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RESEARCH PAPER

The Phenomenology of Falling Ill: An Explication, Critique and Improvement of Sartre's Theory of Embodiment and Alienation

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Abstract In this paper I develop a phenomenology of falling ill by presenting, interpreting and developing the basic model we find in Jean-Paul Sartre's *Being and Nothingness* (1956). The three steps identified by Sartre in this process are analysed, developed further and brought to a five-step model: (1) pre-reflective experience of discomfort, (2) lived, bodily discomfort, (3) suffered illness, (4) disease pondering, and (5) disease state. To fall ill is to fall victim to a gradual process of alienation, and with each step this alienating process is taken to a new qualitative level. Consequently, the five steps of falling ill have not only a contingent chronological order but also a kind of logical order, in that they typically presuppose each other. I adopt Sartre's focus on embodiment as the core ground of the alienation process, but point out that the alienation of the body in illness is not only the experience of a psychic object, but an experience of the independent life of one's own body. This facticity of the body is the result neither of the gaze of the other person, nor of a reflection adopting the outer perspective of the other in an indirect way, but is a result of the very otherness of one's own body, which addresses and plagues us when we fall ill. I use examples of falling ill and being a patient to show how a phenomenology of falling ill can be helpful in educating health-care personnel (and perhaps also patients) about the ways of the lived body.

Keywords Phenomenology · Illness · Sartre · Embodiment · Alienation

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Introduction

Phenomenology of medicine is a field which remains largely to be investigated. The main issues of phenomenologists, in cases of trespassing on the borderlines of "pure" philosophy, have been those belonging to the arts, humanities and social sciences, rather than to medicine. A great deal of phenomenological work consequently remains to be done on core experiences and concepts of medical practice and science. Nevertheless, quite a few phenomenological themes of research which have been central to the development of the tradition during the twentieth century cut through the medical realm, and the work carried out on these themes can therefore be said to have explored the phenomenology of medicine in an indirect manner. A few important examples are phenomenological investigations of the concepts of self, intersubjectivity, body, feeling, action, gender, death, life, nature, ethics, science and technology. A phenomenological theme which is particularly relevant in the case of medicine is "facticity": the attempt to spell out the meaning of everyday life in the everyday world without falling prey to either scientific reductionism or transcendental idealism. As Merleau-Ponty writes in his preface to the *Phenomenology of Perception*, which is a key text of phenomenological methodology:

> Phenomenology is the study of essences; and according to it, all problems amount to finding definitions of essences: the essence of perception, or the essence of consciousness, for example. But phenomenology is also a philosophy which puts essences back into existence, and does not expect to arrive at an understanding of man and the world from any starting point other than that of their 'facticity.' (Merleau-Ponty 1962, p. vii)

Another example of a phenomenological philosopher who has been important to the phenomenology of medicine in an indirect kind of way, is Jean-Paul Sartre. My aim in this paper is to explicate the different steps of the process of falling ill we find developed in *Being and Nothingness* (1956), and also to offer a critique of Sartre's model, thereby being able to develop his theory and state a more comprehensive and accurate understanding of the process in question. Since Sartre's aim in *Being and Nothingness* is merely to use the example of falling ill in the project of developing a more fundamental ontology, it would be unfair to accuse him of failing to give a comprehensive account of the phenomenon in question. However, in my development of Sartre's model, I also try to identify some weak spots of Sartre's phenomenology as such, which, I think, become visible exactly by the example of falling ill.

In the paper I will use the term "illness" for the experiences of the person being ill, in contrast to the term "disease," which will mean a biological process or state of the body that tends to (but does not always, at least immediately) cause the suffering of illness. This accords with standard vocabulary in the philosophy, psychology and sociology of medicine and health care (Nordenfelt 1995). In accordance with the phenomenological idea of the precedence of the first-person perspective, the illness perspective will be my angle of analysis, and the other-person perspective of disease pronouncements will be accessed from the phenomenological, lived perspective as well. This does not mean, however, that I subscribe

to any subjective, or constructivist, position as regards the existence of diseases. The experience of the world (and our bodies belong to this world) is an experience of something that is independent of our experiences (Zahavi 2003). We do not make up the cellular processes of our bodies by way of our experiences any more than we make up the everyday things that surround us in our daily life.

The phenomenology of falling ill is an important topic, I believe, from a number of points of view. First, such a phenomenology could be quite useful to health-care personnel (and patients), in a way similar to what phenomenological models of rehabilitative work strive to bring about (Svenaeus 2001). A focus on the ways of the *lived* body, in contrast and in addition to the biological ways of the body, allows one to integrate the life-world perspective of the patient in medicine and health care in a more substantial way than is possible without that focus. Second, a phenomenology of falling ill could be important to phenomenological theory itself, since it allows us to display parts of the constitutional patterns of experience that dwell in the preconscious background and might therefore escape our attention.

Sartre's Phenomenology of Falling Ill

In the second chapter—"The body"—of the third part—"Being-for-others"—of Jean-Paul Sartre's famous work *Being and Nothingness*, originally published in 1943, we actually find a kind of outline of the phenomenology of falling ill (1956, pp. 401 ff.). Sartre asks how we are to understand the process by which we gradually come to realise that we are ill and might need the attention and advice of a doctor. After having defined and explicated the dual structure of being—being-for-itself (consciousness) and being-in-itself (thingness)—in the preceding two parts of *Being and Nothingness*, Sartre now wants to show how these two forms of being are not only opposed to each other, but also necessarily conjoined, in the human way of existing. The main idea is that the gaze of the other person has the power to objectify me; I turn into a thing for another consciousness by being looked upon and thereby discover my body as an in-itself, which is yet me. This is an experience which, for Sartre, is primarily characterised by feelings of shame, humiliation and even nausea. To become oneself by way of the direct or indirect gaze of the other appears to be a fundamentally *alienating* experience: the self is separated from its true essence—freedom as consciousness—in becoming an in-itself (a thing).

The lived body thus appears to be the place where the being-for-itself finally confronts its being-in-itself, although these two forms of being are necessarily opposed for Sartre. Things (including one's own body) are always things *for* a consciousness, and therefore different from this consciousness. Consciousness is by way of its being nihilation: it negates the things it constitutes in the sense of always being different from them, but it also negates itself in the sense of lacking any essence—consciousness, for Sartre, is pure existence devoid of any essence. Only the other can offer me facticity by objectifying me; his gaze is felt at the heart of my contingent, but yet inevitable, embodiment. Thus in a rather paradoxical way, according to Sartre, I am fundamentally alienated by being some*thing* and not nothing.

In his attempts to uncover the structure of the lived body, Sartre turns to medical examples in the chapter on the body. When my body is examined and understood as a malfunctioning biological object by the doctor, it is, according to Sartre, objectified in a manner analogous to when I am exposed to the gaze of the other in everyday life (1956, p. 466). However, the objectifying quality of the scientific gaze, it appears, is different from everyday objectification in many ways, something that Sartre does not clearly acknowledge. I will return to this.

In discussing the process of falling ill, Sartre also discusses ways in which the lived body can be affected by attunements that interfere with activities we are engaged in before the doctor has entered the scene. His well-known example is the tiredness and headache involved in reading a book late at night. The headache shows itself in the very activity of reading, in which the text gets harder and harder to focus upon and understand. Pain—"douleur" in French—is at this pre-reflective level a lived pain, which does not show itself as a sensation *in* the reader's own body, but rather as a pain belonging to the very activity of reading. The pain is not known—not focused on as an in-itself—but is still *there* in my pre-reflective way of being. As Sartre remarks, if I had broken my finger, this pain would not enter my consciousness until I used the finger to turn the page. When I sit reading, not moving the finger, the pain in the finger sinks back into the contextual bodily ground in which the eye movements are now the focusing figure (1956, p. 440). Pain cannot strictly be said to be either "in the eyes" or "in the world." Pain is a feature of my intentional, bodily being, or, to use the concept of another famous phenomenologist, Martin Heidegger (1996), my "being-in-the-world." Sartre writes:

> Pain is precisely the eyes in so far as consciousness 'exists them.' […] Pain is not considered from a reflective point of view; it is not referred back to a body-for-others. It is the-eyes-as-pain or vision-as-pain. (1956, p. 437)

The pain quality is thus dependent upon the way I choose to focus on the world in different activities (if I stop reading and start listening to the radio, the pain might stop), but it is also dependent upon the way the world sucks me in (the very absorption into the world of the book might make me forget the pain). Nevertheless, the pain in question can also be focused on, made into an object of attention:

> But now suppose that I suddenly cease to read and am at present absorbed in *apprehending* my pain. This means that I direct a reflective consciousness on my present consciousness-as-vision. Thus the actual texture of my consciousness reflected on—in particular my pain—is apprehended and *posited* by my reflective consciousness. (1956, p. 440)

Still, this reflective turn of consciousness, according to Sartre, does not turn pain into an object in the sense of a pain in-itself. Pain, instead, by the turn of consciousness, is made into what Sartre calls a *psychic* object, which in this case is also an *illness* ("mal" in French):

> The psychic object apprehended through pain is *illness*. This object has all the characteristics of pain, but it is transcendent and passive. It is a reality which has its own time, not the time of the external universe nor that of consciousness,

> but psychic time. The psychic object can then support evaluations and various determinations. As such it is distinct even from consciousness and appears through it; it remains permanent while consciousness develops, and it is this very permanence which is the condition of the opacity and the passivity of illness. But on the other hand, this illness in so far as it is apprehended through consciousness has all the characteristics of unity, interiority, and spontaneity which consciousness possesses—but in degraded form. This degradation confers psychic individuality upon it. That is, first of all, the illness has absolute cohesion without parts. In addition it has its own duration since it is outside consciousness and possesses a past and future. But this duration, which is only the projection of the original temporalization, is a multiplicity of interpenetration. The illness is 'penetrating,' 'caressing,' etc. And these characteristics aim only at rendering the way in which this illness is outlined in duration; they are melodic qualities. A pain which is given in twinges followed by lulls is not apprehended by reflection as the pure alteration of painful and non-painful consciousness. For organizing reflection the brief respites *are a part* of the illness just as silences are a part of a melody. The ensemble constitutes the *rhythm* and the *behavior* of the illness. (1956, p. 441)

Sartre's description of the nature of illness as a kind of melody which has a life of its own that influences, and in some cases becomes, the dominating melody of my life, is, to my mind, very apt from a phenomenological perspective. Yet why does Sartre call illness a *psychic* object? Two pages later in the book, in fact, he even calls it "the psychic body" and if anything, this melody appears to be exactly bodily in nature. It is, indeed, the *body* which influences and resists my attempts to make myself at home in the world in illness. The reason for the use of the term "psychic" is that Sartre's line of argument will not allow the body to show itself as an in-itself until the gaze of the other has objectified me. Consciousness as a for-itself bears no *full* relation to the own body, until the gaze of the other has made it mine. The body, so it seems, can become my body only by being turned into my visibility in front of the other. Until then it remains a *psychic* structure of constitution, which can merit, but most often escapes, our attention.

Illness and the Alien Body

It is true that illness, as Sartre writes, is suffered rather than known (1956, p. 443). It is not reflected upon, but rather lived as a melody. Still, this suffering, I believe, is not most adequately described as a psychic object or structure posited by consciousness, but as a for-itself of the person's own body. That is: a for-itself which is mine, yet still alien, since it resists and disturbs, rather than supports, consciousness. This is an aporia for Sartre, of course: in his system only consciousness can display the form of the for-itself's being. And yet this is not completely true, since if the gaze of the other really does have the power to raise my anxiety and shame, it must do so by making *my* body an in-itself. And if the body is mine, it is to a certain extent part of the structure of the for-itself. To say that the

body is mine, in the mere sense of an object constituted by the self-being of consciousness, would be to miss the point that the body is actually at the very heart of my self-being as a *constituting being*, rather than being constituted by me.

My conclusion here would be that Sartre does not need to turn exclusively to the battle between separate consciousnesses to find the in-itself of my for-itself. This in-itself shows itself as a for-itself of my own body in illness. It is thus not exclusively the otherness of the other, but the otherness of my own body—displayed in a painful way in illness—which lends facticity to my existence. Sartre comes close to such an analysis himself in his focus on nausea. He writes: “A dull and inescapable nausea perpetually reveals my body to my consciousness” (1956, p. 445). Yes, but not as a psychic object, but as a vomiting in which the body is *taking over*, displaying a life of its own, which I have to follow whether I want to or not. The body becomes *alien* in illness, and this means exactly that it is other but yet mine: illness is a for-itself of the in-itself experienced as an in-itself of the for-itself by embodied consciousness.

Sartre reserves the in-itself of the body for the phenomenon we call disease, in French “maladie,” namely a process or state in the biological organism which comes to my knowledge through the examinations of the doctor:

> The illness which I suffer I can aim at in its In-itself; that is, precisely in its being-for-others. At this moment I *know* it; that is, I aim at it in its dimension of being which escapes me, at the face which it turns toward others, and my aim is impregnated with the wisdom which language has brought to me—that is, I utilize instrumental concepts which come to me from the other, and which I should in no case have been able to form myself or think of directing upon *my* body. It is by means of the other’s concepts that I *know* my body. (1956, p. 465)

This, to Sartre, is the real face of alienation; only the present or imagined gaze of the other upon my body can offer me that:

> As soon as we *know* the body—that is, as soon as we apprehend it in a purely cognitive intuition—we constitute it by that very intuition with the other’s knowledge; that is, as it would never be for us by itself. The knowable structures of the psychic body therefore simply indicate emptily its perpetual alienation. (1956, p. 465)

But even Sartre has to admit that this “empty” alienation does not have its *root* in the gaze of the other, but in the own body:

> But it follows that even in reflection I assume the other’s point of view on my body; I try to apprehend it as if I were the other in relation to it. It is evident that the categories which I then apply to the illness constitute it *emptily*; that is, in dimensions which escapes me. Why speak then of *intuition*? It is because despite all, the *body which* is suffered serves as a nucleus, as matter for the alienating means which surpass it. (1956, p. 465)

To fall ill is to fall victim to a process of alienation in which the body becomes increasingly disturbing and in the end not mine—despite in some sense always remaining mine, of course; this is why we call it an *alienating* process (Leder 1990; Svenaeus 2001; Toombs 1992; Zaner 1981). For Sartre this alienation is not really

realised until the doctor has turned my body into a biological organism which is found to be out of order. At the two earlier stages of “pre-reflective experiencing” and “illness suffering” the alienation is still blind, it is not experienced or, rather, *reflected* (known) as an in-itself of my body.

A critique of Sartre’s Phenomenology

My first point of criticism of Sartre’s analysis would be that the alienation of the body in illness is not only the experience of a psychic object, a temporal melody of suffering, but an experience of the in-itself of *the body*, an alienation which is lived and therefore, in Heideggerian language, understood, even if it is not conceptualised and named. Illness makes us feel our own bodies: it reveals the body to us in different ways, through making it heavy, stiff, hot, nauseated, plagued by pain, twists, jerks, shivers, etc. This facticity of the body is the result neither of the gaze of the other, nor of a reflection adopting the outer perspective of the other in an indirect way, but of the very otherness of one’s own body which *makes itself known* (addresses itself) to us as a for-itself of the in-itself.

My second point of criticism of Sartre’s analysis would be that the felt and conceptualised perspective of the other will have very different impacts depending upon how the gaze in question approaches us and is received by us. To start with, the gaze of the other which makes me feel, understand and view myself as an object, need not be alienating in the sense of making me foreign to myself in an experience of shame and disgust. The gaze of the mother, of the friend or of the lover could have the opposite result, making me feel secure, important and desirable, and not in spite of, but because of, my body. Sartre overemphasises the combat nature of intersubjectivity—if this is because of the influence of Hegel or the Second World War is not easy to tell, but the nature of the relationship to the other is surely richer than that (Ricoeur 1992).

Indeed, the gaze of the doctor, when he is checking some spots on my skin, or, in an even more scientific, quantifying manner measures my blood pressure, or reads the lab results of a blood test, could be alienating in the sense that I adopt through him a foreign view of that which nevertheless is myself. But this is so in a rather different way than when my stomach hurts, or when my body makes me vomit. And also, the gaze of the doctor need not *only* be a scientific gaze: diagnosis also includes talking to the patient and trying to understand her life predicament in a kind of hermeneutic process (Svenaeus 2001). If I blush, the doctor will not only see and understand this as a physiological reaction, but also as a my-blushing, a my being ashamed of something, and he might very well be interested in this as a life-world issue in making a diagnosis.

A third point of criticism, thus, is that the scientific objectification of the body is just one form of alienation—not the full-blown sense of all other ways of being alienated through illness or the everyday gaze of the other. Indeed, the scientific alienation—evoked by a lab test or an X-ray, for instance—in the typical case rests on a previous alienating process carried out by the body itself in illness. A lab test need not lead to an alienating experience if it does not feed into a suffering which

has already pointed at my own embodiment as a source of suffering and frustration. Just as in the famous Sartrean case when I get caught by the gaze of the other in peeping through the key-hole (1956, pp. 347 ff.), alienation must rest on an embodied misfortune or misgiving: the other (and there through myself) sees me doing something which is wrong and therefore shameful. But do I feel alienated in getting caught by the admiring gaze of the other in performing a piece of music or a dance with success? Hardly.

I can also sit happily watching a simultaneous PET-scan video of my own brain in action without being alienated. Alienation slips in when I have the experience of being controlled and determined by the ways of the brain—in contrast to the ways of my consciousness. The brain must become *me*—and yet other—in the strong sense of *making* my thoughts, not just serving as the necessary materialisation of them. Viewing and understanding the image must change my self-experience in the sense of being controlled or at least limited by a for-itself of my body which is perceived to be other—alien. It is hardly alienating merely to find out that you have a body which can be viewed, investigated and known from the outside. The first mirror may have been alienating to human beings, just as the first photo portrait and the first X-ray were, but this was exactly because the pictures were viewed as in some sense harbouring the self-being of a human, rather than just representing a view from the outside.

An Improved Phenomenology of Falling Ill

Is it possible, given these points of criticism of Sartre's theory, to offer an improved phenomenology of falling ill which would be more to the point in doing justice to the experience in question? After all, Sartre carried out his analyses more than 60 years ago, and he did this in a context in which his primary aim was not to understand the phenomenon of illness, but rather the human predicament as such, and therefore it should hardly surprise us if he did not get every detail right. As indicated above, however, there are indeed structural problems built in to Sartre's theory (the dichotomy of consciousness and thingness) which make it difficult, or even impossible for him, I would say, to find the adequate phenomenological explication of the experience of falling ill.

The three steps Sartre considers important in the process of falling ill he names "douleur," "mal" and "maladie." Kay Toombs, in her study *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient* (1992), has tried to develop Sartre's model by dividing his third step into two distinct ones—"disease pondering" and "disease state." Toombs wants to account for the fact that patients and doctors often have very different thoughts about, and perspectives on, disease—the disease concept of the doctor being more "medical" and scientific in nature than the looser disease concept of many patients. The four steps of falling ill in chronological order thus read in Toombs' translation and extension of Sartre: (1) pre-reflective experiencing of discomfort, (2) suffered illness, (3) disease pondering, and (4) disease state. Let us now put some flesh on the conceptual bones by offering a concrete example (the example is made up, but I have found some inspiration in Hardy (1978, pp. 232–33)). This will make it

possible to develop and improve the Sartrean model. Jane is telling us about the onset of her diabetes:

I suppose I was ill for a year before I knew I had diabetes. It came on when I was about 55, 5 years ago, and I had a classic case, but it was a long time before I knew what was happening to me. I would get terrifically thirsty and was not able to satisfy my thirst. I could be watching television, get up and drink a glass of water and be thirsty again before I sat down. And, of course, this meant that I was running to the toilet all the time, which was embarrassing, but what was worse was that I could not hold it back. When the urge hit me I knew I had about a minute to get to the toilet. This was not too bad at home or at work but it could be a problem when I was in the city—I imagine I have been in every toilet in every shop downtown. Then I began having blurred vision. Once when I was driving to work—I work as a lawyer, a solicitor, in the city centre—my eyes started to blur and I could not read the billboards along the way. This prompted me to see an ophthalmologist, but because this condition of blurred vision came and went, and I could see all right when I was in the doctor's office, he could not find anything wrong, and for some reason or other, he did not think of the possibility that I might have diabetes and, of course, I did not either. I kept getting worse. I lost weight and my legs felt stiff and painful just from walking around at home and in the office. I have never been much for exercise, but now just the thought of my weekly Sunday walk was too much. I felt tired and irritated most of my waking time—at work and at home with my husband. Did not feel like being with people, didn't have the energy. Also, my memory started failing me, I forgot things at work, I forgot what people had told me the day before. I suspected something was wrong, of course, but at the same time I kept reassuring myself that all I really needed was a long holiday. I was working really hard at this time and I thought maybe I was simply getting too old to carry on like this. But to change your way of life is not an easy thing, you're caught up in old habits and it is hard to tell your boss that you're getting old and weak. Finally one evening my husband managed to persuade me to go out with him for dinner with an old friend of ours. As I mentioned, I had not felt like going out and seeing people for the past year—too tired after work. Well, our friend is a doctor and at dinner I started telling him about these strange things that had happened to me lately. He just took one look at me and said, "Be in my office Monday morning." I could tell by the way he said it that he suspected what was wrong with me. He did. He told me later that he felt he knew already then, but he wanted to run some tests before he said I had diabetes.

Jane's life—her being-in-the-world—is gradually transformed in a way that bothers and worries her. The taken-for-grantedness, the transparency of her normal activities, is changed into an effortful striving just to get done what she used to perform easily. Life now offers severe resistance and she feels transformed: Is this still me? Why does my body no longer work the way it used to do? Why has it got out of my control? Life is gradually becoming "out of tune"—she feels dizzy, tired, irritated and pain stricken. Finally (by accident in this case) she seeks the advice of a doctor and finds out she has diabetes.

In the example we can identify all four stages of falling ill that we have found with the help of Sartre and Toombs. The pre-reflective discomfort of the first stage

creeps into experience gradually, making life strange and stressful for Jane. After a while she starts thematizing this experience in terms of time-based, disharmonic structures of thirstiness, needing to empty her bladder, having blurred vision when driving, feeling tired in the evenings, etc. These dissonant structures also make her start wondering if something is "wrong" with her—wrong meaning her having a possible disease. We can imagine this pondering on possible reasons for the strange experiences going on long before Jane meets the doctor—indicating Toombs' third stage of "disease pondering," before the final "disease state," diagnostic pronouncement of her doctor.

Going back to my earlier critique of Sartre's theory of embodiment, we can also discern with the help of the example that the alienation of the body in illness is, indeed, not only the experience of a psychic object, a temporal melody of suffering, but an experience of the in-itself of the person's own body. For Jane, her body "turns up" in different ways, obstructing her everyday doings, in being unusually heavy, stiff, painful, needful, etc. This is how her thinking is led into the disease hypothesis pattern, which is finally brought to the attention of a doctor.

The second step of falling ill—"suffered illness"—is actually preceded not only by "pre-reflective experience of discomfort" but also by a lived, *bodily* discomfort in which the body appears in a lived, rather than directly reflected, way. We are *aware* of our bodily discomfort, not only pre-reflectively in the sense of the pain (to go back to Sartre's example) being in the *reading* or even in the *book*, but in the sense of the pain being in the *eyes* and in the *head*. But we do not thematise the bodily experience in the sense of forming distinct thoughts and hypotheses about it. Sartre actually comes close to addressing this step of falling ill when he writes that:

> Pain is precisely the eyes in so far as consciousness "exists them." […] Pain is not considered from a reflective point of view; it is not referred back to a body-for-others. It is the-eyes-as-pain or vision-as-pain. (1956, p. 437)

The "eyes-as-pain" is, most certainly, a bodily process, with a distinct quality of bodily discomfort, yet Sartre's theory forbids his naming it so, since the body is always first and foremost "a body-for-others."

Phenomenology and Health Care

According to the analysis I have made above we can discern, not only three or four, but five steps in the process of falling ill: (1) pre-reflective experience of discomfort, (2) lived, bodily discomfort, (3) suffered illness, (4) disease pondering, and (5) disease state. To fall ill is to fall victim to a gradual process of alienation, and with each step this alienating process is taken to a new qualitative level. Consequently, the five steps of falling ill have not only a chronological but also a logical relationship to each other. Characteristically, they presuppose each other—that is, you can only suffer illness if you first have suffered lived, bodily discomfort; and you can only suffer lived, bodily discomfort if you have already suffered pre-reflective experience of discomfort. At least, this holds for the first three steps. When it comes to step four, "disease pondering," and step five, "disease state,"

things are a bit trickier. Remember that the step "disease pondering" means that persons are forming hypotheses about what is wrong with them in (loose) medical terms. In the standard case, the reason they do this is that they suffer from illness problems, but of course, there might be other reasons as well. Perhaps a woman has found out that her sister has breast cancer, and since she knows this is often a genetically linked disease, she starts to suspect that she has the disease herself. She starts searching her breasts for lumps, perhaps she goes to the doctor for a diagnostic test. This seems to be an example of falling ill (if she finds out she has the disease) which disregards the first three steps. An even more obvious example of this is finding out that you have a disease (such as breast cancer) by a preventive, screening programme. The doctor gives you the diagnosis (step five) without your having suspected anything about it beforehand.

Another example of falling directly into step five is very sudden onsets of diseases, such as the suffering of a stroke. The person in question does not suffer any preceding symptoms, but suddenly becomes unconscious and, in this case, (partly) paralysed. This is not the standard way to suffer haemorrhages in the brain, since stroke victims most often have preceding headaches or other symptoms before the stroke, but it is possible. Such ways of falling ill, however, are due to inner or outer *injuries* rather than diseases in the strict sense (Nordenfelt 1995).

The five steps of falling ill are not exclusive in the sense that when you enter the next step you leave the experience of the preceding one. Rather, they add in to each other, but preceding steps of experience also take on a new character through being supplanted by new ones in a kind of synthesis. Most striking, perhaps, is how the pre-reflective experience of the first step takes on a bodily, psychic and cognitive character through the succeeding steps. In this way, even a process beginning at step five through a diagnostic procedure—being told by the doctor that you have prostate cancer, for instance—can give rise to thoughts about symptoms that you now remember, but had not thought about earlier: Didn't I really have problems urinating, although I did not pay much attention to it? Didn't I feel a slight discomfort, pain, etc.? And in other cases, when you notice the bodily discomfort before going to the doctor (indeed, in the standard case, this is the very reason for going to the doctor), the pre-reflective suffering often becomes reinterpreted and made more explicitly bodily in nature. That is: the first step's effortful strivings to read, walk, stay concentrated on working duties, etc. are now remembered in terms of a bodily distress, which, when it happened, was there, but stayed in the preconscious background of the activities in question.

What about when falling ill never results in a diagnosis (either because you do not see a doctor, or because the doctor cannot find anything wrong with you)? Are these cases of falling ill even if you do not get a disease in the sense of the medical establishment's declaring you ill? Yes, of course, they are. Step five—"disease state"—in the phenomenology of falling ill does not name a cellular process which starts to exist when the doctor gives you a diagnosis and which did not exist before that time. From a natural scientific point of view, adopting a third-person perspective on the world—and, certainly, our bodies belong to this world—illness is dependent upon diseases, and in most cases these will start to exist in our bodies even before we feel any symptoms. "Disease state", however, names a phenomenological

description and explication of the experience of seeing the doctor and being told certain things about your body. This first-person perspective is the primary point of view of the phenomenologist, and it most certainly also was Sartre's position in *Being and Nothingness* (1956 p. 5 ff.). In fact, many cases of falling ill never do reach the final step of diagnostic declaration, most often because the discomfort in question is mild and typical for diagnoses we know about and do not fear because we know they will pass away by themselves (getting a cold and recovering from it may be the most common example). The fact that it can be hard to distinguish illness from unhappiness and other life problems in cases in which one does not, for various reasons, find any disease which lurks behind the problems in question, is an issue which I do not lay claim to solving in this paper. By way of concluding, however, let me offer a further example, which brings this problem to the surface.

I claimed in the introduction to this paper that a phenomenology of illness is not only interesting from a philosophical point of view but also can have practical implications for health care. Some of the examples I have mentioned above are relevant to this perspective; for instance, through this model, health care personnel could better understand the suffering a patient who is told he has prostate cancer goes through and the retrospective symptoms he might develop. This does not hold only for "victims" of screening programmes, of course. The focus on embodied alienation brings out the experiences patients characteristically go through in falling ill, and the explication and understanding of this process is certainly relevant to the professionals trying to help them. Most striking, perhaps, are the cases in which the doctor does not find any disease (diagnosis), but in which the patient nevertheless appears to be very ill in suffering pain, tiredness, difficulties moving, etc.

Chronic pain patients offer good illustrations of how a phenomenological approach could be of great value in health care, by putting emphasis on the lived body in contrast to the mere biological body of the patient. In helping persons with chronic pain it is often necessary to focus on their everyday style of life—what the phenomenologist calls the "life world"—in order to bring about change and improvement. In the case of the phenomenology of falling ill, another type of patient offers an even more striking example of the immediate benefit of bringing attention to this area. In contemporary health care we find a considerable number of "migrating" patients seeking help for a variety of symptoms without ever getting any satisfactory help. They tend to come back with new symptoms and new ideas for diagnosis, and when they are put off by their doctor they simply seek the help of another one. "Psychosomatics" is a label used for this type of life problems haunting the body and a subgroup of these patients are the ones we call "hypochondriacs."

According to our phenomenological model we can understand the hypochondriac as a person on a permanent search for pre-reflective ailments, which he or she thematizes in terms of hypotheses of various diagnoses. Or, to put it another way: the hypotheses of diseases which constantly plague his or her mind call attention to every discomfort in the preconscious background of his or her focused experience and drive them in the direction of lived, bodily discomfort and illness. The ideal of the "expert patient" taking control of his own care and treatment, in combination with the easily accessed information on the Internet about thousands of diseases as well as the irresponsible headlines and articles on new diagnoses, arguably

responsible for vague symptoms, flashed by the media, make the world a paradise (or perhaps rather a hell) for hypochondriacs. A phenomenology of illness helps us in analysing this situation and perhaps also in approaching the people who suffer from hypochondric symptoms. Considering this, the preventive health care work of tomorrow should be aimed to a large extent at educating people in getting to know and trust their own bodies and, perhaps, forgetting, rather than thinking more about, specific diagnoses.

Conclusion

In this paper I have developed a phenomenology of falling ill by presenting, interpreting and developing the basic model we find in Jean-Paul Sartre's *Being and Nothingness* (1956). The three steps identified by Sartre in this process were developed further and brought to a five-step model, consisting of the following stages characteristic of falling ill: (1) pre-reflective experience of discomfort, (2) lived, bodily discomfort, (3) suffered illness, (4) disease pondering, and (5) disease state. To fall ill is to fall victim to a gradual process of alienation, and with each step this alienating process is taken to a new qualitative level. Consequently, the five steps of falling ill have not only a chronological but also a logical relationship to each other.

I adopted Sartre's focus on embodiment as the core ground of the alienation process, but pointed out that the alienation of the body in illness is not only the experience of a psychic object, a temporal melody of suffering, but an experience of the independent life of one's own body. This facticity of the body is the result neither of the gaze of the other person, nor of a reflection adopting the outer perspective of the other in an indirect way, but of the very otherness of one's own body, which addresses itself to us when we fall ill. Thus the bodily discomfort is typically felt, although it is not thought about in a systematic way, before the doctor, or somebody else, or, indeed, myself, declares any opinions or systematic views about it.

Finally, I illustrated and explored the five-step model by way of different examples of falling ill and being a patient in seeking to show how a phenomenology such as this can be helpful in improving health care and in educating health-care personnel (and perhaps also patients) about the ways of the lived body. Examples used included diabetes, cancer, chronic pain and psychosomatics.

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