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## Many Healths: Nietzsche and Phenomenologies of Illness

**Abstract** This paper considers phenomenological descriptions of health in Gadamer, Heidegger, Merleau-Ponty, and Svenaeus. In these phenomenologies of health, health is understood as a tacit, background state that permits not only normal functioning but also philosophical reflection. Nietzsche’s model of health as a state of intensity that is intimately connected to illness and suffering is then offered as a rejoinder. Nietzsche’s model includes a more complex view of suffering and pain as integrally tied to health, and its language opens up the possibility of many “healths,” providing important theoretical support to phenomenological accounts of the diversity and complexity of health and illness.

**Keywords** Nietzsche, phenomenology, Heidegger, Merleau-Ponty, health, Gadamer, Svenaeus

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### 1 Health as Silent Harmony

Health seems evident; a state, like happiness, that one can easily assess if one possesses it. However, the body gives up its internal functioning coyly, presenting signs that are not always clear. Does feeling energetic mean that health is present, or simply too much caffeine? Or is it a state of mania to be followed by a devastating crash? If I feel well, but a disease inside me will soon bring illness and pain, my body is being worse than coy. Hans-Georg Gadamer writes that health is defined best as a kind of absence, not as a positive sensation. “Health does not actually present itself to us” (Gadamer 1996, 107). Illness is what presents itself as an object, a *Gegenstand*, something to be addressed, quantified, measured, and mastered. Health, on the contrary, does seem to produce a “general feeling of well-being” but is not a condition one can easily objectify and investigate (Gadamer 1996, 112). “Health is not a condition one introspectively feels in oneself. Rather, it is a condition of being involved, of

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being in the world, of being together with one's fellow human beings, of active and rewarding engagement in one's everyday tasks" (Gadamer 1996, 113). For Gadamer, health is intimately tied to the larger lived world—to relationships, to real and possible futures, and to one's work, play, and investments.

Illness disrupts one's natural, unreflective manner of being in the world. This not only allows us to recognize health more clearly, but also might provide us with general philosophical insights into our existential condition. For some phenomenologists, the everyday manner of being-in-the-world obscures our true natures. Illness better illuminates our embodiment and our extension in the world, yet, it often narrows our scope so tightly to the physical that the individual's consideration of the extended environment itself constitutes experience. Against this largely phenomenological view, one can look to Nietzsche's writings on sickness as something essential to health, where he argues for a model in which intensity and perceived exultation are more indicative of health than is normal functioning. This paper will first highlight the phenomenological view of Gadamer, Merleau-Ponty, Heidegger, and Svенеaus, and then turn to Nietzsche's accounts of health and sickness. In so doing, it will draw attention to a model where health is not necessarily co-extensive with long lives or largely pain-free ones.

Citing Heraclitus' words—"The harmony which is hidden is always stronger than that which is revealed"—Gadamer argues that health is just such a secret harmonious connection to the "whole of being," including one's social world (Gadamer 1996, 115). To be healthy, I need not just a body free of disease; I also need to see the world around me as a world that I extend into naturally. My projects and my relationships are not external to my health, but part of it. In this understanding, one can easily see how a stressful situation at work or a broken relationship makes one ill and robs one of health. Illness caused by emotional and situational conditions demonstrates how health is about harmonies that go beyond the individual's body. An example of the close ties between the external and internal worlds of one's body is stress cardiomyopathy, also referred to as "broken heart syndrome":

[A] condition in which intense emotional or physical stress can cause rapid and severe heart muscle weakness (cardiomyopathy). This condition can occur following a variety of emotional stressors such as grief (e.g. death of a loved one), fear, extreme anger, and surprise. It can also occur following numerous physical stressors to the body such as stroke, seizure, difficulty breathing (such as a flare of asthma or emphysema), or significant bleeding. (<http://www.hopkinsmedicine.org/asc/faqs.html>, retrieved 2-13-2015)

To be broken-hearted is as much about the future as about the present. My beloved will no longer shape my world—how do I go on? While stress cardiomyopathy is typically temporary, it can be life-threatening. Our model of health and illness tends to think of the body as the container of either state. When stress is considered a factor in health, such as in the above example, it is often seen as something that “enters” the body and that should be eliminated, much like an infection. However, this doesn’t adequately capture the fact that stress cannot be found with an x-ray or investigated under a microscope. One can track the effects of stress, but stress arises from a shifting complex of experiences including an individual’s relationships, ambitions, and environment, as well as her imagined futures.

For Maurice Merleau-Ponty, Gadamer’s discussion has deep resonances. His work on a healthy body schema possesses similarities to the idea of a hidden harmony that can be disrupted by illness. In the *Phenomenology of Perception*, Merleau-Ponty spends more time examining gross disturbances due to a quantifiable injury or disease than he does examining emotional traumas, but his analysis serves to point out that positivist, mechanical accounts are unable to account for the way in which dysfunctional bodies behave. Moreover, they fail to even understand normal everyday embodiment.

In his discussion of the work of Gelb and Goldstein regarding *Zeigen* (to point) and *Greifen* (to grab), Merleau-Ponty illustrates that we cannot understand the disparity between the two with mechanical models alone since it entails very minor anatomical differences. A patient might, for instance, be incapable of pointing to his nose unless he is allowed to grab it (Merleau-Ponty 1996, 103). The more concrete movement, that of grabbing, is possible whereas the more abstract one, that of pointing, is not. This is curious since it does not seem evident that physiological difference alone could cause this discrepancy. In Gadamer’s language, we can see how the patient who cannot point cannot take up projects in the world. In Merleau-Ponty’s words, the body schema allows my body to become an “attitude” that is “directed toward a certain existing or possible task” (Merleau-Ponty 1996, 100). This makes the healthy, normal body schema concerned with one’s situation in the world, including one’s not-yet-actualized future intentions. Mechanistic explanations cannot understand the possible, the imagined, or the not-yet. It is impossible to explain why one can grab—do the concrete now—but not point—indicate the possible.

Any physiological explanation becomes generalized into mechanistic biology, and any achievement of self-awareness into intellectualist psychology. Such mechanistic physiology or intellectualist psychology then brings behavior down to the same uniform level and wipes out the distinction between abstract and concrete movement, between *Zeigen* [to point] and *Greifen* [to grab]. This distinction can survive only if there are several ways for the body to be a body,

and several ways for consciousness to be consciousness (Merleau-Ponty 1996, 124).

In this passage, Merleau-Ponty draws our attention to the diversity of styles of embodiment and leads us toward questioning unitary understandings of health. If there are two, largely similarly diseased or injured bodies, how can one individual see herself as experiencing a healthy life and the other be paralyzed by stress concerning his work? Possibility is not just a matter of the physical capacity to do a certain skill, but also the imagination's understanding of a complex set of lived future possibilities.

In health, the body schema is largely hidden and allows the individual to extend him- or herself into the world and become busy with projects, be they concrete or abstract. In illness, the breakdown of normal functioning brings the body into focus. Too often, however, the body is considered in isolation, as a static entity that must be corrected with proper medical care. Such approaches fail to explain the varied diversity of how individuals experience illness in that they do not take into account how health is deeply connected to present and future investments contingent upon individual lives. Contemporary work in phenomenologies of health extends key phenomenological conceptions of embodiment such as the body schema, and just what it means to be "in-the-world."<sup>1</sup>

Phenomenologies of health have largely worked from considering phenomenologies of illness, much like how Merleau-Ponty works from abnormal or injured bodily experience to grasp the essential traits of normal experience. Health is more elusive than illness. Some health care practitioners equate health with a biological state, such as the state free from disease or injury that provides for normal functioning described in Christopher Boorse's biostatistical theory. For phenomenology, such an answer fails to capture the sense of health as experiential and as not just something that can be discerned from medical testing or from the capacity to engage in "normal" activities. The other pole would be to simply equate health with a sense of well-being or a feeling of flourishing. This would permit greater flexibility by acknowledging that not all diagnosable illnesses impact each individual in the same manner, and by providing a way to a vision of health within illness and disability. Flourishing also is clearly tied to the virtual: I cannot flourish if I do not perceive the world as a world of possibilities. However, such an approach is not sufficient, since we know that medical tests can reveal an illness that is not perceived by the individual. An all-too-common

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<sup>1</sup> "In the last analysis, if my body can be a 'form' and if there can be, in front of it, important figures against indifferent backgrounds, this occurs in virtue of its being polarized by its tasks, its *existence towards* them, of its collecting together of itself in its pursuit of its aims; the body schema is finally a way of stating that my body is in-the-world" (Merleau-Ponty 1996, 101).

experience that Barbara Ehrenreich reports is the surprise at receiving a diagnosis of an aggressive form of breast cancer despite feeling well and having followed normal health recommendations—“I have no known risk factors, there was no breast cancer in the family, I’d had my babies relatively young and nursed them both. I ate right, drank sparingly, worked out...” (Ehrenreich 2009, 15). Much of our embodied condition passes far beneath the level of conscious awareness. It is beneficial that I do not have to organize my breathing or remind my heart to beat or my stomach to digest food; however, this blindness to my own biological functioning also means that cancer can grow without my knowledge.

Drew Leder (1980) refers to the ways in which our body disappears and is absent from our conscious, mindful experience. What I am attending to at any moment depends upon a complex background of that experience which has faded outside my attention. In certain types of experience, I might turn toward unattended-to aspects (such as thinking about the walls of the coffee shop or some small noise the person next to me is making) rather than remaining focused on my task. However, there are also absent elements to my everyday experience that are, in every normal sense of the word, bodily, but that are completely incapable of being called forth into my awareness other than by metrics that seem disembodied. I have no way of calling to my consciousness how my brain processes information, how blood circulates through my body, or how my digestion works. Of course, in the case of a disorder, these hidden aspects of my body might give me signs indicating something is not normal, but it is also possible that they might not. To know my own condition requires the use of medical tools and the interpretation of the results. A close relationship is thus needed between medical science and phenomenologies of illness. A sense of well-being requires both what one could term external and internal conditions that one may or may not have any agency over.

Working between an acknowledgment of the role of the doctor and the experience of the patient, Fredrik Svenaeus argues that Martin Heidegger provides us with the most valuable way of thinking about health and illness. Heidegger’s idea of “*Unheimlichkeit*”—unhomelikeness—is key to Svenaeus’ account of illness, and he argues that through a certain reading of this concept we can “understand how illness is experienced precisely as a not being at home in my own world” (Svenaeus 2000a, 9). This is not only to associate illness with an anxious, uncanny sentiment, but it is also to elucidate how sickness changes one’s attunement.

Illness, in Svenaeus’ reading of Heidegger, would generally be characterized by an attunement of unhomelikeness, which need not be one of anxiety. Since “attunement” in Heidegger always means attuned understanding as a being-in-the-world, we would here find an outline for conceptualizing illness not only as a feeling but, at the same time, as a mode of understanding. To be ill

would mean experiencing a constant sense of obtrusive unhomelikeness in one's being-in-the-world (Svенеaus 2000a, 10).

The focus on home is important in Svенеaus' account. The idea of *unheimlich* that exists in the German language presents a translation difficulty. In the typical translation, "uncanny," one retains the idea of the peculiarity of the *unheimlich* but loses the "*heim*" or "home" that is present in German. This is an important association for the idea of attunement and for the understanding that shifts in illness. It also distinguishes for Svенеaus the difference between his more Heideggerian-influenced account and that of the uncanny in Freud's work. With Heidegger, there is instead an existential issue at hand—"an unfamiliarity with the world—the very world *that is a part of my own being as a being-in-the-world*" (Svенеaus 2000a, 9. Emphasis mine). Being ill is not being at home, not being able to attend to the world or to allow one's embodied nature to fade into the background. In a similar vein, when one is in a foreign environment, all sorts of mundane activities which are thoughtless at home—moving from place to place, purchasing goods, consuming food—become difficult. As a tourist, I might enjoy these challenges since they are based in my desire to experience something new, but illness as "unhomelike" presents a much more persistent and undesirable set of difficulties. I can't go to work, I can't care for my son, I can't even eat—I am myself and yet my body seems like a foreign burden, calling to mind Delmore Schwartz's poem "The Heavy Bear": "The secret life of belly and bone, / Opaque, too near, my private, yet unknown" (Cf. Bordo 1995, 1). I am not at home even in the most familiar of locales, my own body.

In her description of her chronic and degenerative illness, LAM (lymphangioliomyomatosis), the phenomenologist Havi Carel (2008) notes that not only did her world shrink due to physical inability to engage in the biking and hiking she had previously enjoyed, but her relations with others in the larger social world radically changed, leaving her—as Svенеaus would say—homeless with her friends. Her illness became a strange elephant in the room that no one wanted to address, leaving her feeling obliged to be courageous so as to alleviate their obvious awkwardness:

The status quo seems to be this: don't talk about your illness and we won't talk about our health, our healthy children, our pleasingly predictable lives. We won't talk about how everything worked out fine for us, give or take a difficult labour, a premature baby, or a divorce. This bitterness in me has nowhere to go. It has no place, no name. It is verboten. The strict limitations on what I may or may not say to my closest friends manoeuvre me into a more socially palatable position: being courageous. How brave I am. How uncomplaining. How cheerful in the face of a heavy, sometimes unbearable load. First, I am

set up in a social context that forbids me from talking about my illness. Then, when I turn to other topics, I discover the social reward: I am seen as brave, graceful, a good sport. (Carel 2008, 55)

The homelessness that Carel experiences is not just a personal condition: the ill disrupt the homelikeness of those in their close circles with their unruly bodies that require constant care, with their inability to engage together in previous activities or to fall into traditional topics of conversation. With my ill friend, I can no longer look forward to a world of health where death is but a dim shadow somewhere on the horizon, easily forgotten. Instead, death is right next to her, sometimes acknowledged but always looming. (Carel acknowledges this difficulty for friends and family, but argues that silence is more toxic than making a misstep.) To expand upon the idea of hidden harmony and body schemas above, the way that both health and illness stretch out into the lived situation and into possible, imagined situations involves not just the individual but also all those who have built their own lives with her as a key member.

In phenomenologies of illness, illness is seen as a disruption and breaking of habitual modes of being, interacting, and doing. Some phenomenologically-inspired suggestions for better care are not in-themselves revolutionary as they fit into other contemporary concerns about the reductive state of medical practice that encourage treating the body as a problem to be corrected. Too often health care workers are not provided the training or time to consider the ways in which illness as an experience reaches far beyond perceived pains or disruptions that can be monitored by specialized testing and equipment. While much of actual medical practice does often remain reductive and treats the body as an object, theories, both popular and academic, about how to provide better care have increasingly embraced what can be called “holistic” approaches. In such approaches, patient and physician are encouraged to search for, as Kay Toombs describes it, a shared world that requires the physician to gain insight into the lived experience of the patient (Toombs 1992, 89).

What is more unique in the phenomenological description is that the experience of not-being-at-home, the breakdown of an ease of being-in-the-world and being-with-others—the disruption in one’s intentional arc—is not only a revelation of dysfunctional experience, but also a flipping of the thematic and unthematic. In health, the everyday operations of one’s body fade into the background. When I’m lecturing or having a cocktail with friends, I do not attend to or consider my body schema unless I trip or cough or have some other little awkwardness befall me. This is not to say that in the natural attitude one lives like a disembodied mind coincidentally inhabiting a body. Of course I feel hungry; I have to find a restroom; my feet hurt after standing too long. But these

bodily reminders are at best ones that I hope to take care of so as to no longer have to be conscious of them.

In illness, the problem is that the body is not able to be quieted so that one can attend to other things. Since often the point of phenomenological reflection is to bring to light the ways in which our understanding has been based on crucial misunderstandings of the constitutive role of experience, one might ask if in fact illness reveals our existential condition better than does health. In other words, health is blinding, while illness pulls off the blindfold. Andrew Warsop points out the limits of the “body-as broken-tool” model. Instead, he argues, uncanniness or *unheimlichkeit* fails to capture the nature of the body as not simply a tool, but a living thing in which failures are not always breaks and illness is not always fixed (Warsop 2011, 484–95).

Svenaesus points out that *unheimlichkeit* is aroused in moods of existential anxiety, ones that Heidegger considers necessary to get out of the ontic. I am not at home in illness as I am not at home in a foreign land, but I am also never really at home in my habitual current life insofar as I am both of this world and yet able to stand against it and judge it. Unlike the ocean whose tides and pollution cannot be perceived normatively by it, I find illness both irritating and frightening. I am not a thing-in-itself, I am not continuous with being. Even during periods without perceptible or diagnosed illness, I know that I will die. Does this fact of knowing the inevitability of my death make times of illness more representative of the human condition? Am I more authentic when I experience closeness of death due to my body being undeniably weakened? Am I more distanced from my condition when I feel fine and attend to my projects?

When my frailty and mortality is laid bare and no longer hidden, I can attend to the various practical matters at hand, imagining the hospital or a particular illness, or trying to prolong life. But these do not put me back at home; rather, they merely distract me. Heidegger describes how “thrownness into death” reveals itself in a more “primordial” and “impressive” manner than anxiety (Heidegger 1962, 295). Heidegger considers that Being-toward-death belongs “primordially and essentially in Dasein’s being”; and hence, it must be found in everydayness even if it is hidden (Heidegger 1962, 296). Health can be seen as one reason why our being-toward-death is hidden. Svenaesus writes that “Health is to be understood as a being at home that keeps the not being at home in the world from becoming apparent. The not being at home, which is a basic and necessary condition of human experience, related to our finitude and dependence on others and otherness, is, in illness brought to attention and transformed into a pervasive homelessness” (Svenaesus 2000b, 93). Since illness, whether in oneself or in those whom one cares about, often brings death and anxiety about death to the forefront, would it be appropriate to say that illness is somehow a more philosophically revelatory way of being than the hidden harmony of the healthy?



As Carel writes, “Illness is an abrupt, violent way of revealing the intimately bodily nature of our being” (Carel 2008, 27). Merleau-Ponty emphasizes that the body is not a companion, but the very essence of our identity. “I am not in front of my body, I am in it, or rather I am it” (Merleau-Ponty 1996, 150).

However, against such a view, Heidegger draws a distinction between anxiety and fear. One must not “confuse” philosophical anxiety in the face of death “with fear in the face of one’s demise. This anxiety is not an accidental or random mood of ‘weakness’ in some individual; but, as a basic state-of-mind of Dasein, it amounts to the disclosedness of the fact that Dasein exists as thrown Being *toward* its end” (Heidegger 1962, 295). An obvious point that might lead us to consider illness to be more about particular fears and less about existential angst is that illness is often occupied with physical suffering, and can make the consideration of larger issues difficult, if not impossible. When I am ill, I’m mainly concerned about the most mundane of thoughts—how will I get my child to his school? Will I be able to sleep? Do I need to go to the doctor? Is this really serious or is it something that will pass?—and philosophizing is far down on my list, of which item number one is just surviving until wellness returns. If someone asked me when I was seriously ill about the nature of Dasein, including its directionality toward death, I would not even be capable of focusing seriously on the question since I would need to focus on attending to my basic bodily needs.

In the *Zollikon Seminars*, Heidegger thinks of health and illness as tied together; illness is a privation of health and thus always refers to health. “In that you deal with illness, you are actually dealing with health in the sense that health is lack and has to be restored” (Heidegger 2001, 46). While Heidegger does admit that illness is a kind of being-in-the-world, his view is one where illness is always a deficient privation, and no new possibilities arise from it. Such a model would accord with the idea that while existential anxiety can be authentic, the kinds of existential anxiety that would be revealed by illness would always be particular fears. Petr Kouba (2008) asks in considering Heidegger’s work in the *Zollikon Seminars* if “illness perhaps actually opens up certain possibilities that would remain forever inaccessible without it?” Kouba goes on to point out the example that Merleau-Ponty also uses of how the onset of blindness can evoke other capacities that would otherwise remain diminished.

In Merleau-Ponty’s *Phenomenology of Perception*, there is a strong emphasis in the descriptions of the body of the tacit cogito as tacit, as hidden. When it comes to the forefront of awareness and is needed for everyday actions—when I cannot point without grabbing, when I must instruct my body to perform basic movements—the coherence of the body schema has been disrupted. Merleau-Ponty does not seem to find the disruptions existentially revelatory to the person suffering from them, even if they do help us understand what occurs

beneath awareness in everyday perception. Thus, while it is true that illness brings to the forefront the embodied nature that we can often forget when occupied with our plans and invested in our ideologies, the way it narrows experience so sharply to the immediate makes it far too constricting to evoke philosophical reflection. The intentional arc that connects the embodied subject to the world is broken, referring endlessly back to the body as an obstacle. In the cases where an illness is overcome, such as the use of a cane, what is valuable is when that cane becomes a natural extension of the subject and thus causes the disability to fade into the background. Cases where the illness makes itself constantly known seem to disrupt Merleau-Ponty's understanding of the role of the importance of the unthematic in normal functioning.

Svenaesus would seem to be most likely to celebrate illness or sickness as philosophically revelatory given his focus on the way in which the *unheimlichkeit* of illness is a species of existential angst. However, he does not do so because he argues that while it is true that one's existential condition of finitude is brought to light in illness in a way that is often ignored in health, another aspect of our being-in-the-world, being at home, is ignored. I am not always experiencing a world of foreign intrusion where my body is a heavy burden; I often blend harmoniously with the world and others. It is possible to conclude that despite illness' ability to bring to our awareness our being-in-the-world, the suffering that accompanies it makes it impossible to acknowledge the other ways in which we exist silently connected to the world and others.

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## 2 Many Healths

Above, a certain interpretation of what a phenomenology of health is has evoked the idea of health as a largely hidden part of one's being that permits engagement with others, the world, and philosophical reflection. This model fits well with the everyday concern about illness that highlights the suffering that accompanies it, and the fear of this pain. Pain, suffering, discomfort, and fear of death all necessarily bring the sense of the body's frailty. At the end of the above section, it was noted that due to its flipping of the unthematic parts of our experience—its pointing out our dependence, our being-toward-death—illness could be seen as existentially more revelatory. A few answers to this idea were suggested. One is to follow Heidegger and suggest that illness might be an instance of localized fear of death and not true existential anxiety, with its philosophical import. Another is to suggest like Merleau-Ponty that illness disturbs our tacit manner of engaging with the world and our intending toward it and others, causing us to make the body an object. Finally, after Svenaesus, one can suggest that while

illness reveals some of our existential condition, it covers up the ways in which we are also at home in the world and with others.

In this section, I argue that we should not be too quick to discount the value of illness for existential reflection, and that we should not understand health as a largely hidden experience. In so doing, I will turn to Friedrich Nietzsche's work on health as integrally tied to, even requiring of, illness. Descriptively, Nietzsche's discussions may seem difficult to accord with phenomenologies and personal experiences of illness. However, I think Nietzsche's model of "many healths" complements phenomenological accounts and provides a timely alternative view that counters the increasing medicalization and normalization of our bodies.

There are two kinds of depictions of illness and health in Nietzsche. One diagnoses moralists, in particular Christian moralists and their partners in crime throughout most of the history of Western ethics, with sickness and weakness. In discussing the origin of morals in *On the Genealogy of Morals* Nietzsche argues—amid his curious quasi-historical analysis of the origin of certain moral terms—that prior to our contemporary morality, moral terms were concerned with self-naming and creating distance from the low-born. Original master moralities were not sophisticated, in that they did not depart from the experiences of the knightly-aristocratic class; and were not abstract, in that no attempt was made to universalize them. What they espoused was a strong love of the physical and of health: "The knightly-aristocratic value judgments presupposed a powerful physicality, a flourishing, abundant, even overflowing health, together with that which serves to preserve it: war, adventure, hunt, dancing, war games, and in general all that involves vigorous, free, joyful activity" (Nietzsche 1969a, §1, ¶7, 469). Those not lucky enough to be born into bodies and conditions that fostered such physicality grew resentful and gave birth to what we would now think of as morality—a universal set of judgments that often are decidedly against the physical. Just as the knightly-aristocratic values sprang from the masters' own powerful condition, the slave morality of the priestly class sprang from their weakness. When Odysseus is praised for his looks, cleverness, and skill in battle, it isn't hard to deduce the kinds of persons that might celebrate the values behind those attributes. The impotence of the priests causes them to create values that reject the physical because of their own weakness. They do not create from a love of self, but from a hatred of what they are not: "...As is well known, the priests are the *most evil enemies*—but why? Because they are the most impotent. It is because of their impotence that in them hatred grows to monstrous and uncanny proportions, to the most spiritual and poisonous kind of hatred" (Nietzsche 1969a, §1, ¶7, 469). This hatred is born out of a lack of the kinds of positive qualities that make for a well-lived life. "While every noble morality develops from a triumphant affirmation of itself, slave morality from the outset

says No to what is ‘outside,’ what is ‘different,’ what is ‘not itself’; and *this* No is its creative deed” (Nietzsche 1969a, §1, ¶10, 472). The sophistication of contemporary morality would be lost on Nietzsche’s pre-moral knightly-aristocratic class since, to a large degree, their health is a simple affirmation of what they are and not, as in contemporary Western morality, of what they should be.

This attack makes Nietzsche’s second discussion of sickness and suffering as essential to health, vitality, and overcoming a difficult one to understand. There is no mistaking the distaste he has for moralists. Such descriptions make one assume that only those who possess health in some primitive unreflective manner, such as the one outlined above in phenomenologies of health, could properly be the “masters” that Nietzsche celebrates. It is curious then that Nietzsche celebrates sickness in his other writings.

The values Nietzsche clearly celebrates include not just elitist values that seem untimely today, but also the value of difference, including characteristics that we would normally think are at minimum undesirable, if not outright evil. Suffering is not an objection to a flourishing existence, but actually essential to it:

We think that hardness, forcefulness, slavery, danger in the alley and in the heart, life in hiding, stoicism, the art of experiment and devilry of every kind, that everything evil, terrible, tyrannical in man, everything in him that is kin to beasts of prey and serpents, serves the enhancement of the species “man” as much of its opposite does. (Nietzsche 1969b, ¶44, 244–45)

In this passage from *Beyond Good and Evil*, one notes that improvement or progress is not made solely on the back of “positive” virtues such as charity. Rather, progress is made on the basis of danger as much as on that of clear-headed rational planning.

In a similar vein, health is not the opposite of sickness, but something that takes place in a certain relation to sickness. Since change is inevitable and since our condition leads us not just to the joys of life but also to its obvious difficulties, health outside of sickness is not any more possible than life without death. Nietzsche even counsels that sickness can be philosophically profound insofar as it portrays the vitality of life more explicitly:

For a typically healthy person, conversely, being sick can even become an energetic *stimulus* for life, for living *more*. This, in fact, is how that long period of sickness appears to me *now*: as it were, I discovered anew, including myself; I tasted all good and even little things, as others cannot easily taste them—I turned my will to health, to life, into a philosophy. (Nietzsche 1969c, §1, ¶2, 680)

Even beyond the idea that sickness helps to highlight health, reminding us that health is a positive state of intensity and not a background operation of a well-functioning system, Nietzsche also claims that his sickness has been philosophically profound because it teaches him deeply about embodied diversity as the place from which thought emerges, and not as a convenient location where thought happens to be placed.

I am very conscious of the advantages that my fickle health gives me over all robust squares. A philosopher who has traversed many kinds of health, and keeps traversing them, has passed through an equal number of philosophies; he simply *cannot* keep from transposing his states every time into the most spiritual form and distance: this art of transfiguration is philosophy. We philosophers are not free to divide soul from spirit. We are not thinking frogs, nor objectifying and registering mechanisms with their innards removed: constantly, we have to give birth to our thoughts out of our pain and, like mothers, endow them with all we have of blood, heart, fire, pleasure, passion, agony, conscience, fate, and catastrophe. (Nietzsche 1974, §NP3, 35)

Sickness as perceived suffering, as the unthematic body forcing itself upon the individual requiring a response, is in not an objection to health. This would contradict the idea of illness as privation in Heidegger and, in Merleau-Ponty, the idea of illness as limiting the body's natural, spontaneous extension toward the world. However, in reflection, extreme states of joy or passion are intense and bring us away from unthematic being-in-the-world, yet are typically seen as states that give our lives great meaning. While people must certainly forgo some great passion at times in their lives, or even consistently, for fear they will lose the object of their affection or fail to achieve their ambition, one might suggest that doing so diminishes life even if it preserves it.

It is this turn that one does not find in the phenomenologies of health and illness outlined above: the idea that life extension might be actually unhealthy, rather than healthy in a Nietzschean sense. This idea is worth considering even if it seems, at face value, to oppose the idea of health as a kind of stable background state that allows one to continue into future, yet-unlived worlds. Such a model seems to celebrate life-extension (provided it does not simply bring more sickness than health), but if health is a state of intensity, there might be dangers attached to it that would not extend life and might very likely bring pain. Perhaps moderation, traditionally seen as a hallmark of health, might *limit* health.

Slave moralists do not suffer from sickness as pain and suffering, what they suffer from is a fear of intensity. Marc Letteri argues that Nietzsche teaches us the distinction between “sickness” and “sickliness”:

Health is, however, not simply the absence of weakness: it is, rather, the free admission of weakness into the arena of struggle with the aim of conquering it and thereby becoming stronger. An untested will is an unknown quantity, and a will which actually shirks tests is even worse—much worse. It suffers not from sick*ness* but from sick*liness*: it is characterized by an inveterate inability, an **inability** to deal profitably with impediments and obstacles. (Letteri 1990, 411; emphasis added)

Moralists blame the senses and thus the body for disrupting their search for ‘truth.’ They object to change, divergence, difference—all the elements that constitute our embodied existence. This springs not from a serious desire for universality, but rather from an inability to endure human existence and a search for a solution outside of it. The sickness of the moralist is not physical sickness so much as a kind of inability to face being embodied with its vacillating states, including pain. The weakness of the moralist is thus not necessarily connected to the weakness one has when one has the flu or is being treated for cancer, but rather to a fear of variety since it brings with it great joys and ecstasies, but also suffering and disintegration—in other words, what it is to live.

Why is not intensity, even the intensity of suffering, understood as an all-too-human part of existence? One possibility is that we simply find suffering objectionable. However, this is not obvious since experiences that are sought-after such as natural childbirth and running marathons are both painful and intense, but also celebrated. We would find someone who avoided pain at all costs unreasonable and likely incapable of a kind of life most people would consider worth living. Pain and suffering are not objectionable in-themselves. The issue of death had been raised above—illness reminds us of our own morality and that of those we love. Perhaps as terrifying is how serious illness alters the individual’s sense of self. Many of us in the developed world are pointed toward futures where advances in medical science will keep us existing in states radically different from those we occupy now. To witness those living through long-term cancer treatment, dementia, or Alzheimer’s makes it hard to say that the same individual persists throughout the illness. This “being-toward-illness” means that I will not be when I die, but also that I will likely not be this same me when I am still here. Thus, my imagined future, my very potential future, is one where I exist without being me.

The most striking examples are raised by those with illnesses that strongly alter one’s capacity for self-understanding and connecting various life experiences into a meaningful whole. Peter Sedgwick writes that “A philosophy worthy of the name, Nietzsche thus argues, must celebrate embodiment in all its most painful possibilities, for suffering and illness are connected in an essential way to human identity” (Sedgwick 2013, 308). He goes on to describe his

experience of a dementia unit in the UK where the “victim of dementia” increasingly loses their “ability to narrate their own life...” but still continues to persist in living (Sedgwick 2013, 320–21). This existence that is increasingly a loss of self, or at least a loss of a unitary self, cannot help but bring us to an existential anxiety that can be more acute than the fear of death.

The illusion of a stable identity that lies beneath the vicissitudes of the joyous, painful, and mortal body is needed to support certain ideologies of health. If health is a background state that permits me to engage in my projects, I might be tempted to fall into dualism, seeing the healthy body as a nicely functioning car I drive around in to get to my destinations. When my car breaks down, I am inconvenienced, but I am still me. It also seems to suggest that bodies might differ, as cars do, but that the passengers are all alike. Such a model is often supported by popular language wherein one “fights” the disease, wherein one is encouraged to “take charge” of one’s health as if the healthy-body were an object one can battle or master and that is separate from the willing subject. Nietzsche took such conceptions to task. The moralists want conformity of souls not because conformity exists, but because it serves the aim of distancing one from the body. Identity for Nietzsche cannot be universalized any more than morality. The moralist who wants to deny the charming diversity of life will seek the idea of one way to see health and one way to see suffering. Nietzsche writes:

Let us finally consider how altogether naïve it is to say: “Man ought to be such and such!” Reality shows us an enchanting wealth of types, the abundance of a lavish play and change of forms—and some wretched loafer of a moralist comments: “No! Man ought to be different.” He even knows what man should be like, this wretched bigot and prig: he paints himself on a wall and comments “*Ecce homo!*” (Nietzsche 1976, 491)

What if I am as susceptible to change as my body is? What if illness does alter me forever? What if there are many healths I will undergo and many others that will be forever foreclosed to me? What if I cannot understand my ill friend’s suffering because she is undergoing something radically other, because she is different and will stay different from what she was before? What if painful, intense, even life shortening, experiences can be part of health too? We can now better understand Nietzsche’s call for a radical diversity of ideas of health in *The Gay Science*:

Even the determination of what is healthy for your body depends on your goal, your horizon, your energies, your impulses, your errors, and above all on the ideals and phantasms of your soul. Thus there are innumerable healths of the body; and the more we allow the unique and incomparable to raise its head

again, and the more we abjure the dogma of ‘equality of men,’ the more must the concept of a normal health, along with a normal diet and the normal course of an illness, be abandoned by medical men. Only then would the time have come to reflect on the health and illness of the soul, and to find the peculiar virtue of each man in the health of his soul. In one person, of course, this health could look like its opposite in another person. (Nietzsche 1974, §120, 177)

Phenomenologists, in particular existential phenomenologists, would find much in common with Nietzsche’s celebration of the senses, of change, of accepting aging, birth, death (as discussed above with reference to Heidegger), and difference amongst humans. Merleau-Ponty writes that mechanistic models cannot explain the rich diversity of styles of embodiment. In his lectures on child psychology and pedagogy, Merleau-Ponty repeatedly draws attention to how physical maturation is necessary but not sufficient for development. Merleau-Ponty lectures that, “Development is as little a destiny as it is an unconditioned freedom, for the individual always accomplishes a decisive act of development in a particular corporeal field” (Merleau-Ponty 2010, 407). Hegel’s idea of “surpassing while preserving” is cited as a means to understand how the individual must incorporate earlier stages fully in order to develop. Hence, one can have precocious children or delayed children; it is a matter of their larger connection to others and the world around them. For example, in the case of sexist societies, the closing-off of many possible worlds to a young girl limits her development.<sup>2</sup> Here we can see a tie back to the previous discussion of how health for phenomenologists is also about the possible, and not just the present physical state of the individual.

Yet, despite these resonances with Nietzsche’s texts, phenomenologists might pause at the discussion of intensity and pain as essential for health. After all, it is the suffering of illness that breaks the harmony of the body schema in its everyday actions. It is pain that commonly restricts one’s life. Parts of Nietzsche’s work do not in principle run counter to the kinds of ideas Svenaeus, Carel, Toombs, and others interested in more holistic approaches to medical practice offer. Instead, the idea of many healths that would include pain, suffering, and illness offers an important existential rejoinder when considering just what health is. Sedgwick notes that Nietzsche’s view of health helps to counter the tendency to think of health as something that is the opposite of

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<sup>2</sup> “For Merleau-Ponty development is flexible, but it is not, therefore, without necessary structure. Social norms can negatively influence our attitudes toward our bodies. A society that relegates women to a narrow set of possible roles will likely cause ambivalence if not outright rejection on the part of young women” (Talia 2013, 131).



sickness: “Medical practitioners, therefore, ought to abandon the modern tendency to think of health as the opposite of sickness,” and instead consider health as something tied to one’s frailty and finitude” (Sedgwick 2013, 320). Similar to the idea of *unheimlichkeit*, illness is not a rejection of health but part of what it is to exist—to be both at home and not at home.

Nietzsche’s critique of sickliness rather than sickness as well as the illusion of a stable self provides the phenomenologist with a way to avoid thinking reductively about health as a background. It also suggests that perhaps the intense or even extreme experiences that do not make a longer life likely might be healthy. Life shows itself the most present not when I’m attending to some other task, but when its precarious nature is most present to me, in danger, in extreme experiences, in suffering. While it is valuable to think about how good health often recedes into the background when one takes up tasks, the possible danger is then to think of health as a kind of steady state wherein variance, both individual and social, is an objection to it. If we think about health as “many healths” we capture both individual and social diversity more accurately. Sedgwick argues that medical practice would benefit from giving up the idea of a stable identity:

The frailty of embodiment made manifest by individual suffering and vulnerability to disease shocks us into the uncomfortable acknowledgement of our own finitude. To be human, in other words, means to respond to the travails of arbitrary suffering (i.e. the casual onslaughts of pain that embodiment necessarily entails) by seeking meaning. (Sedgwick 2013, 316)

Identity, both the identity of the self and the idea of an identity to health, misleads medical practice. Sedgwick continues to argue that “Modern medicine’s most pervasive and dubious metaphysical presupposition likewise resides here, for modern medicine’s conception of health presupposes a stable and definable selfhood hidden behind the shifting and mysterious vicissitudes of the suffering body that, as Nietzsche’s explorations of the domain of identity reveal, is a pure chimera” (Sedgwick 2013, 319). A Nietzschean discussion of many healths thus argues for a phenomenological case against health in the singular.

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### 3 Conclusion

The idea of many healths and of health as intensity necessitates the expansion of the concept of health as a tacit background state in Merleau-Ponty, as a secret harmony in Gadamer, and as a being-at-home in Svenaeus. While health may at times recede into the background, this would be but a phase in life. Health may

also be an at times radical, conscious vitality, the perceived overcoming of illness, or the pain at executing a challenging effort. On the other hand, pain and suffering would not always entail an absence of health. The key is the experience in which pain and suffering were understood in the individual's life. The important discussion in phenomenology of the manner in which one's current experience is constituted by the future, insofar as the future represents imagined, potential realities toward which one intends, is key to avoiding seeing pain as simply a negative element of existence. The pain of the athlete, the pain of the lovesick, and the pain of the ill are not necessarily objections to one's desired existence, but rather integral parts of one's identity.

Carel and Toombs' work on phenomenologies of illness and health stresses the difference between the natural attitude of the patient and the naturalistic attitude of the physician. These two approaches cause a systematic distortion between the patient and the physician. In the natural attitude the patient is not taking the world as an object, but rather as an obvious background reality. The physician, as a scientist, takes up the naturalistic attitude where the world is taken as an object and thus dissected. "The aim in the 'naturalistic' (or scientific) attitude is to grasp the nature of 'reality' and to describe 'reality' in terms of some 'objective' description which will accurately characterize the 'thing-in-itself' apart from one's experiencing of it" (Toombs 1992, 14). The physician will thus be blind to the understanding of the patient who does not experience illness as a thing to be diagnosed, but as a part of one's life. Carel likewise points out that the naturalistic attitude will fail to capture "the experience of illness" (Carel 2007, 108). Along with Svenaeus, they call for the aid of phenomenology, and thus the phenomenological attitude, in providing insight into the experiences of the patient with his natural attitude, and those of the physician with his naturalistic attitude in order to provide better care.

The additional existential focus on many healths in Nietzsche is a way in which to expand upon ideas partially present in these phenomenologies by not dividing the experience of the ill from that of the healthy. I think this approach provides an additional means of explaining the diversity of "relevance" that Toombs discusses regarding different patients' reactions to similar illness, as well as how "creativity" in Carel's work is seen as a likely reaction to long-term illness (Toombs 1992, 16–19; Carel 2007, 104–8). Illness and its accompanying suffering are not a discrete experiences had by a certain class of people or by all people at certain times; rather, sickness and health stand together against the backdrop of human being-toward-death, and also being-toward-illness. As we will all face our deaths alone, so too will we encounter futures where cancer, heart disease, bodily injury, or dementia might radically alter us.

In conclusion, I would also suggest that such a model presents a more robust place from which to refuse the increasing medicalization and moralization that

surrounds our expanding scientific knowledge about health as maintaining a certain kind of life without denying its benefits. Controversially, Nietzsche's view permits a way to think about the healthy value of activities and lifestyles that are dangerous. In a world awash with increasing regulation of personal lifestyles due to health concerns, it provides a small space to pause and wonder if life-preservation through "healthy lifestyles" is always life enriching. It can appear that the philosophical point of pursuing phenomenology of illness is to work primarily on the problem of suffering by encouraging more considerate and phenomenologically sensitive health care. While this is a worthy goal, it assumes that working against pain and suffering is always going to be beneficial for the individual. Perhaps not continuing one's existence, despite the availability of interventions to do so, is as valid a desire as continuing it. Perhaps refusing to obey health norms of self-care is one choice amongst many. Perhaps even embracing life-limiting activities should not be so quickly dismissed as indicative of mental disorder or ignorance. If suffering is connected to our existential condition and is not merely a roadblock to some state called wellness, one might find the non-compliant patient or citizen curious, but not in principle broken and in need of intervention and repair.

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