional evaluativism is restricted to cases of acute pain. Acute pain is pain localized in a given region of the body, which the representation tracks and is directed toward. Furthermore, typically, acute pains have a known etiology and they are not long-lasting, i.e., they tend to be resolved with the healing process. Recall what we have said about the agent's point of view. Such pain appears in a certain manner to the agent's interoception. He can point to it, use phenomenal descriptors to communicate it, evaluate it as more or

less disturbing, and so on. Moreover, the agent's perspective on the pain opens a spectrum of alternative actions through which he may reduce the discomfort that his experience can bring. The fact that he can act upon the pain indicates that he exercises, at least to some extent, control over it. In other words, he does not feel as though he is subjected to the coercion of causes over which he has no control. His control over the pain is precisely what allows, according to Bain (2013), a rational explanation of his behavior in relation to it. In short, having pain that is localizable and encompassed by its representation, his behavior becomes rational and fully intelligible to an interpreter.

The problem is that this case of acute pain does not do justice to the complexity of the pain experience. The subject's cognitive control over his pain experience seems to be present in very simple cases such as self-limiting pains, for example, a passing headache or a superficial cut.[6] However, in cases of more complex acute pains, it is not certain that the subject is able to maintain such cognitive control. In some cases of acute pain, the repertoire of actions available to cope with the discomfort of pain is severely limited and proves insufficient. Some examples include more intense traumas, acute pancreatitis, renal colic, and biliary colic.

With regard to such cases, it might be counter-argued that the subject does exercise some degree of control over their pain. After all, they may take medication, call emergency services, and so on. Nevertheless, the loss of cognitive control in these circumstances entails a reduction in the subject's capacity for agency, particularly in their ability to take a stance toward their own pain. We may further observe that this loss of control admits of degrees, rather than being an all-or-nothing phenomenon. Indeed, such a gradation of control may itself serve as an index of the complexity of acute pain (MOROGIELLO et al., 2018). To illustrate this notion of complex acute pain more clearly, consider the case of catastrophizing, where even pains that medicine might classify as simple are experienced by the subject as paralyzing, in such a way as to prevent any control on the part of the subject (SIMIC et al., 2024). These are cases in which the

[6] The idea of cognitive control involves a set of mental capacities that regulate thoughts, emotions, and actions in a flexible, goal-directed manner. It enables the agent to sustain attention, inhibit competing impulses and update mental representations. Moreover, cognitive control is closely tied to the notion of agency, since it provides the conditions under which actions can be ascribed to the subject as intentional. Thus, cognitive control is not merely a psychological mechanism, but also a normative feature of agency: it allows the subject to deliberate, to adopt reasons as motivations, and to resist being passively determined by external or internal pressures. For further discussion, see (BAUMEISTER et al., 2020).

subject feels at the mercy of the pain. There are no available alternatives of action through which he might circumvent the unpleasant aspect of the pain. In other words, he is incapable of taking a stance with respect to his experience. Unlike the cases described by Bain, then, here we have a case of acute pain before which the subject feels himself a passive being confronted with causal coercions.

Although these cases of complex acute pain already pose a problem for traditional evaluativism, the greater problem, in our view, arises in the case of chronic pain, a condition increasingly common in the world's population. It is certain that, as we affirmed in the introduction, pain is not a unified phenomenon that could be explained through the recruitment of a specific set of concepts. Nor is there a single mechanism that generates pain states. It is also not our purpose to move in the direction of a unified theory capable of explaining all pain states. Nevertheless, this does not invalidate the effort to expand, as far as possible, the explanatory boundaries of theories. As we shall see in the next section, the commitment to cognitivism, despite being moderate, prevents evaluativism from explaining chronic pain. Thus, we intend to show that, without this commitment, we can broaden the explanatory scope of evaluativism so that it may encompass more cases of pain than merely self-limiting pain.

2 – The Non-Conceptual Character of Chronic Pain

Chronic pain is defined in the ICD-11[7] as persisting for more than three months, at times even after the healing of the injury that caused it. It is a multidimensional form of pain and has a significant impact on the quality of life of agents, affecting their daily activities, sleep, and overall well-being. What concerns us here is to highlight the difficulty patients face in reporting chronic pain due to the opacity of their interoceptive experiences. Analyses of individuals suffering from chronic pain emphasize the difficulty of finding concepts capable of describing their experiences. On this matter, consider the following reports:

> "I try to speak to doctors about the severity of my pain. My words float strangely in the air. As I pronounce them, I myself become a spectator. As I soon as I begin to speak, I am no longer there." (WASSON, 2016, p;1)

[7] International Classification of Diseases, 11th Revision (ICD-11), World Health Organization (WHO) 2019/2021. Available at https://icd.who.int/browse11.

> "I honestly don't know what it is. And that's pretty frustrating a lot of times. Just the fact that I don't know what it is, you know. I've been frustrated with that. Well, what is this goddamn thing? Why do I have these headaches? The pain is something I can't do anything with. It's out there, it's something that I can't do anything with... It's really been hard for me to deal with that." (HILBERT, 1984, p.374)

> "It was like I felt that there was a part of me that they didn't know about. I couldn't tell people about my pain, so I felt distant and I felt different, I felt like a freak, and no one knew, but I knew I was different." (HILBERT, 1984, p.365)

> "It's like a demon in my head playing chess with me and he makes his move. Every once in a while I'll catch up with him, and then he brings his queen out. Stress definitely plays a part in it... but you never know what part it plays. Sometimes it'll play a part where... it almost seems like more energy. And many times it just drains the ever-loving daylights out of me, and you never know what's going to happen when. Therapists who thought definitely it was stress, they got me, you know, I'd start to think, yeah, that must be right, you know, I'd start to lean more that way. Then after I'd stop seeing them, I'd think well, no, that wasn't true. I mean that's why I'd stop seeing them, because I'd get sick of it. Some of the things I told are changed now. I'm telling you something different. I've had to make adjustments in the patterns. If there is such a thing as a pattern. I'm really not sure that there is... Maybe it can be the way you feel at the time of the interview." (HILBERT, 1984, p.372)

What stands out in these reports is the absence of control on the part of the individuals. It is certain that every pain experience involves some degree of loss of control, but this sensation varies in intensity. From the reports above we can infer that chronic pain seems to undermine the agent's autonomy, given that agents experience it as an uncontrollable and confusing intrusion. There is a neutralization of the sense of control and of alternatives for action.

Pain neuroscience has classified a considerable portion of these cases as nociplastic pain. Basically, nociplastic pain is a problem in the way pain information is processed by the interoceptive system (KOSEK et al., 2024). In fact, it has been empirically demonstrated, by scholars such as Oliveira et. al. (2024) and Horsburgh et al. (2024) that chronic pain severity correlates with poor levels of interoception, leading to the suggestion that loss of control in cases such as the abovementioned can be explained by a problem in interoception. It happens that, due to hypersensitivity of the central nervous system, there is an excess of information to be processed by interoception. In typical

interoceptive cases, certain physiological changes attract the agent's internal attention. In such cases, interoceptive content is easily assimilated into the agent's conceptual repertoire. Given the limits of attentional resources, we may call this content sparse. A typical situation in the case of pain is acute pain, in which interoceptive attention is immediately drawn to a given region of the body. And the mere possibility of localizing the pain generates some degree of control over its description. Chronic pain cases, however, are marked by an excess of information that simultaneously floods interoception.

As we have seen, the interoceptive ability in question concerns the capacity to discriminate internal stimuli through the use of attention. This is interoceptive accuracy, which exists in varying degrees. According to Oliveira et al. (2024), this accuracy performs a self-regulatory function, modulating processes such as temperature, digestion, and pain. The central focus of Oliveira et al.'s investigation was to verify whether a reduction of this ability, resulting in low accuracy, could have a causal impact on chronic pain. In general, the study considered questionnaires that addressed various parameters related to self-regulation, such as the ability to monitor internal stimuli, to avoid stress, and to distract oneself from pain, among others.

The results indicated that individuals with high interoceptive accuracy exhibited higher levels of attentional regulation directed toward bodily sensations, as well as greater confidence in their own bodies and in their ability to perceive them as a basis for self-regulatory behaviors. In contrast, the low interoceptive accuracy profile showed lower levels of bodily confidence and greater difficulty in dealing with bodily sensations, such as regulating internal states. The study suggests that patients with chronic pain face greater challenges in self-monitoring.

This issue was well elucidated in a recent meta-analysis. As in the experiment mentioned above, Horsburgh et al. (2024) concluded that patients reporting chronic pain present low interoceptive accuracy. Experiments that assess accuracy generally involve interoceptive tasks, such as counting one's own heartbeats. The results are then compared with objectively measured data. The closer the individual's performance is to these objective measures, the higher their accuracy. Several experiments have shown that higher interoceptive accuracy is associated with greater pain tolerance, whereas patients with chronic pain present low interoceptive accuracy. This indicates a lack of precision

in self-monitoring. Curiously, these same chronic pain patients report high levels of interoceptive sensitivity. This sensitivity concerns how much individuals claim to be aware of their own pain. To measure this type of sensitivity, the *Body Awareness Questionnaire* (SHIELDS, MALLORY & SIMONS, 1989) is commonly used, in which individuals self-assess on a scale from zero (not at all aware) to five (extremely aware). Strangely enough, research highlights a positive correlation between low interoceptive accuracy and high levels of pain sensitivity.

In light of these experiments, we can state the following: high interoceptive sensitivity, associated with low accuracy, amounts to precisely the opacity of the chronic pain experience to which we referred at the beginning of this section. What occurs is that, in the face of informational overload, the resources of interoceptive attention, which allow the agent to place his pain in perspective, are neutralized. In the absence of accuracy, what is lost is precisely interoceptive attention. This may explain what occurs in the reports of chronic pain we saw above, in particular, the agent's sense of passivity before a pain over which he is unable to take an active stance. Consequently, it is an experience that exceeds the cognitive resources of the agent, through which he could communicate the pain according to minimal standards of discursive rationality. In feeling powerless before a pain that floods his interoception, alternatives of action are not available to him. It is, therefore, an experience that does not provide reasons for acting. Given the non-conceptual and almost unspeakable character of his experience, it likewise does not seem possible for an interpreter to put himself in the patient's place.

In view of what we have argued in this section, it becomes clear that a cognitivist interpretation does not do justice to cases of chronic pain. Faced with this problem, the following alternatives arise: (i) to point to a strictly causal explanation, as in the example we saw concerning volcanic eruption, thereby abandoning any idea of evaluation; or (ii) to explore a naturalized idea of evaluation, through a deflationary conception of affect as negative valence, which does not involve a cognitivist commitment as a necessary condition. In the next section, we shall explore the latter.

3 – Affect as Negative Valence

In this section, we present our proposal regarding the nature of the evaluative component of pain states. We argue that this evaluative component can be understood as

valence. As we will see, this proposal leads to a primitive evaluativism, according to which the valuation of pain states does not depend on the exercise of reflective or rational capacities. The fact that valuations, understood as valences, do not depend on high-level cognitive capacities does not mean, of course, that they cannot be related to such capacities. With this adjustment, we believe that the evaluativist theory of pain not only broadens its explanatory scope, since it can account for cases of chronic pain, but also provides a better explanation of cases of acute pain.

Our first step is to return to what we have said regarding the understanding of affects as emotions in Bain's cognitivism. For him, affects are conceptually structured states and, as such, they play a role in "the game of reasons", i.e., they are capable of playing a role in justifying evaluations and behaviors on the part of the agent whose pain it is. It should also be recalled that the thesis that emotions can influence the experience of pain in different ways is not in dispute. What is at stake is the affective nature of pain states that could explain the evaluative dimension of the experience. Thus, how is it possible to think of the affective nature of pain states without the commitment to cognitivism? We shall defend the idea that this affective component can be conceived as valence. Once the role of this component in the experience of pain is understood, we can reach an intermediate level between strictly causal explanations devoid of agency, on the one hand, and rational explanations that depend on the agent's taking a stance toward his experience, on the other. As we shall see, this level may be regarded as intermediate because, despite passivity and lack of control, there is nonetheless a subject for whom the chronic pain experience presents itself as bad, most of the times, or even as terrible.

Commonly, the term "valence" is used to designate the positive or negative value of mental states. Thus, it is not itself a mental state but rather a property associated with mental states, one that carries a positive or negative value. Normally, the concept of valence is used in the philosophy of emotions. The idea is that emotions contain something that concerns their positivity or negativity. This "something more" is precisely valence. Beyond emotions, valence is a value-laden property that may be present in a considerable number of mental states. For example, hunger and orgasm are not emotions, but they typically have negative and positive valences, respectively. In the same way, pain commonly has negative valence even though it is not an emotion (CARRUTHERS, 2018).

Mental states marked by positive value tend to be maintained by agents; by contrast, mental states marked by negative value tend to be interrupted. To illustrate this point, consider the emotion of fear (PRINZ, 2018). Such an emotion is constituted by a series of physiological changes that can be monitored interoceptively, such as increased heartbeat, dry mouth, constriction of the throat, among others. These reactions are marked by negative values. As the agent accesses these reactions through interoception, the need arises to interrupt the process. Conversely, the set of reactions associated with the emotion of wonder, such as goosebumps, a sense of connection with the environment, and calm, are marked by positive values. In this case, the emotion of wonder is maintained as long as possible.

Broadly speaking, the valence of bodily states can be conceived as an adaptive mechanism that performs a fundamental regulatory function (DAMÁSIO; CARVALHO, 2013). It is a prospective and dynamic mechanism whose role is to guide an organism as it navigates a space of possible states, adjusting its behavioral dynamics accordingly (PEZZULO et al., 2015; HESP et al., 2021). This regulation is not neutral. It operates precisely through minimal normative asymmetries between preferable states and states to be avoided. In this sense, regulation is always regulation *toward* something, and this directness already implies an elementary evaluative distinction. The regulatory character of valence therefore does not exclude its evaluative dimension; on the contrary, it is the very way in which value is realized in an embodied manner within the organism.

This conception makes it possible to treat valence as a form of non-conceptual normativity. Rather than involving explicit representations that a state is good or bad, valence functions as a practical marker of "more of this" or "less of this", structuring gradients of attraction and repulsion that organize the agent's behavior. At this level, its evaluative component does not take the form of propositional content, but of a basic operational parameter that guides the dynamic adjustment between organism and environment. Put differently, valence structures the organism's ongoing engagement with its environment without encoding that process in descriptive or evaluative propositions. It is therefore a process involving an implicit, embodied, and operational form of valuation—one that does not depend on reflective or discursive capacities in order to fulfill its regulatory role.

One way of illustrating valence as a normative signal without representation is through the idea of a "bodily imperative" (KLEIN, 2015). As is well known, imperatives do not have propositional content that describes something as good or bad. Imperatives, unlike descriptions, do not represent states of affairs, nor are they true or false. Their function is to regulate conduct insofar as they point toward a state of affairs to be brought about. They impose an immediate practical orientation: "move away", "stop", "reduce this state".

From a neuroscientific standpoint, this conception receives strong empirical support (BEYELER, A. et al., 2018; WOJICK et al., 2025; KONG et al., 2024). A range of studies indicate that signals of positive and negative valence are encoded in phylogenetically ancient subcortical structures such as the amygdala, the basal ganglia, and brainstem nuclei. These circuits operate rapidly and automatically, and are directly implicated in the modulation of autonomic responses, action selection, and learning. Such findings corroborate the view of valence as a regulatory mechanism that biases the system toward approach, avoidance, or the interruption of certain bodily dynamics. Once again, then, valence should not be understood as the outcome of a reflective appraisal of the stimulus's significance.

In light of this conception of valence, let us consider how it applies to the case of pain. In acute pain, the regulatory function of valence is especially transparent. Valenced pain states enable the organism to regulate the dynamics of its adjustment to the world in ways that preserve bodily integrity. That is, in ways that keep it protected from physical damage. In this respect, valence in acute pain constitutes a strongly adaptive mechanism. Yet the negativity of pain does not seem to depend on the recognition of reasons, the possession of normative concepts, or the capacity to form evaluative judgments. This is evidenced by the fact that, even when a subject knows that a given painful stimulus is not harmful, as in the case of minor cuts to the skin, experimental contexts, or certain psychogenic pains, the unpleasant character of the experience may persist. Moreover, asymbolic subjects, who are capable of undergoing pain without negative valence, exhibit serious impairments in maintaining bodily integrity (BERTHIER et al., 1988).

We claim that, in acute pain, valence performs its regulatory function independently of figuring as a representation. This, however, does not preclude its being recruited by higher cognitive capacities (LEE et al., 2024). The key point is that the

valence of bodily states is neither encapsulated nor confined to subcortical areas in isolation from higher-level cognitive processes. The very fact that it plays a regulatory role in pain experience indicates that it is ordinarily integrated with interoceptive processing and action-oriented control. Indeed, if valence is a functional component integrated into systems of interoceptive attention and action selection, then it can be recruited by personal-level mechanisms to stabilize evaluations of the form "this is bad for me now" in episodes of acute pain.

It is important to note that the recruitment of subpersonal valence at the personal level does not require positing that valence is, in itself, conceptually structured. It is sufficient to recognize that valence is a neurofunctionally integrated component[8]: it is part of the mechanisms that modulate and structure the pain state in real time, thereby providing the support needed for explicit evaluative representations to emerge in a natural and stable way. In this sense, valence is available to interoceptive experience insofar as it imbues the conscious experience of pain with negativity. Similarly, valence can imbue exteroceptive experience with positivity or negativity.[9] Let us examine in more detail how this occurs in the case of acute pain and, subsequently, in the case of chronic pain.

In acute pain, there is a convergence of factors that stabilizes the process by which subpersonal valence is recruited to inform personal-level evaluative representations. Typically, acute pain involves high precision in interoceptive information: it has a sudden onset and an intensity profile that unfolds along a determinate temporal trajectory (RENN; DORSEY, 2025). This reduces ambiguity about what is happening in the body. Such precision provides the cognitive system with a reliable evidential pattern that can guide the interpretation of the episode. Acute pain also commonly allows for a more direct causal mapping, often anchored in a localizable and identifiable event. That is, the pain is experienced as the effect of a concrete injury or threat, rather than as a diffuse or indeterminate phenomenon.

Moreover, insofar as it is negatively valenced, acute pain often occurs in contexts where a corrective action is available: an immediate practical response capable of reducing the threat or modulating the damage, such as withdrawing one's hand,

[8] On neurofunctional integration, which includes the processing of pain signals, see (PESSOA, 2022, pp. 70–80).
[9] The idea that affects permeate exteroceptive experience can be found in Zadra and Clore (2011).

interrupting the movement, changing posture, applying ice, seeking care, and so forth. This element is decisive because it establishes a robust coupling between valence and control: the badness of the experience is not merely a marker of aversiveness, but an orientation toward an intelligible practical sequence (avoid, protect, repair). Finally, acute pain facilitates narrativisation, since the episode can be described in simple and temporally localized terms ("I hurt myself just now", "it happened when I touched it"). The experience thus tends to be rapidly articulated into a first-person report that preserves its causal and temporal structure.

Notice that this role of valence in acute pain can be accommodated within the theoretical framework of evaluativism proposed by Bain. To do so, we need only be more precise about the nature of the evaluative component of pain representation. As we argued earlier, one difficulty for evaluativism is its commitment to the idea that the evaluative component of pain states is constituted by structured emotions. By contrast, our suggestion is that this component can be understood, precisely, as valence. Under conditions of acute pain, negative valence functions as a control signal: it marks a bodily state as bad and, at the same time, efficiently orients the organism toward correcting the deviation. It is linked to bodily processes aimed at reducing damage, restoring equilibrium, and organizing action. In this sense, it is, so to speak, a component of the body's "navigation system" (PEZZULO et al., 2015).

Insofar as it negatively marks what is experienced in acute pain, valence contributes to the efficiency of causal traceability, action availability, and narrativisation. These processes unfold without high cognitive cost because the personal-level evaluation ("this is bad for me now") remains anchored in a relatively stable evidential pattern and in a well-calibrated practical response. Moreover, such an evaluation becomes linguistically shareable, since the subject can express the experience in terms that are intelligible to others ("I cut my finger", "I burned my hand", "I hit my knee"), allowing the evaluative dimension to become communicable, justifiable, and socially recognizable. Thus, in acute pain, the recruitment of subpersonal valence to the personal level not only occurs frequently, but tends to occur in a recurrent and successful manner, generating an experience that is at once affectively negative and evaluatively structured. In short, it seems to us that understanding the affective element of evaluation as valence is not only compatible with Bain's evaluativist framework, but also helps to strengthen the case for

a moderate cognitivism, insofar as it reduces the cognitive burden that might otherwise be imposed on rational processes of pain evaluation.

However, as we argued in the previous section, the difficulty is that chronic pain falls outside the explanatory reach of evaluativist theory. In chronic pain, there is an excess of interoceptive sensitivity: the body becomes a field of vigilance. The body is not merely experienced, but actively monitored by the subject. The subject becomes hypersensitive to micro-fluctuations in interoceptive signals, such as tension, fatigue, pulsations, and changes in temperature, among others. Yet, as we saw above, this does not amount to interoceptive accuracy. Rather, it amounts to an excessive detection of signals, an excess of "noise" that is perceived as relevant. This hypersensitivity thus takes the form of a regime of hypervigilance.

This hypersensitivity tends to generate a paradox: the more the subject attempts to monitor their own body, the more ambiguous signals they encounter (HORSBURGH et al., 2024). Low interoceptive accuracy means that the organism loses the capacity to reliably discriminate the source of discomfort, stabilize a report ("it is muscular pain", "it is inflammation", "it is exertion"), and predict what will happen on the basis of its bodily state. The result is a condition of chronic uncertainty: the body becomes a constant interpretative problem. And this point is crucial: regulatory negative valence depends on a reliable coupling between signal and correction. Without such coupling, negative value no longer informs how to act; it merely keeps the organism in a state of persistent alert.

For this reason, in chronic pain negative valence ceases to regulate and, instead, saturates the pain system. When there is sensitivity without accuracy, negative valence tends to lose specificity. Rather than "this is bad", it becomes "something in the body is bad". The organism fails to identify actions that resolve the pain state. The "less of this" is no longer paired with a "how". In addition, there is a loss of bodily dynamism. Instead of fluctuating with improvement and deterioration, the pain state remains constant. The agent thus comes to organize their life around threat, avoidance, and monitoring. That is, negative valence loses its regulatory function because it no longer operates as a useful marker of pain states. It becomes pervasive insofar as the body is felt as vulnerable, unstable, and unpredictable, such that pain ceases to be an event and becomes a mode of presence. In this way, the "negative" comes to constitute the very mode in which the system continues to function.

Finally, chronic pain also shows that primitive evaluation can become descalibrated without losing its normative character. The persistence of suffering does not result from the absence of value, but from the maintenance of a negatively oriented evaluative stance that no longer fulfills its original adaptive function. The body continues to be experienced as "wrong", "threatened", or "lacking", even in the absence of actual injury. Within an evaluativist framework, this phenomenon becomes difficult to explain if we retain a representational understanding of the evaluative component. Yet it is precisely the kind of case that primitive evaluativism is well suited to capture: an evaluation that not only does not depend on evaluative judgments, but can also lose its regulatory function insofar as it becomes disconnected from the mechanisms responsible for organizing action and, more generally, from other protective procedures.

Final Remarks

Our aim in this paper was to broaden evaluativism's explanatory scope. As we argued, evaluativism's commitment to a cognitivist conception of evaluation restricts its explanatory reach to only a subset of acute pain cases. In order to expand that reach, we proposed a form of primitive evaluativism. We argued that the primitive character of pain's evaluative component should be understood in terms of valence, which, by marking different pain states with a negative value, performs a regulatory function. As we have seen, valence integrates a range of dynamic mechanisms responsible for the organism's adaptation, including those that operate at higher cognitive levels. In this sense, valence can be recruited by cognitive capacities, yet it does not depend on such capacities in order to fulfill its regulatory role in pain. In any case, valence does not require any connection to cognitive capacities in order to play that regulatory role. Moreover, in cases of interoceptive hypersensitivity characteristic of chronic pain, valence ceases to perform its regulatory function and instead comes to saturate the pain system. What remains for the agent is a pain that cannot be readily described or localized, and that lacks a determinate temporal course, yet is nonetheless experienced as strongly negative. Consequently, conceiving pain's evaluative component as basic or primitive as valence allows us to expand evaluativism's explanatory scope without losing sight of its central *explanans*.

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