Petra Hroncová

The therapeutic aspect of philosophical lived-body concept. Application into the area of medical praxis

Studia Philosophiae Christianae 47/3, 105-117

2011

Studia Philosophiae Christianae
UKSW
47(2011)3

PETRA HRONCOVÁ
Department of Philosophy, Trnava University in Trnava, Slovakia

THE THERAPEUTIC ASPECT OF PHILOSOPHICAL LIVED-BODY CONCEPT. APPLICATION INTO THE AREA OF MEDICAL PRAXIS

Key words: body, lived-body, medicine, objectification, isolation, life-context

1. Introduction. 2. Cartesian body. 3. Consequences of the thesis: *cogito ergo sum*. 4. The body in a new dress. 5. Two main problems within the frame of medical praxis. 6. Application of the lived body concept into the medical praxis. 7. Reciprocal medicine of the lived body.

1. INTRODUCTION

Lately there has been a consideration of the therapeutic competence of philosophy. One of the possibilities for demonstrating the therapeutic effect of philosophy is philosophical conception application within the frame of medicine. As the term "therapy" means treatment or an amendment also this actuating of philosophy in the frame of medicine wants to be some amendment, specifically amendment of the traditional approach to a body. American philosophers Drew Leder and Glen A. Mazis are engaged in the idea that we suggest here. According to these philosophers, the traditional model of approaching the body stems from a modern image of a human. That is why the remorse against the paradigm asserting in medicine are headed for the dealing with Descartes and overcoming the optics that his conception has given over us.

2. CARTESIAN BODY

In the 17th century there was a question about the nature of the man to the fore. At that time there was an effort to develop such theory that

would be in its philosophical approach inspired by sciences, by their exactness and clearness, too. Such were aspirations of Descartes who appointed parameters for the aim of answering this question at that time. It is well-known that the leading method, that Descartes tried to climb some basic principles with, was the method of doubt. As the consequence Descartes demolishes all his uncertified beliefs and convictions in the effort of seeking what is *clara et distincta*.

Descartes devotes himself to the problem of the distinction between the body and the mind (soul) in the book *Meditatiiones de prima philosophia*[1], partly in Second and for more detail in Sixth meditation. Already in the Second meditation we can find the first definition or description of the body: "by a body I understand whatever has a determinable shape and a definable location and can occupy space in such a way as to exclude any other body; it can be perceived by touch, sight, hearing, taste or smell, and can be moved in various ways, not by itself but by whatever else comes into contact with it" [Descartes 1911, 17]. From this extensive description we can learn some substantial statements about the body: it occupies some space, it is perceived by senses, it cannot be moved by itself and it has no ability of perceiving. Descartes characterizes the body as something motionless, what takes some place (literally occupies the place) and is possible to be perceived. It seems that such a body is nothing but an object in the world that is perceivable and hence scientifically examinable. Just this understanding of body as the object was, according to Drew Leder, recast into the medicine and represents the main, not the only, expostulation against Cartesian body.

Another of Descartes' works regarding the question of the body is also interesting: *Treatise on Man* (*Traite de l'homme*, 1662), that is a part of the book *The World* (*Le Monde*, 1664). There we can find a detailed description of the body but not as something living and lived, sensing and sentient. Compared to *Meditations*, where the mind (soul) is highlighted, in this work Descartes aims to evoke representation of

[1] Descartes is devoted to body – soul relation problem also in his last work *Passions of the Soul* (*Les passions de l'âme*, 1649), where his aim is to capture rather their unity than difference. Even though the main of his works is considered to be *Meditations* and his philosophy is usually interpreted on the base of this work.

the body as so ordered and functioning machine that it is not needed to think about the mind (soul) as something that makes the body move [Descartes 1998, 171]. The image we create while reading *Treatise on Man* resembles to the machine, mechanism with strictly determined functions. Descartes proposes the view on the body as the machinery of organs and their functions that resembles rather physiological-mechanical analysis than something we live. Drew Leder even says that such body more resembles the corpse [Leder 1998, 119]. While in *Meditations* Descartes proclaims that: "I am not that structure of limbs which is called the human body" [Descartes 1911, 18], in *Treatise on Man* it seems that I am nothing more than this. We can say that these two works represent opposite alternatives.

3. CONSEQUENCES OF THE THESIS: *COGITO ERGO SUM*

The aim of Descartes was to assign a fundamental difference between the body and the mind (soul), what culminates in attribution of the privileged position in our nature to the soul. As a result the body seems to be an unimportant component that loses the property of moving and perceiving that after all, according to Descartes, belong to the mind. Donn Welton says that he thus "(...) reduced the body to what is extended in time and space and, thereby, what is measurable" [Welton 1999, 2].

The most severe consequence of Descartes' view on the body is disintegrate dualistic view on the man that is characterized by disaffection the human from his corporeal living which is connected with mentioned understanding of the body as an object. According to Donn Welton there are two main directions of the consequences of Descartes' conception: the first is the characterization of the mind independent from the body, so the mind therefore represents the opposite towards all that is material; the second direction incites us to reduction of various human experiences on mechanical interactions within the frame of the body [Welton 1999, 2–3]. We think that none of these views is satisfying and adequate. According to Drew Leder and Glen Mazis the second mentioned consequence forms the basic approach to the patients within the frame of medicine. The first mentioned consequence that culminates in understanding of the body as an object – something what

is only added to us and to what we are related rather in instrumental or possessive way – is also important. The question we ask with the help of Leder and Mazis is: What are the possibilities of repression of this reductionism and traditional dualism of the body and the soul within the medicine? The answer on these questions could be the lived-body conception that accrued on the field of phenomenology in 20th century.

4. THE BODY IN A NEW DRESS

A modified paradigm of approaching to the body has been a relatively long time coming. Approximately 300 years after Descartes, the theme Body returned to philosophical discussion and tried to find firm place among philosophical conceptions. But it was not the same body Descartes left on investigation to sciences as a "dead" object. On the contrary, this body extricates from the object status and searches for new assignation, even a new point of view based on which it is supposed to be targeted anew.

In *Cartesian Meditations* [*Cartesianische Meditationen*, 1931] Husserl reveals the body as the fundamental component of monadic ego, so called the sphere "of my own". It is not the kind of body we can talk about as the object among other objects because it does not pertain to the sphere above me but it is of my own. In such a manner Husserl opens a new understanding of the body which he nominates 'lived-body' (*Leib*) in contrast to the body as an object (*Körper*) [Husserl 1993, 90–96]. Such understanding of the body is the central topic of Maurice Merleau-Ponty's philosophy, especially in the work *Phenomenology of perception*. The aim of this new approaching to the body as lived body is a repression of traditional dualism of the body and the soul and so the unification of a man in his corporeal living and allowance of entourage (the world) in which the body is situated, in which the body lives, because "to be the body is to be tied to a certain world" [Merleau-Ponty 2002, 171]. The very spatiality of the body is modified. This development is very striking. It goes from Descartes' *res extensa*, the body which only fills the space, through the basic location of orientation in Husserl's philosophy pending to "spatiality of situation" [Merleau-Ponty 2002, 115] as it is understood by Merleau-

Ponty. If the body was understood as the object and relatively isolated mechanism in the Cartesian sense, the entourage of the existence of the lived-body is fundamentally different. "The body is here not regarded as a passive, impersonal object (...) but the very center of one's experience, moods, expressions and projects" [Leder 1984, 36]. Even Mazis says, that corporeity is "rather dispersed throughout its lived context" [Mazis 2001, 203]. This is closely connected with the fact that the lived-body is understood as "intentional entity" [Leder 1998, 124] that is always more closer to the things it is related to than tighten to itself. The lived body expresses the unity that cannot be divided into parts. It is a matter of whole bodily expression of living creature within the lived world.

5. TWO MAIN PROBLEMS WITHIN THE FRAME OF MEDICAL PRAXIS

If we focus on medical praxis, two foremost serious consequences of the Cartesian approach to the body appear. We outlined them previously: the understanding of the body as an object and in some sense isolated mechanism of the system of organs.

The first problem then is the objectification of the body. As we already said, the body seen through Cartesian conception is the object. The lived-body on the contrary cannot be understood in this manner. Leder claims that: "It is the very nature of the lived body to be both perceiver and perceived, subject and object" [Leder 1998, 128]. However the body is never seen as the only object, it is always also subjectively lived. On illustration of this two-dimensional unity of the lived body Merleau-Ponty uses the example of reciprocally touching hands of one body where the assignations of subject and object still elude.

The problem of objectification is more obvious in the case of illness or pain. Whereas the Cartesian body does not change its model of object in this context, the unity of lived body is disrupted. Leder says that "the unity of the lived-body begins to fall apart in disease" [Leder 1984, 33]. This process of objectification begins in the case of pain or disease and culminates in the medical surrounding. The body makes us notice it through pain and disease. It requests our attention and there-

fore starts to be the object for us. We can even pay attention to a particular part of our body, the one that hurts or is attacked by disease. In the case of pain we start to look upon our body as disintegrated and with distance, it means – in an objectified mode. This approach to the body is, according to Leder, much graded when we decide to see the doctor. We can describe this approach by following: The body-machine does not work as it should, so we vest it in the hands of somebody who is to repair it as a broken object. Of course, this is a simplification, but it illustrates our changing relation to the body in the period of disease or painful injury. Moreover Leder states: "In the physical examination the patient experience her/his body as a scientific object beneath the dispassionate gaze and the probing, palpating fingers of the doctor" [Leder 1984, 33]. This is the place where the Cartesian body is overlapped with the lived body and in medical praxis the lived body is retracted, whereas the body as the object is highlighted. This also suggests that the lived body is primary whereas the body-object submitted under the medical intervention is something secondary and unnatural – something out of the context of the lived body and its world. "The Cartesian body interpreted as 'thing', a mechanical collection of parts extrinsic to the self, is itself brought to the fore as a latent experiential possibility rooted in the illness of the lived-body" [Leder 1984, 33]. Leder and Mazis try to appoint out that a human is the lived body and although in the case of disease the objectified component rises up, in medicine it is inaccurately outline and regarded as the main approach. The consequence is "the body (...) subsumed into a series of readouts and signs (...) is seen as biophysiological functioning" [Mazis 2001, 200]. In the area of medicine then arises a situation described by Leder as follows: "(...) the patient presents the lived-body for treatment while the doctor treats the Cartesian or object body" [Leder 1984, 32]. He even says that the appointment of the doctor with the patient looks like the appointment with the corpse – where the doctor seeks only the mechanical trigger of disease, some disorder, poisoning or trauma [Leder 1984, 33]. The attention of doctor is often concentrated on a particular part of the body instead of the whole lived body in its context of its lived world. In connection with this Leder talks about "an ironical fulfillment of Cartesian dualism – a mind (namely, that

of the doctor) runs the passive and extrinsic body (that of the patient)" [Leder 1984, 35]. The medical intervention within the Cartesian understanding of the body according to Leder allows the body to be "divided into organ systems and parts to be repaired, surgically removed or technologically supplemented in relative isolation" [Leder 1984, 30]. The question is whether this approach is therapeutically effective in the whole sense. Authors we mention here consider this approach to be incomplete.

The lived body offers another interpretation of the ill or painful body, no more as the disorder of the body-machine, or malfunction of isolated mechanism. Thereby we are getting to the second problem, which is the isolation of the body. Glen Mazis says that: "Pain announces something wrong with the body, but not from the body as 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" [Mazis 2001, 205]. Pain seems not to affect only our body but also the relations in which the healthy body has been functioned until now. There is one statement of Merleau-Ponty we can also apply to the case of pain or illness: "(…) it is not only an experience of my body, but an experience of my body-in-the-world" [Merleau-Ponty 2002, 163–164]. Therefore illness is not only a disorder of isolated body but a disruption of the whole context in which the lived body normally lives and practices its intentions in activities. This principled anchorage of the lived body in the world is evident in the case of disease in the negative sense. It is a change in the context of the lived body characterized by isolation or other restrictions. In medical praxis the body is mostly examined as isolated from its life-context, even isolated from its known world, in surgery office – sterilized and unnatural environs with appropriate resources' on its examination. Drew Leder and Glen Mazis emphasize that disease is not the disorder of the isolated mechanism of the body-machine but it is a disruption of the whole lived context of the lived body. Disease causes the isolation from others and restriction of our movements and habits or intentions. Pain in the literal sense "constricts our accustomed context of life" [Mazis 2001, 205], what evokes some kind of isolation. This negative change accrues not only from principled anchoring of the lived body in the world but also from ba-

sic understanding of our body as "centre of potential action" characterized by the attitude "I can" [Merleau-Ponty 2002, 125, 159]. Disease then means the change in the area of what I can. "If each part of the body embodies «I can» relationships to the world (...) pain and illness force me to live my body as «the no longer can»" [Mazis 2001, 206]. Therefore the isolation of the body is understood as impossibility of practicing the accustomed activity and asserting intention within the context of life. Therein it is important to underline the passivity of the patient's body. In the period of illness we are really getting more passive than active what can be seen in our approach to the body not as the possibility of various activities but rather as impossibility of practicing certain activity any more.

If we are to summarize what the disease means in such different approaches to the body, we would say that in the case of the body-object it is a disorder of one of its parts, which invades its functioning, mechanism. In the case of lived body there are more far-reaching consequences, "because disease is enough for the changing of phenomenal world" [Merleau-Ponty 2008, 254]. Isolation of the lived body does not mean isolation within the body – its non-functional part – but isolation from its entire life-context. It can include limiting movement, changes in the senses and with regard to time there can be an excruciating moment of the present and constricted relation to others [Leder 1984, 32].

6. APPLICATION OF THE LIVED BODY CONCEPT INTO THE MEDICAL PRAXIS

Neither Leder nor Mazis criticize the Cartesian approach to the patient as the body-object in the whole sense. They try to reveal limitations of this approach that leads, according to them, to depersonalization of patient, dehumanization in approaching and reductionism of the lived body into the system of measurable laboratory values and number notes [e.g. Leder 1998, 122, 124; Leder 1984, 36]. Indeed both of them are aware of some necessity of this objectified and reducing approach. Disintegrated view on the man has not only negative coextensive terms but it has also substantiation in specialization of parti-

cular departments within the medicine. Also the approach of the doctor to the patient as the object of investigation has substantiation in the sense of efficiency of therapy assessment, ergo the fastest intervention [Leder 1984, 33, 36]. However they call attention to some obstacle in this approach. "When unfamiliar with the patient's being-in-the--world, i.e., history, general functioning, life-style, habits, home and work environment, symptoms may be misinterpreted and inappropriate treatments proposed" [Leder 1984, 37]. They consider the tendency to isolate the body from its life-context, which is anchored in medicine, to be not only the possible resources of improper therapy but also its inefficiency.

Amendment of the traditional approach to the body within the medicine supposed by Leder and Mazis is to comprehend the lived body into medical praxis, which means to make provision for context in which patient normally lives and which is changing by the disease. For all that Glen Mazis underlines the role of emotions in the relation of the patient to the doctor and also to his/her disease and finally to the whole his/her life-context, relations within his/her family, work and so on, because all of this is modified in the life of ill one. Mazis wants to emphasize the fundamental role of a patient's emotional relationships in the disease therapy process, "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" [Mazis 2001, 200–201]. Drew Leder talks about the wider context that also makes provision for patient's emotional frame of mind what he supports by research: "research has suggested that such factors as the emotional state of the patient, the quality of the therapeutic alliance, the patient's self-image and attitude towards illness, recent life changes and current environmental stresses and supports are crucial in predicting the onset and progression of illness" [Leder 1984, 37].

What should then the lived body concept application into the medical praxis be like? Drew Leder as well as Glen Mazis mention the example of leg fracture, when the role of surgical amendment – some "fixation" of the leg – is not a sufficient therapeutic technique, because the mentioned case is not only about the disorder of a part of the body, which inhibits its isolated functioning, but about violation of our who-

le corporeal existence in the relation to its surrounding. Merleau-Ponty says, that: "the various parts of the body are known to us through their functional value only (…)" [Merleau-Ponty 2002, 172]. It means that the broken leg is not only disrupted part of our body, but general disability to walk, so the whole movement of the body is corrupted together with the context of our life and possibilities of acting. From the view of lived body concept it is not possible "to separate" the leg (even relatively) from the human corporeal living within his/her world. The attention paid to the whole patient's life is to supplement the traditional medical intervention. "To operate most effectively the clinician or clinical team must do more than set the fractures properly; they must address the pain, the restricted motility, the constricted possibilities that reconfigure the patient's world", because "this is an injury to the body-as-lived, not just the body-as-machine, and so should be regarded" [Leder 1998, 127]

In medical praxis there is an effort of the doctor to reintegrate the functioning of not only the particular leg but of the whole lived body with its relations to the world – this is what is lacking in the Cartesian approach to the body. We can say that it refers to therapy on several levels. Firstly, there is the therapy of the leg, then therapy of the assumption of the leg – that means of the whole body – and finally there is a therapy in the sense of restoring the old relations within the world of concrete individual or obtaining the new relations. The role of a doctor or medical team should be according to Leder and Mazis extended. As Mazis says: "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" [Mazis 2001, 210]. They should also be engaged in the impact of the disease on patient's private life which includes the acquaintance of the client with possible constraints, and the main task, which is to exert the doctors to offer the client acceptable possibilities of reintegration of their relations to the world, that are adequate to their state.

7. RECIPROCAL MEDICINE OF THE LIVED BODY

This proposition of making provision for the life-context of lived body establishes, according to Leder, some requirements not only within the frame work of medicine but also within the personal approach to the body that is connected to the area of treatment. Specifically the point is an appeal for prevention. An exerted Cartesian model often infiltrates also into our common experience. "Thus there is a tendency in this culture to focus on the body only when ill. (...) we neglect the cultivation of optimally healthy states in our personal habits and medicine" [Leder 1984, 35]. Through the area of medicine we are returning in a roundabout way to common experience and we find out that our body calls for our personal attention and involvement also in our everyday life. Leder, too, comes to the conclusion, that "the most important „treatments"must come on the preventive level through increased personal and social responsibility for health maintenance" [Leder 1984, 35–36].

On the basis of this Leder creates the conception of some reciprocal medicine of the lived body, which underlines interaction of both the illness on our life-context and the consequences of the corporeal living of our world that rebounds in the area of the health. He says that "just as our physical structure lays the groundwork for our mode of being-in--the-world, so our interactions with this world fold back to reshape our body in ways conductive to health or illness. A medicine of the lived body dwells in this intertwining" [Leder 1998, 125]. The therapeutic program based on the lived body conception has two fundamental requirements. One is directed towards medicine and calls for treatment of the lived body not the Cartesian body-machine-object, which means to pay attention to the treatment of the whole patient's life-context. The accent is put on achieving resumption of the ill, treating or already "treated" (in Cartesian sense) body within its life-context. This can be done by restoring of previous relations or by finding new alternatives that are to lead up to the emotional maximization of client's possibilities of becoming involved in accustomed world and help the client to get to the emotional anchorage in it. Health in this sense means not only simple "amendment", but reintegration of the well-being and functioning

within the personal life-context [Mazis 2001, 207–211]. The second requirement within the reciprocal medicine of the lived body aims to potential patient and so is the appeal to *prevention* and *personal involvement* in the treatment process that are based on the personal paying attention to the life-context of our body. Drew Leder summarizes it as follows: "If the objectifying model tends to emphasize an interventionist approach at the point of illness (i.e. fixing the machine), the paradigm of lived embodiment helps to focus attention to the healthy body and personal participation in prevention and treatment" [Leder 1984, 36].

It seems that the lived body conception within the framework of medicine overcomes this area and finally turns our attention also to the sphere of our everyday life, where "treatment" should start in the sense of prevention. The therapeutic program we finally achieve shows therapy to be the primary care and attention towards our body even sooner than medical intervention is needed.

REFERENCES

Descartes (1911), *Meditations on First Philosophy*, in: *The Philosophical Writings of Descartes*, vol. II, Cambridge University Press, Cambridge 1911.

Descartes (1998), *The World and Other Writings*, Cambridge University Press, Cambridge 1998.

Husserl E. (1993), *Karteziánské meditace*, Svoboda-Libertas, Praha 1993.

Leder D. (1998), *A Tale of Two Bodies. Cartesian Corpse and the Lived Body*, in: *Body and Flesh*, ed. D. Welton, Blackwell, Massachusetts 1998.

Leder D. (1984), *Medicine and paradigms of embodiment*, The Journal of Medicine and Philosophy, vol. 9, no. 1, Oxford University Press, Oxford.

Mazis G. A. (2001), *Emotion and Embodiment within the Medical World*, in: *Handbook of Phenomenology and Medicine*, ed. S. K. Toombs, Kluwer Academic, Netherlands 2001.

Merleau-Ponty M. (2002), *Phenomenology of Perception*, Routledge, New York 2002.

Merleau-Ponty M. (2008), *Struktura chování*, Filosofia, Praha 2008.

Welton D. (1999), *The Body*, Blackwell, Massachusetts 1999.

ASPEKTY TERAPEUTYCZNE ZASTOSOWANIA FILOZOFICZNEJ KONCEPCJI „ŻYWEJ CIELESNOŚCI" W PRAKTYCE MEDYCZNEJ

Streszczenie

Artykuł podąża za koncepcjami amerykańskich filozofów Drew Ledera i Glena A. Mazisa, którzy rozważają możliwość zastosowania koncepcji „żywej cielesności" (Maurice Merleau-Ponty) w medycynie. Podstawą tej idei jest kartezjańskie rozumienie cielesności i fenomenologiczne do niej podejście. Wskazuje się dwa podstawowe problemy tradycyjnego medycznego modelu ciała i sugeruje, że można je rozwiązać w koncepcji „żywej cielesności".

Słowa kluczowe: ciało, żywa cielesność, medycyna, obiektywizacja, izolacja