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Issues for a phenomenology of illness – transgressing psychologizations

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Abstract
Phenomenology of illness has grown increasingly popular in recent times. However, the most prominent phenomenologists of illness defend a psychologizing notion of phenomenology, which argues that illness is primarily constituted by embodied experiences, feelings, and emotions of suffering, alienation etc. The article argues that this gives rise to three issues that need to be addressed. (1) How is the theory of embodiment compatible with the strong distinction between disease and illness? (2) What is the difference between problematic embodiment and illness? (3) How is existential edification, that illness can give rise to according to the phenomenologists, to be understood? The article then engages in an analysis of Heidegger's and Waldenfels' phenomenology with the ambition of developing a notion of existence, which can transgress the psychologization of illness. Rather than arguing that illness is constituted by experiences of suffering and alienation, it emphasizes that broaches upon conatively guided activities constitute illness.

Keywords: Phenomenology · Illness · Transcendental phenomenology · Phenomenological psychology · Psychologization · Heidegger

Introduction

Recent years have seen a blossoming of phenomenological perspectives on health and disease. Through insights drawn from traditional phenomenology, several distinct but closely related theories of the *phenomenology of illness* (*PHI*)[1] have been formulated by philosophers such as Carel, Svenaeus, and Toombs with Leder and Zaner as important precursors. Briefly put,

[1] In this context, *phenomenology of illness* specifically refers to the theories of Carel, Svenaeus, and Toombs. The use of the term 'PHI' is therefore a generalization of several quite diverse positions and might seem to be an oversimplified and artificial construct of a theory. What the theories do share, however, is a certain psychologizing approach to phenomenology, and I therefore elect to use the term "PHI" throughout, although the reader should be aware that the philosophies of Carel, Svenaeus, and Toombs are quite nuanced and internally varied.

phenomenologists of illness emphasize the *first-person* rather than the *third-person* perspective. They explicate 'what it is like' to have an illness, and how it affects the sick person's relation to their body, ability to interact with others and surroundings, self-conceptions and so on. Rather than conceiving the body as primarily a conglomerate of biological parts and processes, phenomenologists of illness maintain that there is an intimate – albeit not always harmonic – unity between body and mind. I do not merely *have* a body; I *am* my body. Consequently, consciousness is *embodied* and pathology affects the entire being of the sick person. This conception does not negate but complements a biomedical perspective on pathology. Indeed, phenomenologists maintain the Boorsean distinction between disease and illness (Boorse 1975) but argue that a narrow focus on physiological dysfunction relativizes the existential gravity of illness. For this reason, biomedical accounts of disease must be supplemented by an account of what it is like to live with illness. With Zaner, a distinction can therefore be drawn between two perspectives, namely disease-as-scientifically-constructed and illness-as-lived (Zaner 1981). The former refers to disease as a series of pathological causal processes within the organism and the latter to the lived reality of the sick person, which involves suffering, changes to the body, existential uncertainty etc. For the sick person, it is the suffering that matters. It is the latter perspective that PHI sets itself to disclosing.

There is no doubt that phenomenology of illness has enriched philosophy of health and health research in general through a systematic and methodical focus on the experiential dimensions of health and disease along with illuminating personal accounts of what it is like to live with disease. It uncovers dimensions of illness, which have traditionally been neglected and are fundamentally inaccessible to purely biomedical perspectives. However, there are problematic elements in the way that phenomenology of illness is currently practiced and conceived. One of these issues is that phenomenology of illness has a *psychologizing* understanding of phenomenology. The focus primarily lies on the pathic dimensions of illness, i.e., moods, emotions, feelings of alienation, of suffering, bodily doubt and so on. While the experiential dimension is essential to phenomenology since the phenomena must appear *to* someone, the strong focus on experiences, though bodily-situated and embodied, generates some issues with regards to the strong thesis of embodiment that phenomenologists of illness wish to maintain. To accommodate these issues, a notion of embodiment, which transgresses a more psychologizing understanding of illness, must be developed. I attempt to do this in this paper by steering the discussion towards the performative and practical dimensions of existence by drawing on the Heideggerian phenomenology. Heidegger's philosophy is particularly suited to this purpose because it eschews strong distinctions between mind-body and subject-object by focusing on the way that existence unfolds as a holistic, temporal, and conative activity. The aim of this article is therefore not to show the irrelevance of the phenomenological perspective but to point out and hopefully revise some problematic features of the way that phenomenology is currently conceived within this promising field.

In this article, I firstly offer a brief recap of the defining features of PHI with the aim of drawing out some problematic features thereof, which I elaborate on in the second section. Three specific issues are opened for discussion: (1) the relation between the strong hypothesis of embodiment and the strong distinction between disease and illness, (2) the difference between problematic embodiment and illness, and (3) how existential edification is to be interpreted. I offer tentative answers to these questions by engaging in an analysis of selected passages from the works of Heidegger and Waldenfels.

Setting the stage

The defining feature of phenomenology of illness is its emphasis on the first-person rather than third-person perspective. It attempts to lay bare the meaning structures of experience, *in casu*, the meaning structures of the sick or healthy person's embodiment (Svenaeus 1999, 134–135; Toombs 1992, XIV; Carel 2018, 17). Here, the phenomenologists distinguish sharply between the healthy and sick person's embodiment. Health, it is claimed, is a state of transparency that withdraws from explicit attention (Gadamer 1994, 144; Leder 1990), allowing for uninhibited engagement with the world (Toombs 1992, 34). In health, the body therefore serves the person's different projects and tasks, which the phenomenologists refer to as the *lifeworld*, and which is mostly pre-reflective and non-thematized. This unimpeded engagement with the world becomes problematic in illness. When I find myself unable to complete my daily tasks, when all my activities and interests are accompanied by insistent headaches, nausea, exhaustion etc., the body stops being a tool of my living engagement and becomes a hindrance. The self-sufficiency and self-assuredness that characterizes the state of health dissipates in illness and is replaced by experiences of suffering and anxiety, of lost opportunities, of lack of ability to connect with others and so on.

If the body is not something we have, but something we are, as phenomenologists of illness claim with reference to Merleau-Ponty (Zaner 1981, 47) and if illness effectuates a schism between the lived and physical body, then illness produces a schism in the sick person's being. This schism appears when the body no longer acts as a conduit of the person's will but appears in its physicality, as a dysfunctional object among objects. As an object, the body can malfunction, be objectivized, stigmatized etc. Yet, the body is not accidental to but an inherent part of the living unity that cannot be bracketed. This conflict between both perspectives, the body as dysfunctional object versus living unity respectively, engender the experience of alienation and uncanniness, which Svenaeus (1999, 186) and Toombs (1992, 75) among others emphasize as a core element in the experience of illness. For Svenaeus, 'unhomelikeness' or alienation (a literal translation of Heidegger's term *Unheimlichkeit*, cf. Heidegger 2006, § 40) is constitutive for illness.

Here, two different perspectives are at play: the body in its primordial givenness to consciousness, and the body as physical organism (Carel 2018, 26). Consequently, there are two fundamental perspectives on pathology, namely disease and illness, which is a distinction that

phenomenology of illness adopts from Boorse (1975). 'Disease' designates the failure of a biological part or bodily system to perform within a certain range of normality. Such dysfunction (disease) can occur without crossing the threshold of consciousness, e.g., in asymptomatic diseases like cancer in the early stages or comatose states. Conversely, the experience of being sick (illness) may be given to consciousness without having a (purely) physiological basis, e.g., hypochondria. Embodiment always entails a dual perspective between the body as object, i.e., as affective and passive, and subject, i.e., as engaged and active – the body as *Leib* and *Körper* in Husserl's nomenclature or *corps-propre* and *corps-sujet* in Merleau-Ponty's. By stressing the primordial unity of these, the phenomenologists of illness hope to bridge the mind-body dichotomy.

Pathology is therefore not only something that attacks the body, but the entire being of the sick person and has existential implications in virtue thereof. These are often of a detrimental character – life plans are frustrated, well-being is diminished, the body is weakened and hurting etc. – yet the phenomenologists leave room for the possibility of existentially transformative and edificatory experiences in the wake of illness (e.g., Carel 2018, 214–218; Svenaeus 2018, 26–29). Since the lifeworld is pre-reflexive and characterized by an experience of flow, the relation to one's mortality and deeper values in life are seldom thematized. Illness disrupts this natural state, forcing one to reflect upon these questions. In a certain sense, illness enforces an *epoché* (Husserl 1983, § 32) that enables a more conscious engagement with one's life. This, Carel maintains (2018, 130), supported by empirical science (Albrecht and Devlieger 1999; Birkenbach et al. 2013), need not be detrimental. Instead, well-being can thrive despite – perhaps even because of – illness.

Issues

Husserl distinguishes between *phenomenological psychology* and *transcendental phenomenology*, which are two methods of phenomenological analysis with different goals (cf. Husserl 1968, 343; Zahavi 2013, 38).[2] The former is primarily a descriptive regional analysis of the phenomenal qualities of different acts and states of consciousness, whereas the latter seeks to extricate the conditions of possibility of phenomena. Phenomenologists of illness lean decidedly more towards phenomenological psychology; it is the description of the *experience* of illness, 'what it is like' to be sick, which is the object of study (Carel 2018, 1; Svenaeus 1999, 129), more so than investigations into the constitutive basis of such experiences. Phenomenologists of illness rarely ask what the constitutive basis of illness is because it tries to *understand* rather than *explain* illness. Svenaeus (2019, 467), for example, subscribes to the famous dictum of Karl Jaspers (cf. 1965),[3] which distinguishes between explaining the causal mechanisms that lead to pathology and

[2] Here I am not suggesting a theory of the transcendental Ego but rather the utilization of transcendental phenomenology as a method of investigation.

[3] In the article *Die phänomenologische Forschungsrichtung in der Psychopathologie*, Jaspers writes: "Die psychopathologischen Phänomene legen eine solche isolierende, von Zusammenhängen abstrahierende, phänomenologische Betrachtung, die nur sehen, nicht erklären will, sehr nahe" (1912, 399).

understanding what it is like to live with an illness. The distinction is appealing because it wards off potential attempts at reducing the lifeworld to naturalistic properties, the tacit assumption being that such a reduction would relativize the experiences of the ill person. Yet a narrower focus on a more psychologizing phenomenology has other unfortunate consequences that I explicate below.

The personal impetus for several phenomenologists of illness, e.g., Carel (2019) and Toombs (1992), have been personal cases of illness, which are often utilized in phenomenology of illness to exemplify and draw out salient features of the illness experience. These narratives have yielded very fruitful descriptions of what it is like to live with disease and have enriched what would otherwise be a schematic top-down approach to the study of the phenomenon. However, first-person accounts have an ambivalent status in phenomenology. Explications of personal experiences can naturally inform phenomenological investigations, but what sets phenomenology apart as a science is that it is not a private endeavor but an investigation of conditions of possibility for experience as such. By relying too heavily on personal accounts, one simultaneously risks making the phenomenological analysis unassailable for others as well as making accidental features of illness essential. In this case, the radical doubt, the upheaval of one's lifeworld, that Carel and Toombs draw out as a salient feature of illness (Carel 2018, 42; Toombs 1992, 80), are not essential to all illness experiences, it seems. McConville (2021) argues that congenital illness has a different character.[4] Since there is no life prior to or after illness, there is no radical upheaval of the familiar, loss of prior ability etc. Instead, the lifeworld is from the very outset shaped by illness.

Husserl reflected on this methodological issue. In order to draw out the salient features of a phenomenon, the phenomenologist must sort the accidental features from the essential. At the beginning of the inquiry, an example is therefore posited that serves as a point of reference, which is then compared to other examples of the same phenomenon whereby common features are drawn out via the eidetic variation (Husserl 1973, § 87). When faced with two internally contradictory descriptions of the same phenomenon, the phenomenologist is forced to concede that the common features of the phenomenon were not essential but accidental, and that the phenomenological analysis was not radical enough. McConville's critique demonstrates that loss, though undoubtedly an important element in most illnesses with great repercussions for the life of the afflicted, is not a constitutive feature thereof. In general, phenomenology of illness seems to occupy an awkward place between a more transcendental and naturalized phenomenology, i.e., between a phenomenology that seeks to extricate essential features of a phenomenon, *in casu* illness, or a phenomenology that is more oriented towards systematically describing private experiences and the inner world of the ill person. Regardless of which conception one subscribes to, there is an issue here that the phenomenologists of illness need to more explicitly address.[5]

[4] A similar critique could be made regarding chronic illness.

[5] This is an issue because, according to Husserl, phenomenology as a rigorous science is predicated on not being a method of individual introspection but a systematic analysis of structures of appearances (Husserl 2009), i.e., in not being descriptions of 'my' private experiences but of phenomena 'as such'. In principle, phenomenology is an

Traditionally, phenomenology was not concerned with the investigation of experiences but of *appearances*, though these concepts are often conflated. This distinction might seem inconsequential, but phenomenologists emphasize it in order not to fall victim to that which phenomenologists of illness also seek to avoid, namely, a theory of a disembodied spectator for whom the world is merely given as representations ('Vorstellungen'). That is, a theory where the body acts as a mere appendix to or ontologically distinct from the reflective self, which is often referred to as a sort of Cartesianism in the literature.[6] However, a strong emphasis on experience obscures what must be explained if we operate with a strong notion of embodiment, i.e., how bodily functionality and conscious experience condition one another. Here, I will analyze three specific issues that arise from this: (1) how is the theory of embodiment compatible with the strong distinction between disease and illness? (2) What distinguishes experiences of problematic embodiment from experiences of illness? (3) How should existential edification and transformative experiences in illness be understood? It is my assumption that an investigation of the transcendental properties and genetic conditions for illness can alleviate these issues.

Regarding the first issue, the strong focus on psychological phenomenology leads the phenomenologists of illness to strongly differentiate the experiential from the functional dimensions in pathology. To pick two examples, Carel (Carel 2018, 17) and Svenaeus (2018, 42) adopt the Boorsean distinction between *disease* and *illness* and consequently severs the tie between organismic dysfunctions and 'feeling sick'. It is essential for PHI that "human experience is incarnated" (Leder 1990, 1) and that the body is an *existential*, i.e., a fundamental structure of existence according to Heidegger's terminology (Svenaeus 1999, 183). Consequently, they understand subjectivity not as a body-independent substance of pure cogitations and affections but as an embodied subjectivity. The mind is not independent from but closely tied to and interconnected with the body. Simultaneously, points such as "Illness is, first and foremost, a subjective experience. As such, it is an inner – rather than an outer – event (…)" (Toombs 1992, 23) are commonplace in the literature, which seems to emphasize the ill body *as given to* consciousness. There is here a risk of exchanging the emphasis on the objective body with an emphasis of the lived body, which would be equally one-sided, as Leder warns (Leder 1990, 6; Zaner 1981, 89–90).

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intersubjective enterprise that seeks to investigate essences of appearances. Heidegger strongly underscores the ontological level, i.e., structural or essential features, instead of the ontic or empirical as the main focus of the phenomenological analysis as well (2006, § 3–4). This elaborate discussion between naturalized and transcendental phenomenology is, however, far too extensive to be done justice in this context (cf. for example Zahavi 2013, 2019). Both approaches naturally have their merit, here, I simply wish to make the point that an analysis, which draws less on private experiences and more on the analysis of transcendental conditions, might alleviate some of the issues that PHI faces.

[6] Which is almost a pejorative term in this context even though Descartes is much more nuanced than he is given credit for. In Descartes' view, the soul does not relate to the body like a sailor on her ship who can jump overboard when danger looms (Descartes 2013: 113). The union between body and soul is much more intimate, it forms a unity, and the soul is "truly joined to the whole body" (1989: § 30) though this connection is difficult to (satisfyingly) explain on dualistic terms.

Despite the proposed grounding of illness in an embodied subjectivity, there also seems to be an inconsistency between the theoretical aims of the phenomenologists and the phenomenological descriptions of illness that they provide, namely of illness as consisting of inner experiences of loss, feelings of *Unheimlichkeit* and so on. The phenomenologists of illness maintain the irreducibility of the experiential dimension but neglect the connection between biological functioning and experience, which cannot be conceived as downward or upward causation, as Svenaeus at times explicitly does (1999, 170), if a strong thesis of embodiment is upheld. In essence, a unified theory of mind and body as embodied subjectivity similarly requires a unified theory of disease and illness, but it is difficult to see how these aspects of the same phenomenon form a coherent whole. The ontological status and interrelation of these perspectives on pathology therefore remain unclear.

The second issue is that the clash between the lived and physical body, i.e., a negative awareness or consciousness of one's body, does not in and of itself deliver the means of distinguishing illness from obstructions in embodiment.[7] On the one hand, this is explicitly recognized by the phenomenologists (e.g., Toombs 1992, 62), on the other, "illness manifests itself essentially as a disruption of lived body" (ibid.).[8] Disturbances "… in the various and varying interactions between embodied consciousness and the world" occur on many levels and with high regularity. The transparency of the lived body is quite fragile, and the biological organism perpetually intrudes upon and limits it in uncountable ways. Most intrusions are mild, e.g., when I cannot help but to blush, or laugh and burst into tears at inappropriate moments,[9] when I receive an odd look from a stranger and become aware of my own body, when one coughs, sneezes, regurgitates, gets erections, periods, hot flashes, becomes hungry, thirsty, out of breath, shocked, urgently needs to visit the bathroom, along with the myriad of lesser aches, pains, itches, and indefinable sensations. Core elements of human existence are unintelligible without thematized or challenged embodiment like sexuality, where being 'turned on' or 'turned off' are notoriously independent of conscious choice, or tough physical exertion, which entails a complex interplay between the lived body and the physical limitations of the organism. These disturbances usually do not pose serious challenges to the lived embodiment in the sense that they alienate the afflicted person from the familiar meaning structures of existence. Not even more serious albeit temporary intrusions, such as the common cold, need fundamentally shake this trust. Not every bodily intrusion therefore causes alienation, but this begs the question: if problematic embodiment, understood as the disruption between the objective and lived body with a certain negative awareness and consciousness of one's body as a result, does not constitute illness, what then?

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[7] By aligning itself with normative theories, phenomenologists like Svenaeus (1999, 193) also incur the problem of making plausible demarcations between pathological and "normal" states of being (cf. Kingma 2019 for more on the circumscription problem).

[8] Cf. Svenaeus (1999, 138) for a similar point.

[9] Cf. Plessner's work *Lachen und Weinen. Eine Untersuchung der Grenzen menschlichen Verhaltens* (1982), wherein Plessner argues that laughing and crying as liminal phenomena expose the dual aspect of human nature.

Toombs (1992, 100) and Svenaeus (1999, 164–167) suggest that the difference lies in extent and duration. Carel ruminates on this issue as well and concedes that the model of the transparent body is idealized but maintains that it is a matter of degree whether problematic embodiment constitutes illness (2018, 57–59). This seems implausible for several reasons. To give two examples, the chronically lazy person who wishes to be active but for whom the sluggishness of the body is a constant obstacle, or the aging person who perpetually find themselves less and less able-bodied and are fundamentally bothered thereby, are both cases of durative bodily intrusions that are negatively thematized. Mostly, such types of embodiment are not tinted with the same experiential hue as illness, though they might occasionally be. Moreover, even if granted that duration distinguishes illness from problematic embodiment, this would also include more permanent and fundamental bodily disruptions, such as disability, or changes in life stages like puberty, pregnancy, menopause etc. While there plainly are some common characteristics between these types of existential events, such as bodily uncertainty or loss of familiarity, we commonly associate illness with a degree of suffering or alienation, which these cases only potentially involve.

Regarding the third issue, according to the phenomenologists of health, illness harbors an existentially edifying and transformative potential. Illness brackets the everyday and thereby brings the sick person face to face with their mortality, which occasions a deeper connection with, reflection upon, and appreciation of one's life and values that for the most part lay hidden in 'ordinary' life. Phenomenologists of illness here seem to implicitly rely on the thought figure of *authenticity* especially prevalent within existential philosophy.[10] The general gist being that illness is not necessarily existentially detrimental but enables the sick person to live more purposefully, intensely and genuinely. One of the most striking literary depictions of this comes from Tolstoy's *The Death of Ivan Ilyich*, a very common point of reference in the literature, wherein the protagonist, in all ways an ordinary man who leads a shallow life despite his prominent position as a judge in the supreme court, receives a revelation on his deathbed. Ilyich realizes that his entire life until that point has been a life of 'falsity', of having and acting out the wrong values, but the illness lifts the veil and enables him to realize the 'true' meaning of life in the nick of time.[11]

The thought is compelling, and the psychological edge that it could give the sick person to inscribe their illness in a narrative, which gives it meaning and purpose, should not be underestimated. Nevertheless, the question still lingers whether it is a fallacy, albeit a very human one, or a useful form of self-deceit to expect compensation for the suffering that one needlessly endures. Two immediate concerns raise themselves: is this viewpoint an expression of a survivor bias, which only relays the positive accounts of life overcoming disease? And is it an unduly

[10] Both Carel and Svenaeus operate within this Heideggerian distinc-tion between "Eigentlichkeit" and "Uneigentlichkeit", i.e., authenticity and inauthenticity (Heidegger 2006, § 27), when they relate illness to "being-towards-death" (Carel 2018, 150) or "Unheimlichkeit" (Svenaeus 1999).

[11] Heidegger explicitly refers to *The Death of Ivan Ilyich* in *Being and Time* as an example of a person who does not shy away from their death as 'One' does but gains an authentic relation to it (2006, § 51).

romanticization of illness and suffering? In *The Jargon of Authenticity*, Adorno remarks upon the implicitly moralizing nature of the notion of authenticity as a romanticizing of the 'true' existence that undergirds the present life of inauthenticity.[12] Adorno writes:

> "[In the feeling of meaninglessness] what this consciousness dreads it turns in such a way that the threat seems to be an innate part of it, and thus it weakens that element of the threat which can no longer be grasped in human terms. The fact that on all sides meaning of every kind seems to be impotent against evil [Unheil],[13] that the latter yields no meaning at all, and that the assertion of meaning may even promote evil, is registered as a lack of metaphysical content (…)" (Adorno 2003, 28).

To Adorno, the compulsive need to extract positivity from negativity and meaning from meaninglessness is itself an ideology, which divulges the inability to confront the catastrophe as such. To say that the phenomenologists of illness revert to as crude a theory would be an exaggeration, yet the same distinction between the authentic and inauthentic life seems to pervade the phenomenologists' writing. I will leave this topic as an open question but argue that the transformative and edifying potential of illness can be given another interpretation that is less normatively laden, namely as an *adaptation* of the alien into the lifeworld.

In the following, I suggest that a Heideggerian understanding of existence as a temporal, conatively guided activity might alleviate some of the problematic aspects of a psychologizing understanding of illness. Since Svenaeus has worked extensively with Heidegger's philosophy as well, a short declaration of the differences between our interpretations is warranted. Svenaeus primarily interprets illness as a *Stimmung* (Heidegger 2006, § 29) of uncanniness and "unhomelikeness", i.e., a mood or 'existential feeling', as conceptualized by Ratcliffe (2012a), which causes feelings of suffering and alienation and inhibits the sick person's embodiment, comportment into the world etc. (Svenaeus 2021). Moods differ from emotions in not being object-oriented but rather fundamental affective states that color the entire experiential field. For example, a feeling such as anger is directed at a person, thing, or event that aroused it, whereas depression is a mood that makes the world in its totality appear fundamentally irrelevant, sad, hopeless etc. Svenaeus and I agree that alienation as a mood is undoubtedly an important element in illness, but in the interpretation below it is a consequence rather than primary characteristic of illness. My interpretation of Heidegger emphasizes the dynamic elements of the analysis of *Dasein* to a higher degree, i.e., that existence is a conatively guided, temporal activity and that fundamental broaches

[12] It has been suggested that Heidegger's reassurance that the inauthenticity of "das Man" is not a negative valuation (2006, § 38) nears that of a performative contradiction, given that there is an unmistakable air of negative judgment both in the terminology and the descriptions of the inauthentic life, to which labels such as *alienation* ('Entfremdung'), *being lost* ('Verlorenseins') are attached.

[13] 'Evil' is a quite normative translation of 'Unheil', which can also mean 'misfortune' or 'catastrophe'.

upon this activity generate illness. By underscoring illness as an activity rather than a mood, a more psychologizing phenomenological approach can possibly be transgressed and supplemented.

Functionality and experience

Though having a limited regard for the body, Heidegger has been a large inspiration to phenomenology of health. Yet many phenomenologists bypass a crucial determination of *Dasein*, which could shed some light on the aboveenumerated difficulties, namely that "Dasein is the being [Seiende], which revolves around its own Being [Sein]".[14] In Heidegger's nomenclature, existence has the character of *sorge*, i.e., *care* (Heidegger 2006, § 41). Perhaps it is tempting to read a quasi-Darwinian animalistic striving towards self-preservation, the Freudian pleasure principle, an essentialist teleology etc. into this statement, but this would be a mistake. *Sorge* does not refer to any empirical drive per se, but the structure of striving inherent to existence that founds or shapes all particular drives and projects as such. *Sorge* is not a contingent, empirical property (an 'ontic' trait), but an *ontological* determination (a so-called *Existentiale*). What it means to exist is to be in a constant process of 'caring for' one's existence. The ontological structure of Sorge is what constitutes the meaningfulness of structures of meaning in contrast to the meaninglessness of others.

This can be illustrated in the following way: one always finds oneself amidst the furthering of certain goals and projects. Even when one decides to have no such goals, one is still 'doing something', namely actively trying to be devoid of goals, thereby proving the point negatively. But not all goals can be pursued simultaneously, some opportunities must be realized at the behest of other. Say, if one's purpose in life was to become a great philosopher, this ambition would be difficult to reconcile with a life of intellectual inactivity. This grander meaning trickles down through the entirety of the Dasein's actions and values. I read the book to write the paper, I write the paper to receive recognition from my peers, I receive recognition from my peers to gain traction within the philosophical milieu and so on. All these actions carry an implicit meaning, which ultimately aim at my goal of becoming a great philosopher. Life consists of such intricate structures of cross-connected meanings, which as a totality point towards a given project, according to Heidegger (ibid., § 15). This totality can be called the *lifeworld*,[15] which denotes the whole of familiar structures, habits, meanings, and actions that undergird life in its '*Alltäglichkeit'*, its 'everydayness'. Note, these structures of meaning are not projections of deliberate preferences – the phenomena themselves *appear* to Dasein as more or less meaningful.[16] The book has an allure, exerts a certain pull, as a possibility of realizing a project, while other things leave one indifferent. The world appears to Dasein as normatively structured. These projects are mostly adopted from

[14] "Das Seiende, dem es in seinem Sein um dieses selbst geht" (Heidegger 2006, § 9).
[15] Though this is a Husserlian term (Husserl 2012), I use it to stay within the conceptual framework of PHI.
[16] In *Experience and Judgment*, Husserl emphasizes a similar point, although he distinctly relates it to perception (1973, § 21). Other phenomenologists of health such as Ratcliffe (2012b; Fuchs (2013) have also explored this topic in relation to mental illness where the conative drive is suspended.

what 'one' does, i.e., *das Man* (ibid., § 27), according to Heidegger. Hence the emphasis on the expression that Dasein finds itself in an *understanding* (*Verstehen*) of its world (ibid., § 31). The essence (*Wesen*) of Dasein does therefore not consist in a certain inner feeling or immediate selfpresence, a primary experiential field, or a series of actions contained within the mind carried to fruition in the external world etc. Dasein's being unfolds as an immediate *praxis*, i.e., as active striving and a striving activity.

Heidegger's understanding of existence is therefore less psychologizing. Instead of stressing the qualia of experience, he emphasizes the dynamic nature of existence. Subjectivity is on this account therefore understood as a praxis, i.e., a directed, temporally structured activity laden with structures of meaning. The phenomenologists of illness naturally recognize the dynamical nature of subjectivity and its relation to the body, but the distinguishing property of illness in their account still seems to be encroachments upon embodied consciousness by the physical body with experiences of suffering and alienation as result. We must, however, distinguish between problematic embodiment where the sense of self is intact though the body asserts itself in a troubling way such as aging and pregnancy, and embodiment, which engenders experiences of radical alienation on a fundamental bodily and existential level.

To reiterate, illness is not necessarily engendered by negative disruptions between the lived and physical body, the 1. and 3. person perspective. The body as object may interrupt, impose itself, or change in significant ways without necessarily causing breakdowns in conations. Instead, we might introduce the concept of a *vital break*, which denotes that which fundamentally cannot be integrated into the lifeworld understood as the orders of conations, of sought-after possibilities, preconceived understandings, and habits of actions that is integral to existence. This gives us some distinct advantages in understanding and explaining the embodiment of, e.g., a disabled person in contrast to a sufferer of sclerosis, where the former's mode of embodiment might be entirely integrated into their lifeworld though being limited or thematized and the latter most likely not.

Furthermore, this hints at another way of conceiving the relation between physiological functionality and conscious experience. As stated, the strong thesis of embodiment necessitates that the identification between body and mind goes both ways, though phenomenologists of health have mostly focused their attention on describing the subjective aspects of embodied consciousness. We must, however, assume that a certain objectiveness, physicality and alienness adheres to the body even in the mode of being most familiar to the subject, which phenomenologists such as Svenaeus admit (1999, 157), but which is difficult to reconcile with the paradigm of the withdrawing and transparent body that absorbs its milieu into its mode of being. Hans Jonas proposes the alternative that embodiment is not constituted by smooth and effortless comportment into the world, but that:

> "Experience has its seat in the *effort* I must make to overcome the resistance of worldly matter in my acting and to resist the impact of worldly matter upon myself. This happens through and with my

> body, with its extensive outwardness and its intensive inwardness at once, which both are genuine aspects of myself" (Jonas 2001, 23).

That is to say, subjectivity is constituted not by 'effacing' objectivity but by the subject discovering its limits through *effortful* interaction with its surroundings. In and through resistance, bodily or otherwise, a sense of self is cultivated in direct correlation with the objectivization of the world, which are two aspects of the same process. Exploring this hypothesis further is unfortunately outside the scope of this article, but there are alternatives to the model of the transparent and withdrawing body, which are worth investigating.

Problematic embodiment and illness

The practical engagement, which characterizes existence, is conditioned by, firstly, a temporal structure, and, secondly, a primordial openness to the world, which enables *self-transcendence* but simultaneously opens Dasein to negative experiences. The temporal structure of life discloses itself in the fact that the conations of Dasein are principally without end; it finds itself in the constant process of realizing a not-yet-actual state of affairs. For Dasein, the potential of becoming is just as, if not more, present than the immediate reality, the actual. But these acts are themselves founded in already-established conceptions of the self and world, which lie in the past, and through which Dasein continually draws meaning and purpose. In its engagement with the world, Dasein therefore 'draws in' the three modalities of being, i.e., necessity, reality, and potentiality, and the temporal *exstases*, i.e., past, present, and future, which together form a functional whole. When Dasein acts, it seeks to actualize in the present a future, potential state of affairs based upon a past, and in this sense necessary, understanding of its world. Dasein is never just an object at hand, but a process that is constantly realized but never completed.

This would, however, be unthinkable without a principal *openness* – a term with several extensions in Heidegger's 'fundamental ontology'. It denotes a property of Dasein's own nature (*Wesen*): what project Dasein pursues, what understanding of the world it finds itself in, is contingent. When Dasein acts, it acts not out of biological or ontological necessity but because one out of countless possibilities has been – implicitly or explicitly – chosen. However, it simultaneously denotes that Dasein is open to the world, that it is responsive. Indeed, that it is in virtue of Dasein's ontological responsiveness that phenomena such as anxiety and awareness of death can even present themselves. These phenomena cannot simply be ignored; they present themselves with a certain compulsion and forcefulness because we are delivered to the world. In other words, we cannot not care or not respond to what imposes itself because existence is fundamentally affective and receptive. According to Waldenfels' responsive phenomenology, responses are not first and foremost conscious, deliberate answers; we have always already responded before being aware of doing so (Waldenfels 2011, 37). If someone calls out our name on

the street, we turn our head and listen intently before deliberating how to react. In so far as we register ourselves as the recipient of the call, our response precedes the deliberate answer, and the response eschews a compartmentation into a physiological or psychological reaction: it manifests itself throughout the entire embodiment of the person.

What is of special interest here is why certain responses are elicited and others not. If someone mistook us for another person and called us by a wrong name, we might not react in the slightest though being explicitly addressed. What this simple example demonstrates is that our experience is structured through certain orders, Waldenfels argues, which separates the comprehensible from the incomprehensible, identity from non-identity, the familiar from the alien. As simple a case as hearing an unknown language in contrast to hearing one's mother tongue demonstrates this point. There is nothing alien about the foreign language in and of itself, but it receives the branding of 'foreign' in virtue of not being my mother tongue. Orders are therefore orders in virtue of what they exclude. These "boundaries emerge from ordering processes" (Waldenfels 2011, 8). At the point of confrontation with the phenomenon, certain 'breaking points' (*Bruchlinien*) appear (Waldenfels 2002), through which the intake is 'sorted' into the ordinary or extraordinary. This holds none the less so for pathology, which is one of the experiences of alienation *par excellence.*[17]

The radically alien is that which cannot be assimilated in or fundamentally breaks a given order, a principally non-indifferent experience which one cannot help but pay heed to (Waldenfels, 35–37). According to Heidegger, the absolutely alien is death (Heidegger 2016, § 47), not because it invalidates any particular possibility but *possibilities as such*. Illness can be interpreted in much the same way. If we return to our ambitious philosopher, she might experience an interruption of the ability to carry on with her projects because she is too tired to think, without the meaning structures of her life suffering for this reason. But if she lost cognitive ability, e.g., due to early onset of Alzheimer's, it would in all likeliness be irreconcilable with the conations of her life. Here, the issue is not simply that the experience cannot immediately be assimilated into the lifeworld, but that it fundamentally invalidates it. Not only is she unable to do the intellectual work that the life as a philosopher requires, but the Alzheimer's instates a new order of embodiment incompatible with her projects. The illness does not simply produce inability but changes the meaning structures of life in a fundamental way. The radically alien therefore distinguishes itself from problematic embodiment by having a lifeworld-shattering character. In other words, some affections can be integrated into the lifeworld while others fundamentally cannot, giving rise to alienation. Alienation is therefore not to be construed as a mood or an emotion but as the conflict between the praxis of the individual's life and the new, irreconcilable state of being.

[17] Cf. the essay *Der Kranke als Fremder* (Waldenfels 2016). Here, alienation is to be understood in a different way to Svenaeus' understanding thereof and I will get to the difference shortly.

Life essentially unfolds as a temporally projected activity because existence is always directed towards the future where certain possibilities are sought realized based on preconceived understandings and given conditions of life. The affections that force themselves upon the person must be integrated into this activity. For the large part, these affections, from trivial bodily intrusions such as temporary shortness of breath to significant ones such as aging, are to varying degrees unproblematic. Embodiment can be both thematized and/or problematic and still be integrated in the lifeworld, meaning that understandings and abilities to project one's conatively guided activities into the future do not suffer. Other cases, such as a promising track star falling ill with osteoporosis, is of a more severe character. At first, the onset of physical disability might be slow, gradually growing more and more severe until the point of extensive bodily disability. The issue here lies not in physical disability, which cases such as well-adjusted persons with disabilities attest, but that the care for oneself is obstructed. The order of meanings that governed life for the former track star quite literally has no future, along with the pre-conceived meaning structures of life from which these ambitions drew their meaning and relevance. The possibilities of rising to prominence in the world of athletics are made null. In other words, the care for the self is rendered inviable.[18]

Sorge is however not only an activity, but simultaneously a process of identification, of creating identity. Life is not a thing at hand with a certain essence; life *comes into being through action*, and through acting, Dasein constitutes its identity and implicitly posits the value of the pursued goal because of the contingency of the choice. When an affection brings this dynamic out of play, Dasein undergoes both a crisis of identity as well as meaning. Orders of meaning are constituted by what they exclude, when the meaningless therefore relentlessly imposes itself, it produces a schism in the person's being. As several phenomenologists and medical professionals have noted, patients often refer to their illness as an 'it' (Leder 1990, 76; Toombs 1992, 73), even though this 'it' is part of 'me'. Phenomenologically, this implies a lack of identification: There is a split between the endured affection and the self, between the 'I' and the 'it'.[19] Empirical accounts of the biographical disruption that patients face in the wake of severe illnesses also lend some credence to this theory (Bury 1982). Due to the pathic character of existence, this 'non-I' imposes itself, is autonomous and not under the spell of my will. I am unable to will a pain away, though I can attempt to willfully ignore it, the same way that I am unable to will cancer cells to stop procreating. Consequently, my ability to extend myself in the dynamic activity of creating meaning and identity becomes fundamentally obstructed. This irresolvable conflict between the praxis of the

[18] Cases of permanent, progressive pathology lend themselves well to illustrating this, but an example of a person who suffers an unexpected heart attack could be equally relevant. Though a single event, the heart attack might threaten and invalidate the orders of meanings and ability for temporal projection in much the same way as sclerosis.
[19] Toombs (1992, 75) and Svenaeus (1999, 186) have very similar sounding phrasings of this phenomenon, but the phenomenon is given another interpretation in this context.

individual's life and a new state of being then begets feelings of loss, suffering, and other core features in the experience of illness, which phenomenologists have explored in great detail.

The difference between thematized, problematic embodiment and illness is therefore that the latter not only puts the praxis of life, the care for oneself, to a halt but fundamentally invalidates it temporarily or permanently. That is, rather than as a disruption of the lived body or experiences of alienation, here, illness is understood as a *vital break*, a break in the dynamic, conative activity of life. In the case of Dasein, its freedom to shape life along with its receptiveness and responsiveness towards the world makes it vulnerable to countless ways in which this dynamic activity can be perturbed. This, I claim, is the *differentia specifica* between thematized, problematic embodiment and illness: illness involves a fundamental break with conative activity.

Edification as adaptation

Though a complete revolution of the way that life is conducted is unlikely, the functional openness in Dasein's existence points to the possibility of a new lifeworld, in which the vital break is coped with, i.e., adapted to or integrated into the lifeworld of the person. To reiterate, this is not a matter of conscious, deliberate effort. Dasein cannot help but habituate the circumstances, in which it finds itself, to revert (*zu verfallen*) to a certain everydayness (Heidegger 2006, § 38). Ordinary life, which is sometimes negatively appraised as the 'inauthentic' and 'average', is the saving grace of the ill person, for it is the ability to cope with one's circumstances that makes it possible for the extraordinary to become ordinary and for the alienating to become familiar. And though there is no question that a certain lack of reflectiveness often characterizes everyday life, it seems questionable whether illness actually prompts existential growth, when more often it seems that for the person who suffers, the world shrinks and their entire being is consumed by the affliction. Moreover, demanding a meaning from the inherently meaningless might only serve to further the feeling of alienation and suffering.

There is, however, another sense in which illness can be understood as a catalyst for a recalibration of life, namely as *adaptation*. Illness is the disturbance of the person's lived praxis, their striving for self-unfolding. As such, it carries an implicit impetus; the illness is something to be rid of ("mit dem es fertigzuwerden gilt"), as Gadamer remarks (1994, 135). The contingency of specific existential modes of being and the tendency to habituate the unfamiliar allows the person to integrate the alienating circumstances into their lifeworld. I will not go into detail with the countless ways in which such an adaptation can take place since empirical science can give a much more nuanced picture thereof. Priorities in life shift, expectations are modified, the everyday is restructured, social interactions are more cherished, one's energy is more carefully used and so on. Each of these smaller activities can be interpreted in the same way: as a way of accommodating to or integrating the alien in the lifeworld, whereby it ceases to be alien. Naturally, this process is

seldom exhaustive, and a total accommodation is unlikely, but the 'inauthentic' everydayness of existence allows Dasein a way to make illness less cumbersome.

Conclusions

Phenomenology of illness is a field in development and therefore has some way to go before it is not merely considered an additional perspective, but an integrated part of the understanding of health (cf. Klausen 2021, 12). Though it is most likely true that the phenomenological perspective still encounters resistance from purely biomedical understandings, the phenomenologists of health have themselves played a part in perpetuating a psychologizing understanding of phenomenology, which is hard to integrate in a holistic conception of disease and health. I have tried to argue that the Heideggerian framework could provide a way out of this issue. By interpreting existence as a temporal, conatively driven activity, it transgresses sharp distinctions between disease and illness, physical and lived body. In doing so, it is more adept at maintaining a strong theory of embodiment.

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