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Modalities of Body Experience in Illness and Health[1]

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Abstract

How do we experience our body in illness or health? This is a question that can easily comprise a book-length study. In this article a selection of basic distinctions are explored that may be especially appropriate for pursuing this question. Increasingly the health science professional is becoming aware that people require not only healthcare assistance, surgical intervention, or pharmaceutical treatment, but that the professional must be much more involved in the way that people experience and live with their problems in a different, sometimes deeply personal and unique manner. It is argued that nursing especially is involved in helping the patient, the elderly, the disabled, or the person who for reasons of circumstance is out of step with the body, to recover a liveable relation with his or her psycho-physical being.

At a research conference, two professors, one in nursing education and the other in mathematics education, were engaged in a public discussion about hospital baths. The nursing professor had described the bath in a research presentation as a unique nursing situation where the essence of nursing as caring for the whole person is exemplified. Her portrayal was sensitively drawn, showing how in the bathing of the patient the nurse has opportunity to observe psychological and physical symptoms and to relate to the patient on a deeper and more personal level.

> As I uncover the person, I also uncover myself, open myself to this encounter. Just as the body parts are discreetly uncovered and washed, so in a sense, are the patient's innermost thoughts and feelings uncovered, attended to and touched in a healing manner.

She spoke of a certain symmetry and reciprocity in the relational sphere between nurse and patient. She also criticized the tendency by hospital administrators to relegate bathing to volunteers, helpers, and aids who lack the qualities of the healthcare professional.

The people in the audience were impressed by the descriptions of the bathing. The lowly bath seems indeed to involve a higher wholistic healing relation between nurse and patient. A discussion followed about the nature of healthcare and the need to understand better the healing role of the nurses, physicians, nutritionists, psychologists and other practitioners in the healthcare process. But then the mathematics professor spoke up.

The mathematician had recently experienced congestive heart failure and had undergone emergency by-pass surgery. He recalled the bath as a healing experience. But he was less able to relate to the "higher value and wholistic relationship" through which the nurse had described the importance of the bath. "As a patient," he reminisced,

> my experience of the bath was emersed in a state of psychological density due to the physical trauma of the cardiac arrest I had suffered, and the various medical procedures that left my body sore, numbed and damaged, with tubes sticking out from all sides. In the preceding days I had been stripped, bared, and poked so many times that I no longer felt any indignity about lack of privacy and possible insults of immodesty to my body or its parts. Many of the hospital experiences I now hardly remember. But I remember the bath and how my body felt, and, really, it was hardly a spiritual experience.

I was intrigued by the somewhat provocative exchange between the nurse researcher and the mathematician. So I followed up with a discussion after the session in which I asked the mathematics professor to describe to me in more detail what was the nature of his bath experience during post-operative convalescence. These are his words:

> The bath was a thoroughly visceral experience and the relation to the nurse, too, had that quality of utter physicality. Somehow she seemed to sense the threshold of my body's tolerance for pain and touch. The nurse was washing me, stroking, scrubbing and refreshing my sore and tired body in a way that I experienced as extremely agreeable and consoling--yet there was not a hint of arousal in the experience. I remember that the nurse talked to me all the while she washed my body, although I was too foggy to now remember what she said and what I may have said. It does not matter. I just remember the bathing. How I simply felt so much better, physically better in a way that was indeed experienced as healing. That is the best word I have for it, 'physical healing'. The nurse touching me had a peculiar effect: I was allowed to be myself and to feel my own body again. Later, once I started to feel better, I had to bathe myself.

How could this experiential description be interpreted? First, this story may remind us of the simple phenomenological precept to always try to understand someone from his or her situation, from the way he or she experiences the situation. As physician, nurse, psychologist, teacher, social worker we may think that we know what another person feels; we may believe that we are in a certain way caring and are treating his or her physical and psychological needs, but if this *person's experience* of what we say and do differs from what *we believe* we do, then we may need to suspend our belief in favor of the person's experience.

Second, the anecdote illustrates the complex and ambiguous quality of the experience of the body for the person who is struck with disease or injury. The mathematician obviously experienced his body in a manner very unlike what he was used to in his healthy life. His body had become a source of pain and trouble, a manipulated object that was simultaneously experienced as alien while undeniably himself.

Third, the mathematician speaks of physical healing. The bath made it possible for the patient to feel, not only the comfort of the *nurse's* touch, but his *own* body, *his* whole embodied being. He says, “I was allowed to be myself and feel my own body again.” The physical touch of bathing made it possible for him to re-experience his own skin, his own physical being—in other words, his own self.

Therefore, a fourth point is that in this little narrative there is embedded a thematic way of understanding the experiential nature of healthcare for a patient. The

mathematician's account seems to suggest that the healing relation of the nurse consists precisely in the ability to reunite the patient with his body. Indeed, it is the broken, disrupted, or disturbed relation with the body that seems characteristic of almost all experience of injury or illness. Even people who do not suffer from illness but who benefit from nursing care for reasons of maternity, sudden handicap, or problems with old age are often in need of finding a *liveable relation* with their bodies. In all these contexts, the meaning of healthcare seems to involve the intent to reunite the patient into a liveable relation with his or her body.

The mathematician spoke of another event that raises questions of the involvement of the lived body in illness. He said:

> It was especially during this experience of convalescence that I felt physically confused. Just the short distance to the bathroom seemed like a major project for which I had to plan and get ready. I began to watch my body for strange signs of pain and disquieting irregular symptoms. You see, the odd thing is that, while taking my walks, I became very aware of my pulse and circulatory system. I was very conscious of my heart beating very fast, much too fast. After I walked down some steps in the hospital my heart would just take off and then not seem to know how to settle down once I took a rest. It was quite an alarming sensation, as if my body had become alien to me. I needed someone to understand this, to reassure me, to explain what was happening to me and get me in proper touch with my body, but nobody seemed to know how I felt and what I was going through. And my heart did not seem to realize that it should moderate after the walk was over. The experience of tiredness and of being aware that my brain was all screwed up was also very strange. I would be having a conversation with a nurse or visitor while being so conscious of my tiredness and my scrambled brain, yet the person with whom I was talking did not seem to have the faintest idea. So here I was, talking, while enduring simultaneously this overwhelming sensation that I could not really bear the conversation. This condition of confusion, fatigue and inability to concentrate lasted for several weeks, and in smaller ways, even months.
>
> Gradually things started to settle. I know that this sounds strange and bizarre, but I had the uncanny feeling that my body was taking charge of things, that my circulatory system was relearning somehow the things that it had forgotten how to do.

What I would like to do now is to place these experiential accounts of cardiac illness in the context of some themes of the phenomenology of the body as encountered in the literature. It appears that several modalities can be distinguished. I want to stress, however, that any phenomenological distinctions are only valid to the extent that they inform, confirm, value and validate one's own possible experiences from the perspective of the lifeworld of the subject.

I shall distinguish five basic experiential dimensions that occur in the literature and that seem to resonate with life as we recognize it in anecdotes of illness. I am certainly not suggesting that these five experiential dimensions are exhaustive categories of body experience. Inevitably, these are selective conceptual or thematic simplifications. I have tried to be observant of distinctions that have implications for discussions of illness and

health. Not included in these distinctions are the ways we might experience the dead body of a loved one, the body as constituted by gendered awareness, and so forth.

(A) the body experienced as an aspect of the world
(B) the body experienced as observed
(C) the body experienced as reflective
(D) the body as experienced in the modality of appreciation
(E) the body experienced as call

Each of these dimensions can then be divided into two modalities with respect to the question of whether they concern one's own body experience or one's experience of the other's body.

(1) the body of self as an aspect of the world
(2) the experience of the other's body as an aspect of the world
(3) the body of self experienced as reflective
(4) the experience of reflectivity of the other's body
(5) the body of self as self-observed
(6) the body of self as observed by the glance of the other
(7) the body of self as experienced in the modality of appreciation
(8) the experience of appreciation of the other's body
(9) the body of self experienced as call
(10) the body of other experienced as call by other

These different modes of experiencing our bodies are not offered as theoretical concepts; rather these distinctions aim to describe and frame some common aspects of some possible human experiences that one may be able to recognize in one's own life. The phenomenological approach asks of us that we constantly measure our understandings and insights against the lived reality of our concrete experiences, which, of course, are always more complex than any particular interpretation can portray.

I want to reiterate that these experiential distinctions leave out many other possible experiential qualities that we may discern in the experience of our bodies and the bodies of others. For example, body experiences that tend to be more gendered and body experiences that may be unique to female as compared to male sexuality are not considered here. As well, it is quite possible that in various cultures and subcultures different and distinct nuances of body experience are at play.

In making the following distinctions I orient myself primarily to the literature of the phenomenology of the body as we may find it in the classical works of Sartre (1956), Van den Berg (1953, 1953), Rümke (1953), Merleau-Ponty (1962), Levinas (1981), etc. I will be the first to admit that life is always more complex than any description or interpretation that we may attempt. Phenomenologists like the ones mentioned above did not ask themselves how the body experiences of women, men, children, elderly people, fashion models, ballet artists, athletes, performers, physically challenged, or other groups of people may possess unique and different qualities. For example, the objectified body may acquire different value in the gendered look, in the predatory gaze, in the lover's glance, or in the artist's eyes. The distinctions made here are quite introductory. Nevertheless, I hope that some of these distinctions resonate with health care providers

who need to be aware of how the body is experienced in various modes of wellness or illness, comfort or discomfort.

1. The body of self as as an aspect of the world

The most common manner of experiencing the body is in the mode of near self-forgetfulness. Sartre (1956) speaks of the body as "passed-over-in-silence," le passé sous silence, because we do not ordinarily notice the body much while we are walking, reading, driving a car, teaching a class of students, preparing supper, and generally conducting ourselves in a normal or healthful state. And even this is too general a statement to describe our lived experience, because when I am walking it is not the act of walking that keeps me preoccupied. Rather, I am walking to my classroom from my office, or walking to the blackboard from my place in the room, or walking down the street for shopping at the cornerstore. It is not the physical movement of walking itself but the meaning this walking acquires in my daily projects that makes a stroll along the river valley with a friend different from a walk to the corner mailbox or a walk down the hall in a strange school or hospital. Of course, this does not mean that we are completely unaware of the body or that we cannot recall particular aspects of the body in its silent modality. When we speak of our body as an aspect of our world then our sense of it is a kind of unaware awareness; indeed, our primary occupation is in the world and with the world: with our projects, purposes, relations with others, and the places we travel or inhabit.

Disease too shows itself not always directly or only as a body sensation but also as a changed physiognomy of the world. When I feel the dulling sensations of the flu then my whole world seems to turn dull. We may first discover that we are ill, not because we feel body symptoms, but because we notice how changed aspects of the outside world become symptomatic of something that must be wrong within us. The food looks less appetizing, the radio is too loud, the sunshine too bright or the overcast sky too depressing. Everything seems to become too much, too difficult, too cumbersome. Quite literally the world has become sick. And so, when in the morning I drop everything I touch, I may say to my spouse: "everything is falling down, maybe I'm coming down with something. I wish I could go back to bed."

2. The experience of the other's body as an aspect of the world

When we meet other people in everyday life we first of all meet them through their bodies: a welcoming smile, an outstretched hand, a reluctant gesture or a shy look. And yet, while the body seems to press itself to the forefront and while we are no doubt aware of the other person's embodied state of being, we rarely think of the other person's body; instead we engage in a discussion or work on a shared project. So, just as we bypass our own body in favor of the things in which we are involved, so we may bypass the other person's body who is similarly engaged in the world. We participate so much with the other person's embodied existence that their words become our words, their gestures our gestures. Therefore, it is not surprising perhaps that we may even catch another person's mood or feeling of tiredness as it may be expressed in a sympathetic yawning. Suddenly, in the company of this person, we feel how tired we are while previously we seemed to feel fine.

Sometimes, when we are less engaged and more observant of an other person then we become aware of how that person is emersed in his or her world. For example, I see my son riding his bike down the street, on the wrong side of the road. He does not notice

me, but I see how aptly he steers his bike around parked cars while his hands are not even on the handle bars of his bike but in his coat pockets. I know what that feels like, I have ridden the bike like that myself. My son is totally absorbed by the road while avoiding the curb and the potholes and he does not seem to realize himself how marvelously he is using his feet, legs, and upperbody to keep his balance. In a sense he must forget his body, which I now see, in order to proceed on his bike down the street while avoiding oncoming traffic and without crashing into parked cars. I cannot help but admire his physical skill. Simultaneously I am struck by how much he has grown in the last year and it may occur to me that he is in great need of a haircut. This is my experience of his body.

3. The body of self experienced as encumbered

It is exactly because a person's well-being is disturbed that he or she can no longer live in a self-forgetful, passed-over relation to the body, and to all other dimensions of his or her world. Serious illness changes everything: our sense of time and priorities, our experience of space, our felt relations with others, and our sense of self and of the body. At the moment when our wellness is disturbed then we discover, as it were, our own body. We might say the body reflects on itself as body. We discover the object-like nature of our body when the unity of our existence in the world is broken. This happens when we notice something that is conspicuous such that we begin to reflect on it. A painful sensation in the abdomen, a suspicious lump under the arm, a discoloration of the skin, a strange tightness in the chest. The conspicuous disturbance always possesses the character of an encumbrance, something that confronts us, something that stands before us as it were, and hence the experience of object, the disease as entity. When we sense something conspicuous then we tend to worry. It is when this relation remains disturbed in a disquieting manner that we exist in a protracted state of “dis-ease,” literally un-easiness.

Sometimes only a reassuring explanation is required to appease us and to help us to resume or rebuild an unbroken relation with the body and thus with the world. The power of explanation is quite amazing. A woman experienced for several years unsettling body sensations: partial paralysis, discomfort, and fatigue. She was submitted to a multitude of examinations: broncoscopy, catscan, MRI, and many other unpleasant tests. At one point she was sent to yet an other specialist. He asked her simply to make a piano movement with the fingers of one hand, which she did easily, and then with the fingers of her other hand. “Well,” he said, “it is quite clear: you have Multiple Sclerosis.”

The woman promptly broke down in tears--but not from fright or distress. No, she said, she cried from relief. Finally, after all these years, someone had named her illness. Even though the verdict was terrible, she experienced this diagnosis as an alleviation. She said, “When I now feel disturbing symptoms I can tell myself: 'This is what it is. This is what I have to live with.' It allows me to give the disease a place in my life.”

Explaining can heal, in the sense that it prompts us to a less anxious, more reflective relation with our body. Many people now and then experience something that is worrisome, but usually the diagnosis is reassuring. The physician explains that it is the flu or a bladder infection; and, along with some medication, the explanation is often already enough to make the person feel somewhat better. We soon continue to go about our everyday business, forgetful of our body.

If, for reason of physical discomfort or pain, we had to keep reflectively focussing on our body's state of being while teaching a class of students or while having a conversation with someone, then, as in the case of the mathematician, we would notice

how difficult it becomes to continue in these activities. We would probably experience the situation as unbearable, unnatural, articifial, or forced. It is significant that it is much more difficult to describe the experience of health than the experience of illness. People who are trying to study health or well-being rather than illness discover that the elusiveness of the phenomenon of health parallels the elusiveness of the ordinary experience of the body in its "natural" taken-for-granted or silent modality. As long as we are healthy we may not have reason to take notice of our corporeal being. Unlike a healthy marriage relation which is threatened by the taken-for-grantedness of its partners, a healthy body relation thrives on the smoothness of forgetfulness.

But the body is never completely out of our field of awareness. The body is experienced as passed-over-in-silence; nevertheless, the silent body is prereflectively at the center of our existence and thus, in a mode of unaware awareness, it remains the source of all our activities and feelings. This is true for healthcare professionals as well as for the patients with whom they must deal. The significance of the recognition of the body as passed-over-in-silence for healthcare is that we must learn how to teach the patient, and also the patient's family, to reclaim or reconstitute as best as possible this dimension of the body in its wholly or partially unemcumbered state. This self-forgetful state is what the mathematician was trying to recover.

4. The experience of encumbrance of the other's body

While we must, in a sense, "forget" our body in order to be able to focus attention and awareness toward the projects in the world in which we are engaged, someone else may quietly observe our body and study the manner in which we accomplish things. This then is the body in the fourth modality, as it comes into being under the eyes of someone else. In other words, the body of the other whom I observe becomes my experience.

In The Life of Illness Carol Olson gives witness to the intricate involvements of the way we may experience the other's body as it is encumbered by illness. Carol has been on dialysis for more than twenty years, but what she remembers most from the time in 1971 (when like her other brothers and sisters she too was diagnosed with genetic kidney failure) are tales of the body. She had ample opportunity to observe how the disease ravaged the people around her. For example, she recalls waiting in the dimly-lit hall of the dialysis unit when she noticed Jim, another dialysis patient. In Olson's words:

> I saw Jim leaning against the wall, gasping for air. He was hunchbacked and barrelchested with bone disease. I could see the pain vibrating in him, burning him. And darkly, the fatigue encircled his eyes. Staring at him, I feared my pain. (1993, p. 169)

What Carol saw was somebody's body--a diseased object. And she saw his body with her own body, knowing that his fate was her fate. In a way she already experienced her own body as reflectively engaged in the diseased guise of an other. But the next moment Jim returned her glance, and Carol knew herself as looked at. She says:

> Then he smiled at me. And in his eyes, I saw how strong was this suffering man; how strong, his kindness towards me, how strong, his dignity. I believed if he could live, so could I. I came away from this encounter with new courage. (1993, P. 170)

In this relational regard of the body, Olson found the strength to accept her own diseased body and the life of illness that was in store for her.

It can happen that I meet a friend and that I notice something unusual: he is leaning heavily on a table and he is straining his eyes. “Is something wrong?” I ask, “Are you feeling all right?” My friend may be quite surprised by my question. “Yes, I’m fine. Why do you ask?” Only when I insist that he seems out of sorts may the self-awareness of feeling unwell actually announce itself. Thus, one person may detect in the body of the other person one’s state of well-being from the manner in which he or she is in the world.

Some experienced medical practitioners have developed an uncanny ability of sensing a patient’s state of health. The colour of the skin, the body’s composure, an overly cautious gait—all these may be signs of an oncoming illness or emerging handicap that has not yet fully revealed itself to the person. Similarly, experienced nurses may have an unusual ability of sensing a patient’s critical state or level of comfort or discomfort. A post-operative patient may discover with grateful relief how a small adjustment to the tubing can make breathing easier or swallowing less painful. An experienced nurse may have developed a perceptive eye that can spot trouble in the state of being of a patient even if the nurse is not able to give an explicit reasons.

The implication of our experience of the *other's* body as object for *our* scrutiny is that this modality also makes possible the objectifying medical look and the detached scientific attitude towards the object body. The healthcare professional, the doctor or nurse, meets a person, a patient, who stands in a encumbered relation to the body. And when an illness has manifested itself then it is clear that the sick person cannot, is not allowed to forget his or her body.

5. The body of self as self-observed

But, just as we can see the body of the other in its external dimensions, so the person himself or herself can also do this. For example, we may look in the mirror and observe the shape of our body. Or we can focus on a part of our body and regard this hand or this leg with an almost detached curiosity. We may even feel a kind of existential amazement that this hand, this curious object is a part of our body. This then is a third experiential modality, when one's own body becomes an object for one's own scrutiny--and this occurs especially when the body is rebellious and unreliable.

When we feel sick or we are injured, but we need to climb the stairs or participate in an activity, then the body rebels and refuses to cooperate. When the rebellious body does not want to do, or objects to doing, what *you* want to do, then it announces itself in its objectness. My body lets me know that I am unable, disable— “unable” means literally that I “cannot easily handle,” that I “cannot keep a hold” of things. It is telling that the term ability is related to habilitas, habit or silent routine--as in the silent body. The body has become unreliable; and if I persist in my effort then it may fail me. I become unsteady, slip, let go of my grasp. Or my body protests by acting up and turning overly sensitive and painful. The painful body is not a body constantly in pain; rather, it pains when I try to do something that I am unable to do. And thus I become sensitive to my sensitive body.

But even in a situation of health one's body may play unexpected tricks. You see, almost as soon as my son saw me, he fell off his bike, whereupon he examined his wounded knee just as he examined his bike to determine if either needed some repair. Both the body and the bike were evaluated for their functionality not unlike many an athlete examines the foot as well as the footgear for its instrumental functionality.

However, we are never totally objectified. It is true that each of us can objectify his own body, and manipulate aspects of his appearance or physical condition. Nevertheless one's own body is an object different from all other objects. Merleau-Ponty (1962) has shown this well in pointing out our special relation to our own body. If I am unhappy with the way I look or if I worry about my physical health, then I can try to ignore or suppress the demands my body makes on me, yet I cannot hide from my body. While I can hide my body and thus my-self from the view of others, I cannot separate my body from my sense of self. I can never study my body, be separated from my body, or leave behind my own body in the same way as I can do with other objects. I cannot even see my body in the same way that I can see other bodies or objects. Rather, my body makes it possible that I can see, hear, feel, sense other things in the world. Because I have a body I can explore the things of the world. But I do not have a body by means of which I can explore my own body; rather my own body is such that all other bodies can be there for me and for themselves (see O'Neill 1989).

The healthcare profession is acutely aware of the modern complaint that some physicians, medical technicians, and even nursing staff suffer from a dichotomizing cartesian blindness. They sometimes forget that, in a manner of speaking, there is a person attached to the body. After separating the body from the mind they only have an eye for the body. Recently the healthcare profession has become more aware that illness, disease, healing, and health cannot really be properly understood when the physical is divorced from the spiritual. Reflectively and prereflectively we experience our selves as embodied beings in an inspirited world that confronts us in its materiality, but of which material we are also made. The flesh of the world is our flesh, said Merleau-Ponty (1962). The corps-sujet is that materiality through which we incarnate our understandings, moods, and our fears, anxieties, loves, and desires. Both, body and mind, should be viewed as complex aspects of the indivisible being of the person as he or she exists in his or her world.

Nevertheless, the health-care professional must regard the body-person, at times, in an objectifying body-mind (di)vision. We must observe as well that it is the patient who constantly invites the medical doctor to think in a cartesian manner. The point is that the patient himself or herself cannot help but think this way when consulting the physician with a complaint about some conspicuous physical disturbance. I have begun to notice an irregularity about my body and I become suspicious: is this a sign of some terrible disease? For example, I may feel numb in my arm and I may see it as an oncoming cardiac event or as a sure sign of a stroke. In earlier times one might have suspected the presence of evil spirits giving rise to a debilitating paralysis. Or an affliction was interpreted as a punishment for sins committed. But the modern person lives in a scientized culture and cannot help but adopt the diagnostic attitude of medical science.

So I ask the physician to do what I do and examine my body to determine what is wrong with it. Now, the complaint "I feel sick," "I feel a pain in my abdomen," requires an abstraction, a cognitive objectification of the body sense. The feeling of unwellness has become an awareness of an entity that is a disease. I feel as if some-thing is affecting me, and I say: "I have come down with something" or "I've got something."

Accordingly, for a physician to adopt an objectifying view of a patient's body is in itself not a dehumanizing activity. On the contrary, the many modalities of body experience I mentioned all speak to the complexity and miraculous nature of human existence. In everyday Dutch and German language there exists a common distinction

between lichaam and lijf, Körper and Leib. In English this distinction can only be made somewhat awkwardly using the concepts physical body and lived body. The (objectifying physical) body is an aspect of the lived body, not necessarily its opposite as is often suggested with the distinction object-body and subject-body. Rather, the physical body is the form in which our lived body can show itself as object. It is only when the relation between physical body and lived body is broken that we may speak of an alienated corporeal existence.

6. The body of self as observed by the glance of the other

What happened is that my son on his bike had suddenly seen me. Immediately he cheerfully called me and maneuvered an agile turn-a-bout. This is the fourth experienced modality of the body which happens when the person becomes aware that someone else is watching him. My son caught my admiring glance and he felt himself confirmed in my eyes. Sometimes he loves to show off for his father! But when, the next moment, he also noticed my grim face, and realized my annoyance at his irresponsible biking style, he hesitated, tried to pull his hands from his pockets, lost his concentration, swung wildly off balance, and crashed against the curb. In the space of just a split second, he found out what Sartre says: that when someone watches you, his or her look can be experienced as confirming or as criticizing, positive or negative, subjectifying or objectfying--actually Sartre only had an eye for the negative consequences of the objectifying look; and in this case my son would have agreed with him.

Sartre could be criticized in that he focused mainly on the manner in which the look of the other may rob us of our subjectivity and make us feel like an object. It is indeed a painful experience when, as a patient, one feels as if the sick body has become a thing at the disposal of the medical workers rather than a thing which is meaningfully integrated in one's own life projects. This is how one may feel when one is moved about, fed intravenously, ignored while tested, discussed by others, placed in waiting in the dental chair or in anticipation of treatment, lab work, surgery, or simple recovery.

However, the experience of one's own body can be qualified by the look of the other in several ways. First, if the other person looks at me in a way that partakes in whatever it is that I am doing, then this look allows my body the transparancy of *passé sous silence*. For example, when I am speaking up in the group or when I am a student demonstrating my skill at a mathematics problem in front of the class on the board, then the participatory look of the others allows me to forget my body and focus on my task. This is possible because the look of the others, the teacher and the students, is engaged with me at the blackboard. And if the situation is routine and things go well then I will feel confident, complete my job and return to my seat. In other words, the participatory look produces the passed over, self-forgetful body.

But if the look of the other does *not* center in my landscape but stops in my body then this look can do two things: either it objectifies and makes my body into a thing, an object, or the look may in fact intensify my subjectivity and give me the exceptional right to be myself as someone who has this body. Almost every school child learns the experience of the objectifying critical, mocking, disapproving look with which other kids may sometimes regard him or her. It is the look that produces body image nicknames, such as fatty, skinny, sticks, red, chunk, pimple farm, zit face, crater face, thunder thighs, flab, buns, pecks, pipes (these are some names my kids rattled off). The problem is that

self-consciousness produced by the objectifying look of others makes it very difficult to focus one's attention to the things or the task in which one is engaged.

It sometimes happens that you are doing something or talking with somebody and suddenly you realize that the other person is no longer just listening and responding to you, but is now observing your hands, your gestures, or some other aspect of your body. Teachers and especially psycho-therapists may make the mistake of regarding the other with such a scrutinizing look that their glance hinders the pedagogical or conversational relation that is essential for learning or insight to occur.

And, of course, women know how the look of the male may reduce their sense of self to a mere body as sexual object. Similarly, the child in the wheelchair, the cripple, or the person with physical deformities experiences his or her body as conspicuous. The sexually objectified body or the disfigured conspicuous body is the self-conscious body that knows itself as being looked at with curiosity, aversion, or badly disguised disgust. But, of course, the opposite is also possible. The look of the other may also enhance my feeling of self and subjectivity as in the affirming look of lovers, or as in the experience of the child who calls out, “Look at me, Dad! Look at me, Mom!” This shows that the sixth modality of the body is established in a relational climate; and in this relation the body can be experienced as justified or as denied by the glance of the other.

7. The body of <u>self</u> as experienced in the modality of appreciation

When I become aware of my greying hairs, the aging shape of my own body, the medical condition that changes the way I am used to doing things, or the sudden invasive illness that threatens my life, then I may feel regret at my lost youthfulness or I may feel betrayed by the deceptive disease that has so radically changed my relation to my body and to those parts of my body that are so much my own and so thoroughly familiar to me.

For the person who suffers from severe arthritis the illness is visible in the gnarled strange yet familiar hand. Illness is situated in the experience of cherished parts of one's own body that are familiar and yet may feel strange. Even the general body can be experienced as unacceptable, as in the extreme case of anorexia nervosa (starvation) or bulimia (binging and purging).

The primary appreciation of one's own body may be easily disturbed when we are in the company of others who make us aware of the idiosyncracies of our gestures. I may notice how, while talking with someone, this person seems to be noticing something strange or unusual about the way I talk, the way I look, or the way I use my hands. The self-consciousness created by this appraisive look may turn embarrassing or troublesome when I sense that the person seems to be making a negative or disconcerting judgment about me. So I cannot help but wonder: Do I look sick? Am I making a fool of myself? But it is also possible that the other person suddenly says something flattering. Experiences like this may eventually have certain lasting effects on the nature and quality of the intimate appreciation of one's own embodied being.

Body dissatisfaction is quite common among women and also among men, leading to feelings of low self-esteem. Moreover, many people seem to live in peace with the shape and nature of <u>some</u> parts of their body and in a certain discord with <u>other</u> parts. In a classic article, the phenomenological psychiatrist Rümke (1953) discusses the experience of repulsion of one’s own nose, an issue rarely discussed in the medical literature though plastic surgeons continue to profit from people’s negative appreciation of aspects of their appearance. No doubt there are cultural and gender dimensions to this phenomenology of

body appreciation. It can also happens that one experiences hate, sorrow, or sympathy for some part of one's body. And, in contrast, a part of our body that does not meet with our own approval may contribute to an unexpectedly experienced justification of well-being of the whole body: for example, when being touched, when massaged, or when making love.

The patient in pain, the woman in childbirth, the person recovering from surgery may experience such total sense of surrender to the care of the other that this other is not experienced any longer as a person who may hold judgment about me, who may criticize my behavior, who may objectify my naked body. For a patient in such condition it may not matter any longer that under normal circumstances he or she is quite modest or bashful, quite reluctant to undress in public, to be dressed in clothes that are revealing of body shape. He or she may feel ashamed of being overly fat, thin, or ill-shaped. And yet, this person, now made vulnerable by a medical emergency, the painful labor of childbirth, the physical trauma of an accident, has totally surrendered to the trust of the caring other.

8. The experience of appreciation of the <u>other's</u> body

It is also possible, and even common, that we develop an affective response toward the body or toward certain body parts of the <u>other</u> person. Kouwer (1953) has pointed out that one may cherish an immediate and inexplicable positive or negative appreciation for another person's face, hands, mouth, hair, neck, or his or her general body appearance. Moreover, the experienced physiognomy of the body seems to express aspects of people's character. One's own body is probably always involved in some manner in this affective appreciation of the other person's embodied being. And so, for some people to see obesity in others may create strong feelings of nausea or disgust.

Sometimes a negative appreciation is associated with disfigurement or owed to a certain gesture that makes the other person's body become unacceptable. For example, when I see young people who have engaged in the increasingly common practice of having rings or pins inserted through their noses, I am not yet able to disregard the almost physical sympathic sense that this piercing of a sensitive body part seems to evoke in my own body--it almost physically hurts me. The repulsiveness of certain parts or diseased aspects of the patient's body may carry negative appreciative meaning. The disparaged face of illness shows in the refusal of some physicians to treat patients with serious contagious diseases such as AIDS. And, of course, the now routine measure of putting on protective gloves before touching any part of the patient's body may stimulate in the patient also an ambiguous sense of those covered-over hands as well as a negative sense of one's own body as possibly uncouth, repulsive, or offensive. One might ask in what ways these subtle experiences of body appreciation may interfere with the need to establish a positive relation to one's body.

Beverley, a nurse, described to me how, when working on a children's burn-unit, she often felt strangely uncomfortable when a child, finally healed from terrible burns, left the unit to go back home. The child who initially was horribly disfigured had improved tremendously through delicate plastic surgery, to the delight of all medical doctors and nursing staff. Even the child was pleased, when looking in the mirror again, to see how skin grafts can improve one's appearance. However, Beverley felt ambivalent, because she also knew that when the child would leave to join the outside world again, a terrible shock would usually await for which neither the physician nor the nurse had appropriately prepared the young patient. Beverley and her colleagues had provided care and comfort.

Yet, she said that she felt discomfort that the child may have been ill-served by inappropriate comfort. What does it mean to have a healed body if one is incapable of living with this body in the experiential modalities that make ordinary life liveable?

9. The body of <u>self</u> experienced as call

The modality of the body experienced as call introduces an existential and moral element into the distinctions made thus far. Again, I am not trying to make artificial conceptual-theoretical distinctions; rather, I aim to evoke experiences of the body-person that one may recognize in one's own life. When we meet a friend we greet with a "How are you?" Indeed this reference to "how we are" may make us aware of the general sense of being that we feel "in a knowing kind of way" as a certain mood. And so, rather than routinely responding with "fine" we may actually comment on the way we sense ourselves to be in the "how are you?" "Gee, today I had an off-day; I don't know why I am so down!" or "Really wonderful, I just went to this movie that I must tell you about!"

Life and living with others can be experienced as pleasurable, meaningful, satisfying, loving, secure, joyful; or conversely we may experience our existence as alienating, empty, threatening, meaningless, without purpose. These fundamental life feelings are very much tied up in our body experience.

Even the simple knowledge of a disease that we do not even feel yet, can profoundly impact our pervasive life-feelings. In *<u>The Psychology of the Sickbed</u>*, Van den Berg recounts a disarming illustration from Robert Louis Stevenson's tale, "The Bottle Imp." It is worth retelling. It is the story of a man who experienced exceptional fortune in his life:

> With the help of a magical power, which lives in a bottle, he had become rich. He buys himself a wonderful house on one of the sunny islands of the Pacific. He has it furnished to his taste, sparing neither money nor trouble. And he marries a beautiful and charming girl who fits exactly into these surroundings. When he wakes up in the morning he sings as he gets out of bed, and singing, he washes his healthy body. On a certain morning his wife hears the singing suddenly stop. Surprised by the silence she goes to investigate. She discovers her husband in a state of silent consternation. As an explanation he points at a small insignificant pale spot on his body. He has leprosy. At the discovery of this seemingly insignificant change, his whole existence is ruined. It is no longer of any interest to him that he is a rich man, the owner of one of the most wonderful houses in the world. No longer has he an eye for the beauty of his island; this beauty has disappeared; at the most it is an accentuation of his despair. If he thought of the happiness of his marriage just a moment ago, now his wife belongs to the caste of the healthy, inaccessible to him from now on.

Each and every day there are thousands of people for whom a hitherto untroubled or even pleasurable existence is profoundly put into question by a sudden indication of cancer, a positive HIV-test, or a suspicious sign of Alzheimer's syndrome. For many of these people life, being itself, has become "dis-eased."

10. The body of <u>other</u> experienced as call by other

What the previous distinctions of body experience all have in common is that they are experiences of "the body of self" and other selves which, as such, are always self-

referential. I see the other from my vantage point (with my body) and so I understand the other and even my own body ultimately in a mode of being that has my own existence somehow at the center. Even my own body can thus be experienced as if it were an alter-ego, another self. For example, we sometimes say that “part of me” wanted to do this and “another part of me” wanted to that. But what many people find is that seeking pleasure in work, play, sex, or food is ultimately experienced as unsatisfying. It is difficult to find meaning and purpose completely within the self, in one's own embodied self. This is why self-discovery, self-exploration and other self-referential activities in the end do not always work.

While this fundamental way of self-referentially orienting to the world may be the most common, it is not the only way of experiencing the body. It is also possible to experience the other's body in a manner that precedes any kind of self-referential interest. Levinas (1981) uses the expression “face-to-face,” as a way of describing the nature of this experience. In this relational encounter I do not experience the other as my alter-ego, as another self, with whom I fuse into seamless intersubjective intercorporeality as in Merleau-Ponty's (1962) description of a shared conversation or a shared landscape. Neither is the other a person whom I meaningfully constitute or construct as a member of my social world. Rather, it can happen sometimes that I have a fundamental sense that I do not know who this other is but I experience him or her as a type of call or appeal--this is an experience of otherness that cannot be accomplished in the self-referential attitude.

For Levinas, intersubjectivity, such as the nurse-patient relation, may thus be experienced as relational subjectivity that is penetrated by the other. The ethical in this sense is not an abstraction, requiring moral theorizing or philosophy of ethics; rather, the ethical experience of the other body's call is always in the concrete, in the situation in which this vulnerable other bursts upon my world. Intersubjectivity in this sense is not something that one creates or gives shape to through some kind of decision to be personally responsive in one’s own body awareness. Rather, the other is already given to me as an ethical event in the immediate recognition of his or her vulnerability or weakness. One simply cannot help but feel that the other person, this child, that old woman, has made a claim on one's responsibility. And now the question becomes: what is one going to do about this call? This is where ethical reflection may come in. The pedagogy of teaching seems to share this fundamental ethical complexity of responsibility with the nursing relation.

For Levinas the existential or experiential fact of our responsibility resides first of all in the significance of the face of the other who looks at me—the face that I recognize as my responsibility for the other. That is why it is so difficult to hurt the other when I am face to face with him or her; and why it is easier to joke about the patient whose body lies anaesthesized and covered on the operating table. In this sense the deep meaning of nursing is found outside the self. Responsibility is experienced as “being there” for the other. And this ethical situation cannot be theorized, cannot be conceptually understood as situation in its contingency; rather, it is a kind of moral experience that simply happens to you and that you can validate experientially in your own body knowledge.

Somehow this self-forgetful experience of the vulnerability of the other may have healing consequences for the self. I return again to the mathematician who recounted to me how, in the memory of his suffering father, he found the strength to overcome his own suffering.

> It was my long dead father who, the night before my surgery, provided me with support when I needed it. While I was undergoing all sorts of uncomfortable prep procedures I unexpectedly began to have vivid images of my father who had passed away many years ago when I was still a young man. This was strange since the thought of him occurred to me so seldom. But now I saw him again as he was in my youth, and how he had to endure incredible physical insults and indignities as a result of severe illness. I felt an incredible sense of sorrow for him. He must have experienced great pain from circulatory problems and from out of control insulin reactions; he even had to suffer amputations. As a boy, I had seen in him, what I thought was a superhuman capability to endure and still love others in such endurance. I realized with a shock that he had been younger then than I am now. It was at the thought of his incredible love and suffering that I somehow received the message of courage and support from my memories of him.

Moreover, Levinas shows us that this meeting has a more fundamental ethical structure--as in what may happen when we meet a playing child in the street who greets and smiles at us, or as we sit at the bedside of our own sick son or daughter. The very moment that we turn to this child's face we feel already addressed in our fundamental responsibility, says Levinas. This is feelingly knowing. And now we are no longer the same from the moment before. We are decentered toward the other. This event is prior to reflection, prior to perception even, and prior to understanding the world or even to understanding this particular person who belongs to this face. The ethical experience of the other occurs in the situation in which this vulnerable other bursts upon my world. One nurse said:

> You never ever forget a child who you have nursed for a long time and who has died. Whether you like it or not, such a child has placed a claim on you. One time I became so overwhelmed that the parents said, 'please, cry with us.' But I did not want to do that since I had to go on functioning. I went to the washroom and had a drink of water. And then I returned because I had to support the parents as much as I could. I had to listen to their grieving stories and make sure that they did not have to go home all by themselves. But I heard the heart rending sobbing of the parents for many weeks afterwards.

Of course, we must not confuse the parent-child with the nurse-child relation. The child remains a patient. Another nurse explained it like this:

> The first week I worked in the emergency unit, I had to deal with a child who had almost drowned. When I saw a piece of his hair sticking out from under the sheet I got a terrible shock. For a moment I thought that I had recognized my son. He still had not learned to swim. I completely lost control of myself and had difficulty with my work for the remainder of the day. I always thought that I gave my all to my patients. But then I learned that I am involved differently with patients at an emotional and relational level.

At times the nursing relation is a relation beyond relation. This is the relation of self-other where self is erased (passed over) in the ethical experience of the vulnerability

of the other. Here caring is experienced as an ethical encounter that is beyond relation. Levinas does not speak of “relation beyond relation,” although this notion is somehow implied in his discussion of otherness as “beyond” being. According to Levinas the ethical experience of the other is always located in the person who experiences the other as an appeal to his or her responsibility.

Nevertheless, it may be tempting to reject Levinas' notion of the face, the other, and the ethical experience as too idealistic, too self-effacing, and too sacrificial. Can healthcare professionals continue to feel this sense of responsibility without losing themselves, and without becoming so emotionally drained and distraught that they simply cannot keep their life in control? Or must they, at least in their professional functioning self, become partly detached, partly self-protective, or inevitably somewhat jaded even toward human suffering? Of course these are all possibilities. In addition to dealing with the emotions of patients, family members, and colleagues, healthcare people must come to terms with their own emotional life; and in doing so they also differ just as their jobs, personalities and backgrounds differ.

The liveable body relation

Health science professionals—such as medical practitioners, specialist physicians, nurses, physio-therapists, midwifes and paramedics—are all in different ways involved in helping the patient, the elderly, the disabled, or the person who for reasons of circumstance is out of step with the body, to recover a liveable relation with his or her psycho-physical being. Some people have to learn to live with chronic ailments or pain or permanent handicaps, others with the aftermath of surgery, some with bodies that crave for drugs or alcoho, and again others with the knowledge that a degenerative disease has set in or that death is imminent.

Increasingly the health science professional is becoming aware that people require not just healthcare assistance, surgical intervention, or pharmaceutical treatment, but that the professional must be more involved in the way that people experience and live with their problems in a different, sometimes deeply personal and unique manner. Patients who have received a similar diagnosis may experience their illness in fundamentally different ways. The clinical path of any particular disease may have varying consequences and significance for different individuals. Even this cursory investigation into the various modalities of body experience shows that we may encounter our own body and the bodies of others in complex relational dimensions. None of these dimensions are alien to human existence and yet we may feel alienated in our embodied being if body experience and situated experience are in conflict or disharmony. For example, if I visit my physician with a complaint then I am quite prepared to objectify my body and submit it to medical scrutiny. However, if the physician only has regard for my body as object and forgets that I am the person who <u>is</u> this body, then I may experience alienation: alienation from human relation and alienation from lived body relation.

Similarly, if I suffer from a chronically severe pain or from a crippling disability but am unable to suppress this consuming pain or if I am unable to give this pain or disability a place and meaning in my life, then I must suffer from disintegrative existence: because in our everyday life we regularly must be able to forget our bodies in order to be attentive to the things of the world in which we are involved.

Every person is challenged to develop a liveable relation with his or body in the world. This means that he or she must know that to live means to be a body and to have a

body. A yogi who aims for a harmonious body-mind integrative state of being may objectify aspects of the body through focused meditative exercise in order to subjectify his or her embodied and spiritual existence. But it is unlikely that anyone will ever achieve lasting wholeness or harmonious integration of body-object and body-subject, or that anyone can ever appreciate in a totally positive and permanent manner every aspect of his or her physical existence, or that body-self and body-other can ever be truly reconciled. More likely we must constantly be reflectively engaged in questioning how to live in contextually appropriate relations with the body and how to acknowledge the ultimately mysterious nature of our embodied being such that a possible inspirited body relation may be brought into view. The health science professional can help to bring about reflective awareness of what modalities of body experience are disturbed and what may be done to develop meaningful, worthwhile, and liveable relations between the physical body and the lived body, between the embodied being and the world.

Notes

[i] This text was first presented as a keynote at the Qualitative Research in Healthcare Conference. Penn. State University, Hershey, PA, June 9-13, 1994.

References

Kouwer, B.J. (1953). Gelaat en karakter. In J.H. van den Berg and J. Linschoten (Eds.) Persoon en wereld. Utrecht: Erven J. Bijleveld. pp. 59-73.

Levinas, E. (1981). Otherwise than being or beyond essence. The Hague: Martinus Nijhoff.

Linschoten, J. (1987). Aspects of sexual incarnation: an inquiry concerning the meaning of the body in the sexual encounter. In J.J. Kockelmans (Ed.) Phenomenological psychology: the Dutch School (pp. 149-194). Dordrecht/Boston: Martinus Nijhoff Publishers.

Linschoten, J**.** (1953). Nawoord. Persoon en wereld. In J.H. van den Berg and J. Linschoten (Eds.) Persoon en wereld. Utrecht: Erven J. Bijleveld. pp. 244-253.

Merleau-Ponty, M. (1962). Phenomenology of perception. London: Routledge & Kegan Paul.

Olsen, C. (1992). The life of illness: one woman's journey. Albany, NY: SUNY Press.

O'Neill, J. (1989). The communicative body. Evanston: Northwestern University Press.

Rümke, H.C. (1953). Over afkeer van de eigen neus. In J.H. van den Berg and J. Linschoten (Eds.) Persoon en wereld. Utrecht: Erven J. Bijleveld. pp. 46-58.

Sartre, J.P. (1956). Being and nothingness. New York: Philosophical Library.

Van den Berg, J.H. (1980). The psychology of the sickbed. New York: Humanities Press.

Van den Berg, J.H. (1952). The Human Body and the Significance of Human Movement. Philosophy and Phenomenological Research. Vol. 13, pp. 159-183.

Van den Berg, J.H. and Linschoten, J. (Eds.) (1953). Persoon en wereld. Utrecht: Erven J. Bijleveld.

Van Manen, M. (1990). Researching lived experience: Human science for an action sensitive pedagogy. London, Ont.: Althouse Press; Albany, NY: SUNY Press.

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