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EMOTION AND EMBODIMENT WITHIN THE MEDICAL WORLD

I. THE EMOTIONAL BODY AS RELATIONAL MATRIX EXCEEDS CALCULATIONS

The medical world with its extended chains of instrumental appropriation of the body is perhaps the site in our postmodern world that seems most oppressive to letting the emotions have their voice and sway over the course of our lives. This had seemed true even without the growing managerial cost-accounting that has also come to transform medicine into a further reifying practice. Yet, paradoxically, most medical practice is located between the most routine kind of maintenance and the acute reaction to trauma, i.e. situations that involve a longer term coping with crises and chronic medical conditions that are obvious openings where authentic revelation through the power of emotion is legitimized. Medicine works at the boundaries of many of the most culturally charged terms of identity and meaning, intervening in regions that dramatically change our sense of who we are and what our life is about. Yet it does so blindly and awkwardly, because it intervenes in areas in which the emotional dimensions are central to these identities and meanings without an ontology that allows it fully to comprehend this. Insofar as regaining health entails regaining an emotionally capacious understanding and relationship to changes in embodiment, the biomedical model of body is unable to facilitate full healing.

Whether it is through the removal of a breast, disruptions in movement capacities, or damage to cognitive faculties, to name a few of the myriad examples, the changes in embodiment with which medicine must deal undercut simple exclusionary definitions of mind-body, self-other, nature-technology, freedom-necessity, or gender difference. For example, the biomedical model assumes: (1) that "repairs" to the biochemistry or physiology of the client's "body" exhaust the healing task of the physician, while emotional "adjustments" are a separate matter for other professionals or family members to facilitate in the "emotional" or "mental" realm; (2) that the client is "alone" within the "subjectivity" of his/her emotional struggles, instead of recognizing phenomenologically that emotions are co-constituted with all those involved in the client's world – especially

S.K. Toombs (ed.), Handbook of Phenomenology and Medicine, 197–214.

physicians and other healthcare professionals; (3) that a prosthesis is just a "mechanical part" added on to a functioning organism, not realizing that the client now has a new sense of embodiment which calls for an emotional realignment of relationship if the prosthesis is to become integrated into the "lived body"; and (4) that the client's freedom in an abstract matter of "will" or "mind" confronting a physical world, instead of comprehending how choices are "situated" in a context in which emotional clarification is part of a process of making possible new dimensions of life in working through ambiguous situations with others. Certainly, it is not surprising that, in a cultural context in which gender assumptions are often unconscious, helping clients make emotional shifts in their sense of being gendered beings with differing bodily capacities or appearances is often overlooked.

In all these ways the biomedical model of body keeps apart dimensions of meaning that are treated more holistically through focusing on the emotional sense of the client's embodiment. It is understandable how medical practice can easily slip into these mistakes, since the sudden, acute breakdown of health in which medicine is most spectacularly called into action seems to marginalize the kind of sense to which the emotions are most attuned. Furthermore, as a profession, medical practice has often sought to stabilize its power of intervention in a reduction of the body to an objective map using the emergency as paradigm. However, every emergency takes place within a larger context of the client's life-world.

When assisting healthcare clients in their ability to move beyond the crisis, it is often the case that the more objective indicators of the body's physiological systems fail to fathom the overall well-being of the affected person. Their referents can be perfectly verified and their coherence may seem to have reached closure within the prescribed medical systems of signification. Yet, the state of affairs of client recovery they seek to describe and capture in its truth may utterly elude them. What is most likely to be missed in the exclusive focus on the rationally representable world of the body-as-mechanism is the world of emotional understanding, the dimension of affective feeling that wells up from the body. Certainly the body is partially mechanical, but not solely so, nor are all its dimensions rationally delineable. Vital rhythms of attunement and identity within the client's world are primarily emotionally grasped and articulated. This becomes more obvious when medicine deals with treatment that is not abrupt and invasive, but that helps clients with ways of structuring their world to alter behaviors, diet, activities, expectations, meanings of events, etc. Regardless of whether it is the scope of activity, the kinds of food the client is able to eat, the way

s/he can enter into relationships with others in terms of energy expenditure, excitement levels, nature of sexual options, and so forth, all these dimensions have emotional significance that directly affect how the person fathoms his/her identity and the meaning of his/her life within her/his embodied being. Thus, if healthcare professionals are to assist clients in dealing with traumatic or gradually learned alterations in these dimensions, they must attend to the client's way of affectively embodying herself or himself.

However, even the most traumatic and abrupt medical emergency reveals the unity of embodiment with emotion. Oliver Sacks (1984) relates a striking example of such a moment in which all the medical signs fail to signify. In this instance, Sacks, the noted physician, is the healthcare client at the center of the narrative. Hiking up to a mountain summit at 9,000 feet, above the Hardanger fjord in Norway, he had ignored the sign warning him of the presence of a massive bull until, on his way down, the bull appeared to Sacks in far too close a proximity. In his panicked flight from the bull, Sacks fell and broke his leg and severed the connection to muscles. After surgery, medical interventions, and a period of healing, his surgeon – who is quite pleased with the surgery – examines Sacks. The pain has subsided to a bearable level, the swelling has gone down, and Sacks agrees with the surgeon, "It seems fine, Sir," Sacks responds, "surgically speaking." However, Sacks still cannot even contract his muscles, move his leg, or even feel where his leg is located. He is panicked and discouraged. The surgeon replies to Sacks (1984, p. 105):

> "Nonsense, Sacks," he said sharply and decisively. "There's nothing the matter. Nothing at all. Nothing to be worried about. Nothing at all."
>
> "But..."
>
> He held up his hand, like a policeman halting traffic. "You're completely mistaken," he said with finality. "There's nothing wrong with the leg. You understand that, don't you?"
>
> With a brusque and, it seemed to me, irritable movement, he made for the door, his Juniors departing deferentially before him.

Sacks' physicians were frustrated. They were adamant that the medical findings indicated that his leg had been repaired. All the relevant significations, whether x-rays or lab values, have declared the truth and the rest is some sort of problem with Sacks, not with "the leg." Sacks, of course, is correct that his leg is not "cured," for a leg that is fully functional is one that feels like part of his body, one that feels like it is part of his world, one that not only moves in ways he wishes, but also fits in with the rhythm of his existence. About these things, the doctor's calculations have little to say.

Being the holistic investigator that he is, Sacks finds a meaningful way to rediscover and reintegrate his leg. His solution highlights how the emotions and the body are inseparable, how the emotions of the client permeate his/her world, and how emotional well-being and the health of the client are the same matter. We will use Sack's case as a touchstone in this essay as we unravel the place of the emotions in medical care.

Medicine seems to construct a context that maximizes the extent to which the body can become submerged in discursive practices. The exhaustive batteries of tests circumscribe the meaning of illness into arithmetic values, reified structures, and efficient causal relations. The procedures proliferate to manipulate the body as a mechanism. There is endless analysis, interpretation, and prognostication in diagnosis. The body in its most material reality has been subsumed into a series of readouts and signs. The flesh is seen as biophysiological functioning. Yet, the reality of the client's "condition" is an ever-anxious waiting for how it feels and what it means within the horizon of experience of that person. In excess of the numbers and physiological observations, there is the silence of how the body is present for that unique individual within his/her sense of the world. This is the realm to which discursive practices point and try to map, but they cannot capture or exhaust the pertinent level of meaning. Experiencing this lack in the medical model, clients (and families) often become frustrated as they try to cope with the fact that the well-being of the client is about the quality of his/her relationships that comprise a unique world – a shifting, fragile, and nuanced sense of how its *feels* welling up from the visceral and perceptual depths of experience.

Within the confines of a massive scanner, under the knife of a surgeon, or as part of a mechanically assisted process, the subjectivity of the client is submerged into a cyborg existence of biotechnical machinery. The way in which the client's subjectivity stands uniquely with his/her world – which is the sense that vitalizes emotion – is subordinated to engineering dilemmas of immediate intervention. In the midst of this domain of practical action, the determinate teleology of achieving physical "health" reigns supreme and the emotional experience of the client within this world seems the least determinative factor for assessing the client's well-being. Yet, it is precisely at this moment of breakdown, of life crisis of the body, that emotion erupts – and mere matter and mere discursive formulation miss exactly what is happening to the patient. Thus, at the very moment when clinicians, family, friends, and the client forsake emotional reality as insignificant, they discover that it is the primary reality in several key senses. For, ultimately,

what has been affected is the quality of the relationships of the person to his/her world and this is precisely what the client's deeper sense of the body as "flesh" registers in emotion.

Suffering a medical crisis – and the sudden vulnerability and need for help, not only in dealing with physiological symptoms but also in gaining some rational and emotional understanding of what one is undergoing – reveals there is no isolable subjectivity, or detached realm of the mental, but rather there is the world, others, and self, lived through the perceptual matrix of the body. As Richard Zaner (1981, p. 246) has eloquently stated, this is the realization that illness forces in upon us: "Thus the variety of responses by family, medical or non-medical observers – of facing an 'abyss,' a glass 'wall,' etc. – can be seen as modes of self and other recognition, evoking an awareness of self in respect of its crucially constitutive moment: the other self." Given the Cartesian tradition, it is difficult for many of us to experience this interweavement of persons (rather than being an isolated "I"), and recognize that this is true because we are fleshly creatures whose emotions are not peripheral but at the heart of who we are. This is where medicine can draw upon phenomenology's rich descriptions of how we are co-presences who feel *and* think our way together through the world.

Phenomenology has also revealed the body as "embodying. We are not only interwoven on the bodily, affective realm. The world itself is structured by the body, and the body takes its sense from the demands of the world. Again, the Cartesian sense of an isolated "I" and one that is detached in essence from the world, is not only undermined by the work of phenomenology, it is revealed through the personal experience of illness. The medical crisis is more powerful than a philosophical deconstruction of the objective body: "It is thus not so much that 'the' organic body signals the 'latent crisis of every known ontology.' It is rather that '*my*' organic body does" (Zaner, 1981, p. 21). Merleau-Ponty's (1968) idea of the "flesh" allows us to see the body as a dialogical exchange of significance through the depths of perception that is fluid and revelatory of vital aspects of the world of the client outside the tests of bioscience. As this essay will explore, to be forced to confront through illness that I am a body and am in the world through my body also means that I (and my loved ones) will discover that the primary registration of how I am – and how I am in relation with the world – occurs within emotional revelation of a more complex sense of embodiment.

II. THE NEED FOR MEDICINE TO SEE THE BODY'S EMOTIONAL ENGAGEMENT IN THE WORLD

Using Merleau-Ponty's (1962, 1968) perspective, we can describe embodiment as an ongoing process of inhabiting situations in a relational network of perception as motivated discovery and expression. "Motivated discovery" means that the body encounters its world through *solicitations* from that which is perceived. The body is open to "appeals" from the perceptual field in its ongoing attempt to find meaning in perceptual experience (Merleau-Ponty, 1962, pp. 403-34). So, for example, as we will see in discussing Sacks' (1984) case further, the body does not move by fiat, but because it is drawn into action by its context – whether it is to avoid being hit by an oncoming car, to reach the table where a meal is waiting, or in response to the myriad "appeals" made to us by our environmental context. These appeals will vary in how much they strike our emotional marrow. Avoiding an oncoming car will strike a much deeper chord of panic and will, therefore, be a stronger solicitation to our body than walking towards an unappetizing bowl of mush. It is as seeking, or as intentional – rather than reacting to its environment impassively and mechanically through efficient causal chains of events – that perception occurs. In other words, the body moves into areas of concern, into contexts that have an emotional meaning for us that the body translates into activity. For instance, if someone has a need and skill to type, she may be able to move her hands in dexterous ways when sitting down at a keyboard, yet be unable to perform such motions in response to an abstract command from a physician.

Embodiment is dialogical or responsive in this sense, not mechanically assertive or self-propelled. Embodiment occurs within a context of our personal histories. The context is filled with areas that have emotional significance for us. One person may love to walk on the beach, another to dance, and yet a third person may live with their greatest vitality when working in a printing shop. Arms, legs, and even perceptual organs, are "geared" into these settings. To understand each person's body fully is to have some sense of embodiment in this context of richly emotionally colored areas of concern for that person. How vital this may be for healthcare professionals in treating clients will become most clear when looking at Sacks' attempt to regain the use of his leg. The ambiguities of perception are presented as problems or tasks to be further resolved, ultimately inexhaustibly so. So, for example, we do not merely use our legs to see how strong or coordinated they are, we live them as ways to get up that steep hill to a daughter's school; and we try to decipher an oncoming road sign, in

order to know whether to slow down or not, rather than simply to test our eyesight. Thus, as an "ongoing process," embodiment is not "located" in the body as an isolated object, but is rather "dispersed throughout its lived context (Merleau-Ponty, 1962, p. 248). This context is one marked out by our emotional commitments. So, the body is where my emotional investments are located.

The "relational network" of the perceived situation refers to the fact that each perceived has its identity only within a field where each member of the field takes its meaning from the vantage points of every other member of the field *as if* they all were perceivers (not literally so). So, for example, the sick person lying in a hospital bed can see her husband's body from the vantage of the wall behind him, of the ceiling above their heads, and of her friend standing on the other side of the bedside. This is what "her" vision is about at any moment. "Her" vantage draws on all these other perspectives in their co-presence. The same is true for other dimensions of apprehension: they are all "given" as drawn together from donations of meaning throughout the encompassing "phenomenal field" or "life-world." As an "ongoing process," embodiment is not located in the body as an object we use as a vehicle, but occurs as an evolving, fluctuating, and transforming site of interaction, or interweaving, of perception (and its layers of other concomitant apprehensions) and the world that we *are* (Merleau-Ponty, 1968, pp. 132, 161-62, 229). This notion of the interweaving of perceiver and world, and of perception with all levels of apprehension, undermines the dualistic separation of body from world and of body from mind, imagination, emotion, memory and intuition (Merleau-Ponty, 1968, p. 239).

Merleau-Ponty details how the perceiving body structures what it apprehends through a context and with a habit body of embedded personal, cultural and historical significance, but only does so by constantly shifting itself in relation to how the perceived beckons to it. This renders perceiving-perceived as a system or a relational ebb and flow. The body is an open question to its environment which itself questions back the body for its possible ways of joining in with its unfolding of meaning. In terms of his later formulations, both are of a "flesh" that folds back on itself, enveloping the perceiving-perceived (Merleau-Ponty, 1968, pp. 132, 229). To cite an example used by Merleau-Ponty: it is true that we see a Cezanne painting only within a history of regarding paintings in a certain way which is embedded in a particular culture, history, personal set of experiences, etc. – so one person is apt to approach it reverentially and another dismissively, and a third might have no idea of what they are looking at – but the canvas

itself demands a certain optimal distance from which to be viewed, a certain lighting, a certain posture, a certain rhythm of attention and time of investigation, etc. A similar equilibrating of body and world occurs with all perception and action. Our bodies are shaping and even apprehend the environment, because of what is in the environment itself. This means that, as an embodied being, a healthcare client only has a part of himself (or herself) examined when doctors probe the body in isolation. The relational context of which that body is a node of circulating sense and motivation is missing, or has been replaced by a very impoverished environment. In some sense, the body carries this field or world, or larger sense of the flesh in which it is enfolded, everywhere. So a client may transpose some of the meaning of his/her old context onto the limited hospital context. Perhaps, for example, when confined to the hospital, an avid hiker and bird photographer has a measure of that excitement and love focused on the view from a window at the end of the corridor – a place he may visit once a day. However, this co-presence becomes more and more attenuated as medical examination/intervention becomes prolonged and the body is treated as an isolated physiological object.

A famous line from Merleau-Ponty's (1962, p. xi.) introduction to the *Phenomenology of Perception* is "there is no inner man." In other words, the person is only found in relation to an environment, a world. The same thought is registered in his later formulation by saying that human being is a "dehiscence" or a "deflagration" with the world, a fission with itself into the world and also with the world, from which we return to ourselves at the end of circulating through this world and its significance (Merleau-Ponty, 1964, p. 180). This insight is key to our consideration of emotion, *because emotion is the registration of how it stands with this relationship between the embodying process and the surrounding environment* (Mazis, 1993, p. 22). We could paraphrase Merleau-Ponty's denial of the "inner" person also to say there is no "contained body" or no "inner body mechanism," insofar as this problem of where the body is located arises in medicine. Using emotion as the general term that includes more momentary flashes of affect, the visceral dimension of feelings, and the more longer term passions and emotional attunements to the world, we can say emotion is the lining of bodily perception with a sense of how it qualitatively stands with the web of relationships with the world. As such, the emotions are key resources for medicine to find the "larger" body of the client as interwoven with the world.

However, to consider this more fully, it is important to add to Merleau-Ponty's notion of embodiment by considering Drew Leder's (1990) analysis in *The Absent Body*. Leder emphasizes that this relational interweavement between our embodiment and the world remains largely absent to our explicit awareness. Our embodiment, in general, is unobtrusive, and especially "the hiddenness of vital organs ... is essential to healthy functioning" (Leder, 1990, p. 44). There is a sense in which our perceptions normally take place with the body's presence withdrawn from attention and with the viscera doubly withdrawn into what Leder (1990, p. 53) calls a "depth disappearance" in which they are only very indirectly ever perceivable. Yet, at the moment when medicine intervenes, it is usually when there is what Leder terms "an affective call" of the body in pain of some sort. Pain announces something wrong with the body, but not from the body as an isolated mechanism, but rather as at the heart of all the relationships of the person to the activities, things, and people within his/her world. As Leder (1990, p. 73) puts it, "As such, pain reorganizes our lived space and time, our relations with others and with ourselves." It is only because the body is embodying, forging all these relationships, that the body's disrupted functioning now disrupts them. Yet, the pain itself does not indicate the past relationships, but is an intense focus on the body withdrawn from its normal sphere of interconnection. Leder focuses on the call of pain, but, of course, there are other experiences, such as fatigue or dizziness, etc., with their own affective charge that also disrupt our normal time, space, and context of relationships.

As Leder describes, pain has a compelling quality that constricts our accustomed context of life. The pained body seems an alien body, no longer me. The body that I am normally takes me into the world, or as Merleau-Ponty (1962, p. 235) phrased it, "My body is the fabric into which all objects are woven." This is true of the weakened body, the dizzy body, the disoriented body, etc. All of these conditions are registered in a variety of disruptive emotions, such as psychic pain, fear, frustration, panic, sadness, and other affective registrations of these shifts. With illness, the world that was the body's natural extension seems far away. There is a shift in our embodiment: "We are no longer dispersed out *there* in the world, but suddenly congeal right *here*" (Leder, 1990, p. 75). The world of food, for example, which marked my rhythms of the day and my immersion in certain neighborhoods, my anticipation of certain activities, like cooking and dining with others, etc., is gone in the searing pain of the colon cancer which prevents eating. Similarly, the temporal context is disrupted: "As it pulls us

back to the *here*, so severe pain summons us to the *now*" (Leder, 1990, p. 75). All the projects that were echoes of what my body could do without any thought – that constituted my past and future horizons of engagement – have been put out of play, as the disorientation or weakness or pain absorbs me and undercuts these avenues of involvement. Especially, when symptoms reveal serious illness and disability, the world in space and time sinks away. The medical objectification of the body within the biotechnological focus of practice exacerbates the same sort of de-contextualizing of the body, the same sort of alienation from the world of the body, with which these disruptive feelings and illness already menace the client.

In this sense, medical practice itself is dis-abling. If each part of the body embodies "I can" relationships to the world – such as my arm being a reference to the writing desk in my study, or to the car I can drive, or to the shovel and flower bed I can dig, etc. – and pain and illness force me to live my body as "the no longer can" (Leder, p. 81), this isolates me from all around me. Then, insofar as medicine views the body as an isolated mechanism, it prevents the body from forging new relationships to the world or to renewing the old relationships in new ways. If emotion throws into relief the ways in which person and world are interrelated, then medicine needs to pay attention to the emotions of healthcare clients if it is to assist them to re-achieve health or a sense of well-being. This does not mean necessarily restoring a client's previous physiological functioning (although it may include that) but rather facilitating a restored emotional attunement with the world, no matter how the client's physiological functioning may have become altered. The emotions can allow the world to "come back" into relationship with embodiment and achieve a new sense of meaningfulness. Otherwise, there is no restoration of embodiment and health.

This is what Sacks' doctor didn't understand. For him, the body was a mechanism to repair. However, the living of the body as a way of forging meaningful relationships with the world is inseparable from this physiological functioning. If either alters, so does the other. In Sacks' case, his leg would not function mechanically unless some sense of the emotional excitement and investment in contexts that involved his leg was restored. For other clients, it might be the reverse, i.e. they might need to see how differently functioning aspects of embodiment can lead to new types of relationship with the world. For most clients, as for Sacks, it is probably some of both. Surgically "fixing" the parts of, say, the leg without restoring the leg's – or rather, the person's "legged relationships" – with the world does not allow the person to rediscover well-being, or to achieve health

defined as the ability to lead a meaningful life through making the most fruitful use of the sort of embodiment one has.

If pain, panic, or depression, etc., take the client's embodiment away from its matrix in the world, then other emotions that can restore the diminished connections of orientation, significance and intention should be cultivated as a part of treatment. An important part of the healing process is to catalyze and nurture emotions that restore the interweavement of body and world. Even if pain did not obscure these connections of body and world, and even if medicine did not exacerbate this disconnection with its approach to the isolated body as mechanism to be repaired, the mundane, everyday, absence of awareness of how the body relates to its world probably needs to be undone if the client is to discover ways to restore her/his body's potential connections to the world. Medicine is not solely about "curing" in the sense of replacing body "parts" so that they become "like new." We all age, suffer various illnesses, and eventually die. Medicine as an achievement of well-being is about maximizing our embodiment as a rich matrix for meaning with the world.

To see what this might mean, let's return to Sacks' and his discouragement that his surgically perfect leg has remained "entirely motionless, toneless, senseless, beneath its white sepulcher of chalk." Sacks no longer felt "at one" with his leg, nor did his leg feel like it "fit" into his world. This condition had remained for weeks, although there had been involuntary twitches of "the leg" but, as Sacks eloquently describes it, they had no personal quality, no sense that they were actions, just a functioning of parts. Then, a visitor brought Sacks a tape of Mendelssohn's Violin Concerto. Suddenly, Sacks (1984, p. 119) felt a "decisive effect":

> From the moment the tape started, from the first bars of the Concerto, something happened, something of the sort I had been panting and thirsting for, something that that I had been seeking more and more frenziedly with each passing day, but which had eluded me. Suddenly, wonderfully, I was moved by the music. The music seemed passionately, wonderfully, quiveringly alive and conveyed to me a sweet feeling of life. I felt with the first bars of music, a hope and an intimation that life would return to my leg—that it would be stirred, and stir, with original movement, and recollect or recreate its forgotten motor melody.

In hearing the music, Sacks felt as though he were experiencing the "animating and creative principle of the whole world." For Sacks, music was a vital part of how his body was connected to his world. This sense that "life itself was music" had always profoundly moved him and it was a source of hope and vitality. With the music, he could feel the sparks of life in his healing leg as being hopeful signs of recovery. However, even though Sacks

felt inspired by the music, which was important to his healing, he did not at first realize its importance.

As time passed Sacks' leg gradually resumed more function and he could even walk somewhat, but the leg always felt artificial, awkward, and as if it were not really *his* leg. One day, when he was trying to walk, something else happened:

> And suddenly – into the silence, the silent twittering of motionless frozen images – came music, glorious music, Mendelssohn, fortissimo! Joy, life, intoxicating movement! And as suddenly, without thinking, without intending whatever, I found myself walking, easily, joyfully, *with* the music. ... Suddenly, with no warning, no transition whatever, the leg felt alive, and real, and mine, its moment of actualization precisely consonant with the spontaneous quickening, walking and music (Sacks, 1984, p. 144).

What Sacks discovered was that his leg became *his* when it found its place within the context of part of his world that had great emotional meaning for him. Given its insertion within part of the world of heightened emotional significance for Sacks, the leg became him again, rather than a mere mechanical part to be manipulated. Sacks realized that, before this, all his therapy had been impersonal. It had been rational and cold, but then "came music, warm, vivid, alive, moving personal" (Sacks, 1984, p. 148).

We will return to Sacks' case, because as it turns out, another breakthrough was needed in order for his leg really, fully to become "him" again. This breakthrough has to do with further refinements we must articulate about the role of emotions in healing damaged embodiment. However, it is important to note that we are related to aspects of our world emotionally and for each of us this is a different fabric of connection. If medicine is to heal, it is necessary for some members of the team of caregivers to help clients explore how they are related to the world, especially in reference to the parts (or dimensions) of their embodiment that have become injured or compromised in illness.

III. POTENTIAL DIMENSIONS OF EMOTIONAL HEALING IN MEDICAL CARE

The experience of Oliver Sacks is not unique, but points towards shared structural features of the lived experience of serious illness or physical trauma. If, in the experience of threatening emotions and impaired functioning, every illness involves an alienation from the body, and if medical practice contributes even further to deepening this uncanny

experience (Zaner, 1981, pp. 54-55), then the clients of healthcare require a way to reawaken their bodies to the power of embodying. As Kay Toombs (1993, p. 87) states it boldly: "the objectification of the body results in the loss of embodiment. That is, as an object the body is no longer embodying." Like Sacks, sick and injured persons find themselves displaced from their usual contexts of engagement, of concerns, loves, hates, tasks – lost somewhere in a time and space that have been altered by illness. "Illness is a state of disharmony, disequilibrium, dis-ability, and dis-ease which incorporates *a loss of the familiar world*." (Toombs, 1993, p. 96). If the sick person is to transform the object body that has been "worked upon" by medical science into a power of taking up creatively the myriad relationships s/he has with the world, then s/he must find a way of becoming connected, directed, and responsive again to her/his world. These powers, however, are the powers of emotional engagement with the world. Healing care requires facilitating this emotional discovery since re-embodying the client is world engagement through emotion.

The body as embodying is an ongoing dynamic process of becoming enmeshed in the world and being transformed by its efforts to transform the world through its expression. The emotions are the body's immediate registration of how this interrelation is going: how it has been met and towards where it is heading. However, the emotions themselves are dynamic, always changing, revealing new aspects of the unfolding meshing with the world and others: "within the dawning of emotional sense, the past is ever coming to new significance, is ever becoming, which has always been recognized as the dangerous fluidity of e-motion" (Mazis, 1993, p. 106-107). As such, the emotional sense of the world is fragile, changeable, and in motion. This has threatening aspects and exciting aspects, both of which are central to the experience of those who suffer illness and dis-ease. The threatening aspect of suddenly feeling a loss of security in the body, helplessness, fear, pain, uncertainty, aloneness, and sadness through serious illness, is obvious and unavoidable when one's life or capacities are threatened or permanently compromised. On the other hand, it is the same dynamic and fragile dimension of emotions that has revitalizing potential for all those who suffer illness and injury. However, the healing potential of emotion within the healthcare context will not just happen unless we focus on facilitating its discovery for each client. Learning to forge new emotionally meaningful relationships with aspects of one's life-world through one's altered sense of embodiment is not a separate issue from

achieving health. Thus, medical practice needs to facilitate the emotional side of re-embodiment.

The need for others to enter the emotional world of the healthcare client is crucial in the context of serious illness. One of the shocks of serious illness is this: that this body which opens me to others and to our shared emotional life together seems to have taken me away from others in a way that perhaps none of us can correct. This may be true in a purely physiological way, but perhaps not in a fuller sense. Yet, this is what first strikes the seriously ill person emotionally. As Toombs (1993, p. 96) puts it, "Existential aloneness is necessarily a part of serious illness." Sacks has a very powerful chapter describing how he fell into a limbo and nothingness, into what he called "a hole in reality itself, a hole in time no less than in space, and therefore cannot be conceived as having as term or ending" (Sacks, 1984, pp. 108-109.) The person who becomes ill or injured inevitably feels these moments of being torn away from the rest of humanity; yet, if they are to engage on the journey of coping and healing, it is through others that sick persons are most likely to discover who they are becoming and what their new world is like.

This need for others to enter the void of aloneness is often misunderstood as a need for sympathy or cheerfulness or other solicitous emotional display. Although these emotional interactions may have some constructive role in dire moments of facing serious illness and disease, what the sick person needs is for others to enter the search for greater emotional understanding of who s/he has become in this new phase of embodiment brought about by illness or injury (which also means within a new world in some sense). This does not mean the ill person needs psychotherapy, but it does mean that healthcare professionals who are experienced with the effects of various sorts of illness and trauma need to pay attention to what these effects mean for the everyday lives of their clients. Using the acquired knowledge from past clients, healthcare professionals can then enter into dialogue with new clients concerning these dimensions of illness and injury. It also means that physicians, nurses and other healthcare professionals must be open to exploring with clients the specific emotional impact of illness. When Toombs (1993, p. 111) states, "What the patient seeks is not simply a scientific explanation of the physical symptoms, but also some measure of understanding of the personal impact of the experience of the lived body disruption," she is pointing to a lived meaning that has a major emotional component.

It is on an emotional level that we first succeed in addressing the need of the ill person "to make sense of this particular experience of illness" (Toombs, 1993, p. 111). Healthcare clients need information and intellectual understanding, but what medicine often fails to provide is facilitation of the emotional registration of the client's situation. This is achieved by helping the client to focus on his/her emotional relationships to the world and by exploring the transformations and revelations that have taken place.

Specifically, there are at least three dimensions of emotional understanding that should emphasized in good medical care. One aspect of emotions is their *exploratory* nature: "Through 'feeling' in its emotional sense, the body moves forward gropingly into the world, not as self-sufficient, not as holding a meaning already to be signified ... but rather as touching things in order to be touched back" (Mazis, 1994, p. 30). In making sense of illness and injury, being encouraged to follow up on feelings as they arise and lead to further feelings, images, expressions, and finally insight, is a process that can be supported, encouraged and facilitated by healthcare professionals. Unlike many aspects of medicine that abstract the client from his/her personal situation in order to understand the "case" as one instance among many, emotional clarification requires a movement toward appreciating the client's *existential uniqueness*: "the emotions do not help us move beyond our embodied situation in which we are caught up in particulars, but rather keep us moving back to that point at which we marvel at the singularity of each particular as if it were experienced for the first time" (Mazis, 1994, p. 31). Again, this kind of emotional clarification – from initially vague emotional feelings to those that resonate with who the particular individual is in his/her unique circumstances – is a process of focusing in which a caring, but professional, interlocutor can be tellingly helpful. Finally, there is the *transformative* power of emotion to open the situation: "If one allows emotion to open up surges of sense, new dawnings of relation, then the world, no matter how familiar, can take on radically new identities" (Mazis, 1994, p. 107). Like the other two aspects of emotion, a person with the distance of a professional – but with genuine concern for the particular individual – may be better able to help the client feel new possibilities for his/her transformed embodiment and world than can those who are closest to him/her. Even if the family does help, medical caregivers should be ready to attend to these dimensions of emotional understanding.

To find new ways of understanding the world emotionally, to become emotionally grounded in the particularity of the unique medical and life situation, and to feel new possibilities, are life and death tasks for coping

and healing from dis-ease. A close relative of mine had open-heart surgery that was "very successful" in repairing the damaged biomechanical parts. However, he never achieved any emotional understanding of how he might become a changed person, might understand his personal habits, diet, relations with others, activities, hobbies, etc., in new ways, or come to see new possibilities for activities in life that would help him heal. He was emotionally devastated, felt as if his life was over, felt cut off from the world, could not fathom a new identity, and fell into despair. Not only was the quality of his life horrible for his two remaining years, but his doctors were mystified as to why he died after "successful surgery."

Every serious illness and injury harbors a possibility for falling into despair. The moment of despair is the moment when one feels as though the meaning of life is gone and one no longer has a place in the world. Most illnesses change who we are and what our world is like. If we are not helped to embrace our emotional capacities for forming new relationships with others, the world, and ourselves, we may never heal the breach that has opened with our old life and world. We cannot just retrieve them. Healthcare clients need help to go forward into transformation. This is an emotional task. In a culture that is obsessed with being in control versus the world and others, that structures life according to future goals and accomplishments, that has little emphasis on self-knowledge and meaningful dialogue, that has little tolerance for pain without feeling persecuted by it, that promotes an obsession with cosmetic beauty, and does little to teach people to improvise creatively in order to cope with untoward situations, the emotional demands for healing from serious illness are made much more difficult. To promote capacities for dealing creatively with situations beyond personal immediate control, to experience pain and struggle as meaningful aspects of existence, to find hope in a commitment to shape the life one has been given within restraints so that it is expressive and personally significant, and to experience wonder, appreciation, and joy for whatever level of activity one can carry out with altered capacities, are emotional tasks that healthcare professionals must address in promoting authentic healing. Healthcare is about achieving well-being through embodiment. An example I sometimes recall is a Navajo story of a healing ceremony for an old woman with advanced cancer. She was "healed" even though she died three months later. What this meant was that she again discovered her wonder with life, her enjoyment of her grandchildren, her equanimity in the face of pain, and her gratitude for each day of being alive. This is the kind of promoting of the feeling of vitality that is essential to well-being and healing. Healing can be

augmented by maximum biological functioning (which is the prime goal of the medical model) but is not at all determined by it. Rather, it is promoted by a care for the emotional attunement of the client with their embodied relation with the world.

Coming full circle from his time immersed in isolated nothingness, towards the end of his rehabilitation Sacks realized that, although he had to perform the acts that would allow him the highest level of health he could now achieve, it was others who were as much a part of his emotional ability to go forward:

> But I could not do this by will-power, or on my own steam, alone. The initiation, the impulse, had to come from without. I had to *do* it, give birth to the New Act, but others were needed to deliver me, and *say*, 'Do it!' They were the permitters, the prescribers, the midwives of the act – and of course, its supporters and encouragers (Sacks, 1984, p. 182).

If Sacks was to make the journey back emotionally – which was the same journey as physical rehabilitation – other people had to become part of his psychic structure. Healthcare is not just from "the outside" (concerned with the objective functioning of organic "parts"), it must also infiltrate the world as it is structured by the client's emotional network of relationships. This network is not separable from the client's embodiment. It is its "other side" – a side that requires medical care to achieve the goal of health (i.e. the most meaningful use of one's embodiment to live a meaningful life).

However, Sacks still had one more barrier to cross. He had "forgotten" how to use his knee properly, even after he found his leg's overall rhythm and got back the sensation that it was *his* leg. He went to see another doctor who asked him what activities he truly loved. When Sacks answered that he used to love to swim, the doctor sent him down to a nearby pool in a taxi. Unknown to Sacks, the lifeguard there was the doctor's conspirator. He shoved Sacks into the water, so he would be tricked into swimming. After that the knee "worked," since it had become reintegrated with the rest of the body through a beloved activity. This reintegration could not be rationally planned and executed. It had to be spontaneous – the hallmark of emotional experience. The final answer to Sacks' healing was to be thrown back into the parts of the world that he loved that would spontaneously solicit the actions his body could perform. This kind of "treatment" would not be right for most patients – it was tailored specifically for Sacks. The point is, however, that such a process takes creative thinking and a focus on the person's unique situation. Medicine has to discover, and then creatively use, what each client cares about – what inspires his/her passion. The world,

other people, and our bodies are one circulation of emotional meaning that must be tapped for healing.

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THE BODY, MUSIC, AND HEALING

Music is the sound of life – Carl Nielsen[1]

As true stillness comes upon us, we hear, we hear, and we learn that our whole lives may have the character of finding that anthem which would be native to our own tongue, and which alone can be the true answer to the questioning, the calling, the demand for ultimate reckoning which devolves upon us – Henry Bugbee[2]

Nothing is more ironical than strengths that generate weaknesses. I think particularly of the ability of Western philosophy and science to objectify the world. To so sharply demarcate things and pin them down that they become objects. Ob-jecta – the Latin roots connote things thrown in front of us. So framed and constituted in experience, things transformed into objects "out there" are subjected to scientific observations and experimentations that tease out, or force out, some of their hidden features.

But this strength comes only with a price that is typically hidden. Acts of objectifying the world and turning things into objects become greatly effective within the sphere of scientific and technological control. So effective they become automatic. The result? We tend to lose touch with things in the full amplitude and impact of their immediate sensuous presence; that is, things as they appear to us before they are objectified for the purposes of science, technological control, or for any short ranged gain.

But within things' immediate sensuous presence our species has grown up and taken shape over millions of years of pre-human and human evolution. Indeed, our own immediately lived personal selves tend to be occluded! What we gain in the right hand, we tend to lose from the left.

Probably most who have introduced undergraduate students to philosophy have encountered the first obstacle. Most students come in as "naive realists." "How do we know the world? Well, there are objects out there that stimulate our senses. We open our eyes and see them, and can choose to examine them closely." The students are assuming – without knowing they are assuming – that a prior question has been asked and answered: What makes objectification possible? How have we come to regard things as objects "out there" to be inspected and controlled, rather than as presences that are, perhaps, spirits that control us?

And one's own body, naively-realistically understood? It is another object, just one that is always with us somehow. The price paid for this detachment from one's body is great. We lose touch with ourselves

S.K. Toombs (ed.), Handbook of Phenomenology and Medicine, 215–225.