

Philosophy 132  
Philosophy of Mind  
Handout 16  
Friday November 2 2007

### *1. Different Roles for a Pain System*

There are many forms of damage to the body which bring about biological responses without central monitoring of either damage or response. Why should it be necessary for the organism to know of peripheral distress? Because the information is useful, or because the organism needs to be motivated to respond.

Informational: indicates to an organism the distressed state of the body or body parts in order to facilitate appropriate behaviour.

Affective/Motivational: a motivational system which constrains the organism's activity relative to the distress of body or body parts.

Charles lacks something through not having common pain experience which would interact with his ordinary motivational set and deliberation, but what is it that he lacks?

Is the possibility or impossibility of action always explained by the disvalue in a course of action? If one person succeeds in pressing a button where they risk the loss of a finger, where another fails, is the contrast between them a matter of the latter valuing his or her finger more than the life of a human being?

The concern of self-preservation has a motivational force over external and internal activity (what we can direct our attention to) prior to and independently of our valuing and affective responses to the world.

It thereby acts as a background and frame for what we do deliberate over. (And hence why Charles can be so irrational.)

The example of Charles the leper brings out the distinctive ways in which pain can be motivational in itself and the advantages for the organism of psychological episodes which have this role.

### *2. Affect and Subjectivity*

Pain Sensations involve:

- a.) a noticeable sensuous occurrence in a body part;
- b.) this controls or directs attention to that body part;
- c.) this is associated with a pattern of concern for the body part

*How the Concern Model explains the subjectivity of pain:*

Even if there is no disturbance in bodily tissue where one feels pain, still it hurts because what it is for a body part to hurt is just for one to be engaged in this kind of concern for the body part through the operation of the pain system.

Question: how does the model deal with the difficult cases for the subjectivity of pain?

What should we say about the soldier with trauma?

What should we say about being woken up by pain?

### 3. *Is the Affect of Pain Essential to It?*

A Philosopher's Example: suppose that all of the responses associated with a particular kind of painful sensation – say lower back pain – is associated instead with a particularly pleasant sensation – choose your own favourite example – but the behavioural consequences of each are exchanged. The intrinsic quality of a sensation is one thing; how it causes you to respond is another.

Pathological/Clinical Examples of Pain without Affect?

(A) The use of morphine

(B) Patients with pre-frontal lobotomies

Note the need to distinguish from cases in which (i) the subject lacks all genuine pain sensation, even if they still have other kinds of bodily sensation; (ii) the subject has come not to care about having pains, i.e, secondary affect is lost or suppressed, without the pain itself losing its primary unpleasantness

(C) Pain Asymbolia

In spite of apparently normal pain perception of superficial and deep pain, the patient showed a total lack of withdrawal responses. He tolerated prolonged pinprick or soft-tissue pinching in all four limbs, without adequate grimacing or defensive movement of his limbs. Neither did he show any response after sternal or supraorbital pressure, thus indicating a generalized defect. Such abnormal findings were constantly recorded throughout the daily evaluations of pain. On occasion, the patient willingly offered his hands for pain testing and laughed during stimulation. He had no concern about the defect and appeared highly cooperative during pain evaluation. (Berthier, Starkstein and Leiguarda, 'Pain Asymbolia: A Sensory-Limbic Disconnection Syndrome', *Annals of Neurology*, 24, 1988, p.42.)

Pain stimulation proceeds through broadly two dissociable pathways in the brain – a lateral and a medial route. The latter is connected to cingulate and insular cortices and the limbic system in general which is associated with affect and emotional response; the former connects to somatosensory areas of the cortex and to our capacity to discriminate location and qualitative aspect of sensation. Sufferers from pain asymbolia have intact lateral response but inhibited medial response.

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