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COMMENTARY

Reconceptualizing pain-related behaviour: Introducing the concept of bodily doubt

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When pain persists and becomes chronic, it can lead to disability, depression, loss of social identity, comorbidity and even premature death—and it is the most common reason people seek health care. Most treatments aim at relieving symptoms and preventing disability by helping people self-manage. A patient-centred approach requires that clinicians understand the lived experiences of people who seek their care and address these experiences in ways that are meaningful to them. In this commentary, we introduce the concept of *bodily doubt*, developed by the philosopher Havi Carel (2013), and explain how it can provide novel ways of understanding the chronic and disabling aspects of pain.

To make sense of how people experience and respond to chronic pain, researchers and clinicians have developed a variety of concepts, including pain-related fear, pain self-efficacy and pain catastrophizing. These concepts are foundational for models of pain-related behaviour, assessment scales and therapeutic interventions. But pain researchers also acknowledge that these concepts risk presenting an overly simplistic picture of how we experience and respond to pain (Crombez et al., 2012). We therefore propose that the phenomenological concept of 'pain-related bodily doubt' can complement the concepts currently used in pain research and clinical practice.

When we are healthy, able-bodied, and relatively free of pain, we operate with a tacit sense of *bodily certainty*: the feeling that our body will continue to function as it always has, performing daily activities and coping with new challenges. But, when injured or diagnosed with an illness, this certainty may be transformed into *bodily doubt*: the feeling that our body will fail to fulfil its previous functions, that our legs will no longer carry us up the stairs or that our stomach will not tolerate our next meal (Carel, 2013).

There are at least three core dimensions of bodily doubt that flesh out this experience. First, it involves a loss of continuity, a sense that one's life cannot proceed as before. The previous sense of normalcy is lost—one can no longer rely on former abilities or bodily habits. Bodily doubt can therefore be a healthy adaptation to an impaired or ageing body. Second, it involves a loss of bodily transparency. Rather than fade into the background of awareness when engaged in everyday habitual activities, one's body may become an explicit object of attention. Third, it involves a loss of faith in one's body. Importantly, bodily doubt does not manifest only as an explicit belief. Rather, it is better

understood as a tacit dimension of experience, a background feeling that shapes the implicit sense of what our body is capable of in any given situation.

This account of tacitly doubting our bodily capacities when ill or injured can help us better understand the complex motivations behind pain-related behaviours. Concepts such as pain-related fear and pain catastrophizing, for instance, refer to beliefs or emotions that are typically construed as maladaptive (Quartana et al., 2009). Bodily doubt, by contrast, can be adaptive or maladaptive depending on one's situation and circumstance.

Pain-related self-efficacy is perhaps the most similar concept to bodily doubt currently used within pain research and clinical practice (Nicholas, 2007). But it also differs in important respects. For example, self-efficacy typically refers to explicit beliefs about one's ability to perform an activity or cope with pain. The concepts of bodily certainty and doubt, by contrast, highlight a dynamic movement between implicit and explicit dimensions of experience. In some cases, a loss of capacity can shift how we perceive the possibilities our environment affords and how we interact with it, without attending to this shift. This implicit/explicit distinction may have important implications for how we communicate with and even conduct research on people living with chronic pain. Experiences that typically remain implicit are often difficult to reflect upon, much less put into words. Incorporating a new concept that is specifically meant to capture this dimension of experience may therefore be a boon for both research and clinical practice.

Conceptual models have thus far been unable to adequately capture the full lived experience of chronic pain, which limits our ability to understand and treat it. A new concept of 'pain-related bodily doubt' may complement current concepts and models. However, before we can bring this concept into clinical use, it will require further conceptual development and testing. We will have to (a) conceptually distinguish the concept of bodily doubt from other pain-related concepts currently in use, (b) conduct qualitative studies to establish how the concept of bodily doubt resonates with people living with pain and (c) develop tools for measuring and assessing bodily doubt in clinical contexts. Ultimately, this concept should provide clinicians with a better understanding of how people experience their own bodies and environments when living with chronic pain and provide patients with a concept for effectively communicating their experiences with their clinicians.

AUTHOR CONTRIBUTIONS

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