



Embodiment and Objectification in Illness and Health Care: Taking Phenomenology from Theory to Practice

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Abstract

Aims and Objectives: To demonstrate a conceptual approach to applied phenomenology using the concept of embodiment.

Background: Traditionally, qualitative researchers and healthcare professionals have been taught phenomenological methods, such as the epoché, reduction or bracketing. These methods are typically construed as a way of avoiding biases so that one may attend to the phenomena in an open and unprejudiced way. However, it has also been argued that qualitative researchers and healthcare professionals can benefit from phenomenology's well-articulated theoretical framework, which consists of core concepts, such as selfhood, empathy, temporality, spatiality, affectivity and embodiment.

Design: This is a discursive article that demonstrates a conceptual approach to applied phenomenology.

Method: To outline and explain this approach to applied phenomenology, the Discussion section walks the reader through four stages of phenomenology, which progress incrementally from the most theoretical to the most practical.

Discussion: Part one introduces the philosophical concept of embodiment, which can be applied broadly to any human subject. Part two shows how philosophically trained phenomenologists use the concept of embodiment to describe general features of illness and disability. Part three illustrates how the phenomenological concept of embodiment can inform empirical qualitative studies and reflects on the challenges of integrating philosophy and qualitative research. Part four turns to phenomenology's application in clinical practice and outlines a workshop model that guides clinicians through the process of using phenomenological concepts to better understand patient experience.

Conclusion and Relevance to Clinical Practice: A conceptual approach to applied phenomenology provides a valuable alternative to traditional methodological approaches. Phenomenological concepts provide a foundation for better understanding patient experience in both qualitative health research and clinical practice, and therefore provide resources for enhancing patient care.

KEYWORDS

applied phenomenology, embodiment, nursing practice, nursing research, objectification, patient experience, phenomenology, philosophy, qualitative health research

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1 | AIMS AND OBJECTIVES

Many nurses and qualitative health researchers have turned to philosophical traditions to help them better understand patient experience. Among these traditions, none has been more influential than phenomenology, a philosophical study of human existence, which investigates both the subject of experience and the meaningful objects of experience. For the most part, phenomenology has been applied to health care by adapting its methods for use in qualitative health research and clinical practice.

In this article, I demonstrate an alternative approach to applied phenomenology, which relies on phenomenology's concepts, rather than its methods. To demonstrate this approach, I focus on the phenomenological concept of embodiment, which provides a valuable foundation for understanding a range of experiences in illness and health care. The article has two key aims: first, it provides a philosophical foundation and guide for better understanding embodied experiences in illness and health care; second, it provides a general model for how any core phenomenological concept, such as temporality, selfhood or affectivity, may be applied in healthcare research and clinical practice.

2 | BACKGROUND

The body is central to the practice of nursing and health care. Healthcare professionals learn to attend not only to bodily signs of physiological dysfunction, but also to embodied expressions of pain and discomfort, fear and anxiety, shame and embarrassment. In most cases, healthcare professionals cultivate their attention to the patient's body through hands-on experience and daily clinical practice. But one's ability to properly attend to the patient's body can also be informed by philosophical phenomenology. How do we take resources from philosophical texts and turn them into useful tools for health care, including both qualitative health research and clinical practice? Traditionally, qualitative researchers who use a phenomenological approach are taught phenomenological methods, such as the epoché, reduction or bracketing (Morley, 2010). Within the qualitative literature, these methods are typically construed as a way of avoiding biases so that the researcher can attend to the phenomena in an open and unprejudiced way. Phenomenology's clinical applications have received considerably less attention; but some proposals take a similar approach to qualitative research. Havi Carel, for instance, has proposed a workshop model that uses phenomenological methods, such as the reduction and thematization, to help patients understand and articulate their experiences of illness (Carel, 2012, p. 107).

In contrast to these traditional ways of applying phenomenology outside of philosophy, Dan Zahavi has argued that qualitative researchers and healthcare professionals can benefit from phenomenology's well-articulated theoretical framework, which consists of core concepts, such as selfhood, empathy, temporality, spatiality, affectivity and embodiment (Zahavi, 2019a, 2019b, 2020). This approach draws inspiration from phenomenology's successful applications in psychiatry and the cognitive sciences, which were

What does this paper contribute to the wider global clinical community?

- Provides a clear, accessible introduction to how the phenomenology of embodiment can be applied to illness and health care, including applications in philosophy, qualitative health research and clinical practice.
- Introduces and elaborates a conceptual approach to applied phenomenology, which can facilitate interdisciplinary collaboration between philosophers, on the one hand, and qualitative health researchers and clinicians, on the other.
- Outlines a workshop model that introduces phenomenological concepts to clinicians and walks them through the process of using these concepts to better understand patient experience and, thereby, enhance patient care.

developed independently of phenomenology's applications in qualitative research (Zahavi & Martiny, 2019). For example, one of the most well-known approaches—what Shaun Gallagher calls “front-loaded” phenomenology—incorporates core phenomenological concepts into the initial design of an empirical study (Gallagher, 1997; Gallagher & Zahavi, 2012). With the appropriate concepts in hand, the researcher can effectively delimit the scope of their study by clearly identifying the phenomenon to be investigated. In the case of experimental cognitive science, the researcher's aim is often to identify cognitive mechanisms that underpin experience. However, in principle, the same phenomenological concepts can delimit the scope of a qualitative study and allow the researcher to focus in on a particular aspect of experience. Moreover, as I argue below, the conceptual clarity borne of both philosophical and qualitative applications of phenomenology can inform the understanding of patient experience in clinical practice.

3 | DESIGN

This is a discursive article that demonstrates a conceptual approach to applied phenomenology.

4 | METHOD

I develop this conceptual approach to applied phenomenology in the Discussion section, which is composed of four parts. In part one, I introduce the phenomenological concept of embodiment as it has been developed in the classical and contemporary philosophical literature. In part two, I show how philosophically trained phenomenologists have used the concept of embodiment to understand and articulate bodily experiences in illness and healthcare interactions. I argue, however, that these philosophical applications have been developed in fairly broad strokes—they

provide insight into illness and healthcare experiences in general, but do not typically provide much insight into the nuances of what it is like to live with a specific illness or undergo a specific medical procedure. In part three, I show how qualitative health researchers can use phenomenological concepts as a foundation for their empirical studies of particular patient populations, focusing on a study of women who have undergone breast cancer surgery. In part four, I argue that clinicians may also benefit from a phenomenological understanding of embodiment. I outline a workshop model that I have used to equip clinicians with a sense of how illness and healthcare interactions shape bodily experience, which allows them to ask their patients more illuminating and penetrating questions about their embodied experiences of illness, health care and recovery. These four sections incrementally progress from philosophical theory to clinical practice, starting from the experience of embodiment in general—how anyone would experience one's own body—and moving towards the embodied experiences of particular patients in illness and healthcare interactions.

5 | DISCUSSION

5.1 | Theoretical foundations: Leib and Körper

Before explaining how a conceptual approach to phenomenology can help healthcare professionals understand bodily experiences in illness and clinical encounters, I here introduce the phenomenological concept of embodiment, with a focus on bodily objectification. Most phenomenologists begin from the classic distinction between *Leib* and *Körper*.¹ These German terms do not have perfect English equivalents, but they are often translated as the “lived body” and the “corporeal body,” respectively. How should we distinguish between these two senses of the body? We might say that the lived body is experienced from first-person perspective, whereas the corporeal body is experienced from the third-person perspective. We might point out that the lived body is the body that I *am*, whereas the corporeal body is the body that I *have*. Or, alternatively, we might say that the lived body is associated with subjectivity, whereas the corporeal body is associated with objectivity and objectification. These ways of distinguishing the lived and corporeal body overlap, but they are not exactly the same (Heinämaa, Forthcoming). Each way of characterising the distinction highlights different elements of embodied existence. For our immediate purposes, however, we can put some of these subtlety different ways of drawing the division to the side. Our aim is to use phenomenological concepts to open up a space for thinking about embodied experience in illness and health care. Considering these aims, it is important to keep in mind that the lived and corporeal body are two perspectives on the same body—a body that is always perceiving and engaging with its environment while at the same time a material object within this environment.

How does the healthy, able-bodied person experience their own body in their day to day life? How do I, for instance, experience my own body while walking to work, preparing a meal, or having a conversation? When absorbed in daily activities, my body recedes into the background of experience. It becomes transparent or absent. Drew Leder calls this bodily “dis-appearance” (Leder, 1990, p. 27). The transparent body is the medium of experience—that which we experience through. By fading into the background, it enables and facilitates our experience of others and of our environment. When I sit down to type an email, I hardly notice the precise movements of my fingers as they dart across the keyboard, how my arms rest on the edge of my desk or how I am seated in my chair. But this lack of attentive awareness of my own body allows me to attend to the content of the email, the message I need to convey and so on. In this situation, too much awareness of my own body would hinder my aim. To type a message while attending to the precise movements of my fingers on the keyboard would be a slow, painstaking task, akin to the experience of the child first learning to type.

But it is also too simple to say that my body recedes from awareness and the objects before me come into view. How, for instance, do I experience the keyboard in this situation? The keyboard occupies a middle ground between my body and my object of awareness. In a sense, it too fades from view. As I type away, I do not have to think about where each letter is on the keyboard. My fingers float from one key to the next. Even when I strike the wrong key, I reach for the backspace button without a second thought and continue drafting my message. Phenomenologists refer to this as “incorporation.” Over the course of years, I have developed an array of motor habits: tacit ways of moving my body and engaging with my environment. When I sit down in front of my keyboard, I settle into a well-worn path—just as I do when I get into my car or climb on my bike. The well-habituated body does not engage with an unfamiliar environment of dissociated objects. It gears into a world of what phenomenologists call “affordances”—objects and environments that offer various possibilities for action. Which possibilities they afford depend on one's own motor skills, bodily capacities and personal history. Phenomenologists refer to this mode of bodily experience as the “I can.” This means that we experience our environment in light of our current aims and projects; and it therefore shows up to us as something that frustrates or facilitates these aims. When I walk into the kitchen to make a meal, the knife affords the possibility of cutting vegetables; when I need to get to the pub in the rain, the umbrella affords the possibility of walking without getting wet. And these items afford these possibilities because I have developed the motor habits that allow me to seamlessly incorporate them into my bodily movements.

All of this presumes the smooth functioning of a healthy, able body. But what happens when this seamless integration of body and world is disrupted? Suppose that, as I am typing away, my hands begin to cramp. How does my body awareness shift in this situation? At first, there may be no explicit shift. Without thinking, I may simply move my fingers in a way that is more comfortable. But, eventually,

¹For an extended and accessible introduction to this conceptual distinction, see (Aho & Aho, 2009 Ch. 1).

pain bubbles to the surface of my awareness and my aching hands vie for my attention. My body, previously the medium of experience and action, becomes the primary object of my experience. Leder calls this mode of experience bodily “dys-appearance,” which refers to the “thematization of the body which accompanies dysfunction and problematic states” (Leder, 1990, p. 86). The dys-appearing body is precisely the body that appears in moments of pain, discomfort and so on.

Leder's initial characterisation focuses primarily on first-personal or individual experiences of bodily appearance, such as sensations of pain and physical discomfort. In which other circumstances might the body appear to us in a thematic or explicit way? We do not just use our bodies for completing everyday tasks, such as walking to work, typing an email or preparing a meal. We also engage in a variety of social practices, wherein we perceive the bodies of other people neither as brute, meaningless objects, nor as instruments for manipulation. Rather, we perceive them as expressive of desires, intentions and emotions. In the other's gesture, I see his wariness, his confidence, or his excitement.²

And what about my own expressive body? When I am absorbed in conversation with a friend, my body disappears in the way that Leder describes. But if, for example, I realize that my friend keeps looking at a spot on my shirt, then I may become concerned that I have spilled something on myself without noticing. In this moment, I am wrenched from my fluid engagement in the conversation. I cannot help but to take up my friend's objectifying view and now see myself through his eyes. Leder refers to this as an experience of “social dys-appearance” (Leder, 1990, p. 96). The body shows up to me in a negative way, but precisely in the context of a social encounter. This, of course, is a fairly mundane and harmless example of social dys-appearance. But there are also insidious experiences of social dys-appearance, such as the experience of being a visible minority in a racist society or being visibly disabled in an ableist society.

Leder's characterisation of bodily dys-appearance helps us better understand the dynamics between the lived and corporeal body. But his emphasis on negative experiences of bodily objectification may also be misleading. Kristin Zeiler argues that the phenomenological tradition over-emphasises negative bodily experiences, implying that the only good way of experiencing the body is as absent or transparent (Zeiler, 2010).³ If this were the case, then we would always want to avoid experiencing our body as an object. But this is obviously untrue (see also Legrand, 2007). Zeiler gives the example of a woman swimming on a summer day, feeling the warmth of the water against her skin and the strength of her arms. She might not reflect on her body in this instance—but she could. And, if she does reflect on her body, she may have an experience of her body as “well,

easy or good” despite it becoming the explicit or thematic object of her experience (Zeiler, 2010, p. 338). Zeiler also describes the positive bodily experiences that some women have while pregnant. And we may also consider cases in which one enjoys being overtly sexualised by one's partner, experiencing oneself as an object of sexual desire. But there are plenty of mundane examples as well, such as admiring one's new outfit in the mirror or showing one's tattoo to a friend. These are all cases wherein the body is the explicit object of experience in a positive or enjoyable way. Now that we have an understanding of the general dynamics of bodily experience, we can consider how this way of thinking about the body can help us understand experiences in illness and health care.

5.2 | Philosophical approaches to applied phenomenology

The phenomenological concept of embodiment, including the distinction between the lived and corporeal body, has been applied, to some extent, in qualitative research and clinical practice. However, in most cases, qualitative researchers and clinicians do not draw their concepts directly from the classical, philosophical texts. They often adapt concepts from the work of contemporary, philosophically trained phenomenologists who have already applied these concepts in their philosophical studies of illness. We can think of these philosophical applications as an intermediary step between purely theoretical phenomenology, on the one hand, and applications in empirical qualitative research and in clinical practice, on the other. Because these philosophical applications provide conceptual formulations that are more readily applied in qualitative health research and clinical practice, it is worthwhile to review some of this literature here.

Jenny Slatman and Gili Yaron have, for instance, used the phenomenological concept of embodiment to explore how people experience their own bodies when disfigured. They use the example of a nurse named Leah whose face was disfigured as the result of cancer treatments. They stress that Leah's disfigurement is not something that simply happens to her; she is not a passive object. Rather, “in relating to her condition, she develops various ways of ‘doing’ her body anew—ways that operate both on her body as image (an intentional object of *Körper*) and on her body as lived-through (a sensing self or *Leib*)” (Slatman & Yaron, 2014, p. 231). Others, both friends and strangers, perceive Leah's face in new ways, including as “strange, different, fascinating, or repulsive” (Slatman & Yaron, 2014, p. 231). But is this how everyone experiences the facial disfigurements of others? Not necessarily. Slatman and Yaron consider the example of Royal Air Force aircrew members in the United Kingdom who survived severe burns in the Second World War. In contrast with most people who suffer severe burns, “These men did not have to hide their damaged faces since they were signs of bravery; their faces expressed the honor of having served their country” (Slatman & Yaron, 2014, p. 288). The aircrew members and members of their community

²See (Dolezal, 2015) for an excellent account of experiences of bodily shame, including in health care.

³Zeiler coins the term “eu-appearance,” drawing on the Greek *eu* to refer to bodily experiences that are “well, easy or good” (Zeiler, 2010, p. 338), which she directly contrasts with Leder's “dys-appearance.”

experienced the facial scars in a way that differs substantially from the experience of someone who was burned in an accident. What should we take away from the contrasting examples of Leah, whose face was disfigured by cancer treatment, and the aircrew members, whose faces were disfigured after surviving severe burns in war? Disfigurement is never merely disfigurement. Any bodily feature, especially one that strays from the norm, will always be imbued with a particular meaning within the context of one's life and social situation.

Carel provides another philosophical analysis of embodiment in illness, which helps us flesh out the dynamics between bodily absence and bodily appearance. She argues that in severe or chronic illness, one typically undergoes an experience of bodily doubt. The healthy, able-bodied person typically operates with a sense of bodily certainty. This is the sense that my body will carry on functioning in the way it has always functioned: my legs will climb the stairs, my fingers will type, my stomach will digest and my lungs will breathe. This certainty is not, however, an explicit belief that my body will keep functioning. If someone were to ask me if I thought my legs would always be able to carry me up the stairs, I would readily admit that, one day, when I am much older, my legs will fail me and I will not be able to climb stairs on my own. But this belief is not a genuine feeling of doubt. As soon as I have expressed this fact about my future, I can put it out of my mind and go back to my everyday routine. So, what does Carel mean by bodily doubt and bodily certainty? The kind of certainty that is lost is not so much a belief as a kind of faith. When you have a chronic illness, you realize that you simply had an unquestioned faith in your bodily functioning. After you have witnessed your own body fail you, this faith can no longer remain unquestioned. The possibility of bodily dysfunction now permeates how you find yourself situated in the world, and this fundamentally alters how you experience and relate to your own body (Carel, 2013). Your body—or at least some part of your body—can never fully recede from awareness. Carel argues that bodily doubt has three key components, one of which is a loss of bodily transparency. Where the body was previously absent or transparent, it now “becomes explicitly thematized as a problem. The tacit taken for granted attitude we have towards it (we expect our bodies to perform complex actions, to be pain-free, to allow us to concentrate, and so on) is replaced by an explicit attitude of concern, anxiety, and fear” (Carel, 2013, p. 191).

Moreover, this shift in bodily experience never occurs in isolation. It is always accompanied by a corresponding shift in how one experiences one's environment. S. Kay Toombs provides an illuminating example of how she experienced changes in her environment while living with chronic progressive multiple sclerosis. She says, “The bookcase outside my bedroom was once intended by my body as ‘a repository for books,’ then as ‘that which is to be grasped for support on the way to the bathroom,’ and is now intended as ‘an obstacle to get around with my wheelchair’” (Toombs, 1995, p. 16). In this example, we see how the very same object initially shifts between two kinds of affordance—something

to put books on, then something to grasp for support. But, once Toombs navigates her home in a wheelchair, the bookcase becomes an object of frustration—an obstacle to be avoided. Of course, the physical bookcase itself did not change. What changed was the relation between Toombs' own motor capacities and the objects available to her, which reshaped the sense and meaning of her environment.

In examples like this one, we gain a better understanding of the personal or individual experience of illness and disability. But some phenomenologists have also studied how the ill or disabled body is experienced in the clinical encounter.⁴ Toombs goes so far as to argue that the patient and clinician occupy different worlds: “Within the context of the universe of science, illness is rendered thematic in terms of ‘objective’, quantifiable data. Disease is thus reified as a distinct entity residing in, but in some way separated from, the one who is ill. The patient, however, encounters illness in its immediacy in the context of the world of everyday life, as opposed to the universe of science” (Toombs, 1987, p. 228). Toombs argues that the clinician may fail to address the issues of most concern to the patient because they do not appreciate the lived reality of illness.

Leder makes a similar point when he says that the patient presents his lived body for treatment, but the doctor, by contrast, attends to the patient's corporeal or object body (Leder, 1984, p. 32). He says, “...the doctor examines a *physical* body. Much of her/his medical training has de-emphasized lived embodiment from the first ‘patient’ encounter – that with a cadaver. The predominant task at hand is to search for a mechanical precipitant of disease, be it toxin, trauma, or bug” (Leder, 1984, p. 33). However, Leder also acknowledges that this dualistic view is often too superficial. It is too simple to say that the patient experiences her own body only as lived—as sensing and experiencing—whereas the doctor experiences the patient's body only as a physical thing. In some cases, “The patient as well may have come to regard his/her body in an objectified mode. This process is often begun by the illness itself” (Leder, 1984, p. 33).

These philosophical analyses illuminate embodied experiences that are characteristic of illness and healthcare interactions. In this respect, they are more concrete or particular than what we find in purely theoretical accounts of embodiment, which articulate features of experience that hold for any experiencing subject. But they are also less concrete or particular than what we find in empirical qualitative research. While the philosophical applications described above do appeal to personal experiences of illness, they do not illuminate the experience of an individual or of a particular patient population. Rather, they use concrete examples to reflect upon and describe the characteristic (or even essential) features of severe or chronic illness in general. They therefore represent only the first stage of phenomenological application.

⁴Experiences of clinical interaction have, however, been relatively neglected by philosophically trained phenomenologists. This is an area that would benefit from increased attention from phenomenologists, including both philosophers and qualitative researchers.

5.3 | Embodiment in qualitative health research

The next stage of application is empirical qualitative research. While phenomenology was originally a strictly philosophical field, it has been adapted for qualitative research in psychology, pedagogy and health care, among other fields (see, e.g., Dahlberg, Dahlberg, & Nystrom, 2008; Giorgi, 2009; van Manen, 1990). Traditionally, these approaches adapted phenomenology's philosophical methods for use in empirical research. The Husserlian epoché, for example, is often presented as a technique for bracketing out or suspending one's prejudices, allowing the researcher to study phenomena in an unbiased manner. However, as Zahavi has argued, many of these adaptations are founded in inaccurate interpretations of the phenomenological method (Zahavi, 2019). For this reason, he suggests that qualitative researchers instead draw on phenomenology's theoretical and conceptual foundations, rather than its methods (Zahavi, 2020).

A few researchers have used phenomenological concepts in their qualitative studies and have also provided preliminary reflections on how they incorporate these concepts (Fernandez & Køster, 2019; Klinke, Thorsteinsson, & Jónsdóttir, 2014; Slatman, 2014). Before other researchers can successfully employ conceptual approaches, these techniques will need to be articulated in considerably greater detail. However, for the purposes of this article, I provide an example of one such study, conducted by Slatman along with her collaborators Annemie Halsema and Agnes Meershoek, which uses the dynamics of the lived and corporeal body to understand how women experience and respond to their scars following breast cancer surgery.⁵

Slatman, Halsema, and Meershoek (2016) highlight how their attention to the phenomenological concept of embodiment makes their qualitative approach distinctive:

...our approach [...] slightly differs from the majority of phenomenological studies on breast cancer treatment, because the emphasis in these studies is often put on the question of how women endow meaning to their lives and life-world while living through disease and physical changes. Our analysis, by contrast, focuses on the various ways in which women endow meaning to their changed bodies. We thus apply the phenomenological question of giving meaning (*Sinnggebung*) specifically to the appearance of one's own body.

(Slatman et al., 2016, p. 1615)

Rather than take a broad phenomenological orientation towards one's life and lived world, Slatman, Halsema and Meershoek focused specifically on bodily experience, drawing especially on their understanding of the dynamics between the lived and corporeal body. They

conducted in-depth interviews with 19 female patients with breast cancer. The aim of this study was to understand how women respond to scars after breast surgery. Moreover, the interviews were spaced out over four to six months to study how women's experience of their scars changed over time. By using phenomenological concepts to focus on these aspects of bodily experience, the interviews produced nuanced descriptions of how women experienced their scars.

In one example, they describe how, immediately after surgery, some women experience their own body as a biomedical object. One participant reported, "When I look in the mirror, I think: 'Ah, this has been done nicely' (...) Yes, it is tight, really very tight: very beautiful" (Slatman et al., 2016, p. 1618). As they point out, the woman's reference to beauty is not a traditional aesthetic one. She does not claim that her scar is attractive or makes her more beautiful. Rather, she admires the aesthetics of the surgical skill involved. As they say, "While viewing her body in this way, by adopting a clinical eye, this woman perceived her body in a distant manner. By means of this distancing stance, she perceived her body as an object, assessing whether it has been repaired in either a satisfactory or unsatisfactory way" (Slatman et al., 2016, p. 1618).

By conducting their qualitative study within a phenomenological conceptual framework, Slatman, Halsema and Meershoek obtain empirical descriptions of experience that can be brought into dialogue with philosophical studies. For example, their descriptions provide empirical evidence in support of Zeiler's argument that one may experience one's objectified body in a positive light. And they also highlight the communal or intersubjective nature of these experiences by demonstrating how the biomedical perspective of the clinician can be adopted by the patient. This exemplifies how qualitative studies that draw on phenomenological concepts can flesh out the details of philosophical accounts that may otherwise remain hypothetical or abstract.

We find additional examples of the potential for this kind of interdisciplinary engagement throughout their article. As they point out, women experienced their scars in a variety of ways after they had healed. One woman reported experiences akin to how Leder describes the transition from bodily dys-appearance to bodily dis-appearance:

Well yes, in the beginning, I was constantly looking, and I saw the empty place, the big scar, and that was really strange. It really looked weird: on the one side I have a breast and on the other side there is nothing. But if I look at it now, I just see a body (. . .). I do no longer mention it. I mean, I do not specifically notice, that the breast is no longer there.

(Slatman et al., 2016, p. 1618)

As she explains, immediately after the surgery her scar was a near-constant object of awareness and concern. Yet, as she habituated to this new bodily appearance, the missing breast and the scar itself no longer held her attention. Her body faded into the background of her experience in much the same way that it had before the surgery.

⁵The study uses Interpretative Phenomenological Analysis (IPA) and supplements this methodology with concepts from philosophical phenomenology. However, in principle, phenomenological concepts can be integrated with a variety of qualitative methodologies—not just those that claim roots in phenomenology.

Another woman, however, said that whether or not she wears her prosthesis depends on her interactions with others. When at home, she prefers not to wear the prosthesis. But she puts it on if she will have visitors—not because the alterations in her appearance bother her, but because she is concerned that it might bother them. Here, we see that same outward behaviour (e.g., wearing a prosthesis in public) may stem from different ways of experiencing or relating to one's own body. This example may also complicate Leder's notion of social dys-appearance, since the woman in question recognises that her body shows up to others in a negative or disturbing way, even as she remains largely unphased by this aspect of her appearance.

These phenomenologically informed qualitative studies provide insight into the experiences of particular populations. But they can also expand and revise our philosophical understandings of embodied experience (Zahavi, 2020; Zahavi & Martiny, 2019). Shaun Gallagher refers to this back and forth between philosophy and empirical science as “mutual enlightenment” (Gallagher, 1997; see also Gallagher & Zahavi, 2012). However, whereas the nature of mutual enlightenment between phenomenology and the cognitive sciences has been well articulated, we need further methodological reflections on how philosophical phenomenology and qualitative phenomenology may reciprocally enlighten each other (Gallagher, 2012). Such methodological work will enhance the value of interdisciplinary collaboration between philosophers and qualitative researchers. But, if we look beyond research, there is a further challenge that we have not yet considered: How do we integrate phenomenology and clinical practice?

5.4 | Embodiment in clinical practice

So far, we have examined a purely theoretical account of human embodiment, its philosophical applications to the study of illness and its empirical applications in qualitative health research. But some scholars have also suggested that phenomenological understandings of embodiment in illness and healthcare interactions can be applied directly in clinical practice. Helena Dahlberg argues that phenomenology can enhance person-centred care by opening up a space for articulating the patient's lived experience: “Not least is the understanding of health and illness as ‘lived’ important if we want to promote a person-centred care and thus engage the person as an active partner in her/his care and treatment. If the patient is to be able to partake in discussions and decisions about her/his own care, her/his embodied experience first of all has to be recognized, valued and endorsed” (Dahlberg, 2019). Slatman and Yaron also suggest “that medical practices could be improved if medical professionals could incorporate a wide range of questions about embodied self-experiences in their patient interviews, and if they subsequently could use patients' ‘body-stories’ while counseling them” (Slatman & Yaron, 2014, p. 236). And Marianne Klinke, Björn Thorsteinsson and Helga Jónsdóttir argue that phenomenological concepts of embodiment can help clinicians and patients better understand

embodied experiences that are otherwise difficult to articulate, such as the experience of hemi-spatial neglect following a stroke (Klinke et al., 2014, see also Klinke, Zahavi, Hjaltason, Thorsteinsson, & Jónsdóttir, 2015).

Calls for clinical applications of phenomenology are not difficult to find. But these calls rarely include any directives for how, exactly, one should convey these phenomenological insights to clinicians or patients. Carel's proposal for a phenomenological workshop is a notable exception. Her workshop model is flexible and can be adapted to the needs and interests of participants, engaging them through films, books, images, or music in conjunction with small group discussions and creative activities (Carel, 2012, p. 109). However, her proposal does include a general framework, which guides participants through three methodological stages: “the phenomenological reduction, thematizing illness, and reviewing one's being in the world” (Carel, 2012, p. 107). In the first step, the reduction (or bracketing) is used to distance oneself from taken-for-granted ways of experiencing and understanding the world, especially traditional ways of understanding disease. This allows participants to better reflect on their lived experience of illness (Carel, 2012, p. 107). In the second step, participants thematise their illness, which means that they focus attention on some particular aspect of experience and attend to this aspect of experience in a particular way. Carel explains, for instance, that a patient and clinician may thematise the same illness in two different ways: “A patient may thematize her illness as a central feature of her life, attending to her symptoms as pervasive, while the physician may thematize the illness as a ‘case of cancer,’ attending to symptoms as diagnostic clues” (Carel, 2012, p. 108). In the third step, participants examine how their illness has altered their being in the world—that is, how they find themselves in the midst of their lived, meaningful environment. As she says, “The toolkit uses being in the world to capture the pervasive effects illness may have on one's sense of place, on one's interactions with the environment and with other people, on meanings and norms, and on the nexus of entities, habits, knowledge, and other people that makes up one's world” (Carel, 2012, p. 109).

Carel's workshop model parallels traditional qualitative approaches to applied phenomenology, which also adapt phenomenological methods, such as the reduction and thematisation, to orient the researcher towards the lived world. However, it is also possible to develop a workshop model that uses the approach I have outlined in this article. This workshop model is organised by a single phenomenological concept, rather than by methodological stages. I have piloted this model at workshops for nurses, physicians, rehabilitation therapists and hospital administrators, focusing on embodiment and experiences of bodily objectification. However, the model can, in principle, be used with any core existential structure, such as selfhood, affectivity or temporality. In this outline, I provide my personal reflections on these workshops. I do not draw on participant feedback; but I may address this in future work. After briefly sketching this model, I identify some of the distinctive features of this approach.

How does one organise a phenomenological workshop based on concepts rather than methods? It is best not to jump straight into a discussion of philosophical concepts, since the participants may have no background in philosophy. Rather, the workshop leader should start by presenting a series of questions or prompts that will be of immediate interest to clinicians. For example, drawing on Slatman's work, one might ask, "How do people respond to scars after undergoing surgery?" Or, drawing on Toombs' work, one might ask, "How does the meaning of one's environment alter after losing mobility?" These kinds of questions immediately gear into the day to day lives of both patients and clinicians, and give participants an initial sense of the kinds of questions they will reflect on throughout the workshop.

It may not be immediately clear to the participants how to answer these questions, or even what would count as a good answer. But, at this point, the workshop leader and participants have established some common ground. And this is the stage at which the workshop leader can introduce the phenomenological concept that will allow the participants to appreciate and attempt to answer these questions. To provide this foundation, the workshop leader should introduce the concept of embodiment, including the distinction between the lived and corporeal body (along the lines of what I have provided in Section 1). However, throughout the workshop, there should be a back and forth between abstract concepts, on the one hand, and concrete or personal experiences, on the other. Rather than present the concept through a pure lecture, it is best to incorporate time for the participants to fill out the fairly abstract concepts with their own experiences. For instance, after describing the dynamics between the lived and corporeal body, the workshop leader might briefly describe how bodily disfigurement is always interpreted in a particular way, then ask participants to reflect on cases in which they have coped with some form of bodily disfigurement. Depending on the size of the group, it can be helpful to give participants time to discuss their experiences in smaller groups before asking for a few representatives to share their experiences with everyone.

These discussions achieve a few key aims. First, by discussing personal experiences within the scope of a phenomenological concept, participants will begin to solidify their understanding of the concept through their attempted applications. Second, the variety of shared examples help the participants appreciate just how widely applicable these concepts are; they will quickly see how the concept can enhance their understanding of a range of experiences by facilitating careful and considered reflection. Third, they allow the workshop leader to gauge the participants' understanding of the material and, in some cases, modify specific examples that the participants have offered in a way that better illustrates the concept under discussion. And, fourth, the participants' examples can also allow the workshop leader to guide a participant through the process of reflecting more carefully on their experience, perhaps describing it in greater detail or adding additional nuance; for instance, if a participant points out that, when she was younger, she would find ways to cover a scar on her arm that she was ashamed of, the workshop leader may ask her to describe how she experiences her scar now, how the meaning of

her scar changed over time, and which life events or personal experiences played a role in reshaping the meaning of her scar.

After participants have gained an initial understanding of the phenomenological concepts and how to apply them, they should be given the opportunity to apply these concepts in guided breakout sessions. In my own workshops, I have used the following prompts to structure these breakout sessions:

1. Think of a time when you experienced your own body as an object. Was there a specific event that triggered this experience? Was the experience affectively charged (e.g., did it involve feelings of shame, pride, embarrassment, etc.)? Using some of the concepts introduced in the presentation, try to describe this experience in detail.
2. If you have provided health care for patients/clients, try to identify two cases in which your patients experienced their own body as an object. One case should be a harmful experience of objectification and one should be a beneficial experience of objectification. How did the situation differ between these two cases? What contributed to the experience being beneficial/harmful? Do you think you played a role in how your patient experienced their own body? If so, how?
3. Drawing on some of the concepts introduced in the presentation, try to formulate a few phenomenologically inspired questions that you might ask patients. These questions should help you and the patient better understand their bodily experience of illness or how their healthcare treatment shapes their bodily experience.

When providing this kind of conceptual background and inviting participants to share their own experiences, it is also important to remind participants that the aim of the workshop is not to provide definitive answers to these questions. Rather, the aim is to provide the background that one needs to ask these kinds of questions in a clinical setting and have informed, enlightening conversations about these aspects of experience with their patients.

In one respect, this approach gets participants to the same endpoint that Carel's approach does. It allows participants to reflect upon, describe and develop new understandings of how they find themselves in a lived, meaningful world. But the explicit conceptual framing may also provide a more focused structure for the workshop discussions. The participants may have, or treat, a wide variety of conditions, so the content of their examples will remain diverse. Yet, by focusing on one aspect of experience, such as embodiment, they have a shared framework to build upon and can help each other develop more nuanced understandings of illness experiences. Moreover, within this model, highly specialised workshops may be designed for clinicians or patients with a specific set of concerns, such as those who treat or undergo a specific medical intervention. One might, for instance, develop a workshop that focuses specifically on embodied experience during breast cancer treatment and recovery. Such a workshop could draw not only on the philosophical concept of embodiment, but also on phenomenologically informed qualitative research, providing illustrative examples of how women

experience their own bodies in this situation. However, the workshop should still leave space for alternative ways of understanding and experiencing one's own body in these circumstances, since qualitative studies may represent only a subset of experiences.

An openness to participants' own experiences has been key to the workshop's success. It is all too easy for the workshop leader to keep the discussion focused on a concrete example that they have provided, since they are comfortable discussing and analysing this example from a variety of perspectives. I have found, however, that the workshops are most valuable when participants are given ample opportunity to apply phenomenological concepts to their own experiences. Each group of participants come to the table with their own personal histories and expertise, and should be given the opportunity to explore how phenomenology can help them tackle their unique professional challenges. In some cases, what participants take away from the workshop may not be what the workshop leader originally intended to convey. But the workshop should be considered successful so long as participants achieve an accurate understanding of the general concept and, equipped with this understanding, are able to reflect upon and appreciate experiences of illness, health care and recovery in new and illuminating ways.

6 | CONCLUSION AND RELEVANCE TO CLINICAL PRACTICE

This brings us back to the most important questions: What is the purpose of a conceptual workshop? What kind of positive impact can it have on clinical practice? Phenomenology's conceptual distinctions open up a space for reflecting on experience in a nuanced way. They orient us towards aspects of experience that we typically do not reflect upon, and thereby provide new opportunities for patients to understand and describe their experiences of illness and health care. Clinicians, equipped with a phenomenological understanding of experience, may also be in a better position to empathise with their patients and, thus, engage with them in more meaningful ways (Fernandez et al., 2020). They may, for instance, be able to describe some of the bodily experiences that their patient might undergo as their illness progresses. Or they may be able to formulate questions that help them better understand how their patient is recovering after a procedure. Even when we consider approaches to medicine with limited in-person interaction, such as telehealth, a phenomenological understanding of embodiment may help us better characterise what, exactly, is lost or modified in these modes of interaction.

Phenomenology, whether applied in philosophy, qualitative health research, or clinical practice, can help us understand the experience of being ill and receiving healthcare treatment. However, there is disagreement over how to properly apply phenomenological insights, especially outside of philosophy. In this article, I have argued for an approach that exploits phenomenology's well-developed concepts and conceptual distinctions. Embodiment provides a prime example of just how illuminating a conceptual approach to

applied phenomenology can be. But this same model can be applied across a variety of concepts, allowing us to explore the temporal, spatial and affective aspects of illness, as well as alterations in one's sense of self and relations to others. To obtain a complete picture of any particular way of being in the world, we will, of course, need to examine it through all of these concepts. However, by focusing on each aspect of experience individually, researchers, clinicians and patients will have the opportunity to explore specific aspects of illness and health care with depth and nuance, helping them make sense of things in ways that they were not able to before.

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CONFLICTS OF INTEREST

None.

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