Medicine and Paradigms of Embodiment

ABSTRACT. This paper suggests that the paradigm of the lived-body developed by Straus, Merleau-Ponty and others has important implications for medical practice and theory. Certain recognized flaws in modern medicine, such as its reductionist tendencies and lack of emphasis on preventive measures are shown to be related to the exclusive use of a Cartesian notion of embodiment. Increased attention to the paradigm of the lived-body emphasizing its unity, purposiveness and "enworldment" could help to beneficially reorient practice. Moreover, this portrayal of the body as an intentional entity may provide a better tool than the traditional view for conceptualizing the psychological and personal components of disease etiology as well as some newly developed modes of treatment.

Key Words: Embodiment, Lived-Body, Body-Objectification.

I. THE CARTESIAN BODY

In the 17th century, René Descartes introduced a fundamentally new paradigm of embodiment. Attacking the Aristotelian and magical views of nature that were popular in his day he banished all animation and teleology from the natural realm, attributing such properties to the creator God alone. The human body was fully identified by him with this passive nature. As such, it appeared as mere res extensa, manifesting no intelligence or power of self-movement. These activities were ascribed to mind, res cogitans, the essence of self and the divine aspect of the human being. By way of contrast to the sublimity of mind, the human body was merely a machine driven by mechanical...
causality and susceptible to mathematical analysis like any other component of \textit{res extensa}.

Descartes meant for his philosophy to bear medical fruit. In his \textit{Discourse on Method} he resolved to dedicate his life to the advancement of medicine (1911, p. 130), and followed through in the \textit{Treatise of Man} and \textit{Passions of the Soul} with elaborate theories of human physiology. Even in his more philosophical \textit{Meditations} and \textit{Principles of Philosophy} he attempts to show the relevance of his metaphysics of mind-body interactionism to such vexing medical problems as the "phantom limb" phenomenon and the effects of peripheral nerve blockage (1911, p. 293). Though Descartes's theories of pineal gland transmission and his hydraulic model of the human body were soon outmoded, it must be said that he fulfilled his early dedication to medical advancement. His metaphysics of embodiment did more to permit the achievements of modern medicine than could any particular scientific theory, for it opened up the very possibility of applying post-Galilean science to the human body.

By purging the body of spontaneity, willfulness and occult desires, Cartesian dualism did away with all properties which might have impeded the mathematical-causal analysis of physical functioning. Viewed as a machine, the body can be tested experimentally and blueprinted in detailed anatomical study.

Furthermore, the body is revealed as susceptible to mechanical interventions. The scope of clinical possibilities thus widens commensurate with that of expanding research and technologies. As machine-like, the body can be divided into organ systems and parts to be repaired, surgically removed or technologically supplemented in relative isolation. As subject to mathematical analysis, the body reveals its true condition through laboratory values adjustable by drugs and diet. Ethical prohibitions against invasive treatments become as outmoded as those which prohibited anatomical dissection — since the machine-body is extrinsic to the essential self it can and must be entered, studied, tampered with in order to be repaired.

\section*{II. \textsc{The Lived-Body}}

This Cartesian paradigm has more or less dominated not only the scientific but popular and philosophical views of the body for the last 300 years. However, in the 20th century, arising diversely out of existentialism, Husserlian phenomenology, and German philo-
sophical anthropology, a new concept of the body has emerged. We will focus on two of its most original and articulate spokesmen in Erwin Straus and Maurice Merleau-Ponty. The many similarities of their analyses are striking – their differences, while significant, are not crucial for the purposes of this paper. The paradigm they advance will here be referred to as that of the “lived-body”. While seldom employed in the original writings under scrutiny, this term has served in English as useful shorthand for the concepts we will be examining.

Both Straus and Merleau-Ponty grounded their initial work in a careful, at times laborious critique of the Cartesian portrayal of mind and body and its influence on current psychologies. In their view, the Cartesian categories lead to systematic misdescription of human activity. Bodily acts are not merely mechanical. Nor are all acts with cognitional and volitional status truly “mental”, as Descartes envisioned them, arising out of explicit judgments and acts of will. Rather, an examination of experience reveals that it is the body which first “understands” the world, grasping its surroundings and moving to fulfill its goals. In phenomenological terms, the body is not just a caused mechanism, but an “intentional” entity always directed toward an object pole, a world.

This bodily intentionality is termed “sensing” in Straus’s seminal work, *The Primary World of Senses* (1963). Merleau-Ponty examines much the same phenomenon under the name of perception (1962). The act of sensory perception is analyzed by both men as first and foremost neither a mechanical process nor a type of thought, the Cartesian alternatives. Rather, sensing exhibits a bodily intelligence and affectivity. Influenced by the findings of gestalt psychology, Merleau-Ponty (1962, p. 4) shows how any sensing already recognizes a set of meanings, insofar as part of the perceptual field leaps to the foreground as the center of significance. Moreover, this is an existential significance as Straus describes, having qualities such as the “alluring” or “frightening” (1963, p. 198). That which we sense grabs the interest, calls for further investigation, attracts or repulses.

But this can only be for an active body, one that can move toward, around or away from the object. The sensing of the lived-body is revealed as the result of its capacity of self-movement, its movement the result of sensing. Contra Descartes we lead a unified existence.

The parameters of this existence are set by our physical body, re-envisioned not just as a biological but intentional structure. Thus, for instance, Merleau-Ponty explores the role of embodied sexuality in coloring our world (1962, pp. 154–173). Straus analyzes the
modes of spatiality and communication yielded by the different senses (1963, pp. 367–379), and how our upright posture opens distance, initiates a battle with gravity, and frees the exploring, laboring hands (1966). Furthermore, the lived-body is the ground not only of our predefinitions but our flexibilities and individuality. We develop corporeal skills, habits, styles of expression which set apart who we are and the world in which we live.

Ultimately the lived-body constitutes our being-in-the-world (Merleau-Ponty, 1962, p. 79). It is through our capacities of sensing and moving that we first acquire and inhabit our surroundings. Even the Cartesian world of fixed objects originates as a set of unifications and stabilities in our lived perception. Within such a world even the body itself can come to be seen as a mere physical object. However, the “object body” of Descartes always remains derivative, arising secondarily out of the experience of the lived-body (see Merleau-Ponty, 1962, pp. 67–71, 90–97).

This analysis of lived embodiment was primarily employed by these thinkers to criticize traditional philosophical and psychological approaches to the person. Though others such as Buytendijk and Plügge have sought to apply similar concepts to physical medicine, neither Straus nor Merleau-Ponty worked extensively in this area. A brief outline of the possible medical applications of their work will form the focus of this paper.

III. A PHENOMENOLOGY OF THE CLINICAL ENCOUNTER

First, the descriptions and theory introduced by these men can be used as a tool to analyze embodiment in the medical encounter. Most simply, it could be said that the patient presents the lived-body for treatment while the doctor treats the Cartesian or object body.

The patient may arrive in pain or with other discomforting sensations. His/her possibilities of movement are restricted or in some other way transformed. With these changes in sensing and moving, lived spatiality takes on a new character, experienced perhaps as closing down around the immobilized patient or diseased body part. Temporality may correspondingly contract to the excruciating moment of the present. Life projects are forgotten or modified. Communication with others is constricted or inordinately sought. In its several modalities the I-World relation effected by the lived-body has been transformed until the patient is distressed enough to seek treatment.
But the doctor examines a physical body. Much of her/his medical training has de-emphasized lived embodiment from the first “patient” encounter – that with a cadaver. The predominant task at hand is to search for a mechanical precipitant of disease, be it toxin, trauma, or bug. The physical locus of pathology is isolated such that a focused and efficacious intervention can be made.

This analysis of polarized attitudes toward the body, while revealing, is somewhat oversimplified. The patient as well may have come to regard his/her body in an objectified mode. This process is often begun by the illness itself. As Straus (1963, p. 245) and others have commented, when suffering the body can come to appear as Other. The painful body is experienced no longer as the immediate agent of our desires, but as an alien presence we would be rid of. Similarly, the disabled body appears as exterior to the self by virtue of frustrating our personal intentions. Furthermore, the unity of the lived-body begins to fall apart in disease as our stomach cramps, our breathing emerges in dyspnea. The body then reveals itself as a nexus of semi-autonomous biological processes – Merleau-Ponty (1962, pp. 83–89) discusses this as the ever-present “organismic” or “pre-personal” aspect of the lived-body. Thus 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.

This process of bodily objectification is furthered when the patient seeks clinical assistance. In the physical examination the patient experiences her/his body as a scientific object beneath the dispassionate gaze and the probing, palpating fingers of the doctor. For Sartre (p. 461), (disregarding the possibilities of objectification inherent in the individual’s lived-body) it is this look of the Other which primarily turns the conscious “for itself” body into the thingliness of the “in-itself”. Furthermore, to cooperate with the physician the patient must purposefully take up this manner of self-regard (Spicker, p. 119). The naked body is exposed to examination, the arm to a painful blood test. The patient learns to deliver a history, an objective report of recent bodily occurrences, and to scientifically describe current physical sensations. The observational mode continues as the patient self-administers treatments, reporting back on all changes in the external appearance and internal sensations of the body.

This objectification of the body is often sought for affective reasons by patient and doctor alike. The attitude of clinical detach-
ment may help the patient to remove the self from experienced suffering and attendant fears. Similarly, the doctor may need distance. Merleau-Ponty (1962, pp. 184–186) discusses how the lived-body can recognize and take up the expressiveness of the bodies it communicates with — such, for instance, that we feel the sadness of a tearful face. The doctor, confronted by a seemingly endless chain of suffering, may need to effect a break in this linkage of lived-bodies.

Thus the aforementioned conflict of embodiments which can arise in the clinical encounter is often resolved largely in favor of an hegemony of the object body. But such a resolution is always incomplete for doctor as well as patient. Straus (1963, pp. 107–112) analyzes how the scientist in conducting an investigation of the objectified body always remains within her/his own lived-body while proceeding with the exploration. Similarly, the trained, intelligent hands of the doctor, her/his skillful experienced eye are not seen as bones and tendons, cornea and retina, as are the corresponding organs of the patient — this would only bring the diagnostic work to a halt. The doctor remains a paradigmatic instance of the lived-body in praxis.

Nor will the patient ever escape the lived-body. Pain, while alienating the self from its corporeality is also (as Descartes himself recognized) an irrefutable experience of mind-body unity. That the body is not a mere extrinsic machine but our living center from which radiates all existential possibilities is brought home with a vengeance in illness, suffering, and disability.

Most good medicine will acknowledge this lived embodiment which ever remains in the clinical encounter. A sensitivity is shown by the doctor to the physical experience of the patient and the significance of disease and treatment within the life context. Yet all too often the hegemony of the objectifying model over modern medicine can lead to negligence in these areas.

Straus and Merleau-Ponty examine at length the limitations and mistakes effected by the reflex, physiological, and gestalt psychologies of their day, by virtue of their over-reliance on the Cartesian paradigm and their consequent repression of the lived-body. Analogously, we will attempt to suggest how modern medicine suffers when the lived-body is forgotten. Certain widely cited flaws of current medical practice will be briefly shown to be related to the dominance of the Cartesian paradigm. Then, in a more speculative vein, we will suggest ways in which medical theory and practice might be transformed by attending more fully to lived embodiment.
IV. THE LIMITS OF MEDICAL INTERVENTION

To this point we have focused upon the clinical encounter. The treatment of a sick patient by a physician or other practitioner has indeed formed the central model by which our society conceptualizes issues in health care. Yet this restricted conception is in important ways itself based upon and encouraged by the metaphysics of the object-body.

When the body is not thought of as the essential self, but a machine placed at the disposal of the will, it can be overlooked when it is functioning well. In Heidegger’s terms, as long as the “ready-to-hand” piece of equipment works properly it is hidden from view, un-thematized. One remains primarily concerned with the ends it services. It is only when this equipment in some way breaks down or becomes un-useable that it must be explicitly addressed (Heidegger, 1962, pp. 98–107). Thus there is a tendency in this culture to focus on the body only when ill. In contrast to cultures where the body is viewed as the center of self-actualization, we neglect the cultivation of optimally healthy states in our personal habits and medicine.

Furthermore, when our body is attended to in illness this attention usually consists in handing it over to the doctor. As external to the essential self, the body can be placed fully in the care of another. Recast now not as shaman or healer but as scientist-technician, it is the doctor who is best able to understand and fix the complex mechanism at hand. As he/she thoughtfully adjusts the patient’s laboratory values with medication and intravenous fluids there is an ironical fulfillment of Cartesian dualism – a mind (namely, that of the doctor) runs a passive and extrinsic body (that of the patient).

Yet this disease-orientation and professionalization typical of Western approaches to health care have recently come under criticism in the popular and medical press alike. As life-span increased, living conditions changed, and infectious disease was brought under control, more and more illness in industrialized countries has taken the form of chronic processes related to habits, life-style and environment. Cigarette smoking, stress, exposure to occupational and environmental toxins, minimal exercise, alcohol and poor dietary habits have emerged as the crucial determinants in the etiology of the prevalent diseases of modern life. Such conditions as heart disease, cancer, strokes, arthritis and bronchitis-emphysema for the most part cannot be cured by the physician – merely managed in their progression. The most important “treatments” must come on the preventive level.
through increased personal and social responsibility for health maintenance.

The paradigm of the lived-body could help to reorient health care in such directions. The body is here not regarded as a passive, impersonal object fit to be neglected or given over to the professional, but the very center of one's experience, moods, expressions and projects. As such, a heightened awareness of the body in health, not just at times of breakdown, can result. The cultivation of corporeal self through exercise, diet or whatever emerges is no less important than the development of mind encouraged by Descartes. A sense of personal responsibility for bodily functioning is called for, for the body is what I am. 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 on the healthy body and personal participation in prevention and treatment.

V. MEDICAL PRACTICE: THE BODY REDUCED

When the body does become ill Cartesian medicine has much to offer in the way of efficacious treatments, prolongation of life and the alleviation of suffering. Yet while few shun the services of the modern physician at times of serious illness, many patients experience aspects of their treatment as reductionist or dehumanizing. Once again, the Cartesian metaphysics underlying medical practice is not incidental to this happenstance.

When the patient appears as physiological mechanism, the doctor may neglect personal communication in favor of the immediate scientific task at hand. The envisioning of the body as a machine composed of parts permits the proliferation of specialists, concerned only with a single body-region or organ system. Moreover, an ever-increasing layer of technological instrumentation designed to investigate the machine-body comes to mediate between physician and patient. All these factors can contribute to a patient's sense of having been depersonalized in the clinical encounter, regarded as just a liver or set of laboratory values. Objectification and isolation of the lived-body are hazards of the conflict of embodiments discussed earlier.

This process is furthered by the paradigmatic treatment settings of office and hospital. The body qua scientific object is best studied and treated in these environments where technological equipment is available and conditions are standardized. Removed from home,
family, responsibilities, even clothes, the hospitalized patient does indeed appear as little more than a passive body-object interchangeable with those around it. Similarly, the doctors of the modern hospital become interchangeable — regarded as scientist-technicians able to replicate each other’s results they can be transferred from ward to ward, often to the detriment of continuity of care.

These tendencies of Cartesian medicine have recently been criticized on several levels, once more in both the popular and professional press. It is pointed out that the drift toward overspecialization, lack of continuity of care, and disregard for the patient’s experience and life-context can lead to clinical misjudgements. 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. Even if correctly conducted the medical intervention may be undermined by non-compliance due to client dissatisfaction or misunderstanding.

Furthermore, the unpleasantness which accompanies dehumanized treatment can no longer be regarded as a peripheral concern. 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 toward illness, recent life changes and current environmental stresses and supports are crucial in predicting the onset and progression of illness. These sorts of “subjective” factors indeed form the general background to almost all clinical research and therapy under the name of the “placebo effect”. It is clear that the patient’s belief in and experience of her/his treatment is often the most important mechanism in determining its efficacy, but this is often neglected by the mechanistic approach.

Flaws in medical practice can thus arise from the Cartesian tendency to isolate the body from the essential self and its life-context, and to further divide the body into isolable parts and functions. On the contrary, the paradigm of the lived-body effects a reunification.

First, the body itself is viewed as a unity of sensori-motor intentionality. This suggest that illness, even while bringing a specific physical modality to prominence, will have its effects and significance in a general realignment of our bodily functioning. The specialist cannot neglect the body as unified field. Moreover, bodily function is regarded as always unified with its world. Thus, the etiology and meaning of disease and the possibilities of treatment cannot be understood except by reference to the surroundings and life-projects of the patient. The medical tendency to view disease as occurring
within an isolated entity is counteracted by this recognition of the existential “enworldment” of the body.

In addition, the concept of the lived-body reunifies body with mind, as it ascribes to corporeality the intentional attributes hitherto reserved for res cogitans. This helps to emphasize and clarify how such subjective factors as the patient’s attitude and emotional state can play a crucial role in determining health. Viewed as intentional, bodily functioning can express affective, cognitional influences in a way perhaps inexplicable within the Cartesian model. It is in its overcoming of the mind-body antinomy that the paradigm of lived embodiment may be of greatest interest to medicine. We will thus examine further the import of such a notion in rethinking the etiology and treatment of disease.

VI. THE LIVED-BODY AND THE ETIOLOGY OF DISEASE

The evident importance of subjective and psychosocial factors in the etiology of disease raises the question as to whether these can be adequately modelled by the Cartesian approach. This is generally attempted either via a materialistic monism, whereby all mental functions are collapsed into a physiological model, or by a modified dualism in which mental factors are retained.

The former approach has served to illuminate and legitimate the role of psychological factors in health by suggesting their mediating physical pathways. Research into the autonomic hyperactivity of the Type A personality, and the endorphin component of the placebo effect are examples of such work. Yet to truly incorporate the notion of subjective and psychosocial etiology into a disease model one must be able to address the subject’s purposiveness and relations to the external world. The materialistic model, confined to a mapping of caused, internal physiological processes cannot do this.

Those recognizing the need for preserving reference to the intentionality of behavior frequently employ a covertly dualistic or multicausal model of disease. One must look at a human not just as body but as body and mind, or perhaps as a complex interdependency of body, mind, emotions, and spirit (Pelletier, p. 35). This paradigm attempts to assert the unity of all such levels, but fails to truly address the perennial problem of how physical and mental factors interconnect. The proponents of this holistic approach thus often find themselves leaping from one level of discourse to another, describing the cortical norepinephrine pathways at one moment,
the next the beneficial effects of spiritual belief. While such phenomena are interconnected, the languages used to describe them are not, for they are derived from the two sides of the Cartesian dichotomy and thus have no linking terms. If purely physicalistic description loses the subjectivity of the individual, this multicausal approach has trouble expressing a unity.

The paradigm of the lived-body, wherein subjectivity is always corporeally expressed, avoids these problems. As such it may be better able to address the role of psychological factors in the etiology of physical disease. When disease is understood as arising out of bodily intentionality it can no longer be seen as a merely mechanical event. Falling ill is to some degree a culmination of a purposive response to the perceived enworldment. However, this process is not the result of separable "mental" factors, i.e., conscious reasons and decisions or analogous unconscious processes. The intention is in the body, articulating a preconceptual grasp of the world.

We will give some examples of the sensori-motor intentionality involved in disease. A person may express a subliminal grasp of the world as overpowering, the self as inadequate before it, by assuming a stooped body posture. Years later, the chronic back problems that result come before an orthopedic surgeon. Another body takes up the classic pose of fight or flight in a stressful office situation. Over time the internal hypermobility leads to gastritis, high blood pressure, perhaps a heart attack. The oversecretion of acid, the constriction of an artery exhibits the expressiveness of bodily movement no less than motions externally manifested.

Another person who is restless, unable to eat or sleep properly may develop a viral illness. Her/his past experience, future projects, entire being-in-the-world are expressed in the bodily tension. Despite a conscious desire to take care of the self, this over-alertness leads the body to reject food and sleep and thus ultimately to embrace illness with its attendant possibilities of rest.

Distracted, or eschewing the normal self-preserving reactions, a body may become involved in a serious accident. Another body, experiencing a primordial emptiness, seeks to fill itself with food or smoke — the medical problems of obesity, or cancer and emphysema may result. The leg muscle of a runner tears, clenched too tightly in apprehension.

Such examples could continue indefinitely. They all exhibit illness as a disordered being-in-the-world. A certain preconceptual grasp of enworldment, e.g., as threatening, is expressed in a bodily stance that
leads to illness. As our examples illustrate, this may range from the
stance of a moment to that of a lifetime. In response to its perceived
situation the body expresses itself in habits of posture, tension and
relaxation, sleep, exercise, emotionality, alertness, diet and substance
use that will play a crucial role in determining its health history.

We have been emphasizing the body as an agent of personal
expression. However, as has been discussed, the lived-body also
exhibits a prepersonal or organismic side (Merleau-Ponty, 1962,
p. 84) which is relatively autonomous in the face of our motives.
The body is "uncanny" (Zaner, pp. 47–66) – its nexus of unknown,
automatic processes, while forming the setting for our activity, leaves
us vulnerable to impersonal forces. Undeniably there are many
illnesses that emerge almost totally out of the organismic situation
such that they are not explicable primarily in terms of personal
motivation. One may have a gene for Huntington's chorea that must
be expressed, or may be injured by a falling object, or overwhelmed
by an irresistible microbe. In such cases a straightforward physicalistic
analysis of etiology will best serve.

At the other extreme, the lived-body shades into thinking, conscious
self, for example through its powers of expression in speech (Merleau-
Ponty, 1962, pp. 174–199). Correlatively, our disease can arise not
from preconceptual expressiveness, but directly from explicit
decisions to place the self at risk or engage in self-destructive behavior.

However, these cases where illness has relatively pure physicalistic
or mentalistic origins are now re-envisioned as merely the limiting
instances of bodily intentionality. These extremes are what Cartesian
dualism has presented as rigidly separate categories of causation,
and the sole ontological possibilities thereof. This makes intermediate
"mind-body" causalities anomalous and difficult to conceive. On the
contrary, the paradigm of the lived-body emphasizes such inter-
mediate phenomena as central to the precipitation of most illness,
and provides a language for their articulation. Ultimately one is hard-
pressed to find any limiting case that doesn't include both subjective
and organic features. (For instance, even in the example of Hunting-
ton's chorea, its onset and course will be bound up with psychological
factors.) Most importantly, the entire range of organismic to
personalized features is now viewed as a continuum brought under a
unitary paradigm. The irresolvable antinomies of Cartesianism are
transformed into the dialectical play of the levels of the lived-body.
VII. THE LIVED-BODY AND THE TREATMENT OF DISEASE

This notion has suggestive implications for medical therapy. The traditional options of treatment reflect the Cartesian dualism from which they derive. One may utilize the resources of physical medicine, such as drugs, surgery and the like. Or if personal and psychosomatic factors are clearly primary in the etiology of illness, one is usually referred to the psychiatrist, treater of the mind. A talk therapy is often employed, healing through words, the penultimate mental construction.\(^5\)

However, if many diseases arise from an intermediate bodily intentionality these separated physicalistic and mentalistic approaches may not always best serve. Medications and surgery, while crucial modalities of treatment, often do not address the intentionality behind disease. Conversely, as primarily actualized in a pre-linguistic bodily expressiveness, the intentionality of illness may not always be transformable through language and introspection.

However, many new therapies have appeared, ranging from the medically accepted to the distinctly “alternative”. They seek to foster health not via mechanical interventions or talk but by directly realigning the intentions and processes of the active body. Some examples include the use of biofeedback in the clinical setting; yoga exercise for flexibility and internal toning; the induction of the “relaxation response”; art and dance therapy for psychiatric patients; “Rolfing” and other forms of massage; the employment of visualization techniques to combat cancer; primal scream therapy for the release of trauma and tension; behavioral programs to modify phobic responses; methods such as the “Alexander technique” which reshape bodily posture and movement; autogenic training and other modes of deep muscle-relaxation.

Though it is not always recognized, these therapies operate with an implicit concept of the self closer in spirit to that of Straus and Merleau-Ponty than Descartes. Posture, muscle tension, hormonal and immune functioning are regarded not just as machine processes but as intentional structures which can be volitionally realigned. Techniques such as biofeedback and visualization are used to transform the preconceptual expressiveness of bodily functioning. This bodily functioning, not that of a disembodied consciousness, is regarded as the crucial locus of self-development, and of emotional as well as physical healing. The lived-body is incorporated directly into treatment.
Such therapies would by no means supplant the traditional options modern medicine offers. Nor will all prove efficacious. However, they are too often neglected because our Cartesian heritage does not yield a structure by which they can best be understood. The theory of bodily intentionality helps create a space in which such forms of treatment make eminent sense. If applied to medicine, the paradigm of the lived-body might assist in the explanation and further development of such novel therapeutic techniques.

VIII. CONCLUSION

This paper has attempted to show how diverse features of medical theory and practice are related to the fundamental metaphysics of embodiment on which medicine rests. Recent critiques of modern clinical practice; current research concerning the importance of psychological factors in health; the appearance of novel treatment modalities, have all suggested new directions for medicine. However, these developments cannot be fostered by piecemeal revisions in our conceptual structure — their cumulative effect is to call for the advancement of a new notion of embodiment which will not replace but complement the traditional view. The paradigm of the lived-body, emphasizing its intentional structures, provides a promising direction for further exploration.

NOTES

1 In Descartes's Sixth Meditation (1911, p. 192) he asserts that it is bodily feelings such as pain, hunger and thirst which show that mind does not merely reside in the body as a pilot in a ship but is closely united with it. Such statements, along with those in his famous correspondence with Elizabeth, evidence a more complicated and at times self-contradictory view of mind-body relations than the simple dualism discussed in this paper. However, the latter remained the predominant emphasis of his work and has entered the tradition as "Cartesianism".

2 See esp. Straus (1963, pp. 29–186 and 289–312), and Merleau-Ponty (1963, pp. 7–128). However, this critical emphasis is continued throughout much of their work.

3 In the interests of brevity, the multitude of research in this area will not be individually cited. Pelletier (1979, esp. Chapters 1, 2, and 5) provides a useful summary of such work.

4 A further articulation of the many levels of bodily intentionality, ranging from almost purely organic processes to conscious behaviors, would be an important
area for future work relevant to medicine. Both Straus and Merleau-Ponty, in simply contrasting the lived-body with its objectified correlate, tend to neglect the gradations of awareness and purposiveness which differentiate levels of lived embodiment.

Biological psychiatry will not be given a separate discussion since it merely subsumes mental phenomena under the mechanical model of physical functioning. It is ironic that an increased awareness of mind-body interrelation has principally led, within medicine, not to a richer notion of the body but to a reduced conceptualization of mind.

REFERENCES


