



An Ecology of
Wholeness

MEDICAL HUMANISM, CHRONIC ILLNESS, AND THE BODY IN PAIN

Vinita Agarwal



Medical Humanism, Chronic Illness, and the Body in Pain

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For my family, Scout, Arjun, and Sangeet, who make me whole.
For my father, Ashok Chandra Sharma, who lived a life of chronic pain
with grace. For the *gurus*, who embody the idea of presence.

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Chapter One

The Wholeness Project

To begin a book on wholeness is to face a large expanse of sky and wonder where to begin to grasp it in order to describe its width and breadth. The project is as elusive as it is huge. It is also a reminder of the power of scale. To look up is to be aware of the individual self in a self-reflexive relationship contemplating a larger entity, of a *here* in relationship with a *there*, and of a dialogic connection that speaks to the shared positionality of both perspectives. It's an awareness of an embodied self in engagement with an other. Understood, as an act of agency, one's contemplation of the first step appears as an engagement of dialogic communication with a vast enterprise. The enterprise will evoke the imagination as much as the discursive body, the intangible reality of the embodied self as much as the materiality and inscription of our hopes and fears, our joys and pain, our goals and our constraints, on the construction of our discursive bodies. In the act of looking up at the sky, we look within as we look outward, engaged in sense-making with all that we have, realizing that it is a self-reflexive exercise in grasping all that we are. The act of looking up at the sky could well be an illustration for the act of contemplation of our outward actions and the intentionality that guides them, an act that can be substituted by any other action and that might yet well implicate all the above questions.

Medical Humanism, Chronic Illness, and the Body in Pain: An Ecology of Wholeness is a postmodernist, social constructionist treatise on wholeness. It approaches the construction of wholeness as a journey to the enterprise of a lifetime of living with a chronic condition as it intersects with the thicket of the vast forest of medico-social scientific knowledge and human progress. The ever-deepening expanse of scientific research and technological sophistication takes us further into the space of medico-pharmaceutical, health care, public health, mediated-socio-cultural-communicative, neuroscientific, and biological

universes, affording us ever greater predictive precision and power of replicability that can examine the minute spaces of our DNA within the skin that encases our lived bodies. Present medical knowledge gives us the benefit of knowledge predict our risk of specific diseases and conditions, their antecedents and outcomes, our pasts and our anticipated futures, and all the conditions of their materialization, with impressive and ever-increasing precision.

Within this dynamic and growing universe, the book raises a call to consider the relationality of the individual in dialogic engagement with the whole, of the individual's own awareness of the self in relationship with the body on one hand and the planet of its material existence on the other, and all the many micro- and macro-interactions, contexts, and spaces that we inhabit, and that in turn constitute us, in between. The book takes as its center the chronic condition experience, caused largely by lifestyles, that are preventive in nature, amenable to health promotion, and in many cases, to the benefits of curative treatment that promise long-term survivorship. Chronic conditions and those living with them can well be the poster child for the advances in disease prevention and health promotion efforts of centuries of progress characterizing the evolution of human civilization.

Yet, as this book argues, the complex and multi-perspectival global burden of chronic conditions advances deeper and further than ever before. It seems the advances in the medico-scientific-public health centered socio-cultural-mediated-communicative effort miss a gap in providing a sense of quality-of-life in the care of patients and individuals living with long-term conditions. The ecological model of wholeness developed in the book proposes to integrate current advancements in an integrative framework that (re)orients us to the relationality and dialogic engagement with ourselves and our lived contexts in a way that centers and balances to create a sense of wholeness.

Given all the current advancements, the book asks, why has the meaning of health and treatment, health outcomes and long lives, cures and long-term survivorship, not resulted in individuals who are in engagement with the fulfillment of their highest goals, as current definitions of health and wellness will posit? Why would chronic conditions place an ever-increasing global burden on health care systems, national economies, and social capital, when survivorship and cure ensured by medico-science should be the precursor to much easier, non-scientific, humanistic question of living fulfilled lives? Our communities are characterized by disparities and disadvantage, fissures of racial, national, cultural, and medico-religious-social differences, and filled with anxiety over changing lifestyles, the relationship with the earth's natural resources, the loss of species and ecological diversity, and consumption and excess.

These are questions and challenges raised in the experiences of the individuals I've spoken with during the course of my research on comple-

mentary and alternative medicine providers and their patients—individuals living with chronic pain, who are supporting their biomedical treatment with other forms of care to address side effects of depression or drowsiness feel they have forgotten what it means to live a meaningful life. These are questions raised when we combine multiple, intersecting approaches to ideas of treatment, healing, and cure, and in order to do so successfully, need to be aware of what healing and health means to us by way of providing a cure. They are also raised when we, as social scientists, researchers, educators, and practitioners, recall definitions by leading world bodies and authoritarian global institutions in medical and health care research that are predicated on wholeness. They are relevant to concerns of delivering meaningful patient-centered care that makes a difference in the lives of patients and in our larger communities.

The underlying premise of the book focuses on the nature of wholeness and how it can be conceptualized to be integrated in the lives of individuals with chronic conditions and in conceptualizing patient-centered care. In raising the question of wholeness, the book is concerned not so much with the philosophical, phenomenological inquiry into the nature of meaning and human existence, but with the central premise of proposing an integrative vision of medicine, humanities, and the human expression of wellness in/as healing communication. My goal in engaging in this endeavor, from the vantage point of an individual facing these challenges, is to engage with these concerns in an integrative call for an *ecological model of wholeness*.

The ecological model of wholeness is applied, in this book, to the chronic condition self-management domain, as an illustrative instance, and as a device to exemplify the model's applicability to a range of definitions of wholeness. The social constructionist approach employed in the model encapsulates the invitation for multiple meaning-creation intersections, on the basis of context and individual positionality in the framework. This book is, therefore, a proposition to center the question of wholeness in the dialogic relationship of the individual within the whole. To be whole is to be aware, open, and integrated in our relationship with the self and others, and with diverse human cultures, plant and animal species, and geological ecosystems that construct our lived spaces and our planet Earth. As a state, the project of wholeness presented in this book envisages being open to revising the fundamental definitions of humanism, to rethinking how we position the self in dialogic ways with the body, and to recognize alternative ways of organizing knowledge, human experience, and relationships.

For the chronic illness patient, the chronic condition domain is characterized by discontinuities and fragmented narratives, ruptured identities, and struggles in meaning-making of the daily experience of their illness. The project on

wholeness is particularly relevant to addressing challenges in human health and healing, particularly in patient-centered care in the domain of chronic illness management, where clinician-patient communication in disease management can make an especially impactful contribution to patient outcomes (Street et al., 2009). A social constructionist, humanist approach experience to understanding the constitution of the chronic illness experience can contribute to enhancing not only objective and measurable health-related quality of life indicators, but also, as the book argues, construct an embodied, reflexive awareness of the discursive and material body/self independent of the disease.

Chronic conditions are disruptive, but also preventable, and can be supported by self-management in long-term contexts. They connect with our lifestyles and with our ecological challenges and resonate at a time when we are faced with increasing evidence connecting the health of planetary environmental and geological systems, human biological and social systems, and the individual body's dialogic and regulatory mechanisms. Stressors, dysfunctionality, and misalignment between these, evidence reveals, are closely related with the production of body mass pathologies that underlie chronic conditions (e.g., obesity, cardiovascular risk factors; Tsigos et al., 2016). Living with a chronic illness in the long term is to understand the condition as an experience. Mattingly and Lawlor describe an *experience* as a fleeting, ambiguous, unique, memory-making exercise that lends itself to potentially a multitude of meanings with time; remaking meaning with the future, and the future remaking the meaning set in the past (2001). The long-term, situated nature of chronic illness is characterized by its negotiation in the patient's lived context as a story or a narrative that helps them make sense of their life and its challenges in the context of their evolving symptoms. This exercise, conducted in collaborative partnership with the physician, entails patient reorganization of their experiences to engage in interpretive construction with physicians, their care givers, allied health care professionals, and others (Murphy et al., 2001). The ecology of wholeness centers how we can (re) create individual empowerment and what it means to be human in ways that envision meaningful experiences of healing while foregrounding prevention and management of long-term chronic conditions.

We live in an ever-complex, globally interdependent planet, one characterized by a search for balance between progress, ecosocial stresses, and their attendant impacts on the health and well-being of its inhabitants. The book approaches wholeness as a communicative act—one that constantly revisits, reassesses, and contemplates its engagement with the body/self relationship. In this book, I define *communication* as an engagement that supports mutual dialogic constitution between relational interactants. Within the larger domain of communication, I define *healing communication* as communication that supports

awareness, intentionality, or actionability of the relational integration of the body/self understood in a situated context. In laying out a whole-person, medical humanistic framework of healing for chronic condition contexts grounded within the practice of medicine and health, the chapters in this book construct an ecological understanding of wholeness through a social constructionist lens.

Although the arguments developing wholeness presented in this book enhance everyday lived experiences of healthfulness and healing, due to the pervasiveness, preventive nature, and long-term self-management potential of chronic conditions, they resonate especially with the chronic (or alternatively, noncommunicable diseases, NCD) experience of the individuals, and that of the caregivers, providers, allied health care professionals, and community members involved in their care. Furthermore, as differentiated from acute care contexts, chronic conditions are often long-term, lifestyle- and genetics-based, incremental in their fragmentation of the body/self-identity, and socially invisible in nature. These factors support the social constructionist emphasis on relational, dialogic, and contextual orientation with a related concern with self-identity and situated nature of experiences.

AN ECOLOGY OF WHOLENESS

In this book, I propose an ecological model of wholeness centering the body/self in a dialogic engagement with itself and the contextual layers. I construct the model using a medical humanistic perspective centered in a relational social constructionist approach and employ it in the book to address the challenge of prevention and long-term management of chronic conditions. A medical humanistic approach allows me to emphasize an integrative lens of social justice, locally situated cultural values, and traditional medicine, and through this ecological framework, to suggest ways to cultivate wholeness in the prevention and long-term management of chronic conditions. The social constructionist approach allows me to construct an interdisciplinary and theoretically open dialogic space to articulate, in each chapter, applied practices such as reflection, visualization and art, narrative engagement with our bodies, solitude and meditation, positive lived environments, journaling and telling stories, creating healing spaces, and building an authentic relationship with our food that can help envision and sustain wholeness in our lives and lived contexts. *Medical Humanism, Chronic Illness, and the Body in Pain: An Ecology of Wholeness* invites us to (re)consider *being whole* as an individual, relational, and dialogic premise, one vital for the construction of the paradigms upon which our ideas of collective growth, progress, and change are envisioned.

The chapters on wholeness presented in this book provide a medical humanistic perspective employing a social constructionist epistemological framework for understanding the experience of chronic conditions with healing in the context of a global world with economic flows, technological advances, and cultural connections on the one hand, yet one where the divide between people, resources, nature, and the environment is growing larger than ever before. In this chapter, “The Wholeness Project,” I lay the groundwork for the conceptual understanding of wholeness, situating it in the global challenge of chronic condition management and its ethical dimensions, as explicated through the need for integrative and collaborative perspectives. I then situate the medical humanistic perspective, attending to the employment of the expanded chronic care model, and the parameters of self-management and self-care. Finally, I share a few words on the impetus for the book and the methodological approach employed in the conceptualization and development of the model. I conclude the chapter with a look at the ecology of wholeness model situated within the conceptual layout of the chapters presented in the book.

The proposal for a wholeness approach is particularly relevant to the management of chronic conditions. At a time when an increasing number of individuals globally live with chronic and NCDs, it is important to position the conversation around wholeness and chronic conditions not as polarities with health and disease, but in ways that carefully fill out their meanings and experiences in non-adversarial, integrative ways. More importantly, the book argues, such experiences should be grounded in empowering and fulfilling choices that achieve measurable but personally constructed outcomes of health and disease. Although I will go into the case of chronic conditions in more detail in the second half of this chapter, here at the outset, I will provide a few salient reasons explaining why chronic condition management constitutes an appropriate case for examination in this book.

The book’s focus on the case of chronic condition prevention and management is based on a few salient factors. Even as life expectancies increase, increasing numbers of people are living with chronic conditions than ever before. Chronic diseases are the leading causes of death and disability globally, with about two thirds of the deaths attributed to chronic and NCDs occurring in developing countries. In the United States, about two thirds of all the deaths are attributed to one of five chronic disorders of cancer, chronic obstructive pulmonary disease, diabetes, heart disease, and stroke. Newly classified conditions such as obesity alone cost the US health care system about USD 147 billion a year (Centers for Disease Prevention and Control, CDC, 2019). Likewise, CDC statistics show that about 1 in 4 adults in the United States lives with arthritis, making it a leading cause of disability and a common cause of chronic pain. A humanistic approach to conceptualizing health and disease in

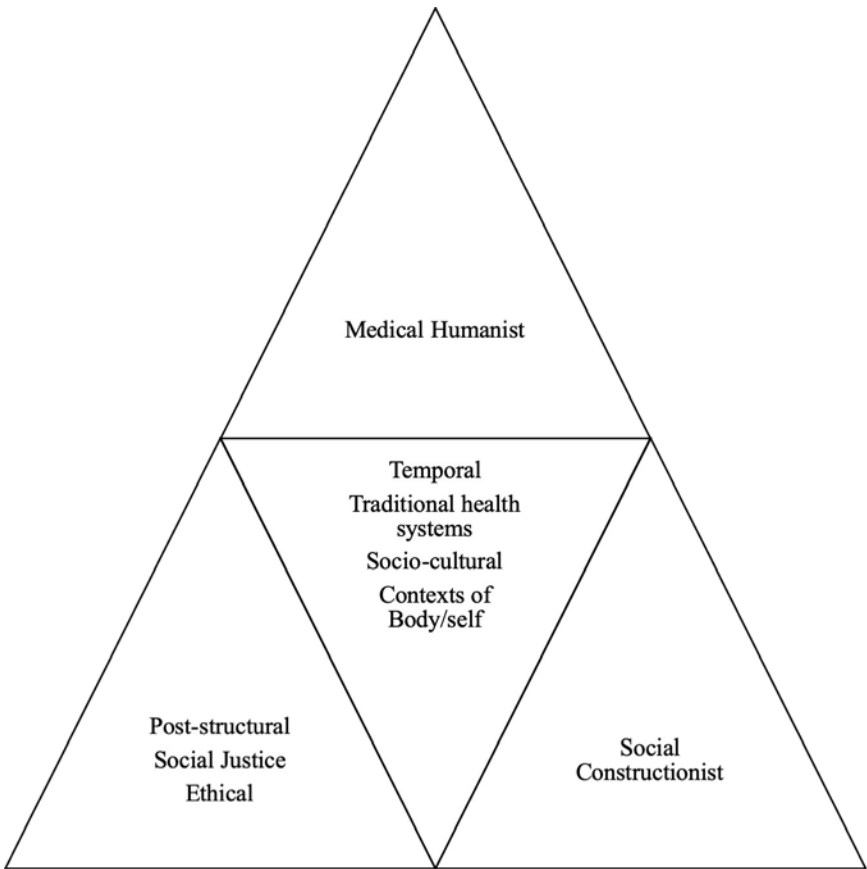


Figure 1.1. A medical humanist, social constructionist approach to wholeness. *Figure created by author.*

the domain of chronic conditions has the potential to guide how prevention and treatment of disease progressions that are often characterized by long-term management of pain, debilitation, or disability can be reframed in meaningful ways to further an integrative human vision of wholeness.

THE ARGUMENT FOR A MEDICAL HUMANISTIC APPROACH

By taking a medical humanistic approach, the book argues for a praxis informed by reflection and insight into the experience of connecting the human condition with the relational and ecosocial from a dialogic and mutually constitutive perspective (figure 1.1). These intersectionalities invite us to look

at religion and philosophy as much as they invite us to re-examine the intersections of multiple epistemologies and definitions of science and medicine. Modern science and medicine have led to the eradication of many diseases, brought health, and long life, and furthered the ability to conquer formidable assaults from viruses, microbes, the environment, accidents, and the body's own genes with dependability and reliability.

A distinctive feature of the intellectual history of twentieth-century medicine is its alignment with science, guided by objectivity, hyper-specialization, bureaucratization, technology, and the pursuit of knowledge for its own sake. Although it is not the goal of this book to position humanism and science as basic polarities, a deeper look at this relationship is warranted if an effort to balance the practice of medicine with humanism has to be fully understood as reflecting distinctive approaches to comprehending human existence. As Pellegrino argues, the practice of medicine fundamentally lies between the practice of science and its humanistic principles, and the domination of any one over the other is bound to compromise the authenticity and ethicality of the knowledge and practice of both (1981). The enduring prevalence of chronic conditions is a call to address the challenge of (re)conceptualizing difference to understand disparities and social organization in ways that support what is vital in our individual lifestyles, traditions, communities, and cultures.

Keeping differences alive and nurturing their uniqueness within a global landscape is central to the project of achieving health and mitigating the ruptures caused by lifelong chronic conditions. The arguments in this book present a framework illustrating how the project of medical humanism is central to the endeavor of accomplishing individual and social wholeness. In part, a starting point for this project of wholeness lies in revisiting the processes of training and education of those who work toward cultivating health in our society. Several thinkers have called for a revision in medical education and curricula to include the human and the social alongside the objective and the medical. Spivak (2003), for instance, calls for an enabling vision of humanism through language-based humanities and teaching, a humanism that can cultivate a capacity to produce a qualitatively different, pluralistic form of pedagogies. What will make such forms of pedagogies vital is their validation of both humanistic ethics and human rights principles with equity and humility, an openness to being “intended toward the other,” not merely through rationality and reason, nor of an unnamed otherness, or, as Spivak puts it, as a derivative of an “alterity” that is unnamed (pp. 72–73). Such moves call for more than an addition of educational programs promoting an awareness of the other. What is needed is a fundamental understanding of such identifications and integrations as they operate within a living framework of difference and otherness, to construct a dialogic engagement that promotes a critical and

continuing work toward the alignment of the individual and the universal, the objective and the subjective, the traditional and the contemporary, and the humanistic and the objective.

Such integrations are possible but made challenging in the absence of the basic supports of global equity and justice. Our present circumstances are characterized by an increasing global divide in economics and the attendant disparities in access, availability, and engagement with fundamental health services and advances. The statistics from the international non-governmental agencies and national centers are striking and only too familiar. I will take a moment to highlight a few here to lay out the ways in which a deeper examination for the call of wholeness as a way of thinking about human health can be re-examined and, indeed, should be carefully investigated, developed, and explicated.

More than 80 percent of the world's population lives in developing countries and approximately half the world's population cannot access essential health services. Even as the number of people able to obtain essential life-saving services like immunizations, family planning, antiretroviral treatment for the human immunodeficiency virus (HIV), or insecticide-treated bed nets for preventing malaria has increased in the twenty-first century, gaps in availability of services in certain regions of the world, such as in Sub-Saharan Africa and South Asia, have become especially acute.

At the same time, the proportion of gross national product (GNP) spent on health care has increased sharply in industrialized countries. According to the Centers for Medicare and Medicaid Services (CMS), the United States alone spends about 50 percent (USD 1.2 trillion) of the total health care expenditure in the world on 5 percent of the world's population. The national health spending in the United States is projected to reach approximately USD 6 trillion in 2027 (CMS). These global ruptures in access and equity, further accentuated by loss of public trust in the medical profession, have undermined the larger social structure and threatened the equitable delivery of essential health and social services foundational for supporting a basic quality of life.

(Re)thinking Wholeness in a Fractured Self/World

Taking a relational, dialogic view of wholeness is central to guiding the achievements of modern science and technology ethically and deliberatively. They are key to accomplishing an integrative relationship of the individual within the multiple cultural logics underlying lifestyle-based conditions and the competing medical worldviews of our present landscape. A relational perspective emphasizes connections and an integrative approach. It positions the self, the individual, within a larger whole and provides the individual the tools to reflect upon the self from within this network of relationships. Moreover,

the ecological model of wholeness proposed in the book goes beyond articulating a relational approach to equip the individual to envision how each part affects the other in dynamic ways. Doing so can help move us toward making a difference in the many chronic health conditions premised on the problems of access and inequity on the one hand, and the crises of modernity and its market-driven excesses on the other (Gergen & Gergen, 2004). Alongside these postmodernist and structural-economic factors, others have emphasized the social constructionist shaping of disease, as through the use of metaphors that add to suffering and exacerbate fear of certain conditions such as cancer (Sontag, 2001). The relational perspective emphasizes the integrative aspect of language and lived experience, the construction of chronic illness as a disease, and the patient's reflexive and embodied experience through the discursive and material body in ways that can reshape the illness experience.

These connections are pervasive in their effects while being diffuse in their relationship with the structural causes of global inequity. Critics note that growing global inequity is fed by Third World debt and governance challenges and complicated by structural adjustment policies of intranational agencies such as the International Monetary Fund (IMF) and the World Bank (WB), prolonged social and national conflict, and increasing consumerism (Benatar et al., 2003). Benatar et al. argue that the individual determinants of health are increasingly dependent upon addressing these factors in the context of eroding social norms and traditional practices that provide a protective buffer guiding moral and social progress. Such profound interdependence of the individual and the global is acutely felt in the domain of preventable lifestyle conditions that underlie chronic diseases such as diabetes, rheumatoid arthritis, and chronic obstructive pulmonary disease (COPD) than ever before. The call for global health ethics to guide policymaking in the health care arena targets the negative impact of climate change, loss of species diversity, and destruction of environmental capital to create a framework of international collaboration and trust to sustain equity, peace, freedom, and justice (Benatar et al., 2003).

The connections between climate change and structural-economic policies speaks to the larger issues of disparities and inequity in general. NCDs kill about 41 million people, accounting for about 71 percent of all deaths globally every year, with more than three quarters of global NCD deaths occurring in low- and middle-income countries (WHO, 2019). The four main groups of diseases include cardiovascular diseases (e.g., heart attacks, strokes), cancers, respiratory diseases (e.g., chronic obstructive pulmonary disease, asthma), and diabetes. Their primary drivers are related to rapid unplanned urbanization and the globalization of unhealthy lifestyles, including poor diet and lack of physical activity that result in metabolic risk factors such as raised blood

pressure, blood glucose, blood lipids, and obesity. Economically and socially disadvantaged groups are especially vulnerable to NCDs and their negative impacts such as through loss of household income and through vulnerability to poverty. Primary health care services that emphasize early detection and treatment can lessen the impact of NCDs on individuals and society (WHO, 2019). In addressing the health challenges of NCDs, we need to situate understandings of wholeness with access to traditional lifestyle and medicine alongside biomedical screening and treatment approaches.

Wholeness has been discussed in many ways by international agencies, wellness advocates, and sustainability experts, mostly by way of general references to a connection of mind, body, and spirit. However, these generalized references to connecting mind, body, and spirit in care suggest a need for greater explication and development in order to be conceptually, theoretically, and pragmatically helpful for those struggling with chronic diseases on a day-to-day basis and their providers and caregivers. This book makes a unique contribution by developing a conceptual framework for an ecology of wholeness through the lens of social constructionism. The emphasis on relationality and dialogic engagement laid out in this book proposes the bringing together of the philosophical orientations of interdisciplinary approaches from humanities and sciences to address the ontological orientations of the indigenous and the other while including forms of knowledges that may appear irrational, primitive, or prehistoric.

Such an ecological model of wholeness involves constructing a critique of the larger project of humanism, health, and medicine as a starting point to connect with diverse cultural logics and contexts of their enactment. By connecting diverse practices in medicine and health with a reflection on the self and the body, these chapters on wholeness articulate a social constructionist perspective on an integrative understanding to reshape the chronic disease experience. The chapters take an integrative and medical humanistic approach to bring together disciplinary insights from geography, anthropology, art, and health economics among others with health and medicine to propose a framework for understanding change in the body and self through a relational lens for those living with chronic conditions.

Health and disease have shaped the course of civilizations in the past. Historic evidence indicates the emergence of infectious diseases has been associated with shifts in socioeconomic and cultural practices (Wallace et al., 2019). Advances in the etiology of diseases and their relationship with planetary ecology have deepened our understandings of the connections between human health and our planet. Evolutionary biology, focusing on connections between the *homo sapiens sapiens* (Latin for “wise man”) over the last 10,000 years as they evolved from hunter-gatherers to technologically

advanced, longer-living beings, has the potential to better understand autoimmune diseases and psychiatric disorders. In its exploration of factors ranging from our evolving symbiotic relationship with bacteria to the employment of vaccination for public health, evolutionary biology sees the body as an adaptive organism comprising a hundred trillion individual cells each following a strategy of differentiating to maximize not health but reproductive efficiencies. This view displaces the previous structural paradigm of diseases and highlights how evolutionary thinking can illuminate unexpected facets for medical practice (Dybas, 2007; Stearns et al., 2010). Understanding how cellular and genetic pathways play an important role in adaptive responses and evolutionary processes has, in turn, helped explain many aspects of the etiology of human genetic diseases and, ultimately, shed light on less well understood aspects of the body's healing mechanisms.

For instance, science has begun to understand how the epigenetic state is altered with environmental and lifestyle factors in many diseases, and this understanding is leading the way to greater insights in the fields of lifestyle-related chronic conditions related with nutrition, behavior, stress, physical activity, and working activity (Algeria-Torres et al., 2013; Ishino et al., 2013). Insights connecting biology, genetics, and the environment are reshaping biomedical approaches. By forcing us to rethink their deterministic assumptions, these newer arguments connecting evolutionary biology, epigenetics, and chronic diseases make a strong case for taking into account factors such as lifestyle and nutrition and their connection with globalization and neoliberal policies to better understand their impact on NCDs (Wallace et al., 2019). These findings reinforce the implications of increased global interdependence and the need to situate reflective, dialogical, and ethical approaches to address emergent challenges to individual, community, and public health.

The increased attention on marginalization, social disparities, neoliberal philosophies, and their relationship with paternalistic and deterministic models of health care with respect to individual and community-level health outcomes is emblematic of the foregrounding of concerns pertaining to economic disparity, social justice, and global health ethics (Dutta-Bergman, 2007). The disparities evidenced in the numbers is revealing. For instance, in the second decade of the twenty-first century, the richest 10 percent have up to 40 percent of global income whereas the poorest 10 percent earn only between 2 to 7 percent (United Nations Development Program, UNDP, 2019). Scholars have drawn attention to the implications of the neoliberal doctrine of development and progress on a multitude of factors including positioning natural resources as commodity exports and an over-dominance of cultivated, agricultural land (60 percent) in proportion to Earth's ice-free land surface (40 percent; Wallace et al., 2019).

Statistics illustrating a similar imbalance can be found for a range of other environmental impacts such as the overwhelming percentage of livestock as representing the vertebrate biomass on Earth today. These imbalances also play out in individual terms, particularly in regions where people survive on USD 1.90 or less a day. Out-of-pocket health expenses have pushed more households globally into extreme poverty (WHO, 2019). Scholars have warned that globalization will negatively affect the public health of those in the developing world by eroding the knowledge and practice of indigenous or traditional medicine, while doing little to make Western medicine economically or geographically accessible (Aginam, 2000). The increasing prevalence of chronic conditions means that the impacts on individual health of global imbalances are being felt everywhere—from the more developed, industrialized nations to the low- and middle-income nations.

Ethical Parameters and Social Justice

The realities reflected by such statistics bring to the fore the ethical parameters of individual and community health, environment, and progress. Health care ethics traditionally emphasizes the four basic principles comprising autonomy, justice, beneficence, and non-maleficence. Their application to public health goals has given importance to the multiple connections and considerations of social, economic, and environmental factors. The public health focus within this landscape characterized by the tensions of multilateralism and destabilization is faced with debates on how to address the burden of NCDs and the social determinants of health (including income, community resources, and structural racism; Jennings et al., 1988; Institute of Medicine, IOM, 2005). In addition to individual autonomy, the IOM considers a commitment to social justice, a prevention orientation, and providing adequate social support essential to discussions of individual health promotion in the chronic care domain (2005).

The arguments surrounding these perspectives are consistent with the viewpoint that individual health is intimately linked with issues of human rights, economic opportunities, law, policy, governance, and peaceful co-existence with sustainable development and environmental protections in a complex and interdependent world (Benatar et al., 2003). Social justice, comprising the values of fairness and equity, particularly with respect to the need of marginalized communities and individuals, is considered a core principle of the mission of public health. In guiding our decisions on the direction of the policy and application of medicine in society and for the benefit of individuals, bioethics has been an important support to medical humanities. The field of bioethics, with its attention to developments in science, technology,

medicine, and care from an interdisciplinary perspective, and drawing upon theology, religion, philosophy, and law, among other disciplines, has contributed to understanding the ethical principles undergirding the practice of medicine and allocation of health care resources.

Bioethics can support the dialogue needed to provide direction guiding the role of medical technology in our experience of health care, meanings of health and disease, and how we seek to achieve these. Bioethicists recognize the need to take an inclusive view of the relationships and partnerships necessary for fostering the dialogues centering around a critical examination of their role and influence on human development and progress. These conversations are central to guiding the ethical practice of medicine in many contexts, such as, in providing a voice to disadvantaged or vulnerable populations, those who are chronically ill, or those in palliative care. To contextualize the integrative nature of these discussions, I'll provide an overview of two initiatives here to illustrate their main parameters.

Integration and Collaboration

The first, the One Health Initiative, acknowledges these imperatives, adopting a “collaborative, multisectoral, and transdisciplinary approach—working at the local, regional, national, and global levels—with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment” (CDC, 2019). The philosophy of the One Health Initiative draws upon the recognition that planetary environmental health will affect human and animal health through contamination, pollution, climate change, and the emergence of new infectious agents. The second move is the recognition of traditional, indigenous, and local systems of knowledge and how their alternative logics can be integrated with the more objective basis of biomedical research to optimize health care access, delivery, and outcomes.

The main philosophical arguments driving the One Health Initiative draw upon the ecosystemic theory. Recent global trends in emerging infectious diseases and their economic and public health impacts have drawn attention to the correlations between environmental impacts, planetary ecology, and socio-economic trends with human health. In the last half of the twentieth century and the first decades of the twenty-first, emerging infectious diseases have ranged from the HIV pandemic, SARS (severe acute respiratory virus), Ebola, and Zika, to name a few. Their emergence highlights the impacts of urbanization on livelihoods, risk exposures, disparities, and chronic and degenerative diseases. The One Health approach adopts a relational, ecological emphasis, drawing upon the ecosystemic theory that states that the health

of organisms in the field is relational and that animals and pathogens are embedded in webs of interaction across populations and species. Its mission statement recognizes that human health, animal health, and the health of the ecosystem are inextricably linked. Thus, to achieve health from a whole person approach, the Initiative seeks to “promote, improve, and defend the health and well-being of all species by enhancing cooperation and collaboration between physicians, veterinarians, other scientific health and environmental professionals and by promoting strengths in leadership and management to achieve these goals” (One Health Initiative, 2019). These initiatives seek to achieve greater prevention of infectious and chronic diseases; promote information sharing related to disease detection, diagnosis, education, and research; set up interdisciplinary programs in education, training, research, and policy; and facilitate development of new therapies and approaches to treatments in ethical ways (One Health Commission, 2019). Although it has been critiqued for a deterministic bias, the initiative still goes a long way toward recognizing in actionable ways the connectivity and interdependence that are salient to human health.

The second example considers the move to recognize alternative, culturally situated logics in how health care initiatives are implemented, how their outcomes assessed, and how we articulate the practice of medicine more explicitly in furthering the ethical principle of fairness and equity in medicine. These considerations are especially relevant to the increasing numbers of individuals living with chronic conditions whose preventable nature and lifestyle orientation make them particularly well-situated to making a meaningful difference, particularly as the marginalized and vulnerable populations are most susceptible to their negative outcomes. WHO’s goal for universal health coverage emphasizes the social justice principle of fairness by ensuring all people have access to health promotion, disease prevention, treatment, and rehabilitation in an affordable manner (2013). This has meant acknowledging that traditional medicine (TM) is the primary source of health care where availability and access of allopathic services is limited.

In certain regions of Africa, for instance, the ratio of traditional healers to population far exceeds the ratio of allopathic doctors to the population. These imbalances provide a compelling rationale for considering how complementary and alternative medicine (CAM) systems that are culturally appropriate and readily available in local contexts should be included in appropriate ways with biomedicine as a support to individual health in different regions of the world. This is the imperative of national bodies in the United States such as the National Center for Complementary and Integrative Health (NCCIH), whose focus centers on supporting basic research for identifying and addressing important regulatory, safety, and implementation mechanisms to achieve

safe and efficacious integration between different knowledge systems. The vast scale of work needed to be done to explore the knowledge base of the different traditional systems globally emphasizes the many hurdles that need to be overcome in this direction and recognizes that more work is needed to develop a truly integrative system. The challenges of poor product and mechanistic research, poor communication between health care professionals and patients, and poor documentation and follow-through of side effects have hampered the integration process (WHO, 2013). Yet, the move is important in bringing health care in culturally meaningful ways to individuals from different philosophical orientations and to do so in an ethical manner that emphasizes equity and access and protects the family structure and social fabric of communities.

By recognizing the challenges of providing allopathic care in underserved areas equitably to all communities across the globe, initiatives that work toward finding ways of supporting traditional and complementary medicine (T&CM) systems at the primary and preventive level are important for addressing chronic conditions in ways that can make a meaningful difference. Such initiatives open to integrating traditional health care systems can further the ability to increase access to complementary and alternative models of health care (WHO, 2013). T&CM modalities are globally accessible and contribute to ensuring access to care that is close to homes, culturally acceptable, trusted, and affordable, while helping meet the quality-of-life needs of those living with chronic care conditions. The inclusivity of different health care systems has been categorized by WHO across a continuum by the range of approaches taken across global regions. For instance, national areas/regions where CAM is officially incorporated at all levels (e.g., from primary clinics to research, implementation, and regulation at national policy level) are categorized as an integrative system; regions where CAM is recognized, but not fully integrated (e.g., quality control or implementation concerns are still being addressed) are categorized as an inclusive system; and regions where the allopathic system is recognized and supported by the state legally are categorized as a tolerant system. These initiatives are important for chronic condition management because of the preventable nature of chronic conditions and their origin in lifestyle-based factors, which are closely connected with culture and particularly amenable to the preventive focus of many traditional medicine contexts.

Some broad considerations will help illustrate the cautionary facets of CAM integration. First, the use of CAM approaches is not uniform by chronic condition type globally. The use of T&CM approaches has been found to vary by the prevalence of specific types of chronic conditions in different national contexts. For instance, trends show that those with chronic musculoskeletal

conditions and multiple sclerosis patients were more likely to use T&CM in the United States; those with cerebrovascular accidents, intervertebral disc displacements, hemorrhoids, ischemic heart disease, and essential hypertension were more likely to use T&CM in China; and bone, joint, and muscle system disorders, dyspepsia, osteoarthritis of the knee, and facial service disorders were relevant predictors of T&CM use in the Republic of Korea. Second, while lifestyle approaches and local preventive CAM modalities can, with proper regulation, oversight, and research, contribute to promoting equity and access to health, wellness, and people-centered care, their implementation has to be guided with caution (Patwardhan, 2005). For instance, while traditional pharmacological preparations make greater use of local resources for local needs in their formulation, their overuse risks the health and diversity of herbal resources in these ecosystems. Thus, it is important that regulations to protect the natural resources of the ecological systems from which the raw materials for traditional medicine (TM) are extracted are in place alongside guidelines for integration (Li et al., 2015). The next section presents the scope and depth of chronic conditions and NCDs globally and within the United States. By situating the preceding discussion toward understanding the challenges presented by chronic conditions and highlighting the depth and urgency with which we need to examine the discourses of alternative and mainstream medicine practices, subjective and objective knowledge, integrative and complementary approaches, and scientific and traditional ontologies, the book seeks to envisage their pragmatic impacts and praxis in constituting wholeness for individuals in empowering and self-directed ways.

As this discussion illustrates, the multiplicity of links between the environment, markets, natural resources, and lifestyle and culture complicate the interdependence underlying global disparities. These interconnections are particularly well illustrated in the domain of chronic health conditions. Recent scholarly work has helped draw attention to these connections. The export of processed food (as a Western market artifact), for example, has been critiqued as changing dietary conditions globally and perhaps fueling a global obesity pandemic (Aginam, 2000, p. 612). If the obesity pandemic is attributed as a metabolic correlate of a neoliberal model of development (Wallace et al., 2019), the need for recognizing how social practices and institutional policies support or discourage particular social norms, beliefs, and values becomes relevant in ethical considerations of lifestyle practices. Lifestyle practices draw upon local norms and bridge the social and the global in impactful ways in the realm of prevalence and treatment of chronic conditions. In the next section I present a brief overview of medical humanities as it furthers an ethical, relational, and dialogic way of approaching medicine, health, and healing in the context of chronic diseases globally.

MEDICAL HUMANISM IN CHRONIC DISEASE MANAGEMENT

The culture of medicine and medical practice is intertwined with the culture of the age in which it is enacted and that of the local and individual contexts of its practitioners. To be practiced ethically, these need to be in alignment with their way of being enacted in thought, action, and practice, in the local contexts in which health is understood and contextualized. To translate ethical reasoning into ethical practice, Kong (2015) argues for the creation of an ethics community that nurtures and supports professionals, provides moral resources and a moral imagination, and helps reflection in engagement with the four principles of social justice such as fairness, equity, access, and autonomy. While medical education today emphasizes competency-based outcomes such as those backed by assessment-driven learning and a free-market model of an education system, human values, cultural norms, and local ethical frameworks can emphasize its connection with living, diverse communities.

This integration can be made possible through a framework of medical humanism. Those arguing for the greater insertion of a liberal education in medical education, have advocated for the need to cultivate room for non-technical information that is not directly relevant to the practical, technical parameters of medicine (Pellegrino, 1981). The liberal arts and humanities provide the vocabulary and the logics to critique biomedical practice from a meta-analytic perspective in ways that can then serve as a guiding force for its practical application. For instance, critiquing biomedicine as a product of the Euro-centric framework of humanism is to open the possibility of examining the practice of medicine as situated within the hegemonic space of universalization, liberal humanist discourses on rights, and the politics of difference that place the Western subject as the ideal subject figure of all histories and societies. This vocabulary and meta-analytic glance opens the space to negotiate other ways of being human that are empowering of the minorities and indigenous cultures without being adversarial or antithetical to the project of euro-humanism (Pawar, 2011). Considering healing, health, and medicine from a framework of cultural diversity, hegemony, and universalism opens possibilities to critique the normativity of the *homo europaes* in this landscape, according an equitable space of self-determination to the indigenous other (Pawar, 2011). Such a critique is particularly relevant to the field of medicine if we understand health and healing as a human right and center the social justice framework of equity and access in making care available in ways that are efficacious but also culturally meaningful.

In chronic condition management, the absence of care that connects with human values, health, and healing and privileges only an outcomes-driven

and adverse-event focused measurement emphasis runs the danger of dependence on pharmacological treatment at the cost of an emphasis on quality of life. Drawing upon the postcolonial critique of the humanistic subject and the other, Bhabha argues that minority cultural rights stand in the liminal spaces between individual needs and obligations, and collective claims and choices, in a hybrid cultural milieu (2000). This book provides a medical humanist approach to centering wholeness in chronic condition management by foregrounding the human and the cultural in the space of how we approach prevention of lifestyle-based conditions. In the practice of medicine for chronic disease management, this hybrid space is occupied by immigrants, refugees, and diasporic populations who are within yet distinctive forms of national cultures, and who, as this book argues, are caught between navigating the liminal spaces of cultural health practices and local values at the intersection of normative universal modes of disease management.

To situate the medical humanistic approach to chronic disease management as an element of the postmodernist framework presented in this book, I'll provide an illustrative example. African liberative ethics, for example, reflect and embody the history of, and are an "outcome of communal and individual reflections on the meaning of life and how to achieve freedom in the face of oppressive systems" (Chitando, 2013, p. 31). In grappling with HIV/AIDS (acquired immunodeficiency syndrome), violence, land rights, and epidemics, African ethics emphasize harmonious relationships within communities as opposed to individualism (illustrated by the concept of *ubuntu*, the humanist perspective describing correct communal behavior, or spirit of connectedness), promoting the values of personal growth within the community, and thus situating community and solidarity as central to the process of ethical decision making in guiding individual lifestyle choices. In this context, the HIV/AIDS epidemic is closely connected with ethical considerations of healing at a communal level, including a focus on questions of access that illuminate the intersections of land, environmental conservatism, reconciliation, dispossession (culturally, politically, and economically), violence, and displacement as fundamental to healing alongside pharmacological treatment. The emphasis on the ethics of resistance, discrimination, and transformation to challenge some of the oppressive themes and support empowerment then becomes a relevant project to curbing spread of HIV/AIDS and supporting reintegration of individuals in the management of HIV/AIDS disease progression and post-treatment journey.

Medical humanism can provide meaningful support to the practice of medicine in the case of chronic disease management emphasizing prevention and long-term disease management to bring health in ways that also empower and make the patient whole. Centering medical health ethics emphasizes

compassion, empathy, and identification with psychosocial considerations, and on the cultural, social, and educational implications of medicine as a profession. Informing medicine, with its technocentric, practical, material, and objective paradigms, with the values, culture, and the idiosyncratic individual has often begun to define the parameters of what it means to think about health, medicine, and decision making within these realms.

The humanities offer a unique insight into the practice of medicine through their ability to capture and comprehend the human experiences of happiness, hope, and despair in the experience of health and disease. Long-term management of chronic conditions involves making decisions that lie at the intersection of personal life choices and social norms, community structures, and family roles. It can be argued that the humanities bring to a biomedical approach to understanding chronic condition management a sensitivity and nuance that is culturally grounded and respectful of individual empowerment. For instance, literature simulates many illness experiences to induce empathy; history locates the health care professional within a landscape along with the patient and society, in a moment of time and a frame of geography and culture; while philosophy helps weigh the essential nature of acts performed under medicine (Pellegrino, 1981). These provide vital insight to insert the humanities in the practice of medicine, while acknowledging the integrity of their distinctive positions toward a shared goal.

Chronic and Noncommunicable Diseases

Most chronic health conditions are driven by lifestyle factors that are easily preventable or manageable in nonpharmacological ways through behavior and lifestyle modifications. The challenge of health care systems is to improve quality of life, and healthy life expectancy, and reduce health care costs across the life span. Addressing such conditions involves initiatives that reduce the leading causes of infant death and illness, strengthen healthy communities, support child care programs and schools, help adults lead active lives and increase use of preventive screening services, and promote quality of life and independence for people as they age. Achieving these goals requires a multipronged approach that understands the prevalence of chronic diseases and their risk factors to improve our lived environments so that it is easier for people to make healthy choices. These healthy choices include both behavioral and structural facets such as creating environments that promote exercising, strengthening health care systems to deliver prevention services that keep people well and diagnose diseases early, and connecting clinical services to community programs that help people prevent and manage their own chronic conditions.

The expanded chronic care model (Expanded CCM, Barr et al., 2003) envisions an integration of the CCM with population health promotion. In this way, it seeks to move beyond reducing the burden of chronic disease to integrating disease prevention by guiding action that addresses the role of social determinants of health in supporting healthy people and communities. The ECCM includes a focus of practice to work toward health outcomes for individual care alongside communities and populations. The ECCM envisions an exchange of ideas, resources, and people between the formal health systems and the community, and their relationship with the four areas of focus: self-management support, decision support, delivery system design, and information systems. The self management/ develop personal skills focus references self-management support such as health literacy initiatives in coping, development of personal skills for health and wellness for the individual, communities, and the health system.

The delivery system design/re-orient health services criteria refers to encouraging health care professionals to not only provide clinical and curative services but also to fulfill the population health promotion imperative to support individuals and communities in a more holistic way. The focus here is to shift the emphasis on connecting health with socio-politico-economical and physical environment conditions and foreground the emphasis on health promotion. As Barr et al. (2003) describe it, in the action area of decision support, the emphasis is on supporting professionals and individuals to address disease impact and decision making in ways that support health and well-being. In the action area of information systems, clinical informatics could emphasize new programs, evaluate established ones, and support new ways of knowing. In building healthy public policy, the development and implementation of population health policies for organizational and governmental policy and legislation fosters equitable, safe, and healthy environments (Barr et al., 2003).

In creating healthy environments, the focus is on going beyond social supports for health and quality of life to create supportive environments that entail working to generate tailored and optimum living conditions. It advocates for going beyond protection of natural and biophysical environment to include strategies to support conditions for optimal levels of health in social and community environments. In strengthening community action, the ECCM action area advocates collaboration with community groups to achieve priorities and goals that enhance community health, encourage effective public participation, and support individuals to find their own ways for managing health and community (Barr et al., 2003).

As the traditional paternalistic model of health care, where the patient was a passive recipient of care from expert providers (e.g., physicians), shifts toward more equitable, collaborative partnerships, such models provide a collaborative

framework based on an equal partnership to achieve health care goals. The shift from paternalistic models envisions the patient as an actively involved participant in their care (Epstein & Street, 2011). Living with chronic conditions requires day-to-day monitoring of physical and psychosocial problems and their self-management by the individual over their life span. It also requires individuals to have knowledge of the condition and its treatment, performance of condition management activities, and application of necessary skills to maintain adequate psychosocial functioning. The collaborative orientation shifts the responsibility of day-to-day management to the patient from health care professionals, thus positioning the patient as the “expert,” able to access information relevant to their health care needs and to design and carry out the self-management tasks needed for their condition at a given point in time. This shift has prioritized notions such as “self-care” and “self-management.” As discussed later in this chapter, self-care has been interpreted as a preventative strategy, a task performed by healthy people, often in home-based settings (Clark et al., 1991). Self-management, in contrast, is understood as “the day-to-day tasks an individual must undertake to control or reduce the impact of disease on physical health status. At-home management tasks and strategies are undertaken with the collaboration and guidance of the individual’s physician and other health care providers” (Clark et al., 1991).

Keeping in mind the complexity of tasks that the individual must undertake to self-manage their condition, Barlow et al. (2002, p. 178) define self-management of chronic conditions as a “dynamic and continuous process of self-regulation,” one that encompasses “the ability to monitor one’s condition and to effect the cognitive, behavioral, and emotional responses necessary to maintain a satisfactory quality of life.” Several components of self-management have been identified in research and scholarly literature. These range from the ability to obtain information about the condition and its treatment to managing symptoms (pain management, fatigue management, sleep management, self-monitoring), psychosocial consequences (anger management, depression, disease acceptance, emotion and stress management), lifestyle (exercise, leisure, nutrition, smoking), social support (family, friends, peer and work groups), and communication (assertiveness and ability to communicate effectively with doctors). In their research examining the relationship between communication and healing outcomes, Street et al. (20) identify the pathways of access to care, patient knowledge and shared understanding, therapeutic relationship, patients’ ability to manage emotions, social support, patient empowerment and agency, and evidence- and values-based decision making as being central to achieving optimal health outcomes through clinical encounters.

As human beings, it can be argued that we don't instinctively yearn for health, we don't always consciously strive for a healthful existence, we have no overriding primal desire to stay or become healthy at all costs. Indeed, many of us often don't think about health and healing at all, except in its absence in our lives, families, or communities. We may believe that we value our health, but this condition is true to the extent that we value our health only as a consequence of a rational fear of our human condition if we lose the attributes of good health. We do not, really, care much about health or healing in the absence of such a fear. More importantly, we don't usually think about the nature of health and its positionality in our lives until we are faced with an acute or chronic health condition that pushes health-related outcomes, positive or negative, at the forefront of our awareness. Indeed, it may be more accurate and reasonable to assert that we recognize the impulse of hunger more acutely and primally from the moment of our conception. Our bodies are discursively and materially tuned to respond to hunger, to procure food and resources, and to survive against the possibility of hunger than they are to instinctively protect our health from the moment of our birth.

It would be more appropriate to state that our education system and social conditioning makes us aware that health and healing are means to an end. With good health, we are free to ignore our bodies so we may do the things we like to do, and unless we explicitly recognize this, we often do ignore the healthy body. Within this paradigm, health and healing are mechanisms for living a whole life, an essential pre-condition to achieving our goals during our lifetimes, to be able to avoid bodily discomfort, and to not be distracted by pain or symptoms that remind us of our frail human bodies. WHO defines health in the preamble to the Constitution of the WHO as adopted by the International Health Conference, New York, June 19–July 22, 1946, and signed on July 22, 1946 by the representatives of 61 states (records of WHO, no. 2, p. 100) and entered into force on April 7, 1948: "*Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.*" *Medical Humanism, Chronic Illness, and the Body in Pain: An Ecology of Wholeness* is a book that invites us to ask what we would like to understand by health and wholeness as individuals work toward healing and health. Like health, the term *wholeness* is conceptually vast, connecting domains from religion to health, to bodily injury, and relationships.

As a testimony to its conceptual vastness, wholeness is evoked with the congregation in a church by the priest and with the patient in a hospital by the nurse. To think about healing in relationship with wholeness, for instance, might arguably evoke health, but although health and healing are closely related, and health is a central concept that supports healing in important ways, they are, nevertheless, conceptually distinct terms. This book undertakes an

examination of wholeness and its relationship with health and healing through centering the body. Through the lens of the body, it invites us to investigate, from our own perspectives, the multiple layered meanings of healing. Thus, it invites us to create an infinite set of possibilities that are as unique as they are universally applicable to the lived conditions and the larger dimension of existence. The multiplicity of meanings of wholeness arises from the many contexts where health and healing are enacted and constructed, and the specific needs communicated through those settings. Although a hospital may be a distinct environment in terms of the rules, regulations, and practices enacted therein from the church or the site of religious rituals and discourses, wholeness references a common ground of motivations in chronic condition self-management that draws its participants, willingly or unwillingly, within that discursive space.

This book is about those practices, their meanings, and the motivations that propel the notion of wholeness to the center stage of so many conversations centered on long-term chronic disease management in the contemporary age. It proposes an ecology of wholeness as a way to advance the interdisciplinary understandings that can help construct the relationships and processes of healing. The domain of chronic conditions and NCDs is distinguished by its close relationship with lifestyle factors and thus, the agency of the individual in preventing the condition or promoting their health. Given the relevance of this point, at this juncture, I will take a few moments to clarify the intersection of chronic diseases with self-care and self-management, and explicate the differences between the two terms themselves.

Self-Management and Self-Care

Self-care draws upon the basis that the individual is in the best position to take care of themselves as they know what they are going through. It draws upon the patient-centered turn in the practice of health care, which starts with the assumption that in order to be effective, health care should place the patient that it treats at the center and begin to design its treatment approach and interventions keeping in mind the patient's experiences and conditions (Epstein & Street, 2011). Most research findings suggest that providers can support patient self-care if they are trained to implement a few evidence-based practices (Wagner et al., 1996). These include engaging in collaborative problem definition involving patients and care providers (Suarez Vazquez et al., 2017). Research findings suggest that this is achieved through targeting patient issues and encouraging patient goal setting, emotion management, defining and addressing uncertainty, active and sustained follow-up, and designing education and training components that support individual level behavior change (McCormack et al., 2011).

Such practices involve the patient's ability to define and identify what practices make them feel better and what practices make them feel worse with respect to the treatment. It involves helping patients identify how to structure and implement behaviors that promote the goals of their health care plans (Alpay et al., 2011), while decreasing and eliminating behaviors that impede or reverse the parameters of their health care treatment plans. Self-care is an important support to patient outcomes. Drawing upon notions of patient empowerment, it seeks to provide the patient themselves the tools for their own health outcomes, such as by enhancing health literacy (Schulz & Nakamoto, 2013). Using multiple sources, such as the electronic health record (EHR), the patient's own information, and physician recommendations on a web/mobile based platform (EMPOWER) that supports self-management activities of patients and providers has been shown to have important practice implications in diabetes management for both patients and the physician as well as for the patient-provider relationship (Mantwill et al., 2015). As a collaborative, co-constructed relationship, the patient is in the driver's seat, and the provider is in the passenger's seat, next to the driver, watching where they are going, and perhaps monitoring for any unnoticed obstacles, but letting the patient lead the way in implementing their mutually agreed-upon plan in their lives.

Self-care has been documented to prevent burnout, compassion fatigue, and vicarious traumatization in behavioral medicine, psychotherapy, and counseling. It has been documented that self-care affects health outcomes through several pathways including adhering to treatment regimes, maintaining good physical health through lifestyle choices, monitoring symptoms to inform treatment and self-care decisions, monitoring and managing stress and/or emotional consequences of illness, interacting effectively with health professionals to ensure that patients' needs are expressed and addressed, and using social support networks to help to achieve the above (Greaves & Campbell, 2007). It is generally understood that self-care is something that patients do all the time and that, in most cases, the majority of care received by patients with long-term conditions is self-care. There is considerable scope for improving self-care. As well as being a crucial element of illness management, self-care in the form of day-to-day lifestyle behaviors is also the basis of preventative care. The drive to prevent more illness by promoting healthy behaviors increases the need for effective systems of self-management.

Self-Management

Closely related to self-care, the construct of self-management emphasizes structured guidance through patient-provider consultations, ongoing follow-ups, and provision of self-help materials. It alludes to a more guided approach,

one which privileges the health care interaction and institutional settings more than self-care. A large body of communication research has examined variables in chronic illness that support self-management behaviors such as self-efficacy (Willis, 2016), social networks (Roblin, 2011), health literacy (Shaw et al., 2012; Waverjin et al., 2016), culture and talk (Cooke-Jackson, 2011), and language and linguistics (Perera et al., 2012). In this case, medication adherence and management of side effects through nursing support for a multiple sclerosis patient would be a good example of self-management, where taking daily walks and avoiding sugar might be a major component of self-care discussions for a pre-diabetic individual. A smaller branch of communication research in the chronic disease management domain has examined provider variables such as physician certainty and curiosity (Shields et al., 2013), message framing and patient compliance (Zhao et al., 2012), and communication over different channels such as online and web-based information seeking and literacy (Stellefson et al., 2018).

Much of the emphasis in communication research on patient self-management has been in the direction of understanding decision making and the factors that impact it such as culture and the patient's health literacy. To support self-management, communication research suggests that provider communication should emphasize patient needs (Friedman et al., 2012), and employ combinations of strategies to improve a patient's disease or treatment knowledge (e.g., health literacy, Press et al., 2013), access to services (Mead et al., 2019), or independent monitoring of symptoms (Gambling & Long, 2010). The patient empowerment paradigm has included communication scholarship examining collaborative decision making (Kaminsky & Finlay, 2019), concordance based on culture in provider-patient interaction (Alden et al., 2010), epistemic expertise (Mikesell et al., 2016), and patient education (Scherr et al., 2017), among other variables. This emphasis has yielded valuable research findings establishing the contribution of various factors in the doctor-patient communication and relationship context that lead to improved patient empowerment outcomes such as medication adherence, asking questions, or active patient involvement in the chronic condition domain.

The investigations in such research have leaned on health behavior change theories to understand the cognitive and affective bases of patient empowerment. Health behavior change theories (e.g., theory of planned behavior) and models such as Siminoff and Step's communication model of shared decision making have been adapted for use in patient empowerment when making decisions. Researchers Quick et al. (2018) employ the extended parallel processes model to investigate fear control processes while Greene employs the theory of active involvement (2013) in adolescents' message planning behaviors. The theory of active planning, for instance, conceptualizes arousal as

involvement, skill production or knowledge gains as outcomes, and reflection as perceived discrepancy along with related cognitions such as expectations, norms, and intentions in producing behavior change. Gaps in the empowerment paradigm from patient perception include communication that elicits questions, presents all treatment choices, and encourages patients to take responsibility without placing blame such as in diabetes, for instances of poor glycemic control (Wan, 2012). The emphasis is on supporting the patient's independent decision making skills through improving communication-related factors during the provider-patient encounter.

Self-Care and Self-Management

Both self-care and self-management are patient-centered and empowering approaches that have the potential for providing a pathway to achieve health and receive treatment without living and being treated as a patient without power or control over their situation. Both offer choices in the provider's ability to tailor a treatment to the patient and for the patient to be able to collaborate with their health care provider in understanding and determining the choice of treatment that should guide their care. Both self-care and self-management illuminate the challenges facing our health care professionals. The burden of providing care that addresses the needs of our current social structures—both in human, and in institutional and economic terms—is immense. On the one hand, self-care and self-management initiatives seek to bridge this gap with the need to provide care in human, empowering ways. On the other hand, providers too, as recent research findings have increasingly recognized, are over-burdened and over-stretched, facing burnout and stress at alarmingly higher rates.

A key basis for both self-care and self-management initiatives is the ability of the provider and the patient toward working collaboratively to make shared decisions. For the dialogue to be successful, it requires the ability of the individual and the provider to be self-aware of what they seek to achieve and how it can best be achieved. Current training and education has attended to the factors influencing how the first of these conditions can be met, while remaining largely ignoring the equally critical second half of this equation. Recent findings have taken note of the shared trauma felt by health care providers and recognized that the most well-intentioned dialogues, implemented with the best of education and training in collaborative decision making, will come to naught if either the provider or the patient is not sufficiently self-aware, or equipped to be self-aware, of what they want through the treatment, and how they'd like to see it achieved beyond its pharmacological mechanisms.

Considerations of how we cultivate self-awareness and recognition of the many dimensions involving the experience of disease through our mind and

bodies working together, when discussed, have fallen upon medical philosophers, nurses, social workers, psychologists, and other supportive, frontline, or allied health professionals, while remaining largely outside the purview of the practicing medical professional. While these are worthy avenues for such discussions, the circle is not complete until we don't recognize, implement, and educate professionals through the touchpoints of the medical system from the patient to the medical provider. These are central to how the practice of medicine approaches care of the patient and long-term well-being of the health care provider, and key to how the institutional structures comprising the health care system manages implementation and delivery of patient care.

THE IMPETUS FOR THE BOOK

The book is grounded on processes that are inspired from my cultural backdrop supported by formal continuing studies in the Indian traditional whole system approach of Ayurveda and its preventative, lifestyle focus on health and chronic disease management alongside my training in Vipassana meditation, which takes its Buddhist roots from ancient Indian philosophy. Bringing together my formal academic credentials in communication, and research in patient-centered communication, the chapters in the book construct the emphasis on the self, the body, and the relationship between the two in articulating its ecological model wholeness. The model incorporates time, solitude, nature, and nourishment as salient dimensions based on an integration of both Ayurvedic medical science and Buddhist meditation philosophies, in combination with the patient-centered research findings from my recent research on chronic pain patients and CAM treatments. In integrating the vastly different ontological approaches, the traditional whole system medical philosophy of Ayurveda, and findings from contemporary Western biomedical sciences and emerging research, the book is, at its heart, an integrative project, constructed in the spirit of wholeness, bringing together the contrasting approaches and worldviews in a relational, dialogic engagement with each other.

The first half of the book lays out the conceptualization of the individual as the reflexive self, the embodied self, the discursive body, and the material body. In the second half, the book traces the relationship of the self with the ecological elements of nature of time, solitude, and nature as dimensions that give the human condition its flow and structure. The final epilogue chapter aligns the human condition and its quest for structure and flow through an integrative lens of continuity and dualisms that increases awareness of a whole-ness framework. Each chapter is organized thus: the first half builds the central argument by drawing upon extant and emergent research find-

ings, followed by its application to chronic disease management, and finally, concluding by laying out pragmatic implications for addressing the challenge of chronic illness. The proposed ecology of wholeness introduced in this chapter suggests empowering ways of aligning the body in pain with meaningful experiences that support wholeness in long-term chronic disease self-management. The conceptual layout of the book will preview in brief the theoretical assumptions employed in crafting each chapter.

Conceptual Layout of the Book

The book articulates an ecological framework for wholeness in chronic disease management through conceptualizing communication, language, and relating in a multi-layered framework based on a medical humanistic approach and the ethical principles of social justice. As a meta-analytic, integrative project, it conceptualizes the experience of chronic illness as a process of meaning-making that empowers the individual and enriches a holistic understanding of the individual self. By grounding the ecological model of wholeness upon medical humanities as a foundational principle and a backdrop of whole-system philosophies of traditional medical systems as a relational frame, the book suggests strategies, activities, and engagements that individuals, caregivers, and providers can use to promote wholeness in preventing and managing chronic disease (figure 1.2).

Integrating the Reflexive/Embodied and Discursive/Material

Theoretically, the book is organized in three main sections. The first two chapters that comprise the first section describe *the wholeness project* with its focus on the medical humanist ethical framework as applied to the global health challenge of chronic condition management and the *social constructionist epistemological framework*. Together, the first two chapters lay the conceptual and theoretical foundations for the model. The social constructionist approach emphasizes the relational, dialogic, and situated nature of experience in lived settings.

The second section centers the experiencing individual as the frame of reference. It comprises four chapters, each of which describes one element of the core body/self axis that anchors the model. The four chapters in this section are organized around the relationship between the self and the body. They explicate the central idea of wholeness and integrity intertwined with the progressive awareness of the human self/body relationship. *Medical Humanism, Chronic Illness, and the Body in Pain* begins its journey in the first chapter with an examination of *the reflexive self* as the core of our efforts

to be self-aware, and continues in the next chapter to *the embodied self*, as beginning to experience our self and the world interface through our bodies. The following chapter on *the discursive body* examines the bond that defines how we communicate, connect, relate, and experience our body and the self. It contends this bond is one of deliberative openness as vulnerability to the construction of the self complete with contradictions, complexities, tensions, and harmony. It presents an argument for understanding the multiple, often contradictory discursive constructions of the self as an act of deliberative openness, without striving to accept or reject, legitimize or resist, any discursive construction to constitute balance and strength from acceptance and control. In the next chapter in this section, titled, “The Material Body,” the idea of the tangible, attitude-intention-behavior centered body is situated within the communicative context of its mediated construction alongside its depiction in the biophysiological domain of public health and medical science imperatives of primary, secondary, and tertiary prevention and promotion.

The third section comprises the outer contextual layers of the model which provide the relational body/self anchor a dialogic context for its construction and engagement to constitute wholeness. The three layers are discussed in order in the chapters from the innermost, or the one closest to the body/self axis to the outermost, or the one closest to the larger environment for the expres-

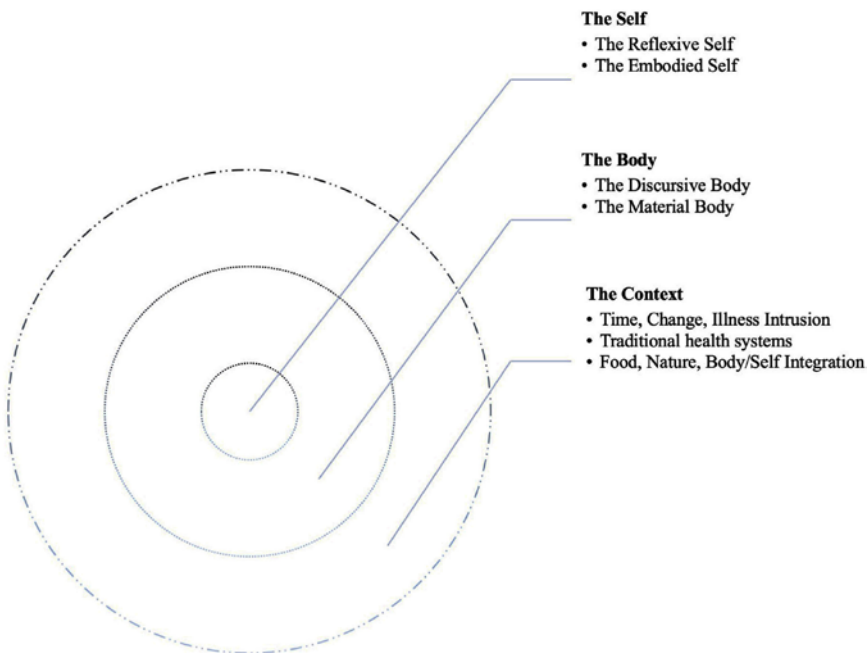


Figure 1.2. The ecological model of wholeness. *Figure created by author.*

sion of the body/self. The first layer, presented in the chapter “Time, Change, and Illness Intrusion,” develops the idea of temporality as an a-linear concept that grounds the body/self in the notion of subjective change relationship with self-concept and self-identity. This chapter centers the experience of subjective change as a defining element of the chronic condition experience and explicates it through subjective time in the experience of chronic illness to envision it as an experience of wholeness. The next chapter, “Traditional Health Systems,” presents the second outer layer that addresses the grounding of our experiences in the mind/body axis as constructed through the context of each of our individual ontological frameworks. It develops the idea of solitude, silence, and presence and the practices that can be employed to cultivate these in a manner that integrates the three layers and the body/self axis. These practices include, for instance, the construction of healing spaces like healing gardens in health care institutions and community settings, wilderness experiences, meditative reading, and narrative restructuring through journaling.

The third layer is presented in the final chapter in the book, “Food, Nature, and Body/Self Integration,” which articulates the idea of cultivating the self-reflexive, embodied awareness of the relationship of the self with the discursive and material body and its contextual layers through the connections between food and nature as resource and nourishment. It constructs an awareness of each of our eco-social secular-medico-cultural roots positioned in the heterodox religious and socio-cultural systems that give them meaning to tie in the idea of food and nourishment with its goal of connecting us with our individual purpose and its enactment in life. Through a self-reflexive, embodied awareness of these connections, the chapter argues, the biomedical treatments and long-term lifestyle programs, public health initiatives, and the health care continuum can be positioned in a meaning-making framework that give them relevance and integrate the fractured experience of the body in pain in a sense of balance and harmony with purpose that constitutes wholeness as the conceptualization and actualization of human health and healing goals.

Chapter Two

A Social Constructionist Epistemology

In developing the ecological model of wholeness, the book centers the case of the chronic illness experience that can be useful for individuals, caregivers, and health care professionals. The postmodernist patient-centered care ontology of chronic illness experience is developed as a social constructionist critique presenting the body in reflexive engagement with the self, the body in embodied engagement with the self, the discursive body, and the material body to construct a model of wholeness. The construction of wholeness constitutes the body/self praxis through developing a relational and dialogic approach (Buber, 1970) with understandings of time in/as change and movement anchored in a-linearity; presence in/as solitude referencing the traditional health system relationship of health, the body; and the self, and food in/as nature and body/self integration.

In its central premise, the book has presented the ecology of wholeness as a socially constructed epistemology constituted through the multilayered tensions at the intersection of the material and the discursive, the symbolic and the representative, and the fractured and the integrative. To live with a chronic condition is to negotiate the multiple unique and often idiopathic, complex understandings of the body on a daily basis. The long-term chronic illness experience is characterized by a fractured body/self relationship. To situate these multiple understandings in an ecology of wholeness, the book has examined the dialogic relationship of the body/self as the reflexive self, the embodied self, the discursive body, and the material body in a contextual relationship informed by its subjective environment (constitution through time as change and transition), traditional health environment (mind/body integration in solitude as presence), and the socio-cultural environment (food as nature and nourishment).

The body/self relationship has centered the development of wholeness in the book through the inclusive lens of reflexive self, the embodied self, the

discursive body, and the material body. Social constructionism's concerns with materiality, agency, and critical approaches to integrating theory and its pragmatic implications inform the development of wholeness by taking a relational approach to healing. This chapter focuses on the idea of healing as it constitutes wholeness from a social constructionist perspective to expand the theoretical framework underpinning the development of wholeness through the lens of the body/self and its relationship with subjective time, traditional health systems, and the socio-cultural environment.

The social constructionist perspective emphasizes the co-construction of lived reality as an intersectional endeavor, one where multiple meanings of reality are continually negotiated. In approaching the ecological model of wholeness through the lens of social constructionism, the book is premised on the argument that healing constituted through communication is situated, intersectional, multivocal, and collaborative. The body/self anchor looks inward and outward in dialogic engagement with its environment to construct wholeness through the processes of healing. Understanding each moment as unique and subjectively shaped by the individual, the body/self anchor focuses on the co-construction of the healing experience in the engagement of the reflexive self and the embodied self. In defining the self as reflexive and embodied, the book takes a unique approach to both healing and the conceptualization of the self.

In this book, I develop the argument that the social constructionist premise as applied to the body/self anchor asserts that the self itself is co-constructed in relationship with its reflexive and embodied dimensions. It is in continual engagement with the body, which is co-constructed in relationship with its discursive and material dimensions. The body/self thus serves as the foundation, or the anchor, for the construction of human experience. From a social constructionist lens, the body/self anchor is not a unitary concept or one in a determinist relationship with the processes of engaging with the real world outside. Instead, it is in engagement with its own dimensions that constitute both the body and the self, and the body/self is in engagement with each other. Thus, the book takes a unique approach to centering the conceptualization of wholeness in the body/self anchor conceptualized through a social constructionist perspective. Applied to the case of chronic illness self-management, the socially constructed conceptualization of the body/self anchor is a significant contribution to understanding the constitution of wholeness as centered within the body/self in relationship with subjective time, traditional health systems, and socio-cultural environment. The social constructionist approach centers the development of the body/self as a continually (re) interpreted, situated, reflexive and embodied, dialogic anchor engaged in a

meaning-making relationship with subjective time, traditional health systems, and the social-cultural environment of its context.

The three environmental/contextual layers of subjective time, traditional health systems, and socio-cultural environment are developed from a social constructionist perspective as being in dialogic engagement with each other and the body/self. The body/self anchor, when constituted as a healing context (e.g., through guided solitude, embodied subjectivity and subjective change, and nature and nourishment, as discussed in the later chapters) constructs wholeness as a state of integrative, ethical, reflexive, multi-perspectival sense of uniquely defined body/self in constant engagement with itself and the environment. The social constructionist experience cultivates a glance where multiple meanings and intersectional experiences in multidimensional ways over subjective time, subjective change, and nature and nourishment can be constituted and modified. As the chapters in the book demonstrate, the chronic condition experience, where narrative fragmentation, body avoidance, and social isolation can lead to comorbidities such as depression, anxiety, and stress, can be shaped in ways that cultivate body awareness constituted by presence, reflection, body acceptance, and agency.

Interpretive and critical research in communication has the potential to make a meaningful and deep impact in health contexts (Zoller & Kline, 2008). Work that connects theory and praxis on the one hand with interdisciplinary, international, multi-methodological, and cross-cultural research on the other (Mol, 2002), can be particularly impactful in health contexts that touch upon these intersections. Omilion-Hodges et al.'s (2019) account of meaning-making around dying and death using coordinated management of meaning theory allows them to provide a communicative account of death that includes multiple perspectives of family members, medical professionals, and young adults. By taking a social constructionist perspective, from a range of interdisciplinary perspectives, on a multicultural approach to conceptualizing healing and wholeness in patient-centered care, the book critiques the experience of chronic illness in a manner that emphasizes individual agency and choice. The long-term nature of chronic conditions and their connection with lifestyle factors positions communication scholarship that connects identity, body/self narratives, and socio-cultural norms as an appropriate knowledge framework to address the fractured narratives of chronic conditions and its attendant comorbidities such as pain. These (re) position the chronic illness experience in a continually negotiated social context, wherein biographic reconstructions can serve as a discursive resource while opening opportunities for contingent intersectionality to construct a coherent body/self identity.

This book takes a social constructionist approach to speak to the contextual, dialogic, relational engagement of the body in the context of understanding wholeness from an interdisciplinary, multi-perspectival examination. The different elements of wholeness presented in the book are developed to identify the pragmatic applications deepening understandings of and accomplishing wholeness in the chronic care context. In this chapter, I discuss the social constructionist perspective from organizing to marginalization to highlight the central arguments in each element of the wholeness approach by patients, by health care providers, and in health care contexts such as in furthering understandings of patient-centered communication. The alternative ways of constructing thinking and accomplishment of wholeness articulated in this book extend and support current scholarship of social justice and structural transformation that has been advocated by critical cultural scholars in health communication (e.g., Dutta, 2010). Examining the theoretical and narrative intersectionality of the chronic illness experience from the social constructionist perspective is generative of a situated knowledge-praxis supporting those addressing chronic illness challenges, either as providers, patients, caregivers, or well-wishers.

Integrative and multicultural approaches, such as the ecological model of wholeness, are characterized by an interdisciplinary and global perspective in their theoretical and knowledge orientations and in their acknowledgment of multiple positionalities (Condit, 2015). In alignment with, and alongside current work, these epistemologies can inform application in patient-centered communication in a range of contexts. These contexts include the notion of interactional sensitivity exploring how physicians can negotiate challenging interactions during routine chronic illness visits (Koenig et al., 2014). The treatise on wholeness enriches the contribution of communication scholars such as Koenig et al. (2014) in negotiating medical decision making to balance individual patient values and preferences within the larger chronic illness trajectory.

The book extends the above perspectives in several major ways. First, the model is not conceived in opposition to dominant clinical approaches, but rather to opening integrative pathways to imagining healing and wholeness. Second, through envisioning wholeness in healing as centered in the reflexive and embodied self and discursive/material body, the book situates the body/self axis in dialogic engagement with the environment. The lived environment is mutually constituted by the central body/self axis in relationship with the values and practices that engage its embodiment in ethical ways of health and healing. The model envisages these values and practices as the environmental layers that co-constitute the body/self through subjective time and change, through traditional practices of health and medicine, and through

its discursively and materially constituted relations of nature, food, and its nourishment. The social constructionist epistemology allows me to envisage wholeness as an experiential, continually negotiated phenomenon, grounded in and sustained through the reflexive and embodied self and the discursive and material body in agency with the experiential layers of time and change, health and medicine, and nature and nourishment.

The social constructionist epistemology is uniquely situated to address, in an integrative manner, the experiential praxis from reflection and a pre-discursive self alongside the narrative and story construction of the embodied self. The body/self axis is placed in alignment with the contextual constitution of the intersubjectively aware discursive body and the material body from public health and bicellular and neuroscientific findings (figure 2.1). In creating coherence through the unique affordances of a relational constructionist account of narrative, Gergen and Gergen (2011) critique the narrative tensions that break apart

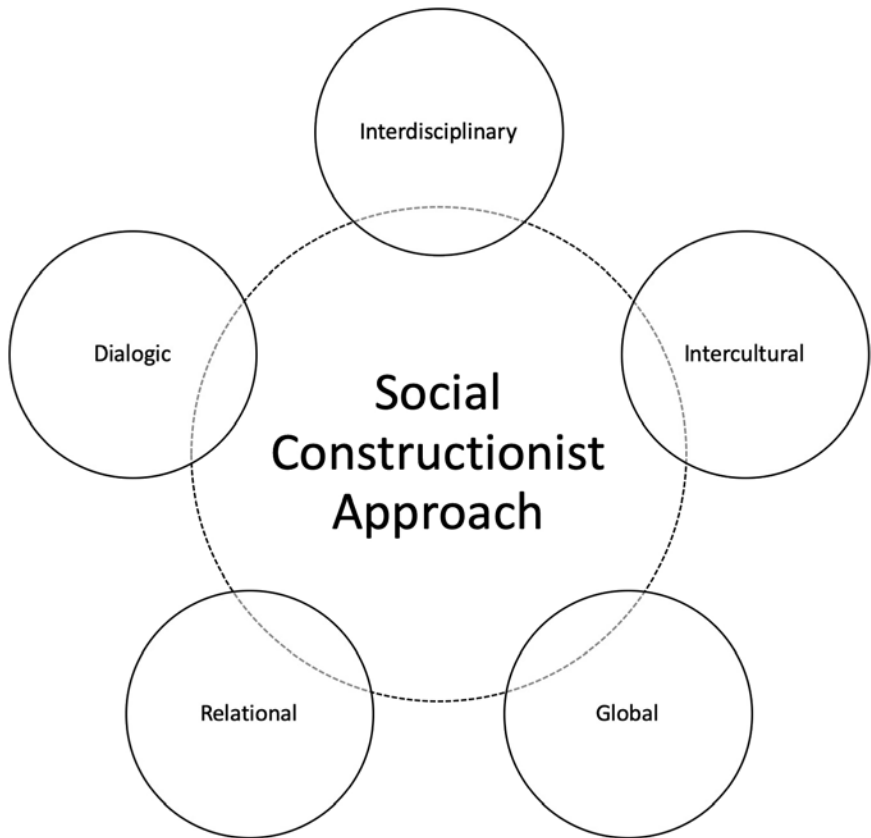


Figure 2.1. The social constructionist approach to wholeness. *Figure created by author.*

into experience versus those that deconstruct experience, or singularity of self-narratives versus a multiplicity-centered approach. In the central concern of the ecology of wholeness with constituting an integrative, relational, dialogic, and situated orientation over the long-term, it is centered in experience that is unique with the individual, and amenable to a multivocal meaning-making endeavor based on the individual's singular account of narrative at that moment.

Patient-Centered Care in Chronic Illness: An Argument for Wholeness

Chronic illness negotiation is challenging for individuals across their life contexts in domains ranging from their workplace identity (e.g., Butler & Modaff, 2016) to family relations (e.g., Badr & Acitelli, 2005). The multiple invisible (Clemens, 2018, for a personal narrative of living with chronic autoimmune disease) and under-acknowledged challenges in its negotiation by individuals (Edley & Battaglia, 2016, for an autoethnographic journey of chronic illness) highlights the need for practices that recognize how care can be provided in empowering ways across life contexts and how such care can be communicated across multiple relational domains (Burgess et al., 2019 for health care providers' responses to narrative communication in racial contexts). By critiquing the social construction of a chronic illness trajectory from the perspective of wholeness, the book contributes to patient-centered care scholarship that can assist patients, physicians, and stakeholders in decision making (e.g., Gaglio, 2016), self-management, and lifestyle alignment in long-term and sustainable ways.

The notion of patient-centered care outlined in the framework of wholeness developed in this book furthers understandings of patient care from a variety of perspectives such as those focusing on assessing patient ratings on care and care quality (e.g., Finney et al., 2015), patient health literacy, language barriers (Karliner et al., 2011), or assessment of communication styles between the patient and the physician (e.g., Cegala et al., 2009). The considerations undergirding patient-centered care highlight the congruence of the patient's values and expectations and their perception of the values and expectations about the physicians, patients, and the clinical encounter, leading researchers to advocate for deeper understanding of diversity of patient communication preferences (Swenson et al., 2006) and for provider training in patient-centered care (e.g., Venetis et al., 2009). Researchers working on patient-centered care in domains ranging from oncology to type 2 diabetes management find that integrative teams and approaches provide a better approach to achieving patient-centered care, such as through establishing a care community (Haidet et al., 2009).

The arguments developed in the book propose centering wholeness in the chronic illness experience grounded upon patient agency in relational and dialogic ways with the environment and its different constitutional elements such as time, solitude, and food. Current approaches taken in communication research on patient-centered communication have focused on instrumental and assessment-oriented categories to define and operationalize patient-centered communication and to assessing care through constructs like patient satisfaction and patient advancement in the self-management process. For instance, Calata and Schulz (2009), in advocating patient-centered care in patient self-management of chronic low back pain (CLBP) highlight self-comprehension, improvement of argumentative abilities, orientation, development of self-confidence, and maintenance of a high level of attention as factors that can support a tailored application of CLBP self-management process. Understanding the elements of wholeness from a deeper integrative postmodernist ontology as developed in this book can enrich what providers and health care teams can do to support patient-centered constructs identified by the researchers. In the absence of such understandings of wholeness, achieving patient self-comprehension or improvement of argumentative abilities, for instance, can be superficial benefits, but not sustainable and empowering in their long-term benefits.

Validating patient concerns by employing attentiveness voice tone have been identified as markers of physician willingness to discuss emotionally challenging topics, and as facets that can be potentially cultivated through physician mindfulness training (Shields et al., 2009). The focus of such research scholarship has been on functional achievement of criteria in ways that can enable information gathering from patients or delivery of communication-based traits such as attentiveness to patient concerns (Shields et al., 2009). Emphasizing functional achievement while ignoring the embodied presence of the physician biases such research in favor of a task-oriented focus in patient care. Thus, it potentially limits the ability of its findings to envisage inclusive healing outcomes that empower the patient and are professionally fulfilling for the provider. This gap is addressed by the emphasis on patient environment, and a whole-person understanding of their illness trajectory builds on prior research (Agarwal, 2019) and is developed further in this book.

Researchers have attended to patient empowerment in considerations of patient-centered care. Holmström and Röing (2010), for instance, focus on patient centeredness and patient empowerment in discussing patient autonomy and involvement in care. Their research finds that patient empowerment may be a broader concept, one which places greater burdens on caregivers and care organizations, which can be achieved by patient-centeredness, but

state that patients can also empower themselves. Their findings, however, do not go into how patients could empower themselves or how patient centeredness and patient empowerment could be distinguished in ways that connected with quality of life and long-term self-management by patients themselves. Others taking an inter-cultural approach (e.g., Bergman & Connaughton, 2013, in their study on Hispanic prenatal patients) identify elements such as friendly relationship, effective medical care, language spoken, understanding of information, and elimination of racism as themes that were important to furthering patient satisfaction with the health care experience, making patients feel better understood and believe the information given.

Although helpful in its functional aspects of providing physicians with itemizable behaviors to target during the patient encounter and assessment-amenable outcomes for patient-centered communication, the themes envision patient-centeredness in ways that can integrate the interest in discursive construction of the illness and the patient in the context of the lived experience, embodiment, and socio-cultural rituals as constitutive performance (Csordas, 1994; Mattingly & Lawlor, 2000). Jackson's examination in Csordas's book centers the tension between the body as object and subject in the chronic pain domain, an aspect which is extended in the integrative focus of the ecology of wholeness model developed in this book. Mattingly and Lawlor argue that in the construction of health and healing, narrative structure is central in the manner it pervades our life, centering temporality and cultural life, the structural and the symbolic, performance and interaction, while being mindful of power, social positions, identity, and agency. Current approaches focus on utilitarian and economic factors that optimize efficiencies and foreground assessment-oriented outcomes such as patient-provider relationship satisfaction and patient costs. This predominant focus on efficiencies oftentimes has the consequence of increased patient dependence in the health care relationship and increased provider burnout. These stem in part from a lack of conceptualization of avenues and norms in the encounter to situate the ethos and delivery of care in their own and their patients' lives in human, lived ways.

Drawing upon a medical humanist approach, the present book is an argument to conceptualize care in the chronic illness domain specifically by envisioning integration, awareness, and fulfillment through a social constructionist lens. The social constructionist approach threads through the chapters starting from the body/self relationship and expanding to a contextual awareness to articulate an ecology of wholeness. By connecting the postmodernist onto-epistemological-praxis in patient care, individual empowerment, and patient-provider communication in ways that center the dialogic and the experiential to extend the functional and instrumental, the construction of wholeness develops a body/self-centered contextual perspective on ethically

constituted patient-centered care. The integrative paradigm proposed by the ecology of wholeness is vitally needed in the domain of chronic care management. The call to actualize such a vision of global patient-centered care made by health communication scholars includes holistic preventive strategies that attend to health inequality, health literacy, and health behaviors (Ratzan, 2010). The burden of chronic illnesses is global and disproportionately shouldered largely by the marginalized and disempowered communities.

Chronic illnesses are also often preventive in nature and situated in traditional lifestyle-based health care approaches that are locally and culturally grounded in global communities. By empowering the individual in conceptualizing the body/self anchor and integrating the context through subjective time, traditional health systems, and the socio-cultural environment, the ecological model brings together the longitudinal arc of the individual's narrative biographical arc, the traditional health care approaches, and the socio-cultural values grounding local communities in developing the ecology of wholeness. In doing so, the contributions of the book are individual, communal, and social, its glance relational and dialogic, and its vision contextualizes the integrative and the ethical in the constitution of wholeness.

A Social Constructionist Approach to Wholeness

The social constructionist approach centers the individual experience in a relational context such that subjective, intersubjective, and socio-cultural meaning-making frameworks evolve in engagement with the individual's body/self. Lupton's examination of the symbolic meanings of health, healing, and illness views the social construction of health and illness through the lens of the individual's experience as sociocultural representations. Lupton's argument that "health, illness, and disease, and health care may all be viewed as sociocultural products . . . therefore [it is] important to analyze the nature of their social and cultural representations and the symbolic meanings that surround them" (2003, p. 50). Only in doing so, for example, can we challenge dominant discourses, or focus on the intersections of practices, identity, norms, and the body/self. In the ecological model of wholeness, the contextual discourses of the subjective environment (time/subjective change), traditional health environment (intersubjective awareness/ solitude/ presence), and socio-cultural environment (ecosocial awareness/secular-medical philosophies/integrative object-subject directed anthropocentric view) build on the body/self relations to explain how illness experiences are produced and can be re-oriented through a multivocal, integrative, and ethical constitution of the body/self in wholeness.

Continual meaning-making of an illness experience on a moment-by-moment basis heightens the fractured perception of the body/self as it struggles to maintain integrity within its subjective, relational, and socio-cultural spheres. Chronic illness narratives are characterized by fear, body avoidance, fractured identities, and a disrupted sense of self, leaving individuals struggling with isolation, depression, and a disconnect with the activities and goals that motivated and engaged them. Rebuilding these connections in ways that are uniquely expressed in each individual's own lived context is a challenge that treatment, medication adherence, or patient-centered care outcomes, such as patient satisfaction with information given or trust in the provider, will not be sufficient to address. While these criteria are important for patient-centered care, the chronic illness experience is long term, incremental, and often invisible in the manifestation of its effects. In this book I argue that long-term treatment, and current biomedical models of chronic care management as appropriate, need to be supported by the cultivation of individual agency and awareness of the body/self relationship.

The chronic illness experience foregrounds the narrative (re)construction of unique and individual biographical arcs. Social constructionism fosters an awareness that knowledge and the ways of understanding we adopt are historically and culturally specific and dependent upon social processes and social action (Gergen, 1991). There is no one way that all bodies with a specific chronic condition will necessarily belong to the chronically ill. In such instances, the perspective of scholars who have critiqued the culturally situated context (e.g., Airhihenbuwa & Obregon, 2000) becomes valuable in understanding the challenge of wholeness. While health literacy and patient empowerment paradigms support the construction of the active and involved patient, the wholeness approach re-orientes the patient identity to an integrative, connected body/self relationship centering the reflexive/embodied self and the discursive/material body in particular temporally and culturally situated, identity-based intersubjective awareness.

Wholeness is a complex phenomenon. Thus, even though a treatment regimen may be uniform across individuals, it cannot, for instance, be cultivated through a "deficit approach that blames people" (Pleasant, 2014, p. 1483) or be set in a standardized protocol applied across cultures and social groups. Rather, communication, language, culture, and meaning-making of practices and norms becomes more important in shaping how individuals make sense of their illness experience as it develops and changes through the course of a lifetime. Thompson and Dori-Hacohen (2012) communicative constitution of subjects, objects, discourses, and persons in an interactional context, where even communication can be envisaged as self-reflexive. Positioned alongside relational and dialogic approaches, the model envisages the constitution of

the changing body/self as one imbued with agency, ownership, awareness, and choice, to propose a paradigm that extends and then re-orientes current chronic care management models to go beyond unitary functional behavior recommendations and standardized collaborative decision-making protocols.

This iterative constitution of the body/self in context is at the heart of the postmodernist social constructionist approach to wholeness that emphasizes inclusivity and interdisciplinarity in a global, intercultural, and ethical framework. A social constructionist perspective emphasizes how “selves are constituted through interactional frames which are themselves constituted through interaction by the selves of the very participants that are taking part in the interaction” (Thompson & Dori-Hacohen, 2012). Those who are chronically ill are resistant to envisaging alternative self-concepts and self-images because of their taken-for-granted and invisible assumptions about themselves (Charmaz, 2002). This premise grounds the themes and elements that structure the construction of the ecological model of wholeness in the anchor of the fractured body/self relationship for an individual for whom the daily challenges of their chronic health condition predominantly structures their lived experience. For instance, reflections supported through art in the chapter on the reflexive self provide the material ground to structure discursive agency, a means to articulate the pre-verbal in the present, to reclaim a vision of the self that accepts the new vulnerability/ies of the body through the intensely subjective task of symbolic transformation of its meaning. Likewise, an examination of food as nature and medicine, in the chapter on food, nature, and body/self integration constituting an ecosocial awareness predicated on an integrative trans-anthropocentric conscience, proposes the cultivation of a historic-secular-medical perspective uniquely grounded in socio-cultural value-based frameworks.

Anchored in the reflexive/embodied self and the discursive/material body, this book’s examination of wholeness centers the body and its discursive/material agency to trace out, build, contemplate, and critique its different forms and relationships, to envisage a seamless boundary between the self/body situated within the temporal, traditional health systems, and socio-cultural context (similar in some ways, but distinct from Tracy and Trethewey’s, 2005, examination of the crystallized self). In integrating interdisciplinary perspectives throughout the book, drawing from the humanities and the natural and social sciences such as from communication, art, anthropology, philosophy, public health, neuroscience, and cellular biology, among others, the book has evoked a medical humanist knowledge bricoleur’s tapestry set within the overarching framework of the social constructionist perspective (figure 2.1). The social constructionist perspective provides a valuable relational and dialogical framework for understanding how diseases are experienced in

lived contexts. By expanding the experience of health, healing, illness, and disease beyond social-scientific and biological mechanisms, social constructionism brings into the frame the patient's lived contexts and management of the disease in relationship with their work, family, and social environments (Berger & Luckmann, 1967). The different chapters developing the ecology of wholeness proposed in the book illustrate the multiple dimensions of dialogic engagement with the body/self and its multivocal engagement with the context to articulate the construction of wholeness in relationship with disease, illness, health, and healing.

Toward this end, the book presents the body/self axis of the ecology through the dimensions of the self as the reflexive self and the embodied self and the dimensions of the body as the discursive body and the material body. The reflexive and embodied self looks inward to constitute itself outward in its reflexive and embodied dimensions. In particular, I argue in the chapter on the embodied self for embodiment shift in the realm of the self, such that the self is embodied, rather than the other way around as in present literature, where the body is understood in embodied terms. The body is not always obedient, its perceptions not always rational, and the tension between its constitution/dissolution and its discursive and material construction is not always satisfactorily conceptualizable through prevention and treatment-driven foci of techno-medical advances. The journey to wholeness is both iterative and recursive, moving both inward and outward as reflexive and embodied, forward and backward in the temporal narrative structuring of time and change, and across the present in centering subjective change with intersubjective body awareness and ecosocial ethics.

The praxis of such an ecology emphasizes the imbuing of action with intention, and thought and behavior with integration, deliberation, and contemplation. It is shaped by relationships, both personal, interpersonal, and mediated (e.g., Ashcraft & Mumby, 2004; celebrity health narratives, Beck et al., 2014; medical communication, Palmer-Wackerly & Krieger, 2015), and the less well-researched, but equally important, dimension of temporality. As Bakhtin noted many decades earlier, the premise of this book has extended the notion of dialogic as an orientation toward, an anticipation of, and in relation to others, such that all discourse is fundamentally dialogic, contingent, and plural (1981). The richness of healing contexts, accordingly, is constituted through and embedded in the constructive tensions between the reflexive and the embodied self, the discursive and the material body, and the enactment of agency, choice, relationality, and dialogic potential across the subjective, the traditional health, and the socio-cultural health domains.

THE ECOLOGICAL MODEL OF WHOLENESS

The dialogic body/self-engagement developed in the second section of the book (chapters 3 to 6) provides an argument for the inner-outer dimensions of the dialogic construction of wholeness, structured around the central arc of the body and looking inward to its self-reflexive engagement with itself, at its own embodied subjectivity, and the spaces of relating between itself and the other, to conclude with situating the body within the cellular and the institutional structures that provide it context and meaning (figure 3.1). The argument presented here is informed by and goes beyond the tensions of discourse and context to consider the material/discursive, dialogic/relational, self/other (identity relations, such as other-other, I/Thou; Buber, 1970). The book considers these in the environmental contexts developed in the third section of the book (chapters 7–9 on subjective environment-time, traditional health environment-solitude, and communal environment-food), in the context of chronic conditions.

The Reflexive Self

In chapter 3 on *the reflexive self*, the body/self relationship is constructed along the reflexive and embodied self, and the discursive and material body in iterative, dialogic engagement with each other to constitute a constantly evolving, integrative whole. The symbolic communicative nature of self-reflexivity shapes the dialogic engagement with our body, both giving it unbounded potential in the case of illness narratives and engaging with the body to shape its material experiences. The chapter builds on the philosophical perspective of self-reflexivity as a discursive and symbolic communication with the self. The idea of self-reflexivity in dialogic engagement with the other is proposed in sharing an overlap with the other's symbolic and discursive understandings. Frey (1996) employs social constructionism to understand how symbols, rituals, and myths converge to create shared meanings that help define health and illness experience. The socio-cultural context within which the meaning-making process of illness experience is enacted plays an important role in shaping the individual patient trajectory.

Patient-centered care in this perspective is grounded in the idea of difference and shared meaning-making. In contexts of health and relationships, Baxter and Montgomery's (1996) argument emphasizes difference through relational dialectics, a social self embedded in multivocal oppositions, and an indeterminate notion of change. The elements of contextual relationality, engagement, and time/change/temporality are especially significant in the chronic illness experience as it evolves over the course of a lifetime. As

Wood (2004) notes, dialogue as praxis implies the nonlinearity and multivocality of communication; an embracing of tensions; its emergent, fluid, dependent, and temporary nature; contextual, mutually shaping; and the accomplishment of the self through dialogue.

Chapter 3 on *the reflexive self* examines how the long-drawn, invisible nature of chronic illnesses and their comorbidities modifies the nature of dialogic engagement of the other/body/self. Other-directed dialogue in the case of chronic illness narratives, which fracture the sense of self, are in important ways directed toward the integration of the body/self through dialogic engagement. Extending the relational, dialogic communication perspective to the domain of the Buberian dialogic I-Thou in the relationship of the self with the self, the reflexive self critiques the notion of mute reflexivity (Franks, 2003).

Building the contingent, contextual nature of a dialogic orientation of the other (context)/body/self, and the potential of transformative engagement with differences inherent in the critical possibilities of dialogue between the elements of this ecology, that allow for multiple voices, perspectives, and ideologies, comprises a foundational goal of this book. Anderson, Baxter, and Cissna (2004) highlight the reflexive understanding of self, and attentiveness with the importance of embodied knowledge in knowing the self and the other. The chapter proposes the dialogic engagement of self-reflexivity in guided mediation, embodied interaction, and intuitive listening as they cultivate a contemplative self-awareness. In the chronic illness experience, the other/body/self context emphasizes the cultivation of contemplative solitude, an awareness of self-presence, as a mode to cultivate body awareness and acceptance in context.

The Embodied Self

The fourth chapter illustrates the nature of *the embodied self* expanded to relational encounters as a multifaceted endeavor that incorporates a range of positionalities. Examining embodiment as a pre-reflective, non-discursive way of knowing and symbolizing the human body from the disciplinary position of art, and adopting a phenomenological perspective, the chapter examines the relationship with the body as a representational form of being-in-the-world (Chaplin, 2005). In building on the conceptualization of embodiment, and in order for each one of us to accomplish this in our own way, the book has explored agency, identity, and the self in dialogic relationship with the body on the one hand, and the contextual attributes of time and change, solitude and presence, and food and medicine on the other. Communication scholars have considered communication as constitutive not only of particular cultures but also of members' bodies through its structuring influence on social discourses such as gender and the micro-practices of culture through power, ideology,

and hegemony for marginalized voices (Trethewey, 2000). The intersection of cultures, bodies, social discourses, and practices allows for a rich postmodernist ontological development of patient-centered care as offered in this book with attention to the integration of the chronic illness body/self narrative.

The embodied self visualizes art as praxis in bringing less understood and articulated voices as an agency in exploring experiences symbolically represented through liberatory ideas such as freedom and power. Thus evoking art and architecture, the embodied self foregrounds imagination in understanding how the communicative management of tensions in chronic care management can be translated across multiple settings, such that, as researchers Rafferty and Sullivan note, “health professionals, [who] are best positioned to lay the groundwork for a partnership . . . can initiate collaborative relationships” (2017, p. 1158). How different processes, such as gathering information, can be constructed as an embodied encounter, and the implications of embodied subjectivity in conceptualizing chronic care, are presented in this chapter through a healing approach examining meaning-making, emotion, coherence, and assigning significance.

The Discursive Body

The discursive body (chapter 5) is critiqued in conversation with the other to constitute wholeness by understanding the intersubjective relationship of the self and the body. Burr (2003) elaborates the context of the situated nature of knowledge and culture, as well as the modes and frames of understanding, as being predicated on the social processes of dialogic interaction. The spaces of dialogic engagement with the self and the contextual other open opportunities for agency and choice but also expose spaces of vulnerability. Buzzanell’s (1994) encouragement to look beyond linearity and autonomy to cultivate community, integrative thinking, and connectedness as drawn from feminist theorizing, values, and practice provide an opportunity to illuminate how openness and change can structure the chronic illness experience.

The chapter considers the discursive self manifest through the tensions between dwelling and mobility, control and letting go, and growth and change. In these interstitial spaces, it offers the discursive body ways of articulating agency through the reflexive and embodied self and the environment to define the situated nature of its illness experience. The idea of the discursive body highlights the multiple entry points of identity and positionality, critical in cultivating integrative coherence through the experiences of a chronic condition, in interpretation and relating, in relations of power and knowledge, and in bringing together into a whole the individual and contextual struggles with reflexivity and perspective.

The Material Body

The material body (chapter 6) is examined both from a social constructionist approach, in dialogic engagement with our perception of health and agency, and from a public health approach as our perceptions change from the pre-diseased to diseased stage. Martin and Peterson (2009) argue for the inclusion of social construction of chronicity in chronic disease as “encapsulating the world views of the chronically ill, and the medical and health system constructions of chronic disease, through the nature of care for chronic conditions.” By examining the discourse and nature of construction of disease and illness, Martin and Peterson argue, a radical redesign of the health systems can help evidence-based medicine lead in design of health cultures that are not based on disease-based performance incentives to prioritize narratives of illness and the social reconstruction of illness and wellness. Examining data from public health studies on the one hand and findings from cellular biology on the other, the chapter connects social disparities and their structural correlates with the transition from states of health to pre-disease to disease in preventive medicine and health promotion. The chapter connects these macro-social perspectives on the one hand and critical post-structural understandings on the other with the bio-cellular mechanisms and institutional structures that support these stages to provide an insight into the relationships between self-reflexivity, embodiment, and vulnerability.

The third section brings together the context categorized as the subjective environment, the traditional health environment, and the socio-cultural environment. The argument that knowledge assumes a social constructionist theory of communication and healing, emphasizes, in Shotter and Gergen’s words, human functioning with others, the theory of person as intertwined with the theory of knowledge, and the pre-eminence of dialogue in constructed knowledge (Shotter & Gergen, 2016). Context, narratives, and stories help reveal the unique themes and “internal shape of accounts” as they construct experience (Gubrium & Holstein, 2008, p. 245). The chapter emphasizes agency through embodiment and dialogue in the space of vulnerability and change, sustenance and presence, in building a proposition for wholeness as a dialogue between an evolving self in relationship with “everyday life and its constituent elements” (p. 3). The context is in relational engagement with the body/self axis to constitute wholeness in the individual sense-making process of the chronic illness management condition.

Time, Change, and Illness Intrusion

The seventh chapter on *the subjective environment-time* critiques Buber’s analysis of the binary (appearance and reality, mind and matter, nature and

spirit) and the dialogic need for a multiple view of reality and experience that privileges silence as a space of relating and sharing experience within the self and its present perceptions (1970). Buber's recognition of the pre-verbal language asserts the influence of unconditionality and presence for self-expression and the other. Starting with the relationship of time with change, the chapter's argument engages the notion of linearity as salient in understanding how self-concept and the chronic condition can be understood in transformative dialogic engagement. A dialogic perspective brings in considerations of values, ethics, relation, reflexivity, mutually engaged performance, community, and responsibility (Anderson, Baxter, & Cissna, 2004), all central features in this examination of healing and health. The notion of subjective time and acceptance in relationship with the illness identity is constructed to illustrate time perception and its empowering potential during physically challenging stages.

Traditional Health Systems

The *traditional health environment-solitude* of chapter 8 extends the relationship of the self-other (Buber, 1970), with an inquiry into solitude, building an argument, first, carefully distinguishing solitude and silence. Second, it constructs the argument for solitude in the relationship with the self through evoking the idea of presence, and an authentic way of being that can provide a foundation for growth and engagement for those constantly grappling with a chronically ill body. In line with Ashcraft and Mumby's (2004) frames for exploring the relationship among discourses and organizing from a gender-based perspective, highlighting how identity shapes communication (frame 1), the role of routines and interaction (frame 2), institutions and discourse communities (frame 3), and societal discourses (frame 4), the chapters propose, build, and support the argument for a dialogic reconstruction of the relationship with the self, in engagement with the other, including the spaces of time, solitude, and food as discursive/material resources that can speak uniquely to the experience of those living with a chronic condition. Extending Ashcraft and Mumby's (2004) framework, other researchers have also examined the empowering and transformative potential of discourse communities. Harter (2004) discusses farming cooperatives as (gendered) discourse communities as well as the historical, cultural, political, and social environments in which they are situated. The conceptualization of solitude, presence, and silence is connected with nonverbal communication and transformative potential of carefully structured sensory stimuli with implications for power, voice, access, and dominance in care.

Food, Nature, Body/Self Integration

Chapter 9 on *the communal environment: food* brings together the main threads in the second section of the book around the idea of nourishment and sustenance as connected with, part of, and comprising the healing spaces of one's own physiological body, of being connected with the meanings of being whole, grounded in understandings of research connecting food with mental states and emerging understandings of health and lifestyle and medicine and integrity. Often, the chronically ill body forces a pause in the relentless march toward life goals, career ambitions, family obligations, and much more. Positioning the body as the performative site of discourses of power (Foucault, 1980), the constitutive view of communication draws upon poststructuralist theory to examine how bodies as the material aspect of our body is appropriated by and transformed by the socio-political discourses of power (Trethewey, 2000). The preceding chapters have explored what it means to live with a chronic condition meaningfully and with vitality, to grow in one's agency and engagement with the other, and to do so by constructing the attributes of freedom, power, and imagination through the (im)perfect human form.

CONSTRUCTING WHOLENESS: A CALL FOR PRAXIS

Communication scholars have proposed social construction approaches that critique it epistemologically (Shotter & Gergen, 1994) and propose its application in research and praxis (Bartesaghi & Castor, 2016) with implications at global and local levels. Bottom-up approaches include the voices of those at the margins in privileging the lived experience over theory-driven approaches (Dutta, 2010). These perspectives are important in cultivating understandings of how chronic conditions shape the body and how their lived experience is in turn, shaped by the body. A key window to understanding the self in chronic illness is through its dialogic, relational engagement with what it means to be embodied.

Communication in this book has been understood as the process by which relationships are constituted. It has taken the relationship with one's body to be the most primordial of all. In investigating what it means to be embodied, the chapter argues, we follow the subterranean roots of how the pre-reflective, non-discursive ways of knowing are constituted through the body, the community and rituals of belonging it is connected with in giving significance to the meaning of its human form and its limitations. Chronic conditions, as they occupy the unique transitory, dialogic space of the whole, integrated self and the fractured self as the other, are best captured in the relativist rejection of

truth (Cruikshank, 2012). These discursive bonds give the chronic condition meaning, and in engaging with the body and its condition through a dialogic lens, we can begin to situate materiality with agency.

The construction of wholeness is a challenge for the twenty-first-century healing project, yet one that has not been addressed through the lens of social constructionism. Wholeness has taken many forms—from the one planet, one health initiatives, to the mind-body-spirit critiques and the move toward a more functional assessment of medicine in health and healing through integrative medicine. Allen's (2005) theorizing of "difference matters" evokes the integration of voice, identity, and power in constructing difference as communicatively accomplished in the sense-making processes of individuals. Communication has the potential to make a difference in relational, interpersonal, collective, and individual levels (Frey, 2009). In other words, how we talk about difference is important in shaping our construction of wholeness as a phenomenon whose intersections and tensions inform our understanding of health and disease. The discursive and material construction of wholeness as developed in this book has foregrounded the relativism between the self and the body and the vulnerable, intersubjective space between them, and placed these in relationship with time and change, presence and silence, and nourishment and nature.

Chapter Three

The Reflexive Self

Self-reflexivity is a contested concept, laden with a diversity of meanings and definitions that lend considerable ambiguity to the term. Being self-reflexive is to be self-aware or to cultivate an awareness of one's own identity through quiet, thoughtful reflection. In this chapter, I argue that cultivating self-reflexivity, while seemingly an abstract exercise, has never been more important toward our health and well-being as whole human beings, individually, socially, and professionally. Centering this examination of *the reflexive self* on wholeness as a reflexive act of cultivating one's relationship with oneself and others through awareness of the self can support healing communication through diverse understandings of patient-centered care to enrich the therapeutic relationship. By drawing upon the symbolic interactionist perspective to develop healing communication as a dialogic endeavor, the reflexive self creates a relational space where self- and other-directed awareness can be held in contemplative simultaneity to construct care.

The chapter explicates self-reflexivity conceptually and situates it in the context of how language functions dialogically to create understandings of one's self, the perceptions of one's body, and the sense-making process evoked in the interpretive act of contextualizing the chronic pain experiences. While cultivating a reflexive self is foundational to the well-being of individuals with chronic conditions, and their providers and caregivers, it is not an easy state to achieve without guided training or support. Collaborations of meditation groups, yoga, and sound-based chanting or gong therapy modalities that support somatic awareness, body acceptance, and harmony with primary health care centers and community-based groups can be an effective and efficacious way of promoting wholeness experiences that can support self-management, integration, and transformation of the fractured self identified in chronic pain.

The Reflexive Self in Chronic Pain

It is in being self-reflexive that we start to identify an image of who we are and articulate it for ourselves. Self-reflexivity is a channel for monitoring the relations of the self with the social world. Such monitoring can be transformative. The etymological root of the word “reflexive” is derived from “to bend back upon oneself” (Finlay & Gough, 2003, p. ix). In beginning this work on healing communication with self-reflexivity, the journey toward wholeness begins with centering communication with the self as a mode of healing that promotes transformation through integration. As we knit stories and tell narratives of our bodily experiences and sensations, we relate to ourselves discursively, constructing a discursive mode of self-reflexivity. In progressing from discursive to embodied self-reflexivity, we transition from the discursive to the embodied self, cultivating a pre-verbal, reflexive awareness of the self/body, communicated by the body as expressing our identity and relations in the social world.

Embodied self-reflexivity implies relating to one’s sense of self through nonverbal, experiential modes of communication with the self, by positioning the individual themselves as a conscious observer. Thus, self-reflexive events begin with awareness of the body and involve different stages ranging from the purely discursive, to labeling, to being completely sensory, nonverbal, and experiential. When the body is characterized by pain or discomfort or long-term illness, the process of cultivating a reflexive self-awareness can be made especially challenging, even a luxury not afforded by those healthy enough to be able to put in the effort and training. Body avoidance is a major challenge to self-reflexive awareness that patients living with chronic pain will understand intimately. Although communication can be central in bringing about functional outcomes such as medication adherence and drivers such as internal motivation (Street & Epstein, 2009), the chapter acknowledges at the outset that it is a challenge to cultivate a reflexive awareness of the self when the foundational experience of the body is fractured by chronic pain and prolonged illness.

In this chapter, I approach this challenge through, first, explicating the conceptual notion of self-reflexivity and what it means to be self-reflexive before situating self-reflexivity in healing contexts by drawing upon the theoretical premise of symbolic interactionism. I develop the concept of self-reflexivity in chronic pain contexts to situate the individual in a relational and dialogic relationship with the self, provider, and caregivers. Central to the idea of self-reflexivity is the premise drawn from symbolic interactionism that “we come to know who and what we are through interaction with others” (Stryker & Serpe, 1982). (Re)flexivity evokes an interpretivist ontology, imploring one to look again, to interpret and make sense of reality through employing

language, consciousness, shared meaning, or instruments to understand that meaning does not reside in an objectively defined world and that reality is relative, that is, perceived intersubjectively based on social and experiential understandings, time, context, culture, and values. In a range of health care contexts including nursing, there is a need to develop an understanding of how complex ways of knowing can promote critical reflection and application of professional learning. In acute care and community care settings, the empirical, aesthetic, self-knowledge, ethical, and emancipatory ways of knowing standard in nursing practice are also key to developing reflexivity in clinical practice (Campbell et al., 2018).

The chapter constructs the premise for *healing communication* through self-reflexivity. Recent interest in identifying the mechanisms by which self-reflexivity plays a role in influencing health conditions in a variety of contexts provides promising evidence. For example, in a study of patient experiences with a program for eating disorders, the healing mechanisms were related to patient self-development, self-determination, and personal decisions to change in a positive way (Pettersen et al., 2010). In this study, the researchers found that awareness and understanding of what caused the eating disorders coupled with reflection upon different scenarios helped patients feel more ready to change those behaviors, and thus stand a greater chance of addressing the eating disorders. The researchers found that what participants actually wanted to change was shaped by how participants thought about and related with other people. However, there is still much we do not fully understand about how precisely mechanisms of self-reflexive practices such as mindfulness and meditation drive health change.

A meta-review of mindfulness-based cognitive therapy (MBCT) notes individuals engaged in practices of mindfulness or meta-awareness activities are more likely to have differential health outcomes in a variety of domains such as recurrent major depressive disorder (van der Velden et al., 2015). Their study indicates that alternations in mindfulness, rumination, worry, compassion, and meta-awareness were associated mediated MBCT effect on treatment outcome. Although more research is needed on the specific causal mechanisms, their study finds that alterations in attention, memory specificity, self-discrepancy, emotional reactivity, and momentary positive and negative affect may play a role in how MBCT exerts its clinical effects. Likewise, researchers investigating different kinds of mindfulness and self-awareness practices have found improved outcomes in opioid-treated chronic pain and chronic disabling conditions through the acceptance-based, self-reflective processes supported by these practices. Researchers hypothesize that these practices may encourage an empowering and personalized approach addressing the whole patient (Zgierska et al., 2016). In communication, providers'

self-reflexive understanding of their own illness and faith experiences has been found to help them relate with their patients' unique experiences (Agarwal, 2018).

Gaining precise understandings of how the healing mechanisms of self-reflexivity exert their clinical effects is the subject of an emerging but promising field of mind-body research from a range of disciplines. Some models, such as Mezirow's model of transformative learning in adult education, suggest that the practice of critical reflection alters the cognitive schema underlying an individual's perspective on a subject, thus leading to behavior change. Early work from the nineties in this area suggests that the practice of intentional introspection for the purpose of improving a behavior or process can help one achieve a desired outcome (Rosenberg, 1990). Thus, the concepts and practice of reflexivity have long been applied toward improving oneself and solving problems. In the last half of the chapter, I bring together the current understandings of self-reflexivity with the role of communication in cultivating and sustaining different practices incorporating a self-reflexive approach toward healing.

SELF-REFLEXIVITY

Self-reflexivity can be described as a conscious awareness of the self. Imagine an individual standing at the edge of a clear blue pond and looking at his or her reflection on a sunny day. The reflection in its physical appearance is intimately connected with the individual's sense of self. Self-reflexivity seeks to expand and deepen this notion to experience a continuous state of self-awareness unmediated by the perception of a mediating materiality (e.g., cognitive perceptions). Yet, visualizing an image is both a useful and productive beginning for the journey toward understanding self-reflexivity, at the heart of which is the inherent tension to simultaneously grasp the social and the personal. In other words, while self-reflexivity is centered upon the notion of the self, in order to grasp the nature of the self, it is important to grasp the nature of the world and the relationship of the self in the world. This chapter examines the communicative constitution of the relationship of the self in the world to cultivate self-reflexivity as healing communication.

Neuroscientists estimate that as much as 98% of what the brain does is outside of conscious awareness (Gazzaniga, 1998). Like neuroscience, the theories of behavior change employed by psychologists and communication scientists posit that intention precedes actual behaviors and the intentions themselves are comprised of explicit and implicit assumptions, thoughts, and beliefs (e.g., the health belief model, Rosenstock, 1990; the theory of planned

behavior, Ajzen, 1991; the social cognitive theory, Bandura, 1986; the trans-theoretical model, Prochaska et al., 1993). Neuroscience, like psychoanalysis, portrays consciousness as just the tip of the iceberg, with mental processes, including thoughts and emotions, often occurring without the individual's conscious awareness. However, a major distinction among neuroscientists between "the self" and "the conscious self" is based not on the psychoanalytic view of a dynamic unconscious but on a biological unconscious governed by the rules and constraints of neural circuitry and neurophysiology (LeDoux, 2002). It is worth understanding the neurophysiological perspective to gain an understanding of the biological processes underlying consciously cultivated psychological and communicative intentions.

From a neurophysiological perspective, the experience of self in self-reflexivity, although perceived as real by the individual, is a fleeting biological state configured through neural synapses (LeDoux, Debiec, & Moss, 2003). Most biologists believe that a vast majority of an individual's affective and emotional work occurs out-of-awareness of the individual (LeDoux, 1996) such that conscious emotions are more alike to "frills that have added icing to the emotional cake" (p. 302), that is, the tiny visible tip of the iceberg. From a biological perspective, by the time we become aware of an experience, it has been processed many times over by our underlying neural networks. This unconscious backdrop shapes perception and constructs our conscious experience of ourselves and the present moment (Cozolino, 2010). Further, accounts of the self that are learned by our brains early in life skew us toward reductive self-experiences that bias our understandings of ourselves and our inherent "goodness" (Gazzaniga, 1998).

Our vast out-of-consciousness-self is shaped by numerous influences that we do not yet fully understand and highlight the role of our relationality with our lived contexts. Evidence from neuroscience seems to suggest that relatively little of our potential self-experience can be explicitly grasped. Rizzolatti and his research team (Di Pellegrino et al., 1992) examined the mirror neuron system and its role in constituting our self-knowledge and other-recognition in macaque monkeys. This system was first observed when macaque monkeys acted and when, though inactive, they observed the same action being performed by another primate.

The significance of the mirror neuron system lies in its operational mechanisms that underscore the challenge in humans to experience ourselves as removed from our relationality with others (Rizzolatti & Craighero, 2004, among others). The *embodied simulation* of shared neural activation patterns between actor and observer illuminates important aspects of intersubjectivity and how our biology grounds our presence in others and theirs in us (Gallese, 2005, 2008, 2009). Such research has yielded important insights connecting

our biological selves with the identificatory mechanisms involved in, for example, unconscious communication, empathy, and projective identification, and how we inevitably shape our own neural processes through the presence of others, our positioning in specific contexts, and our lived environments.

Being Self-Reflexive: A Symbolic Interactionist View

As humans, we are fundamentally connected with others in our capacity to understand ourselves relationally. We see ourselves in relationship with others. It is in our engagement with others that we learn about the external world and ourselves as situated within this world. Some researchers have argued that our interactions are mostly pre-reflective in that we do not consciously reflect before engaging (Merleau-Ponty's, 1945 phenomenological view). These tenets are fundamental to the symbolic interactionist perspective and illuminate a valuable relationship between language, relationality, and the self. Self-reflexivity can be described as a form of internal conversation that draws upon interactions with others to make meaning of experiences. It is predicated on the assumption that the individual and the world are interrelated and engaged in a dialogic relationship. Some researchers celebrate reflexivity as an essential human capacity, while others view it as a self-critical lens, and still others utilize it to introspect for personal insight or interrogate the rhetoric underlying shared social discourses (e.g., Schutz, 1973, who discussed human meaning-making as a process of assuming a reciprocity of perspectives and managing uncertainty in interactions).

In each of these facets, self-reflexivity facilitates a continuous state of self-awareness that supports different viewpoints and entryways to understanding ourselves. Most studies of self-reflexivity interrogate the connection between language and communication. Self-reflexivity as the "conscious turning of the individual toward (him/her) self" suggests being self-reflexive is to be both the observer and the object of observation. Theoretically, engagement with self-reflexivity implies self-knowledge through self-monitoring. This self-monitoring is predicated on our communication with ourselves. In his paper, Pagis suggests that self-knowledge and self-monitoring evoke two distinct forms of self-reflexive processes: one centered on the discursive act of exploring ones' relationship with oneself through the use of language, or a form of communication involved in during the practice of communicating with oneself. The other involves embodied self-reflexivity, which is the process of feeling the body, wherein the relation with oneself unfolds through the body by way of practices that increase awareness of sensations. Meditation, yoga, and dance are examples of practices that can facilitate the refinement of an embodied self-reflexivity.

Psychologists posit a model of mutual interaction in constituting therapeutic action. Here, self-reflexivity integrates both the intrapsychic (i.e., experiences occurring within ones' psyche) and intersubjective (i.e., experiences existing between conscious minds). While neurophysiologists, biologists, and psychologists all agree that self-reflexivity involves language and communication, the precise mechanisms through which self-reflexivity involves language are still under investigation. Social psychologists broaden this view to our positioning in society to posit that self-reflexive practices are a factor of the post-modern culture characterizing the current century—one where simultaneous access to information and multiple ways of enacting identity collide. They suggest that there is no objective, external *out-there* for an individual to grasp, that reality is socially constructed by each through their unique interaction with their context. For this body of scholarship, self-reflexivity is assumed to be central to the concept of a reflexive modernity, associated in turn, with the importance given to discursive self-expression as a way of constituting ourselves in contemporary culture (Giddens, 1991).

In postmodernity, individuals understand their self-identity as a reflexive project. Instead of taking for granted who we are, social psychologists posit that we actively shape, reflect on, and monitor our selves, crafting and creating our biographical narratives as we go through life. We treat our identities as a project, something that we actively construct and are ultimately responsible for (Giddens, 1991). This biography, then, is both a means and an expression of our self-reflexivity. For such scholars, self-identity "is not a set of traits or observable characteristics. It is a person's own reflexive understanding of their biography." More importantly, "self-identity has continuity—that is, it cannot easily be completely changed at will—but that continuity is only a product of the person's reflexive beliefs about their own biography" (Giddens, 1991).

Self-reflexivity can be understood as dependent upon, or expressed through, language as a means to communicate with oneself. Language, through the employment of words, helps to communicate our understanding of the self to ourselves. As the fourth chapter on the embodied self will delve into, understanding the discursively constituted self-image (i.e., self-concept) constitutes the embodied experience, or experience perceived through the body. In embodied experience, the sensual feeling or perception of the body through the senses, is considered to be pre-reflective—one that requires an internal conversation to enter a reflexive mode. There has been some critique of the discursive emphasis on self-reflexivity as having led to a reduction in the way self-reflexivity is cultivated, with an over-emphasis on talking, journaling, and reading books in cultivating the experience of self-reflexivity. They caution that such

practices, while important and central to the practice of self-reflexivity, run the danger of being too caught up in *articulating* self-reflexivity.

As sentient human beings interacting with the world, the self-reflexive individual is not simply conscious but is conscious *of* things. In the process of negotiating the interaction with the social world, with things, self-reflexivity takes meaning-making at the core of human experience. Self-reflexivity endows us with the agency and the ability to actively make sense of our experiences and each other within the constraints of the world in which we live. Social psychologists such as Cooley (1902) and Mead (1934) assert that human self-reflexivity emerges from the social process, in as much as sociality calls upon the individual to take the role of the other as well as understand the self from the other's perspective. A reflexive attitude helps contextualize our experiences as social beings in the context in which they happen and through encompassing the ways in which we make sense of our experiences and ourselves as bound by time and place.

The natural sciences and philosophies have emphasized different aspects of reflexivity. The humanistic-phenomenological and psychoanalytic gaze emphasizes self-knowledge whereas a critical approach (e.g., feminism) prioritizes socio-political positionality in raising awareness of particular social conditions, and social-constructionist approaches attend to discourse in the production of knowledge. In research, reflexivity allows researchers to turn the critical gaze toward himself or herself. In psychology, reflexive self-awareness is an intellectual and emotional process that involves conscious and unconscious mentation or thought process that draws upon symbolic, iconic, and enactive representations, and involves the mediation of the verbal and bodily selves, the other-as-subject, and the other-as-object (Aron, 2000).

Self-Reflexivity in Healing

The hyperawareness of body cultivated through self-reflexive practice is fundamental to the healing and self-transformative experience. As the center of the experience of health and well-being, illness, and disease, the body is central to the conceptualization of self-reflexivity in healing and healthfulness. In medicine, the body has been recognized as the site of physiological, cognitive, and affective experiences where the meanings of health and disease are constructed and experienced (Lupton, 2012). In other words, we feel, understand, and make sense of our disease and illness experience through our body. In turn, a self-reflexive investigation into the body can provide deep and rich understandings of the body. Such understandings provide valuable insights that acknowledge how the body is a source of lived knowledge and, thus, a partner in the journey toward healing and health (Ellingson, 2006).

A self-reflexive attitude is central to cultivating a holistic approach to health and healing. Research focusing on reflexivity in healing and health care is relatively new and suggests several exciting directions bringing together the interdisciplinary fields of neuropsychology, humanities, and health care professions. For example, emerging research in meditation and mind-body studies highlights the reflexive nature of the human mind and its fundamental role in the healing process. Philosophers refer to being self-reflexive as a discursive, abstract, and symbolic form of communication with oneself. For human beings, one of the most important, yet most ignored, actions we do at every moment of our lives is our ability to reference ourselves in our ongoing, evolving, complex communication with our self.

In exploring the symbolic communicative nature of self-reflexivity, Buddhist teachings have been integrated with research in social psychology to shed light on the mechanisms of self-reflexivity. Kwee, Gergen, and Koshikawa note that, because of the fundamentally socially situated nature of the human condition, we experience and interpret the world from particular perspectives and can never fully escape this subjectivity—each of us has our own presuppositions, beliefs, and predilections, and these make up our horizon of understanding (2006). They argue that when two individuals share overlap in their horizons, each can be understood by the other. This aspect can inform the providers' relationship with the patient in chronic care and pain management domains in critical ways.

In relationships, through making ourselves aware of our own feelings about and expectations of the other (e.g., patient), an individual can begin to fully appreciate the nature of the illness or disease perception, its relationship to the individual's personal and professional lives, and our relationship as a provider and experiencer in the world with those whom we wish to heal. In other words, by engaging in reflexivity—that is, proactively exploring the self at the start of the healing process/relationship—the provider can enter into a dialogue with their clients and use each client's presentation of self to come to make sense of the phenomenon anew. For example, we use discursive resources such as internal words and forms of communication to relate to ourselves. Being self-reflexive is to construct this image of oneself at each moment of our lives in a deliberative, thoughtful, and self-aware manner. This line of thinking in general follows from the central phenomenological claim that "the body is the mirror of our being" (Merleau-Ponty, 2002, p. 198). Phenomenology, a science that examines consciousness, phenomena, and the nature of human experience, posits that concurrent to sensing the world, human beings have the unique facility to sense themselves sensing the world. Understanding ourselves as whole human beings is central to the idea of starting healing.

Embodied self-reflexivity anchors wholeness through language and relating with the self in dialogic engagement with the other. In interactionist theory, narrative frames our embodied subjectivity where the embodied self is centered in experience through its discursive construction in language (Holstein & Gubrium, 2000; Waskul & Vannini, 2006). The perspective on self-reflexivity that originates from and is experienced through the body has been recognized in different ways (e.g., the notion of “mute reflexivity,” Franks, 2003, p. 623). The notion of awareness referenced in self-reflexivity can be understood as giving full attention, of deliberately concentrating one’s mind on a physiological or cognitive experience. Experiences such as disease, illness, and healing convey dimensions of embodied self-reflexivity in emphasizing body sensations, reactions, and the monitoring of the nonverbal meaning hidden in physiological perceptions. Understood in this manner, the language of the body can be used consciously and reflexively as a means of communication to connect with the self.

In this discussion exploring self-reflexivity with health and healing at an intimate, individual level, it is important to clarify that reflexivity is distinct from reflection. Reflection is the *thinking about* something after the event to make sense of events in particular contexts. A reflective practice in caring professions such as nursing, for example, will involve making sense of the particular problem, contextualizing that process of sense-making with observations to reach an informed conclusion, and the application of that conclusion in practice (Dewey, 1933; Somerville & Keeling, 2004). In contrast, reflexivity is a more immediate, dynamic, and continuing process of self-awareness (Finlay & Gough, 2003). Reflexivity, on the other hand, involves a thoughtful, self-aware analysis of the intersubjective dynamics between the subject and the object. Reflexivity employs language to construct a working narrative of one’s experience and situate it in dialogic engagement with oneself, to understand the experience of one’s own body through its negotiation and navigation of its struggles with health and healing (Denzin, 1989; Holstein & Gubrium, 2000).

Reflexivity, thus, is a defining feature of human consciousness: the human being is uniquely capable of being aware of being aware, as for example, in the performance of a variety of roles in our social, professional, personal lives. The process of understanding a context *qualitatively* implies cultivating a complex, deep, and rich experience with the object of interest. Ultimately, the goal of self-reflexivity in healing is to promote greater insights into the personal and social experience of the self in a dynamic manner as it constitutes the whole person. Understanding self-reflexivity in healing is to engage in a project of self-transformation through the individual’s close examination of the intersubjective dimensions of the self. Self-awareness of

our subjective processes is continually negotiated through our interactions with others. This intersubjectivity, or the negotiation of our subjectivity in social interaction, constitutes the socially constructed nature of our experience. Furthermore, by negotiating meanings in a range of social contexts, taken for granted meanings and assumptions can be revealed and critiqued, thus affording an opportunity to create illuminating, empowering accounts of oneself. In a similar vein, perspectives from social constructionism and discursive psychology argue that interpretations, particularly from authoritative sources (such as doctors and scientists), construct reality. They do so through legitimizing specific professional accounts that draw upon commonsense beliefs of who is knowledgeable, qualified, and therefore, privileged to speak in particular contexts (Foucault, 1972). Being cognizant of such assumptions and how they warrant certain accounts and challenge others (e.g., of patients and individuals) can be empowering for patients and others seeking to heal when employed with care and deliberation.

Self-reflexivity and reflexivity in general has been greatly written about as a research approach. A particular approach to being reflexive in gaining knowledge about another group or context is called reflexive accounting (Denzin & Lincoln, 1984). In reflexive accounting, the researcher draws upon different people's accounts of the context, from different perspectives (e.g., participants, experts, insiders, outsiders in a social group), to construct knowledge about a particular phenomenon or object of interest. In a very particular, time-intensive, and in-depth manner, the researcher is seeking to gather *truth through subjectivity* (Denzin & Lincoln, 1984). Personal reflexivity also encompasses situating the researcher and his/her knowledge making practices within relevant contexts, whether interpersonal, institutional, or cultural. This approach operates on the assumption that our experiences are affected by our encounters. Here, self-reflexivity is an approach that allows us to gain meaningful insights through reflecting upon *how*.

SELF-REFLEXIVE HEALING COMMUNICATION

Communication researchers examining subjectivity in health care have attended to the components of the physical body, the co-dependence between bodies, and the social and lived contexts within which the body is situated (Krieger, 2005). Communication that inculcates self-reflexive modes of thinking through self-expression, pre-verbal self-directed communication, and relational interaction can help bring inner states of cognition and affect into conscious awareness through constructing particular belief systems, ways of thinking, and imagining the world. Such communication can be a

powerful healing mechanism as the self integrates, accepts, and learns to adapt through its own embodied experiences. Below, healing communication as it is constructed through self-reflexivity is discussed in patient-provider communication in particular and therapeutic relationships in general.

Self-Reflexivity in Patient-Provider Communication

In a patient-centered communication approach, providers seek to make sense of the patients' perception of the meaning of their bodily symptoms in the context of their complex life situations. For example, providers may seek to employ narrative communicative styles that mirror their patients' mental state through self-awareness and self-reflexivity (Davidsen, 2009). Cultivating self-reflexivity in the patient-provider consultation allows the individual to integrate illness and disease. Healing communication draws upon self-reflexivity through cultivating access to a self-conscious account of the production of knowledge as it is being produced. In provider-patient communication, provider self-reflexivity can help bridge the gap between the patient's perspective and the provider's understanding of the patient's health in immediate and direct ways (Agarwal, 2018; Baarts et al., 2000). *Healing communication* through self-reflexivity in the provider-patient context allows the provider to openness to the insights of another person (in this case, the patient) to aid a mutual form of self-and other-directed understanding. Rather than positioning the patient as an objective, static entity, the provider adopts an open-ended understanding of their own self, situating their communication on an understanding that is never fully separable from the relational matrix formed with the patient and the care context.

In other words, the provider-patient healing communication is fluid—comprising competing context-dependent forms shaped by multiple factors. Seen in isolation, the provider's communication drawing upon self-reflexivity may be unengaged from the other (i.e., the patient), but when seen in relationship with the patient it is liberated from its defense mechanisms including dissociation and self-bias. Furthermore, the role of the provider as an expert removed from engagement with the patient experience is unduly reductive. In order for providers to engage more deeply with their own reflectivity and their patients' subjectivities, such embodied self-reflexivity is necessary (Renik, 1999). Self-reflexivity on the part of the provider in the provider-patient relationship also benefits the provider in valuable ways. In opening a space of meaningful engagement with the patients' illness experience, providers are also able to recognize the forms of resistance that can impede their growth as professionals (Searles, 1975). As Searles noted, if providers isolate themselves within the relational interaction, they are less likely to be found and to

find their patients. For Searles, as providers' subjective involvement is seen and assigned meaning by the patient, the goals of self-reflexivity are supported for both the provider and the patient if the provider approaches their patients as collaborators.

This body of research draws upon the assumption that patient interaction invites self-examination for both the provider and the patient. In the provider-patient interaction, providers take for granted the assumption that they are fully aware of themselves and in control of the patient-provider relationship. Self-reflexivity is productive in contexts that require complex understandings of patient experiences such as chronic long-term care and advance care planning in palliative care. In these contexts, religiosity, trust, and patient-clinician comfort provide support to informal, communication-focused approaches are cross-culturally appropriate (McDermott & Selman, 2018). Provider self-reflexivity can help engender insightful patient understandings and outcomes. Provider self-reflexivity can be cultivated not through solitary introspection but by seeing oneself through others' eyes, in this case, their patient's eyes. The process involved in encouraging the patients' self-reflexivity is a relational process, starting with, and contingent upon, recognition of the person's individuality by the caregiver (Beebe & Lachmann, 2003). The provider-patient relationship can facilitate intersubjectivity through cultivating a mutual recognition of each other's understanding of the self. In this case, the individual self-reflexive process itself relies upon social interaction in order to be learned. In other words, the act of becoming self-aware is part of a lifelong communicative process rooted in the constantly evolving dialectics of self- and other-directed experience.

Patient-centered care is recognized as a valuable step in patient empowerment. In advocating for a values-centered framework of patient-centered care, researchers Epstein and Street (2011) find meaningful deliberation between the patient and the provider in a way that creates shared understandings is important. Their model proposes direct and indirect pathways by which communication shapes the patient's health outcomes (Street et al., 2009). In this model, they position communication functions (such as responding to emotions, managing uncertainty, enabling self-management) as antecedent to proximal outcomes (e.g., understanding, trust, feeling "known," feeling involved) and intermediate outcomes (e.g., access to care, quality medical decisions, self-care skills), which support the achievement of final patient health outcomes (e.g., survival, vitality, reduced suffering, pain control). For the provider, in proposing a values-based framework, Epstein and Street (2011) describe the philosophical basis of patient-centered care as one that justifies respecting patient preferences on moral grounds, not in relationship with health outcomes. They propose that the processes of patient-centered

care should be explicated to understand which outcomes (e.g., trust, motivation for change) are salient in mitigating the patient's distress and uncertainty with respect to the chronic illness. For the patient, Epstein and Street (2011) propose that it is important to cultivate self-awareness through training that helps them understand and assess the physicians' patient-centeredness.

However, a few scholars have argued that it is beneficial in provider self-growth as well and in avoiding provider burnout. As a mutual exercise, it is argued that the patient and the provider are seen as partners in the relationship. Self-reflexivity here helps both partners engage in meaningful dialogue with the other (Auerbach & Blatt, 2001). If self-reflexivity in the healing communication frames the patient-provider relationship as a partnership, how each individual perceives the relationship in turn also shapes individual subjectivity through the relationship. Although both partners work in a goal-driven setting, it is important to integrate external experiences in the process of mutually-recognizing the communication in the relationship (Gerson, 2004). Building on the belief that both the patient and the analyst, rather than only the patient or only the analyst, choose to communicate both consciously and unconsciously is to acknowledge the premise that the interaction context is open to external influences (Gill, 1984).

Rather than be understood as a one-time information exchange, self-reflexivity in the somatic and affective forms of information exchanged in this process furthers the interaction through keeping the idea of self-monitoring and self-awareness at the center of the relationship. Self-reflexivity encourages a form of self-representation to others that addresses the limitations of the de-contextualized, self-contained, independent static positionality of the provider in the provider-patient relationship. Similar to the psychoanalytic model, the self-reflexivity on the part of the provider helps include provider acknowledgment of their limitations, allowing the provider to be humble and eschew an expert positionality in favor of learning from their patients in a partnership (Hoffman et al., 2009). While few communication scholars have examined self-reflexivity explicitly in the health care relationship, emergent literature suggests myriad ways of enriching the provider-patient communication relationship for promising work in this direction. In communication contexts, such as complementary and alternative medicine provider-patient relationships, provider employment of their own embodied self-reflexivity of their illness and faith has been suggested to support provider role in healing. By reflecting upon their own illness and faith experiences to relate with their patients and connecting their patients' illness and faith experiences with their healing (Agarwal, 2018).

Such contexts suggest different roles and perspectives for embodied self-reflexivity in the provider-patient relationship. By reflecting upon their own

illness and faith experiences with self-awareness, monitoring, and consciousness of their own body, providers sought to serve as a refuge for, and be present for, their patients and to connect their faith in the power of the body's energy and intention to heal with their patients' belief in their own body's ability to heal. Coming from the communication field, this study advances understandings of the use of the providers' body in how disease is constructed as a subjective experience and healing as embodied through their own illness and faith experiences (Agarwal, 2017). In examining self-reflexivity to enrich provider understandings, the provider-patient relationship can be seen as a context to inform provider understanding of the patients' subjective experience of disease. Such rich understandings can deepen the ability of the provider to construct care in their work as healers. Embodied self-reflexivity aids the attention given to the providers' body situated as an agent in the healing process. Through embodied self-reflexivity, the provider can co-construct the meanings of disease and healing with the patient by fully engaging with their own and the patient's lived experiences.

Agarwal's (2018) study suggests that providers can employ embodied self-reflexivity in patient care by constructing intersubjective understandings of their own and their patients' illness and faith experiences in using their conscious self-awareness and monitoring of their own bodies in the relationship. Thus, the providers' work can be seen to include contextual and relational aspects of the therapeutic relationship to connect the patient's physiological, spiritual, and emotional healing with their own. The study offers insights into how providers employ self-reflexivity to help their patients find meaning in their illness by reflecting upon their own illness struggles as a patient and serving as a refuge where the patient could find strength and learn to forgive. Such insights were meaningful for patients and the providers alike. Centering the providers' experience of their own body's illness in interpreting their patients' experiences offers for patients and providers a space of shared vulnerability (Thompson, 2012). The self-reflexive process serves as a bridge for the social, cognitive, and affective dimensions of healing.

Connecting healing with faith as belief in the power of the body to heal itself using imagination and visualization allows the providers to relate with their patients' faith as a healing power in empowering ways. The provider's self-reflexive awareness of their faith experiences illustrates a way for providers to guide the patient to become aware of, and reflect upon, their belief in their own strength and ability to heal in the healing context. The co-construction of meanings of health and disease achieved by provider self-reflection on their own faith can support the patients' recognition of their ability to define transformative healing.

THERAPEUTIC RELATIONSHIPS AND HEALING COMMUNICATION

In the therapeutic relationship, as Aron (2000) explains, self-reflexivity is not accomplished by an isolated mind in private contemplation as in meditation, but rather always involves a cognitive and affective sharing between two individuals. Self-reflexivity in the therapeutic relationship is closely linked to listening as an analytic instrument to create an intersubjective, analytic space (Lee & Prior, 2013). Healing communication calls upon a form of intuitive listening that arises from a subconscious recognition of the subject that has not currently been consciously recognized. *Intuitive listening* is described as being accompanied by an experiential state that is receptive to waking fantasies, spontaneous intuitions, visceral sensations, and fleeting thoughts and images in which the listener hears what is absent as well as what is present (Gurevich, 2008). When listening intuitively, the listener is aware of everything spoken and unspoken, known and unknown as an occasion for significance (Cayne & Loewenthal, 2007). The recognition of the mutual nature of the intuitive analytic listening process implies, on the provider's end, a recognition of questions related to self-disclosure and mutual analysis and the symmetry–asymmetry dimension of the analytic relationship.

In their research on how communication pathways may lead to improved health outcomes, Street et al. (2009) argue that attention needs to be paid to the more indirect routes that may affect certain outcomes such as satisfaction with care, self-efficacy, and shared understanding. The researchers argue that provider-patient communication can contribute to improved patient health through seven pathways that they identified as “access to needed care, increased patient knowledge and shared understanding, enhancing therapeutic alliances . . . emotional self-management, social support and advocacy resources, increasing the quality of medical decisions . . . and enabling patient agency” (p. 297). These pathways require communication that supports intersubjective awareness in bringing about mutual understanding of the dialogic circumstances.

The argument presented in this chapter proposes that intersubjective awareness facilitated through healing communication is constituted through a multi-level process. This process highlights intuitive listening in self-reflexive therapeutic relationships as a process that can play a key role in self-management by individuals addressing chronic pain (figure 3.1). By tapping into the body's inner state, intuitive listening references recent findings on interoceptive sensibility. Emerging research mapping the neurophysiology of the brain reveals that consciousness encompasses not only active thinking but also interoceptive information and awareness of inner states. However,

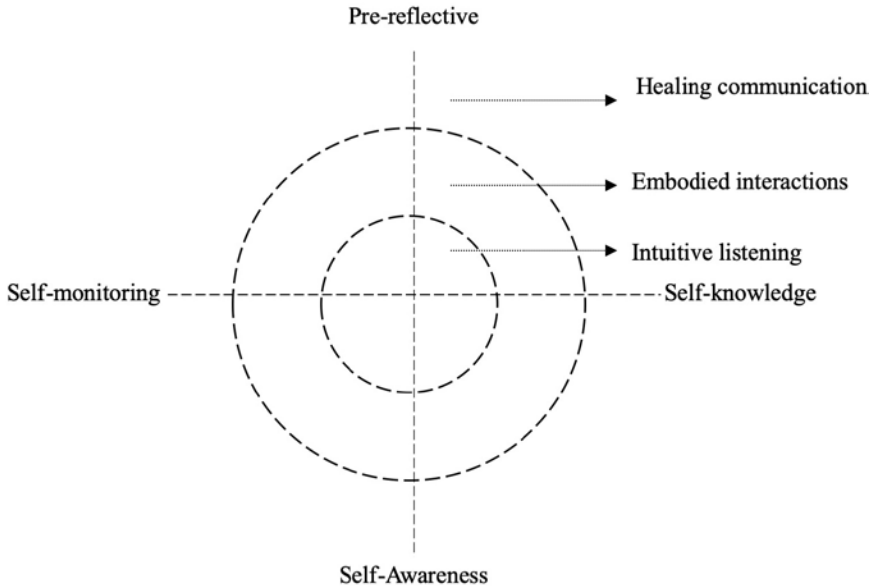


Figure 3.1. The reflexive self. *Figure created by author.*

this body of research faces limitations currently including the extent of concordance between interoception across bodily axes, the robustness of the relationships detected, to characterize and compare different types of interoceptive accuracy alongside sensibility and awareness measures (Garfinkel et al., 2015). Interoception is the body-brain axis of sensation that addresses the perception of the internal body organs including emotional states (Cameron, 2001).

Recent interest in the embodied dimension of cognition as it influences how internal body signals may shape cognition (Dunn et al., 2010) has focused on clarifying the measurement and conceptual boundaries of interoceptive accuracy, interoceptive awareness, interoceptive sensitivity, and interoception with greater accuracy (Garfinkel & Critchley, 2013). Garfinkel and Critchley define interoception as the ability to detect internal bodily sensations. Likewise, interoceptive sensibility is the self-perceived dispositional tendency to be internally self-focused and interoceptively cognizant, and interoceptive awareness is defined as the metacognitive awareness of interoceptive accuracy. The inner states include dreams, memories, and related sensory data. Both the conscious and unconscious brains operate continuously in interactive, dialogic discourse with the individual's internal and external relational matrix. The individual's consciousness, research suggests, shifts through foreground and background to constitute it as an ever-evolving conscious state from a multitude of possibilities (Maroda, 1999). These lend credence to

the provider's embodied self-reflexivity through informed self-disclosure to extend personal spaces in revealing themselves (Renik, 2006).

Other researchers find that one of the ways to support patients through the therapeutic relationship is to include communication that reveals the providers' mind in action (Bromberg, 2006). In fact, over the past twenty years or so, there has been a growing trend toward facilitating patients getting to know the provider as separate subjects. These advances reflect the relational/ intersubjective turn in psychoanalytic theory and practice. Pragmatically, as a matter of technique, those concerning whether, when, and how much a provider communication should choose to self-disclose in the therapeutic relationship raise complex issues in the context of healing. These issues speak toward the provider's judgment about what constitutes therapeutic action, associated with one's orientation to mutuality, symmetry, neutrality, authority, expertise, power, intimacy, and a host of other fundamental considerations in the healing communication.

One might argue that to be self-reflexive is a struggle, fraught with the challenge of continually negotiating self-awareness, and requires experience with cultivating a refined awareness of self and its health conditions. It is not easy to reflect upon pain or engage with the unpleasant sensations in one's body, as research examining the impact of trauma (e.g., SAMHSA, 2014), and PTSD support-groups (PTSD, 2005) will illustrate. Most patients in pain describe the insurmountable challenge of being unable to engage in body acceptance and ownership and a frustration with their inability to go beyond a body they feel they are trapped in. For instance, the engagement of self-reflexivity to understand and transform one's pain experiences challenges the individual to stay in the pain, to reflect upon it, and to be conscious of their struggles with pain in order to eventually contemplate, surmount, and transform the pain experiences. Self-reflexivity training practices that engage the practicing individual to dwell upon the pain to (re)orient its embodied dimension can be supported by self-reflexivity in dialogic engagement with the discursive/material body and the contextual layers discussed in the later chapters of the book. These practices are integrative and balancing in suggesting how intersubjective awareness and a dialogic positioning within the context can be supports toward re-envisioning the body and its experiences with its changing state and perceptions of spatiality and time. The social constructionist approach applied to the development of the body/self axis and the contextual layers of the wholeness model provides a way to (re)orient the individual in a network of intersubjective meaning making processes for defining acceptance, balance, and openness to a diverse range of experiences. Incorporating the dimensions can serve as key components in constructing

wholeness that provides self-reflexive practices the meaning making anchor constituting through wholeness in their treatments and CAM practices.

Most accounts of self-identity and change will invoke self-reflexivity at the heart of the project. However, the arguments presented in this chapter support informed self-disclosure in dialogic, relational contexts as a way of cultivating self-reflexive healing communication. For providers, it can heighten the experiential dimension of the relationship and, at their best, advance constructive new relational experiences that can be internalized, adaptively expanding and reshaping internal structure (Frank & Frank, 1991). In order to achieve the transformative potential of self-reflexivity in chronic illness contexts, however, openness in the communication is essential. Scholars who argue for restraint in a dialogic provider-patient encounter see a risk in self-disclosure, in a risk of bringing an analytic interaction to a real relationship between the provider and the patient (Meissner, 2002).

Opportunities to offer self-reflexivity training that addresses these challenges can be worthwhile in chronic illness management for both an overburdened health care system and patient empowerment. Meditation exercises that cultivate somatic awareness and equanimity can be particularly useful for individuals living with chronic pain to attain independence from pharmacological dependence. Derivative programs such as mindfulness-based training and body acceptance through yoga, chants, gongs, and sounds create harmony, body acceptance, and integration through disruption. Such exercises can be offered through community settings in collaboration with primary and community-level health care centers to decrease reliance on medical options for long-term chronic condition management and enhance patient capacity to cultivate quality-of-life experiences through body acceptance and harmony. Integration of self-reflexivity to promote body acceptance, harmony, and awareness in relational and contextual ways constitutes wholeness that transforms the chronic pain experience through relationality and dialogic engagement.

For the provider, self-reflexivity training focusing on inter-relational awareness of the self/other in embodied ways through dialogic engagement can equip them with the capabilities to construct intersubjective patient encounters and promote patient empowerment. Dyadic patient-provider relationships accommodate a two-person form of self-awareness that is both intersubjective and individual, self-contained awareness, and oriented toward fluid relational processes rather than static knowledge. Such a relationship also recognizes that much of the processing of experiences in the brain is procedural rather than declarative and allows for information-focused yet open-ended engagement during their time with the patient. Through self-reflexive training, by imagining their own and the patient's states, the provider encompasses both of the individuals' experience in relation to the other in the

context of healing communication. This allows the provider to compare, contrast, and negotiate their own state with the patient's reading of the provider's state, the provider's reading of the patient's state compared with the patient's own reading of it, and so on, thus allowing the patient to know the provider deeply and to give the provider useful insight (Gallese & Lakoff, 2005).

Thus, embodied interactions when shared through mutual self-reflexive communication not only facilitate mutual intuition but also may scaffold more propositional, cognitively complex understanding of the other, facilitating the provider's identification and interpretive work (Gallese, 2005). In the therapeutic relationship, self-reflexivity involves the capacity to hold in mind both the subjective and objective aspects of both self and object, and to shift fluidly between them, thus evoking the capacity to make smooth transitions (Auerbach & Blatt, 2001). The goal of self-reflexivity is broader in scope than that of isolated self-analysis and involves an important dialectical aspect of awareness of the self in an intersubjective field—that is, taking a reading on self as both self and other, and other as both self and other. Thus, self-reflexivity is a centrally involved dimension in therapeutic action; it creates space for mutual influence—allowing the providers' empathy and view of herself, like the patient's self view and that of the provider, to be shaped jointly.

In advocating for a mutually constructed provider and patient engagement of self-reflexivity, the healing communication expands the therapeutic relationship as one that includes the provider's embodied interaction in the ongoing negotiation of competing and intersecting meanings of health and healing. Study findings indicate the provider's act of self-reflexivity in engaging their own illness and faith experiences through their body strives to create transformative experiences for the patient by aligning the patient's meanings of health and faith-based experiences to constitute healing (Agarwal, 2018). It is important to note that awareness understood as mindfulness involves both the body and the mind in a synchronized awareness process—a point many meditative techniques embody. For example, while a part of the mind monitors the somatic information, in Vipassana meditation, the sensations of the body, and nothing else, become the center of attention, as the meditator attempts to monitor every single detail. The emphasis, thus, is not on visualization but rather on feeling or *perceiving*.

Likewise, this exercise is done through the mind's eye, with actual physical observation being discouraged. Such exercises in self-reflexivity, while seemingly abstract, have a tremendous pragmatic benefit. For providers facing burnout, constructing inclusive understandings of health by focusing on how the provider's self-reflexive awareness of their own bodies can be a site for understanding patient disease experiences in ways that invite multiple meanings of healing in a dialogic process (Agarwal, 2018). The provider's

self-reflexive awareness of their own illness and faith experiences to make sense of their patients' illness struggles further scholarly understandings of healing as constructed through the body and manifest in the unique relational and intersectional contexts of the patient (Lupton, 2012).

Including the provider's body in healing contexts deepens the therapeutic relationship as a site for patient empowerment through the embodied interaction. Recognizing provider self-reflexive awareness of their own body allows researchers to examine subjectivity as a space for constructing patient ownership of healing at the intersection of relational, spiritual, and physiological contexts (Agarwal, 2019). By recognizing the need to include provider self-reflexivity as constitutive of shared meaning making in an embodied interaction, providers can construct care based on mutually defined therapeutic goals (Charon, 2001). By drawing upon the providers' experiences of illness and faith, the embodied interaction can expand the provider's role as one of empowering their patients to reframe their subjective understandings of illness and faith. The interdependency of such interactions goes beyond meeting the patient's physiological treatment to address them as a whole person (Agarwal, 2018) while envisaging the embodied interaction as a meaningful healing space. Attending to the provider's body in an embodied interaction to create intersubjective understandings of health and illness situates the body as a physiological, social, and spiritual entity intimately connected with the healing experience. In this manner, embodied self-reflexivity can be understood phenomenologically in the symbolic interactionist relationship of the agentic body and the self in the following description:

The enigma is that my body simultaneously sees and is seen. That which looks at all things can also look at itself and recognize, in what it sees, the "other side" of its power of looking. It sees itself seeing; it touches itself touching; it is visible and sensitive for itself . . . There is a human body when, between seeing and the seen, between touching and the touched, between one eye and the other, between hand and hand, a blending of some sort takes place—when the spark is lit between the sensing and the sensible. (Merleau-Ponty, 1974, pp. 283–284)

In patient-provider contexts, thus, self-reflexivity is a fundamentally embodied phenomenon. From a symbolic interactionist perspective, attending to CAM providers' self-reflexive experiences in the embodied interaction constructs the therapeutic relationship as an intersubjective site where the meaning of wholeness is continually negotiated relationally. Here, the provider-patient discussions of the desired health outcomes are centered around their meaning within the lived body. The provider comprehends the other's body through their own body—the other's perceptions through their own interpretations of their own actions on the other's body. With training,

self-reflexivity can be a powerful tool in creating empowering understandings of health and illness experiences and reframing meaning-making from physiological, relational, and spiritual contexts through the body. Self-reflexivity is embodied because it constitutes healing through the body reflecting upon itself through its own sense of self and the other's body and self. It is the interactional sphere through which two bodies make sense of the subjective meanings of health in a continuous act of reflection and integration.

Self-reflexive processes support healing through embodied interaction by including both the provider and the patient as partners in co-constructing goals through mutual relational engagement. In my research, I find that providers' self-reflexivity of their own illness and faith experiences can enable their work through relating with the agentic capacity of their own and their patients' body in enduring ways (Agarwal, 2018). Provider cultivation of embodied self-reflexivity during the provider-patient interaction enables them to make sense of their patients' experiences to construct co-production of meaning that supports wholeness experiences for the patient. In turn, my study findings (Agarwal, 2015; 2019) support a symbolic interactionist view by envisaging the provider as a whole person in the health care relationship. Integrating the body in self-reflexive ways can create an empowered healing space for both the provider and the patient. Furthermore, focusing on provider self-reflexivity through attending to their own body's experiences of health and illness can provide an opportunity to conceptualize intersubjectivity in the health care interaction through envisaging both the provider and the patient and construct delivery of care in mutual physiological, relational, and spiritual contexts.

The form of embodied self-reflexivity promoted by different forms of meditation cultivate in the practitioner a sense of detached observer to the process of observing one's own bodies physical and somatic sensations without reacting or otherwise attempting to judge them. In Vipassana meditation, by grasping at the awareness and the process of turning it to a message to oneself regarding the state of one's body, the somatic self is brought into consciousness, alongside a moment of verbal interpretation, which posits the event as a discursive construction. These sensations encompass an interpretation of the situation, an interpretation presented through an embodied medium, motivating action owing to their status as being pleasant or unpleasant, fearful or dangerous, and so on. To disrupt the reaction is to interrupt the flow of the reflexive feedback loops that lead to a protective response. With training, the practice of being attentive to embodied signals, of observing sensations objectively becomes a habit of monitoring the self. With training, individuals can become habituated to be in a constant state of body awareness as a deliberative, conscious tool. Such attentiveness can help the practitioner to observe

and detect minute changes in the physiological and somatic functions of the body and to monitor these through bodily awareness. Self-reflexivity, in this case, helps individuals monitor and detect changes while remaining anchored in contemplative and non-judgmental bodily awareness.

Self-reflexivity cultivated via different forms of meditation can help individuals become aware of the feedback loops, interpretations, and meaning-making that occurs in the discursive realm as form of internal conversation that connects bodily experiences to symbolic worlds of meaning. Integrating self-reflexivity in an embodied provider-patient interaction through the lens of symbolic interactionism envisages the providers' role in narrative co-construction through dialogic contexts with the patient. These communicative interactions become empowering for patient empowerment in reframing pain and chronic illness experiences and addressing provider burnout. In exploring the communicative dimensions of an embodied interaction, integrating self-reflexivity in healing communication through narratives, intuitive listening, and interoceptive awareness can promote a mutually relational contemplative stance.

In envisaging patient-centered care, self-reflexivity problematizes self/other, internal/external, and exhaustive/binary states. Given the open, inclusive nature of meaning-making and interpretation the exposition on self-reflexivity in this chapter has cultivated, self-reflexivity practices can serve as a mode for integrating diverse chronic illness experiences in a way that supports tailored patient communication. Practitioners may interpret different forms of communication and follow these interpretations in making notes or in talking with others. Such communication supports movement from the embodied to the discursive realm or sustain a space where both realms can co-exist in a complementary manner. Embodied self-reflexivity foregrounds the practice of cultivating a reflexive self that allows for fluid movement of contemplative attention from our bodies to our lived contexts and opening the ability of our bodies and its senses to the process of an awareness of ourselves sensing the world. For individuals living with chronic illnesses and pain, this ability can be transformative in decreasing or eliminating medication dependence and shifting control and agency vital in defining and maintaining productive lifestyles back with the individual.

Recent public health movements have invoked cultural change to improve health and reduce health disparities, particularly in the domain of chronic illness management. The CAM practitioner's openness to complex and contradictory understandings of their own and the patient's body provides an instance of provider-patient therapeutic relationship that situates the patient's experiences in the context of their lifeworld (Agarwal, 2018; du Pré, 2002; Sharf & Vanderford, 2003). Furthermore, attributes like openness, perceived

control, and provision of chronic care management support have contributed to the increasing use of CAM approaches by patients (Thomson et al., 2012). As this chapter has argued, the integration of a reflexive self through meditation training or body awareness, harmony, and alignment through somatic practices like yoga, sound/gong therapy, and chanting can build embodied interactions and support intersubjective dialogic spaces of provider-patient interaction. In particular domains (e.g., palliative care, long-term chronic care, or terminal illnesses), the provider-patient relationship can be deepened as providers integrate their own health and illness experiences in co-creating treatment plans that empower the patient and address their idiopathic challenges.

Ultimately, healing communication centers self-reflexive awareness of self/other experiences in dialogic relational spaces to support diverse understandings of patient-centered care provided in chronic illness management and create spaces for individuals to integrate in self-defining ways with their evolving self/bodies in long-term chronic illness management. Healing communication that envisages a reflexive self empowers chronic pain patients to integrate through awareness and alignment of their body/self experience. The next chapter will develop the embodied self in engagement with the reflexive self that connects the body with the idea of symbolic representations, spatiality, and experientially inscribed body-knowledges.

Chapter Four

The Embodied Self

In this chapter, I consider the self as an embodied entity. I examine the body as the site of our lived experiences and the knowledge we cultivate through those experiences. Through situating embodiment in relationship with the reflexive self, the chapter explores a pre-reflective and pre-verbal self at the intersection of body, art, and spatiality. The chapter develops these ideas in the context of understanding and guiding the healing process through expanding intersubjective engagement with objects and symbols located within the culture and assigning significance to specific practices and ways of being. The intersubjective experiences are constructed as dialogical engagement with the reflexive self and the discursive/material body situated in the contextual layers. It considers applied contexts such as the experience of trauma in engaging with experiences, assigning significance and meaning, and guiding the body/self through awareness of agency and intentionality to connect with the physiological processes of health and disease.

Our body is the site of our worldly experiences. We experience the ups and downs of our relationships and navigate our lived contexts through our bodies, mind, emotions, and consciousness. For the body in chronic pain, these experiences encompass a world of fear, avoidance, depression, and isolation. The body in chronic pain is a site of fractured experiences and narrative disruptions that interrupt the individual's capacity to guide their own functional abilities and situate themselves harmoniously in the flow of time. In healing, we think of ourselves as being restored or becoming whole. Our embodied self is situated in a state of wholeness characterized by narrative coherence and flow of temporality, functionality, and materiality. We recall past experiences and articulate future ones through the narrative intentionality embodied in the experience of time through the body (e.g., Husserl, 1893–1917). As the chapter on *time* contends in greater detail, our narrative engagement with

our stories and how we describe our hopes and fears is encapsulated through embodied temporalities experienced through our body. The body is a central element in the accomplishment of healing. In drawing attention to the embodied self as a center for healing, the chapter connects the idea of healing as accomplished, or made visible through the body.

Embodiment is the representation or expression of an idea or quality, one that is presumably otherwise abstract or intangible. Our materiality is inherent in the tangible physicality of our physiological and lived experiences. It makes us open to being acted upon and gives us agency as acting agents, to be simultaneously a receiver and a giver, and an active and dynamic participant and co-constituent of our experiences. As the previous chapter on *the reflexive self* has argued, alongside being sentient beings, we are also unique in being self-reflexive of our awareness. In other words, from a phenomenological point of view, we are aware of our own capacity to feel and be perceived as feeling beings. This implies that the body is simultaneously a subject and an object for our experience of ourselves. In other words, we both *have* and *are* the body (Wehrle, 2019). The embodied self connects the body with the idea of experiencing integration with its lived contexts in open, relational ways rather than a body in resistance and pain that is treated by, and treats, the self as an objective other. Examining healing through embodiment foregrounds the processual nature of becoming whole. This process references an essential quality of healing that goes beyond the physiological state-based treatment of the body and its biochemical, cellular mechanisms and components in discrete provider-patient encounters.

Several foundational books on the topic of embodiment and health have laid the foundation for research on the body and its experiences. In her edited book on embodiment, caring, and ethics from a phenomenological perspective, Benner (1984) lays out the lifeworld experiences of the disabled and the elderly to illustrate how these give shape to very unique illness constraints and enablers and thereby maps out very different worlds for different individuals. Several important quandaries that are implicated with the question of embodiment raised in the book comprise aspects of the present investigation into wholeness and healing in chronic care. A key assertion in the book is that understanding embodied health perspectives is not only important, it is morally essential for those who provide care in order to provide ethical care. Questions of how much and to what extent can tradition be relied upon unconditionally in treating patients become especially poignant when these values are placed in conflict between the providers and the patients who come from different systems.

The question of what constitutes ethical care and its epistemically framed concerns also arise when the embodied condition is examined through the

lens of the social constructionist approach. If caring involves stepping out of one's frame of reference, then it attends to the other's needs from their perspective, and hence cannot be bound by protocol and fixed rules. Likewise, questions of time are raised from a phenomenological point of view in nursing when addressing how to anticipate its significance to future events as they are assigned by those who will be affected by them. These concerns are addressed from a phenomenological perspective in nursing care and illuminate the ethical concerns underlying the need for an embodied approach.

The present book's focus on the embodied self as it constitutes wholeness extends concerns of sociologists from a social constructionist perspective on wholeness of the body/self. In their edited collection on the body and embodiment through a symbolic interactionism perspective, Waskul and Vannini (2006) provide a sociological view of the body from a reflexive (transembodiment, networked body), dramaturgical (body as performance), phenomenological (e.g., interpretive sociology), semiotical (e.g., dualism of body-image), and narrative (e.g., pregnancy, masculinity) lens. Grounded in a sociological perspective, the critique of embodiment in this collection provides a look at what it means to be embodied and the processes of embodiment exemplified in the different facets of the critique.

For instance, the dramaturgical examination of the body and embodiment looks at how social order is sustained in "dramatic body-rituals that are bound by and are constituents of body order" to argue that the "body and experiences of embodiment are produced in the doings of people by social and cultural rituals that are personal and communal" (p. 7). In its examination of embodiment, Waskul and Vannini's book illustrates the many ways embodiment and the body intersects with the multiple contexts of our interactional lives. While their focus is on the body in interaction in a range of contexts from a sociological perspective, the present book shares and extends lines of thought on reflexivity and cultural identity. The embodied self, developed and presented in the present book, is an essential constituent of the body/self anchor centering the model for wholeness.

Krieger's (2005) work on embodiment, situated in epidemiology, centers ecosocial theory and epidemiological inquiry to recognize that human bodies, as biological and social organisms, tell stories about the conditions of their existence, that these stories may or may not match others' accounts, and that bodies tell stories that people would not or cannot tell. Her work emphasizes that understandings of social disparities can be obtained through examining the social, material, and ecological contexts in which we are born, interact, and live meaningful lives. Her work, too, connects the deterministic and the disembodied (mechanisms and behaviors, and genes and cells) with the embodied approaches. Others, such as Slatman (2014), who have examined

embodiment in medical practices, focus on the patient's lived experience to conceptualize the body as a condition for "world-disclosing," but also one that is acted upon and changed by external forces, and hence, in order to be fully understood, should be understood through phenomenology as well as sociology. Slatman's argument for medicine to be interpreted in light of its phenomenological and sociological analyses is extended in the present book's argument that while embodiment is a necessary perspective to bring into the practice of health and medicine, it needs to be situated in a multiperspectival, integrated frame in order to constitute an understanding of wholeness.

Distinct from, but extending the above perspectives, and centering embodiment in healing and wholeness through a social constructionist, medical humanist lens, the ecological model of wholeness proposed in this book presents a unique argument for the embodied self in relationship with a discursive and material body. In doing so, it argues for an examination of the reflexive and embodied self in dialogic engagement with a discursive and material body understood in relationship with context including subjective time, traditional health systems, and the socio-cultural environment. In examining healing through the lens of embodiment in space, place, and time, we approach the body as intimately connected with the emotional, cognitive, and spiritual forms of its being. Embodiment, thus, evokes the qualities of healing that go beyond physiological treatment to bring into being, to foreground the material in relationship with the perceptual and the symbolic, in intentionality and action, space and place, and time and temporality. The embodied self takes a deeper look at the phenomenon of embodiment to draw out its meanings and relationships with the processes of experiencing the lived, perceptual world in chronic illness contexts. Embodiment is an act of embodying the self. The embodied self lends itself to constructing healing as a phenomenon in relational engagement with the discursive/material body. In this manner, I argue, the phenomenon of the embodied self can be understood as personification of the idea of healing.

As a process, the embodied self can exemplify healing as a symbol of integrating the body and its experiences as connecting intentionality with an authentic expression through the body, one that is illustrative of a reification of the principle of becoming whole, of integration, and of the approach that facilitates these processes. An idea, intentionality, or outcome embodied through the self is suggestive of a realization of the self accomplished through an action and serving as an archetype for a concept. Embodying a healing self suggests the process of constructing its materiality through the body, its relationships, spaces, and lived contexts.

Embodying a healing self can thus include the act of organizing, incorporating, embracing, or comprising the elements that comprise wholeness into

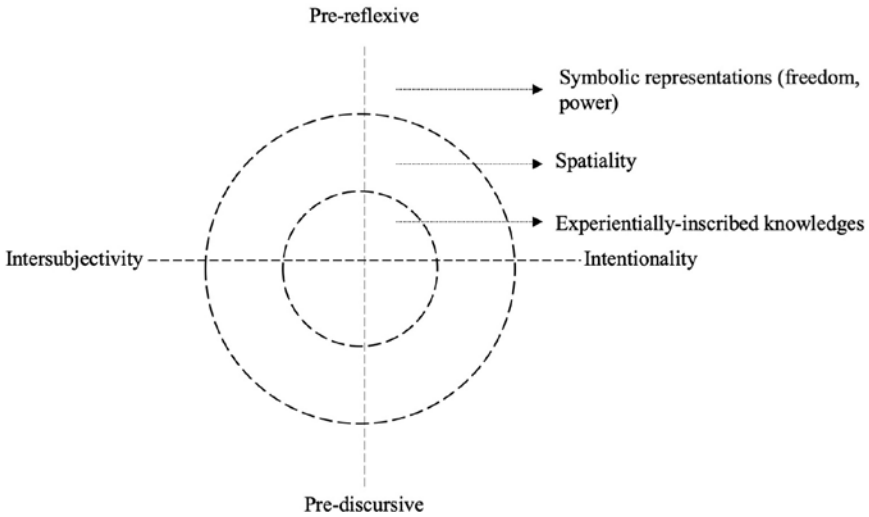


Figure 4.1. The embodied self. *Figure created by author.*

a coherent form. In attending to healing, embodiment references the idea of healing as syncretized through the body. In other words, the body can be thought of as expressing the idea of healing as a personification of its abstract enjoining of the spirit and emotions. Imagining the idea of healing in its embodied form is to imagine the idea of healing as it is provided a form for its expression, and of how the conjoining of healing and its expression is made visible and tangible through the body. It follows that healing embodied is the embracing of the abstract principle of healing and idea of healing in a material, corporeal, or tangible form.

The myriad above expressions can help in situating the conceptual space of embodiment within the processes of healing. The central argument put forward in this chapter posits that healing is both an act of embodiment and a process of embodying the principle of wholeness through relating with the connections that make us whole. The chapter builds on the assertion that healing is communicatively expressed through actions, words, thoughts, and presence that is oriented toward the accomplishment of wholeness based on the integrity of the self. Healing is an individual, patient-centered act, one that continually engages with the internal/external and environmental/contextual, factors that comprise it. Centering the embodied self in the healing process is fundamentally empowering for the chronic illness experience as it invites the individual to communicatively envision the unique materiality of wholeness (figure 4.1). The sense of imagined and constructed wholeness is not analogous with the biomedical models of a human body, but rather draws upon intentionality to construct quality of life experiences. Thus, one person with

a missing limb may feel whole, and indeed, perceive a higher quality of life than another individual, who with their limbs may feel incomplete and unable to get past a minor headache. Healing as the embodied self is the sum of its parts and interdependent with the material/discursive body.

In developing this argument from a medical humanist perspective, I examine literature exploring embodiment from the humanities in relationship with epidemiological and nursing approaches to chronic care. As greater advances in the tools and technologies supporting neuroscientific data are allowing scientists a close, first-hand look at the cellular and neurological processes underlying cognition, emotion, and intention, the complex relationships between how we think, what we think, and who we are, is becoming clearer. Of particular interest to this treatise on wholeness is the relationship with the embodiment of our intentions. Such intentions can be individually cultivated through the relationship with a provider. This chapter explores how healing intentions can support wholeness in the context of chronic condition management. The chapter is laid out in three broad sections. The first section lays out how embodiment has been discussed in the literature. The second section provides a framework for positioning embodiment to connect it with the idea of healing. The third section provides a way for thinking about healing through embodiment as seen through the different medical philosophies and approaches. Finally, the fourth section lays out how the relationship of healing and embodiment can help further wholeness as an integration of both the concepts of healing and embodiment.

THE SELF AS EMBODIMENT

The idea of embodiment is grounded in cultivating an awareness of the materiality of the self alongside experiencing its meanings as situated within the lived world. A close examination of how the human body has been understood from the vantage point of different disciplines allows for a richer understanding of embodiment.

The Primordial Self as Body, Art, and Spatiality

As healing is intimately tied with the body, in order to understand healing, it is imperative to have a layered understanding of the self through the body. One of the disciplines that has been fundamentally concerned with the representation of the human form is art. The representation of the human form has taken myriad approaches and interpretations in art through the ages. Healing is a process of constructing anew our relations with our own bodies. Our physical

bodies may be damaged or hurting, but art asks us to imagine our bodies as we perceive them, know them, or believe them to be. It does so in ways that are unique and distinct from our habitual and non-reflective ways of approaching our bodies in isolation. Bodies in pain or bodies that are hurt or diseased or otherwise imbued with meanings and feelings can be limiting as these are processed through multiple layers of interaction and communication, enacted through several contexts and encounters. From a phenomenological perspective, art provides a pre-reflective and non-discursive mode of knowing and symbolizing the human body. Because art by its very form encourages a form of reflection and absorption that precludes words and discourse in its meaning making, the conceptualization of the human body can be seen through the lens of embodiment as a form of being-in-the-world (Chaplin, 2005).

For scholars of art, the human self, in the materiality of its physicality, emotions, and cognitive states, grounds the idea of embodiment. Aesthetic interrogations of the human form delve into the human body and its physically observable parts and elements (such as expressions, gestures, positioning, physicality, appearance). Starting with art as a way of approaching the human self as form privileges the pre-discursive mode of knowing. It delves into a conceptualization of the human encounter with its environment to depict discursive constructions like gender, social class, race, and their experiences such as marginalization, power, and healthfulness in pre-verbal ways. Such depictions illuminate the meaning of being embodied in ways that strive to go beyond a mind-body duality. In art, the material aspect of the body concerns itself with representations of the physicality of its interactions with the lived environment. The body/mind aspect in art holds the potential of exploring the experiences that are symbolically represented in and by the body such as freedom, power, and imagination. Through centering these ideas in representing the human body as an aesthetic form, embodying healing can be conceived as an act of imagination, an exploration of the freedom of potentiality, and the exercise of constructing it through the hands of the individual themselves.

Theories of art and embodiment that examine the biological and physiological materiality of the body at the intersection of its aesthetic representation are replete with potential for furthering understandings of body/mind integration in chronic illness contexts. Explorations of the aesthetics of the form provide a way to think about identity, community, belonging, and culture to incorporate values and states that give meaning to the human condition (Chaplin, 2005). Such interrogations are central to the idea of healing as they connect the chronic illness experience with its culturally mediated elements and provide a way of situating meaning in long-term experiences of pain or illness management.

Community, rituals, and belonging, for instance, all reference elements where the human body can be seen relationally in social contexts in ways

that give both its form and presence a meaning anchored in signifiers beyond physiological materiality. For instance, depictions of disease can be seen in ways that promote a connection with community events and rituals. They can be envisaged as related with seasons or as gestures of how individual and community actions are recursively given meaning. Likewise, depictions of disease can be employed to assign or remove ownership, agency, or collaborative responsibility for individual actions, such as those illustrated by the navigation of tensions between self and community health awareness in vaccination decisions. Through a pre-reflective form of representation such as art, the body is recognized in ways that relates with social values that reference their deeper relationship with individual values.

Healing does not happen in a vacuum. Like all other processes, it needs a context to give it meaning. The event of a sickness, an accident, or a disease can spur awareness, cognitions, and feelings, but they do not in and of themselves spur meaning making. We look for meaning making frameworks within ourselves as constituted through our influences from outside ourselves. Such outside influences may include art, the practice of medicine, cultural values, social relationships, and our own motivations and goals. Beyond the aesthetics of the human form such as disintegration and debilitation from aging or disease, the focus in art on symbols also intersects with the biological understandings of the human body. Art provides such a context in a profound way. Representations of the human form, in going beyond human anatomy, reference the intersection of culture, meaning making, mind and feeling, and a community replete with a historical context.

Meaning making processes take on a heightened symbolic dimension when understood through the lens of art as the process of being imbued with significance allocated to bodily sensations. This relationship between biophysiological functioning of the body and meaning making processes has been examined through studying how images impart significance through symbols to the visual image. Meaning making processes, through this lens, are symbolic, appreciating the imparting of significance with bodily sensations. Art is effective in its potential to reframe illness experiences through its concern with the projection of inner mental and affective states in relationship with the environment. The connection of such forms of awareness with the external objects in the environment through symbolization can provide a way to reframe illness understandings through dialogue in diverse contexts.

Conceptualizing the Embodied Self

Any investigation into healing through the lens of art is an investigation of the relationship of imagination with representation in unique and individual

ways to evoke the intentionality and possibilities of human purpose. Meaning making, from this vantage point connects the internal to the external states of the individual, and in doing so, the subjective experience with the objective experience. From this vantage point, employing art to depict the intersection of the human body and its health and illness experiences brings embodiment to the center stage of objectification and sensory processes. As a frame for our encounters with our environment, art functions as a healing ground where imagination structures and inspires what we think we can see, do, believe, imagine, or feel. If our body and its feelings are the primordial means of interacting with the environment, then embodiment and symbolization are intimately connected through our sensory perceptions. Perceptions seek to grasp and represent the external world, and the external world, in turn, represents these objects back to us for symbolic meaning making. Standing in an intimate relationship with art allows us to create meaning for our own experiences through its symbolic representations.

Through art, the senses of movement, touch, temperature, sound, and smell are interpreted and grounded in a temporal-spatial pre-reflexive meaning-making framework. Healing through art foregrounds how we imbue objects, sounds, movement, language, and form with particular forms of meanings, and relatedly, feelings (e.g., fear and joy). Envisaging spatiality in an abstract and material form, art provides a way to conceptualize the embodied self. It takes us beyond the body to the domain of meaning making. Understanding the embodied self as a pre-reflexive, pre-verbal way of being, art provides one means to empower the fractured body in pain through its ability to guide the use of visualization and imagery in giving form to identity, values, and ideologies. Healing starts from the use of empowering ways of imagining an identity. The project of meaning making of the reflexive and embodied identity with its material expression through a perfect or flawed body is one that is grounded in imagination, a discursive visualization, which contextualizes the body/self in relationship with a world to imbue with purpose and agency its interactions with its elements. Art provides the vocabulary to channel the use of language, imagery, and symbols that employ tactile sensations of objects to transfer their meaning to non-material inferences and internal states such as character (toughness or sentimentality) or mood (joy or sadness). In the contemplation of the work in relationship with its conceptualization of the human body, healing is constructed through the process of giving meaning to the experiences of the different states of the body.

Even as art gives meaning and form to these relations of body/self, it provides a context for the individual to experience the spatiality of these relations in a unique way within the individual's own surroundings. Interrogating the relations of the self with the lived objects, spaces, and natural environments can

be an empowering act of release of the limitations imposed by long-term disease and pain. Through the tools of embodiment and introspection connected with meaning making of body/self experiences, art provides a way of examining unique and individual meanings of health and sickness. In constructing these meanings of health and sickness, art provides a way of approaching the body through the perspective of its primordial, pre-reflective relationship with the self. An examination of the body/self relationship through art emphasizes an awareness of what the individual sees, thinks, believes, imagines, or conceptualizes the body to be, in relationship with the objects and spaces of its lived environment. In so doing, it situates body awareness in relationship with its environment.

Art provides a way of communicating with the experiences of the self, in the moment of their creation, and thus, to speak with the temporally-grounded, present body. Embodiment foregrounds the individual's experiencing of this lived environment through the body in empowering ways. Understanding the act of experiencing with the mode of sensory and mental interrogation that makes the first connection between the biophysiological body and the subjective experience of the objective environment is to engage in a symbolic transformation of its meaning. Thus, the embodied self constructed through art is guided to channel and explore individual understandings of imagination, representation, and their relationship with the processes of engaged meaning making situated in the moment. These connections and understandings are relevant to the idea of healing in ways that construct wholeness through the debilitating and disempowering experiences of living with long-term chronic disease and pain.

BEING/BECOMING EMBODIED

In the above discussion on art, perception is examined as occupying a pre-reflective and pre-verbal space. Perceptions are a temporally grounded construct of the mind, framed by prior experiences and oriented toward future expectations. As an embodied entity, bodies construct and are constructed by the meanings of thoughts and feelings as these evolve and are imagined in relationship with the environment. From the perspective of the phenomenological reflection on perception (Merleau-Ponty, 1945), the embodied self, in its act of being continually, dynamically involved with the world, is situated in an active engagement and exchange of perceptions with the objects of its interaction. Healing is a process presupposing a beginning and an end. Rather than imagine it as a process related to illness and disease, the idea of con-

structuring healing as a process through art broadens imagination of the body/self in relationship with the context of its actions, desires, and motivations.

For poets, writers, singers, and others in the artistic fields, the embodied self foregrounds materiality through the body; thus, communication that facilitates embodiment is central to the project of healing. Communication that facilitates embodiment puts the human experience center stage in a way that transforms it and gives it meaning that does not directly connect with its temporality or materiality. For bodies in pain, such a capacity for transformation can be healing beyond treatment. Healing supported through embodiment empowers the individual to imagine their identity in integration with their material bodies, but not limited in its capacity for expression of the self through the limitations of its material self. Foregrounding the embodied self also recognizes the presence of the self in context with its relationality with others. For instance, Williams (1984) explored beliefs of why people thought they got arthritis to understand the embodied experience as a narrative reconstruction of their changing relationship with the lived world and the genesis of illness within it. It's a recognition that actions affect the individual as much as they affect their relational others. Accordingly, it is a recognition of an accountability attached with those actions such that actions have the potential to help heal or harm. Communication that facilitates and supports the embodied self cultivates a recognition that why we do something has a more subtle but equally important effect. In other words, it is a recognition that intentions, hopes, and fears that underlie behaviors and actions constitute the individual in more fundamental ways than the consequences of the actions themselves.

Art and Healing

The realm of art delves into reflections of hopes, goals, aspirations, and fears through the language of imagination and representation. Facilitating healing through art in the management of long-term illnesses that are debilitating and involve lifestyle management along with continuing treatment is empowering in its intersection with individual agency and relationality. Such healing fosters a project of imagination that can be understood through the perspective of actions, behaviors, words, language, and its constitutive enactment across the different spheres of the lived experience. From this perspective, intentions are not merely situated in an attitude-norms-behavior driven framework, but comprise a richer, more deeply integrated realm of consciousness that is enacted through the body.

Herein, intentionality is the dialogic engagement of the individual's consciousness with the environment wherein symbols and discursive representations are secondary derivative expressions that mediate the body's

relationship with the environment. Such embodied experiences that relate the body/self in empowering ways build a sense of wholeness that is disrupted in long-term chronic pain experiences. Wholeness approaches the ability to construct healing as it can be supported by the individual themselves considered in alignment with or independent of parallel medicine or intervention-based treatments in the management of chronic conditions. In individual treatment protocols. In providing insight and support for individuals, their caregivers, and allied health care professionals involved in the long-term management of chronic conditions, the approach on wholeness can address gaps related to human quality of life, empowerment, and self-fulfillment in the biomedical focus on preventing or modifying disease trajectories in the human physiology. Wholeness considers healing as an exercise that begins before, and continues through, any events or conditions that affect the human body. Thus, wholeness has a parallel, preventative focus that can be especially relevant to addressing the chronic illness management domain.

As a preventative approach, wholeness interrogates healing through the lens of health and disease, rather than address health and disease, and its treatments, through the lens of healing. Its fundamental goal is not to offer an alternative to medical approaches or to provide guidance on treatment for different health conditions, but to develop an understanding of individually centered healing that can support, but is independent of, physiological conditions such as health and disease. Health may be supported by biological markers; healing does not have to be. The embodied self can support the relatedness of health and healing, and it can also cultivate the agency to maintain the two as independent facets of each other. An interrogation of health will consider the human physiology and its optimal functioning. An interrogation on *healing*, on the other hand, emphasizes the relationality and engagement of feelings, thoughts, imagination, and language, and how their engagement with physical and imagined objects can bring together the cognitive, the physical, and the affective, in a form constituted of ideas, in a realm where form and disciplinary discourse fuse as a process (figure 4.1).

A few important insights regarding embodiment can be drawn from this discussion. By situating the body as the primary mode of expression of healing, the embodied self prioritizes a pre-reflective perception and form of experience. Through experiencing, first and foremost, from our bodies, we (re)learn the meaning of perceptions as syncretized experience (e.g., color, sounds). Emphasizing the embodied nature of the perceiving subject, Merleau-Ponty's work (1945; 1974) centers on the unity of the subject and the object. For Merleau-Ponty, experience is embodied, and the body-subject goes beyond physiological functioning at a biological level to be understood as a complex web of culturally mediated embodied encounters with the world.

Likewise, individual experiences are also projected on objective objects and forms, bringing the inner and outer worlds together.

The reflexive self presented the argument on cultivating self-reflexivity in the therapeutic relationship in order to bring an awareness of oneself in the health care encounter that is informed by ways of seeing ourselves in expansive ways. Healing is the embodiment of personal meaning of health and the location of our existence in our world. As scholars of art note, art brings the body back to its primordial aesthetic experience as a means of affective contact with the world, in response to which we open ourselves up to metaphoric meaning to inhabit the world. Art enables a healing imagination by making visible the movements and mechanisms of daily actions as situated in particular time-place-space modalities, while considering the composition of material (social and cultural) and bodily practices (e.g., gestures, movements) as these go through the processes through which concepts are formed (Hutchins, 2008).

Spatiality and Healing

Considering healing within a body positioned in a spatial context provides the individual with the language of movement and boundaries, and an ability to embody these with the experiences and meaning making. Given the centrality of the body's relations with the environment in constituting the lived experience, attending to the spatiality of embodiment can provide useful insights in constituting wholeness. Constructing environments that frame us in alignment with our inner values, embodying the individual's vision of health as harmony and balance, provides a means to embody healing in external spaces and lived environments. More importantly, such exercises help envisage healing as the alignment of boundaries between the internal and the external, and to see both as spatial embodiments communicating the idea of healing. Patients with chronic pain often note the fracturing of the inner experience of pain and debilitation as disrupting their ability to sense and relate with their lived spaces (Agarwal, 2019). Through CAM practices, when the inner/outer spaces are opened up to each other such that the individual is able to sense and navigate their way through their environment with ease, the experience of chronic illness is qualitatively changed. Constituting wholeness through shaping spatiality in the chronic pain experience implies recognizing the perception and alignment of the inner/outer values with spatiality. Space is imbued with values and norms, even as it symbolically and pragmatically engages with their spatial experience in the perceptions of openness, feelings of belonging or alienation, of tactile integrity, or of disruption and conflict.

The embodied self recognizes the connections between the built and constructed environment. These environments allow us to situate the lived

experience in sensory and kinaesthetic ways, allowing for positioning individual lives and meanings as they are in dialogic engagement with the real, felt, and imaginary representations of their form. It is imaginable, then, that a space seen as healing, helps, in turn, envisage the idea of healing through the relationship of movements and usage engaged with the objects and boundaries that define it in predictable and unpredictable ways. Spaces can spur dialogue with the body/self relationship through an unexpected, quixotical, or unpracticed way of moving through space, using space, or being in space. The project of constituting wholeness is one of exploring the unexpected, of being free to evoke the imaginary into being within the spaces of existence.

Chronic illness and pain constrain the perception of lived spaces (Agarwal, 2019); engaging space to be liberatory opens up the relationship of the fractured and isolated self with the body in pain. Expanding spaces of doing, being, and imagining is empowering for bodies that are walled off in fear of pain. Space, from architecture, is considered as both a displaced and displacing medium, a fluid and boundary-effacing medium that structures our experiences. By expanding and nurturing the ideas of wholeness in individual and tailored ways, space can be imagined as a means for a very personal and intimate conversation on healing, one that is predicated on how the body/self relationship is iteratively (re)structured in an approach to the construction of its lived spaces.

As the body/self relationship is framed by space, the body/self relationship also frames the lived spaces in a dynamic, dialogic relationship. Perhaps a better way to approach the healing dimension of spaces is to ask the question: how can an individual embody a space to understand its central imperative and thus, in turn, to begin to shape the space in ways that support the alignment of individual body/self relationship. In doing so, the interaction with spaces can be approached deliberately, encouraging the individual to reflect upon their own identity and values and relating with their manifestation in the spatiality of their lived spaces. Chronic illnesses disrupt the ability to reflect upon the body/self alignment in meaningful ways and impede the individual's ability to construct their identity in empowering ways.

Space can be a powerful material medium in supporting the dialogic self/body relationship. The healthy body's relationship with space is partial and functional. Most often, the movement through lived spaces is a factor of dependability, functionality, and practicality, one focused on avoiding objects and perceiving them, but not relating with them; of observing them, but not being in dynamic or active engagement with them. However, constructed with care toward the individual's unique intentionality, body/self relationship, and goals, the objects and spaces in their material expression can be contemplated, even in their functional imperative, to provide a way to reach

from one point to another or to fulfill a specific function (figure 4.1). However, in thinking about spaces in a merely functional way, we discount the fundamental relationality of their external, environmental dimension with our body/self. Spaces cannot, and should not, be taken for granted as passive presence around us through which we navigate our lives, mostly in a utilitarian, functional, or pleasure-seeking manner.

Consider an illustrative example. For instance, I might go around a coffee table placed in the center of my living room in order to reach the window on the other end. I might extend my hand to place my tea cup on a coaster next to my seating arrangement. In all these mundane and routine actions, the spaces and objects that define my space are reduced to functional attributes, in a passive and unitary relation with my senses of sight and touch. I might get some pleasure from admiring the table lamp I bought at an art fair. I could take pleasure in its form, its aesthetic presence, or even, as the first half of the chapter on art discussed, in its representation of a specific symbolic attribute. Each of these movements should be supported by spaces designed to promote reflection, body/self expression through action but also, more deeply, contemplation of the relationality and connectedness between the body/self and the environment. In turn, such relationships support wholeness as a form of communication between the external and the internal, and the alignment of the two.

Yet there is more to spaces that remains unexamined if we stop at this point. Architects, for instance, think about spaces in different ways that may include but go beyond mere functionality and movement through space. Several scholars from art and architecture provide an interesting foray into spaces that I would like to take a moment to connect with the idea of healing. Let's start with one instance. Museums and art galleries employ the embodiment of material and abstract in communicating an idea in a tangible, actionable manner particularly well. In looking deeper at the relationship between the body/self and the environment, the example of creative practices highlights how the space in a gallery is in a delicate interaction with the presentation of art and its construction for the audience as a meeting place. Thus, environment is embodied, not merely functional, and in promoting wholeness, it presupposes a living and dynamic human interaction, one that is not passive, functional, or merely utilitarian.

Drawing upon Husserl's phenomenology (1893–1917) helps in constructing a critique of embodiment in more complex ways. For Husserl, the body is the essential center from which we embody our lives, and the body in its materiality and ideation is both an enabling agent in encouraging us to imagine ways through which we can explore a greater degree of possibilities, and a limiting agent, when calling attention to its dysfunctionality. In mapping the array for such possibilities, Husserl proposes we extend our natural-scientific

presuppositions, reflecting upon them in particular as they apply to embodiment. Husserl examines a subjectivity that is embodied in and of itself, rather than through the body. For Husserl, in his phenomenology of embodiment, the body is a center of experience, but also, in a related sense, an embodied agent through which we relate with other embodied agents within a shared lived space of a coherent and ever-explorable world. This imagination project holds the potential to use community spaces and lived surroundings as a mode of creative expression in individual ways.

Responding to and contemplating these spaces can open up people in chronic pain to spaces beyond the body, and support body awareness and acceptance (Agarwal, 2019). Husserl's line of thought takes embodiment to its purest form—to encourage an imagination of the body as pure experience by an embodied experienter. In some ways this allows the body to be experienced as a spatially extended form governed by causal laws, much like the physical inanimate world that we inhabit through our experience, and whose objects and arrangements we embody with our feelings. Likewise, embodied personhood emphasizes the communal experiencing of situations, gestures, and activities in ways that gives them meaning to emphasize the personalistic attitude that focuses on personal and social experience in the world of everyday life and the cultural world of the human sciences. Herein, our intersubjective encounters are experienced as embodied, and our lived encounters are, first, and foremost, embodied.

This underscores how individual actions are enacted as embodied, without conscious attention to their underlying neurophysiological processes. In the social sphere, actions are defined through the social norms that define us, the language that we use for communicating, and our behaviors. These norms guide individual interaction with embodied others, and not with material, objectified others animated by minds. This embodied communal experience constitutes the foundation of the collective social experience, community, and society. Physical limitations (e.g., due to injury or chronic illness) are, from this perspective, as much subjectively as objectively experienced. Thus, even as scientific constructs inform our embodiment, the primordial embodied experience of the body/self and body subjectivity stays intact.

On another front, this implies that for scientists themselves, their own lived embodied experience serves as the tools of perception, communication, evidence gathering, and examination of their own analyses. For Husserl, the lived body grounds experiences, whether tactile, emotional, spatial, or kinesthetic. By making the body the center of experience as a mode of inquiry, phenomenology enables modes of inquiry that interrogate embodiment in profound yet everyday ways. Thus, the embodied experience from one individual's point of view forms one center for experiencing a structure

of possibilities. This experiencing of one's own experience comprises sensations perceived within the body as well as on the body and can be described as a relational body/self awareness of one's own sensations. Likewise, the ability to undertake action is a central feature of embodiment, where the self is explicitly involved in initiating and directing the action and exemplifies the body/self relationality of an embodied self in space.

EMBODIMENT IN/AS HEALING COMMUNICATION

As the previous discussion with art and spatiality suggests, the embodied relationship with the objects and spatiality of the immediate environment can be central to understanding and guiding the healing process. The final section of this chapter examines how the body/self defined by chronic illness can employ daily relationships enacted within routine engagements and structured through lived spaces or represented in culturally mediated forms to constitute healing. We experience our feelings and conduct our actions as embodied entities. Within the same logic, examinations of embodiment have extended the phenomenon to related contexts such as knowledge generation. Gieser (2008) points out how embodied knowledge is cultivated through the practitioners' own engagement with their environment and situated social relationships, through fine-tuning their perception through observation and imitation, in ways that transfer into shifts in one's own perceptions (Ellingson, 2008).

The process of healing is a step toward starting the journey to wholeness. It means understanding both health and healing as two distinct constructs, one where health is central, but not a necessary condition toward being healed. The discursive exposition on interdisciplinary perspectives makes sense if we consider healing distinct from the goals and epistemological boundaries of the medico-biochemical-pharmaceutical standpoint with its emphasis on a depersonalized critique of health as an objectified, commodified, and standardized practice (Timmermans & Almeling, 2009). This conceptualization of health in modern medicine is certainly an important part of the healing conversation; however, healing is constructed in this book within the framework of becoming whole and health is examined within that frame of reference. In the embodied self, art and architecture are positioned as entry points to examining how embodiment is central to understanding the body/self in relationship with the sum total the individual experience. In line with its social constructionist approach, the following chapters explicate different dimensions of lived experiences to tease out their relationship with the body/self and the construction of wholeness as a step toward healing. These experi-

ences are a construction of, and in relationship with, the healing journey that is central to integrating with the chronic illness identity.

Each of us, sick or healthy, able or disabled or differently abled, is on a journey toward health and healing. The construction of normality in health assumes an interpretation of normality and an implicit assumption of a normal range. From a poststructuralist standpoint, embodiment can help explain how the subject—in this case the healing subject—is constituted as normal. Foucault (1972) maintained that norms are situated within discourses and operate in implicit ways within normalized discourses. Although Foucault never addressed experience and embodiment from a phenomenological perspective, several critiques have sought to place Foucault's thought in parallel with Merleau-Ponty and Husserl to conceptualize the human body (Wehrle, 2016). Critiques placing Foucault's thoughts on norms, normality, and discourses in relationship with embodiment have drawn upon the idea of how cultural norms help shape our perspective on the world (Wehrle, 2016). Such critiques also consider how we perceive and are affected by the world, situating this influence from the earliest of stages of experience, where embodied experience starts, in passive ways. These passive experiences allow for norms to be inscribed in the body. This constitutes, from a Foucauldian poststructuralist standpoint, what can be understood as normative embodiment.

Culture and embodiment have been examined by Durt and his colleagues (2018) as well. Their examination of embodiment and intercorporeality is set against the role of intersubjective sociality with reference to culture. These scholars start from lived embodiment and develop a first- and second-person account of embodiment in relationship with and constituting culture. Examining consciousness and culture by investigating their relation to significance is important in extending embodiment beyond phenomenological aspects and culture beyond thick descriptions. Consciousness discloses aspects of significance, while culture covers shared significance and behaviors that enact significance. In choosing how conscious experiences are constructed within the realm of imparting significance to specific forms of experience, knowledge is embodied within a normative cultural framework to provide it meaning and a way for actualization. In healing, it is important to consider how the engagement with objects and symbols located within the culture illustrates how significance and meaning is assigned to specific practices, objects, or ways of being. In this relationship of significance and meaning making, intersubjective experiences are constructed as a dialogic engagement between individual consciousness and its culturally mediated encounters. The intersubjectivity both constitutes the individual experience and provides a way of being within this framework.

We assign significances to our experiences at every lived moment of our lives, in conscious and subconscious ways. The process of assigning significances to our experience is to assign a whole meaning to it in engagement with its parts, and in turn to be assigned meaning within its framework. Interestingly, Durt et al. have sought to understand how each of us interacts uniquely with different forms of communication and cultivates unique styles of social understanding to make different forms of meaning making. Embodiment enables the evocation of the concept of body memory as comprising the implicit memory.

Fundamentally, embodiment is mediated by the body and actualized without explicit intention in the lived experience such as in habitual behaviors, habituated perceptions, and instrumental skills or behavioral and cultural habits. The body/self and its relationship with embodied interaction occurs within this context. Within the micro-universe of each individual experience, the individual definition of normality is assigned and shapes engagement with this larger environment. Embodied interaction, when considered in engagement with objects and symbols and seen as situated within a culturally mediated context, considers the body/self in dialogue with its meaning in relationship with individual identity, and to assign meaning that is unique to the interaction with the lived perspective as these construct a world that is unique to the individual. Foregrounding this world in healing helps construct what is normal in a tailored way, within the realm of significances and consciousness that permeates the interactions and relations occurring within this context. Healing, then, becomes a project of re-envisioning normal within the individual's own intersubjective, unique, idiopathic, and eclectic worlds. This helps in envisaging healing as a journey that is individual as well as collective, both a project of art and imagination on the one hand, and spaces, movement, and boundaries on the other.

EMBODIED CONTEXTS AND HEALING COMMUNICATION

Embodiment is gaining traction in medico-psycho-social literature. In part, this is due to the acknowledgment of a gap in the project of health, and of delivering health to a normative human body situated within the logic defining a population-based imperative. As a macro-interpretation of a human society this makes sense as a starting point, but only takes us so far if taken to be a complete argument for health and healing in and of itself. As we reach the limits of this logic, we find that although we thought we had achieved health-related outcomes, we did not *feel* healthy. If asked, we might agree our body was in a state of health if we did not have a disease diagnosis or if we were

not actively under medical treatment for a disease. However, even so, we are plagued with a nagging suspicion of not entirely being sure we understand what it means to be healthy and if, in the absence of disease, and being of sound mind and spirit, we really are healthy in the fullest way that a human being can embody health. The health care context provides many instances of physicians and nurses addressing the human condition beyond its biochemical manifestations. I consider some of these instances in some detail in this section to illustrate the connections between healing and embodiment and to situate this within the framework of delivering health care.

For instance, in healing, Ray (2006) examines an exemplar case illustrating the importance of clinicians attending to embodiment and embodied engagement in traumatic clinical situations. Ray contends that by promoting listening and responding to embodied sensations, perceptions, and feelings, embodiment and embodied engagement offer a way to understand the experience of trauma. Ray's research highlights the need to explore the meanings associated with traumatic events using the lens of embodied approaches to encourage reflective practice. The findings highlight the importance of integrating the embodied experiences of both the nurse and the patient for healing to happen. Here, healing is a process of reflection, of feeling with a whole body, of providing care within the recognition of an interactive, relational space constructed by the provider and the patient in dialogue with each other.

The healing process involves learning the ability to engage reflectively with our experiences. However, just engaging with experiences is not sufficient to constitute healing, even as it may define the start of the healing experience. Healing occurs in the journey from engaging to sense making to constructing experiences and assigning them significance and meaning. These experiences can be understood as healing only if they come from a space of individual meaning making, the space evoked by the artist or constructed by the architect that goes beyond functionality and utilitarian criteria of normality. From a psychological perspective, the following study serves as an exemplar for current understanding of and conventional research approaches into an arguably experimental premise. In this exemplar, investigators Taylor, Lord, Bond et al. (2009) design a study to evaluate attitude embodiment effects. They define these effects as occurring when the position or movement of a person's physical body changes the way the person evaluates an object.

In other words, they seek to capture embodiment from the perspective of attitude, or how an individual's attitude toward an object shifts in spatial relationship, such as one of movement with respect to the object. The idea of attitude embodiment has been discussed extensively in the field of psychology. The basic premise of this concept of attitude embodiment is that the body and its functions such as movements, gestures, expressions—the entire domain

of physiological and affective communication—is a form of agency in and of itself that shapes how the individual relates to different objects and messages as forms of persuasive communication. This field of research illustrates healing and its connection with embodiment as a cognitive and affective construct. It presents healing and embodiment as related intimately with each other. Likewise, social psychologists explore embodied perspectives as they inform thoughts, feelings, and behavior in relationship with the lived environment. Different areas of investigation, from vastly different perspectives, note that embodiment connections go deeper than the individual imagination.

We are our bodies in ways that are more significant than the awareness of the identity and the body/self. At the same time, the individual is in a deeper relationship with the environment and its expressions that surround, co-create, and construct us than was ever thought possible. Each of these micro-relations has the potential to heal and is a significant component of how a healing relationship is constructed in the lived context. Healing, as a process of rediscovering wholeness, of embarking on a journey that takes the fractured body/self from a state of incompleteness to one of engaged, informed, and aware wholeness, is not ultimately connected with being a particular type of body, communicating a particular type of personality, or being classified within a particular type of health condition.

Healing centers the body/self and its mutual expression, as they define, and are defined by their relationship with the environment. To the extent the individual can guide and be aware of their agency, intentions, voice, and beliefs in their mutual expression materially and discursively, healing connects with the physiological processes of health and disease. Increasingly, the relationship of body/self expression and its alignment with physiological outcomes from the field of neuroscience has provided evidentiary links between discursive and material communication processes and outcomes. Neuroscience has made significant advances in this area toward explaining the mechanisms through which actions that connect the body, mind, and behaviors occur. In one such study researchers Lopez et al. (2008) examine body ownership and embodiment as two distinct but fundamental mechanisms of self-consciousness. By reviewing neurological data about paroxysmal illusions, the researchers find that feelings of body ownership and embodiment shift with the individual's ability to continually integrate and process information coming from their sensory and proprioceptive cues.

Neurological processes shape how the body continually engages with the processing of cues drawn from various inputs obtained through the body. These cues, when not processed fully, lead to what the study classifies as paroxysmal illusions, which include out-of-body experiences, autoscopic hallucination, and feeling-of-a-presence. Neurological research highlights the

ways in which the processing of lived environments is intimately connected with the body's physiological processes informed by neuronal networks. Such research provides better understandings of the mechanisms by which spatial and environmental elements relate with body/self processes and their integration in constructs such as embodiment.

When relationships with the body ownership, embodiment, and sensory cues are disturbed or impaired, it leads to a disintegration of bodily information processing and altered feelings of body ownership and embodiment. Our engagement with the environment is vital and dynamic, individual and unique. It is based on physiology and on the neurological interpretation of signals and cues. These elements are a vital component of our embodiment, and play a role in situating our embodied experiences in healing relations. Such research suggests that as agents who guide our sensory inputs, however micro perceptual, being aware of our relationship with our bodies in dynamic interaction with our environments is a vital step in the constitution of wholeness. The processes of the reflexive self as presented in the previous chapter support our awareness of the body in interaction with the environment.

Thus, self-reflexivity has an intimate relationship with the idea of the embodied self. To understand healing processes more fully from this perspective, van der Riet (1999) looked at cultivating healing through introspection and behavior. van der Riet (1999) approached healing from the perspective of Mezirow's model of transformative learning in adult education. Mezirow's model of transformative learning posits that transformative learning includes the constructs of discrimination, reflection, affective ability to change, inclusivity, and openness. Healing mechanisms of self-reflexivity exert their clinical effects through specific mechanisms. This study draws upon critical reflection as it alters the cognitive schema underlying an individual's perspective on a subject in leading to behavior change. The transformational model provides evidence of perspective transformation from a constructivist approach to how social structures and belief systems can shape learning, particularly in the context of dilemmas that challenge the validity of pre-existing values (Christie et al., 2015), and suggests how intentional introspection to improve behavior can achieve desired outcomes (Rosenberg, 1990). Such connections provide further insight into illuminating how self-reflexive communication supporting reflection along with discrimination, emotional stability, openness, and inclusivity can help with the healing process.

Healing communication supporting self-reflexivity and embodiment constructs wholeness as body/self integrity in its lived contexts. For instance, holistic care approaches in nursing often view the process of caregiving as a personal endeavor, attending closely to personal growth alongside health care outcomes. Ellingson and Borofka (2020) provide an insight into the

lived experience of cancer using a critical embodiment lens, describing the embodied experience of chronic late effects of treatment through the themes of bodies-in-relation, bodies entangled with biomedical actants, and dynamic embodiment. Research from nursing practice and education for patients with colorectal cancer provides another interesting perspective on examining embodied body/self experiences. In the context of cancer care, similar to the chronic care continuum, long-term survivorship is challenged by body/self disruption and loss of quality of life. In this context, Ramfelt and colleagues (2002) explore the meaning of illness as constructed through an emotional and interaction-based framework. The meaning of illness, they find, lies in achieving emotional coherence through what they label *unified embodiment*. Unified embodiment is characterized by hope and faith, a strong self-value, and an anticipated future. Conversely, dichotomized embodiment is characterized by struggle, loss of temporality, nonmovement, and lack of hope and faith.

Following the argument on wholeness developed in this book, emotional coherence supports wholeness by aligning the meaning of illness with a sense of unified embodiment. The embodied self, as constructed in this chapter, embodies coherence in conceptualizing patient care, particularly in those professions that seek to heal others, are more concerned with health and healing in professional settings, and are in more immediate and direct praxis-oriented contexts.

Patient-centered care promoting wholeness thus emphasizes body/self integration through connecting values, openness, and inclusivity with temporality, and faith. The need to attend to patients' embodied knowledge, for instance, has been emphasized in communication initiatives seeking to encourage patient participation (Kirksey, 2017). The processes of gathering information in patient-centered care (Epstein & Street, 2011) can be conceptualized as an embodied encounter (Agarwal, 2018). Focusing on the communication-centered information gathering and giving processes in patient-centered care envisaged as a whole-person project, understanding qualitative approaches to the researcher-subject relationship can provide further insight into embodiment. In qualitative research, the relationship between the researcher and the researched, or the subject/object relationship in the knowledge domain, can be structured as a complete relationship through the lens of embodiment. In an interesting foray, researchers Sharma et al. (2009) look at researcher embodiment as including the role of religious, spiritual, and cultural plurality in how researchers construct emotional and bodily ways of knowing and experiences of difference such as culture, race, and religion as embodied experiences. In doing so, the examination of healing and embodiment in relational encounters expands beyond the individual sphere to the domain of a multifaceted, multilevel endeavor that can potentially include a range of

roles and positionalities. Central to the understanding of wholeness from the perspective of the embodied self is the sensory experience of the body in static or dynamic states, being still or moving, in relationship with objects and space, in alignment with its own emotions, or in its engagement with caregivers and learning contexts as they promote healing.

By moving across disciplinary silos and integrating different constructs that have been examined through discipline-specific ways, the overarching meaning of healing as it constitutes wholeness is constructed through the idea of integrating, bridging, and informing the body/self alignment in different contexts. Neuroscience, social psychology, and phenomenology have each contributed valuable insights that enrich understanding of the multi-level relationships between embodiment and healing, emphasizing how understanding healing as a way of being is central to illuminating the enactment of behaviors on a day-to-day basis. Researchers who study the perception of the movement and position of the body from a physiological standpoint, or proprioception, have been interested in the physiological structure of the consciousness experience to enhance understandings of the body/self constitution in the healing experience. This approach intersects with that of phenomenology and philosophy. As an instance of one of the studies that employ this approach, Longo et al.'s (2008) research into the structure of conscious experience emphasizes location and agency in proprioceptive biases. They approach phenomenology from an empirical perspective in interesting ways. Taking a psychometric approach, the researchers examine what it is like to have a body. Their study finds the components of ownership, location, and agency were central to the experience of having a body and predicted the proprioceptive biases of individuals as it shaped the structure of conscious experience. The understandings garnered from such studies can be informative particularly in considering the patient role.

The relationship between patient embodiment and decision making in health care was further illuminated in an interesting finding by researchers Lende and colleagues (2009). These researchers delve into data suggesting that African American women don't undergo breast cancer screening as often as other races, leading to higher mortality. Besides the risk factors and socio-economic aspects, the researchers' findings take an interesting turn by illuminating the embodied nature of decision making that underlies their choices. The researchers employ embodiment in a public health context to understand the nature of the relationship of the women with their own bodies. They find that embodied understandings of the body also play a role in women's decisions regarding screening and treatment. These understandings of embodiment impact healing as a way to approach wholeness, an argument put forward by this chapter. A more well-trodden path in the literature on

embodiment has focused on the idea of suffering and healing. The literature here, which comes from religion, spirituality, or psychology, lends itself well to the chronic pain context. Drawing out the distinctions between suffering and pain help illuminate the chronic pain experience. Suffering as subjective pain perceived from a lack, a denial, a sense of incompleteness in an area of the individual's life, is often placed conceptually in opposition to healing, which, in turn, is posited as a cure for addressing suffering.

The approach on wholeness argued for in this book does not define wholeness as a lack of any other construct such as health or disease or suffering. The book has argued that a lack of something can be understood as a negative, a gap, but healing is a project that approaches wholeness on its own terms, whether from an individual or a social perspective, and with or without pain, disease, or suffering. From this perspective, disease and ill health occupy a shared ground with health, healing, or suffering, but the idea of wholeness is not predicated on any one individual construct. In other words, the book puts forth the premise that it is not necessary to envisage the possibility of being sick to be able to conceptualize the possibility of health. Therefore, just as disease and ill-health is related with, but not central or inevitable to, the idea of healing, suffering can be related with, but is not central to, conceptualizing the idea of healing.

Suffering can and has been examined from a health care perspective. These examinations suggest useful insights for both suffering and embodiment in clinical practice, particularly in the domain of patient-centered care. From this perspective, embodiment can inform what it means to be healed, and how critical reflection, for instance, into the other's experiences in a biomedical context can lead to better provision of meaningful health care (e.g., Radley 2000). If we understand health and disease as not predicated upon each other for meaning making, we begin to understand health on its own terms, and the idea of healing and being whole even in the presence of disease or suffering. In epidemiological terms, examination of embodiment generates a consideration of genotypes, an environment (such as the genetic environment or an external environment) that connects the internal to the external (such as through gene regulation and expression; e.g., Krieger, 2005). Understanding human beings as being simultaneously social and biological organisms, the notion of embodiment explored in the epidemiological context advances the claims that the body tells stories that are intertwined fundamentally with the individual's existence, that some of the stories our bodies tell match other people's stated accounts, but not always, and that some of the stories that our bodies tell are those that people cannot or will not tell, maybe because they are unable, forbidden, or choose not to tell. In all these renderings, embodiment is a project of the stories our bodies tell, a compendium of narratives

that relate temporally and contextually, the state of the individual's health with their experiences.

In positioning this epidemiological work on embodiment alongside healing, the connections with science and social equity become more apparent, especially as embodiment positions bodies as active and engaged entities. To illustrate, from an epidemiological point of view, the process of engaging in a temporal transformation of bodily characteristics is an active and dynamic means of engaging with the world. All bodily engagement employing embodiment is conceptualized as a deliberate act undertaken by conscious agency. However, interestingly, these perspectives make a useful distinction in the realm of decision making and agency between choice and conscious choice. Here, conscious choice is understood as choice made by the individual with awareness of psychosocial risk factors and in an embodied manner.

Such distinctions lead to interesting questions of what bodies do and what bodies experience within intersections of what bodies say (such as the stories bodies tell, Charmaz, 2002). The epidemiological literature, in considering embodiment, moves from the biological to the shaping of the biological through exposure to the environment. In doing so, the epidemiological literature moves from a disembodied to an embodied study of human culture, behavior, and emotion, situated in an understanding how these factors have an impact on our health through shaping how we experience the phenomenon of living in our bodies. For example, epidemiologists will be interested in embodiment and health from the perspective of being interested in how the use of language, consumption of food, and enactment of sexual practices and identities influence our health. In the development of wholeness, the argument presented in this book posits that healing and embodiment are intimately related. Embodiment provides an antonym anchoring the otherwise disembodied understandings of genes, minds, and behaviors by grounding them in subjectivities and providing a constructive, integrative approach to epidemiology. In other words, embodiment is how we discern meaning from the critical aspects of the conditions of people's lives from the stories their bodies tell, inviting us to position the interpretation of what is spoken in such contexts in light of what is hidden or denied, and pushes us to provide evidence for self-report and other accounts.

In conceptualizing the whole body, the assumption that a whole body is also an integral body, a body that perceives itself as an integrated entity, helps build the argument that health is important to understanding healing but not necessarily a germane condition for being healed. The embodied self further develops the ideas constructed in the reflexive self to position healing as a complex, multi-level concept. Embodiment can thus be understood as an intersectional phenomenon constructed at the borders of the body narrative, of the materially defined components that comprise the body, and of the

situatedness of the constructed body in its lived environment. These distinct perspectives bring together the neural pathways, care pathways, and narrative pathways into understanding health and its deeper constitution through the biological, social, cultural, and sensory components. Central to the wholeness approach, the embodied self invites a consideration of connections between these distinct perspectives in constructing understandings of human experience and healing. For example, considering the embodiment of social conditions and its relationship with healing will make a meaningful contribution in the rehabilitation of chronic pain patients in empowering ways that connect with their narrative constitution of self, of relationships as centered in community norms and values, and the temporality of their illness trajectory. The later chapters in the book consider some of these elements in constructing wholeness, highlighting how the journey toward embodied understandings of the self in healing is both uniquely individual and highly subjective.

Embodiment is central to the idea of healing. In taking a social constructionist approach to healing, the chapter has developed deeper understandings of the embodied self by understanding our bodies as our home. It has conceptualized our bodies as the foundational base from which we understand, perceive, and make meaning of our situated experiences in the world. While health or suffering may describe the state of its being at any point of time, our bodies are always on a journey of healing. In order to illustrate the overlapping meanings of healing and how these multiple levels connect and intersect, *the embodied self* developed an argument for embodiment as a component of wholeness by delving into art, anthropology, architecture, and medicine to understand the intersecting ways healing can be conceptualized as embodied. Each of these perspectives illustrated how embodiment was constructed, relational, dialogic, and subjective.

Healing is a pre-reflective, pre-verbal process. We are not always born healthy, but we are always born with the capacity to heal. The argument in the embodied self describes how, first, art provides us with the tools to rediscover a pre-reflective, pre-discursive mode of communication with the self. Art provides us with the space to speak with others and the world in ways that enable us to visualize a unique subjectivity, to unite the subjective with its own pre-reflective state and thus to help construct healing. Second, by critiquing how spatiality can be related with as an embodied state and how the meanings of spatiality provide a unique context for healing, the chapter has sought to situate *the embodied self* in the material space of its environment. In doing so, the embodied self asserts that the body/self relationship as it shapes the experience of the world can be spatially managed. We live in our bodies and our bodies exist in space. The lived environment of our homes and communities, and our health care settings constitutes examples of spaces that are traversed by the body.

The embodied self, critiqued through spatiality, constructs arguably one of the most primitive and primeval relationships of the human condition. Space is central to healing. The idea of space, how we constitute space, how we use it, how we see ourselves in relationship with space, and how we make meaning from space, illustrate how spatiality and embodiment are intimately connected with healing. Finally, understanding our behaviors and relationships as embodied expands ways of approaching population health, health care contexts, and health care relationships as healing and to tap into the potential of health care structures to construct wholeness through integrating an embodied experience. The next chapter develops the discursive body as constituted through subjective change. The notion of cultivating deliberative openness to the discursive body being constituted through subjective experience of change is proposed through the idea of vulnerability. In cultivating this openness to subjective change, the discursive body is situated in dialogic engagement with the embodied self presented in this chapter and the material body explicated in chapter 6.

Chapter Five

The Discursive Body

In this chapter, I examine the positionality of the discursive body in relationship with the reflexive/embodied self explicated in the previous chapters in the chronic illness experience. I seek to develop the constitution of wholeness by foregrounding embodied subjectivity, subjective change, and intersubjectivity in the discursive body. I discuss how a dialogic and relational perspective on the reflexive/embodied self enriches how we approach the management of long-term conditions in everyday life. In doing so, the chapter advances the ecological model of wholeness for examining the relationship between the reflexive/embodied self and discursive/material body. Focusing attention on the discursive body through a dialogic and relational framework enables an examination of how vulnerability and change intersect with daily experiences to constitute subjective well-being and intersubjectivity. Shifting away from the dominant focus on body in medical work such as medical interactions, particularly with respect to technology such as that used in diagnostic testing, and education as an anatomical entity, the chapter argues for a fine grained analysis of the relationship of the reflexive and embodied self at the intersection of the discursive and material body. In this chapter, I consider how the discursive body is constituted in subjective change, through its openness as presence in the moment, deliberative choice of vulnerability, and a (re)oriented construction of ownership and acceptance. I discuss the notions of intersubjective awareness, constructed difference, and embodied subjectivity that position the discursive body in relationship with the nature of its own experience of difference.

This chapter examines the individual subjectivity as it constitutes its lived experience, taking the lived body as its subject. I argue that this relationship is powerful in its constitutive potential to shape both individual experiences and their construction of the chronic pain experience. This chapter argues for the need to examine how openness to the unexpected in our subjective

constructions offer the possibility of healing as wholeness. How we organize our subjective experiences brings certain ideas and concepts into awareness, makes space for including others from the outside, and pushes others in the background. Drawing upon the social constructionist premise of the relationship of subjective time, traditional health systems, and the socio-cultural environment in dialogic engagement with the construction of the discursive/material body, this chapter explores what it means to open up to discontinuities and ruptures of each chronic illness experience through anchoring in the reflexive/embodied self.

Health, illness, and healing are a fundamental aspect of our existence. A baby cries when it feels uncomfortable or unwell. A child will tell its mother he or she feels hot or tired or uncomfortable. An adult will look for a way to address a headache. There is no moment that passes by when our state of health does not provide a foundation for our thoughts and actions, however consciously or unconsciously. The basic foundation of our lives evokes fundamental questions of our understandings of health and illness. Such questions do not just involve the body. Most of the analyses in the area of body and body work in medicine focus on how professionals examine and position the body, the organization of the body as a site of clinical activity, such as a body being acted upon, or acting upon another in a health care interaction. Because our physical bodies are connected with the mind, questions of health and the body are as much questions of the intersectionality of the body and the mind.

Seen from a biochemical perspective, the definition of health is fairly uniform and tied to understandings of the operations of the objective human form. Examples of such instances are manifold. For instance, some simple examples we encounter in our daily lives include having a fever, high blood pressure, or indicators in the blood profile that are over or under the normal range. All these criteria are a cause for concern to a greater and lesser degree and would well persuade us to get them looked at by our doctor to ensure we address any underlying imbalances. Yet there are other ways when our perceptions of being healthy or diseased vary based on individual, cultural, and social norms. We judge ourselves as being healthy or moving towards health by subjective, deeply personal criteria that often do not have a close relationship with biomedically defined criteria. In some cultures, health may be understood as a balance of health and disease. Healing may involve practices that reconcile health and illness in ways that achieve a balance of their manifestation. Other healing practices may cultivate acceptances and understandings of health and disease in a way that brings a balance of our approach to their manifestations in our lives.

Our bodies communicate our subjective experiences. Facial expressions, actions, such as gaze and gesture, and verbal communication construct our

health experiences in intimate ways. This is illustrated in studies showing how cancer patients reveal how their bodies make cancer visible with implications for provider-patient relationships (Beach, 2019; Ellingson, 2006). Supportive nonverbal behaviors in the physician-patient communication are also shown to modify subjectively rated pain, and these relationships vary by gender. In the case of men, high physician nonverbal support behaviors decreased subjective pain ratings and memory of pain whereas in the case of women, high nonverbal support increased pain ratings and memory of pain (Ruben et al., 2017). Understanding the discursive construction of our bodies as they go through various experiences has the potential to improve personalized care and health care communication.

Healing experiences are entwined with the values and ideals normalized in the complementary practice of health care (Sointu, 2013). Culturally based healing approaches are grounded in understandings of health, illness, and healing that incorporate social, cognitive, physical, philosophical, and medical criteria. Traditional healing approaches from different cultures call for the articulation of analytical frameworks that include but go further beyond individually centered biomedical ideas that anchor the physiological body. Scholars who have examined the intersection of the individual and the cultural in constituting health argue for a deeper and more comprehensive phenomenological understanding of embodied subjectivity. Understandings gleaned from frameworks that expand beyond cartesian and binary positions can pave the way for more nuanced understandings into the experiences of healing.

It is vital, then, to open a window for understanding discourses of health and wellness in relationship with the body and subjectivity generated from vastly distinct cultural frameworks. Only by doing so can we open the possibility for understanding how concepts like inner intelligence and consciousness can expand our healing awareness. The holistic health domain centers self-aware and embodied experiences in the generation of healing experiences. Traditional health sciences include practices of cultivating self-awareness in the process of achieving healing and health. This chapter explores how the embodied nature of subjectivity evokes conscious vulnerability through cultural practices. Health and healing reflect cultural practices that are situated in subjective experiences and vice versa. Cultural practices are embodiments of values, norms, and philosophies of the social landscapes of their origin. The inclusion of practices from various positionalities gives form to the abstract philosophical ideas that ground them and provide a context in which their meaning can be interpreted and applied. The notion of embodied subjectivities is especially important to the communication of the practices and philosophies at a germane, intrinsic level.

EMBODIED SUBJECTIVITY

Although we are primarily seen as bodies in the health care landscape, we interact as people. As our next chapter will discuss in detail, in our daily lives, we perceive, relate, feel, and live as individuals who, if healthy, are often not even aware of their bodies. We see our bodies through the lens of the social relationships, norms, and values within which the body is embedded. How we see ourselves is centrally a feature of who we are as constituted through the social relations and structures that define us. In other words, our relationships and ambitions, our feelings and accomplishments, our hope and fears, are all perceived through and inscribed in our bodies in an embodied way. We carry ourselves as a sum total of our experiences and feelings, fears and goals, positions and roles. Conversely, when we see others whom we recognize, are connected to, or share a workspace with, we relate with them on an embodied plane.

My encounter with my physician is an embodied encounter. When we meet a nurse practitioner, get our blood work done, or make an appointment with a physician's office, we are doing so as embodied individuals, not simply and merely as bodies (limbs, torsos, or heads and feet) navigating a space. The physician's actions take place in a context of medical education and practice that structures and guides the medical encounter in highly specialized and precise ways (Frankel, 1983; Heath, 2006). Although we take this for granted, we never really stop to consider how and in what ways our understanding of being embodied impacts our subjectivities, and how embodied subjectivities impact our health and healing efforts. Healing is not merely an effort of making a part or a sum of parts biochemically normal. Simply achieving normality so will not be enough to constitute what makes us human in the absence of healing. Healing addresses the connections that impart the sum total of our limbs and body parts with our sense of being who we are. We are seen as individuals with specific qualities that have specific meanings based on the social and cultural context. For example, gender has a range of meanings in different cultures, meanings that are enacted with respect to expectations of roles, conformities, behaviors, and appearances.

Gendered attributes are given value as superior or inferior, desirable or undesirable, attractive or unattractive through the norms that construct that culture. The meanings given to our body, likewise, are constructed through myriad representations, forms, social practices, languages, ideologies, images, ideas, desires, and such. To the extent that we see ourselves as individuals with a socially inscribed body, it can be said that our lives are lived as embodied subjectivities. Often such socially inscribed attributes are evaluated with respect to an established norm. For example, the male norm of an

athletic, strong, heterosexual, authoritative body may construct alternative sexual, physical, or personality traits as deviant and inferior. Because of its evaluative nature, social construction of symbols and their inscription in our lived contexts has real implications for individuals and communities, and how choices and decisions based upon normative ideals open up or exclude particular groups. The body is, in other words, the site of culturally specific discourses that have tangible material consequences within particular discursive practices and social regimes. Even as a body is not a neutral and passive entity, it is not an ideal, constructed object as envisaged within the regime of biomedical discourse.

By understanding the body as a lived-in entity, a site where our embodied subjectivity is enacted in myriad diverse and particular ways, our relationships and ambitions, our feelings and accomplishments, our hope and fears all become included within the contextual space of health and healing. From an embodied perspective, every action is an act of becoming, a process. For example, when we see someone whom we care for or recognize, the process of our relating with them is constituted in an embodied plane. In subscribing to this point of view, scholars start with the assumption that a health care encounter, such as that in nursing practice, is always an encounter between embodied individuals (Groenhout et al., 2005). When we meet a nurse practitioner, get our blood work done, or make an appointment with a physician's office, we are doing so as embodied individuals, not as bodies navigating a space. Although we take this for granted, we never really stop to consider how and in what ways our understanding of being embodied impacts our subjectivities, and how embodied subjectivities impact our health and healing efforts.

To begin, we have a simple premise. A vase of flowers in front of me is not a pure object: simply a vase of glass, filled with water and flowers, and nothing else. Instead, it is imbued with a context, identifiable from sense categories such as touch, smell, shape, and taste. To delve deeper, it is embodied with a scientific context, a biological premise: an assumption that the vase may get dusty over the next few days, where the water will muddy up if not refreshed, where the flowers will droop in a while, fade, and likely need to be thrown away. Likewise, the vase has a sensory context, whereby the flowers have a color that is pleasing in its associations (pink, red, and white), with green leaves and stems; the vase is transparent glass, which allows for a full view of the stems and the water; the flowers have a matte texture, but no smell; and so on. Each of these sensations is evocative of a feeling, an association that helps us situate the vase as an aesthetic object.

Moreover, the vase and flowers may have a temporal context connected with past memories and events, even if unrelated with the current vase. For

example, it may be in the same associational zone as many other vases that I may have seen in movies, stores, advertisements, books, or my own past. Perhaps the vase and flowers in these societal and media images were resonant with love and joy, freshness, vibrancy, and celebration. In my own personal life, perhaps they were connected with a sad moment in my life, one characterizing rejection or betrayal. Either ways, the vase will take on a meaning in my life that is unique to my context and sensory perception of the same objective form. All the objects and spaces in my lived environment have a deep, mutual, and uniquely personal connection with me and my well-being.

Thus, the basis to the scholarly argument that just as physical objects are never encountered as a pure, uninterpreted sense data, but synthesized by an *a priori* set of categories, leads to the corollary that assumptions and perspectival beliefs shape the way those objects are experienced and understood. As we experience the form of external objects, we give the objects meaning. This meaning is symbolically imbued with our relationships, experiences, cultural identities, and social contexts, even our own subjective perceptions of change and time and ecosocial relationships, as contended by the ecological model of wholeness. The experience of these objects is given meaning as I frame it in my communication with others in different contexts. Our assumptions of illness, disease, and healing are not constructed in isolation or merely in relationship with our bodily states either. Our understanding of our health and healing is shaped in and through its relationship with its environment, its food, the objects perceived by its sensory organs, and the thoughts generated during work. By the same coin, our health does not fall apart in a vacuum. As such, its disruption, maintenance, or upkeep cannot be understood in a vacuum either.

Health and healing experiences are born and sustained only by understanding the totality of a client's mental and physical experiences. These experiences include the myriad objects, relationships, spaces, and environments within which the individual acts, draws from, relates, and moves within their daily lives. Beyond their effect on biochemical processes (infections from surfaces or the impact of external temperature on the body's functioning), elements of our environment influence who we are and hence how we constitute ourselves through our actions and thoughts in fundamental ways. Healing goes beyond health and subjective perceptions of disease as illness (as Sontag, 1978, has argued) to include these influences on the individual's functioning and way of being. Understanding modes and constitution of healing to constitute wholeness asks us to frame and approach the world with a relational and dialogic perspective. Language gives form to, expresses, and constructs our relationship with the world. The use of specific words such as inner intelligence or inner awareness is given meaning within the cultural

frameworks they arise from and the contexts of interpretation that give the meaning value. Let me explain this with an example.

My annual wellness check-up with my physician may seem to be about assessing my vital statistics and charts of biochemical and physical functioning, but they are given meaning within a social and cultural context. The body in a medical encounter is situated at the intersection of myriad contexts, including the embodied provider (Goodwin, 2003). Therefore, these meaning-making frameworks involve both my physician and I, but go beyond to include the nurses, the office practice, the health care system, insurance structures, educational systems within which the physician was trained. Furthermore, they include how I, as the patient was educated, the cultural values and norms of what makes a healthy human being, my roles and responsibilities as a patient, and my physician's roles and responsibilities as a medical practitioner whose duty is to make the patients in his or her care healthy. Our mutual values and norms may shape this encounter as well. We may both be comfortable understanding and communicating our interpretations of the tests, the physician's actions, and the patient's role within a common social framework. In this case, decisions that involve whether I need to go in for further testing or what is within a normal range make sense within an interpretive framework that includes both of us. Now things might get a little complicated if one of us was from a different social or cultural interpretive framework.

The physician might look at the radiology charts and describe the medical observations and their implications to me to help me interpret and make sense of my body in biomedical terms (Lindwall, 2014). If my physician, instead of talking about different cellular counts and their normal ranges, spoke with me in the language of balancing my energy, my *doshas* (as an Ayurvedic physician), or of bringing my inner intelligence in line with my actions, I would either have to be a part of the same cultural framework as my physician or I would be totally at a loss for understanding the meaning behind those words. Equally significantly, I would be unable to meaningfully situate those understandings in an ontological framework within which those frameworks of health and its outcomes make sense and have significance or add value to my life. Arguably those words may even seem so alien and strange that I might give up the attempt to make meaning from them altogether and call that approach irrational and unfathomable.

Anthropologists have long drawn upon such interpretive frameworks in approaching their understanding of different cultures and their practices (Duranti, 1992; Hall, 1966). Objectification of bodies in relationships and the processes of imbuing it with meaning has been examined by anthropologists in some depth. By taking a brief foray into the anthropologists' view of the body and culture, the nuanced relationship of healing with subjectivity and

intersubjectivity as evoked by religious and spiritual practices can be clarified. Anthropologists have examined how we embody our context through examining the relationship of culture and the self. Anthropology approaches this by examining embodiment through understanding the body as an object. However, for an anthropologist, the body is not an object to be studied simply in relation to culture, but as a constituted subject of culture, that which makes culture possible (Hallowell, 1955). This is an important distinction. Let me clarify this in a few paragraphs.

Orienting the discursive body as an objectified embodied entity imbued with meaning not only links our behavior with the objective world but also links our perceptual mechanisms with social constraints and meanings. For instance, the individual body can be positioned in relationship with other objects within that culture, including abstract principles and reified objects. Such principles and constructs are employed in varied and fascinating ways by different cultures in approaching healing. For instance, energy fields and channels are imagined in very unique ways by different traditions and situated within a cosmology that relates the human body with the macro universe in a complex and layered framework. In this manner, orienting the self with respect to objects, space, and time helps, equally importantly, to locate healing of an individual within a sense of spiritual and corporeal framework that is cultural in its origins. These ideas help in understanding healing by helping us situate the idea of relationships beyond the more obvious interpersonal realm to spaces and the objects they contain to explicate how diverse cultures imbue prayer objects and religious spaces with healing significance.

Such discussions help clarify the project of subjectivity as an individual-cultural construct. Ritual healing and ritual language, for one, evoke embodied selves in a behavioral environment that goes beyond a single event. In religion and spirituality, the locus of the sacred is the body. Religious practices of healing thus help us re-examine how the body has been imagined in different cultures in accordance with distinct interpretations of healing. Each traditional system of healing brings with it a unique understanding of the body and what constitutes health and disease in relationship with individual subjectivity. Understanding the body as an intersubjective other helps us investigate the possibility of healing as openness to vulnerability. Vulnerability allows us to imagine the dialogic possibility with the body as the other, and intersubjectivity as a construction of the social relations governing our lived world. Wholeness, then, is constituted in the intersubjective relationship of the self and the body and in the openness and vulnerability of our relationship with the body as it helps healing processes. This is discussed in the next section.

THE WHOLE BODY AND/AS THE INCOMPLETE BODY

Health is central to our vision of the body. Discussions of the body are intimately connected with considerations of health and healing. Considering the body as a borderless construct of subject-object relations, one that turns the idea of being an object to being a subject through the idea of embodied subjectivity, opens up numerous possibilities. For one, health problems have an immediate impact on our life, going beyond mere absence of disease to a sense of connection and wholeness of self. Approaching health through the lens of normality and statistically defined criteria reinforces the idea that health is a natural, normative state and ill health a deviation from the natural state. Foregrounding subjectivity and intersubjectivity in understanding health and healing highlight the unique ways in which each individual's own positionality within a cultural framework grounds the health and healing relationship.

Illness gets perceived by an individual in various ways. Chronic illness has most often been perceived as a form of betrayal of one's body or a form of alienation from one's body. A healthy body is not perceived consciously—it is a transparent entity. It is understood as being invulnerable, whole, complete. Conversely, an ill body is somewhat incomplete, lacking. The experience of subjectivity as an ill person is that of a continuous awareness of a lack and incompleteness. Yet, even though the healthy body is invisible, transparent and evocative in its dimensions, it obviates the fact that it is vulnerable to illness and disease at every living moment. It can be argued that the only permanence in this relationship of the body with health is vulnerability. The state of being constantly vulnerable to disease, to change, to illness, and perhaps, back to health is the one constant in our relationship with our bodies. The healthy body is vulnerable, always, to disease and illness. A fundamental assertion of this book is that no body is perfect in its strength or state of health in every way. Accepting this vulnerability, this *a priori* fact of an imperfect body as the natural, healthy state of the body is a precondition to approaching any discussion on healing.

The hint of disease, the ever-present potential, the vulnerability to disease is a natural factor in the very constitution of the body. Our bodies are vulnerable, always open to the possibility of falling ill, whether through susceptibility, risk, or imperfect prevention; the body has a fragile, impermanent relationship with health. Our bodies are in a perpetually changing relationship with illness and disease. Vulnerability is a form of openness to being affected and to affecting another state, another individual, another position, in both positive and negative ways. If we examine vulnerability from the standpoint of healing, then for a healthy person, the position of vulnerability implies an

openness to being affected by disease and illness in unexpected ways. Illness does not simply change the body; it also affects our sense of who we are, however temporarily or permanently. To be aware of our intersubjective relationships is to open a conceptualization of the self or self-identity as always possible to change. Such discursive openness to our own bodies is relevant for the well-being of providers as much as patients (Veksler, 2016). Health and disease, thus, change our bodies and make us vulnerable in ways that are closely connected with our self-identity. Approaching this argument from the other direction, an examination of how the self-identity of an individual changes with health or sickness, the experience of being healthy or sick, describes the ways these states can affect the life of an individual.

Just as the health of an individual is accepted as a normal state of being, the healthy individual's perspective is treated as normative in our lived experiences. We judge our way of thinking, living, and being in the world through the yardstick of a perfectly healthy person. Healing requires cultivating the acceptance that illness is a natural condition that shapes our experience of the world in a specific set of ways. Although the illness interactions may be different and imperfect by the standards of a perfectly healthy body, from the subjective point of view of the individual, they are accepted as a natural state. Not surprisingly, when we deny our vulnerability as a fundamental experience, we deny the possibility that illness is an ever-present part of life. In this book, I argue for increased awareness of the need to recognize illness as an unrelated, qualitatively different state from health, one that is not defined in relationship with healthfulness, but on its own terms, as an ever-present state of discursive vulnerability.

While health makes our bodies transparent to us, the illness state marks a shift to recognizing and becoming aware of our bodies. Seen in comparison with a healthy body, an illness state can appear as a natural counterpoint of one that is not whole, not complete, not transparent. However, seen in and of itself, an illness state makes possible new definitions of health. An alternative viewpoint makes possible alternative ways of understanding health that are deeper and more connected with our fundamental experience of reality and vulnerability. It allows us to recognize illness on its own terms as an independent subjective state, one distinct from another, unrelated state of healthfulness. Vulnerability and intersubjectivity grounded in the premise of health and illness as equivalent states of being, help further the understanding of healing. Vulnerability constitutes an important bridge to grounding our awareness in healing in each state. We don't have to be sick or ill or diseased to consider ideas of healing. Likewise, illness and disease is not a state that is naturally connected with health. It is an independent state of the self, bridged by vulnerability with health on the other end.

This idea has been articulated in existing scholarship. For instance, some have suggested the notion of health within illness—the positionality of a chronically ill person who can reconfigure their illness identity as healthful on its own terms (Karnilowicz, 2011). The notion of health within illness provides a framework for thinking about how individuals reframe their goals and reflect upon their abilities. As a corollary to this argument, healing can be understood as a form of restored equilibrium between a person's goals and abilities, a sense of well-being, and therefore happiness constructed through a sense of balance and acceptance of both ends of the spectrum. The next subsection explores the idea of vulnerability in the differing states of the body further.

Healing through Intersubjective Awareness and Change

Intersubjective awareness of the self and the other through a discursive awareness of the body allows avenues for openness to being affected by any condition or state and to be able to change one's self-concept to an altered revised version with a modified set of abilities. This set of abilities is a form of adaptation to a changed sense of self and self-concept. Intersubjective awareness, in implicating the notion of openness to discursive reconstruction of the body, is closely connected with the idea of being vulnerable to change as a choice. The vulnerable self includes the possibility of the self that is open to change through choice and agency. In this regard, theories of change and self help explain how individuals value change.

Certain forms of awareness and change, such as those involving unconscious biases, can be addressed through dialogic engagement. For instance, Burgess et al. (2019) find that while narratives can open spaces for engagement of difference in patient-provider communication, providers who attribute health care inequalities more to their own biases resonated more with the persistent racism narratives. In contrast, providers who espoused a low attribution to the provider's own racial biases, supported a color-blind ideology that did not sufficiently take into account the role of systemic racial bias in perpetuating health care inequality. Change and the idea of discursively constructed difference are closely interconnected in the realm of health care, healing, and the constitution of wholeness. Cultivating an awareness of the body/self through illuminating the notions of subjective change, intersubjectivity, change, and openness can enhance an individual's own relationship with their body and the provider-patient relationship.

A challenge of healing lies in understanding the changes in the body during health or illness. These are discursively constructed and narratively expressed and suggest the need to cultivate an intersubjective frame of awareness. As

Mattingly (1988) compellingly argues, therapeutic narratives connect in complex ways with constituting the clinical experience as healing through integrating the human condition with what she labels narrative drama. At the heart of change is the tension arising from the need to privilege the original normative state. In a state where healthfulness is considered the default normal, any deviation from the original state is perceived as a negative change. For instance, a body in pain in a provider-patient encounter is identified through the intersection of the patient's knowledge of their own body and identification of pain in that body. How that pain is communicated in response to the physician's inquiry, and the physician's interpretation of their own clinical knowledge about pain and bodies shapes the understanding of pain during a primary care consultation (McArthur, 2019). The discursive construction of the body through identification of difference in sensation and perception as a shift away from the state of non-pain defined as healthful takes place within the knowledge space of biomedical culture wherein the clinical expertise of the provider's anatomical knowledge of the body is co-constructed with that of the patient's embodied knowledge of their body.

Intersubjectivity is grounded in the idea of bodily awareness, connecting the body simultaneously as an object and metaphor with notions of self, person, and subject. Considering the reflexive self from the third chapter as negotiated through interaction and intersubjectivity, its continual evolution with the changing states of the discursive/material body calls upon a range of strategies such as accommodation, rejection, or transformation. When a particular state, such as that of optimum physical functionality, is privileged, the shift away from that state is perceived as undesirable. We instinctively resist the idea of being open to a change that takes us away from a privileged norm. The intersubjective engagement of the reflexive self and discursive body takes place in the realm of interpretation and management of the self with the changing body. Openness to change, such as that which is incremental in nature, is closely tied to openness to shifts in self-identity and, more importantly, to an awareness of and an acceptance of a state of self-identity as continually shifting as a complete whole, independent of health or disease status. This openness to a shift in one's self-identity, and the construction of one's self-identity as subjectivity as negotiable, can be understood as openness to being vulnerable in an intersubjective frame. In this sense, vulnerability is connected intimately with the idea of embodied subjectivity as the notion of openness of self to a multiplicity of discursive interpretations. For the body with chronic illness, the shift of the body/self relationship is in discursive balance with an intersubjective context of self-other, where the other can be the discourses of changing self-identity or the mediated construction of the self.

In body-mass pathologies, for example, the overweight body negotiates the discourses of a changing self-identity at the intersection of body mass index (BMI) discourses that prescribe ideological visions of bodies (Gerbensky-Kerber, 2011) to construct the evolving illness-identity as coherent or fractured narratives. In positioning the discursively negotiated body in alignment with the material body discussed in the next chapter, the reflexive/embodied openness to change in self-identity defines vulnerability as a state inscribed with agency and deliberate choice in the ecological model of wholeness. The discursive body, constituted in negotiations of vulnerability and openness to subjective change by a reflexive, embodied self, is an active participant in the construction of biographically coherent narratives through the chronic-illness self-management process.

The reflexive self foregrounds the looking inward toward a reflective constitution of one's identity. The discursive body, in intersubjective engagement with the reflexive, embodied self, constitutes its vulnerability as openness to change. Accepting the nature of change as inevitable, its evaluation as positive or negative, and by association, as desired or undesired, produces and reveals challenging dilemmas in contexts such as age and chronic illness (Degnen, 2012). Such dilemmas often arise from the social pressures for maintaining consistency of the reflexive/embodied self in a stable relationship with a discursive/material body.

Understanding the discursive body as a subjective self, the ethic of vulnerability as an open self allows the individual to examine the notion of selfhood, subjective change, and healing in constitutive ways for transformation and integration of the reflexive/embodied self. The reflexive/embodied self inscribed through the discursive body shaped with vulnerability to subjective change allows the body/self to reintegrate its biographical narratives as transformative through the environmental layers of subjective change, traditional notions of health, and social-cultural norms. Acknowledging vulnerability through the lens of intersubjective awareness within the context of the environmental ethics is to construct it as a healing space, open to discursive co-construction with another and between different states of one's own body. Thus, this perspective deepens our ability to see change as a continuum of an embodied subjectivity. The co-construction of an intersubjective, vulnerable self, open to change and integration, informs the reflexive/embodied self with agency and coherence, allowing for integrative adaptive outcomes.

Our assessments of the self/body relationship as it constitutes healing in ways that produce wholeness are largely ignored in favor of more evaluative and pragmatic assessments of continuity, rupture, and consistency. Within this rather short-framed lens, we make comparisons between message frames to emphasize gain, or loss, or a balanced approach (e.g., Mays & Douglas in

indoor tanning decisions, 2017), social comparisons (e.g., body size and body satisfaction, Clayton et al., 2017), and between our past and future selves (Palmer-Wackerly et al., 2018). Such concerns with maintaining consistency and assimilating ruptures have been the focus of communication theories.

The communication theory of identity (CTI) takes a multilayered look at how identity is experienced at multiple levels (self, communication or enactment, relationship, and community), is multifaceted and dynamic, and can be communicated both verbally and behaviorally in diverse ways over time (Hecht & Lu, 2014). However, the premise encapsulated in such perspectives does not always sufficiently capture the dynamic reflexive/embodied, discursive/material self/body relationship during intimate biographical and physiological ruptures over time. I argue that in the context of such intimate changes as evoked through the chronic illness experience, wholeness can be foregrounded through an ecological model that considers how body/self evolves with changing intersubjectivity, situated in shifting settings of subjective time, traditional health values and frameworks, and socio-cultural environments.

An intersubjectively constituted, vulnerable state of deliberate openness to body/self change projects movement as a coherent dialectic tension between evolution and consistency over the life span of the individual to see the reflexive/embodied body/self as a dynamic whole from a self- and other-directed perspective. Vulnerability constituted through awareness of a deliberately cultivated intersubjective state is inclusive and allows for both illness and healthful self-concepts constructed beyond the Cartesian binary. By being a deliberative act of choice, such vulnerability takes the state of the body discursively constructed as healthful or diseased as a continuum, allowing for self-consistency anchored in the reflexive/embodied self during change. By aligning our cognitive and affective responses on the foundation of a consistent, open sense of self, a vulnerable state allows the individual to see the world and their circumstances as controllable, predictable, and expected. It allows individuals to recognize and be open to change in meaningful ways to support their healing process.

By promoting stability during change, vulnerability provides several documented benefits. A robust line of scholarship has argued for working to maintain the sense of consistency of the self. For Keyes and Ryff (2000), a consistent sense of self promotes self-confidence, which maintains initiative and propels action in social ways. For instance, during times of illness transitions, inconsistent feedback of a sense of self often causes distress because it interrupts the organized system of beliefs (i.e., experience) that form the basis of self-evaluation. However, although such frameworks identify the productive value of maintaining consistency, they betray a fear of inconsistency, or at the very least present inconsistency as an undesirable state. The construction of incon-

sistency and invulnerability as being suggestive of rigidity limits the manner in which an acceptable form of self can be conceptualized. Such rigidity disadvantages the human condition which is, inevitably, characterized by change.

As I argue in this book, in such instances, accepting vulnerability and change as part of a consistently evolving framework constitutes stability and openness to ruptures as opportunities that are part of the reflexive/embodied body/self narrative in individually constructed and experientially situated ways. Because individuals are open to subjective change, the vulnerability to reconstructing the body/self relationship over time, within the experiential environmental ambit of traditional health landscape and socio-cultural values is more likely to enable them to change in positive ways. The continual re-configuring of the changing discursive/material body narrative is a creative, life-giving task. This task is accomplished deliberately, with openness to disruptions and ruptures and the agency to construct these within reshaped narratives of the reflexive/embodied self not as a reactionary measure to disease, age, or other experience, but one within the ambit of the ecological model of wholeness.

In general, research finds that individuals struggle to accommodate unplanned and unexpected change, particularly when such change is perceived as negative. People tend to see themselves in a poorer light when faced with change that they were not prepared for beforehand and did not interpret as a positive change. Individuals assess themselves negatively when faced with idealized-body imagery (Knobloch-Westerwick, 2015). When individuals try to change, such as in the domain of ideal body weight perceptions with respect to media imagery, finer distinctions between self-evaluation and self-improvement and their relationship with social comparison and body satisfaction have been noted (Knobloch-Westerwick, 2015). These ideas underscore the nature of change and individual perceptions of vulnerability alongside its evaluative nature. These studies reveal the relationship between how individual motivation to seek change influences how that change is perceived and the reasons motivating the change. This body of research produced ample findings demonstrating the nature of social and self-directed comparisons in the domain of the body and health outcomes. The findings from this literature illuminate the inevitable nature of change that underlies the struggle for health outcomes in various interpersonal, social, health care, and mediated domains. However, they stop short of considering the nature of such change as it is shaped within the body/self relationship itself and as it changes with the experiential, lived contexts that shape the body/self recursively. Examining the discursive body in an intersubjective relationship with subjective change and the material body in alignment with the environ-

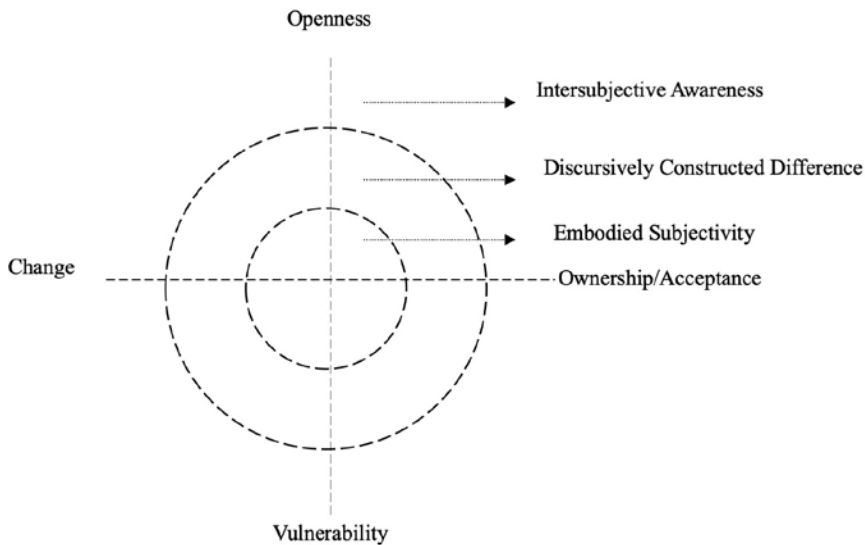


Figure 5.1. The discursive body. *Figure created by author.*

mental dimensions of the proposed ecology of wholeness model constitute it in dynamically evolving, experientially grounded ways.

Although I have argued that change is an inevitable characteristic of nature and the human condition, there is an unacknowledged resistance to the idea of constructing change as a fundamental part of the individual self-identity and self-concept domain. In healing that supports the constitution of wholeness, I argue, acceptance and awareness of the possibility and experience of change is a continual process. Health-related change is a specific form of change that connects fundamentally with our sense of who we are, as our bodies and its state of health and disease affects our subjectivity in highly nuanced and complex ways. How we face change makes all the difference in our healing approach and outcomes. Will we be unprepared for the possibility of change and be taken unawares when it does come about? Or, will we be aware of the fundamental inevitability of change and be prepared for making a difference in our approach, whichever way we can? In a study conducted within a medically underserved region of the Appalachian region in the United States, researchers Record et al. (2017) found that in making sense of breast cancer screening practices, women revealed confidence in knowledge of other women's experiences with breast cancer diagnoses and their own knowledge of their body, while accepting the value of overtesting in its potential to save a life. In the larger context, this body of research demonstrates that experiential knowledge of change in the body and of knowing one's own body shapes decisions to protect or prevent undesirable health diagnoses.

In this book, I situate the above arguments within a fundamentally deeper framework of the evolving body/self to provide insight into the constitution of wholeness and, as a part of that project, into the constitution of the discursive body that is shaped by openness to change and deliberate vulnerability between the reflexive/embodied self and the material body (figure 5.1). Thus, to develop the argument for wholeness is to center it in an examination of the nature of change itself, and to understand change in relationship with the discursive and material body and the reflexive and embodied self in its experiential lived environment.

Models such as the selective exposure self- and affect-management model seek to understand exposure to health information and health behaviors and have been employed in behavior change research in health communication. In this vein, a large body of health communication research has investigated behavior change as an outcome of health message characteristics (e.g., message framing) or source characteristics (e.g., credibility), channel characteristics, or attitudes toward the target behaviors (e.g., desirable or recommended; Westerwick et al., 2017), among a domain of other related variables. The focus of these approaches is structured closely within the domain of change management and behavior management and tilts in measurable and predictable ways toward the goals of disease prevention and health promotion.

Understanding the change through conceptualizing it in body/self relations takes a step back to constituting it in the lived experience of the individual. It seeks the deliberate choosing of specific forms of change as vulnerability to understand the situated nature of change from the environment from which it arises and is shaped over time. It also takes into account the contradictory and complicated nature of change. In its evaluative nature as conceptualized in mainstream health communication and behavior change research, change can be discomfiting or feel like a challenge. It requires us to make a decision to accept it, consider our response to it, or reject it. To heal, openness to change through the lens of vulnerability fosters a sense of evoking change, which is an epistemological shift in constructing the acceptability of the inevitability of change. A deliberative shift in the body/self axis of constituting change as inevitable, calls forth a reflexive/embodied self which situates change in the discursive/material body in alignment with subjective change, traditional health, and social-cultural norms.

Arguably, healing is a process of an evolving of the body/self in an integrative manner through change. I situate the idea of subjective change as an environment for the body/self in section III of this book, but will develop its relationship with vulnerability as it constitutes the discursive self in this chapter. Change, whether expected or unexpected, planned or unplanned, is challenging. Keyes and Ryff (2000) posit that temporally, subjective change

can be unsettling because it takes time for people to get used to new ideas and a new version of themselves. They sought to understand how much time must pass before we get used to the idea of a new version of ourselves and explored the notion that the reactive and evocative triggers of subjective change and causes of duration of subjective change are important considerations in such individual determinations of subjective change. The idea of reacting to change or of evoking change as being qualitatively different in its influence on shaping the subjective perception of change contributes to understanding the discursive body. It enables us to understand its constitution through vulnerability as deliberative openness to change in this chapter.

This openness to change cultivated as a deliberative act provides an avenue to readdress the Cartesian duality in the framing of health and illness as opposing states between which individuals must orient their decision-making process through messages, source credibility, channel use, and the like. Deliberative openness to change through the vulnerable discursive body constitutes a dynamic relationship to understanding the body/self as whole with respect to an integrative and dialogic framework. Contextualizing the individual as the intersubjective body/self situated within the lived, experiential environment supports multiple contradictory and parallel meanings of change in relationship with physiological and psychosocial health outcomes.

Situated in the ecological model of wholeness, for example, the discursive body open to the scars of lumpectomy or mastectomy takes uniquely defined approaches to reconstructing wholeness in the long term. These individually defined approaches are distinct from the health outcomes of the surgical procedures themselves. My research with CAM providers treating long-term breast cancer survivors shows their struggles aligning with depression and denial over lost self or diminished bodies with the evolved body/self shaped through a self-reflexive and embodied experience. The self-reflexive embodied experience defines its evolved body/self relationship within the frame of subjective change, traditional health, and the socio-cultural environment. In the next section of this chapter, I extend the idea of discursive openness to change and vulnerability to subjective well-being.

Subjective Well-Being

Each of us, at every moment of our lives, has an implicit sense of how well we judge ourselves to feel we are doing, how we feel about our body, and how we feel about our health. This sense of how well we are doing emerges a priori to our health status in as much as we don't first think about the state of our health before feeling good or bad about ourselves. In fact, we first

engage in sense making about our well-being before delving deeper into any problems we identify in the perception of our well-being. This intimate and ongoing sense-making exercise is captured by the construct of subjective well-being. The idea of subjective change, then, is intimately tied in to the idea of subjective well-being. When we perceive a shift in our perception of the body and its general state of integrity, it is an experience of subjective change. Cultivating an openness to change implies an openness to perceiving all states of change without resistance to the unpleasant states or an implicit bias in seeking to constitute ourselves in any one particular way. I develop the idea of the discursive body as grounded in the notion of subjective change as experienced through subjective well-being and shifts in the perception of one's health.

However, I broaden up the discursive body to extend this idea of subjective change to openness to deliberative vulnerability. The notion of deliberative vulnerability proposed with reference to the discursive body alludes to the openness to being constituted intersubjectively in ways that are not guided by an overt or subtle sense of control, preference, or bias. This openness to modes of possibilities in envisioning oneself in particular ways is an important facet of maintaining a connection with our context in dynamic and relational ways. In psychological literature, subjective well-being reflects an overall evaluation of the quality of a person's life from her or his own perspective. It is also something that is lost when people describe their chronic condition experience. The tangible, perceptible connectedness in the moment to be constituted by intersubjective experiences and to maintain a sense of relationality with our inner sense of subjective well-being and change on the other hand is part of what I define as the constitution of wholeness through the discursive body. In the ecological model of wholeness, the discursive body is situated in relational engagement with the embodied self and the material body. This deliberative openness of the discursive body to inner experiences on the one hand references its connection with the embodied/reflexive self on the other hand.

Vulnerability in the discursive body can be understood as openness to be constituted through a range of influences such as the media, one's physiological changes, and the socio-environmental influences that can describe the material body. By consciously cultivating openness and vulnerability, the discursive body enacts a choice to gain a sense of control over the construction of its experiences. Moreover, the deliberative openness and vulnerability to acceptance of discursive constitution and perception of a range of states of subjective wellness support the feelings of body acceptance and relating with others in the moment. These experiences are connect with body acceptance and ownership and are central to feelings of wholeness and healing.

Vulnerability, openness, control, and ownership are critical components of feeling whole and connected, and of the larger discursive domain of freedom, power, and relationality. Together, these elements are a key component of the discursive body as situated in relational engagement with the material body discussed in the next chapter and the reflexive and embodied self discussed in previous chapters.

As I will argue in this section, approaches that center subjective well-being foster healing from the individual's own perspective in meaningful long-term ways. As a psychological construct, subjective well-being is connected with positive and negative affect or feelings, finding meaning in life, and motivation to pursue goals. Highlighting the subjective aspect, according to Diener et al. (2018), emphasizes the interest in the evaluation of the quality of a person's life from that person's own perspective, as distinct from other broader forms of well-being. For example, objective models of well-being list criteria such as the critical ingredients required for a person to have a good life. In other words, the subjective aspect tends to focus more deeply on the individual's self-reflexive and embodied engagement with their lived experiences. The objective models, by contrast, focus more on the assessment of well-being in alignment with normatively defined criteria such as body satisfaction or life satisfaction arising from a good life.

The discursive body as constituted through its self-reflexive and embodied engagement with the self constructs itself in a multiplicity of intersectional and contextual ways to constitute a sense of well-being. Both objective and subjective well-being, although distinct in their foci, are closely related with each other. Objective well-being's focus on a priori defined criteria such as the determinants of life satisfaction through being able to carry out tasks such as find information online and feel connected has been shown to impact subjective well-being (Hofer et al., 2019; Rui et al., 2019). Besides objective well-being, subjective well-being is shaped by additional contextual factors that draw upon social comparison, interpersonal interactions, and personal longitudinal comparisons over time. In this direction, some findings have examined the quality of social interaction, such as studying how others' self-presentation on social media increases their own perception of subjective well-being (Fan et al., 2019). Others in communication have examined the role of media as an entertainment resource enhancing the user's sense of subjective well-being, when not being perceived by the individual as being used to procrastinate (Reinecke & Hofmann, 2016). These and many other contextual variables play into an individual's assessment of their own well-being in objective and subjective ways. This body of research focuses on the individual's relationship with these contextual variables in constituting their sense of subjective well-being.

The individual's relationship with themselves has also been addressed in some research on subjective well-being. Besides personal and social relationships, there has been an interest in understanding the role of time in subjective well-being perceptions. Aging, in particular, has seen a large body of research focusing on subjective well-being. In aging research, the concept of time has been examined as central to subjective well-being perceptions (Hoppmann et al., 2017). As chapter 7 on time, change, and illness intrusion elaborates in greater detail, in challenging the assumption of linearity in the experience of change, our self-concept changes with the notion of subjective time in complex ways in dialogic and relational engagement with the body to constitute body acceptance and awareness. The perception of time has a subjective dimension that can help illuminate how well-being can be related with healing based on individual perspectives. For instance, Hoppmann et al.'s (2015) research reveals that older adults who perceive their future time as more limited are expected to report higher subjective well-being particularly with regards to emotional components.

This body of work suggests that the relationship between future time-perceptions and subjective well-being points to the need to better understand the role of individual resources for the realization of socioemotional goals, so that these can fuel subjective well-being. Another model Hoppmann et al. (2015) employ includes individual resources in greater depth. Individual resources are included in models of strength and vulnerability integrations (Charles, 2010; Charles & Luong, 2013), and posit that older adults must also be capable of using effective strategies that enhance well-being, which is only possible if they have the physical and cognitive capacity to limit or avoid exposure to negative situations (strengths). Conversely, if older adults are unable to employ such strategies due to chronic health constraints or cognitive limitations (vulnerabilities), well-being can be compromised. In such research, subjective well-being is positioned alongside present-past-future time orientation and individual resources. Individual resources are broadly categorized as strengths and vulnerabilities. The notion of vulnerabilities in such research as a weakness that hampers an individual's cognitive and affective resource usage is conceptually and pragmatically distinct from the constitution of vulnerability as a resource for the discursively constituted body. In particular, vulnerability in the ecology of wholeness model proposed in this book is distinct from cognitive limitations in being a resource to openness to reconstitutions of the reflexive/embodied self. This form of deliberative vulnerability is a resource that evolves along with the discursive/material body interpreted in context of the multilayered environmental dimensions including subjective time.

Conceptualizing subjective well-being in relationship with the reflexive/embodied self as a resource for the discursive/material body enriches and

enhances the vision of the individual as an agentic being in an environment of change, traditional health landscapes, and socio-cultural values. In clinical and social scientific research, embodied sensations have largely been difficult to conceptualize; hence, to operationalize and measure. Yet, as this book has argued, the research approaching embodied work from different disciplinary areas has contributed greatly to understandings of the experiential and individual constructions of health in broader and deeper ways. Several modalities from the complementary and alternative therapies involve the practitioner and the individual in healing practices that focus upon and seek to balance the energy fields to create health and balance, with self-esteem, subjective well-being, and a positive self-concept being its related positive outcomes. In order to expand on the discursive body in relationship with the body/self, in the next section I develop the connections between intersubjectivity, subjectivity, and healing, with a focus on CAM therapies such as biofield therapies, connecting the concepts of healing and embodied subjectivity with a look at clinical research on interoception and mind-body science.

INTERSUBJECTIVITY, SUBJECTIVITY, AND HEALING

In our discussions thus far in this chapter, embodied subjectivity and subjective well-being are intimately connected in the field of healing practices through the ideas of openness and vulnerability. In this section, I present how the implementation, conceptualization, and evaluation of subjective well-being has been examined in the various alternative medicine practices, as well as through medical technological advancements, and more recent conceptual advancements in areas such as interoception and mind-body science. Alongside the more deterministic fields, the fields of healing therapies that employ energy, vital force, and other more abstract indicators for their success have made some headway in applying their healing therapies in several clinical domains to understand wellness and healing. Some healing therapies such as biofield therapy have been examined with respect to their effect on chronic and debilitating medical conditions such as cancer and HIV.

Constructing and eliciting stories about the body/self through a reflexive/embodied self model in relationship with the discursive/material body highlights opportunities for exploring the intersectionality between representation and analysis of the form, performance, and content of the experiential domain. Communication scholarship has examined narratives to understand the situated, contextual, and intimate nature of illness and healing. For instance, a narrative approach undergirds the delicate exploration of healing and mortality to understand illness meaning making processes (Sharf, 2009).

Understanding narrative as a communicative act, in a special issue on narrative medicine, Harter and Bochner (2009) highlight the body of work in health communication toward development of narrative theory and practice in health and healing to further their understanding and performance. Situating the narrative turn in health communication, the authors highlight how the scholarship of qualitative researchers employing narrative sensibilities have provided a framework for understanding the organization of meaning making in health-related domains (Bochner, 2002; Charon, 2006; Harter et al., 2005; Sharf & Vanderford, 2003).

Provider frustrations in capturing the patient experience through charted medical history or medical synopses have played a role in transforming the practice of medicine from a purely clinical one to assisted by and assisting, a fundamentally humanist endeavor (Kleinman, 1988). In extending this body of research on embodied healing contexts negotiated by providers in multiple settings (Charon 2009), my research findings in this area with CAM providers and their clients suggests that the embodied and reflexive role of the provider in the provider-client therapeutic relationship supports healing in ways that constitute wholeness (Agarwal, 2019). From the perspective of subjective change, narratives are valuable in reframing the temporality in the sense making process while reorienting to change through the notion of subjective time discussed in greater detail in chapter 7. As narrative gives meaning to experience, it creates understandings of the phenomenon in insightful and constructive ways supporting by organizing experience and reality in terms of expectations and understandings as emergent constructions of reality. Although biomedical approaches have been critiqued for their traditional hostility to connotative discourse, this disjunct is mitigated in recent quandaries stemming from a crisis of representation in capturing the clinical experience and highlighting the narrative qualities of clinical work in the medical domain, particularly that which foregrounds human drama surrounding illness (Sacks, 1987). Taking a social constructionist approach, discursive approaches to healing that employ experiential and interpretive modes such as in many CAM modalities, the employment of narratives cultivates the options to consider multiple alternative readings, opening possibilities and raising newer avenues for inquiry into the domain.

In CAM therapeutic approaches, well-being is defined as a combination of reduced experiential suffering, increased quality of life, and positive subjective perception of affect, where affect ranges from pleasure-oriented feelings such as happiness, joy, and peace (hedonism) to a sense of purposefulness and meaning, spirituality, and social connections (eudemonism; Hu et al., 2019). In their research project, Hu et al. note positive affect has been demonstrated to have protective and resilience-imparting affects in health contexts

such as cancer where they are associated with adaptive coping. Using a CAM therapy, and acupressure, the researchers examine how well-being and healing is achieved through stimulation of acupuncture points and restoring the unobstructed flow of *qi* energy. Studies demonstrate increased body awareness and body ownership alongside a relational and intersubjective experience of well-being through therapeutic touch while promoting embodied selfhood and interoceptive awareness, where interoceptive awareness is defined as awareness of internal physiological states (Hu et al., 2019).

Like acupressure, biofield therapies tap into the philosophy that humans have an energetic dimension. While not scientifically measurable under current circumstances, the biofield practitioners seek to balance out the disturbance in the energy field caused by physical and psychological symptoms in individuals (Baldwin & Trent, 2017). Examples of biofield therapy applications can be more readily found in indigenous systems of healing such as Ayurvedic and Chinese medicine that rest on concepts of a vital force as being central to healing. For Baldwin and Trent (2017), endogenous biofields, detected from the heart (ECG), brain (EEG), and muscle (EMG), are clinically recognized indicators of health and disease. For instance, the physician employs specific practices to structure the prenatal ultrasound images for a pregnant woman in embodied and spatially distributed ways (Nishizaka, 2014), which comprises an instance of the discursive construction of another entity.

The advancement of technology such as with the development of modern superconducting quantum interference devices has formed the basis of clinical medical tools for measuring biomagnetic fields in the heart and brain. Biofield in contemporary science employs these therapies in myriad ways. Typically, they involve the practitioner interacting with the body's bioenergetic field, rather than the physical body, with a goal to influence the electrostatic field that surrounds and penetrates the human body (based on measurements of extracellular ion fluxes and voltage potential differences). More recently, neuroscientists and cognitive scientists have sought to identify and measure the mechanisms of such energy fields and their outcomes by relating with the physiological processes through assessing interoceptive awareness. Some therapeutic providers use their own hands to sense and alter endogenous biofields for improving physical and psychologic health. The myriad practices that fall under the rubric of biofield therapies include Reiki, Therapeutic Touch, Healing Touch, and external *qigong*.

Greater insights into subjective well-being has been obtained through findings from the field of neuroscience and cognitive science. These findings illuminate how intersubjectivity and subjective change is constituted and negotiated at a neurological level to explain how embodied experience and intersubjectivity is constituted. For instance, acupressure and biofield thera-

pies are perceived and experienced in embodied ways by the body/self as is the experience of chronic illness. Openness to therapeutic touch suggests a potential for the discursive constitution of the embodied experience as facilitating subjective change. Interoception can illuminate the neurophysiological processes underlying the ecological model of wholeness proposed in this book by calling upon the interplay between perception of body states as the material body in the ecology of wholeness on the one hand and the cognitive appraisal of these states as the discursive body in the model proposed in this study on the other to inform response selection. The discursive body is constituted through openness as deliberative vulnerability to subjective change at the intersection of the reflexive/embodied self and the material body in dialogic engagement with subjective time, traditional health systems, and socio-cultural environments (figure 5.1).

Broader definitions of interoception describe it as a multi-dimensional construct that also takes into account how people attend to, appraise, and respond to these sensations. The response itself has been defined in neurophysiological terms through the signals in the body as they interact to comprise thought, awareness, and action and has been employed to explain the formation of self-concept and subjective responses such as subjective well-being, and thus is a powerful motivator of behavior in the pursuit of these states (Farb et al., 2015). In essence, how we pay attention or allocate attention to different things can be guided through contemplative training and practices.

Contemplative practices emphasize openness and acceptance of experiences without judgment or assessment and preconditioned action to guide selection of experiences or responses based on external (e.g., social norms) criteria. By emphasizing the reflexive/embodied body/self at their center, contemplative practices anchor the discursive body (e.g., as deliberative vulnerability to subjective change) and the material body (e.g., as its neurophysiological processes) in the ecological model of wholeness in attentiveness and presence in the moment. In doing so, contemplative practices constitute the discursive body as open to subjective change through cultivating deliberate vulnerability to experiences in the present without attending to consequences or evaluative and assessment-oriented reflexive criteria. These contemplative practices, at their simplest, can include paying attention to the breath or being mindful of behaviors in the moment daily life.

The discursive body, as a presence, fully available alongside the material body as a vulnerable resource, open to subjective change, in the moment, is a powerful integrative asset to reframe the chronic pain experience. Individuals in chronic pain explain how their experiences evoke an absence from their presence, a withdrawal from the lived experience, a fear and an avoidance of the body and the environment. Guidance through contemplative training can

emphasize openness to experiences beyond categorizing them in advance as positive or negative, and openness to environments in ways that may, in the short term, appear counter-intuitive and maladaptive but align in the long term with the openness to subjective change in non-binary ways to ultimately constitute healing. In doing so, practitioners can cultivate in their patients, through particular meditation practices, an acceptance of vulnerability constituted as the discursive body open to subjective change, in the moment in dialogic relationship with the reflexive/embodied self. The discursive body does not avoid negative experiences such as those arising from social, subjective, material, physiological, or related factors. In the acceptance of rejection and of physiological pain as a discursive strategy the individual can be trained to cultivate acceptance through deliberative vulnerability as openness to subjective change.

Neuroscientific research illuminates the material processes underlying contemplative and therapeutic practices through explaining how interoceptive processing is shaped by experience, or how we understand experience, and use this information to better manage and understand well-being. The material body, the subject of the next chapter, is in intimate relationship with the discursive body as both are centered around the self/body axis where the self is constituted as the reflexive/embodied self. The ecological model of wholeness thus constitutes healing in engaging the discursive body's construction of chronic illness and pain through deliberative vulnerability to subjective change in reflexive and embodied ways with the material body's perceptions of pain signals. The integrative and contextual framework constituting the ecological model of wholeness brings together the chronic illness experience in a dialogic, relational whole, by constituting acceptance, awareness, ownership, and agency.

From the perspective of the material body, which I will discuss in greater detail in chapter 6, contemplative science suggests that reflection on interoceptive process assists adaptive behavior by disrupting overlearned perceptual and interpretive habits formed through cognitive development and aligning behavior with higher-order intentions. Simply put, approaches guided by cognitive science state that as we become more aware of the mechanisms by which we pay attention to particular events and occurrences around us or as we increase selective awareness of our surroundings, such as understanding how the breath guides attention to various processes, we become more mindful. These processes call upon the constitution of the discursive body through cultivation of deliberative vulnerability to subjective change, situated within the context of subjective time, traditional health systems, and socio-cultural environment. I delve deeper into each of these layers in the upcoming chap-

ters to develop the ecological model of wholeness with attention to the case of the chronic illness experience.

Understanding healing from the perspective of interoception connects the embodied self with awareness of ongoing interoceptive interactions. Such a perspective allows for two complementary senses to emerge, both connected with subjective well-being in fundamental ways. The first, presence, as a component of the discursive self, highlights one's connection to the moment, and grounds one in the present. The second, agency, reflects one's ability to effect change, and understood as a component of the discursive self, is critiqued by neuroscientific researchers as being foundational in determining a person's sense of subjective well-being (Seth et al., 2011). Healing processes such as acupuncture and biofield therapies, and contemplative approaches such as particular forms of meditation training, employ neuroscientific mechanisms of interoception that constitute the material body in dialogic ways in relationship with the discursive body as openness to subjective change.

Constituting vulnerability through the discursive body supports presence, ownership, and agency in the patient's reflexive/embodied experience through the practitioner-patient relationship for chronic illness management. The next section develops the chapter's argument on subjective well-being, embodied subjectivity, vulnerability, and openness as these are employed in the construction of the discursive body in the ecological model of wholeness.

Wholeness, Intersubjective Awareness, and the Discursive Body

Mind-body studies have helped us shed light on how we sense our bodies as discursive constructions and how we interpret these constructions in very real ways through the material body. As the above section shows, substantive research in this direction has shed light on the employment of contemplative practices such as meditation to achieve integration of the discursive/material body and reflexive/embodied self in multiple ways. Meditative approaches support integration of the reflexive/embodied self with the discursive/material body through dialogic engagement with physiology and presence. In some forms of meditation, such as Vipassana, individuals guide attention intentionally and deliberately toward cultivating inner awareness in structured and focused ways. Increasing inner knowledge of one's own physiology, cognition, and perceptual awareness can constitute experiential awareness that lends control and agency on the one hand and an observational understanding, acceptance, and analysis of the full range of sensory states of the material body without evaluation or assessment. Such a discursively constituted vulnerable body is open to interpretations of its whole self in reflexive and embodied ways while being present in the moment. The state

of dialogic and intersubjective integration constituted through the discursive body as vulnerable to subjective change creates narrative coherence and balance as being grounded in the present.

Focusing narrowly on the outcomes of meditative and contemplative science as characterized in the clinical domain, important distinctions emerge that must be recognized and investigated if we are to imagine a meaningful integration of the discursive and the material body through CAM practices and meditation. First, although both share the same goals (e.g., reducing human suffering), they take vastly different philosophical (ontological, epistemological, and axiological) approaches. Mind-body practices such as meditation integrate the discursive and the material body in dialogic and relational ways with the reflexive and embodied self. They cultivate the discursive body through the lens of subjective change as a deliberate choice to accept vulnerability as openness. Meditation practices such as Vipassana provide rigor and structure in training individuals to cultivate discursive openness as vulnerability in focused, actionable, and deliberate ways. In Vipassana, the practitioner identifies, analyzes, and accepts all sensation from pain to joy in the body as equal through openness and vulnerability in dialogic engagement with the material body in pain. Such training calls upon presence in the moment, in the lived dimensions of the environment as constituted in the model for wholeness as subjective change, traditional health systems, and socio-cultural environments.

In chapter 6, I consider the material body and its relationship with its physiological processes on the one hand and public health imperatives on the other, in greater detail. However, in its engagement with the discursive body, I would like to take a moment to illuminate the relationship between interoceptive processes, cognition, and the self that provide the individual with a sense of self as it situates itself in alignment with the internal state of its material body. In interoceptive processes, cognitive representations of the self (as a sense of self, identity, being) are based on embodied sensory experience. It follows that greater interoceptive self-representation provides a more nuanced sense of self such that the individual is better situated to engage in greater moment-by-moment adaptation and vice versa for better adaptive responses in the cognitive, affective, and behavioral domains (Mehling et al., 2011). Delving into the intersectionality of the discursive body with the material body in the ecological model of wholeness, considered in line with the neuroscientific research into interoceptive mechanisms, suggests that by accepting internal change, the motivational force of the physiological change is minimized without requiring the suppression of expectations or interoceptive signals.

The neuroscientific literature connects the material body and its processes at the intersection of the discursive body and its challenges with, for example, pain management in insightful ways. In fact, the use of overt active inference to resolve unexpected events has been associated with a sense of agency, a feeling of control over one's actions in the world, that one can act to produce particular results. Meditative practices support the construction of vulnerability by promoting acceptance of change, change whether positive or joyful or negative and painful. They also help the practitioner accept the condition of pain alongside its treatment, providing its practitioners a way to build peace and integrate nonpharmacological approaches especially when dealing with chronic pain.

In the ecological model of wholeness, the discursive body and the material body co-constitute each other. Similar to the idea of interoceptive awareness that references an internal awareness, presence accesses an external experience of awareness of self in dialogic engagement with the material body. Research demonstrates that through a sense of being accessible in a tangible space, presence bridges the gap between experience and internal states and the external states that guide behavior. Integrity of engagement within and between the internal and external states constituted through presence is expressed as subjective well-being. An individual's agency that constitutes subjective well-being references the ability to act in a manner that constructs meaningful presence through action. CAM practices, such as acupressure, biofield therapies, and mind/body practices such as meditation support body awareness in experiential and pre-discursive ways to constitute presence and agency as experiential, lived moments of action.

The chronic illness domain is unique in the manner in which it supports the contribution of patient self-management approaches. The provider can make a significant contribution to shaping productive forms of self-management through the provider-patient communication. Provider co-construction of patient narratives to reimagine the relationship of the chronic illness in the patient's lived environment of the patient can help the patient envisage active health participation in ways that impart agency and control (Sharf, Haidet, & Kroll, 2005). The authors draw upon findings that suggest that communicative behaviors that characterize active patient participation include asking questions, expressing concerns, stating preferences, making suggestions, and sharing one's narrative (Street, 2001).

These communicative behaviors support provider-patient communication through co-creating shared meanings of the chronic illness experience. In my research with CAM patients, management of chronic conditions through the CAM therapeutic relationship was facilitated through the provider's empathetic listening in ways that connected the mind and the body to sup-

port patient self-affirmation of pain experiences and self-reflective learning (Agarwal, 2018). The findings suggested that provider-patient communication that centers patient subjectivity and co-construction of meaning making supports self-management of pain (Agarwal, 2018). The provider-patient domain, imagined as a space for co-constructing intersubjective awareness grounded in the idea of body awareness and presence, opens opportunities for integrating subjective change through the discursive body in situated and individually defined ways to reconstitute the evolving body/self.

The chronic pain domain is characterized by a complex blend of somatic, interpersonal, and cognitive-affective elements (Wasson, 2018). The turn in narrative medicine to alleviate suffering beyond diagnosing and treating requires the provider to be open to the patient's experience in a way that enables the provider to be a co-participant in the patient experience (Egnew, 2018). Viewing chronic illness through the lens of suffering highlights the alienation of the body/self, and loss of identity and bodily integrity (Cassell, 2013) that require a more nuanced understanding of subjective change and subjective time to capture the illness experience. Advocating for deliberative openness to change through vulnerability in constituting the discursive body provides an opportunity to reframe the body/self relationship in dialogic engagement with subjective change situated in its experience of subjective time, traditional health systems, and socio-cultural environment.

Even as clinicians feel poorly equipped to address the body/self awareness, and continuity concerns in an integrative manner to provide care that supports self-management in the long term, the ecological model of wholeness provides a foundation from which to constitute the reflexive/embodied self in dialogic engagement with the discursive/material body as it relates with its lived environments of subjective change, traditional health system, and socio-cultural values to constitute wholeness. Although body awareness and acceptance therapies have been found to be helpful in the treatment of physical pain in conditions like post-traumatic stress disorder (PTSD), they are rarely used due to lack of sufficient research. For the chronic pain patient, for whom body awareness is a struggle, such therapies increase health related quality of life (Gard, 2005; Price et al., 2007). In a study on PTSD patients, body awareness and body ownership was shown to associate with dissociation reduction and affect regulation to establish continuity in self/body narratives that are disrupted as a form of dissociative coping mechanisms (Price et al., 2007). Taken together, the idea of agency and presence support the embodied self as it is constituted in relationship with the lived environment in dialogic engagement with the discursive/material body.

Some recent lines of thought have extended this notion in intriguing ways. For example, the idea of embodied subjective understanding has been ex-

tended to connect to the idea of well-being through the notion of “dwelling-mobility” proposed by Galvin and Todres (2011). This notion offers an embodied subjective understanding of well-being to capture the range of well-being experiences within a coherent existential whole. In some ways, this notion examines the tension between presence as being and agency as mobility and connects it to the psychological states (such as motivations for mobility). Dwelling-mobility provides support for the idea developed in this chapter of subjective change as anchored in the reflexive/embodied self and constructed through the intersubjectively constituted vulnerable state of deliberative openness of the discursive body. Galvin and Todres articulated the deepest essence of well-being as a unity of dwelling and mobility. They delve deeper into the foundation of well-being to probe what it means to be present (as a form of “dwelling”) and how this notion mobilizes into accessing fields of possibility and making these possible materially (through the idea of “mobility”; 2011). In these threads, the idea of being present in one’s body and of being at home provide a foundation to the processes of subjective change in integrative ways.

The ecology of wholeness model suggests avenues for maintaining a stable yet evolving reflexive/embodied self and discursive/material body during debilitating ruptures and discontinuities of chronic conditions. Understanding the provider-patient relationship in clinical settings through the lens of the ecology of wholeness model provides an opportunity for addressing the elements of chronic pain management in a manner that allows individuals to integrate over time with subjective changes in their body/self and experience of subjective time, traditional health systems, and the socio-cultural landscape. CAM practices like acupressure and biofield therapies cultivate body awareness through embodied therapeutic relationships that ground patient construction of subjective change through the discursive body. Mind-body approaches like meditation construct the discursive body in the present through subjective change without evaluative or assessment-orientations.

In a dialogic engagement with the reflexive/embodied self, the discursive body integrates the chronic illness management process through subjective change, deliberative vulnerability, and agency. The discursive body’s openness to change through presence in the moment supports intersubjective awareness and body ownership and organizes experience in relational engagement with subjective time, traditional health systems, and socio-cultural environment. These elements place it in relational engagement with the material body constituted through communicative mediated and physiological constructions as discussed in depth in the next chapter. Together the discursive and material body are in relational engagement with the reflexive and embodied self in constituting the core anchor of the ecological model of wholeness.

Chapter Six

The Material Body

Our bodies shape our perception of the world. They are the primary means by which we relate with the world, and through which the world—and others—relate with us. The body is the primary and, arguably, earliest site of our experiences. The time of our birth harkens to us our arrival with an awareness, however primal, of ourselves through our hunger, joy, and pain. As we grow, the body is where we become aware of our physical selves—our arms and legs, hair and nails. We also learn to associate our feelings with our self—to see the body as the site of our experiences, expressions, and constructions of our feelings of joy and sadness, anger and regret, and all the range of emotions that fill our lives. We grow as our bodies, through our material selves as our primary mode of being who we are and experiencing who and what we are not.

In this chapter, I develop the material body in relational engagement with the discursive body and the reflexive/embodied self to constitute the anchor of the ecology of wholeness model. I construct the material body through its communicative mediated representations as they construct risk and particular social groups, disease conditions, and individuals in relationship with the body and the physiological composition in relationship with the stages of the healthy body, the body in transition, and the diseased body. The discursive/material body, along with the reflexive/embodied self, are in dialogic engagement with the three contextual/environmental layers of the experience of temporality through time, change, and illness intrusion, of the relationality between the self and the body through solitude, silence, and presence in traditional health systems, and of ecosocial sensibilities, religious-secular heterodox medical beliefs and a (trans)anthropocentric sensibility in our relationship with food, nature, and body/self integration to constitute wholeness.

Healing is intimately connected with a perception of awareness of self as complete in context in a way that constitutes the whole with integrity. In this premise, health and healing don't necessarily predicate each other or go hand-in-hand. They may, of course, support each other. In this book, I have argued that it is not always necessary to be healthy in order to feel healed or vice versa. In fact, healing as it constitutes wholeness is important at all stages of health. The goal of this chapter is to understand healing in the context of the healthy body, the diseased body, and the body in transition.

The fragmented experience of the chronic illness has been well documented. For instance, medical and biological research has mapped the domain of the physiological body with increasing accuracy and refinement. Likewise, findings from the public health literature have closely identified the challenges of addressing the structural and socio-cultural factors underlying the knowledge gap for equity in health delivery and access. Furthermore, communication scholarship has attested to the role of media, messages, interpersonal provider-patient communication, and social norms in addressing the challenged of chronic condition management globally.

In this chapter, I examine these findings from the biomedical, public health, and communicative domains to give the reader an integrative insight into the knowledge domain that constitutes our material body. The goal of this chapter is to provide a framework for integrating the scientific landscape of the material body in a relational perspective of the body/self with the environmental context in ways that can constitute wholeness for the individual living with chronic conditions as situated in their lived spatiality, communities, neighborhoods, and the planet. Engaging the body/self in context in ways that constitute wholeness, I argue, can help bring together the evidence-based, replicable, objectivist, reductionist knowledge findings in a framework that does not only envisage success on an initiative-by-initiative basis, or even by population or disease-domain subcategories, but connects each successful implementation through including the knowledge findings of these domains with the larger eco-social project of planetary well-being integrated with the body/self.

While the embodied self conceptualized an experientially inscribed intersubjective awareness of symbolic representations the embodied dimensions of the self, and the discursive body examined the constitution of deliberative openness to experience of the self in relationship with the environment and with the body, the material body is the physical form and composition, the tangible, sensory body that is our medium experience the world through the reflexive/embodied self and the discursive body. In the chapter on the embodied self, we had discussed the relationship of our body and its experiences with healing. The embodied self was in engagement with the reflexive self as it constituted the body/self anchor of the ecological model of wholeness. The

body axis was constituted of the discursive/material body. This chapter focuses on the relationship between the body, health, and healing to situate the material body in the ecological model of wholeness. In this chapter, I develop the premise that an effort to understand healing must involve an effort to understand the discursive body in relationship with its different material states of health. Through the embodied expressions of our sensations and feelings, thoughts and desires, in engagement with our reflexive self, we learn who we are. Often, we understand the reflection of our inner desires and motivations as they ground their external expressions in defining our self-identity and self-concept. In another sense of the word, we may say these experiences, in turn, define the site of their expression, the body. Our body defines us, in our experience of ourselves, of others' experience of us, and as the site of inscription of our identity.

Our body provides us with the material means for navigating the world and discharging our actions, and partners with us in communicating who we are to ourselves and others. We learn the meaning of health and disease, mobility and stillness, voice and silence, as the language in which our bodies speak with us. The physiology of the body defines us, even as its engagement with the environment of subjective time, subjective change, and food and nature constitutes its narratives. Under most ordinary conditions, we do things with our bodies, without giving too much thought to our relationship with our bodies. The food we eat, the environment we live in, our lifestyle of leisure, work, physical labor, exercise, or relaxation constitutes the physiological make up of our bodies every moment of our lives. Even as we make our bodies, our bodies make us. At the most basic level they tell us what we can do, whether it is running a four-minute mile, climbing a wall, tolerating heat and cold, sensing light and dark, or extending ourselves in the lived spaces of our habitats. Most of the time, we understand its logic and how it communicates with us. If we eat more than our capacity, we know our body will put on weight and that it will result in our not being able to run a four-minute mile any longer. As rational partners in our relationship with our bodies, most of the time we are readily able to make the association between the decisions we make and how it changes our body's relationship with us. We are also readily able to make the association between our decisions and the limits posed on our intent by the physical limitations of our bodies. For instance, I may want to lift one hundred pound weights, but will understand if my body tells me that it is unable to do so in its current state. Thus, as with a functional relationship, we can see the consequences of our actions on our bodies and vice versa, and most of us are cognizant, most of the time, of our capacity to make the connection between the two.

We constitute our bodies in important and vital ways, but we are not simply our bodies. Our bodies make and define us and mediate our relationship with the world. Everything we do in the world, we do through the medium of our bodies. However, our body is ultimately, a consequence of what we are. This idea is somewhat different from the idea that our body is us. There is no doubt we live in, through, and with our bodies. In fact, our bodies are so intimate to the foundations of our existence and self-identity, we often take the language in which it relates with us for granted. We assume we are simply our bodies and our bodies, in turn, are what makes us. We assume—we believe, we experience, our bodies as the self, and our lived experiences in relationship with our bodies. In fact, this connection is so intimate and so complete, that for most of our lives, we can safely assert, most of us can pass by without ever questioning its validity. As long as we are able to actualize who we are through our bodies without the disruption of our body calling attention to itself, we never really need to examine this relationship. If we desire to move toward the door, and our body does our bidding, we don't realize the relationship between our thoughts, intentions, and action. If we desire to enjoy an ice cream, and we get to enjoy the taste of its sweet cool flavor, and our body is able to digest its contents, there is no disruption really in the cycle. We can continue to remain blissfully unaware of the ability of the body to confer upon us the right to enjoy its presence.

However, a slight shift in this relationship begins to happen when things are not all right. When something unexpected happens, such as when our actions and desires don't lead to the expected outcomes, a degree of discomfort begins to set in. Unexpected health outcomes or undesirable states of pain can bring about a disruption in our lives and in our relationship with our body. We eat healthy, but something goes wrong, and we're diagnosed with a health condition, despite our best intentions. Our bodies communicate with us as a distinct entity when something isn't right. The language of symptoms, for example, begins to appear to us as a strange voice, an undesirable phenomenon, one that brings with it pain or discomfort and difficulty managing the experience. We may struggle to reconcile our increasingly alienating bodies with our goals. We may be challenged to communicate our desires with our body and have our body seamlessly relate with us as our healthy body once did. For those in this situation, such as those diagnosed with certain chronic conditions, it begins to appear as though the body is its own person. At such moments, our biggest realization is that our perceiving, feeling, thinking body is not entirely the same as the part of us that is desiring, expecting, enacting, or deciding. We are not only our bodies. The relationship between our body and who we are is not always well understood as we don't give it much thought in our healthy state. As we begin to realize from moments of disruption

tion, our bodies are connected with us in deeper and often very complex and challenging ways. For most of us, such disruptive moments are relatively minor and far enough in between. An influenza (flu) infection raises our body temperature and we need to rest or have medication to get better. We take rational actions as appropriate like avoiding undue exertion and drinking lots of fluids. Based on our actions, we expect we will recover in due course, and head back to work, our routines, and our daily lives.

Consider, however, when we are living with a body that is constantly in pain, regardless of what we do. When we are faced with living with a deteriorating body or a body in pain, disruption, or disease, we are forced to listen to our body's often strange voice, speak with us all the time, interrupt what we're doing, or even force us to change our life plans. We are forced to stop our normal routine and modify it to meet our body's needs. As our needs and goals begin to separate from what our body can accomplish with us, we begin to realize that perhaps we are not our body, that we are not the pain, or the limitations that our body imposes on us. Although the pain limits what we can do and how our desires may get fulfilled or modified, the language of our body's pain doesn't define us. The body then appears as a distinct entity of its own, communicating with us in an often strange language, however intimately it continues to shape our experiences, this time apparently without our permission. Unpleasant sensations interrupt our thought and intentions and force us to pay attention to the body speaking to us on its own terms about itself. The sick person is forced to take time out and attend to the body's needs and acknowledge its presence. We may slowly be forced to recognize that our body's language and needs may be distinct from ours, and it may be an entirely alien body, but that it still relates with us in the same intimate ways. For example, a multiple sclerosis patient may want to walk outside in the summer sun. However, a neurological flare-up may prevent that person from enjoying the sunshine, feeling pain and discomfort instead.

At such times, those who live with pain or chronic conditions, for example, begin to realize that while we are the body with the pain, we are not simply the body with the pain. We realize that we have a deep and intimate relationship with our bodies. While the body's functionality may be disrupted due to a diseased condition, this disruption does not always mean that the self that is us is also diseased or disrupted in its functioning at the same time. We start to face the recognition that we are also, in some important way, distinct from our bodies. In pain, disruption, or disease, the boundaries of our bodies as they constitute us begin to come into definition. At such times, we grapple with the persistent fragility of the bond that co-creates our mutually interwoven, yet distinct existences. It may seem to a person living with chronic pain, for example, that their body doesn't listen to them and continues to persist in a

state of pain. Or they may feel as though their body is now a mystery to them, an enemy in rebellion, even, or a disenfranchised, sulking child who doesn't listen, an antithetical alter-ego with whom they are unfairly bound at the hip, forced to live their lives out together as with an evil twin.

The discursive body accepts openness and vulnerability to the unexpected, to pain, disease, and illness, and to alternative conceptualizations of our self-identity as an act of agency, a deliberate choice to accept vulnerability to change. In shifting from health to disease, from functionality to possible impairment, the illness state appears distinguished from our transparent healthy bodies as being out of our control, intransigent, rebellious, and different. The discursive body seeks to recognize illness on its own terms as constituting its subjectivity, as being part of its own self-identity as an illness-identity. In this sense, the chapter on the discursive body argues, intersubjective awareness makes possible the facility to engage in discursive reconstruction of the body through accepting vulnerability to change as a choice. It acknowledges its intersubjective and interactional negotiation with the material body through possible strategies such as passive inaction, accommodation, rejection, or transformation. In the shift of the body/self relationship brought about by chronic illness, the intersubjective negotiation of the self alongside the discourse of self-identity are in an intimate relationship with the mediated materiality of the body. This chapter focuses healing at the mediated intersection of our body where it takes shape as a distinct entity in the body/self relationship and traces its movement through the different states of transition to understand the health and illness experience from a lens of care transition and their attendant cognitive and psychological factors.

In this chapter, I delve into our relationship with our material body in order to provide insight into the healthy body, the body in transition, and the diseased body. In this process, I explore how healing can be constructed through awareness and knowledge of how the mediated material body functions in relationship with its internal and external environment during the three states of being the healthy body, the body in transition, and the diseased body. The ecological model of wholeness posits the body/self relationship as an anchor with the environment to constituting healing as wholeness as an integrative, relational, and dialogic engagement between the discursive/material body.

The reflexive/embodied self, in engagement with the discursive/material body, constantly interprets and constitutes itself in dialogic relationship with subjective time, subjective change, and the socio-cultural environment. The discursive body, constituted through deliberate openness to subjective change and vulnerability as openness to change, supports the material body in its healthful, diseased, or transitory stage. The material body, in turn, supports the discursive body through its affordances, through the mediated shifts in

experience that illuminate and conceal, and through permitting some activities while limiting others. In order to develop the material body, in this chapter, I will draw upon literature organized along the public health continuum of health and disease. First, I'll present how we view our bodies as healthy individuals, and how this relationship gradually changes as the health status changes. Through this process, I explore the body/self relationship and the material body as it relates with subjective time, the traditional health system, and the socio-cultural environment to constitute wholeness. First, let's start with the healthy body.

THE HEALTHY BODY

The healthy body has been constructed in a range of ways in the media. These representations often conflate beauty ideals such as thinness (Conlin & Bissell, 2014) with health. In this section, I will cover what defines a healthy body, its relationship with the environment, and the healing resources it needs to maintain a state of health. Understanding how the inner physiology and outer environment of the body are related in the healing process can provide insights into the resources a body needs to stay healthy. The chapter argues that healing, for the material body, is the ability of the body to maintain a balance between the three states of health, disease, and transition, such that the overall manifest state is a stable stage of health. The section also highlights the role of the creative arts (such as music therapy) in supporting health and in the humanization of medicine. Such an examination helps to illuminate how social disparities and inequities disadvantage specific groups of people in ways that make them more susceptible to chronic conditions. It also provides an insight into healing and the role that the arts can play in public health programs to constitute integrity through subjective time, the traditional health system, and socio-cultural environment as wholeness.

A healthy body seems invincible. When we have good health, everything seems possible, within the reach of achievability. We don't really need to think much about our body's wishes as distinct from us at all. In fact, we seem integrated in mind, body, and spirit, whether we are aware of it or not. Most often, we are not aware of it, precisely because this relationship is so seamless as to appear to be one of itself. The relevance of the notion of healing may be difficult to grasp at this stage. The WHO defines the healthy body by the oneness of its connections between the mind, body, and spirit. A healthy body is by definition understood as one that integrates the mind, body, and spirit seamlessly, one that connects with the ecology of wholeness model as a body replete with integrity of the body/self and its environment. Other sources and

bodies of literature refer to a healthy body variously as one experiencing a state of emotional, social, and physical well-being. From this perspective, then, a healed body is a healthy body, one that is constituted by a sense of integrity between its elements. The healthy material body is understood as a resource for living a full life, in the absence of disease, in a way that allows an individual to achieve their full potential through action and behavior. Such definitions of health understand disease biochemically, through a cellular mechanistic processual model, whereby the operation of the inner physiological mechanisms of our bodies, its cellular reactions, connectivity, and mechanisms identify our state of health and, conversely, disease.

Our body does not exist in a vacuum. At a very basic level, we live in relationship with our physical environment. Our actions and desires draw from and are enacted in the context of our physical environment. In terms of pathology, the study of disease mechanism and progression, our bodies are constantly under siege—deteriorating, fighting, rebuilding, and recovering. A healthy body is able to fight off infections and other harmful substances so their symptoms are never manifest and an underlying pathology does not take hold in our bodies. Seen mechanistically, our bodies are engaged in a process of maintaining a balanced relationship with the environment and countering challenges from sources like pathogens, toxins, and food waste.

Let me further explain the notion of healing in the healthy body from a biochemical point of view with an example of the pathogenesis of cancer. Environmental carcinogenic agents, or substances that cause cancer, have been identified as including chemicals, radiation, or viruses that cause abnormalities in cell behavior causing it to respond by continual unregulated proliferation, growing and dividing in an uncontrolled manner, and invading normal tissues and organs to spread in the body. The development of tumors usually begins from single cells that begin to proliferate abnormally in a complex, multistep process of malignancy. Because it is a multistep process, many factors may influence the likelihood that cancer will develop, such that no one single cause of cancer can be identified. Such cells undergo a progressive capacity for proliferation, survival, invasion, and metastasis.

Alongside facing environmental factors that might make cells cancerous, our bodies are embedded in physical environments that comprise smoke, dust, and other agents. In this environment, our bodies are continually working to achieve a balance of detoxification and elimination to maintain a state of health. From a biochemical perspective, then, a healthy body is a body whose internal cellular functioning is able to continually engage in the process of maintaining this balance successfully in order to keep up the functioning of the various organs in an optimal state. Our bodies, surrounded by the external environment that both provides nutrients and oxygen necessary for

life and serves as a receptacle for the waste materials generated by the body, is in a dynamic state of balance with its internal environment, which is maintained by the cellular, biological mechanisms. Our skin separates the internal environment from the external environment, while within our bodies, cellular membranes act as a barrier and regulate the substances entering and leaving the cell. The cellular membrane is semi-permeable, allowing certain types of molecules to pass through and blocking others, such that smaller molecules go through more easily than larger molecules. This membrane maintains the selective nature of permeability, governing what substances can enter and leave the cell.

Through this selective process, called homeostasis, the internal environment of the body is maintained more or less constant in balance within a narrow range of limits. Diseases often arise due to a disturbance of this homeostasis or balance in the cellular environment. The cellular environment, for example, maintains a balance in temperature, water and electrolytes, pH of body fluids, blood glucose level, pressure, and tissue oxygen and carbon dioxide levels. Homeostatic imbalance typically occurs when the body is unable to regulate a physiological variable within a normal range. Once this environment is in a state of imbalance, and the cell is no longer able to maintain homeostasis, an abnormal state results, proving detrimental to the body's well-being and giving rise to diseases. While this description outlines the basic physiological mechanism that occurs in the body, healing is addressed by cultivating the inner awareness of the body to be able to access and utilize necessary elements in order to maintain this state of homeostasis.

A body in good health maintains an optimum and balanced functioning of physiology through these myriad and continuous challenges to its functioning. The resources it draws upon for nourishment to maintain a state of health include environmental inputs from nature such as sunshine, fresh air, and nutrition such as food and water. As the final chapter on food, nature, and body/self integration will delve into greater detail, we draw upon our natural environment—water and fluids, oxygen from air, minerals, and other elements that we gain from our diet and nutrition to constitute, maintain, and sustain our material body. They help us heal. In this instance, healing is the ability to construct a balance between the resources needed by the body and those provided in the environment to maintain optimal physical health. In order to heal, the healthy body must know itself and its needs. The body must be aware of the optimal choice from all the resources available to fully achieve its functional goals. Maintaining a state of health, or achieving a balance, signifies the body's ability to recover, rejuvenate, and sustain itself through the imbalances that may occur due to regulation of the varying internal and external environmental inputs.

The physical, natural environment is just one facet of the environment of the body/self integration. We live, grow, work, and exist in physical spaces and communities among human-constructed and natural elements. For example, our physical, lived spaces can be dark or bright, clean or polluted, airy or dingy, with ample trees or devoid of nature. Increasingly, our technological environment and facility with using technological devices has the potential to make an impact on our health outcomes as well. Molina and Sundar (2020) employ the motivational technology model and self-determination theory to examine the relationship between the technological affordances of a well ranked body building and weightlifting app called Body Space and its behavioral outcomes. The researchers measured the behavioral outcomes as number of workouts tracked, weight lifted, and cardio hours spent, and the goal attainment rate as the percentage of body fat and weight goal achieved. Their analysis found that the relationships varied by gender, and that the use of features of the app that elicited relatedness, autonomy, and competence were predictors of exercise outcomes.

The physical environment is just one aspect of the environment our body is immersed in during its lifetime. In maintaining a state of health, we engage with not only the physical environment but also the constructed environment of our internal and external resources. These resources include our traditional health system environment encompassing education, entertainment, social relationships, relaxation, and a productive lifestyle. For healing to truly happen, a healthy person needs a balance of these and other internal factors such as the ability to adjust in a balanced manner to internal and external change, which is discussed in greater detail in the next chapter on time, change, and illness intrusion. According to the public health perspective, our dynamic balance with environment is important for maintaining a state of health. A lack in any of these collective inputs can cause an imbalance in that part of our body's ability to maintain an optimal functioning of the mind, body, and spirit. The presence of disparities in the ability to access and in the ability to fully avail of, such resources, in a way that best meets the individual goals of each person, can give rise to imbalances in the individual's ability to recover from setbacks to their health.

Disparities in access to or ability to optimally avail the resources required for the full and balanced growth of each individual in a healthy manner can lead to an inability to adjust to change and heal in ways that are meaningful and sustainable. In this way, public health experts posit that health and disease are opposite sides of a coin. Following a social constructionist approach, this equation can be understood from a contextual perspective as well. This view of health as wholeness approaches health as a state of being actively engaged in an exchange and transformation of resources to actively adapt to

and maintain a state of internal and external balance. Conversely, it posits that the manifestation of diseases and their connection with disparities emerges in terms of the ability to access, adapt to, or effectively utilize, such resources to maintain an equilibrium in the body's internal and external environment.

By going into this discussion of the internal and external state of the material body, this chapter places the material body in relationship with the discursive body to emphasize how societal disparities eventually manifest as ill-health at an individual level. While each one of us faces challenges to optimal health at every moment of our lives, it is those with adequate levels of resources at an internal and external body/self relationship with the environment who are more likely to be able to effectively manage their health outcomes. It is important to keep in mind that equity in availability, access, and management of internal and external resources has a deep relationship with individual-level health outcomes and social disparities. The Institute of Medicine (IOM) provides several resources to help make these connections clear.

In particular, IOM has taken several important steps in building the connections between maintaining health through preventive medicine, the resources required, and integrative medicine. The efforts to support the human body to maintain its state of health is supported by the goals of preventive medicine. Preventive medicine seeks to enhance the lives of individuals by

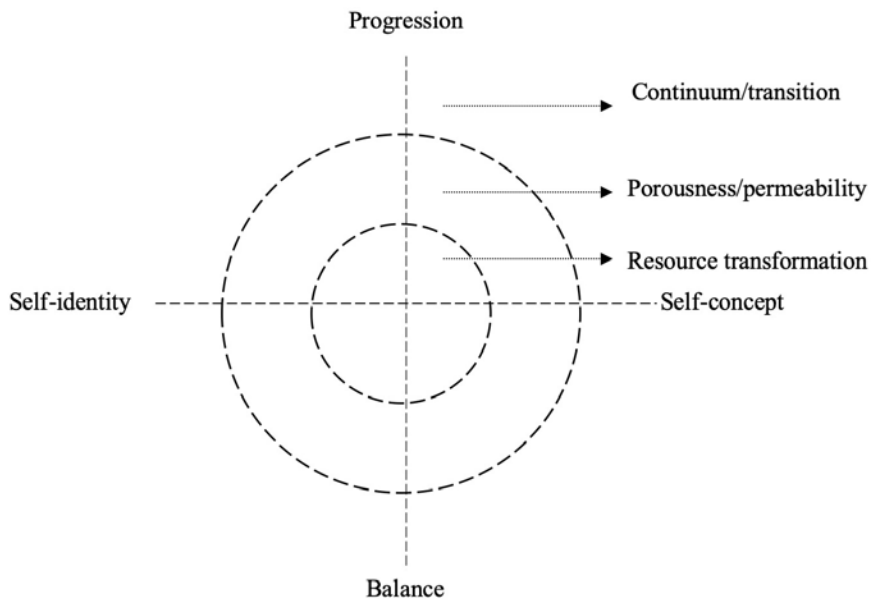


Figure 6.1. The material body. *Figure created by author.*

helping them improve their own health. Initiatives that comprise preventive medicine lie in a continuum alongside similar efforts made in public health to promote health in communities through organized efforts. Such initiatives are significant in the chronic condition management model. Even as the dividing line between preventive medicine and public health is not entirely distinct, the goals of prevention and treatment also progressively blur into each other (Katz & Ali, 2009). Health literacy initiatives, situated within the traditional health system of the ecology of wholeness model help enhance an individual's ability to engage in meaning making that utilizes external and internal resources to balance the individual's needs.

Extending the discursive body discussed in the previous chapter, the health literacy initiatives, for instance, enhance the material body's ability to organize the deliberative vulnerability as openness to a continuum of health and illness. Such situatedness is unique to the individual's needs and enhances the understandings from public health perspectives to engage with the tools that enable individuals to navigate the health-related characteristics of the environments in which they live (AHRQ, 2019). These upstream factors, according to AHRQ, contribute to health outcomes. For example, they influence the proximal factors of imparting an ability to navigate the health care system. In recent decades, awareness of the differences brought by educational disparities in personal health behaviors have become greatly recognized.

This recognition has also drawn attention to the challenges to health posed by exposure to chronic stress, a burden often faced disproportionately by those on the margins of society. Education, for instance, provides health literacy, which contributes to a range of factors such as decision making in health care encounters. Situated in association with the resources identified in the ecological model of wholeness such as those imparted by the ability of the individual to navigate their environment of time (e.g., through subjective change), traditional health systems (e.g., through CAM systems), and the socio-cultural environment (e.g., through food and nourishment), education and literacy can be envisioned as means to constitute wholeness as integrity and dialogic engagement that actively maintains a balanced sense of body/self in its environment. Such a sense of wholeness is an important element of managing long-term chronic conditions and a valuable support in addressing some of the gaps in traditional biomedical health care through medication adherence and treatment support through collaborative decision making and health literacy.

Many decades of substantive research from a range of disciplines has drawn attention to the important relationship between health and education and highlighted the role of education as an important external resource that impacts the body's internal environment. This relationship is deep and com-

plex. Such research provides ample evidence that on the one hand, health impacts educational attainment. On the other hand, we realize the many ways that the conditions of an individual's life course impact both health and education. For example, early childhood experiences make an important contribution to an individual's health status. Among external resources that our body is in engagement with, the creative arts and cultural environment are also important. Engagement with the creative arts, like education, also has myriad health benefits. Creative arts can include music engagement, visual arts therapy, movement based creative expression, and expressive writing and have been shown to reduce adverse physiological and psychological outcomes (Stuckey & Nobel, 2010). However, while the research in this direction shows a positive relationship, the extent to which these interventions enhance health status is still under investigation.

The role of the creative arts has recently gained traction because of an increasing realization of the limits of modern medicine. Among its documented gaps is a concern that along with its hyper-specialization and use of technology, challenges in fully addressing well-being for those suffering from chronic conditions have led to patients and providers who are increasingly unsatisfied with the health system. Evidence suggests patients lack a feeling of well-being through pharmacological modes of treatment and providers are challenged with burnout. Furthermore, the health care relationship can often be stressful. Beyond being functional, predicated on information-giving and gathering, or an active patient involvement at best, the health care relationship often falls short on addressing the whole patient in the chronic illness management domain. The realization of such limitations and its associated frustrations for both doctors and patients has spurred recent interest in envisaging a humanistic approach to the provision of medicine.

In part, the initiative to envisage a humanist approach to the practice of medicine has taken the form of narrative medicine. With its focus on understanding the lifeworld of the patient and furthering the patient provider relationship to provide care that is situated in the lived contexts of the patient, narrative medicine has made valuable contributions to the clinical domain. Beyond narrative medicine, the humanization of medical practice has taken several other integrative approaches to constitute care. Several of these initiatives, such as those involving art and spirituality, are described in the other chapters of this book. To illustrate, music therapy has been investigated from myriad approaches to understand its influence on health. The curative power of music, for instance, was investigated within the frame of the current clinical relationship with diseases and medical practice by Lippi and others (2010). They note that this relationship is an old one, and more relevant today as narrative-based medicine. In an effort to balance the practice of medicine as based on scientific

knowledge, problem solving, and decision making with its relational, holistic dimensions, the humanization of medicine has gained prominence. This move acknowledges that the practice of medicine is also a relationship between two individuals, their bodies, mind, and spirit, and one in which both bring their emotions, feelings, expectations, and fears into the process.

Recognizing this, WHO offered a concept of health care where social and subjective components of well-being were emphasized. The biopsychosocial model, as it is called, seeks to bring the physician's attention to the organic, lived aspects of the disease and its social, behavioral, and psychological features. The focus also shifts from trying to only explain a phenomenon as health or disease to understanding it and evoking healing. As exemplified by the integration of medical humanities, this translates to a shift from seeing the patient as an objective entity needing treatment to a care-based approach, attention to the relationship and the environment of care, and the sensitization of the providers to this relationship. These elements help conceptualize healing in the health care context. Here, as Lippi and colleagues argue (2010), music can serve as a companion to both the healthy and the sick. The role of music in therapeutic practice has become more relevant than ever as advances in neurological research provides concrete evidence of the mechanisms connecting the two and their educational, scientific, and professional outputs.

The clinical effects of music have been examined in many disease conditions. White (1999), for example, studied the effect of music on cardiac autonomic balance and anxiety in patients after an acute myocardial infarction. This study found relaxing music can induce a relaxation response in patients that could reverse the effects of the stress response that had led to the heart condition. Others, such as Sabel and colleagues (2018), propose adopting a psychosomatic approach, or one that privileges behavior, psychology, and social components in treating conditions to bring about stress reduction and relaxation. Techniques such as meditation are gaining prominence for their role in relaxation, stress reduction, and behavior modification as a preventive measure in addressing a variety of conditions. The benefits of meditation practices in addressing chronic conditions, in particular, have seen an upswing of interest, with many studies indicating its promising role in reducing blood pressure, anxiety and depression, and insomnia (NCCIH, 2019). Other areas have also seen a corresponding growth. These range from art therapy to dance therapy and imagery. Such practices are increasingly being acknowledged as being central to well-being and health. Their contribution to helping people address a range of conditions such as dementia, Alzheimer's disease, and mental illness seems promising. Some researchers, such as Zellig et al. (2019), have examined how such art therapy contributes to a sense of community through creativity that nurtures inclusion and participation. As the

chapter on the embodied self discussed in great detail, the arts are an important element in healing. In examining the body in the health care continuum, the focus of this chapter, art has helped people living with conditions such as dementia through creating a sense of independence, connections with others, and enabled, active individuals, who felt capable of participating in their communities and living productive lives. Dance and music allow people to be able to express themselves and communicate empathy (Gujing et al., 2019). As an embodied expression of the self, art forms like dance address the intersectionality of the anchoring dimension of the ecology of wholeness model to bring together the reflexive self, embodied self, the discursive body, and the material-corporeal body in uniquely individual modes of being.

By creating relationships that are nurturing and supportive, in a longitudinal manner, expressive environments invite an exploration of a humanistic approach in health care are important elements in the chronic self-management support process to create wholeness. The material body, as this section has shown, itself seeks to maintain a state of balance or homeostasis that is understood as good health. Any disruption in the body's internal or external environment that makes it harder for our bodies to maintain this balance will lead to stress, ill-health, and disease. The internal and external environment should comprise not only the nutrients and chemical factors necessary to keep the cellular mechanisms functioning properly, but also external elements such as education, art, culture, and healthy environments that allow people to fully develop their capacity as human beings. Moreover, such resources constitute healing by giving people the ability and agency to guide their own health, access health resources, and construct positive lived environments.

Acknowledging the role of balance and equilibrium in health, the WHO has defined holistic health as "viewing man in his totality within a wide ecological spectrum, and . . . emphasizing the view that ill health or disease is brought about by an imbalance, or disequilibrium, of man in his total ecological system and not only by the causative agent and pathogenic evolution." Education and engagement with the arts are only a few factors that help construct and maintain a healthy body. Health promotion efforts help in the prevention of diseases and also seek to cultivate a positive feeling of health and vitality essential to a healthy body (Katz et al., 2009). In a study that examined how sociodemographic and psychosocial factors shaped pregnant women's use of Web-based goals to set and monitor their personal goals for healthy diet and physical activity, researchers Kim et al. (2015) tested a Web-based intervention promoting appropriate gestational weight gain. Their study found that women who believed that appropriate weight gain would lead to healthy outcomes for their child were more likely to engage in setting a goal and monitor their progress. Such findings suggest, as the authors note,

avenues to shape psychosocial and motivational factors across racial and sociodemographic groups to reach at risk subpopulations, such as African-American women, in ways that can guide their construction and monitoring of gestational weight gain goals.

Health communication strategies examined by researchers such as entertainment education (EE) can support involvement and message processing important to health promotion message design. Studies find health information recall, for instance, can vary based on the degree to which content is integrated with the narrative content of EE messages and that a perception of the health topic as being personally relevant supported the systematic processing of the information in the EE messages (Quintero Johnson et al., 2013). Other researchers have examined representations on media, such as of poor and working-class Black women and middle-class overweight Black women, along with the increased presence of Black women as diet spokeswomen to understand how socioeconomic class constructs “good” weight and “bad” weight in differential ways (Thompson, 2015). Such studies illuminate the role of the media in shaping contemporary discourses around such health topics in differential ways. These nonmedical interventions may depend on media-related and structural improvements in society to enable a larger section of society to benefit from their goals. Structural goals include initiatives such as the provision of healthy community environments (e.g., safe running pathways) or basic life structures (e.g., freedom from poverty and environmental pollution).

The construction of the healthy body, physically, representationally, and in mediated ways, requires attention to the contextual layers of the ecological model of wholeness. These layers are discussed in detail later in the book. Applications of these contextual layers include, in the case of the material body, temporal, traditional health system, and socio-cultural discourses of how we represent subjective time (for instance, age-related perceptions), subjective change and intersubjective awareness (for instance, in how we talk about and engage dialogically in online or interpersonal discussions on the body), and socio-cultural environment (for instance, how we locate food and nourishment differentially in subcultures in our society). An integrated body/self experience connects us, in accordance with the expanded chronic care model (ECCM) discussed earlier in the book, and WHO’s definition, with our physical, mental, emotional, and spiritual states in relationship with our lived environments. A healthy physical body enables us to explore our body’s boundaries and expand them in directions that challenge us and give us joy, peace, and fulfillment through engaging in activities that motivate us and fulfill us at a deeper level. The next section covers what happens when the body shifts from its healthful state but is not yet sick or diseased.

THE BODY IN TRANSITION

The body in transition takes us on a journey into this complex state where the body is healthy and appears healthy but may have shifted, in subtle ways, towards susceptibility to a disease or sickness. It examines how the body in transition is a state that is known in many ways, from pre-disease to being at risk for a disease. Human communication plays an important role in shaping how we understand risk and how particular groups are constructed in ways that can deeply affect their social relationships and identity. The construction of risk, although important, emphasizes individual conceptions that are, in turn, connected with consequences of risk discourse (concerns with construction of risk, and how these constructions evoke social and material consequences for particular groups of people, Striley & Field-Springer, 2014). In their theorization of risk, researchers Striley and Field-Springer examine infant-feeding discourse for their analysis. As they state, first-order risks are constructed claims about specific threats to the physical body, and the most well-examined in health communication literature. However, these have implications for individuals and collectives, such as in the construction of second-order risks, which come into existence when the individual is perceived as insufficiently avoiding first-order risks. Such second-order risks evoke threats to individual values, their sense of goodness and character, and the relationships. The role of communication to construct and reproduce particular constructions of risks thus can make a deep impact on individual identity, social relations, and cultural imagination.

I start by discussing how a chronic condition is understood and how a chronic condition state can arise from a pre-diseased body in transition. I discuss the impact of chronic conditions to make their connection with the public health concerns of screening; disease detection and prevention, and health promotion; and their role in preventing chronic conditions. One of the goals of this section is to clarify the relationship between health, risk, and pre-disease. These connections construct the material body in the dominant social scientific, humanistic, and medical discourses and recursively shape its engagement with the discursive body. The ecological model of wholeness, centered on the body/self axis, is constituted by the discursive body in engagement with the material body. Understood alongside the deliberative vulnerability and openness of the discursive body presented in the previous chapter, the material body is concerned with its biomedical construction in public health. The ecological model of wholeness presents the material body in alignment with subjective time and intersubjective awareness and change through the lens of traditional health systems at the environmental level (figure 6.1).

Screening and Detection

Once a disease becomes long standing, it acquires the status of a chronic disease and slips into a critical and often irreversible disease state. Most scientists agree that it is crucial we make every effort as a society to detect and treat diseases in their early stages, so they do not take root. As discussed in the section above, chronic diseases can be of many types and comprise a vast range in duration. The two-pronged goals of detection comprise efforts, combining a clinical testing and research perspective on the one hand and a public health perspective on the other. In the first, the molecular clinical perspective, looks at the dynamical organizations of molecular modules, or networks, during the early development of disease from the pre-disease to the disease state to diagnosis and treatment. The second, the public health perspective, focuses on primary prevention, secondary prevention, and tertiary prevention to bring large-scale awareness. Such large-scale awareness can support healthy lifestyles, diagnosis, and treatment. This section will take a closer look at prevention to understand the connection between detection and the transition of a healthy body in a pre-disease state.

The material body in its healthy state maintains equilibrium without seemingly any overt effort on the part of the individual. It appears to go about doing its job autonomously as the individual stays busy with their routine lifestyle activities and life goals. It is only when this state of equilibrium shifts, whether due to external or internal stressors or pathogens, and when the body struggles to maintain its balance, that we begin to get a sense of something not being quite right once in a while. Screening programs are designed to identify conditions that have not quite yet reached the classification of disease, but the individual doesn't quite feel disease-free. A transitory stage, then, for the most time, feels disease free. While this transitory, in-between state may still be perceived as healthy, particularly if the individual does not overtly detect any changes, it is nevertheless a state that demands enhanced attention and greater care. In fact, it is important to provide adequate detection and counseling at this time to prevent the onset of chronic conditions. Such steps comprise primary prevention. This state has sometimes been labeled as "pre-disease" (Viera, 2011).

In primary prevention, the goal is to foster wellness in general and reduce the likelihood of disease, disability, and premature death. Such efforts during primary prevention are directed in a nonspecific manner (e.g., through lifestyle interventions, physical activity, and dietary practices), while also attending to the specific protection needed against the inception of complex diseases (e.g., through immunization). Transition is a stage of movement and change. Biologically, for instance, as discussed in the first half of this chapter, in the development of cancer, this implies that the potential tumor begins

from single cells that then begin to proliferate abnormally. These cells only gradually become malignant through a progressive series of alterations. This is substantiated by the indication that most cancers tend to occur later in life. For example, colon cancer incidence increases more than tenfold between the ages of 30 and 50, and another tenfold between the ages of 50 and 70 years. This suggests that cancer development is based on multiple abnormalities that accumulate over periods of many years. During its progression, the individual's health environment is in a state of flux, and the focus shifts to preventing adverse health outcomes and on restoring the original balance.

An individual is said to be in a pre-disease state when the following three conditions are achieved (Viera, 2011). First, the individual should be significantly more at risk of developing the disease than an individual who is not in a pre-disease stage. Second, there should be a feasible intervention that, when targeted to individuals with pre-disease, effectively reduces their likelihood of developing disease. Third, the benefits of intervening during the pre-disease stage must outweigh the harms in the population (Viera, 2011). Let's understand the relationship between risk, health, and pre-disease with an example from IOM. Taking the case of prediabetes or prehypertension, for instance, individuals who have higher-than-normal blood glucose level and elevated blood pressure don't yet have fully realized diabetes or hypertension. However, they are at a higher risk of these conditions. Here, the term "pre" illustrates that they are at a higher risk of being diagnosed with these conditions.

In such conditions, as the IOM notes, lifestyle modifications, such as a focus on regular exercise, aerobic activity, and resistance training can make a difference. Education, training, and awareness components are also important in addressing the goals of primary prevention (IOM, 2009). Studies find that programs that train individuals to effectively utilize strategies such as goal setting, problem solving, feedback, self-monitoring, and modeling can encourage positive behavior change (Bushman, 2014) and are more effective in harnessing the positive effects of lifestyle changes. In the "pre-disease" transitory stages, detection and primary prevention is usually deemed most useful. The next section will focus on prevention and its accompanying partner, health promotion. Primary prevention, according to the CDC, focuses on designing interventions before negative health effects actually occur. Primary prevention can reduce the possibility of the body moving into a diseased stage and can employ interventions such as vaccinations and reducing risky behaviors such as tobacco use in achieving its goals. This is further discussed in the next section.

Prevention and Promotion

As the IOM (2009) notes, disease prevention and promotion of health are closely related, particularly in the domain of chronic disease management. The efforts in both these instances are to prevent diseases. Prevention can be understood from a public health and physiological perspective. Taking a public health perspective, primary prevention and health promotion initiatives are important for addressing those conditions whose incidence is on the rise, such as diabetes, through taking appropriate measures in advance (IOM, 2009). Research on biomarkers from a biochemical perspective can help us understand the physiological efforts that support prevention.

The material body is described through a biomedical lens in this section to understand its intersectionality with the reflexive and embodied self. The discursive and material body is situated in the environmental context to explicate the chronic illness self management domain from a wholeness perspective. In elaborating upon these findings here, my goal is to make a case for including these understandings as a component of the material body, alongside the other elements of the material body, in the complete ecological model of wholeness.

Such implementations, I argue, sidestep the eventuality of reductionist, objectivist medico-scientific approaches to apply evidence-based findings in segmented populations under narrowly defined criteria, to assess outcomes one by one on an individual basis. Such programmatic implementations fall short of constituting wholeness in a way that constructs an integrative, harmonious vision of the individual situated in an ecosocial context within their neighborhoods, communities, and the planet. Consequences of such a lack of wholeness vision, I assert, are intimately connected with planetary fragmentation and fragmentation of the individual reflexive/embodied self that is insufficiently attended to by a pharmacological cure supported by lifestyle and health literacy messages disseminated in the media.

Primary prevention utilizes many factors for health promotion. These include lifestyle counseling, dietary guidance, stress mitigation techniques, improving sleep quality, and using nutraceuticals and herbal supplements (Katz et al., 2019). These are further discussed in the chapter on food, nature, and body/self integration, and complementary and alternative approaches targeting these techniques, which are the focus of the chapter on traditional health system. Education and awareness play an important role in preventing the development of chronic conditions. To support those who are in a transition, pre-disease stage, the prevention framework strengthens individual knowledge and skills, promotes community education, helps by educating health care providers and professionals, and mobilizes neighborhoods and communities, alongside addressing other structural aspects (CDC, 2019).

Building on primary prevention, secondary prevention addresses screening and related initiatives to identify diseases and conditions that are still in early stages of manifestation, or in the pre-disease stage. In this stage, their signs and symptoms are not yet perceived. The goal of secondary prevention efforts is to decrease the chances of such conditions to become fully manifest. Complementary and alternative medicine approaches can be helpful in supporting the goals of prevention and health promotion. Secondary prevention focuses on detection and management of disease while it is still largely pre-symptomatic for the individual, although it may be detectable through clinical testing. While such efforts may be able to prevent the disease from starting, but they may not be able to obviate progression to disease. Secondary prevention can be visualized as a next line of defense against the actual realization of disease state. Screening efforts, for instance, help in early detection (e.g., mammography, colonoscopy) or cardiac risk screening (e.g., blood pressure screens). Pre-symptomatic diagnosis and treatment through screening programs is called secondary prevention.

One of the ways that communication researchers have focused on the promotion of public health screening efforts stems from the focus on message design. Holt et al. (2009), for instance, discuss how the framing of health messages to increase colorectal cancer screening in African American churches was well received when spiritual themes, such as stewardship over the body, being well to serve God, and using faith to overcome fear, were integrated in materials that showed African Americans in real settings, with bright color schemes and uplifting messages that emphasized prevention and early detection. Best et al. (2015) examine culturally framed communication to increase breast cancer screening among African American women and find that health communication materials that contain messages including a focus on the body as a temple, that going to the doctor does not make one faithless, or that God did not give a spirit of fear were important in designing culturally appropriate messages.

Others have examined variables such as language of materials for colorectal cancer screening (e.g., between English and Spanish speakers, Ramirez-Zohfeld et al., 2015), relationships among parent-child weight status (for weight-related behavior change, Leary et al., 2013), knowledge and awareness among cultural groups (such as perception of cervical cancer among Hispanic American and African American teenage girls, Mosavel et al., 2007), and structural changes in policy environment and environmental interventions (e.g., for STI screening, Sweat et al., 2006). I take the reader through a small journey down the biologically informed landscape of the material body in order to situate these multiple threads in the ecological model of wholeness in this chapter.

The third step in this process is tertiary prevention. In brief, tertiary prevention efforts have the goal of managing disease post diagnosis, to slow or stop

disease progression through measures such as chemotherapy, rehabilitation, or screening (CDC, 2019). At a biochemical level, much interest has centered around trying to identify how early diagnosis of complex diseases can be done through accurate medical testing. Scientists are currently engaged in finding accurate and robust biological markers, or biomarkers, for identifying the presence of a disease. Each biomarker can be specific to a disease. Glucose levels, for instance, are used as biomarkers for detecting the presence of diabetes. Some types of biomarkers include molecular biomarkers, network biomarkers, and dynamical network biomarkers. Molecular biomarkers provide an accessible way of data measurement to help distinguish disease samples from normal samples in clinical testing. It is hoped that by understanding the relevance of each biomarker, disease diagnosis and treatment will be more accurate and targeted.

Some types of biomarkers include molecular biomarkers, network biomarkers, and dynamical network biomarkers. A molecular biomarker can be helpful in identifying individuals susceptible to disease. Network biomarkers or module biomarkers, for instance, are considered more robust in their ability to characterize diseases. While both molecular and network biomarkers are able to distinguish disease samples from normal samples in clinical testing, they cannot identify pre-disease samples because of the static nature of this state. Thus, they cannot help with early diagnosis. For example, biomarkers of exposure to toxic environmental substances (such as lead exposure) can help in measuring the internal dose of the environmental exposure. External exposure can be measured by assessing the concentration of the toxin in an individual's environment. An internal measurement can be obtained by identifying how much of the toxin is present in target organs or body fluids. Other ways in which molecular biomarkers help is in their ability to identify individuals susceptible to a disease in a population based on a specific "genotype" associated with a disease, rather than a report of a family history of the disease. Work in this area (e.g., Liu et al., 2014; Li et al., 2014; Zeng et al., 2014) is focused on developing dynamical network biomarkers that can help distinguish a pre-disease state from normal and disease states more accurately and help with early diagnosis of the complex diseases.

Pre-disease and the transition to disease can be understood at a cellular level. For instance, with chronic stress, it is found that the healthy psycho-immune-neuroendocrine (PINE) network involved in major depressive disorders moves to a progressively unstable but still reversible pre-disease state. Most scientists agree that identifying the critical state or pre-transition state just before the occurrence of a phase transition is an important but challenging task (Chen et al., 2016). The gradual parameter variations are challeng-

ing to detect because the state of the system may show little obvious change before the critical transition between the pre-disease and disease phases.

The biomedical knowledge of the body/self relationship provides an essential knowledge and awareness dimension that enhances the literacy factor of the chronic care management challenge in important ways. Understood from the perspective of the ecological model of wholeness, the biomedical knowledge of the material body situates it in a cohesive framework of understanding in relationship with the reflexive and embodied self and the discursive body. While health literacy initiatives designed following the evidence-based findings (discussed a little bit further down in this chapter), the ecological model for constituting wholeness posits that such findings, implemented piecemeal in different initiatives, do not provide an integrative or balanced experience that connects the individual in meaningful ways with their own material body situated in a dialogic relationship with their reflexive and embodied self and discursive body. As a consequence, the initiatives, while significant and successful in targeted subpopulations and in segmented outcomes, apply to a very narrow and specific range of human experience and do not construct a chronic care management domain that enhances meaningful connections within the life span and the ecosocial challenges that are needed to address current global individual and planetary crises.

The phase transition is generally understood to be composed of three stages: the before-transition stage, the pre-transition state, and the after-transition state. The switching point from these states is communicated by our bodies through early-warning signals that communicate an upcoming phase transition. In the case of continued presence of chronic stress and other factors including genetic predisposition, intrauterine, and developmental factors, the healthy, but pre-disease state PINE network makes an irreversible critical transition to a diseased phase, in interaction with a pre-dispositional vulnerability and external stress caused by life experiences (the diathesis stress model). Recent research seeks to identify the processes that examine the differential associations between the observed molecules in the normal and pre-disease states and utilizing this information to measure the critical transition to the disease state (Chen et al., 2017).

Studies on the PINE pre-disease state have posited this as a “universal pre-disease state” for a range of noncommunicable diseases. Critical transition of the PINE network may lead to one of several frequently associated disease states, as identified in common Chronic Illness Risk Network (CIRN; Stapelberg et al., 2019). Examining the pre-disease state more closely in conjunction with the diathesis and CIRN model can provide a deeper understanding into how related chronic conditions arise. Currently, the progression of complex diseases (e.g., diabetes, cancer) is understood to be a nonlinear

process going from a normal state to a pre-disease state to a disease state. The pre-disease state is the critical state or tipping point immediately preceding the disease state. Traditional biomarkers aim to identify a disease state by looking at the information of differential expressions for the observed molecules. However, although science has made great strides in detection, the minute nature of changes at the signals on a molecular level between the normal and pre-disease states often makes such progression challenging to detect. Current medical challenges include identifying a way to unravel these molecular processes. By understanding the underlying mechanism of the dynamical progression when a biological system is near the tipping point, one can detect the early-warning signal of an imminent critical transition. This information can then help prevent it with timely intervention.

As the workgroup report from the Institute of Medicine (IOM, 2009) notes, both preventive medicine and public health share the objectives of promoting general health, preventing specific diseases, and applying epidemiological concepts and techniques toward meeting these goals. In this direction, there is a great deal of synergy between integrative medicine and preventive medicine such that the holistic approach of integrative medicine helps overcome what the IOM calls the “traditional wall of silence” between complementary and alternative medicine and conventional practice and reducing negative outcomes or gaps in care. This chapter concludes by taking a brief look at what happens beyond pre-disease and transition phases to examine the diseased body.

THE DISEASED BODY

The diseased body speaks its own language. Following the ecological model of wholeness, each of us experiences our own instance of allergy in our own embodied, subjective, and uniquely temporally, socio-culturally positioned ways. The diseased body, unlike the tentative, rather negotiable voice of the body in transition, constructs its own unique relationship with the body/self anchor of the ecological model of wholeness. This language, in the context of chronic conditions, straddles the unique, individual components of the body/self, and the contextual elements. In this manner, it is constructed uniquely in each instance and by each individual at each moment in time, in ways that can seem productive and oriented toward wholeness as situated along its infinite experiential tangents.

Sontag's (1978) foundational inquiry into examining not only the diseased physical body but also the use of illness as a metaphor illustrates this subjective relationship. Her assertion that illness is not a metaphor and that in some ways, as she puts it, “the healthiest way of being ill—is one most purified of,

most resistant to, metaphoric thinking” (p. 3) illuminates how illness straddles the subjective and the objective in individual, collective, and social ways and challenges interpretation (e.g., via metaphor and language) while being, in some ways, constituted through interpretation (e.g., of the doctor, the technology). The diseased body, in Sontag’s essay, is made transparent by the doctor, the technology, such as X-rays, who then interpret their “opaque body” to the patient (p. 12). While the communication of the diseased body may be different from the communication of a healthy body, or arguably more transparent or opaque, as argued by Sontag in her classic essay, our relationship with the diseased body can nevertheless be a productive and powerful one.

With proper understanding of the structural and physiological factors that define a chronic condition, an individual can construct a positive, enabling, and healing relationship with their body. This section lays out the foundations that comprise such a healing communication in greater detail. Once disease has manifested in the body, achieving health requires treatment, rehabilitation, disability limitation, and related processes such as social support. Frohlich (2016) observed online communities of people with inflammatory bowel disease (IBD) to see how individuals with IBD used social media to redefine what it means to live with the disease. He found that the online communities, meant for support and education, also helped individuals refigure the body as beautiful, IBD as serious and deadly, disease making the individual stronger, and IBD as invisible, but needing to be made visible, thus reconceptualizing their sense of self and the disease.

Even when the health of a body is no longer in the domain of preventive medicine, recent research in medical science indicates that preventive medicine should still play some supportive role in its treatment. Several examples can help illustrate the shifting boundaries in this stage. Biomedically, for example, preventing early cancer from metastasizing, or coronary disease from inducing a myocardial infarction or heart failure, or restoring functional ability through rehabilitation are situations where how we choose to interpret disease and treatment is often key to understanding where prevention is situated in the domain of disease manifestation. To better understand this statement, consider the instance when coronary artery disease is the disease diagnosis of an individual (IOM, 2009). The treatment will focus on preventing progression to myocardial infarction and will thus be categorized as tertiary prevention. However, we could identify myocardial infarction as the disease. In this case, then, the treatment of coronary atherosclerosis would be considered secondary prevention. This example illustrates a key point. Each stage of prevention is an opportunity to integrate health promotion and disease prevention, and this includes even the diseased stage (IOM, 2009). Treatment of the body supported by the elements of the ecological model of

wholeness can provide an integrative approach to the physiological concerns of the material body.

Understanding Chronic Conditions

Many complex diseases today have no cure. While diagnoses of previously fatal conditions like tuberculosis (TB), HIV/AIDS, and cancer largely meant a shorter life span, today many of these are in the realm of chronic conditions with long-term survivorship rates giving individuals a chance to live healthy, productive, fulfilled lives. More people than ever globally suffer from complex and chronic illnesses. Thus, it becomes even more paramount to make an effort to promote education for maintaining health as well as to prevent disease. This section looks at what are chronic conditions, their lifestyle and prevention factors, and how structural social inequities may compromise the ability of specific sections of our society to stay healthy.

As a definition, a chronic disease is a disease that lasts more than three months and may get worse over time (National Cancer Institute, 2019). Thus, at its core, it has a temporal experiential element that often will span the course of an individual's lifetime. As discussed in the first chapter of the book, although chronic conditions tend to occur more in older adults above fifty years of age, and cannot be cured, these can be controlled to a great extent through lifestyle and awareness. Others define chronic diseases as conditions that last one year or more and require ongoing medical attention or impact functional activities important for daily living. Yet other definitions emphasize the aspect of non-communicability of chronic diseases, referring to them as NCDs. Some examples of chronic diseases include cancer, heart disease, stroke, diabetes, and arthritis. Often, diseases such as cancer and HIV transition from being terminal to chronic. While there may be many differences in how we choose to define chronic diseases, there is no doubt that their burden is high, both on the people shouldering their weight, their caregivers and families, and on the health care system treating individuals with chronic diseases. Globally, NCDs kill 41 million people, accounting for about 71 percent of all deaths each year, as reported by the WHO (2018). About a three-quarters of these deaths occur in low- and middle-income countries, driven by rapid unplanned urbanization and globalization of unhealthy lifestyles. Unhealthy diets, lack of exercise, tobacco use, and use of alcohol contribute to these figures. Their increase globally particularly impacts the poverty reduction initiatives in low-income countries, where these challenges are compounded by increasing household costs of health care.

The impact of screening, detection, and health promotion messages examined in communication research is made more vital as numerous studies

have established the disproportionate burden of chronic illness on the disadvantaged. Vulnerable and socially disadvantaged people get sicker and die sooner than their more privileged counterparts. Description of heart disease in Clarke and Binns's (2006) research illustrates that magazine portrayal reveals optimism about medicine, medicine as "good" versus the body as "bad," heart disease as an individual responsibility and as a condition that generates fear, while inadequately discussing social structural causation factors. The high prevalence of NCDs slows economic growth and exacerbates poverty in low-income countries. In the United States, the National Health Council reports that chronic conditions alone are responsible for an economic burden of USD 3.1 trillion stemming from the seven most prevalent conditions (cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions, and mental illness). Chronic conditions are the leading cause of death and disability in the United States, with approximately six in ten American adults having at least one chronic condition and four in ten adults living with two or more chronic conditions (CDC, 2019).

The above discussion illustrates the multiple, objectively measurable ways in which the impact of chronic conditions plays out in our individual, communal, and social lives. As the ecological model of wholeness suggests, the traditional health system context referenced by CAM and the biomedical onto-epistemological situatedness of the body/self anchor contributes to the mediated construction of temporality and the socio-cultural environment of the chronic disease context. The traditional health system context will be discussed in detail in chapter 8 of the book, but in this chapter, I will bring together the implications of the findings as applied to the body/self anchor and the three contextual layers of the model toward the conclusion. Section III covers practices that can be employed to integrate the contextual layers in practice in the chronic care management domain in ways that create integrative and balanced experiences of wholeness tailored to the individual body/self experience.

A large body of communication research has examined screening through the lens of culture. Such research can provide ways of effectively communicating messages that address the barriers to screening. For instance, in examining cervical cancer screening among Latinas, Nancy et al. (2018) find that structural barriers, fatalism, religious service attendance, perceived susceptibility, costs, and cues to action are associated with Pap test compliance. Language as a barrier has been examined among immigrant women in cancer information comprehension (e.g., Thomson & Hoffman-Goetz, 2011), while Cohen et al. (2016) identify sociocultural barriers to mammography adherence among Appalachian Kentucky women. Cohen et al., for instance, find that women's descriptions of pain and embarrassment, and the lack of personal or

professional experiences, fear of cancer, and poor communication with their providers were a barrier to mammography adherence and follow-up care.

Cultural appropriateness of health communication messages addresses the intersection of individual identity and social values (Tan & Cho, 2019). In addressing culturally grounded communication, Baezconde-Garbanati et al. (2014) constructed a culturally specific narrative to use as a behavioral change communication tool. Their narrative health communication intervention, called Tamale Lesson, was aimed at promoting cervical cancer screening in Mexican American women, and its success highlighted the power of culturally grounded narrative/storytelling in addressing health disparities. Provider-patient communication in colorectal cancer screening (Ge et al., 2009), celebrity illness disclosures as shaping audience involvement by message frame (Drizin et al., 2018; Myrick, 2019), and cultural grounding (Hecht et al., 2006) have furthered how health communication messages can be designed and framed in promoting screening and detection messages among different groups in appropriate ways. Tan and Cho (2019), for instance, highlight how messages included the epidemiological bases of the intervention and the language of the population more often than the cultural features and cultural beliefs and values of that inform cultural tailoring through using acculturation or cultural identity frameworks. Reduction of cultural barriers and supporting cultural strengths can help address health disparities in this area.

This body of research suggests that even though chronic diseases have such a high burden, they can often be prevented or controlled through communication factors informing education and knowledge in culturally sensitive ways, leading to awareness of simple lifestyle patterns. The ecological model of wholeness provides a framework for the integration of the substantive findings in the literature presented above in the communication and public health domain to constitute wholeness. The findings from the different factors identifying causes and effects of disparities and related challenges to grappling with the chronic condition management landscape can be integrated in the design of practices suggested in the next section of the chapter on the environmental level of traditional health systems in creating a context that constitutes wholeness through integrating the large body of individual research findings in this domain in a coherent model (figure 7.1). Detection and screening are important elements for preventing the negative outcomes of NCDs. While the use of screening tests has increased in the United States in recent years, not everyone who needs these tests is able to receive them.

Factors Influencing Chronic Conditions

Research shows that although screening rates differ by condition, certain groups generally are less likely to get screened. Cultural factors certainly play into how different groups see screening and prevention efforts (Dutta, 2007). Such groups include those who don't have health insurance, those who fall into the low-income category, and those who live in under-resourced rural areas (Health Policy Institute, 2019). These screening guidelines and conditions have been identified for several conditions, including precancerous lesions, increased intraocular pressure, prediabetes, and prehypertension.

A wide range of factors contributing to global health disparities have been examined in a rich body of communication literature. These range from examinations of digital divide and the ability to access health information online (Borg et al., 2019; Dobransky & Hargittai, 2012; Hinnant et al., 2019), literacy and education (Simonds et al., 2017; Yamashita et al., 2015), gender (Philbin et al., 2019; Zimmerman, 2018), race and socio-economic status (SES; Burgess et al., 2019; Moran et al., 2019; Pena-Y-Lillo & Lee, 2019), race and culture (Dillon & Basu, 2016), age (Skurka, 2019), rural-urban divide (Estrada et al., 2018), public attitudes about attributions of responsibility (Lundell et al., 2013) and health information channels (Kelley et al., 2016; Manierre, 2016), to social capital/neighborhoods (Matsaganis et al., 2015; Zhao et al., 2019), among others.

Beyond the structural and socio-economic factors underlying inequity and access touched upon in the first chapter, lifestyle factors such as smoking and excessive alcohol, stress, and depression, for instance, are common risk factors for obesity, a chronic health condition of being above normal weight. Obesity, in turn, is related to other diseases such as arthritis, stroke, heart attack, asthma, and type 2 diabetes, among other social and emotional issues. It is crucial to understand how people who are obese see their body and see themselves through their body. Representational understandings of the obesity experience, such as in journalism, can further help health care practitioners address the common risk factors such as alcohol, depression, and smoking in positive ways (Garyantes et al., 2019). Some research findings suggest that health computer-tailored technology can support health promotion behaviors such as physical activity, which could then serve as a gateway behavior targeting multiple behavior changes (Schulz et al., 2015). As a chronic condition, obesity is considered related to a person's lifestyle characteristics such as low physical activity and a high calorie/fat diet. In the United States, the surgeon general has declared that obesity has reached epidemic proportions with 35 percent of women and 31 percent of men seriously overweight and

15 percent of children between the ages of six and nineteen being seriously overweight (CDC, 2019). Understood as a chronic condition, obesity can be seen as shaping and being shaped by how an individual sees themselves and their relationship with their body in both material and discursive ways.

The body/self anchor of the ecological model of wholeness centers the individual in dialogic engagement with their reflexive and embodied self and the discursive and material body. The reflexive self is understood in a relational and dialogic relationship with the self, provider, and caregivers. The discussion on the material body in this chapter explicates in detail the constitution of the self in alignment with a public health model through a bio-medical and socio-cultural lens as the body in chronic illness moves from the healthy body to the body in transition and the diseased body. The reflexive self of the ecological model of wholeness as presented in chapter 3 elaborated on the construction of the self through self-awareness, self-monitoring, and self-knowledge in a reflective manner. The reflexive self developed in the book evokes an interpretivist ontology, encouraging the individual to look in deeper ways at the material constitution of their body in intersubjective ways situate their ownership of intentionality and action as these are inscribed on the self.

The embodied self in dialogic engagement with the reflexive self emphasizes the pre-discursive and pre-reflexive dimensions of intersubjectivity and intentionality to constitute the self as embodied. The model envisages the second dimension of the self as embodied, in dialogic engagement with the reflexive self. This implies that the self is a priori privileged as intentional and whose intentionality acts through the discursive and material body dimensions. In the chronic illness domain, the ecological model of wholeness suggests approaches and practices that provide the epistemological praxis to structure the body/self dimensions to constitute wholeness. The intentionality of the embodied self, thus constituted, can be supported by symbolic representations of freedom, agency, and power, elements of spatiality that structure the lived spatial environment in harmony and balance with the individual's relationship with their lived elements, and being mindful of the experientially inscribed knowledges that constitute their experiential environment to constitute wholeness in the chronic illness self-management domain.

Centering the contextual dimensions addressed in section II of the book explaining the ecological model of wholeness can be employed to guide design and implementation of practices to address the concerns raised in this chapter on the challenges and stages of change particular to the body with chronic illness to envision these as constituting wholeness. The time, change, and illness orientation covered in chapter 7 as communicated in the media can create supportive, unbiased past/future constructions of the self as the material

body changes. Such representations can include a nuanced and multi-layered positioning of the chronic condition through the lens of a-linearity, or as not shaped through comparisons between an idealized or anticipated past/future or a feared/avoidance-oriented past/future in shaping its messages.

The traditional health systems orientation (covered in chapter 8) will envisage the combination of biomedical evidence-based, diverse treatment options, supported in part by validated CAM care, and coupled with patient-centered, holistic orientations that respects patients' beliefs and communicates compassion. The IOM advocates an approach that communicates respect for evidence-based medicine, while being responsive to the needs of the patient, and addresses the whole-person vision of health. Such integrations will need to be mediated through a thoughtfully constructed temporality and the socio-cultural environment to address body/self anchor through the elements centering the individual including solitude, silence, and compassionate, available self-presence.

Finally, the third contextual level of food, nature, and body/self integration is addressed through situating the relationship of food as a material and discursive phenomenon balancing consumption and nourishment within a religious-cultural knowledge paradigm of sustainability. Sustainability is envisioned through a body/self/anthropomorphic intersectionality that emphasizes an ecosocial identity of the body/self connected with nature. The individual, situated in a secular, historical, geographical frame, envisions the body/self/other relations in and through community in nature to constitute wholeness in ways that manage the fragmentation and dissipation of the body/self characterizing the long-term struggles of living with chronic illness. The practices for integrating each of these contextual levels are discussed in the next three chapters, in the third and final section on the environment of the ecological model of wholeness. In the next chapter on time, change, and illness intrusion, the first contextual layer of the environment, I present the ideas of how long term changes in the body/self as developed in the chapter on discursive self through subjective change are situated in a-linearity, self-concept/self-identity, and the idea of subjective time.

Chapter Seven

Time, Change, and Illness Intrusion

Time is central to the idea of healing. Healing is about adjusting to change. Changes in life status are inevitable. Our circumstances evolve, our neighborhoods change and grow, our personal lives shift with time. We were once a child, a student, a new employee, and are perhaps now a young professional or a senior executive or a new mother or a grandfather. Our neighborhood trees become bigger or fall down with storms. Roads get built and houses come up or are demolished to be replaced by newer structures. Our neighbors' children grow up and have children of their own. Likewise, change permeates our own lives. We build families—simple or complex, big or small—and relationships with myriad other human beings in various ways. Recognizing, observing, acknowledging, and growing with change is part of the adaptive processes constituting health and well-being. This chapter examines self-concept in relation to the notion of subjective time to understand the change brought about in chronic illnesses and management of their long-term challenges. From the lens of self-concept theory, the sense of self is continuously affected by one's experiences. Chronic illnesses provide an illustrative case for understanding the management of significant adaptive challenges that fracture the individual's sense of self and self-narratives in disruptive and debilitating ways.

Although change is inevitable and constant, it is not always visible to most of us in easily identifiable ways. For healthy individuals, because shifts of time in our lives are so gradual and incremental in the moment, we don't often remain aware of the moment in its ever-changing nature. For individuals living long term with a chronic disease, the sense of self often becomes closely associated with the disease, its treatment, and disease-related experiences, resulting in illness-related self-representations (Devins et al., 1997). In such instances, the notion of self-concept is shaped in uniquely

challenging ways with the perception of change and subjective time. In healthy individuals, the conscious attention is directed outwards toward meeting the identifiable needs of the moment, not so much toward understanding the nature of the moment itself. Yet within the moment itself, change continues, one micro-moment by micro-moment. As with the lived micro- and macro-environment, the body too is in a state of constant change. Some changes are obvious, such as birthdays and anniversaries marked by community and family celebrations. Others are obvious in our carriage. We grow in height, our voice cracks, other physiological changes are reflected in our appearance as our hair grows or changes color and our feet size or skin texture increases. Perhaps we build muscle. We lactate. We shave. Community traditions such as the bar mitzvah and coming-of-age ceremonies in different cultures help us recognize and acknowledge the passage of time, and with it, change.

At other times, change can seem disruptive. Changes that are perceived as disruptive are often not as subtle and demand our attention in unexpected ways. An example of a disruptive change is when our body status suddenly shifts in its functionality with an accident or injury. Other examples of disruptive change can range from losing an arm, getting a life-changing health diagnosis, or being sick with a fever. Such changes force us to rest in order to recuperate. Sometimes disruptive changes compel us to take time out from work to visit the doctor. At other times, a diagnosis compels us to adjust with an altered sense of life span. Whether invisible or visible, subtle or sudden, celebrated or disruptive, understanding the nature of time and change calls for adjustment and coherence in the individual or collective sensemaking process.

Needless to say, we've all experienced change. To illustrate, let's play a simple thought exercise. Let's imagine I have asked you to close your eyes and think of what the notion of change meant to you. Starting from the moment of our existence from a single cell structure, our bodies are in a state of change. We are all, every one of us, intimately familiar with change. Change not only defines our own bodies, but also is everywhere around us from the microcosm to the macrocosm, constituting the very nature of the living to the non-living states of matter that surround us. We are immersed in an ocean of change. Yet, it is challenging to define the nature of change. How can the notion of change be defined? Health behavior change theories, for instance, define change of some observable behavior as captured over time. Qualitative analysts understand change perceptually by delving into the nature of the perceived progression of a phenomenon or experience over time. The one constant in all the definitions of change is time. Change involves a form of progression of state, of matter, of being, of behavior, or of experience. Objects and experiences, for instance, change—they progress in nature, quantity,

quality, and so on, and in doing so, it becomes possible to identify a state along an axis of time that can be classified as a before or an after.

One of the salient ways we make sense of change as progression in our lived experiences is as a process. This chapter is about time and its relationship with change in the construction of wholeness. In developing an argument about the relationship of time and change, this chapter constructs an argument about what change means to the chronic illness experience and how such understandings can be employed in constructing healing encounters, experiences, and environments. By examining the subjective meanings and effects of change, the chapter opens possibilities of observing the lived experience of the body/self in its reflexive/embodied and discursive/material dimensions through the lens of time. Long-term survivorship experiences in particular are characterized by the overwhelming, yet incredibly subtle, day-to-day lived negotiation of time and change in the manifestation of illness intrusion. Centering understandings of how subjective change is given meaning in long-term survivorship can construct dialogic approaches to healing that identify and locate the invisible ways in which the chronic illness experience is co-constituted by the individual's evolving relationship with their lived environments over time.

THE ASSUMPTION OF LINEARITY

Viewed from a social constructionist perspective, the experience of change is centered in relationality and dialogic engagement with body/self and the lived environment. In the chronic illness experience, change defines how the body/self is experienced along a temporal, relational continuum. Present experiences are made sense of through narratives employing different lenses, such as how one's identity and self-concept shifts from past experiences and in envisioning their implications in the future. Seen from the reference point of the body/self in chronic illness, change highlights notions of identity and self-concept as being conscious of the experience of a *before* and an *after*. Most experiences of health or illness that provide an evidence of before and an after are temporally defined. The construction of the body/self in the present itself engages narrative sense making of the perception of an ever-changing moment of time.

Although the subjective experience of chronic conditions challenge the individual to see themselves beyond a body in pain, engaging the body/self in experiences that connect the subjective environment can help anchor and shift the perception of pain in relationship with time. Art, for instance, in its contemplative function, can support experiences of stability in the accep-

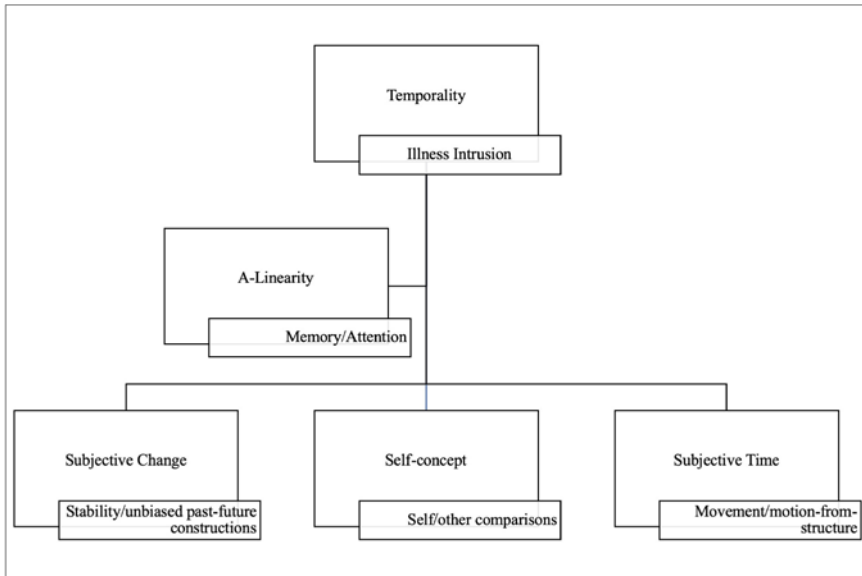


Figure 7.1. Time, change, illness intrusion. Figure created by author.

tance of change through the present. Buber's notion of the I/Thou (1970) in a relational and dialogic approach can be integrated to construct the reflexive and embodied self in the present. Such interpretive approaches to shaping the chronic illness experience acknowledge that the changing present is ever-constant. Those living with chronic conditions and their comorbidities are typically challenged to anchor themselves in the present and to be open to new experiences and their lived environment. Shifting how the pain experience is interpreted and narratively engaged in a dialogic understanding of change with the individual's subjective experience of it can help structure open dialogic approaches.

Each change, however miniscule, requires an adjustment. Some adjustments are more straightforward in their behavioral exemplification. However, these adjustments follow a less explicitly obvious phase of decision making. These processes, extensively documented in behavior-change theories of health, include variables such as intentions, norms, attitudes, awareness, cues, intentions, and knowledge. Such adjustments can be physiological, emotional, cognitive, or spiritual. Community and social structures help us adjust through celebrations and recognitions of change that reinforce an acknowledgment of the accompanying shifts in roles, demeanors, responsibilities, and status in life. Although changes are linear in nature by virtue of having a before, a present, and an after, they are not necessarily smooth. They could be invisible and tiny, and we might never notice them happening, such as a

strand of hair growing or graying. We only grasp change once it reaches an order of magnitude perceptible to our eyes, hands, thoughts, intentions, and measuring instruments.

Technology can help us identify some changes before our conscious capacities can observe these. A mammogram can help detect a cellular abnormality. A CAT scan can help identify a brain wave. An ECG can detect a change in our electro-cardio rhythm. These changes are, regardless of our attention to them, happening in our bodies. We just are not able to see them. For instance, the autonomous nervous system (ANS) regulates our heart rate by the operation of the sympathetic and parasympathetic nervous system. Our endocrine system is responsible for the hormones that regulate many of the physiological changes in our body, including those of growth and sexual development. These subtle changes occur through our lifetimes at the subconscious level, most often without our explicit knowledge or control.

Sudden, disruptive changes give us less time to adjust. Life events like an automobile accident often happen without our having enough time to prepare for them or without the subconscious processes that more predictable changes involve. Thus, we don't get to evolve into them through miniscule moment by moment changes. In some cases, we may be thrust into conversations with medical professionals following an unexpected diagnosis. We may dislike the altered sensory perceptions we face due to an accident. We may wake up after a coma with an unexpected amputation from a rare disease. Regardless of the cause of the change, the requirement of adjusting to change remains a constant. However, just as with expected changes, unexpected changes force us to face them and acknowledge their reality. In the process, we are faced with accepting change not just in our bodies, but also at our cognitive and affective levels, in a short period of time. We are faced with accepting a change in our concept of who we are with our changed internal and external circumstances without the comfort of being oblivious to it on a moment-by-moment basis.

Such circumstances affect our sense of well-being and may force us to examine our relationship with our bodies and our self in deep and challenging ways. In order to understand the relationship of change with healing, it is important to understand how change affects our perception of who we are. One of the concepts that is useful in providing an insight into our sense of what we can do, and our perceived status and abilities, is self-concept. The next section takes a deeper look at self-concept theory and how diseases and illnesses are perceived by individuals. It examines concepts like illness identity and illness intrusiveness from different disciplinary perspectives such as communication and psychological research that have examined how people perceive and live with illness and disease.

Change and the Self

Self-concept is a multidimensional construct. Its conceptual domain captures what individuals believe about their own status and abilities, their attributes of who they are, and the nature of their self. It considers the degree to which different aspects of the self are integrated into a well-defined whole or self-aspect clarity (Campbell, 1990). Assessments of self-concept also include a sense of continuity of the self over time, or self-continuity, which provides a sense of connection between one's past and one's present (Bluck & Alea, 2008). Higgins et al. (1987) distinguished the ideal self as the self-concept representing hopes and aspirations, the ought self as the self-concept representing duties and responsibilities, and the actual self as the self-concept representing actual attributes. Psychologists have examined self-continuity by differentiating distinct aspects of the self and the organization of the self with respect to specialization of the structures and functions, such as into physical, social, and spatial-symbolic domains.

Likewise, self-identities are understood through their process of being differentiated and organized continually, with past identities being continually discarded and new ones being continually assimilated. Such identity work requires maintaining a structural integrity in the extended sense of self or the superordinate identity to maintain self-continuity of an enduring sense of self over time (Erickson, 1994). Developmental psychologists have suggested the self develops along the dimensions of sociality and temporality (Bird & Reese, 2008). Self-continuity, which is a temporal dimension, cannot be constructed without awareness of the self as distinct from others (sociality), referencing self-knowledge. Second, a self-boundary helps maintain self-continuity, which helps to meet the needs of self-protection and self-expansion.

Self-concept clarity and self-concept continuity are considered foundational to self-identity, or the viewing of the self as the same person in the midst of contextual or life changes (Gregg & Sedikides, 2018). Self-concept clarity is considered an individual resource positively associated with various outcomes such as couple relationship well-being (Parise et al., 2019). In other words, a clear and coherent self-concept can provide a supportive structure to facilitate the sense of an enduring self. Self-concept comprises an existential self and a categorical self (Lewis, 1990). The different components of self-concept are associated with self-perceptions specific to an individual skill or domain, such as social functioning, academic performance, and physical attributes (Piers & Herzberg, 2002). In general, positive self-concept provides us with positive beliefs about our potential and capabilities and is understood to be associated with psychological well-being and successful functioning (Baumeister, 1999; Craven & Marsh, 2008).

Self-concept comprises self-image (one's image or view of oneself), self-esteem (an evaluation of worth), and the ideal-self (the desirable self, what one wishes one really was like). In research findings, self-concept constructs relate positively with meaning in life (Schlegel et al., 2009) and psychological health (Ritchie et al, 2011) among other outcomes. For instance, in type 1 diabetes patients, illness self-concept has been found to be negatively related to emotional stability, self-esteem, and diabetes integration (Luyckx et al., 2015). For adolescents, self-concept has been found to be important in adjustment to changes related with chronic illness (Emerson et al., 2019). As Devins et al. (1997) note, loss of physical strength, economic hardships, and dependencies on medical technology are some of the commonly documented challenges faced by patients of end-stage renal disease (ESRD). These illness-induced disruptions bring about the necessity of adjusting to change in lifestyle routines, interests, and activities and negatively influence quality of life. Illness-induced disruptions, or as psychologists will label the term, illness intrusiveness, are understood as disease-related physiological changes and functional deficits, and pain, physical disability, fatigue, and reduced energy levels (Devins et al., 1997). Illness intrusiveness plays a role in how chronic disease has an impact on psychosocial well-being.

The subjective experience of change can be explored through the lens of self-concept theory. Individuals feel a lack of control over their lives (for example, as described through the construct of lack of perceived control through health behavior change theories) and an inability to include positive experiences in their lives. Self-concept has been found to be a useful variable influencing how an individual is affected by chronic disease (Devins et al., 1997). Keyes and Ryff (2000) draw upon self-concept theory, which suggests that perceived improvement should increase both positive and negative mental health as it violates the self-consistency standard but satisfies the self-enhancement standard, to examine the consequences of perceived improvements and perceived declines in life. They find that changes in subjectivity produce complex mental health profiles because such changes are understood through multiple self-standards and are experienced through distinct reactive channels. For instance, at points in life when individuals noted greater perceived improvement, findings suggest that at such times individuals were also more likely to perceive increase in both negative and positive health, whereas perceived decline exhibited a double-dose effect on mental health. Such findings from current research suggest that the subjective perception of change is central to examining what individuals believe about how well they are doing.

Subjective change references an appraisal that the individual experiencing the change is a new or different kind of person. It references that some aspect of one's functioning has improved or declined. In assessing the nature of

change, individuals believe they have become better or worse as a person by appraising whether they have more or less or any attribute (e.g., as parents, as healthy individuals). To illustrate, the social dimension of the self is affected by chronic disease management in the ability of the individual to perform certain roles. Thus, self-concept is vulnerable to states that disrupt role performance (Charmaz, 1991). Chronic illnesses and pain are central to disruptions in role performance in ways that are made more challenging due to their often invisible and debilitating nature.

Important role performances that can be affected by chronic conditions include being a parent, a colleague, a friend, a sibling, and other family and professional roles. For instance, multiple sclerosis patients who report challenges in pursuing family activities together, such as spending a day at the beach or hiking with children and pets, report greater debilitation in their self-concept. For stroke patients, for instance, Ellis-Hill and Horn (2000) examined changes in self-concept and found that stroke patients had a negative sense of self, decreased social activity, and greater psychological morbidity despite rehabilitation efforts. Thus, examining the intersection of the body/self with change through the lens of self-concept can help illuminate how illness impacts individuals in different ways. More importantly, because self-concept provides an entry way to understanding the meaning of illness for each individual (Ellis-Hill & Horn, 2000), such understandings suggest dialogic and relational spaces for shaping the chronic illness experience in subjective ways.

In living with chronic conditions, an individual's prior experiences, or the experiences that the individual enjoyed before the onset of the chronic disease, become relegated to the background of their present and perceived future possibilities, or the "former self." In Devin et al.'s (1997) study, the negative impacts of illness intrusiveness on self-concept was observed to play out in a nuanced way for chronic kidney disease patients. They found that as illness intrusiveness increased, well-being decreased for older patients who saw their identity as similar to that of the typical chronic kidney patient. In contrast, for those patients who did not see themselves as similar to the chronic kidney patient, increasing illness intrusiveness did not impact self-concept negatively. However, when illness intrusiveness was high, changes in self-concept emphasize the negative effects of illness intrusiveness and thereby increase its overall disruptive potential. This impact has been projected to vary across different stages of life, based on how an individual appraises his or her disease, the effectiveness of their coping strategies, and the perceived emotional impact of illness at different stages of their life.

Communication researchers have attended to the role of regulatory frames employed with health messages that can vary with motivations to engage

in health promotion or prevention. Findings suggest that individuals with a promotion-oriented motivation focus on avoiding losses or negative outcomes. Messages, too, in health communication research, can be framed in terms of a prevention or a promotion focus (such as by highlighting desirable outcomes or negative outcomes or an aspirational self or by emphasizing a need or responsibility; Higgins, 1997). Self-affirmation theory states that individuals strive to maintain an overall sense of self-integrity and to see themselves as adaptively and ethically adequate (Cohen & Sherman, 2014). This implies that people are fundamentally motivated to maintain a positive self-perception (Steele, 1988). In the presence of negative information, such as constraints brought about by chronic condition management, individuals either exhibit defensive reactions such as avoidance or seek to reaffirm their self-worth in another domain because the message is perceived as a threat to their self-worth. By (re)orienting an individual's sense of subjective time, the contextual dimension of time, change, and illness intrusion can be conceptualized in the chronic care domain to evoke adaptive self-perceptions. In a related domain, it has been found that information seeking motivates prosocial behavioral change (Dobransky & Hargittai, 2012; Niederdeppe et al., 2007), implying that seeking health-related information promotes healthy activities and adaptive behaviors (Gibson et al., 2016; Lambert & Loiselle, 2007).

Considering the (re)orientation of subjective time as a contextual layer for the reflexive/emodied self and discursive/material body in change can provide insight into the processes of self-affirmation that draw upon protective self-perception processes. From the perspective of this theoretical framework, intersubjective awareness of the discursive body cultivating subjective change over time through the time, change, and illness intrusion contextual layer can be oriented toward positive adaptive behaviors conceptualized through the reflexive and embodied self and in relational engagement with the traditional health systems and food, nature, and body/self integration contexts discussed in the upcoming chapters. A substantive body of health communication research finds that self-affirmed individuals are more receptive and less biased during threats to their self-concept and thus better able to engage in adaptive behaviors (Demetriades & Walter, 2016; Epton et al., 2015; Sherman & Cohen, 2006; Spencer et al., 2001; Sweeney & Moyer, 2015; van Koningsbruggen et al., 2009). Increased self-efficacy, in turn, has been found to be related to long-term use of health information by individuals (Rimal, 2001). Such adaptive forms of subjective change can constitute wholeness because of their alignment with the self/other comparisons and stability and unbiased acceptance of past-future constructions of deliberative vulnerability envisioned through the discursive body. Moreover, following the ecology of wholeness model, the movement and motion from the structure of subjective

time provides a supportive frame to navigate the temporality of long-term chronic condition management.

Findings from psychology suggest that defining oneself in terms of one's disease and its treatment may constrain how individuals view the range and diversity of opportunities for rewarding experiences available to them, besides making them susceptible to greater emotional distress and loss of well-being. Expanding one's self-concept beyond the illness identity can help open individuals to a larger range of opportunities that can improve their quality of life. Here, too, studies find that the notion of change, such as age, plays a role. For instance, younger people are more likely to experience an increase in psychological well-being even with rising illness intrusiveness when they associate with their chronic kidney patient identity (Beanland et al., 2003). Psychologists' hypothesize that this may be because, for younger people, the onset of chronic life-threatening illness may actually serve as a motivator to work toward keeping the freedom to pursue one's life goals (e.g., pursuing career opportunities and personal independence), by constituting what is termed "crisis as a catalyst for development" (Lieberman & Peskin, 1992, p. 131). Younger individuals may be supported by a higher degree of self-efficacy in the present and optimism for the envisioned future (Gutmann, 1995).

The subjective experience of time and change are salient factors in managing the relationship of self-concept with illness perceptions in adaptive or maladaptive ways. In such cases, Devin et al. (1997) speculate that older adults, conversely, have already managed the developmental milestones of their career and independence and see these in their narrative trajectory, as situated in their past. Additionally, in relationship with the idea of change, in the process of navigating their illness identity, older adults may be more focused with losses associated with maturity (e.g., aging, loss of loved ones, retirement, Hurlock, 1980).

Illness identity has been defined as the set of roles and attitudes that an individual develops in relation to his or her understanding of having an illness, or the degree to which a chronic illness is integrated into one's identity (Oris et al., 2018). The authors find illness identity to have four states including engulfment, rejection, acceptance, and enrichment. In this case, the authors found rejection and engulfment to be instances of maladaptive states (psychological and physical functioning) while acceptance and enrichment were more closely identifiable as instances of adaptive psychological and physical functioning (Oris et al., 2018). The argument developed in this chapter suggests the close relationship of time and subjective change needs to be better understood in light of self-concept and illness identity, and specifically, with respect to the case of chronic conditions, with constructs identified in research such as illness intrusiveness. These relationships are in intimate dia-

logic engagement with the reflexive and embodied self, supporting a contextualization of experiences temporally and spatially in and through the body.

How individuals manage their disease or illness centers upon how individuals make sense of their illness experiences individually and relationally, over a temporal and spatial continuum, such as that highlighted in role performances. The variation in nature of adaptation to illness disruptions across individuals has been examined through the lens of illness perceptions (i.e., how people think about and perceive their disease). Illness perceptions are closely associated with construct of quality of life, performance of self-care, medication adherence, and general health care use, among others. To investigate the effect of illness identity on mental illness, Yanos et al. (2010) hypothesized that illness identity will negatively affect an individual's self-concept, hopes, and self-esteem (understood as the evaluative aspects of the self, or self-regard, Baker & Gallant, 1985). They propose a model to explain how a composite of social, psychological, and clinical factors can constitute barriers to recovery. This relationship between illness perceptions and self-concept is, as the chapter argues, salient in constituting the subjective environment of how time is experienced as subjective change.

Experiencing change positively as a cognitive construct is related with body acceptance as a facet of the embodied self. The embodied self is closely integrated with the mind/body as presented in the first section of the book. In chronic illness contexts, acknowledging the embodied nature of the self through reflexive activities that highlight the subjective environment of time through spatiality such as art and architecture can offer transformative opportunities. In a study, Van Bulck and colleagues (2018) examined individuals living with a heart condition. Such individuals face challenges on a daily level with maintaining strict medication regimens, treatments, and lifestyle changes, amid the ever-present life-threatening nature of the condition. Van Bulck (2018) and colleagues found that those who accept their health condition had fewer physical symptoms of heart disease and less depression, even as those who felt enriched paradoxically often had an increased presence of physical symptoms of their heart disease. While such studies suggest the importance of self-reflexive awareness and body acceptance in the experience of illness, the lived experience of illness is central to the healing and self-transformative experience in embodied ways.

Charmaz's (1990) employment of a social constructionist approach to study changes in self-concept provides a helpful inroad to understanding the lived negotiation of change during chronic illness. As Charmaz (1990) explains, her use of social constructionism is guided by the creation by ill people of "taken-for-granted interactions, emotions, definitions, ideas, and knowledge about illness and about self," and "researchers' sociological con-

structions which they develop, in turn, by studying chronically ill people's constructions" (p. 1161). Communication researcher Kristen Blinne (2012), for instance, documented the impact of her diagnosis with a degenerative joint disease and the associated chronic pain on her self-identity using traditional Chinese medicine (TCM) approaches. Her approach "remapping" her life, and thus to "communicate, connect, and share all that we are, have been, and will be," helped her find harmony in disharmony by "(re)storying" her illness identity. Her reflections on her changing body and identity illustrate the challenges of grappling with chronic illnesses. Such instances illustrate the book's argument on how patient-centered communication can benefit from a deeper integration of the reflexive self to support an embodied hyper-awareness of the body in ways that are self-transformative and healing.

Change is not perceived in a vacuum. Most often, people interpret change in the context of the past, such as who they were, and the future, such as who they are becoming. In making such judgments, people also make assessments about their abilities and functioning (for example, abilities and functioning as improving or declining) based on aspects of their behavior that may have been enhanced or damaged by specific experiences, thus shaping their self-concept accordingly. As can be imagined, such processes are complex and operate at multiple levels. For instance, research finds that health consciousness relates to fear and self-efficacy in the domain of mental illness (Lee, 2019). Perception of change, along with its interpretation, is an evaluative process. Even as we seek to assess it in terms of improvement or decline, or favorable and unfavorable, we link these assessments with the corresponding feelings that arise with these comparative modes of evaluation and our personal interpretational frameworks.

The consequences of subjective change as related with chronic illness management are paradoxical. Communication is central to the management of chronic health conditions through its impact on shaping the experience of difference and well-being (Cardillo, 2010). For instance, how information gathered on the chronic condition is discussed in the patient-provider context can make a meaningful impact on patient outcomes. Findings suggest that individuals may assess a piece of information about themselves (e.g., improvement) according to multiple standards. By employing multiple levels of assessment, any one piece of information may be assessed as favorable by one standard and unfavorable by another.

By providing insight relating information gathering and sense making with assessment of information in the patient encounter, provider training in communication can improve patient outcomes. In a study on how patients engage in serious illness conversations with doctors using information obtained from sources other than their doctors, researchers Garden and Seiler (2017)

employ Street's ecological perspective of communication to analyze patient interviews. They find that doctors who were more attentive made patients feel more comfortable with sharing information obtained from external sources with them and thus were able to construct more productive conversations. In this case, feelings (good or bad) about information were found to vary based on whether people react to this information cognitively and affectively.

Cognitive and affective reaction is thus fundamentally wrapped up with the process of change. As inevitable as change is, we can imagine that our cognitive and affective reactions to change are equally continuous and unending. Moreover, since we often give rise to multiple intersecting and layered cognitive and affective reactions, this continual cycle of change and reactions can get very complicated, particularly as it operates without a break, developing from one micro-change to the next. Often thoughts are not in alignment with feelings. Often when something is viewed as bad overall or good overall, there is usually an alignment between thoughts and feelings. However, when an experience appears good by one standard and bad by another, individuals may feel contradictory and conflicted in terms of emotions and thoughts. What this implies, then, is that along with change and its interrelated reactions, cognitive and affective, comes conflict and a contradictory sense of evaluations. Understanding the cognitive and affective processes and their relationship with change, particularly in the body/self dimension as experienced in long-term conditions, can help in shaping the perception of change with self-identity in productive ways.

The mind, as the seat of cognitive assessments, is understood as a system of interrelated parts that collects, evaluates, and reacts to information gathered from the body and, as the reflexive self, from the mind itself. It comprises mechanisms that generate the information and standards for evaluating information received as meaningful or relevant, and a reactive system whereby it is seen as embodied. The project to fully understand the mind and the mechanisms through which the mind/body relationship operates has been the subject of a vast compendium of studies from physiological, philosophical, and humanistic perspectives.

At the very basic level, the mind has been described in two dimensions. First, the mind has been understood as that substance which has the capacity to sense and feel (such as, to experience something), and second, as that which has the capacity to plan and act (such as, to have agency; Gray, 2007). Others have noted the capacity of the mind for emotional responsiveness and other characteristics of human nature and constituting human uniqueness, such as a capacity to exhibit civility, rationality, morality, and social evaluation (e.g., warmth and competence). In these functions, mind emerges in the capacity to feel, to do, or both. In other words, current understandings suggest that the

mind, in relationship with the sensory perceptual framework of the body, provides the basis through which we receive, interpret, evaluate, and react to the sensations and perceptions that arise as a way of responding to the continual mechanisms of change that are ceaselessly happening inside and outside us. Such research suggests that for individuals to use multiple standards to collect information about themselves, along with employing a variety of standards to judge whether that information is good or bad, performs both a protective and predictive role in determining how people assess and perceive the cognitive and affective consequences of subjective change. The assessment of subjective change is crucial to the experience of chronic illness self-management.

Mind perception entails mental capacities that are also related with other entities. Some of these have been examined in current research and suggest interesting directions for understanding the mind/body relationship in illness and healing. The subjective dimension of assessment of many of the comorbidities associated with chronic illnesses, such as chronic pain, suggests that an experience that would be perceived as highly debilitating by one individual may be perceived as being perhaps a moderate impairment or even a minor distraction for another. Such assessments can be seen as being closely related to another construct that has received attention in recent research, that of moral judgment, or how an individual assigns ethical meaning to an experience. The concept of moral judgment, defined by Kurt Gray et al. (2012) as the process of labeling other entities as right or wrong, good or bad, is, as the authors argue, closely connected with mind perception. In fact, Gray et al. (2012) argue that mind perception is the essence of moral judgment. Their paper presents an elaborate exposition of how mind perception unifies morality across explanatory levels (such as those linked with agency and experience or agents and patients). These understandings provide a deeper insight into how communication in the provider-patient relationship can approach the mind/body/self relationship with greater nuance and differentiation in presenting information in diagnostic and prognostic conversations.

Equally importantly, the book argues, the understanding of time and change with subjective change and chronic illness management is central to healing in ways that can be integrative and constitute wholeness. As the progression of chronic illnesses is incremental over time, the notion of subjective change can be shaped through deeper insight into the mind/self relationship. As the human mind is fundamentally self-reflexive in nature, its capacity to shape the perception of change, such as through moral judgment, has the potential to impart individuals agency and direction in their self-management efforts. Furthermore, as the chapter on the reflexive self has argued, given the socially situated nature of the human experience, such understandings are fundamentally dialogic and relational.

Change and Time

The notions of time and change, from the above discussion, appear closely intertwined. From physicists to philosophers, the nature and very existence of time has been an enigma that is challenging to understand, explain, and define in absolute or qualitative terms. Many researchers have sought to figure out the dilemma whether time is a socially constructed phenomenon or truly an objective property of the physical universe or somewhere in between. Time has been studied indirectly through its relationship with change from multiple disciplinary perspectives. Change exemplifies the passage of time, and as such, can be studied to examine one property of time. Although change necessarily must include the notion of time, it is debatable whether time itself must include the notion of change.

One phenomenon that has been examined in understanding the nature of physiological change with time is aging. It has been argued that change can be explained through models examining aging and its related mechanisms. One of the prominent models in this domain is the stereotype embodiment model (Fawsitt & Setti, 2017). According to this model, there are three main pathways for processing change. These are the physiological pathway, the behavioral pathway, and the psychological pathway. The physiological pathway is related to psychological reactions (such as stress, accommodation) caused by considering the mechanisms of aging as applicable to oneself. The behavioral pathway acts through focusing on behaviors as a form of reaction to aging. The psychological pathway relates to the psychological mechanisms through which an individual reacts to aging-related changes. One of the drawbacks of the model currently is a lack of sufficient understanding of the mechanisms underlying the salient relationships. These remain unspecified with regard to their mechanisms, leaving researchers with a gap in figuring out how the cognitive and psychological dimensions behind these pathways can be employed to better understand aging-related processes.

According to the model, the psychological pathway is involved with assessing the cognitive impact of the change. Investigations employing the stereotype embodiment theory (such as Levy, 2009) find an element of memory interference associated with the three mechanisms involved in the assessment of the change. In this case, along with memory, attention is also affected. Thus, change is perceived through the lens of memory that connects past perceptions with future expectations and present adaptations. The implications of this line of research suggest that by shaping how change is perceived in the present, its memory in the past can be shaped in efficacious or debilitating ways. For instance, individuals may have difficulty in inhibiting irrelevant stimuli related to the memory-attention continuum.

A perception of decreased self-efficacy can lead older adults to increase their dependence on care when exposed to negative perceptions of aging-related changes. Conversely, perceptions of increased self-efficacy associated with positive perceptions of age-related changes can be associated with greater agency and empowerment in the present. These relationships co-occur in individuals with age-related changes in ways that have an overall impact on the performance of the individual. Negative perceptions associated with negative memories and greater attention to lower self-efficacy behaviors can have poor outcomes as age-related changes increase. In turn, poor performance is associated with further withdrawal of effort and consequently, a normalization of decline. Ample research evidence suggests that when decline related to aging is normalized, often poorer health choices are the outcome.

Continuing the examination of change and time through the lens of physiological change and aging, numerous negative outcomes of aging-related change perceptions have been found. Preliminary findings show these include deleterious states, like anticipated future loneliness and isolation, and in the present, avoidance of social situations that are perceived as threatening. In turn, the health outcomes associated with such behaviors of social withdrawal and poor health choices include long-term poorer physical, cognitive, and mental health feeding the negative cycle of poor performance, withdrawal of effort, and poor perception of ability to do things socially and professionally. This negative cycle can play in significantly harmful ways into normalized expectations associated with chronic conditions, such as heart conditions and diabetes, that have long-term prognoses. However, when the notion of change is presented as central to understanding healing, it can be argued that such a premise will include observations of what it means to accept all manner of change as a healthy state. Change, interpreted through the lens of healing, will necessarily be a positive phenomenon. In the example of aging, age-related change will be perceived as positive with accompanying associations of positive normative behaviors and agency. Furthermore, critiquing change through a social constructionist lens highlights how its relational, dialogic, and perceptual qualities can be shaped through communicative encounters in a range of settings.

In the context of chronic illness, cultural norms and perceptions shape individual expectations of what change should look like and how to anticipate and prepare for change. Moreover, the memory of a past is perceived in biased ways as healthier, more normative in its desirable outcomes, and in ways that lend greater attentional relevance to qualities that may not be as relevant to the present, such as the capacity to live a certain lifestyle or eat specific types of food. In the social and scientific paradigm of our age as exemplified by our culture, and indeed, the scientific investigations of the last century,

change has centered on perceptions and adaptations to illness intrusions and the notion of positive change and negative change on constructs like illness identity and self-concept.

This chapter argues that all forms of change should be accepted as inevitable and similar in nature. Acknowledging the nature of change as constitutive of our existence and that of our lived environment—concrete spaces, wildlife, traffic, heart beats—creates the nature of change in the present as neutral and its memory, therefore, as unbiased and objective, or at the very least, positive. Representations of change should go beyond duality and binaries (such as good and bad, for instance) when imagining time in memory or attentional space. Even though more work needs to be done to unpack the psychological mechanisms of change processing related to identity, self-concept, and stereotypes and how these ultimately influence the health of vulnerable and affected populations, and much work that has been covered has not been included in this book on wholeness, the chapter constructs the argument that change, in its inevitable nature, is also a neutral entity, made otherwise only by the socially constructed, normative, or relational biases we bring to its subjective construction.

Closely related to change, the notion of time is also a socially constructed phenomenon. As an objective construct, time has been conceptualized in varied ways across disciplines. For instance, Scott and Powell (2018) provide a concise overview of time in their book. Biologists may present time in reference to the perception of time in the human brain, while botanists may employ other objective measures to define time. For Einstein, famously, time was understood as a component of the space-time fabric. Its temporality is relative. In its subjective interpretation, past, present, and future as perceptions of time, were equally relevant to the individual experiencing them, and could be speeded up or slowed down under specific conditions of gravity and speed. From this perspective, we on planet earth perceive ourselves to be sharing a universal present as our perceptions synchronize with our shared perceptions of gravity and speed. Connecting the notion of time with the argument for subjective change, this universal present is conditioned by a subjective experience of the past and a subjective expectation of an anticipated future, or conditioned by the perception of subjective time.

Recently, subjective time has been the focus of intense research ranging from behavioral and cognitive analyses to neuroscientific technological imaging studies. Neuroscientific studies identify different neural regions of the brain as they experience the past, the present, and the future. Thus, by connecting with human biology, the focus of these studies on the experience of past and future, or change, has also contributed to the understanding of subjective time. Subjective time has been defined through the lens of mental time. By this yardstick, the context of thinking about time in which any kind

of event occurs is, in absolute, physical time terms (i.e., clock or calendar), a non-present time that exists in the remembrance or recall of a past or in an imagining or construction of a future. In this perspective, then, past and future are defined from the lens of a perceiving observer and not from a consideration of physical reality *per se* (Nyberg et al., 2010). Nyberg et al. (2010) employ the idea of *chronesthesia*, defined as a form of consciousness that allows individuals to think about the subjective time in which they live and that makes it possible to mentally travel in such time. Others have grappled with the view that time is, in some respects very space-like, whereby, in simple terms, things have space-like and time-like properties (spatial and temporal).

The chapter began with an exposition on the universal presence of change and has presented arguments that have constructed this relationship with the experience subjective of change, subjective time, self-concept, and self-identity. Further, the chapter has presented the notion of subjective change and time and a property of the subjective environment in constructing wholeness through healing experiences. As Nicholas Measor argues in an exposition on subjective and objective time, “the identity of things over time is the relation which holds between parts which are parts of the same thing” (1986, p. 209), thus time is much like space, only something more in addition to space. Sackett et al. (2010) consider the argument that time appears to fly when we are having fun and become interminably slow when we are undergoing an unpleasant or undesirable experience. In other words, they consider an explanation for the position that the subjective duration of time often is not the same as the objective duration of time. In this context, Sackett et al. (2010) focus on evaluations of time and how they differ when people feel they are having fun and time flew by or when they feel time dragged on. In doing so, they rely on theories of sense making processes and thinking, or metacognition. Overall, they find that subjective time perception, that is, whether time seemed to fly or drag on, did indeed have an effect on how much fun people thought they were having. They find that feelings of time distortion (flying or dragging conditions) cue inferences of enjoyment, only when the subjective time progression is surprising or unexpected (i.e., individuals were not expecting time to fly by).

These relationships highlight the mind/body relationship in long-term, health-related sense making and suggest the potentiality for connecting memory and attention to the healing framework of interpreting long-term changes in chronic illnesses with a physiological, psychological, and behavioral dimension. Subjective time has been examined in numerous other ways that offer promising potential. For instance, people have considered the influence of human movement or velocity on subjective time (Orgs et al., 2011), of introspection on subjective time (Corallo et al., 2008), of action preparation

on subjective passage of time (Hagura et al., 2012), or of goal conflict from a consumer behavior perspective (Etkin et al., 2015). What all such investigations have in common is the mechanism involved in the processing of change. Some, such as Orgs et al. examined how the human brain processes change in visual information based on its perception of the human body form and its movement. Their approach draws from the structure-from-motion perspective from movement kinematics and motion-from-structure perspective which comes from illusion of movement and memory bias. Others, such as Corallo et al. (2008), look at the introspective response from the perspective of mental chronometry and cognitive processes. Their study shows that we process different cognitive events distinctly from the perspective of their functioning as internal markers for time estimation. Consistent with models of conscious experience that equate access to consciousness with information processing, they note that introspection about time spent on a task mostly reflects the duration of the central processing of the task.

The close relationship of the concepts of subjective time, change, attention, and memory is foundational to the reflexive and embodied self in space. Social constructionist approach to the passage of time and the relationship of the environment as proposed in this book focuses the construction of healing spaces on these relationships in ways that constitute wholeness in individual narratives and experiences. For instance, attentional orienting, one of the related concepts referenced in Corallo et al.'s (2018) study, draws upon the notion of amount of change *perceived* (rather than through an absolute clock). Mind/body exercises that shape how individuals direct their attention and interpret it can be employed to integrate contemplative movement (e.g., through yoga or *tai chi*) in attending to the notion of time as subjective change (being goal driven, enjoying or feeling fulfilled by the activity) to shape the perception of chronic pain over time. *The embodied self* presented in an earlier chapter in the book as shaped through art and architecture can experience time in ways that construct wholeness through integrating its culturally mediated elements conjoined with rituals of belonging that construct the changing human body relationally in social contexts.

This book argues that medical humanities are central to the development of an awareness of wholeness in the construction of subjective time and change that conceptualizes the embodied self in a temporal-spatial-pre-reflexive meaning making frame (figure 7.1). Time itself is a challenging notion to capture in strictly absolute, objective terms in relationship with the subjectively changing experiences of the human body. However, movement through time, duration of time, embodiment through time, and spatiality through time are some of the many ways in which the chapter proposes the subjective environment of time can be integrated to construct wholeness in the human experience

of incremental, invisible change. To illustrate, in Hagura et al.'s study, the focus is on the duration of time when action occurs (2012). These researchers are interested in understanding how time is perceived when an action is being performed, such as when a batter prepares to strike a ball with a bat.

Colloquially, as in movies, such a moment is depicted in slow motion. Hagura et al. are interested, not in the before and after of the moment of action, but in seeing whether such perceptual distortions of time around action execution is a product of actual change in how sensory information is processed at that moment. Such perceptions can be valuable in understanding micro-increments of change, as those that characterize our lived experiences and the constructed nature of the lived world around us. To illustrate this argument from yet another perspective, consider the notion of goal setting. Goal setting has been examined in communication research in the chronic care encounter. For instance, collaborative goal setting is an important stage in patient-provider communication for chronic patients, and one which highlights the centrality of dialogue and relational communication (Bigi, 2014). In this domain, other forms of decision making have also been found to be related with goal setting. Etkin et al. (2015) approach the same issue from the perspective of marketing research. They observe that marketers feel pressed for time to understand how consumers spend time and thus, to get a judgment of what they are willing to pay in order to save time. They find that consumers' subjective perceptions of goal conflict, or the number of goals competing for consumers' time, makes them feel like they have less time. In this case, it is the perception of change understood from the point of view of amount of goals to be accomplished.

Dialogue and relationality shape how we construct time such as through the perceptual distortion of time around action execution or decision making. Furthermore, multiple constructs, such as goal setting and decision making, play a role in the subjective perception of change. Time is an important element in interpreting change. As the chapter argues, temporality is embedded in the very nature of change. Temporal self-comparison mechanisms as those described above generate information about personal change. People think about change in the context of who they were or who they are becoming. Temporality provides a context to evaluations, subjective and objective, related with the amount of change as well. Individuals examine the similarity of some facet of the self in relation to the past or compare the present with an anticipation of the future, thus helping people assess or judge whether and how much they believe they have changed or may change. Such assessments are described as feeling better or worse in terms of personal qualities, abilities, or functioning improving or declining. Temporal comparisons are related to social comparisons, which foreground their interpersonal and ahistorical quality, and which together allow individuals to better understand themselves

and diagnose or anticipate their personal capabilities in the present/future continuum (figure 7.1). The role of the body/self is intimately connected with the construction of the present/future continuum through cognitive and affective perceptual elements in relationship with subjective time and change. By recognizing their role in memory construction, assigning attentional relevance, goal setting, and the contribution of relational and dialogic elements in the perception of cultural norms, for instance, change and time can be subjectively constructed through communication in a range of settings.

CHANGE AND HEALING

By employing a social constructionist approach grounded within a medical humanities perspective, this book has asserted the centrality of healing in the mutual shaping of the body/self expression in relationship with the environment. In the humanities, healing and sickness have been of interest for social anthropologists, sociologists, philosophers, and physicians. As the discussion in the previous half of this chapter has suggested, communication that brings about healing in ways that constitute wholeness must take into account complex and multiple understandings of the subjective environment of time as they intersect with the reflexive and embodied self in alignment with the discursive and material body. These understandings are in relationship with the body/self processes of body ownership, body acceptance, and the information processing of sensory cues that is conducted through the neurological processes in the body. Together, these create a subjective environment of integrity and alignment with the experiences of subjective change and presence in the chronic illness trajectory, and our openness and inclusive relationship with them.

Time denotes a process and references an empirical perception of change located in some dimension of perceivable experience. Consequently, by sharpening the perception of change, or modifying the attentional relevance to specific aspects of the change, the manner in which an individual engages with the content and the nature of lived experiences is also modified in fundamentally distinct ways. Fabrega (1997) argues that the biological roots of understanding sickness and healing (disease, injury, and their responses through the years) intersects meaningfully with the sociological and cultural factors that modify their character and content. In other words, the social and the cultural create conditions for different forms of sickness and healing.

These conditions can range from social structure, medical problems and their definitions, to how meaning is assigned culturally to diseases and the practices of healing. The process of healing through processing change in

more nuanced and differentiated manner is important to the process of treatment and recovery, particularly in conditions with a long-term survivorship rate. Those who have undergone breast cancer mastectomy and reconstruction face the process of adjusting to their evolving embodied, gendered, and sexual identity (Loaring et al., 2015). For women, postoperative satisfaction with how they looked in the past or with how well-prepared they were for their postoperative experiences of pain, recovery, and scarring is usually documented by studies to be very low. These processes, based on the approach taken in this chapter, evoke the constructs of subjective time and change, memory, attentional relevance, moral judgment, anticipated futures as shaped by socio-cultural norms, the relational, and dialogic construction of bodily integrity, body acceptance, and self-awareness of change among many other constructs.

In fact, because psychosocial threats proceed most surgery and interventions where invasive actions lead to a change in outward appearances, these can be classified as disruptive, sudden changes. However, in these instances, the disruptive nature of the change evolves into an incremental, chronic pain with increasingly invisible, but equally powerful, socio-psychological effects. In breast cancer treatment, surgery is employed to remove cancerous tissue, such as during mastectomy when the whole breast area is removed, or lumpectomy, when part of the breast is removed. Adjuvant treatment including chemotherapy and radiotherapy to either reduce the tumor prior to surgery or to prevent its recurrence is also often employed. In healing and survivorship, thus, at the very least, it is not simply the change involved, but also the nature of the change, the agency of the experiencer in the change, and the duration of the change that is involved. Moreover, the social constructionist nature of this examination on healing communication permits me to highlight the nature of values, hope, and faith in this context. In this instance, emotional coherence, as the chapter on embodied self presents, can be central to the construction of meaning in alignment with the chronic condition to create a sense of unified embodiment that is closely related with the praxis of wholeness.

At the beginning of the chapter, I had commented how we are immersed in an ocean of change. I noted that change is, in fact, our essence, and that we truly know only the experience of change. Thus, if we accept the fundamental nature of change in constituting the nature of our perception and the context of the body/self, the conceptualization of wholeness becomes implicated in the conceptualization of the subjective environment of time and change within which it is embedded. Each of the body's physiological responses and perceptions—from the primal nature of hunger perception to that of chronic pain—is shaped by its relationship with subjective change in fundamental ways. Take the very simple experience of being hungry. MacCormack et al.

(2018) discuss how feeling hungry as a physiological state influences experiences and perceptions. The commonly heard term “hanger,” or being angry because of hunger, exemplifies how emotion makes hunger meaningful. According to MacCormack et al., individuals conceptualize hunger as emotion when not focused on the emotional nature of their feelings. Their research substantiates the complexity of the body/self relationship with the subjective environment of time as change. In this case, the affective feelings can be expressed into words to regulate or reduce the intensity of affect. Likewise, bodily phenomena that seem distally linked to the present context (e.g., hunger in the presence of an offense) may still ultimately influence behavior in that context, that is, affective representations in the brain incorporate ongoing bodily changes. Memory and attention, culture and norms, spatiality and its constituents (movement, duration, alignment) are all shaped by and, in turn, shape the reflexive and embodied self in relationship with the material/discursive body (figure 7.1).

The above premise has implications for conceptualizing subjective time and change in ways that can constitute wholeness through the chronic illness experience. For instance, (re)aligning and (re)focusing memory and attention with subjective change is important if healing practices that align the reflexive self toward subjective change, such as in journaling, writing, talking, or describing changes with our loved ones, care providers, or colleagues, are to cultivate wholeness. This line of argument underscores the mutual-shaping relationship in the body/self with the cognitive and affective processes of the mind. As a simple illustrative example, this argument exemplifies the potential of effective healing communication of mind/body approaches in chronic condition management: by regulating our emotions, we are also able to gain control over regulating the experience of subjective change. Conceptualizing subjective change through the lens of cognitive/affective regulation provides an interesting and tangible way to approach healing in a wholeness framework. Cultivating temporal stability in emotions (e.g., through meditation and related mind-body techniques) can cultivate control over the subjective change as it shapes attributes such as self-efficacy, values, and moral judgment from expectations of health and disease. Eliminating rather than stilling these vacillations construct a sense of continuity in an anchor in the present. Emotional and cognitive stability alludes to a sense of continuity in emotions and thoughts in the near future, present, and near past. When grappling with subjective changes in chronic illness management, this sense of emotional stability can provide an anchor to control and direct subjective change in other dimensions.

Following the ecology of wholeness developed in this book, to begin to perceive the benefit of wholeness in conceptualizing healing through the

subjective environment of time and change, the mere fact of recognition of pervasive, continual change with the reflexive/embodied self is transformative. This recognition is awareness centered not in the binary of healing as opposed to disease or sickness, but in the accomplished state of movement in stillness, or perfection in the moment, without prior conceptions of a desirable healthful state or a fear of a future illness state. Healing communication is about cultivating body acceptance by alignment with change, with cultivating a discursive body presence that changes in step with our material bodies, with being in the flow with the reflexive/embodied body/self.

Carefully cultivated intentionality can have powerful effects. Recent placebo effects research at the intersection of socio-cultural meaning-making processes have focused on intentionality and the body through what can be described as a systems approach perspective. Placebos are defined as ineffective treatments that lack an explanatory framework to the properties of a condition on which the treatment aims to act. Ongaro et al. (2017) investigate the fact that often placebos can have notable therapeutic effects. They posit that the placebo effect arises from the relationship between a culturally meaningful entity, such as a treatment, and our intentionality with the environment, such as the healing potential of the treatment, and the body's healing responses. In order to draw out this relationship, they posit the concept of enactive conceptions. They argue that an individual's body processes and intentionality, and the meaningful properties of the context, form a single dynamic system and constitute appropriate bodily changes through cognition accommodation. The concept of a single dynamic system is appropriate to our discussion of change. A single dynamic system is central to the experience of subjective change in ways that evoke wholeness if centered through mind/body approaches of meditation through shaping enactive conceptions that cultivate cognition accommodation. In line with the ecology of wholeness framework, by integrating the reflexive and embodied self with the material and discursive aspects of the body through, in this case, enactive conceptualizations that bring about cognition accommodation, the material/discursive aspects of the body are positioned in alignment with the body's healing processes and intentionality.

Because change is an ever-present constant, in understanding the nature of change through our subjectively constituted body/self, wholeness can be constructed in the cultivation of stability. This stability can be anchored in the enactive conceptualization of a cognitive or affective self or in myriad other ways. The fundamental nature of healing, this chapter on subjective environment of time argues, is about understanding how our relationship with change is interrelated with our relationship of the reflexive/embodied body/self in material/discursive ways. In exploring the idea of subjective change

for the chronic illness domain, the chapter has examined self-concept and self-identity as aspects that are challenged by the incremental and invisible nature of change involved in chronic illnesses and survivorship experiences.

Following the previously detailed section on self-concept, our self-concept determines who we are physically, socially, relationally, spatially, and temporally. When we relate our self-concept dynamically within the same perception as change of healing and disease, we are in alignment with change and can enact adaptive responses. Our self-concept can change with respect to our appraisal of what we are capable of doing and with respect to accommodation for any attribute on which we perceive ourselves as having improved or worsened. If we are stable in those aspects on which our self-concept depends, we are able to create a positive alignment of change and healing even through disruptive illnesses and disease conditions. Contextual factors such as the subjective environment of time can provide one such resource for constituting stability in the ecology of wholeness.

Many healing therapies can be examined through this lens and their communicative efficacy explored to constitute wholeness through different domains such as in the chronic illness experience. For instance, Rossetini et al.'s (2018) study starts with placebo and nocebo effects. Placebo and nocebo effects are defined as embodied psycho-neurobiological responses capable of modulating pain and producing changes at different neurobiological, perceptual, and cognitive levels. According to Rossetini et al., healing rituals can be seen as triggering contextual factors that act through neural networks and neurotransmitters in therapeutic encounters such as those between providers and patients. Manipulating these can help bring in a measure of control and healing to the health care context and provide therapeutical action within a clinical setting. In this context, manipulating healing rituals can address pain modulation by encompassing internal, external, or relational elements such as patient expectations, history, clinician behavior, verbal suggestions, patient-centered approach, marketing features of treatment, health care setting, and many other factors. Each of the aspects of expectation, history, behavior, and setting constitute therapeutical action within a subjective environment of time and change. Accordingly, evoking the dimensions of self-concept and self-identity through the lens of memory and attention guided by intersubjective sense making constructs an anchor in the present in communicative patient-provider settings or community-based healer-guided settings.

The reflexive/embodied self is aware and accepting of a non-binary understanding of healing and disease. Contexts of subjective change construct wholeness through integration and stabilization of experience in dynamic ways as it moves through and constitutes the identity and self-concept of the individual. Change is stability and awareness of a nonjudgmental present

in relationship with unbiased constructions of the past and future. Such conceptualizations can be agentic and productive of empowering embodied and reflexive self centered in wholeness regardless of the experience of pain, burdens, fixity in time, or deteriorating functionality in the material body. Cognitive and affective stability provides a foundation to begin this journey. These are deeply co-constituted with the mind, the seat of cognitive-affective assessments, and the reactive system which guides our responses to change.

Spiritual healing or healing using cultural-scientific/religious/belief/faith-based approaches to health employ myriad forms such as neuropsychological guided imaginary programs, neo-shamanistic soul revival, Ayurveda, Traditional Chinese Medicine, and Buddhist attention techniques. Our experience, however, is also shaped by the nature of the time in which we appropriate it and consume it. In a post-modern era like the twenty-first century, where critical modernist perspectives, globalization, and cosmopolitanism exist alongside emerging nationalism, issues of power, inequality, and dependencies play into the nature of how we consume time. In all these approaches, the experience of the participants in the ritual is an important factor in the determination of structural changes within the ritual (Koch, 2015). As Koch argues, when a desired change takes place “in the style of experience, motivations, needs, and expectations of the participants,” the ritual is experienced as “appropriate, helpful, and effective”; alternatively, it is experienced as “empty” (pp. 433–434).

From this perspective, the paradigm of alternative modernities makes it possible to describe the local relation and articulation of traditional and modern, participation and exclusion, localization and globalization, and to translate this to healing practices. In her larger argument are embedded the understandings of time and healing that can help us unpack the present moment: how perceptions of global and local, modernist and post-modernist, cosmopolitanism and nationalism shape notions of space and time (Koch, 2015). These are, to some extent, culturally situated positions, doubtless, and evoke the questions of power, access, resources, and ideologies. Through them, then, emerges a form of grasping time situated in the transcultural, technologically mediated, or socially determined moment. Perhaps this question is more germane to how we consume healing as it is shaped by our existence at a particular moment of time. But, nevertheless, its relevance shapes our relationship with how we understand healing in equally important ways. For Fabrega (1997), disease and physiological processes can be categorized as biologically based substrates of the medical, where sickness and healing are the socially and culturally based constructions of the medical. Sickness can be described as the socially constructed expression of a subjective state of illness and correspondingly, healing, centering medical humanities and social

constructionist approaches, can be understood as the socially constructed efforts, procedures, and medicines for addressing illness.

Socially and culturally based experiences are the composite of the stories we tell about our lives. Gomersall and Madill (2015) examine chronic illness narratives as grounding of biographical disturbances in time and space, coining an interesting term “chronotype disruption” in which recognizable patterns of time and space are expressed through narrative forms. They employ Bakhtin’s notion of the chronotope to situate this representation as comprising not just the features of a narrative, but also the field of possibilities. They include the assumptions of what is considered as knowledge and the embodied, lived experience of what the observer feels as the truth as supports for what we employ for our narratives. The authors argue that chronotope disruption of healing experiences, as it is communicated by patients, will shape the way the health condition is experienced and interpreted, akin to the self-regulation model of illness. Their attention to the chronotope stems from the perspective of agency and the constancy of the self with respect to time, particularly in chronic illnesses.

Subjective time itself can be explored and categorized in different ways. Although research is only beginning to investigate these distinctions, some findings suggest interesting approaches for patient-provider communication. For instance, in type 2 diabetes, a chronic illness, Gomersall and Madill (2015) posit that conceptualizing variations of time such as provisional time, fading time, closing time, focusing time, and duration time can help in structuring the narratives of the disease course. The narrative construction of time is intimately connected with the discursive and material body in the ecology of wholeness as it changes through the disease course. Here narratives are employed to integrate time and change by helping illuminate the relationship of change in the body, time, and space, through being conscious of illness. Similar to the unified embodiment theory, this is an instance of a coherence-creating approach that exemplifies the ecology of wholeness framework in an interesting manner. In this particular approach, Gomersall and Madill connect the coherence-creating framework to the idea that the narrative form helps us employ time to make coherence and wholeness particularly relevant in disruptive experiences. Interestingly, other research suggests interesting avenues to consider applications of the ecology of wholeness in the chronic illness domain. For instance, Khosnood et al. (2018) express a related idea in somewhat similar terms. In examining mind-body strategies in healing from cancer, they identify two central themes of healing: being connected to the body (comprising being aware of intelligence and body nurturing) and mindfully reconnected to the self (using embodying knowledge, living for the moment, and being connected to nature).

The presence of constant change in time and experience grounds the idea of stability and stillness in the body/self through reflexivity and embodiment. Several CAM practices, such as yoga and tai chi, integrate stillness and movement through breath (self) and the body (material and discursive). As such, they lend themselves particularly well to embodied interventions in chronic pain and related conditions where body/self change can be incremental and invisible. Sneed and Hammer (2018), examine the significance in the mind-body connection through yoga as a form of embodied intervention. In their study, each participant noted greater insight into mind-body connection and the effect of cognition and emotion on the body, observed how the body can be used to improve coping through movement and breathing, and experienced different thoughts and emotions associated with different areas of their bodies. They started with the assumption that body experience may be as important as cognitive and emotional experience. In drawing out the power of the mind, whether through time or change, healing can be constituted as a way of achieving coherence, stability, and wholeness of experience. The reflexive/embodied self in alignment with the material/discursive body is central to the approach of cultivating coping and healing in ways that construct wholeness. Readers may recall that in earlier comments in the chapter, mind perception was intimately connected with moral judgment, and hence with agency and experience (Gray et al., 2012). The ecology of wholeness framework emphasizes the creation of dialogic and relational spaces wherein integrative experiences can be made meaningful when grounded in non-judgmental forms of coherence and stability.

In the body/self framework of wholeness, the mind and its related multiple constructs, such as self-concept and self-identity discussed in this chapter, are closely related. Identities associated with our bodies, or embodied identities, evoke a person's physical or physiological state to make a claim about who they are (Wiggins, 2014). For any context where change is inevitable, such an embodied identity, if fixed in interactional processes, can become a challenge toward accommodating change. Wiggins posits that we should theorize identity as dynamic. Understanding identity as accomplished through social interaction, their suggestions for examinations from how people interact from different spatial levels (e.g., online or virtual spaces) have important implications. These implications suggest, for instance, that gestures and other ethnomethodological approaches, can yield positive avenues to consider healing, particularly as a pathway to conceptualize embodied identities without the limits of Cartesian model of bodies and identities. Research within this paradigm has been critiqued for pathologizing the body and its practices (from the "outside" looking in, as it were) rather than situating bodies within a broader cultural and interactional framework. In parallel to, but distinct

from, psychological debates about the ontological status of bodies vis-à-vis discourse, there have been significant developments within ethnomethodology and conversation analysis on gesture, embodiment, and multimodality. The ecology of wholeness framework constructing the reflexive/embodied self in alignment with the discursive/material body is fundamentally circular, an exercise in stability in movement, situated within the subjective environment of time and change.

This chapter develops the argument that time constitutes the subjective environment in which our mind/self relationship is embodied. It presents subjective change as the mechanism through which we experience time in productive or debilitating ways and examines the notion of subjective change in the case of chronic illness management (figure 7.1). In taking a medical humanistic perspective, the book has centered the premise that healing can be constituted by envisaging both health and disease as two sides of the same coin and both experiences as non-binary and equivalent in nature. Both time and change are objective, neutral constructs that are, paradoxically, always perceived subjectively. Delving into deeper understandings of the relationship between time and its subjective perception through subjective change, this chapter has presented arguments to center healing in ways that cultivate wholeness through a mind/self relationship supported by the reflexive and embodied self.

The potential to constitute productive awareness of subjective change in ways that imparts agency and healing in long-term chronic illness management suggests the central role of communication in this domain. The provider-patient context in the diagnosis or prognosis-related communication can be attentive to the mind/body relationship in the perception of time as subjective change in situated ways. Shaping moral judgment and the perception of age as chronicity in self-concept and self-identity narratives can be salient areas where the dialogic potential of healing relationships that constitute wholeness through intersubjective awareness can make a difference in the long-term nature of survivorship and chronic illnesses.

In alignment with the subjective nature of healing, we experience both time and change in their subjective dimensions in making sense of our embodied experiences. Developing the reflexive self through cultivating intersubjective awareness of change, its moral dimensions, chronicity, and the material/discursive aspects of the body are central to understanding and navigating the long-term nature of survivorship and chronic illness experiences. Similar to subjective change, the notion of subjective time has been related with how change is processed. Research suggests its close relationship with perceived movement, introspection, attentional orientation, goal setting, and many other constructs that are salient to the chronic illness experience. If healing has to

constitute wholeness, therefore, its relationship as embodied discursively and materially with the notion of subjective time and change has to be taken into account in designing the individual's environment and in shaping interpersonal relationships such as in provider-patient or caregiver communication.

To constitute wholeness, healing is a space where the individual can experience stillness embodied as a lack of contradiction, conflict, movement, and inward/outward attentional orientation to embody change in a way that neither fights nor opposes a condition (i.e., disease), nor leans or moves toward another condition (i.e., health). In creating stillness between the perceived polarities of illness and pain as disease or healthfulness as a pain free condition, the individual experience of subjective change is (re)shaped to constitute wholeness as a value-free, reflexive, embodied condition that is open and agentic. In the next chapter on traditional health systems, I situate the a-linearity of subjective time as a stability in perceived polarities and change within the ideas of solitude, time, and presence to connect these with the practices of the reflexive/embodied self in ways that can constitute wholeness through body/self integration and meaningful relationality.

Chapter Eight

Traditional Health Systems

In this chapter, I ground the idea of solitude and presence as a contextual mode of relating with the body/self through the lens of traditional health systems. The social constructionist approach to understanding wholeness reveals how solitude, as an act, a process, or a state, takes its meanings and constitutes its outcomes, productive or detrimental, from the socio-cultural contexts of traditional health systems in which it is enacted. The traditional health environment, replete with values, norms, and practices, imbues the meaning making frameworks within which silence is constructed, interpreted, and assimilated in particular ways with the values and meaning making frames that are seen as healing and agentic in one context but perhaps oppressive, ambiguous, and punitive in another. This chapter develops the conceptual meanings of solitude in relationship with the related, but conceptually distinct, ideas of silence and presence. When applied to the domain of chronic illness management in health care contexts, ranging from provider-patient interactions to religious and traditional health contexts, the chapter develops the argument that the work of healing is intimately associated with solitude, even though health care settings are organized as interactive spaces, and the process itself is fundamentally relational and dialogic. Moreover, the state of solitude does not by itself imply healing or even the idea of being alone, but, as I argue, a complex, multilayered, communicative space of agency and action that can be productive or detrimental in its outcomes.

In this chapter, I examine healing through the lens of solitude. I tie in the idea of solitude, silence, and presence as transformative, and whose practices are central to cultivating wholeness in individuals who are living with chronic conditions. The chapter considers research in the patient-provider communication in cancer care, palliative care, and dementia, and in contexts of trauma, bereavement, and loss. It considers when silence is therapeutic and

conditions when it serves as an oppressive and punitive force, in supporting stigma or cultural taboos around health related meaning making. To construct wholeness, the chapter presents forms of silence that allow cultivation of the presence of a self and the practices and conditions that support integration, an authentic personhood, and relatedness with the body/self through silence in productive and transformative ways. In doing so, it teases out the implications of practices of healing in traditional health approaches for clinical contexts and provider-patient interaction. Finally, the chapter presents characteristics of healing contexts such as charismatic healing in traditional approaches, the construction of healing spaces such as healing gardens and wilderness exploration in hospital-based settings, and healing practices such as meditative reading, narrative construction, and the work of forgetting.

Through the lens of the body/self ecological framework of wholeness, the reflexive/embodied self is in relationship with the discursive/material body, where healing is the process of becoming whole through centering of integrating through relating with self and environment, and of being present with or without others. Our body/self experiences are given meaning in dialogic engagement with the socially constructed knowledge discourses of its lived environment. Enacted in the traditional health environment of the socio-cultural context of solitude and silence as idea and practice, examining the body/self through the lens of solitude constitutes the reflexive/embodied self and material/discursive body through the historically, socially, and culturally contingent forms of social action that underlie practices of solitude and its particular experiences and outcomes in that context.

Healing and health are active, dynamic processes, involving the agency of the one cultivating healing, or the one cultivating health. In this chapter, solitude, silence, and presence are developed conceptually with respect to their role in healing and health, and the active agency of silence, solitude, and presence that we evoke from within ourselves, in order to do so. The medical humanist approach taken in the book allows for the paradoxes and tensions in constructing solitude to illuminate difference, socio-cultural contingency, and multiplicity of epistemological approaches of distinct disciplinary domains. In adopting this approach, I identify the contradictions surrounding solitude and silence, from the penal system symbolized by, at one extreme, its super-max solitude imprisonment paradigm to the other extreme, the work of the monk and the ascetic. The state of solitude in these contexts is considered through a social constructionist lens as it is defined by spaces that cultivate solitude (the prison cell, the cave, the healing garden), to the contents that define solitude from cognitive functions, to affect, presence, and relating with an abstract other/self relationship.

Silence, solitude, and presence are ambiguous terms, surrounded by a great deal of complexity and contradiction in their conceptual underpinnings and complicating their potential application in health efforts in many settings. In some cultures, being alone is feared, abhorred, or associated with anti-social attributes and stigmatized. In others, solitude is considered a desirable and even perhaps an aspirational state, one that is essential to a meditative and contemplative state. In the popular imagination solitude is described as a condition characterized with being situated in an undisturbed environment of stillness. Perhaps we imagine an individual in isolation, in a peaceful setting, one that is wholesome and secluded, in a natural world of revelatory sounds and seasons. We imagine quiet. In solitude, we imagine, the individual has no one around to speak with, so we can picture the individual being silent. Perhaps the individual is in the presence of nature. Nature is there, ever-present, either as a backdrop or as an active participant in the setting through weather or in its beauty. We can also imagine a boisterous, rambunctious party, and an individual standing in silence. Perhaps that individual looks like they are alone, in solitude, despite the noisy and social setting. In this case, the individual presumably has many people around to interact with but seems silent or alone, in solitude, despite the opportunity to interact. In this setting, the individual may be approached by people at the party who want to talk. Perhaps the individual does talk with them, but you get the impression they are still alone, choosing solitude as a state of mind.

At the onset, I'd like to make some very important distinctions. These will help approach the subject matter of this chapter with clarity and focus and address some important points of confusion that surround these terms in day-to-day life. As I will argue in this chapter, solitude is not about *being alone*, just as silence is not about *being quiet*, or presence about *being present*. These are passive states. These states describe, with a sense of passivity, what happens when we are put in a situation of silence, solitude, or presence. It communicates what happens *to us* when there is no one around us, when we are not talking, when we are not around others. In order for silence, solitude, or presence to be healing, the chapter argues, solitude, presence, and silence should be understood and cultivated as relational constructs. They imply a deep frame of connecting with others and ourselves, with objects and spaces, with nature and boundaries. The concepts reference a relationship with others that is constituted through relating without distractions, noise, or clutter. It is through this carefully cultivated clarity and focus that we slowly, deeply, and carefully learn to engage, relate, and grow in order to absorb, give, and develop.

As elemental and primal that a state of solitude may seem, it is anything but. In its complexity and contradictions, struggles and quandaries, spaces and cracks, boundaries and contents, we find that solitude provides us with

a vital and seminal way to connect, integrate, identify, and sustain a sense of wholeness. In fact, it is in these tensions and in the cracks of these ruptures defining solitude, this chapter argues, that we do the intense work that is required to tap into what makes us whole, present, and integrated. This work of relating and connecting at a deep and integrated level means that even as solitude and silence stand by themselves, they are not meaningful unless interpreted and experienced in relationship with being with others.

In other words, the chapter argues for the carefully cultivated, deliberative, guided effort of constructing *intentional* solitude and silence, rather than one that is passively or thrust upon one through the lack of someone else in the environment or a temporary period of being alone and quiet. The states I consider in this chapter are states described by agency, choice, mindfulness, and empowerment. For instance, in this chapter, I will push the boundaries of silence to envisage not just communicative silence, whereby we are silent in solitude with the absence of verbalizing and sound, but silence to the presence of thoughts within oneself and internal or external communication through gestures. In order to develop the overlapping and intersecting dimensions of solitude with the ideas of presence, silence, and healing, I will examine literature in communication, nursing, pastoral psychotherapy, and religion and spirituality, among others to develop my argument in ways that can incorporate the contribution from multiple epistemological approaches and in multivocal ways.

EXPERIENCING SOLITUDE

Silence is a state. It defines a moment. It is a process. It is an act. It is a perception. Understood as a way of being in one's presence, solitude can take on multiple overlapping meanings both conducive and detrimental to the notion of healing in ways that constitute wholeness. To be productive, solitude should cultivate an authenticity and harmony of the body/self in their reflexive/embodied and discursive/material dimensions. Solitude that does the work of ordering and organizing inner/outer activity, contemplation, and engagement enables embodied sensemaking of the reflexive self constitutes wholeness. In body/self narratives disrupted by chronic pain, this work should align action, such as in the workplace or in social roles, with the changes in the awareness of the discursive and material body in those contexts in coherent and integrative ways.

In his essay on solitude, Morgan describes solitude as an "environment for human development, allowing various elements of the psyche to harmonize in an authentic way" (p. 18). In this interpretation, solitude emphasizes the in-

ternalized psyche as harmonizing and authentic, and the “involvement in the rush of activity and personal investment in the outer world” as overemphasizing “the role of psychic structures geared toward outer activity” such that they “isolat(e) and submerg(e) those psychic structures which tend to unify the person and open one to a larger world” (pp. 18–19). In this interpretation, isolation is put forward as disordering and distorting, the antithesis of an “authentic way of being in the world” (p. 19). For Morgan, solitude is a choice. Just as one chooses to meet friends, hang out with colleagues, or spend time with family, one chooses solitude to be with oneself. For Morgan, this is a “decision for ‘available self-presence’” (p. 19). This time with oneself, when one experiences oneself, is not empty time. Being available and present for oneself, hence, it is not a quiet time of empty relationality, but one of meaningful connecting with the self.

It can be challenging to cultivate available self-presence through silence. For one, the human mind is a constant moving presence. It does not allow one to stay in the moment. Second, it is noisy, full of thoughts and chatter of images, ideas, plans, feelings, aspirations, and memories, among countless other types of thoughts. Quiet time, spent alone, without others’ company, is inevitably time spent in the distracting environment of one’s mind. While it offers the potential for reflection and insight, available self-presence is not always productive. Solitude, with the best of intentions, does not come naturally and has to be carefully cultivated for it to be a positive practice. If not undertaken with deliberativeness and guidance, rather than being an insightful, reflective technique, it can be, possibly, a deeply disturbing time.

An instance of enforced solitude without proper guidance or deliberative training of the mind for the purpose of disciplinary goals can be found in the penal justice system. For those in the field of corrections, solitude is a powerful, oppressive state that can be employed as a punishment, such as by the criminal justice system for individuals classified as hardened criminals. Employment of solitude toward such goals has raised serious concern, such as the powerful manner in which it can serve as a dehumanizing force (Human Rights Watch, 2000). In solitary imprisonment, individuals may be kept in near-total isolation and restraint for years on end as part of a long-term strategy of correctional management and control. This form of isolation is characterized by isolation from human interaction, removal from the natural rhythms of social life, removal of access to self-improvement or educational programs, constraints on movement outside their cells beyond a few hours per week, under constant surveillance, not in presence of another person without restraints, and with no opportunity to touch another human being with affection or caring or receive such in return.

Under these conditions, the construction of solitude can be critiqued as an imposition of force on another human being. A large body of research has described the negative psychological effects of isolation and the psychological trauma created by solitary confinement units in supermax prisons (Haney, 2003). These go beyond the harmful effects of acute sensory deprivation and psychological distress caused by lack of social contact. Ruminations or intrusive thoughts, oversensitivity to external stimuli, confused thought processes, and difficulties with attention are commonly documented psychopathological symptoms of isolation (Metzner & Fellner, 2013). Besides the above, solitary imprisonment has been known to give rise to many symptoms of psychopathology. These include insomnia, anxiety, panic, rage, paranoia, self-mutilations, withdrawal, hypersensitivity, hallucinations, depression, and suicidal ideation and behavior (Arrigo & Bullock, 2008). Supermax units are characterized by placing individuals in virtually isolated conditions, complete idleness, and minimal human contact with almost no interpersonal face-to-face interaction that is not mediated through technology such as videoconferencing and telemedicine.

While forceful imposition of solitude can repress, cause trauma, and dehumanize, contemplative solitude undertaken with guidance and training can be constructed as a force to connect and elevate such that its discursive and material practices can enable individuals to reintegrate with a body in chronic pain and recover fractured narratives of a body/self long disrupted through decades of chronic illness. Much has been written about the benefits of solitude in the psychospiritual literature. Although such writings do not make the connection with trained and untrained solitude, they do extol the benefits of solitude. Here, solitude is described in lofty terms. Solitude has been described as the act of being present to oneself. It's described as a time to "refocus," to be "aware," to "feel more integrated, more self-possessed, more focused," as a "choice to attend to the quiet, and the Self that emerged in its ambience" (p. 19). The company of one's own mind is possibly a time to reflect upon and learn about one's own mind or a time to be oblivious to its actions but enjoy the experiences and recollections playing out in one's mind.

While the mind guides much of our self-identity and self-concept work, grounding our actions, values, and beliefs in our ways of being in the world, the mind by itself remains an unidentified, transparent entity to the untrained individual through their lifetime. The work of engaging with one's mind requires deliberative practice and careful guidance. In serving as a process that facilitates the mind/body connection through self-reflexivity and cultivating an embodied self, solitude implies a state of being alone and presumes a condition of silence.

However, a key point in beginning to understand silence emerges from here. Silence as a lack of communication does not emerge with the absence of a social other. In solitude, we are left in the company of our own noisy minds. Without carefully guided practice to cultivate self-reflexivity in productive ways, such solitude could lead not to contemplative, reconstructive silence, but fragmentation, insanity, and significant confusion and loss of self-identity. We could enjoy the antics of our mind when we are by ourselves. We could also, by the same coin, also suffer greatly, be pushed to the brink of insanity in the presence of solitude, left alone with ourselves, with the endless, ceaseless, noisy, relentless antics of our minds. Silence with an external other is not the same as the silence with the reflexive self. Instead of ordering our relationships and oneself, having solitude thrust upon oneself could well have the potential to slowly destroy us through the uncontrolled agency of our own minds.

While the above discussion has centered on solitude, I want to take this space to construct a connection to the context of silence in relationship with solitude. At the onset of the chapter, I had argued that solitude, silence, and presence are deeply and intimately connected with each other. In considering solitude, we've considered the notion of space and thought, identity and choice, agency and action. Similar to the problem of reframing solitude as positive and in tapping into its transformative potential, silence risks the narrow focus of being a symptom of specific negative contexts and debilitating or pathological preconditions. The many mainstream findings on silence discuss the multitudinous contexts where silence is a symptom of maladjustment, frustration, alienation, anger, repressed emotions, conflict, confusion, stigma, or othering, of silencing another's identity and position, rights and agency. These findings demonstrate considerable validity in clinical contexts. Because clinical contexts are central to the goals of wholeness in healing, the next section focuses on the practices and outcomes of intentionally and unintentionally enacted silence in clinical contexts.

Silence in Clinical Contexts

As the previous section has argued, silence is a powerful communicative tool in health care contexts with tangible and specific effects on patient care and health outcomes. However, as this section will illuminate, little or no attention has been paid to understanding the notion of silence and its role in clinical contexts. In fact, few studies, if any at all, have focused on the role of silence in the clinical setting. Those investigations that do mention silence as a process or an outcome do so as an unintended observation or finding from the study. In this section, I provide a few examples of recent research on

silence in contexts of problematic or challenging health care contexts ranging from cancer to menstruation to sexual health. In each of these contexts, silence is characterized by a unique dimension that defines the constraints and resources, dilemmas and boundary conditions, potentials and pitfalls inherent in the employment of silence in that context and how silence serves to organize the tensions in the clinical encounter in order to protect certain interests and address others.

When silence is employed in clinical encounters to ignore specific discussions and actions that may potentially have benefits for specific interaction participants, it can serve as a form of barrier to integration and alignment of different interests. An examination from a recent study illustrates the interest in the negative consequences of silence in palliative care. In this example, Lemus-Riscanevo et al. (2019) consider how the current discussions around chronic condition management have ignored integration with palliative care. The consequences of this lack of integration around palliative care are communication failures and their association with what they call a *conspiracy of silence*. Accordingly, the authors look at the consequences of this form of enacting silence and find that communication failure, limited life expectancy prognosis, lack of autonomy, overburden, family malfunction and coping, and health care dehumanization are consequences of the conspiracy of silence in palliative care. Similarly, silence has been understood in the context of setting goals of care for cancer patients during hospitalization. Piggott et al. (2019) were concerned with understanding barriers to care from the perspectives of staff oncologists, oncology residents, and oncology nurses. This form of silence was constituted of barriers to accept poor diagnoses, difficulty understanding the real barriers faced by the patients and limitations of life-sustaining treatments, a lack of capacity to make goals of care decisions, and language barriers (Piggott et al., 2019).

Most examinations of silence in clinical research have minimized and often ignored its meaningful conceptualization, often defining it as an unidimensional act (e.g., not speaking/communicating) or presenting it in a negative frame (e.g., silence as a filler space that creates communicative barriers). However, even in the most basic investigation of the identification of silence as a simple act, a few studies provide evidence of its potential. In this book, I want to take the space to argue for the work of creating, maintaining, and sustaining silence as a resource, a potential for reflection, a content of insights, and an antecedent of transformation, change, and identity-building. Much work has been done in this direction on the context of cancer and silence. Van Humbeeck et al. (2019), in an example of recent research in this area, suggests that as life expectancy increases in cancer survivorship, oncology care should account for communicative factors that may be influenced by cancer in the

communication of cancer patients with older parents. In this context, where there is a hidden and complex dimension of giving information and talking about feelings, silence was characterized by different forms of solicitude (self- and other-protection).

More conventionally, when attention has been paid to silence, it has been conceptualized as a form of resistance or isolation. In the context of changing cancer care, self-administration of oral chemotherapy has been the subject of recent investigations such as Mitchell et al.'s (2019) study on obtaining shared agreement on the prescription and administration of self-administered medication between health care professionals and patients. Silence here was a component of the patient journey from telling to sharing to silence in the diagnosis to posttreatment process in colorectal cancer. Moving from autocracy to physiological concordance to holistic concordance to finally silence, the patients felt isolated and unsupported in the final phase, which they described under the theme of silence as a communicative device between the oncology team and the patients. In illness communication, silence has been investigated as a conversational feature of a natural clinical setting in palliative care. Visser et al. (2019) examine the impact of two types of oncologists' bad news, emotion-oriented communication on participants' recall of medical information as mediated by reduction in emotional stress and moderated by personal characteristics. The authors find that with acknowledging, exploring, empathic, and supportive statements, and attentive silence, the oncologists' communication resulted in better information recognition, irrespective of emotional stress. While the first example illustrated the employment of silence as an expression of isolation and lack of support, the second provides an instance of attentive silence as communicating care and presence.

In the domain of patient-physician interaction, acknowledging patient vulnerability through emphasizing unacknowledged shame, illness, and social bonds is important. Here, if not employed with thought, silence or lack of relevant response may be detrimental to collaborative problem solving and decision making. In interaction contexts of negative, severe, ambiguous, or vulnerable communication, silence needs to be acknowledged as a powerful tool that can support or hamper communication, patient-provider relationships, and patient health outcomes. Positioned within the traditional health environment discourse in the Western biomedical knowledge frame, silence is seen as a predominantly negative process at worst, and an empty, inconsequential act at best, one that has, consequently, not been the focus of much work seeking to locate the role of silence in the clinical encounter in particular or in health care settings in general. As this book argues, shifting the positioning of silence from being a meaningless process to one with powerful consequences can associate with silence the multiplicity of meanings

and potentiality that illuminate the complexity of its content and enactment. In taking a social constructionist approach, the chapter provides a way of situating this inquiry into silence in the care context in multiple, contradictory, overlapping, and sense-making ways. In doing so, it highlights the need to consider solitude, silence, and presence as a key component of the traditional health environment in the larger health care context, and particularly in the context of chronic illness management, where the role of silence and its relationship with solitude and presence can be seen as a foundational element of the body/self, as developed in the ecology of wholeness.

By focusing attention on solitude, silence, and presence, and the relationship between the three, this chapter constructs an argument for greater attention to understanding these three conceptually, and exploring their relationships in the health care context, and finally, to training health care professionals in clinical and community settings, in employing silence mindfully and with care (figure 8.1). Individuals with serious health and illness challenges need adequate care in community or health care settings. Patient-physician nonverbal communication during clinical examination has been examined by Park and Park (2018). Here, facial expressions, matched voice tone, speech rate, voice volume, and absence of unnecessary silence was considered a more positive form of patient-physician interaction. In other contexts, it becomes important to consider the experiences of laypeople communicating with seriously ill peers (Somes et al., 2018). Using end-of-life advance care planning conversations as their study domain, Somes et al. (2018) performed a qualitative meta-synthesis of several databases including data regarding communication and laypersons in advance care planning, palliative care, or end-of-life settings. The study finds that laypeople perspectives on communication skills were characterized as including rapport building, discussing sensitive issues, ability to listen and allow silence, and responding to emotions. The contexts of care highlighting both the opportunities and barriers posed by silence in health care contexts emphasize the need for greater attention to training of health care professionals in identification and employment of silence as a communicative tool with specific and powerful interactional and patient care outcomes.

Two additional clinical care contexts serve to illuminate instances where silence has been given some attention. The first is dementia care, and the second is the larger context of women's health, in which I consider two instances—one of breast health, and the other of menstruation. Dementia treatment treats silence as worthy of its own examination in part because of the emphasis on sensory stimuli in the treatment protocol of the disease. Thus, it is no surprise that studies on dementia treatment, where high levels of sensory stimuli are considered detrimental, have focused on the examination

of silence as a treatment approach. For instance, Fein (2018) describes the Resonant Silent Technique, whereby a calming and peaceful environment is created through multiple periods of silence following sound.

The idea here is to use subtle sound and intentional silence to create a quieting environment. Such an environment is reported to help make dementia patients feel less anxious, more relaxed and cooperative, emotionally appreciative, and empathetic, and to demonstrate improved concentration, eye contact, and communication. Although focused on dementia treatment, the findings from such research indicate the potential for sound, and by association, silence, in its intentional, positive effects, to create empathy, relaxation, and relational openness. While this investigation on silence in the domain of dementia treatment does not delve into the nature and conditions of silence and the multilayered nature of its constitution, it does provide an instance that highlights the positive potential of intentional use of silence in a clinical domain.

Second, in the domain of women's health, silence has been critiqued from a poststructural and ideological framework. Gender has been a topic of research in feminist literature wherein attention to silence has centered on the intersections of silence and its enactment with notions of dominance, voice, access, power, and hierarchy in care. Even in this domain, though, examinations of silence reveal its positionality in research goals as being more of an unintended, secondary nature. Menstruation, as an example, is described as a salient topic for young women, as Rubinsky et al. (2018) note. In examining supportive communication characteristics around this intersectional experience, Rubinsky et al. (2018) find that themes of boundary management, impersonality, silence, and accidents characterize the communication experiences. Silence can be interpreted ambiguously here, with a potential to liberate as well as constrain. The findings suggest verbalizing conversations that normalize, accept, and validate period pain and its management, as well as resources and access, would be valuable. Here silence serves to counter this access to resources, and in doing so, represses and creates conditions for oppression and exclusion of women from settings such as schools and the workplace. Silence in this case is the inability to express and communicate due to cultural and structural constraints and the creation of stigma and taboo that serves to exclude and oppress.

There have been some contexts in clinical research where findings have suggested that silence is beneficial. Toward this end, let me start with providing a few findings from the relatively recent interest in silence that is a cause for specific conditions and transformations, as opposed to earlier research whereby silence was the symptom of various negative and debilitating conditions. The context of bereavement, of punishment, of a moment of anger or loss, all are seemingly captured in and through silence. Silence endures

during such events, emphasizing the larger-than nature characteristic of such experiences and giving voice to the solitude of the inner state of the actors and the context. Such inner solitude illuminates the premise that each of us is alone with our thoughts at such moments, processing and making meaning on our own before we can share and communicate empathy or support or understanding. Capretto (2015), for instance, examines silence as therapeutic in the work of the pastor. Addressing trauma, grief, and loss among members of the congregation are often the task of the pastor and are often conducted through intentional use of silence. Here, too, silence characterizes the listening of the pastor as an active trait. In being silent, one creates the space to listen. Silence in this evocation is openness to communication and relating. Instead of creating boundaries and building walls around topics of discussion or labeling them as taboo, such silence creates a space of openness, empathetic understanding, and relationality.

Intentional silence, cultivated with the goal of creating an open discursive space of relationality, can be a mechanism for creating agency and illuminating spaces of personal expansion in another through communicating embodied acceptance of another’s experience without the use of words. In this form, silence expands beyond words to communicate the limits of language spoken through words and emphasizes the a priori power of the embodied experience to relate with another. Capretto draws upon the silence of the hospice chaplain

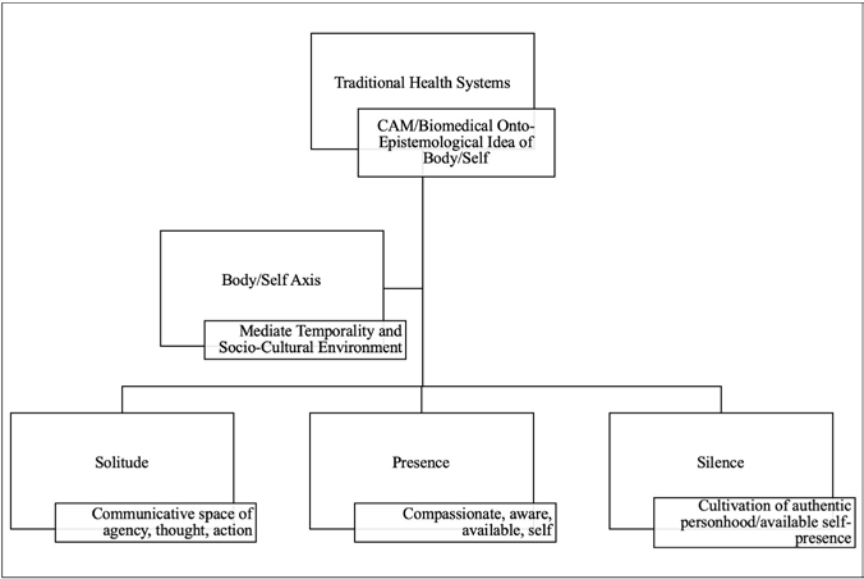


Figure 8.1. Traditional health systems. *Figure created by author.*

and describes it as the “acceptance of the limits of empathic language, and the affirmation of psychological difference and theological wholeness.” Capretto’s paper (2015) takes as its starting point the history of attachment and mourning theory, to describe empathy in the therapeutic relationship and how it makes a psychic difference. For Capretto, silence is a resource for empathetic language in the grief process. The notion of silence as a resource for empathetic language goes beyond addressing the emotion of grief to creating spaces of openness and relating that are valuable in the provider-patient encounter. In the case of chronic pain and illnesses, the provider’s ability to employ intentional silence to understand the invisibility of the experience and its material consequences can provide patients a valuable resource (Agarwal, 2018).

While research has largely ignored silence in favor of words thus far, this chapter makes a call to focus on silence as a space that gives words meaning, and hence can be more powerful than words. Using the reflexive and embodied self as a framework, silence can be employed to focus the dialogic engagement with another in deliberate, ethical, and powerful ways. Understood as a traditional health environment through its ability to structure our interpretational framework at a pre-discursive and pre-verbal level, silence is one of the earliest pre-cultural phenomena that guides how we as individuals perceive and make sense of another’s intentions and words, actions and behaviors, as well as interpret contexts as open or closed, supportive or repressive, empowering or debilitating. In these and other profound ways, silence is intimately related with health, healing, and wholeness. A majority of current work, even in the field of communication, has attended to verbalizations, actions, and nonverbal gestures as contexts where human agency was exemplified in ways that could make a difference. On the contrary, some recent findings in emerging research now appear to suggest, silence, solitude, and presence are more powerful in their ability to transform as opposed to behaviors and actions that emphasize action. In part, the premise presented here is that silence precedes action, that it is in silence, however brief or un-intentional, that we do the work of connecting with ourselves and, thereby, with others. Attending to the complex and intersecting spaces of solitude, silence, and presence has the power to shape healing interactions in the provider-patient domain as well as in productive relationships that support healing and healthy environments.

Therapeutic silence is central in relationships where psychological well-being is the focus of the provider-patient communication. Rather than a resource, the psychotherapeutic context has focused on the interactional perspective on constructing silence as a strategic device during the interaction, such as during turn taking, before and after specific conversational moments, and during specific forms of disclosures to communicate comfort and emotion in the therapist-client relationship. Such studies have examined silence as

a communicative event in health care contexts. Hill et al. (2018) investigate the antecedents, occurrences, and consequences of silence events in psychodynamic psychotherapy sessions. They note turn taking in speaking, and moments of pause and reflection. They record collaboration, connections, and insightful and relational elements before, during, and after such moments in the client-therapist interaction. What they find interesting is that in the client-therapist interaction sessions, silence served a multi-perspectival role. Silence provided the client a space for reflection, to the therapist a space to communicate support and comfort, and sustained the relationship by strengthening the connection and relational factors (e.g., therapist was able to communicate connection, emotion, and meaning with the client). In another research from the psychotherapeutic relationship context, Lane et al. (2002) too find similar outcomes. They find that silence enables the therapist to facilitate client communication of emotional and relational messages of need and meaning with a feeling of safety, understanding, and containment.

In developing this argument on solitude, silence, and presence as a traditional health environment of healing that sustains and creates wholeness, I build the solitude/silence/presence relationship in dialogic engagement with the subjective environment of time and change. Creating space with specific characteristics through silence is a powerful instance of the reflexive and embodied self engaged in healing communication through discursive and material ways to create wholeness. Understanding silence as the foreground of our cultural values, whereby our actions, words, and gestures are given meaning through their absence by their framing with silence in unique and particular ways in each culture, silence pervades presence and absence, expression and meaning making, intentionality and action.

It is thus a central component of our traditional health environment. Silence can serve as a boundary and as a container, framing space with meaning and providing it context for reflection. In these moments, bound and contained by silence, meaning emerges in part through reflection and the work of organizing what is present in the *before* and the what is anticipated in the *after* of the moment. More significantly, the work of silence is in the conscious and trained effort of constructing information that can sustain the present moment of silence with potential. The work of creating silence lies in organizing the relational space to construct the present moment of silence as emerging from subjective time and change but actualizing in the present.

Silence, then, is the work of managing the moment itself in doing the work of analytical organizing, critique, predication, and sense-making in order to provide context and content not just for the immediate future, but of a way of thinking and organizing that material itself. The work of silence is the work of cultivating transformation. One might wonder if health care contexts are

the only contexts where healing should be considered when we talk about silence. If we're concerned with healing, then the notion of silence should apply to everyday contexts as well. Johannesen, way back in 1974, considered a similar premise. He called for an examination of silence in ordinary, everyday human communication processes. Johannesen proposed the need to (re) examine silence from the context of human thought, cultural development, civic life, and pathological settings. I extend this argument further to call for an examination of ways that solitude, presence, and silence can be integrated as healing communication in our everyday lives. Although conversation, boundless engagement, and strategic communication are prioritized for specific modernistic, post-capital, production, and social organization motives, human society can ultimately benefit if training in solitude and silence were imparted as social resources to communicate healing, sustain the cultivation of a reflexive and embodied self, and construct relational engagement with the discursive and material bodies engaged in social organization of roles in families, workplaces, and community settings. In the next section, I consider the relationship of solitude and silence more intimately.

Solitude as Silence

In the earlier half of this chapter, I argued that insufficient focus had been given to silence as a relational and healing communicative construct on its own. In this section, I would like to make the point that even as insufficient attention has been paid to silence on its own merit, this lack of attention is made even more detrimental in its impact owing to the evaluative and judgmental focus of the research that has identified silence in its findings even as an unintended outcome or effect. In fact, in this vein, a large body of literature from diverse fields has developed around the notion of silence and its antecedents, outcomes, and manifestations. In this literature, silence is an offshoot of solitude, and often considered as an outcome that needs to be evaluated in terms of its helpful or unhelpful impact on health care outcomes. While useful, this approach has some noteworthy limitations. One of my main concerns with this approach lies in its singular evaluative focus. Silence, from such a perspective, becomes the main outcome through which solitude is judged. Here, too, inadvertently, the major criteria is punitive and judgmental: Is silence good or bad? Does it help or harm? Certainly, there are merits to an evaluative approach, particularly in outcomes-driven research settings. We wouldn't know in a pithy, easy-to-understand manner whether such forms of silence have brought about any transformation in the lives of those it touches.

However, a purely evaluative focus draws attention away from understanding in an unbiased manner what constitutes silence and how it is framed

and constituted through the lens of our traditional health values, norms, and paradigms that define our age and culture, and serve to form the onto-epistemological frame within which all meanings of silence are given form in evaluative and assessment-driven ways, rather than to explore the meaning in the absence of words. In part, this traditional health focus is exemplary of the evidence-based knowledge paradigm of attending to what is in order to acknowledge what is not. In the axiological scale of defining what is, greater value is assigned to the material content of expression rather than its presence in non-material, if impactful, and powerful ways. This narrow and tight approach to knowledge construction has its merits but risks equally great gaps in knowledge by ignoring what is not easily obvious and verifiable, yet sensed and material in its benefits, even if these emerge consistently and powerfully in research.

Let me illustrate. Oncology nurses, for instance, are frequently in touch with contexts of loss and suffering in their work. Their work is emotionally demanding, and they often work in a setting that does not give them an opportunity to express their personal suffering or the emotional toll of the work on their well-being (Phillips & Volker, 2019). This is one form of silence, one that is externally imposed by structural conditions in the workplace, that stifles expression and communication of emotional contexts. In this silence, the structural and cultural forces defining a profession serve to restrict communication and expression of those who work within that culture.

As a restrictive, constraining form of silence, it has negative effects on those who labor under its strictures, such that oncology nurses report higher rates of burnout, compassion fatigue, and negative emotional impacts (Phillips & Volker, 2019). By understanding silence and the ways in which it can both constrain and liberate, healing communication can be constructed for both oncology nurses and the patients they serve in ethical and culturally sensitive ways. Attending to the construction of such forms of silence can be a powerful healing mechanism for oncology settings and the health care professionals, patients, and staff that work in these demanding contexts to heal. Forms of healing constructed through the self-reflexivity of individuals involved, in embodied ways, through the discursive and material expressions of their presence can address intentional communication and constitute wholeness even during and through challenging treatment regimens. Silence and solitude can be a healing space through their engagement of subjective change and time in the process of diagnosis, treatment, and recovery.

Framed within a social constructionist approach, the dialogic and relational nature of the traditional health environment constituted by solitude, silence, and presence foregrounds its intimate connection with the socio-cultural norms and values of the contexts these are given meaning in for their partici-

pants. In each culture, specific and very particular forms of silence surround topics that are deemed culturally taboo. A popular instance can be found in topics concerning sexuality, relationships, and intimacy (Urry et al., 2019). With a lack of cultural opportunities to express perceptions and understandings of sexuality and sexual concerns, participant sense making is peripheralized, thus stifling recovery in holistic mental health settings. Such a form of silence surrounding an issue is characterized by a lack of avenues to bring up particular topics, such as in mental health settings, thus leaving participants with no accepted social or cultural spaces whereby to give voice to particular experiences. In a similar vein, stigma and its discursive and material formations in particular cultures has deep and lasting effects on *all* the participants of those cultures, placing its ethical burden of implementation and victimization not just upon those it visits in that cultural setting. Stigma is a discursive form of materializing silence.

To illustrate, one particular form of stigma receiving recent interest in health care settings concerns the stigma of stillbirth. Here, emerging research interest (e.g., Urry et al., 2019) reveals how often the bereaved parents' emotions and experiences are undermined, closed-off to opportunities for communication, and thereby, the resource of sense-making in relational ways. Thus, such contexts give rise to a form of silence that stills meaning-making in relationship with identity, transformation, and belonging. Silence serves to exclude and reinforce the discursive placement of being outside accepted contexts (in domains constituted by shame, embarrassment, guilt, and blame), even as it is materially contradicted by the acceptance of the parents' in health care settings in their grief and in the acknowledgment of their status. I argue here that if silence can be powerful enough to still meaning making and to exclude in its discursive/material effects, it contains the power to performatively engage its semantic opposite in the body/self and its subjective environments in communicating healing to constitute wholeness. In the next section, I consider solitude with presence to explore such intersections.

Solitude and Presence

Undertaken by choice, a state of solitude is characterized by a few common physical and cognitive features. Although it may signify at first glance a state of being alone, solitude is more than its discursive and material bodily state of aloneness. Seen through an ecological framework of wholeness, solitude connects the reflexive/embodied self with the discursive/material body in an environment shaped by its traditional health values, and subjective time, and one contained by its socio-cultural environment of food, nature, and the body/self expression. Solitude, in alignment with silence and presence, constitutes

wholeness through contemplative engagement with subjective change and time and in relationship with the socio-cultural environment of food, nature, and body/self expression. In chronic illness, such connections are expansive, creating a space of movement in time framed by anchoring in the present, and creative expression in the social-cultural realm.

From an ecology of wholeness perspective, solitude is defined as an internal environment of anchoring and balance, of a relationality with the body/self in harmony with the discursive/material body. As a physical state, it can be described as connecting with a mental state, a way of being in the world mentally and physically, a moment of attentiveness and presence. It may involve being available to be present for oneself, a moment that allows for emergence of a centering force, an internal mechanism that grounds one's identity, which has been labeled as the "self" by Hanes (2003), and a grounding of the self with one's outer identity that re-energizes and focuses the self. This grounding can be the foundation of a feeling of integration and wholeness that refocuses the personhood of an individual. Hanes (2003) defines solitude as "a way of being of a person, an ambience of quiet and stillness, characterized by aloneness, by self-presence, by openness to the emergence of the self, and willingly chosen as a style for living a whole and integrative life" (p. 20). Solitude is a relational, attentive presence, communicating healing through its constitutive dimension of openness and integrativeness.

Productive solitude invites us to integrate with our true and transcendental selves, one that can be described as a construction of wholeness through and from an individual health status. In psycho-religious-spiritual literature, solitude has been framed as a move toward the development of an authentic personhood. As cultivating an authentic personhood, the self as illuminated by solitude is defined through multiple levels. While simplistic and arguably binary in their boundary definition of the public, true, and transpersonal selves, this premise is illuminating to consider, if only for a moment. According to this literature, it is the simple, external, public, surface self that communicates and interacts with the external world. The second is the true self that forms the seat of our identity, the expression of our individual being, and consciousness. The third is the transpersonal self, the collective unconscious, that connects with the unitive experience of all manifestation and our individual surface and true selves. In psychology, the self is a basic, grounding, structural element of the human psyche, from which the ego emerges as the acting element, connecting with the consciousness to explain experience.

One promising feature of the critique of solitude in alignment with personhood is the emerging focus on individuation and wholeness. Herein, the goal of the self is to strive toward wholeness and personhood, through the process of individuation, employing ever-deepening relatedness between the

ego and the self, one that is cultivated in an environment of solitude (Hanes, 2003). This wholeness is a move toward health and harmony, to grow and to be whole. In this context, solitude creates an environment in which the self can be experienced, without external tasks, interactions, distractions, and engagements. Here, solitude is restorative; it is a precondition to achieving wholeness, to integrate through employing a dialogic relationship, an ordering within one's inner space, and of one's self in their full awareness. In order to cultivate solitude, an individual should be free from plans, distractions, and myths, and engaged in a quest for deep personal authenticity, a transformation, honesty, entanglements, struggle, and harmony. Quietude and silence can be worthy goals, imparted through education and training as self-reflexivity and embodied relating in early childhood to be practiced through adulthood, privileged as a valuable healing communication resource that emphasizes ethical communication and relating and not feared as anti-social or negative traits.

This chapter lays the basis for educational institutions and higher education associations to consider including intentional, deliberative silence as a mode of healing communication that can have benefits in making our social, individual, and global spaces whole. Solitude requires thus, once engaged, a desire and a conscious decision, to remain in and intentionally maintain the state. Genuine solitude is often described as a struggle, a deep, courageous, hard work that requires constant vigilance and determination to maintain. Similar to courses in public speaking and sales pitching, educational institutions imparting courses in intentional silence can serve a valuable resource toward making our societies more humane, ethical, relational, and reflective in their communication by genuinely connecting the reflexive and embodied self to its discursive and material expression through the body. To this extent, solitude is a trained, deliberate exercise in letting go, to be in the natural flow of one's own nature, to feel responsive to the world as it is presented to us, understanding this state to be of one of wholeness. This feeling of letting go is one of being open and inviting, of willing decisiveness and resolve, responsive and relaxed, not the undermining and stress-inducing striving and self-possession, not a willful suppression of an individual's humanity, and not a forced and punitive submission of the material and discursive body. Creating humanizing experiences for human beings, from our children to our hardened criminals can help create conditions for healing communication in ways that makes our lived spaces healthier and balanced.

Productive solitude is a deliberate, slow, careful stilling of distraction in the mind and the thoughts to illuminate the power of thoughts as they arise. Solitude and silence, therefore, go hand in hand, in order to fully grasp the presence of oneself. Being aware that solitude and silence are imbued with

deeply traditional health values that permeate our health environment can be illustrated through an example. Solitude allows us the space to engage in contemplative discernment through a purity of the mind and body from distractions. Solitude has not always been viewed positively in spirituality. In American history of spirituality, focused on Protestantism, Christian recluses, living their lives with “penance and solitude, undisturbed by the various occupations which fill the time, and exercise the faculties, of reasonable, active, and social beings” (Schmidt, 2012, p. 68) have been thought of with suspicion as negatively impacting civic and religious life. Healing presence is a complex phenomenon, described by McDonough-Means et al. (2009) as an “interpersonal, intrapersonal, and transpersonal to transcendent phenomenon that leads to a beneficial, therapeutic, and/or positive spiritual change within another individual (healee) and also within the healer.” Consistent with this and my own research (Agarwal, 2017, 2018), the healer and the provider is in an intimate, dialogic, healing space with those it serves, and this relationship has a dialectical impact on both constituting its space. The change envisaged here is not merely behavioral, it is reflexive/embodyed in nature, connecting meaning with the self and its ethical embodiment in a healing space.

The space of constructing solitude from an ecology of wholeness framework is dialogical and relational with the inner spheres of the body/self and the subjective change environment that constitute it and the outer one of socio-cultural environment nourishes it. Presence cultivated with conscious awareness of such solitude is intentional and empowered to foster healing at the bio-psycho-social-spiritual levels of the human being and integrating the environment and the relationship between the healer and the healee. Such an integrative ecological model of wholeness is echoed in the relationship between the healer and the healee. Bolles and Malley (2004) examine the healing effect as an entangled phenomenon. The authors propose that envisioning the healing environment as an entangled phenomenon can benefit the healee’s capacity for response. In their study on optimal healing environments, Bolles and Maley (2004) identify the relationship between the healer and the clients as a key element for exploration, definition, measurement, and interpretation. Although the authors don’t note healing presence as a focus of their study, their findings are relevant to this argument as the notion of relationship dynamics as resources in the healing process is important to furthering understanding of this concept proposed in the present book.

Solitude in Healing Relationships

Healing is a relational and dialogic process. Thus, the dynamics of the relationships between the healers and clients are critical to the effectiveness

of healing as a process of transformation (Agarwal, 2018). For Bolles and Malley, an examination of how healers can be emotionally available in relationship-centered care is important. One of the notions that can inform such calls in research is the notion of the healer as the healing presence, and the healee in a healing environment. As this chapter has argued, these are concepts that can be supported and cultivated through use of silence and solitude as constituting the traditional health environment in which the transformative potential of healing toward wholeness can occur. The notion of healers has been articulated as conceptually distinct from the biomedically trained provider in the present medical landscape. While the two forms of training are foundationally distinct, I invite the consideration of an integrative landscape wherein the biomedically trained provider is not constrained by artificially created boundaries from their ability to employ solitude, silence, and presence in the health care domain.

Connecting the health care professional to their own vision of their humanity does not detract from the standardized rigor and objective criterion of biomedical care. On the contrary, it serves to enrich it by placing those with the knowledge of biomedical practice in touch with the mechanisms of reflexivity and embodiment that are central to the application of biomedical knowledge in the discursive and material realm of the body. The idea of the health care professional as a healer has generated some interest. Let me illustrate with an example. In an elementary pragmatically focused proposition, Schmidt (2004) takes a closer look at the role of the health care professional in creating an optimal healing environment through focusing on the inner state and way of being to create a healing intention. The basic idea underlying Schmidt's approach is that the health care professional is the originator of every healing effort and intention. Taking this as the starting point, the healer or the health care professional should have an accepting, mindful, and warm-hearted relationship with themselves to be able to effectively cultivate a healing intention. In order to cultivate a healing attitude toward the self, there should be a symmetry between their relationship with the inner and the outer worlds. In other words, compassion and mindfulness, themselves related to each other, are primary to all healing intentionality. As Schmidt explains, compassion connects the patient's suffering with the healer's own suffering, and this emotional connection is the start of the healing relationship. Schmidt utilizes the relationship between the ability of the health care professional to elicit self-healing powers in patients through his or her inner attitudes to outline the creation of optimal healing environments. Closely connected to the idea of the healing presence is the research that illuminates the healing processes that make for an effective healer.

This integrative proposal is in essence is the criterion of wholeness and it is in dialogic and relational alignment with the goals of modern medicine. The work of healers is distinct in praxis but conjoined in its onto-epistemological goals with that of modern medicine. Kenny (2012) attempts to synthesize some of the core processes the healers go through to illuminate this relationship in his research. After conducting an extensive literature review of seminal texts and current literature, Kenny identifies the themes of healer in a healing encounter. He defines the healer as a facilitator, who connects to sources of healing, an appreciation of the healee, an expanded sense of spirituality, an acknowledgment of the wider archetypal significance of the healer, the importance of the wound, and the role that these can play in the process of personal transformation and acceptance.

Such themes serve to deepen the understanding of presence in this chapter. As I argue, solitude and healing are closely related. In this relationship, the healer has a very significant, complex, and delicate role to play. The healing presence is constituted through facilitating a connection to healing resources and acceptance of the healee, embodying the healer archetypes and cultivating a deeper understanding of spirituality. In the next section on solitude and healing, I consider some practical implementations of the concepts of solitude, silence, and presence in health care settings and individual practice that can constitute healing and wholeness. I first consider healing contexts of socio-culturally grounded rituals and related healing spaces such as healing gardens and wilderness environments. Next, I present individual healing practices such as meditative reading and narrative restructuring as cultivating wholeness through connecting the reflexive/embodied, and the discursive/material in practices that individuals can inculcate in their daily lives to construct wholeness through chronic illness and pain.

SOLITUDE AND HEALING

Healing Contexts

Healing Rituals. Healing and solitude have been enacted in a variety of settings. In describing charismatic healing as a system of ritual performance constituted by “types of healing event, genres or forms of healing prayer, and ritual acts of empowerment,” Csordas notes, “healing is not only the relief of illness and distress, and not only a ‘sign to unbelievers’ of divine power, but an instrument for molding the sacred self for both healers and patients” (1994, pp. 25-26). The events, genres, and acts mobilize and organize the self-processes. In this approach, healing prayer for oneself or others was practiced in the solitude of private devotion, supporting the idea of religious

healing through solitary rituals, where the healing happens with or without the healer through activating endogenous self-processes.

Charismatic healing participates in the broader cultural discourse at the intersections of psychosomatic and holistic healing. Here, healing is understood as a composite of physical healing (of bodily illness), inner healing (of emotional illness and distress), and deliverance (from adverse effects of evil spirits). Here, inner healing referred to emotional problems (or what the charismatics labeled the *healing of relationships*, or *healing of memories*). These reference emotional woundedness as the consequence of traumatic life events, solved through reconstruction and inserting the presence of Christ in the biographical moments of the individual's life. The allocation of space for spiritual healing, a way of providing peace and acceptance of divine will to those not physically or emotionally healed was integrated to support the coherence of healing practice. Performative acts (saying something) of charismatic healing include verbal and nonverbal actions and are central to the healing processes. These have been critiqued as healing through empowerment, protection, revelation, deliverance, deliverance, sacramental grace, and emotional release.

The dimension of ancestral healing performed in the American cultural context through the severance of bondage (ostensibly to restore the cultural ideal of ego integrity and psychological differentiation) is central to healing rituals. In most ethnomedical systems, this is performed through reestablishing the bonds between these ancestors and the individual. Through cataloging the repertoire of healing acts, Csordas argues, these rituals thematize autobiographical events, emotional thoughts and behaviors, their interpretation must take into account their multidimensional nature, implicit cultural meaning, and explicit experiential content to co-create therapeutic persuasion which enhances phenomenological engagement, consciousness of the sacred, and disinhibition of cognitive barriers, all central to cultural performance as therapeutic process. In clinical contexts, healing narratives inform how the narratives that support decision making at every turn are constructed and interpreted. Mattingly and Lawlor (2001) present the instance illustrating this through the organizing role of the diagnosis in framing what constitutes appropriate treatment. The issue at the center of this conversation is how some categories are given greater emphasis and clinical attention. While the power of diagnosis doesn't impact patient health, the manner in which it connects with hierarchy in the provider-patient relationship is significant, whereby the provider has the means to actualize the diagnosis and thereby the treatment. Given the outsize role of technology in the Western diagnostic model, the highly visible machinery of the modern clinic is characterized by complex processes, routinization, dispassion, and a removal of human agency, increasingly even from the interpretive process.

Mattingly and Lawlor (2001) critique these dispassionate, technology-driven spaces through the lens of the healing dramas they nevertheless sustain, arguing that in these narrative moments, healing may not mean a return to normal, pre-diagnosis faculties, or simply reclaiming a body, but discovering how and where new movement and capacities can be made manifest. In order to discover the healing dramas and the moments of their manifestation, the meaningfulness of the situated, lived, everyday moment is powerful. Mattingly and Lawlor label this criterion as the “stake-ness” inherent in the moment, where the moments experienced by the participants are identified as significant and seek to construct them using what they term “therapeutic emplotment.” The idea here is to create activities that are imaginative and rich in possibilities and convey meaning where the liberating potential of the material that is present can be illuminated while what is lost can be seen in context. Seen through the lens of social construction theory, such healing dramas are necessarily in the moment, improvisational, spontaneous, and iterative, with each character finding a part and connecting to what happens next. In the chronic illness management landscape, the actors can be therapists, family members, patients, and the health care team, all coming together to create significant experience, centering around the creation and interpretation of a healing drama unique to the characters and context. Clearly here, too, drama is understood in phenomenological terms, as an experience of the body, whereby the body is constituted by the experience and the identity and all the possibilities of manifestation and obstacles and barriers inherent therein. Cure, in this context, is the journey, not the resumption of prior activities and lifestyles, but the discovery of possibility. The idea of uncertainty is significantly tied in with silence in interesting ways. Uncertainty is intrinsic to contexts of health, one that is often associated with debilitating feelings of stress, avoidance, and resistance. These detrimental associations are negatively connected with the individual’s well-being. George and Lowe (2019) examine this context of uncertainty, suggesting that instead of approaching resilience to improve the health care professional’s well-being, a better understanding of uncertainty itself is warranted.

The conventional wisdom has been to avoid uncertainty and manage uncertainty through bringing in more of its conceptual opposite, that is, information and communication that might increase certainty and confidence. However, the authors suggest that in doing so, we have been ignoring the potential of uncertainty itself. To promote well-being, uncertainty in environmental contexts can be accepted on its own terms as a positive state that can promote well-being if understood in the proper context. Seen in this manner, they argue, uncertainty can be an opportunity to promote well-being in manage the complexity of everyday interactions in a health care professional’s work con-

texts. Their paper puts forth the strategies of promoting well-being through being comfortable in not knowing, preserving uncertainty through effective communication, and using reflective silence to tap into the impact of uncertainty on an individual's well-being. In furthering the argument put forward in this chapter, such findings provide evidence from multiple domains on the impact of silence. Reflective silence has been suggested as a resource in managing uncertainty in ways that can promote well-being.

Silence itself is a neutral act. It is the intention and context in which it is enacted that gives it meaning and power to transform. In the above instance, reflective silence is sustained in a context where uncertainty prevails. Such reflective silence provides an opportunity for health care professionals to manage uncertainty, characterized by a lack of information. In this instance, reflective silence opens a space to organize information and information gaps in a coherent manner. Silence is not a negative space of no talking or making no noise. Instead, it is a space of cognitive action, of metacognition to bring about an ordering of alternatives, to make sense of what is in light of what isn't. Such actions cannot be brought about when we are engaged in cognitive and verbal activity or in processing cognitive and verbal information coming our way. The reflective potential of silence is transformative. It is the space where we can move from acting to experiencing, from being agents to becoming embodied participants, from influencing to observing. This chapter presents the argument that such work is transformative because of its dynamic passivity. The individual is actively engaged in maintaining a balance between different forms of information processing, that is, cognitive mapping, and in reflecting upon the act of processing, that is, meaning making.

Healing Spaces. The idea of a healing space has received interest from multiple perspectives. One is the objective and subjective space of a healing garden, most often associated with institutional health care structures or civic spaces. The second is the idea of the healing space of the healer's knowledge that supports knowledge and judgment in astute, sensitive, and nuanced ways in caregiving. In this section of the chapter, I will consider both in part. Let me bring up the more nuanced idea of the healing space as a space within the healer themselves first. This interpretation has received relatively less interest thus far, although it is a far more subtle and far-reaching examination of the concept.

In current biomedical models, the technical, machine-driven understanding of illness diagnosis and treatment is emphasized. Often, this is done at the expense of a broader understanding of illness and healing as relational and embodied (Pohlman et al., 2013). Biomedical understandings are limited in their ontological and epistemological assumptions because of their paradigmatic approach of objectifying the body and the world, and thereby

all attendant concepts of illness meanings, therapeutic relationships, and healing practices. This objectification subsumes all practice starting from evidence-based medicine, and clinical understandings of disease and the human body. I want to build on Pohlman et al.'s (2013) advocacy for a balance in this relationship by cultivating experiential knowledge. Here, I suggest, the healing space can help provide multiple ways of knowing, cultivating a knowledge of the body in lived contexts, and the meaning and sense-making contexts underlying healing and illness experiences.

As the first part of this section on healing spaces, I argue that his idea of the healing space as an ontological, epistemological knowledge space of openness to experiential forms of knowledge and meaning making is significant in creating a relationship and environment of healing. Connections with nature have been found to be beneficial to the human condition for many centuries and have been manifestly extolled in extant poetry and literature. In contemporary contexts, military veterans managing stress and injuries have been found to benefit from activities that bring them closer to nature, such as hiking, fishing, farming, gardening, and relationships with dogs and horses.

Healing Gardens. Westlund (2015) theorizes that these benefits support conventional treatment through the healing and relief brought about through the sensory experience, safety, sense of purpose, and relationships cultivated in these connections. Healing gardens have been found to provide solitude and social activity to people recovering from illness and their caregivers. These spaces are being recognized as essential to meeting demands of patient- and family-centered care. Recent research has fueled an interest in evidence-based design which links patient outcomes and satisfaction to the hospital's physical environment (Hines, 2005). In a critique of Bloch's cancer parks by Evan, Phillips, and Hohmann (2003), the authors discuss the idea that the success of cancer cures is in the patient's belief in the cure, and the park serves to nurture cancer patients' faith in their own survival. Common programmatic elements in the parks suggest curative possibilities. These include signage that equates cancer with survivorship. As opposed to supporting therapeutic elements, Bloch's parks emphasize survivability beliefs, information, and hope in visible, crowded venues.

Many of the messages included in the park emphasize practical information, research and sources, hope, identity, and narrative. Research finds that they reduce stress and tension. In addition, working with horticultural therapists in the garden has been documented to improve memory and provide sensory stimulation and exercise. The work done at healing gardens provides patients with active and passive recreation in outdoor health care settings. They comprise well-acknowledged healing places in health care settings.

Healing here has been recognized as occurring through supporting reflection and quietude in solitary nature-based settings (Hines, 2005).

For hospital-based settings, healing gardens are being increasingly seen as an aspect of patient-centered care. As healing environments gain recognition, they both counteract the stereotypical image of a hospital experience, while creating a patient-supported work that grows and changes with time. Healing gardens might include a place for sitting, such as a patio; for walking, such as walking paths; for reflection, such as a water feature; for solitude, such as secluded seating areas; and calm structures, such as shady, rustic-style shelter overhangs. Healing gardens emphasize considerations of privacy, quiet conversation, comfort, and security. A main feature of healing gardens is to be engaging and calming, communicate a sense of a cared-for space, connectivity, accessibility, and shared interaction (Hines, 2005). Design considerations in healing gardens seek to balance familiarity, hominess, and beauty with simplicity, unity, and easy-to-understand ordering. Establishing connections between designers, hospital staff, and patients is key to creating truly therapeutic gardens (Hines, 2005). Others have emphasized the importance of connecting the garden with a specific hospital program, to tie the garden to the clinical program of care.

Such considerations include exercise and physical therapy, as well as distraction from pain and stress. Burt (1998) considers healing gardens in discussing the impact of external stimuli with a focus on nature and our relationship with it. She finds that nature and landscapes are restorative on an emotional level and healing on a physical level (e.g., by bringing about a drop in blood pressure, less analgesic use). She considers healing gardens as helping achieve a spiritual balance with different spatial relationships. Integrating a model for spiritual growth and the model for vantage points within a landscape, she seeks to explain the spiritual healing powers of a healing garden within health care facilities. For Burt (1998), a healing garden should incorporate four phases: the journey, sensory awareness, self-awareness, and spiritual attunement. In promoting the idea of a spiritual self, a landscape connects spatial relationships with emotional spaces cultivated through landscapes. Horticultural therapy is defined as promoting awareness and well-being by improving the body, mind, and spirit. Drawing upon four archetypes (the warrior, the healer, the visionary, and the teacher) from the Celtic, Nordic, and Native American indigenous traditions to live in harmony and balance with the environment, Burt identifies the four ways of being as: show up and be present, do what has heart and meaning, tell the truth, and let it go.

Wilderness Spaces. These ways of being are connected with experiencing spatial exploration in developmental phases through adulthood as connected with nature (as the sea, the cave, the harbor, the promontory, the island, the

mountain, and the sky). Rothenberg's (1995) work on healing through the wilderness experience advocates for the wilderness experience as an essential ground of healing. He connects our consumption of wilderness as healing to a critique of the culture that creates reality and processes information in ways that have caused an environmental crisis on our planet. Such cultural symbols are, Rothenberg argues, transmitted through our culture's language, stories, myths, assumptions, and values that penetrate into and are supported by mental processes. A critique of the mind and nature involves understanding the psychological processes underlying culture and its modes of knowing and socialization. The folly of dualism lies in its subtle push to choose one side as reality and the other as subservient to reality. For Greenway (1995), the dualism that characterizes our culture (mind and body, matter and spirit, visible and invisible) underlie the split between our physiological processes that are embedded in natural systems and our collective cognitive processes that believes itself distinct from natural systems.

If we privilege the techno-capitalistic modes of progress and knowledge, it becomes easy to assign natural systems to an inferior status as something to objectify, conquer, exploit, destroy, master, or study. It is this sense of dualism that precludes us from appreciating the connectedness in its whole dimension including the emotional, experiential, interactive sense of relating. As emotional intimacy is made possible through integrating the knowledge from nature, the pathogenesis of our culture with regard to nature means we will have to leave culture and immerse oneself in nature to appreciate emotional integrity. A great deal of the problem lies in, as Greenway notes, "the appetites rooted in our culture's mythologies of human superiority and autonomy are virtually impossible to assuage" (1995, p. 187).

Thus, in seeking to utilize the wilderness environment for healing, we reflect our own cultural values upon it, we are in some ways exploiting wilderness for therapy, just like other forms of exploitation down history. If the wilderness experience has to transform, we need to open ourselves to it fully and wholly, leave aside the dualistic processing of culture, and find communion with (not project) the realm of natural processes. In other words, we need to not experience wilderness as something "out there," but as an experience integrated with our cultural values through silence and solitude. The task is to open up without intrusion. Here, healing or transforming is when the "separation from (and thus superiority over) nature appears not as an all-encompassing reality, but an interesting idea" (Greenway, 1995, pp. 189-190). The losses psychologically of being estranged from a whole connection and sense of connectedness with nature are sustained by the dualistic way of processing information, are the cause of much of the disruption and pathogenesis we see in our lives.

Through critiquing this dualism, Greenway finds that nature pervades every aspect of our lives and that we just need to realize it and become aware of its operation beneath our conscious levels of consumption of culture. Experiences of meditation and wilderness are identically about reclaiming awareness and that such awareness is what we call “healing” as it has the capacity to make permeable the walls created by a dualistically dominated mode of knowing. The lessons in healing from the wilderness experience is that it can heal our relationship with nature, but that this is not unique to wilderness, which provides one conducive setting to learn it, but in a culturally grounded epistemology that reconnects our full consciousness with our full immersion in nature, and when we recreate communities, institutions, and new forms of culture that contain the fullness of both.

Healing spaces constructed in clinical settings draw on the premise that people often make judgments and modify their behavior regarding the quality of treatment based on external stimuli such as the built environment. Rehn et al. (2017) designed an experiment to test the effect of the built environment on individual judgments and behavior with respect to a health-related issue using the renovation of a rehabilitation clinic as the setting. Here, as the clinic was being modernized, the entrance, the lobby, and a few of the patient rooms were changed. A service counter and coffee bar were added to the lobby along with lighter coloring and new flooring material. The space thus appeared more modern with clean lines and an aesthetic space. Rehn et al. (2017) found that these changes in the built environment had an effect on patient behaviors and perceptions. They found that patients were more likely to state their intention to change their health behavior in this setting. They also rated the quality of the food higher in the modernized clinic. Overall, the researchers conclude that the presence of aesthetic attributes like architectural design along with weather have an effect as perceptual placebos toward directly influencing judgment outcomes and behavioral intentions.

Healing Practices

Meditative Reading. Meditation’s contested position at the intersection of healing and religion has precluded a rigorous analysis of its history in the humanities (Stock, 2006). In Western meditative traditions, contemplative practice is usually presented in a culturally neutral, decontextualized manner to avoid an accusation of bias. In exploring the connections between reading and healing during the twentieth and twenty-first centuries, Stock (2006) notes that this has been spurred mostly by the neurosciences, which take a biocultural model to bridge psychology, literature, and healing. Here, meditation becomes a phenomenon reflecting a recurring feature of thinking itself.

For scholars studying this area, reading is analogous with oral performances in the fields of grammar and rhetoric in terms of its separation between the voice and the mind—akin to the influence of biblical commentary connecting the act of reading with the text read. Here, meaning is created by means of a bridge between the eye and the symbol rather than the eye alone, and interpretation moves from the interior of the mind, where, according to Plato, each person makes meaning through silent dialogue with the soul, to the outside, where meaning is derived from writings. As Stock argues, the act of meditation, as an intellectual exercise, and the product, which is a thought genre, reading, and meditation are differentiated and interconnected within the phenomenological time-consciousness of the perceiving and thinking subject. The biocultural model strikes a balance between the internal and external factors in the reading process. Stock points out that Western meditative traditions differ from the Eastern in showing greater interest in retaining knowledge in the mind, whereas in Eastern forms of the practice, meditative reading can exclude rational thinking, and instrumental reading can exclude contemplation. In Western meditative traditions, a combination of meditative and analytical reading is presented, which act as a support for each other. In Eastern meditative traditions, sensory and perceptual processes are not retained in the intellectual and interpretive processes.

Narrative Restructuring. The role of the imagination in the healing process involves visual imagery, meditation, and hypnosis. Thus Stock, linking text, speech, and image within a model of healing, connects with the historical the notion that human disease has a material and a spiritual component. From this perspective, the mind-body healing revival seeks to retrieve the role of the imagination, spiritual, and narrative traditions in Western culture as a whole (i.e., beyond medicine). Here, the role of narrative in the conceptualization of illness and healing is historically reviewed as connecting cultural guilt and illness, and the role of emotional communities, which offer collective support for healing narratives. The relationship between storytelling and psychotherapy focuses attention on reading, writing, and remembering as dimensions of the healing process in a way that reinstates self-understanding as techniques to be utilized in clinical and hospital settings. The literary-medical coherence seeks to examine fragmented illness experiences so as to create a space within the mind in which healing narratives can take place. By connecting the healing narratives to cultural mythologies, healing takes place by building solidarity with other people and the creation of textual communities, where texts whose interpretation within groups brings about behavioral changes.

Narratives are central to the project of story-telling. Their examination in literary contexts, such as in children's literature can provide insights into the therapeutic potential of healing constructed as a narrative activity.

In order to achieve healing through narrative construction, the elements of analysis, relating, and dialogic construction of events, values, and beliefs is central. A life-narrative focus that weaves together the central threads of an individual's beliefs, experiences, influences, goals, and self-concept can provide ways of structuring adaptive and physiological information to construct wholeness through the chronic illness experience. Such experiences go beyond the episodic, moment-by-moment character of the condition to engage in narrative sense making within a values- and spirituality-based larger-than-life frame. These aspects often characterize the provider patient interaction in the CAM domain (Agarwal, 2018; Sharf, 2009). In alternative medicine, healing of the whole person has been examined through insights gleaned from children's literature.

In shedding light on narrative and healing, Stock reviews critiques to note that life's wholeness as a narrative can be brought into perspective through literature and stories. In examining the power of narratives to heal, Stock (2006) notes that curing and healing are interpreted as episode and story respectively in narratives. The notion of cure here applies to the narrative, while the notion of healing is related to the entire narrative sequence from the inception of illness to the final act. Here disease cure does not address the internalization of its narrative and emotional context or the psychological scars of being associated with the community that suffers from that disease. Healing, like storytelling, is both a literary and therapeutic activity. The healer is a physician who is capable of grasping the narrative shapes of the lived experience of those to whom he is addressing his words. Stock points out that just as Western meditation combines rational and mystical designs, the healing process brings together biomedical analysis and narrative competence.

Narratives construct healing through framing the events from one's own life in a larger tapestry of values drawn from the traditional health landscape of the individual's context. For instance, in cultures where reflective meditation and an iterative, circular world-view of the human condition is a commonly accepted practice integrated in health approaches, considering larger notions of action/reaction, cause/effect, and agency/individuality in the context of a self/larger-than-self agenda makes intuitive sense. In such contexts, the act of reflection is an act of reconstitution, of acknowledging, accepting, and letting go, but also living it through for its effects with acceptance. In more linear cultures, the act of remembering and forgetting makes more intuitive sense in the context of personal growth. For instance, to reclaim the meditative and narrative aspects of traditional Western healing practices, the purpose of reflective engagement is to let go of the past such that healing stories are both retrospective and projective, as pointed out by the Stoics (Stock,

2006). The emphasis in healing is to construct empowered future scenarios out of real events.

The power of stories is not only in that they are a shared cultural resource (e.g., Gospel narratives), but also in their simple, direct, and unambiguous nature. Considering the provider-patient encounter through a hermeneutic lens, each party tries to determine the latent meaning of the other. Contemporary mind-body medicine lacks a shared context of metaphysical assumptions of a collective narrative that is applicable to both parties in a diagnostic interview, such that apart from biomedical considerations, a traditional element in the healing process, which is interpretive rather than explanatory, can be mobilized. Here, the meditative and non-meditative reading distinction is important whereby an imaginative cue enables the subject to enter into conversation with her or his thinking.

The ecological framework of wholeness conceptualizes healing through an integration of an authentic reflexive/embodied self in relational and dialogic engagement with the discursive/material body as situated in the subjective environment, the traditional health environment, and the socio-cultural environment. Engaging meditation as healing should be employed with caution. Some scholars have identified the pitfalls inherent in thoughtless and hasty application of meditation and healing practices as a cure-all. It should be greatly emphasized that training and education should take care to acknowledge the dangers of conceptual elitism, interiorist doctrines, or the ascent of the mind where healing and spiritual progress depend upon adherence to nonrational principles or loyalty to charismatic individuals, or worship of material objects (Stock, 2006). In order to be truly constitutive of wholeness, the integrative landscape of the body/self and the environment can ground its conceptualization and application in authenticity, ethicality, and connectedness.

The generative, productive dimension of solitude suggests powerful avenues for creating healing. Recent research is beginning to recognize the need for solitude as a productive domain essential for personal and ethical development. These are recent conversations and present a dramatic shift from a focus on health outcomes and their relationship with sociability, interpersonal relationality, and verbal communication. This chapter has developed the argument that solitude, silence, and presence play a crucial role in creating a healing relationship, a reflexive healer's presence, and an environment in alignment with the traditional health values of the individual's life narratives.

Connecting the three main concepts addressed in this chapter—those of solitude, silence, and presence—is the larger thread of spirituality and religiosity. As a field of burgeoning clinical interest, the relationship between spirituality and health has been noted by many to be the true frontier for research, and one with high public interest (Miller & Thoresen, 2003). This is not

surprising as multiple studies have repeatedly reinforced the strong connections between spiritual and religious factors and health as well as emphasized their clinical relevance. Much of the conceptualization in this chapter has critiqued the assumption of mind-body dualism in envisaging a holistic around of an embodied experience of healing. As Mullis (2015) argues, this form of embodied experience is supported through cultivating increased proprioceptive and kinesthetic sensations to produce somatic integration and feelings of well-being while reducing physical and mental stress. Miller and Thoresen (2003), for example, review literature that provides epidemiological evidence that links religiousness with morbidity and mortality, as well as evidence of biological pathways that link spirituality and religiosity with health.

The business world has always been preoccupied with the external as a way to encourage work cultures, team building, client management, lead generation, production management, and so on. In recent years, however, a small but influential type of literature is emerging that is concerned with the shift in the understanding of work. Some authors suggest that the notion of solitude, a voluntary, self-chosen disconnection from excessive sociality, can provide the mental space necessary for reflective thinking. The authors understand solitude as a voluntarily activated state conducive to reflection and disconnection from immediate social and time pressures. Such types of solitude, the authors argue, can create increasing congruence between authenticity and demands to act, often in immediate and fast-moving contexts without due time to reflect, in ethical ways, characterized by integrity and fairness.

A voluntarily chosen state of solitude is intimately connected with the idea of intentional silence. For instance, in the field of holistic nursing, intentional silence can communicate compassion and respect and enhance the therapeutic relationship between the nurse and the patient (Kemerer, 2016). This shift is slowly acknowledging the need for mental space, for a temporary, but voluntary disconnection from sociality and situatedness to create spaces conducive to discerning functions, thoughtful engagement, and ethical dilemmas in supporting the process of healing. Even as these shifts acknowledge distinct, objective spaces of cognition, empathy, and sociality, the chapter argues for an integrative, ethical, and humanistic perspective. The traditional health system space is certainly conducive to such a shift at the present moment. Seen perhaps as an outcome of larger post-modern, twenty-first-century economic shifts, characterized by shifts in society's relationship with technology and culture, greater attention is being paid to the lack of time and space for extended, isolated periods of reflection.

Constructed and employed in appropriate contexts, silence can frame a moment with presence characterized by compassion and acceptance, whereby the health care professional, the caregiver, the patient, and each individual as

a human being can employ silence to construct wholeness in acknowledging, processing and reflecting upon subjective changes in chronic illness. Dialogic and relational engagements defined by solitude, silence, and presence characterize the reflexive/embodied self and discursive/material body in environments of subjective change, traditional health practices, and socio-cultural values to comprise wholeness as an integrative state of balance and reflection. The third and final aspect of the environment, the socio-cultural environment, is discussed in relationship with food, nature, and the body/self integration in the chronic illness context in the next chapter.

Chapter Nine

Food, Nature, and Body/Self-Integration

Food sustains life. Food is the nourishment that comes from elements that provide the essential ingredients comprising everything that is living, from the tiniest microorganism to the mightiest creature, and including every form and shape of life in between, to continue its work of living. Indeed, it can be argued that food not only sustains life, it *is* life. Food is life in the sense that food constitutes life and that life, in turn, constitutes food. In the same vein, it would be fair to say that we accept the premise of our basic recursive, iterative compositional relationship with food without question. While we are aware of the global challenge to the universal availability of food or access to food, we remain oblivious to the need for a reflective critique to the fundamental taken-for-granted premise of *our right to food*. Beyond the above-mentioned constraints acknowledged in all major global policy bodies such as those of food access, availability, and affordability, we don't question our relationship position with food in/as comprising our body/self as a dialogic one. If we do give it a thought, say with friends after dinner, we might mull interesting questions like: Could we be living, breathing beings without food? Does food shape who we are as living, sentient beings, or as a society, a culture, a community, or a civilization? Ultimately, we are secure in our confidence that, given the right food, it would automatically bestow us with the benefits of the nutrients it contains.

This chapter seeks to understand the nature of food from a reflexive/embodyed and discursive/material framework centered in the body/self. In doing so, it considers what food means to us individually, how we as a society are positioned in relationship with food, and its construction in the socio-cultural meaning making resources at our disposal. More importantly, this chapter presents how our relationship with our food constitutes the myriad embodiments of our self in relationship with food and how food shapes our reflexive

selves and its discursive and material evolution during the incremental moments of subjective time and change of our living journeys. In doing so, the chapter refocuses our gaze to reimagine the multiplicity of meanings evoked by food with each moment in time and with each possibility of change inherent in that moment of time, and its constitution with presence and solitude. The chapter situates this discussion in the macro-debates of how our relationship with food connects with our health status in ways that include and go beyond the global public health nutritional imperative to consume a nutritionally balanced, ethically sourced, and developmentally appropriate meal. While nutrition has not received as much interest from health care providers in hospital contexts and is not currently a discipline in regular graduate courses in medicine, interest in nutrition is increasingly becoming of great relevance to clinical contexts (Carbone & Zoellner, 2012), suggesting the possibility of a deeper exploration of the relationship between food, nature, and body/self integration in ways that constitute health but also wholeness.

Food has come to mean many things in our socio-cultural environment today. Its many meanings are located in popular understandings ranging from food as a response to satisfy our hunger, as an object of consumption, as a process around which we build community, as a symbolic context through which we constitute our culture or connect with other cultures, or as a means to fulfill our goals of growth, strength, health, and ability to perform and sustain ourselves as living beings. Although food certainly is all of the above, as this chapter argues, it is not simply some combination of, or merely all of the above. Rather, we need to move beyond simplistic, deterministic structures and boundaries to explore integrative, layered, and relational ways of thinking about food as it shapes us, and is, in turn, shaped by us. Following the ecological framework of wholeness, this chapter invites the reader to shift from a unitary mode of thinking about food to an awareness of the potential for multiple meanings in the production, preparation, and consumption of food. In doing so, we also gain deeper understandings that move us toward reimagining our relationship with food and its contribution to the lifestyle, behavioral, chronic, noncommunicable, and mental health challenges facing us today. Indeed, as a consequence of the inquiry pursued in this chapter, I hope that we begin to recognize and acknowledge the many ways that our relationship with food has become fraught with contradictions, a struggle with our identity, and complicated by underlying tensions that have profound implications for our health and healing as human beings.

The production and consumption of food integrates social identity, communal history, and cultural practices. Our relationship with food in contemporary times is shaped by mediated and social influences. These influences range from a discursive and socio-cultural disruptions, representations, and

concern with appearances that warp the primal relationship with food. Contemporary signifiers and constructions of food are often riddled with distrust over its authenticity and ethicality, tinged with geopolitical anxiety over food deserts, food availability, food access, and food appropriateness, and defined by the subservience of food to our relentless drive to consume, be productive, achieve, earn, spend, work, or play in ever more luxurious and expansive ways than ever before. Health literacy initiatives, defined as the degree to which individuals obtain, process, and understand basic health outcomes relate with nutritional information and services, enable individuals to have the resources to make informed health decisions (Carbone & Zoellner, 2012). Even as our society has moved forward in historical-industrial ways over the past centuries, food has been minimized, industrialized, and appropriated into tiny compartments of time and sorted into neat pill boxes of corporate production. Yet, when we describe our march to this point in time where we stand today as an act of progress, the achievements seem hollow, empty, and lacking in meaning that connects in tangible ways with the body/self and its environment.

For the affluent, the overabundance of food is not any more significant than hunger and deprivation are to those without access to food. Food deserts, food apartheid, or food oppression have been used to denote the condition of being time poor, or cash poor, and without nutritionally balanced and culturally appropriate food, both in terms of geographical, economic, and social access and its availability as a utilizable resource. Both ends of the spectrum are characterized by a lack—whether of a multiple, ethically balanced, connected meaning of food or of the educational, economic, and socio-cultural resources necessary to access and construct a healthy relationship with food. Public health challenges pursue us doggedly, from obesity to heart disease and chronic conditions such as type 2 diabetes. In their varying manifestations, these disparities and gaps affect the affluent as well as the marginalized, regardless of access to economic capital and the power to purchase food. While overall global life spans may have increased, despite the widening disparities gap, our quality of life has gone down by at least as many indicators.

Food is a critical resource for life-sustaining activities. The life-sustaining function of living beings and planetary ecosystems is fundamentally connected. Economic, social, and educational disparities and the attendant universal ills of violence, extremism, global migration, and extinction of species have become more extreme or speedier in their declines. In this chapter, I develop the argument of revisiting our relationship with food, healing, and wholeness from its primal and prehistoric position to its location in a contemporary landscape. Our relationship with food, nature, and the socio-cultural environment is the foundation of our body/self integration. This chapter

lays out the dynamic relationship of the social-cultural environment with the subjective environment of change and the traditional health environment of solitude, silence, and presence through which wholeness is constituted through relating food, nature, with the body/self integration at the center of the ecological model of wholeness.

At the center of this web of relationships and tensions, decline and progress, is the availability of sufficient, safe, and nutritious food for everyone globally. One of the ways the relationship of our contemporary society with food is conceptualized is through the idea of food security. The United Nation's Committee on World Food Security defines food security as physical, social, and economic access to sufficient, safe, and nutritious food for all people, at all times, in a manner that meets food preferences for an active and healthy life (International Food Policy Research Institute, IFPRI.org). The US government aims to support global food security through programs that focus on capacity-building, increasing productivity, conducting climate change assessments, supporting sustainable economic growth, and researching topics ranging from food safety, soil systems, biotechnology, and plant and animal disease control (USDA.gov). These concerns are related with planetary challenges of climate change, population growth, and environmental stressors that call for a global response to natural resource management in areas such as water allocation, land use patterns, food harvest, food processing, sustainable agricultural technologies, and issues including balancing meat consumption needs with the ecological costs of its production (IFPRI.org). Food is intertwined in our culture and in the web of planetary relationships, yet its primary status can be described as a commodity in today's industrialized and mechanized modes of agricultural production, retail distribution, and consumption.

The multiple meanings of food and ways in which human social organization in different historical-cultural periods has related with food has centered the axis around which human civilization has grown, evolving from its agrarian roots to its socio-cultural differentiation and stratification on the one hand and the establishment of global trade networks, tourism, and cultural bridges on the other. While food served as a dynamic force for the emergence of cultural identity and societal stability, discovery of new lands, and providing the foundation for economic exchange and regional cooperation on the one hand, it also played a role in the spread of infectious diseases such as the Black Death in the fourteenth century, and the different types of avian influenza from infected poultry such as the H9N2 in 2019 (WHO, 2020). As the WHO notes, unsafe food is the cause of more than 200 diseases from cancers to diarrhea, and the burden of disease and death from contaminated food falls upon children under five years of age, the elderly, and the sick. Because food

supply chains today cross national borders, food safety affects socioeconomic development, national economies, tourism, and trade.

Although these associations are important, for the most part in our lives, we predominantly consider food as an object to purchase and consume. For this purpose, we make a trip to the grocery or the farmers' market, for instance. Keeping social-economic factors aside for a moment, this is what our contact with food looks like today: We pick our food in the grocery, bring it home, cook it as needed, and eat it, often in the company of our gadgets, family or friends, and media. In this cycle, we might consider nutrition, and perhaps give a thought to the farmer, or the practices of storage and production that might help us choose organic, local, or genetically modified organisms (GMO) free food. Within this simplistic narrative, the process of bringing food to a family's table to a fair extent exemplifies how our objectification of food treats it as a product. In this albeit simplistic picture, food is a product made by nature for our benefit, and one that we have given space to be present within our society's ambit for our consumption. Such a relationship with our food, I argue, diminishes the nourishing power of food even as it diminishes our ability to gain nourishment from the food we eat. As our ability to impact, physically, with our presence as tourists, inhabitants, scientists, corporations, or explorers, every corner of the earth increases, no plant, animal, or living organism is entirely free today of this objectification. Climate change, intensifying droughts, loss of fertile lands, and a host of market disruptions have exacerbated food insecurity in the developing world. In the United States, unhealthy eating habits are seen as responsible for obesity and other metabolic disorders which disproportionately affect the low-income communities and communities of color (Chen, 2009). I seek to broaden our thoughts about food to enlarge upon ideas of sustenance, the body/self relationship, and the socio-cultural environment.

In this chapter, I make a call to shift our way of thinking about food in paradigmatic ways. Let us imagine, for a moment that food, like nature, is not something *out there* for our pleasure to consume or even to draw upon at will for our survival. Let us keep aside considerations of ethicality of food production, sourcing, access, and distribution as secondary concerns. Consider, instead, the notion that the innate human urge for survival does not rationalize a justification for its fulfillment. In other words, the premise that human survival is not in and of itself a paramount motive that can justify the human urge for consumption and advancement. Survival is, at best, a Darwinian, primal, animal instinct. Winning and surviving are binary, linear, and ultimately, facetious and empty conditions that symbolize pleasures, victories, joys, and achievements within which defeat is already implicated. In other words, there is no victory without the possibility of defeat, if not ours; then of another's.

Thus, if we eat food as a resource that is our right, we create the possibility of a life that has, at least as one of its goals, the pursuit of classifying food as an object and a product. Recent scientific advances from the humanities and medicine support the idea that food, nature, and living organisms, such as human beings, are all connected, in deeper and more profound ways than ever imagined.

The notion of *Gaia*, comprising an “Earth systems science” perspective, seen as a socio-cultural narrative, envisions human beings as part of a larger, living ecosystem that mutually co-constructs its existence from its constitutive material processes such as the geo-chemical reactions to atmospheric content, ocean salinity, and global temperature, that keep conditions on Earth optimal for life to maintain a balance of its cultural, inter- and intra-species diversity as a larger, whole organism. Thus, it views all organic and inorganic components of the earth as a single living, self-regulating system and advocates for modeling human endeavors such as in cultural, economic, social, and policy fields in alignment (www.Gaiatheory.org). The notion of food implies sustenance and nourishment in different forms for different components of this system. Thinking in relational terms about food evokes a recognition of the knowledge and practices in use by traditional societies for many millennia and rediscovering their value in shaping contemporary needs.

This chapter constructs food as an element of nature, space, time, ecology, and the environment, that sustains ecological systems, soil composition, geological balance, and the optimal functioning of plants, animals, and human beings in balance such that even as individual human beings are nourished, they in turn provide nourishment to other elements of their communities, neighborhoods, environments, and regional, national, global systems on which their health depends. The idea of food as a component of wholeness constructs food as substance, nourishment, and constitutive to form the basis of a self-reflexive and embodied relationship with food.

Traditional cultures, in particular, position food at the center of health, long life, and ideal functional status, equating food with medicine. The idea and function of food is both material and discursive. Allocating food a central role in all dimensions of our life constructs its function as integrating the body/self. Food is central to multiple facets of our lives. Communities exploring innovative connections such as that between food and the planning of our urban environments connect the two around the idea of food system planning. Food system planning, in turn, depends upon balanced connections between the act of eating, which is material, and its constitution in content and practice through cultural and community beliefs and practices, which is discursive. As Chen argues, “maintaining health begins with eating and understanding how food becomes categorized by cultural systems of knowledge” (2009, p. 109).

Each individual relates with their own construction of food in unique and particular ways, building our own situated, evolving relationship with the idea of nourishment and the goals of nourishment. Dickerson (2010), in examining integrative challenges toward understanding food in family therapy, categorizes these epistemological challenges as individualizing, systems, and post structural. Each culture has its own onto-epistemological perspectives to the understanding of food and nourishment in ways that connect ecological, cross-cultural, and economic-policy-social functions of human development and organizing as a society. These distinctions can often appear too different to be integrative across cultures and their ontologies. Integration of theoretical perspectives may, in most situations, be feasible within epistemologies. Some argue that practices and concepts can be adopted across theories and epistemologies, but that theories cannot be integrated across epistemologies. From a social constructionist perspective, in explicating the notion of food and culture (Bruss et al., 2005), the role of deterministic structures, such as institutions, in society, is often best captured by the structural perspective, and of human agency by post structural thinking. Ultimately, one's epistemological stance will factor in the approach one takes to this relationship.

While the idea of nourishment primarily implies food, nature, time, and space can also be considered sources of nourishment. Food and elements of nature, space, and time are linked with the body's physiology in traditional medicine systems, and provide nourishment to the subtle tissues, metabolic processes, and circulatory or eliminatory functions associated with them. In some traditional whole systems approaches to medicine, such as Ayurveda, therapies for health derive from the idea that living in harmony with nature, space, and time is the necessary foundation of all good health. These approaches are integrative in their conceptualization of food, nourishment, and nutrition through elements that are not defined or measured objectively through existing technological instruments. However, the knowledge premise of their conceptualization in the body's physiology draws upon objectively defined criteria and they are often assessed through the provider's own body.

Distinct epistemological systems to thinking about healing and health in an integrative manner offer promising avenues for conceptualizing the philosophical position of food and nutrition as nourishment in our lives. As I have argued in research published elsewhere, the epistemological frames of legitimization and identity, sense and intuition, and environment and community are salient themes in CAM provider arguments in reconciling their treatment philosophies with biomedical approaches (Agarwal, 2018).

The argument for broadening our conceptualization of food and its relationship with nourishment can be usefully developed through the socio-cultural lens of the ways food has been approached in human society. Although food,

through the lens of nutrition, dietetics, and its compositional qualities of proteins, vitamins, carbohydrates, and minerals is important, exploring the relationship of food with the role of food in our traditions, medicine, and culture can help us construct food in an integrative manner. (Re)shaping our approach to food and nourishment can help address the challenges of disparities in access, overconsumption, improper consumption, and a consumerist-market oriented attitude toward our relationship with food. A meaning making framework drawn from the ecology of wholeness encourages us to examine why we eat, and how our relationship with food contributes to an integrative world in a reflexive/embodied and discursive/material body/self framework.

By filling out the boundaries and relationships between food, nutrition, and nourishment on the one hand, and chronicity (e.g., biorhythms), tradition (e.g., historical-geographic relevance), and values (e.g., religion and seasons) on the other, I hope to deepen our understandings of food as a vital component in constituting wholeness in preventing and managing chronic illness. Such relationships include but extend the role of food in promoting a deficiency- and disease-free survival and optimum functioning of the physiological body. To do this, I will start by laying out the parameters of the social scientific view of food and health outcomes, and the modern food systems approach as it connects with food as nutrition. Following this, I will develop the argument for food in/as healing, and conclude the chapter with offering a connected web perspective on wholeness and a deeper understanding of how we can conceptualize food in reflexive and embodied ways through our discursive and material self/body.

FOOD, NUTRITION, AND HEALTH

The Social Scientific Construction of Food and Health

Some of the lines of inquiry that have driven the social scientific construction of food in relationship with health concern behaviors, beliefs, motivations, and values. The questions investigated include why we eat the types of foods we eat, our motivations, our food behaviors, what environments and contexts we eat our food in, and how our behavior is affected by different types of foods. Several factors have shaped the form of interest in this functional instrumental relationship with food. These factors give meaning to particular questions and notions of health and well-being. For instance, large-scale societal concerns like food security and food deserts or population health based insights into how food is marketed to adolescents or made available to different sections of our society underlie questions of social justice.

As noted in the first half of this chapter, food security has been an important element in the multifactorial systems analysis of health and well-being. In turn, these questions stem from a concern with equity, access, and availability of culturally and nutritionally appropriate food. In this line of research, scientists believe that studying the interaction between food supply and understanding the factors making up the food ecosystem can shed light on individual and population health. Such concerns resound the concerns with global hunger, malnutrition, marginalization, and poverty and shed light on their connections with conflict, climate change, food waste, and violence.

The United States Department of Agriculture (USDA) introduced the Food Desert Locator in 2011 to help identify areas with “limited access to affordable and nutritious food, particularly such an area of predominantly lower-income neighborhoods and communities,” (Title VI, Sec. 7527, 2008 Farm Bill; USDA, 2009, p. 1) and addressing these are central to combating obesity (e.g., in Michelle Obama’s “Let’s Move” initiative to combat childhood obesity). Current arguments lean toward support for the idea of food as pure nourishment and as a more positive and well-being centered perspective of human eating behavior (Cornil et al., 2016; Renner et al., 2012), with support for policy advocating a shift from *food as health* to *food as well-being*. (Block et al., 2011). In proposing the idea of food as well-being, research findings indicate that healthy food choices (e.g., fruits and vegetables) have not only physical but also mental health benefits and would be seen as a long-term investment in future well-being, predicting increases in happiness, life satisfaction, and well-being (Mujcic et al., 2016). Some of these findings are discussed later in the chapter.

The World Food Program (USA) notes that although the world produces enough food to feed everyone on the planet, the major drivers of hunger, such as conflict, violence, and climate change, are human-made (WFPUSA.org). The statistics are revealing. For instance, in two thirds of the countries globally, women are more likely than men to suffer from malnourishment, and over 80 percent of the world’s hungry people live in disaster-prone countries. Jaron and Galal (2009) argue that a critical analysis of the health system must also include considerations of disparity in food security since it represents one of the most dramatic indicators of economic and health inequality. The authors argue that promoting agricultural development, economic growth, and education assistance is needed to mitigate chronic hunger causes and further human health and well-being (Jaron & Galal, 2009). Distributing food supplies alone does not contribute to lowering food insecurity. With evidence from recent scientific studies, it is apparent that the links connecting chronic disease prevalence in both developing and developed world contexts with dietary and lifestyle changes are strong (WHO, 2020). That our food choices

are shaped by our lifestyles and vice versa, which has facilitated a broader and deeper examination of food in our lives beyond access and availability. Recent population-based epidemiological evidence has clarified the role of diet in preventing and controlling chronic diseases such as obesity, cardiovascular disease, hypertension, certain types of cancers, and their related co-morbidities (WHO, 2020). Beyond availability, equity, and access, the relationship of food with physical exercise, dietary patterns (e.g., diets high in saturated fat), and socio-cultural values is being acknowledged as the root of chronic disease in ecological, societal, and behavioral mechanisms.

We understand the idea of being nourished through being sustained, being supported in our growth, and being restored in being able to develop in our faculties. The field of nutrigenomics concerns itself with explicating individual nutrient-gene propensities to respond to nutritional stimuli in terms of their impact on human health (Isaak & Siow, 2013). The disciplines concerned with the areas of diet, nutrition, wellness, and health emphasize prevention as a first line of approach to disease management. For instance, a registered dietician (e.g., a registered dietitian) is involved with nutrition and health of individuals and communities and emphasizes nutrition and diet as a primary consideration of healthfulness. A nutritional scientist employs the knowledge of chemistry, physiology, and biochemistry along with genetics, zoology, microbiology, chemistry, physics, and mathematics to understand the mechanisms through which dietary factors act and are metabolized. This helps a nutritionist understand how we utilize food for growth and metabolism in both normal and disease states.

Our food choices are shaped by how we understand and define health. These understandings are shaped to a great extent by socio-cultural factors. Therefore, the push to broaden the definition of food and its relationship with human health has also supported different ways of defining health. In a study seeking to understand food choices between organic and functional foods and their association with healthy lifestyles, health was defined at the cognitive-emotional level and at the behavioral level (Goetzke et al., 2014). This study, conducted in a German sample, sought to understand the extent to which the consumption of organic and functional foods is characterized by a healthier lifestyle and a higher level of well-being.

As the recognition of the deeper connections between lifestyle, cultural-philosophical systems, and individual understandings of health are recognized, evidence illuminating their role in shaping food choices and the goals for consuming food will become more available. The authors find that although health is an important aspect for both functional and organic food consumption, these two forms of consumption are influenced by different understandings of health. Specifically, their study indicates that organic food

consumption is influenced by an overall holistic healthy lifestyle that includes a healthy diet and physical exercise, while functional food consumption is characterized by small adjustments to lifestyle to enhance health and increase psychological well-being. Such findings place the discursive/material conceptualization of the body as related with the process of envisioning its goals for human existence. Approaching our individual relationship with food invokes the need to take a deeper look at how we understand food and its role in our lives on the one hand, and how we make meaning of health, healing, and wholeness on the other.

The dietetics program has evolved to take the recent evidence into account in practice. As an interdisciplinary program, dietetics involves the practice of integrating biochemical, physiological, social, and managerial concepts into the science of nutrition to help clients achieve a healthy lifestyle in various settings including hospitals, long-term care facilities, public health agencies, food industry, and research labs. Such a degree provides practitioners the credentials to administer medical nutrition therapy in a health care setting or directing food service operations needed for prevention and treatment of disease. Credentials such as a clinical nutrition masters degree help practitioners gain knowledge of the evidence base underlying this discipline and perform duties, such as recognizing and responding to new advancements in clinical nutrition practice, policy, and research and in leading professional teams in nutrition-related services. Such advancements in the knowledge base of nutrition, medical nutrition therapy, and the science of nutrition to help clients achieve healthy lifestyles illustrates an important opportunity to bridge traditional medical knowledge systems such as Ayurveda, that are predominantly nutrition-based in their approach to health, healing, and wholeness and its relationship with prevention and lifestyle-based approaches in a whole systems approach.

Recently, researchers have been taking a fresh look at the notion of food as medicine as it traditionally undergirds most CAM whole systems medical approaches such as TCM and Ayurveda. Healthy food and healthy environments as interventional factors are increasingly the focus of our attention in the wake of promising findings in a realm of areas such as mental health, quality of life, and the relationship between the environment and epigenetics in shaping health outcomes. From a social scientific approach, the findings from this body of research deepen our understanding of the epigenetic, cellular mechanisms on the one hand and marketing and social environment factors on the other by which food shapes our health outcomes. What we eat is being recognized as being beneficial to our health not just in the near future but many decades down the line. In this regard, health and well-being outcomes may operate and exhibit their influences differently. The mechanisms underlying

how health, physical well-being, and mental well-being relate with food and lifestyle are not entirely clear. However, recent studies are lending weight to the significance of this relationship. For instance, Mujcic and Oswald (2016) show that improvements in physical health continue to occur many decades later but well-being improvements from eating fruits and vegetables are close to immediate. These findings go a step further from physical health to well-being and its relationship with the chronicity of effects.

What we eat determines what we are physically but also shapes how we constitute ourselves discursively. Mental well-being is one construct that perhaps comes close to being operationalized in understanding discursive conceptualizations of the body in a way that references its relationship with larger human goals. Johnson et al. (2017) contribute to the evidence base that connects healthy lifestyle interventions with improved mental well-being and note mental well-being is protective of future health. They examine changes in mental well-being in a healthy lifestyle program set in the UK (One Body, One Life). Significant improvements were found in mental well-being in their study participants directly after the intervention, supporting the body of knowledge on the contribution of lifestyle interventions on promoting and sustaining mental well-being. Mental and physical well-being capture one aspect of the discursive/material body in a way that is centered in relationships and offers a promising start to thinking closely about our relationship with food. Knowledge, the socio-cultural environment of our upbringing, and lifestyle go hand-in-hand with the reflexive/embodied ontological understandings of food as a vital component of our socio-cultural environment in preventing and managing long-term chronic conditions and promoting overall well-being of the body/self.

Recent openness to integrative approaches in science has supported greater understandings of the body/self integration and its relationship with food. One of the fields where this movement is making a difference to understanding the relationship of food with the body/self and traditional medical approaches is the field of epigenetics. The focus in epigenetics on the body's genetic mechanisms and environmental cues alongside their physical expression through the body provides social scientific evidence for thinking about the relationship of the body/self in reflexive/embodied ways. Stevens et al. (2018) examine how our genes respond to the environment to understand and manage health and disease. They focus on the epigenetic mechanism that appears to underlie the interaction between environmental factors, such as diet, and our genome. By focusing on the modification involving methylation of cytosine residues in DNA, the authors examine how dietary elements may indirectly influence genomic pathways. This allows them to examine biochemical links between nutritional quality and mental health. These approaches offer interesting

and vital viewpoints in considering nutrition (e.g., as vitamins, minerals, or dietary supplements) and treatment of mental disorders or promoting mental well-being and mental health. The findings from such research connect the genetic mechanisms (e.g., genetic manipulation of DNA) with diet, nutrition, and nourishment and provide clinical evidence in support of the food as medicine argument.

Along with evidence at the bicellular genetic level, the relationship of food with public health outcomes and the environment is being studied in recent research. Such research is finding support for evidence connecting food with climate and environmental change (C-E-C), health, and quality of life. Raiten and Aimone (2017) connect the relationship of food with nutrition and as a biological variable that is related with C-E-C and global health challenges. In a similar vein, a study by Hoerr et al. (2017) examines the ecological association of dietary food intake with mental health outcomes on group level across countries. Using published data from the World Mental Health Survey, they compare lifetime prevalence of four categories of mental health disorders (anxiety, mood, impulse control, and substance use disorders) with a country's fish/seafood and sugar/sweetener supply quantity. They find that sugar and sweetener supply quantity was significantly and positively associated with anxiety disorders, mood disorders, impulse control disorders, and substance abuse disorders. This examination provides evidence supporting the need to attend to type and quality of food supply with mental health disorders, and more broadly connects food with health in the mental health domain. The connections of food and nutrition with individual and public health outcomes, and the environment provide support for arguments to attend to the ways we think about food and how our relationship with food shapes not only our food choices but also the types of health outcomes evidenced.

Such studies provide the evidence base required to guide population approaches that improve food security and intake of high-quality diets to protect people from mental health issues. For instance, correlations with food and nutrition (e.g., suboptimal intakes of folate and iron) and mental health outcomes were also observed by Davison et al. (2017) in Canadian adults. The use of supplements with depression and quality of life has been examined using fish oil by Parletta et al. (2016), who found that reduced depression was correlated with increased MedDiet score, nuts, and vegetable diversity. In another double-blind, placebo-controlled trial study, Mohammadi et al. (2016) examined the effects of probiotic yogurt and multispecies probiotic capsule supplementation on mental health and the hypothalamic-pituitary-adrenal axis using the general health questionnaire and depression anxiety and stress scale. The researchers found significant improvements in general

health and mental health parameters in the groups that consumed probiotic yogurt or multispecies probiotic capsule.

Scientific evidence supporting the gut microbiome in relation to health maintenance and links with various disease states afflicting humans, from metabolic to mental health, has grown dramatically in the last few years. One of the foci in the field of research in nutritional epidemiology is the emerging interest in assessing the link between nutritional quality and mental health. Such interest is bolstered by the studies that have found that several food patterns could be associated with a reduced risk of depression among adults. Moreover, this association is consistent across countries, cultures, and populations according to several systematic reviews and meta-analyses of observational studies. The scientific report of the 2015 Dietary Guidelines for Americans Advisory Committee concluded that current evidence is still limited.

Probiotics are recognized as helpful in keeping harmful, intestinal microorganisms in check, aiding digestion and nutrient absorption, and contributing to immune function. Probiotics improve microbial balance in the intestinal tract and promote the return to a baseline microbial community following events such as antibiotic therapy. Prebiotics are selectively fermented ingredients that allow specific changes, both in the composition and/or activity in the gastrointestinal microflora, which confers benefits upon host well-being and health. Likewise, psychobiotics are defined as live bacteria (e.g., in probiotics) which, when ingested, confer mental health benefits through interactions with commensal gut bacteria.

This research in the field of nutritional medicine has shaped how integrative medicine employing herbal therapies, relaxation strategies, and psychotherapies can build on a patient's personal meaning making and spiritual goal setting processes (Shah et al., 2017). Researchers have examined gut-brain signaling mechanisms enabling psychobiotic effects, such as metabolite production (Linares et al., 2016; Martínez-González & Sánchez-Villegas, 2016; Sarkar et al., 2016; Schmidt, 2015), and asserted the need to examine mental health and gut-based connections. Such models of care involving mental health, quality of life, and spiritual goal setting in clinical contexts involves a comprehensive person-centered model of care (Shah et al., 2017).

As this field expands, nascent areas such as the field of “nutritional psychiatry” offer promise for addressing the disease burden associated with mental disorders (Jacka, 2017). New intervention studies implementing dietary changes also suggest promise for the prevention and treatment of depression, with data pointing to the utility of selected nutraceuticals as adjunctive treatments for mental disorders and as monotherapies for conditions such as attention deficit hyperactivity disorder (ADHD). While the findings are promising, there are still gaps in understandings. Some of the challenges facing this field

currently lie in replicability testing and scaling up to clinical and population level dietary strategies by identifying the biological pathways, targets, and mediational associations, predictors of treatment response, and policy change to improve the food environment at the population level (Jacka, 2017). With this body of research, food as health and food as well-being is moving into mainstream clinical, nutrition science, and related fields like urban planning, nutraceuticals, nutritional psychiatry, and the brain-gut connection mechanisms.

Modern Food Systems and Nutrition

Food forms a vital support for our mental, physical, and emotional growth. Food serves its primary purpose as nourishment from our earliest conception of human health and sustenance. Early work in this area, such as the Garden City movement in the United Kingdom, connected concerns of urban planning with production, distribution, and consumption of industry and agriculture (Howard, 1902). In the United States, food has not traditionally been considered part of urban planning, being assigned as a topic of importance to rural areas (Sonnino, 2009). Recent attention to food insecurity and food deserts has renewed this link. Of particular interest is the connection between food retail distribution planning and its impact on access to nutritious food, which, as scholars note, should take into account access for all, fostering connections with local producers, regulating price of nutritious products in food shops, and developing of food hubs. With a focus on ideas connecting food from source to consumption such as provision of Green Food Carts to increase access through local street food vendors, and institutionalizing open air farmers' markets and organic food markets, such initiatives also preserve socio-cultural vitality through the food culture of local neighborhoods as places for social interaction, connection, and exchange.

The modern food system ignores the soil-food-health connection, but in doing so, it also views food as an objectified collection of distinct objects, rather than a web of relationships. Given that health-related choices are influenced by the individual's socio-cultural environment, the soil-food-health connection includes their social identity and the social norms that affect wider constraints on behaviors (Costa Font et al., 2013). Examined relationally, nourishment is oriented toward the actualization of one's inherent potential, the integration of one's physical, mental, and spiritual capacities to their full expression. Nourishment is a process that serves to sustain and nurture to promote growth and development. In its most basic interpretation, food is commonly understood to provide nourishment in line with its cataloged nutrient content. Adequate nutrition is considered crucial for the body to heal effectively.

Food affects our physiology in many ways, from the complex and abstract to the more visible and material. Obesity has garnered attention as a public health issue in recent decades. The World Health Organization (WHO) has argued that the impact of the obesity epidemic on noncommunicable diseases such as cardiovascular diseases, diabetes, and cancer threatens health systems and poses one of the greatest challenges to public health in the twenty-first century. The factors influencing obesity and how it shapes the prevalence of chronic illness are multiple and complex. For instance, how food is marketed (No et al., 2014) and the social environment in which food is consumed (Utter et al., 2017) has an influence on children's food preferences and consumption habits. Others such as Li (2017) have been interested in the challenges on ecological perspectives on food and eco-environments (aquaculture, agriculture, and entire food systems) through human interventions to lower adverse effects on biodiversity through the lens of Chinese "One Health" vision, with the "One World" concept under the Ecological Public Health Model for sustaining our environment and planet earth, echoing Confucian theory for environmental ethics of ecological harmony.

The role of the environment is becoming an increasingly acknowledged factor in this relationship. Food has been considered an agent of social change. It has been the source of interest in relationship with the time we take to prepare it. Slow Food Nation, deriving from an event in San Francisco (Nestle, 2009), symbolizes one such element in the food resolution. These movements address the production and consumption of our food system in relationship with the environment. The concept of nourishment, viewed through its relationship with food, space, and nature, references much more than the act of assimilating food within our bodies. As Humphries et al. (2016) note, recent decades have seen a shift in how we think about food. This shift can be described as a move toward thinking about food not in isolationist terms, but as linked with other elements of public health, food systems, food behavior, food ways, belief, systems, values, assumptions, and relationships to the food system, and approaches to understanding the impacts of food systems on human health.

FOOD IS/AS HEALING

Preventable diseases linked to lifestyle choices are closely associated with food habits. Research examining the link between preventable chronic conditions, environmental, and lifestyle factors generally reinforces the need to design behaviorally compatible incentives that are essential to the pursuit of desirable health outcomes. Food provides an anchor to consider the reflexive/emodied self in relationship with the discursive/material body in the chronic

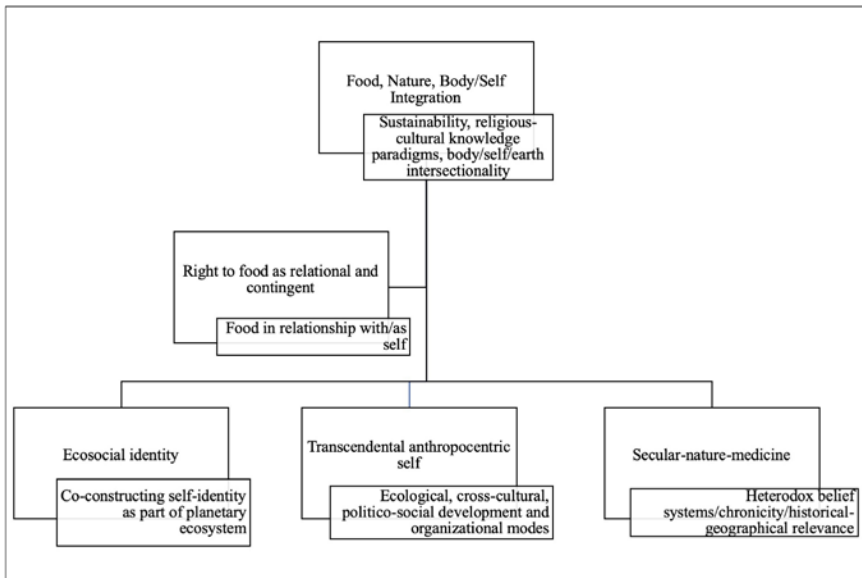


Figure 9.1. Food, nature, body/self integration. Figure created by author.

illness domain. As the preceding discussion illustrates, food places us in relationship with our historico-political, economic, and socio-cultural roots while anchoring the individual to their own relationship with food.

Our socio-cultural context provides the meaning making framework within which we make sense of how we approach food and how it constitutes who we are as individuals and in our social, communal context. Practices that cultivate self-reflexive awareness of our food experiences support the connection between our material acts of engaging with the processes of food procurement, preparation, and consumption with the discursive act of constructing satisfaction from our position in the food cycle. Supporting self-knowledge of the material and discursive location of food in our socio-cultural identity and self-monitoring our dialogic engagement with food is made possible through the lens of the body/self placed in a context of subjective change, traditional health practices, and socio-cultural contexts. Evoking self-reflexive processes enable us to discursively construct our self-and social identity. Self-reflexive processes support awareness of the embodied role of food as it constitutes our body and its sensations as a pre-discursive way of communicating with ourselves. Moreover, such self-reflexive processes cultivate a body/self relationship that centers the body in relationship with the self and the context of change, health practices, and socio-cultural norms.

Envisaging food as healing draws from a holistic perspective toward food as nature, healing as individual, communal, and spiritual, and context as

ecological, cultural, and natural (figure 9.1). Holistic thinking is encouraged through bringing about an awareness of how seemingly individual, agentic actions are, in fact, deeply connected with other environmental and natural elements such as trees or mountains, organisms from the microbiome to the inter-species relationships, and logic, religious, and alternative belief systems. Recognizing the links between these elements helps create a recognition of different ways of approaching knowledge generation in terms of cultural knowledge paradigms that appear to not meet the objective and logic-driven criteria in Western science systems. Humphries et al. (2016) advocate the idea of critiquing assumptions that have been held as a gold standard for establishing and testing knowledge claims, of being open to new forms of information, and of lowering barriers to understandings that are created by an unquestioning reliance even if on a limited form of logic-driven rationality as a legitimate test of truth.

Socio-cultural beliefs connect the language, arts, religion, and historical context in a communicative act with the self and its evolving identity. Our traditional health practices provide us with a worldview that anchors our sense of self in a dialogic relationship with our food-related experiences. The Native American spiritual belief in animism states that every natural existing object has a spirit, with particular traits, significance, and meaning, and that these are connected with individuals and communities. As these links are reshaped through external influences, they also modify the individual's relationship with food. Obesity provides a good context to illustrate the link between food, the environment, and lifestyle factors. It has been suggested that an "obesogenic" environment may be responsible for a large portion of the obesity increase rates globally. An obesogenic environment refers to one that promotes excessive caloric food intake and discourages physical activity in multiple ways (Costa Font et al., 2013). Socio-cultural movements seeking to counteract the detrimental influences of such market-driven environments are characterized on the production side by an ability to procure good, clean fair food, farm-animal welfare, organic foods, locally-grown foods, safe food, and good pet foods. On the consumption side, the elements include anti-trans-fat, anti-high fructose corn syrup, and calorie labeling movements. For both production and consumption, the movements include the community food security movement and the better farm bill movement.

Like art, food can function to foreground the body/self's embodied primordial sensory experiences as a way of constructing relationship with the external communities. Connecting food with the reflection upon the movements and practices that ground its norms in our culture opens us up to the environment and the world in embodied ways. Some recent work has gone beyond the environment, lifestyle, food, and health connection in making the case for food

as relationship in more fundamental ways. Kirschenmann (2010) evoked the relationships between soil health, human health, and agriculture made in 1940 by Sir Albert Howard. The ecological argument was the evolution in nature of the means to produce health-promoting foods from healthy soils that revitalize immune systems to keep us healthy (Kirschenmann, 2010). Embodiment can translate the body's relations with the environment in constituting the lived experience and hence, in constituting wholeness, in important ways.

Carefully cultivated, embodied, self-reflexive relationships connecting the body-food experience are fragile and raise poignant questions that go beyond the consumption, production, lifestyle, and food security concerns. From a critical perspective, Shiva (2016) extends the food as relationship argument to the evocative question of our responsibility to other species. She asks: Do the boundaries between species have integrity? Or are these boundaries mere constructs that should be broken for human convenience? Her call to "transgress boundaries" by both patriarchal capitalists and postmodern feminists complicates the assumptions of who is being protected by what actions and how these affect the freedom of those connected in this cycle (Shiva, 2016). The sustainability argument put forward by Brennan (1984, 2014) advocates thinking beyond anthropocentric concerns in sustainability to include the health and well-being of other creatures, recognizing that we are all related. The anthropocentric arguments relate food with the health of all, in both psychological and physical ways, to propose an interconnected approach of all elements, one organism.

Each one of us is drawn to certain types of foods more than others based on a range of intersecting factors such as time of day, placement or appearance of food, its social context, and our own mood and emotion, among a host of other variables. Food has a symbolic, material, representational, and social value that connects with personal happiness and well-being. The intersectionality of food with these reflexive/embodied and material/discursive factors suggests that decision making with respect to food choices is not as straightforward as availability in the grocery store or the time and resources to prepare a specific type of balanced meal. Wahl et al. (2017) investigated in-the-moment experienced eating happiness in real time covering the complete diversity of food intake to find that fruit and vegetable consumption contributes the largest share to eating happiness and can be an investment in the in-the-moment well-being. The constructed nature of the social value of food is situated in the symbolic and the representative as much as it draws upon the sensory and the biological (figure 9.1). Examining food through the lens of community, personal satisfaction, and social well-being suggests looking beyond health outcomes to integrative, situated, and relational understandings of food.

The multi-vocal understandings of food in relationship with our body/self are illustrated through the material capacities of taste and smell and discursive

constructions of memories, sociability, mood, and emotion. This also implies that although people often have a spontaneous unhealthy-tasty intuition, with a stronger happiness boosting effect of unhealthy foods, this does not differ on average from healthy food choices (e.g., dinner has a comparable happiness signature to snacking). While food is impacted by emotion, the relationship works both ways as the impact of different food categories on wellness might not be directly related to biological effects but may come from conditioning as food is often paired with positive experienced situations such as social interactions. Even so, this relationship is not as straightforward as might appear, as not the entire range of emotions, positive and negative, triggers eating. Emotions, moods, and context trigger eating behaviors that constitute our food decisions in complex ways. For instance, distracted eating, or eating when in a heightened state of anxiety, stress, or motional arousal, is associated with distorted eating behaviors such as overeating or making specific types of food choices, such as those high in sugars or fats (Bennett et al., 2012; Nolan & Geliebter, 2012). Thus, while our social values and behaviors relate with our food choices, our food choices are also shaped by our moods and emotional states. Cultivating agency and choice, and addressing access and availability, can give us partial knowledge on how one factor under a particular condition may contribute to some extent to a part of one decision. However, understanding and shaping our relationship with food as individuals who are a part of a living historical-social-economical cultural landscape requires situating the food in our reflexive/embodied and discursive/material ecological understandings of the whole body/self seen as an integrated organism in a vital relationship with its socio-cultural environment.

Communal practices, human health, and the natural world have long been connected through social customs, political ideologies, and religious beliefs. Ethical stewardship of the Earth formed the basis of the Old Testament, and the New Testament emphasizes the moral principle of giving food to the hungry and water to the poor. The Taoists believed the opposites, *yin* and *yang*, were at the center of the universe with man as the microcosm, and animals, plants, and all living beings played a significant role in the community. According to the transcendentalists, the right foods could provide the resources needed for spiritual regeneration (Eden, 2011). Some argue the desire to create sustainable communities has led us to consider social health as a second habitat that requires our attention (Eden, 2008). In this case, the assumption is that achieving the goals of sustainability is a collective effort echoed in religions from Mahayana Buddhism to the Bhagvad Gita and the Christian concept of cosmic unity that has parallels in agriculture (Falvey, 2005). These parallels equate genetic modification with ethnic cleansing, language diversity with sustainable culture, and societal imbalance with an unsustainable world.

The social constructionist approach highlights the relevance of communication, language, and culture in the meaning making processes relevant to the construction of any phenomenon. Food in the United States is also shaped historically by its intersections with religion and political ideology. The nineteenth-century American Protestant beliefs were infused with democratic ideology. The United States version of European romanticism, transcendentalism, strengthened the belief between the continuity of nature, human society, and human personhood and urged Christians to look within themselves as well as to nature for personal growth. Themes of nature, ecological sustainability, human potential, and spiritual regeneration have been connected in many ways both in literature and philosophical-religious movements to provide support for the idea of food as nature and medicine with an integration of body/self.

THE CONNECTED WEB OF FOOD

A key goal of this chapter is to understand food as relational and dialogic social constructionist perspective in the context of chronic illness self-management. The social constructionist perspective emphasizes the role of interactional frames in constituting self-identity as it engages in meaning making with respect to bringing a phenomenon such as the experience of chronic disease beyond its biomechanical mechanisms into the realm of the lived socio-cultural context. This chapter foregrounds the context of socio-cultural environment in shaping the dialogic engagement of the body/self in reflexive/embodied and discursive/material ways in constituting wholeness. Culture has been defined as “a system of inherited conceptions expressed in symbolic forms by means of which men (sic) communicate, perpetuate, and develop their knowledge about and attitudes toward life,” and whereby “man is an animal suspended in webs of significance he himself has spun” (Geertz, 1973). Nothing symbolizes the materiality of this web of symbolic knowledges and attitudes toward life referenced by Geertz more than food. We, as human beings, are embedded in, and constituted through, our conceptualization, construction, and consumption of food.

The food choices we make are deeply cultural. Processes of food production and consumption involve many intersections and interactions with different substances and food materials. Anthropologists have given us many theoretical perspectives in thinking about food through a cultural lens. The structuralist or symbolic perspective argues that culture is an ideological system whereby meaning is ascribed to things according to apparently arbitrary symbolic values. In understanding our food choices, we need to consider each case on an individual basis and in relation to the context in which the

food preferences occur. Some anthropologists, such as Mary Douglas (1966), argue that food preferences are based on maintaining social order and purity, and this priority is exemplified in classificatory systems. The classificatory systems distinguish between values assigned to food such as clean/unclean, pure/impure, edible/inedible.

Considering the self-reflexive, embodied, body/self relationship as constructed with food provides the individual with the spatial language of movement and boundaries imbued with the discursive and material experiences of food given meaning through our socio-cultural environment. In an iterative manner, these non-verbal, pre-reflexive processes have a powerful communicative potential that goes beyond language to place the body's relation with the food environment in constituting their socio-cultural experience, centering embodiment to constitute wholeness. By way of an illustrative example, seen through the lens of religion, individuals strive toward purity and unity with God, therefore eating impure foods will be considered polluting. In this instance, therefore, the central root meaning of Holy is "wholeness" and "completeness" (Douglas, 1996). The cultural materialism theoretical school (Marvin Harris, 1979), centering a material infrastructure perspective on society, understands the "material infrastructure" of society as the conditions from which particular cultural practices, such as those of food, emerge and which give them meaning in embodied, discursive, and material ways.

The etic structural-material infrastructure around food, with the notion of food deserts, the farm-to-table movement, and that surrounding the ethics of meat consumption as explained in the preceding section, plays a deterministic role in shaping the "structure" of social or cultural institutions such as the cultural economy of food and the political organization of food organization and distribution. It also shapes the internal behaviors and ways of thinking about the socio-cultural reality of food in discursive and material ways as, for instance, reifying animals and plant as products *out there* for human consumption. The substantivist critique in the 1960s to the cultural materialist perspective locates the reframing of human activity in capitalist terms as an ethnocentric act, and one that perhaps plays a salient role in shaping our understandings of what constitutes food and our right to consumption. While some have cautioned against the tendency to portray the cultural materialist model in deterministic ways because it denies human choice and agency in shaping cultural practices, self-reflexive awareness of the embodied relationship with food can ground such experiences centering the body's relations with the environment and its self-reflexive awareness of its own vision of harmony and balance. In such contexts, an individual's relationship with food may become an iconic marker of their religious, socio-cultural, or nationalist

identity which provide the means to shape the spatial embodiments in ways that constitute healing and wholeness.

Through the lens of the ecological framework of wholeness, the materialist focus on nutrition, public health, and the healthy body can be enhanced with a reflexive awareness of the constructivist nature of symbolic and representational value of food as nourishment. Experiencing food through individual choice and agency foregrounds embodied relations with the individual's navigation of their perception of subjective change, traditional health, and socio-cultural environment. Even as concerns of equity, access, and availability are addressed in public health policy domains, individual agency shapes perceptions of subjective change and the socio-cultural resources comprising the informal values, beliefs, and norms of its subcultures and it is participants. Some researchers have looked at food as a mnemonic device, whereby the overlapping of multiple sensory experiences (termed "synesthesia" by David Sutton, 1997, 2001) comprises a form of food memory, transforming food into a mnemonic device as a means of experiencing other cultures and historical-religious-political contexts. Constructing food as a constituent, a construction, a participant in our identity suggests we examine its material and discursive elements in a collaborative and agentic manner, whereby food too enters into a dialogic relationship with us in a two-way relationship.

Envisaging a dialogic relationship as equitable asks its participants to view each other as equal participants in the context. In an earlier section of this chapter, it was argued that living beings subsist on living matter as food. The dialogic relationship of food as nature with the human species can be thought of in material and structural terms not in a binary but an integrative manner. Policy-making shifts guided by an awareness of the propositions of socio-cultural movements such as those arguing for One Earth, One Health, and similar eco-sustainability proponents along with religious and cultural groups (e.g., Mahayana Buddhism, specific Christian sects, Hinduism, Native Americans and others), position nature and human beings as co-constituents in a systemic ontology. Positioning the individual in a dialogic relationship with communities they inhabit shifts the self-reflexive awareness of the natural resources in that community from an external object to an embodied self. Eco-sustainability policies, education, and behaviors imbued with a reflexive/embodied self-discursive/material body in harmony with healing contexts co-construct individual level subjective change with religious-historical-medical traditional health environments and socio-cultural environments. In the contemporary living context, eco-sustainability principles anchored in the ecology of wholeness model constitutes wholeness by emphasizing relativity and connection between food as mutually-constitutive, and co-constituting with the act of its consumption.

Existence of practices involving consumption of non-living matter (e.g., mineral or metals) suggests the acceptance at various points of human civilization of a religious perspective that, some have speculated, may address physiological deficiencies and other material facets of health-related functioning. The instance of geophagy, or earth eating, is a nearly universal cross-cultural phenomenon. Hunter (1973) notes that there is evidence of its various manifestations in the Mediterranean world of Roman and later times, in medieval Western Europe, and in present-day Iran, India, China, Oceania, Africa, and Indonesia. Geophagy is a highly diverse phenomenon reflecting religious belief, cultural practice, psychiatric disorder, pathogenic reaction, and physiological need: analyses of Ghanaian clays provide the basis for a culture-nutrition hypothesis, which is then examined in light of supporting and contrary evidence supplied by previous research. Hunter examines geophagy in the United States as a culture transfer from Africa. It is speculated that pica, the compulsive eating of nonfoods due to nutritional deficiencies, may have been prevalent in those ages.

Earth eating has formed part of many religious rites and ceremonies. In Christianity, soft whitish stones from the Bethlehem grotto are rubbed in water for nursing mothers. Earth has been consumed as a popular medicine to treat certain diseases. The Sinopic red ochre, called *sphragis*, was found in the Greek island of Lemnos, collected from the ground and caves, mixed with goat's blood, leavened, and molded into lozenges to be used as an astringent in ancient times (Pliny 35.31; Duffin et al., 2013; Everett, 2012). The use of earth in medicine is distinguished from the function of food as nourishment and has been marked by ceremony. Digging for clays from Lemnos was, for instance, done on a particular day in the year, witnessed by a large number of onlookers, marked by many ceremonies, officiated by a priestess, and involved water from a nearby stream. Much has been documented in the line of using clays and earth for medicinal purposes in different cultures (Grivetti, 1978). Kaolin, a form of soft white clay, is used in Chinese herbal medicine while the Aztecs use Bentonite clay as a healing mask, and Ayurvedic medicine uses trace amounts of gold and other rare earths and metals (such as Zinc in the form of *jasada bhasma* for diabetes or iron as *loha bhasma*).

Gold as *swarna bhasma* in Ayurveda, for instance, was used by Chinese and Egyptian civilizations as well. Their use in powdered or calcified forms with herbs has been described in contemporary Ayurvedic literature as falling within the ambit of nanomedicine for diagnosis, cure, and prevention of diseases and reducing dependence on drugs. As pharmacological preparations, the herbal-metallic compounds are prepared under the quality assurance and control criteria to assess their bioaccessibility, absorption, distribution, metabolistic, and eliminative properties. Concerns with their interactions and

metal poisoning (e.g., with lead, mercury, and arsenic compounds) from inappropriate usage have led to calls for pharmacovigilance for their disposition, efficacy, and toxicity (Li et al., 2019). Alongside evidence of their clinical efficacy, concerns of toxicity under conditions of improper processing, purification, and preparation are currently being addressed for different traditional medicines including Siddha, Unani, Tibetan, Chinese, and Ayurveda under the National Pharmacovigilance Programme proposed in India.

Viewed from a socio-cultural lens, such practices demonstrate the intersectionality of the body with the earth and the environment in constituting embodied medical experiences while acknowledging the symbolic, material, and representational value of these relationships through religious practices and communal celebrations. Holistic medico-religious practices are constitutive of healing as reminders of connections between the human body/self and its larger context in integrative ways. Opening up the spaces of the holistic and the biomedical through integrative approaches connects individual and community inner/outer values with the spatiality and pragmatic practices of their medical utilization. For individuals living with chronic pain, connections with their inner and outer experiences establish an integrative sense of body/self, providing avenues for narrative construction in self and other-directed ways, anchored in temporal, cultural, and spatial values. Integrative approaches support the embodied self that recognizes the connections between the body/self and the constructed environment in dialogic and innovative ways. (Re)positioning food as a relational space embodied by individuals for sense-making of chronic illness experiences supports the alignment of the reflexive/embodied and material/discursive dimensions. Chronic illness management supported through integrative experiences connecting lifestyles, ecologically grounded sense-making, and the body's regulatory mechanisms constitutes wholeness targeting dysfunctionality and fragmentation characterizing imbalance in environmental and psychological stresses underlying body mass pathologies. A social constructionist, relational, dialogic approach drawing on a medical humanistic perspective guiding conventional and allied health care patient-provider communication can imbue the ethics of health care contexts with everyday lived experiences constituting healing as wholeness.

FOOD, EMBODIMENTS, AND TRADITION

Chronic illness changes the embodied meaning-making process through which individuals make sense of their lived experiences. The history of food as medicine offers a way to see the healing properties of food within a larger context. A close examination of the links between traditional food and medicine offers

multiperspectival approaches to address global lifestyle-based chronic conditions such as cardiovascular disease (CVD), diabetes, and obesity. This section brings together the discursive and material dimensions of the body with chronic illness from a reflexive and embodied lens, situated in the context of temporality as subjective change, traditional health, and socio-cultural environments. Conceptualizing empathy in patient care includes communication that demonstrates caring in an affective terms expressed in behaviors that communicate an embodied understanding of the other's lived experiences. In the ecological model of wholeness in chronic illness self-management, food as a constitutive mode of communication centers the self-reflexive awareness of the individual upon their own body and its illness experiences. The experience of food procurement, preparation, and consumption is grounded in embodied processes, cultivated through empathetic Bakhtinian dialogic approaches and situating themselves in individual, socio-cultural, secular, heterodox frames.

The goal of dialogue in chronic illness management, from a Bakhtinian perspective, is to cultivate understanding an active process of talking and listening. At one level, this implies interpersonal contexts of listening between the doctor and the patient during the health care consultation. At another level, it implies placing distinct medical systems in a dialogic engagement with each other such that the education, specialization, and training in one is enhanced by and sensitive to the knowledge orientation of the other and able to enter into a relational interchange in specific contexts to the benefit of each and the patient.

Eastern health care practices circumvent mind-body dualism and object-subject directed anthropocentric boundaries in envisaging integrative embodied experiences with eco-sustainability grounded secular-medical philosophies. Recent research developments in embodied constructs illuminate the role of interoception in shaping a sense of embodied self connect mental health and consciousness in ways that offer generative understandings (Seth et al., 2016). Through cultivating greater proprioceptive and kinesthetic sensations that produce somatic integration and feelings of well-being, embodied cognition suggests neuroscientific approaches for reducing physical and mental stress and their associated body mass pathologies. Embodied cognition is conceptualized as independence of thought from perception, and action informing cognition made possible by the representational distinction between concepts and sensorimotor representations (Mahon, 2015). The material/discursive body dimension is referenced by interoceptive awareness and its relationship with helping us perceive feelings from our body's internal and external sensations and guiding awareness of our physical and physiological condition also illuminates the underlying neuroscientific mechanisms as they conceptualize subjective feelings, selfhood, and self-awareness (Seth & Friston, 2016).

The cognitive-affective dimension of food evokes critical elements of self-hood, cultural identity, and belonging. Preparing foods with spices and herbs has been traditionally considered a form of preventive medicine shared by many cultural traditional forms of medicine. Other means of preparing food materials include making tinctures, concentrates, and essences. Traditional medicine paradigms connect the material, sensory, and affective identity-based associations of food preparations and their medical mechanisms. For instance, spices occupy a spectrum of beliefs about foods that have specific medicinal properties. Spices have been used both as food and as medicine. They are believed to purify, tone, and heal the body or extend life and have been used in ancient Chinese, Greco-Islamic, and Ayurvedic medicine that continue to employ and inform their use in contemporary beliefs about diet and nutrition. The notion of *food and medicine*, and *food as medicine* in fact, have been interchangeable through the traditional medicine systems. Traditional medical systems and their underlying ontologies view the individual as one element in an epistemological orientation toward integration and balance as wholeness at a systemic level. The individual is a unique combination of the philosophical properties of the elements that comprise their body. The epistemological-axiological-praxis continuum is situated in a discursive/material, reflexive/embodied integrative ontology.

The shared connections made in traditional health systems between nature, food, and medicine are valuable. However, alongside the concern with toxicovigilance, traditional medical knowledge systems are challenged to codify their oral traditions and practices to make them accessible and verifiable in contemporary terms. The ontological concern with food as medicine and nature as fundamentally connected with the human body/self identity is shared across traditional systems of health, healing, and medicine. Greek and Chinese systems of traditional medicine share the characteristics of secularization of medical knowledge from spiritual forms of healing, an emphasis on regulation of hygiene and nutrition, and notions of balance with the environment (Chen, 2009). Chen (2009) argues that practitioners, rather than thinking of traditional medicinal systems as distinct or separate, engage with translations and exchange of knowledge. Secularization of medicine implies that theories of healing with food and their attendant concerns with climate, region, and taste from folk or heterodox spiritual practices are foregrounded. Systematically associating food with its medicinal properties and their effects on human health is critical to the process of classification of food as medicine and as an institutional practice. This brings it out of the oral tradition of traditional medicine systems and into a more codified system of contemporary knowledge.

Traditional medical systems orient the body/self with environmental elements of air, water, temperature, earth, and space. The classification of the four humors, or fluids that influence the body's health, tissues and structural elements, and metabolism was associated with different body types in both Ayurveda and TCM. In Ayurvedic theories of diet and nutrition, these elements are closely related with nature as food that nourished the qualities of each of these elements and their corresponding bodily functions. Each body is uniquely connected with other living bodies in sharing the properties of the elements that nourishes those functions. The functions and their elements exhibits particular properties under different geographical, seasonal, diurnal, and geological time in a unique relationship with each individual body's composition of the dominance and expression of each element and its properties.

Ayurveda, loosely translated as the science of life, is considered one of the most ancient systems of medicine and has been the traditional system of health care in India for more than 5,000 years. In a complete Ayurvedic medical evaluation, individual time is situated in a recursive domain as a balance of one's karmic intentions, actions, and behaviors with one's physical form expressed in nature (species, health, strength of various bodily systems, character, and resources available of time, cognitive and spiritual ability, education, money, and so on). Nature, too, in its complete evaluation, connects the elements of air, water, earth, space, and temperature with the cosmic nature of sun, moon, space, directions, and ether. Their combinations in our body, nature, and the environment, as they move from subtle waves to grosser wave forms, express in different visible, material, and tangible ways to the human senses. Thus, balance in the body is associated with balance in its relationship with nature and the environment. Any imbalance, as it accumulates and takes hold, affects the functions of that cellular metabolic process, organ, and system, followed by related systems in the human body. While imbalance is preventable and reversible at early stages, more accumulated stages of imbalance express in chronic conditions.

In descriptions of the food-digestion-health cycle, the above relationships are refined greatly and tailored in very granular ways in their considerations of the *rogi* (patient) during medical education. The six tastes of food (*rasa*), each, for instance, vary in their mechanisms of action and outcomes with the digestive fire (or capacity), strength, which determine how each food is processed, stored, and metabolized. Each food, in turn, is associated with its own combination of *doshas* (regulatory principles, or humors) and propensity to support certain cognitive, affective, and spiritual capacities (such as *sattvic*, or spiritual; *karmic*, or action-oriented; and *tamasic*, or oriented toward inaction or inappropriate action). Because the properties of food such as taste, texture, and its bodily functions varied greatly, and in nuanced and particular

ways, digestion and its assimilation into the body is given very in-depth attention in traditional systems. From such a viewpoint, the health and outcomes of food, nature, the environment, and the cosmic environment are intimately connected with the individual health, actions, and their impact on individual, community, nature, and the environment.

According to Ayurvedic medicine, the body is composed of three body *doshas*, three mental *doshas*, seven *dhatu*s, and ten *malas* (metabolic end products). The harmony among the body *doshas* of *vata* (nervous system), *pitta* (enzymes), and *kapha* (mucus) and the *gunas*, or mental *doshas*, constitutes health, and their disharmony constitutes disease. The management of illness requires balancing the *doshas* back into a harmonious state through lifestyle interventions, spiritual nurturing, and treatment with herbo-mineral formulas based on one's mental and bodily constitution (Mishra et al. (2001). According to Ayurveda, each individual is born with a specific proportion of *tridoshas* that are not only genetically determined but also influenced by the environment during fetal development. Jointly they determine a person's basic constitution, which is termed their "*prakriti*." Development and progression of different diseases with their subtypes are thought to depend on the origin and mechanism of perturbation of the *doshas*, and the aim of therapeutic practice is to ensure that the *doshas* retain their homeostatic state. Prasher et al. (2016) suggest an "Ayurgenomics" approach can be used to integrate the *trisutra* concept of Ayurveda with genomics through connecting with western systems biology conceptualized in translational medicine that envisages the integration of multiscale genetic, cellular, physiological, and environmental networks to predict phenotypic outcomes of perturbations.

The body/self material/discursive dimension centers the process of recovery and healing. Embracing our physicality is an important aspect of claiming the process of becoming well through illness. Dance, for instance, has been critiqued as a practice that can mitigate human suffering through connecting the human spirit with its physicality and emotion, such as by considering dance as a form of dialogue (Purser, 2017). In its embodied subjectivity dimension, dance functions as healing (following Merleau-Ponty) with intersubjectivity as intercorporeality of the material/discursive body in an ecological framework of wholeness in ways that liberate it from Cartesian limitations. From a medical humanist perspective, dance heals because it reconnects us with embodied subjectivity, and intersubjectively with the other—to construct experiences in relation to the environmental dimensions of subjective change, traditional health, and socio-cultural environments.

Interdisciplinary approaches to healing emphasize whole person approaches that connect research in the areas of attachment, trauma, and the neurobiology of emotion (Wilkinson, 2017). Such interdisciplinary connections

enable the mind, brain, and body to heal particularly in terms of traumatic early interactive experiences that are held outside of human awareness for clinical practice. As a relational whole body/self whole, it helps to recognize its materiality and discursive constructions through different perspectives on embodiment in healing in the aftermath of experiences like breast cancer treatment. Slatman et al. (2016) describe women's experiences relating with a body that appears to oneself in various ways as experiences that go together with one's body "at a distance" and experiences that go together with one's body's "closeness." The discussion of food, nutrition, nourishment, and healing emphasizes that the body in healing is not just an object. Food shapes our relationship with our body and shapes as well as is shaped through different bodily experiences.

From a social constructionist perspective, considering our relationship with food as shaped by embodied cognition references a multifaceted theoretical proposition drawn from cognitive science that cognitive processes are influenced by the body, are oriented toward action, situated in the environment, and may occur with or without internal representations (Goldinger et al., 2016). Consider findings from research indicating that language processing activates perceptual simulations (Tillman et al., 2018). In other words, language encodes embodied perceptual information such that how and what we speak shape our feelings and perceptions toward that object in emotional-cognitive-physical ways. Tillman et al. (2018) test whether comprehension of emotion words can be explained by an embodied cognition or a language statistics account in a corpus linguistic study comparing emotions words. They showed that words denoting the same emotions (happy-delighted) co-occur more frequently than different emotions (happy-angry). Their findings demonstrate that language processing does not always rely solely on perceptual simulation. In arguing for pre-discursive, reflective modes of body/self relationality, the ecology of wholeness proposal provides a framework to situate investigations of such reflexive/embodied, and material/discursive relationships into the ambit of provider-patient communication and the therapeutic relationship.

The socially constructed reflexive/embodied self proposed in the ecological model of wholeness for prevention and long term management of chronic illness has drawn upon historically-politically contingent narratives, economics, psychology, religion, and philosophy, among other approaches from a medical humanist perspective. Embodiment research has seen a great deal of interest in understanding the lived illness experience to inform a variety of health care contexts. Evidence-based research from the neurosciences and related disciplines offers the potential to see its applications enter the clinical domain. However, critiques about its generalizability and application in facets such as embodied cognition remain areas for further work. The notion

of embodied cognition has been critiqued on the basis that basic principles from embodiment theory are either vague (e.g., the premise that perception is influenced by the body) or offer nothing new (e.g., cognition evolved to optimize survival, emotions affect cognition, perception-action couplings are important; Goldinger et al., 2016). Although the role of psychosocial factors in contributing to physical and mental health outcomes is recognized, the non-mechanistic focus and lack of specificity in embodiment research and embodied cognition specifically in guiding clinicians to focus on social, psychological, and/or biological factors in individual cases challenge its integration (Smith et al., 2019). Such considerations bear further examination and attention in future research for their potential to support ecologically defined wholeness and healing in health care contexts.

The ecological framework of wholeness provides an insight into constructing health care contexts on a principle of relational and dialogic ethics that consider the reflexive/embodied self and its material/discursive elements, the community, and the eco-sustainability relationships in a framework of time, traditional health care knowledges, and socio-cultural values. Such relationships emphasize the ethical basis in approaching the body/self relationship. The framework of relational ethics guiding health care interactions is based in clinical relationships on fostering growth, healing, and health through the foundational concepts of mutual respect, engagement, embodiment, and environment. They can help us understand, for instance, how nursing leadership can support nurses who care for patients requesting medical assistance in dying (Thiele & Dunsford, 2017). Similar issues extend the understanding of professionalism in health care, focusing on character traits, attitudes, or behaviors to better explore ethical demands of the healing relationship by focusing on trustworthiness with respect to the professional commitment to take care of those seeking help. Because our willingness and ability to trust health professionals or health care institutions are affected by our personality, culture, race, and numerous socioeconomic factors, the attitudes and behaviors that help construct trust are patient and context specific. The socio-cultural approach undergirding the medical humanist approach to the ecological model of wholeness integrates relational ethics, professionalism, and trust at its core in healing communication to constitute integrative, relational spaces.

In the context of healing communication and wholeness as proposed in this book and in the instance of shaping the individual relationship with food, the role of personalized dialogue and conditions of trust building gain salience. Healing communication takes relational, dialogic ethics at its core. Empathy is central to ethics as sharing in the feelings of another, or as a means of coming to a direct appreciation of the other, or as an expression of caring in the clinical context is close observation, precise listening, and responsive

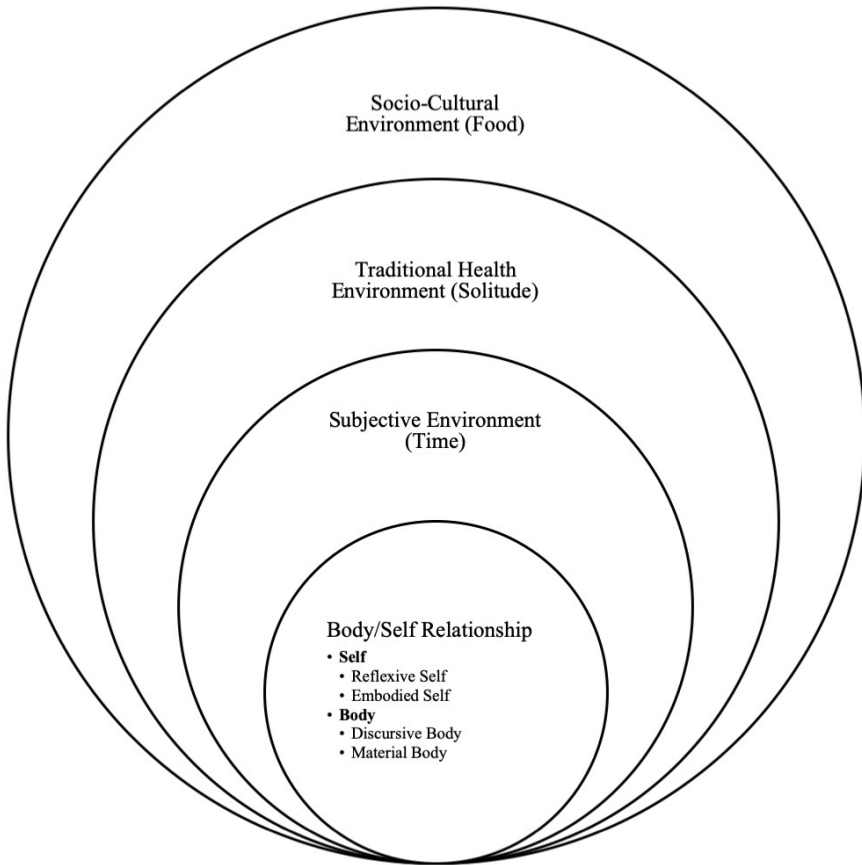


Figure 9.2. Ecological model of wholeness in chronic disease management. *Figure created by author.*

questioning, along with direct, committed engagement and actions to address the patient's problem (Weiner Auster, 2007). Empathy is understood as a form of emotional engagement beneficial to patient care where dialogue is a precondition for positive change (Seikkula & Trimble, 2005). In seeking to understand how empathy becomes a healing experience from the perspective of a dialogic partner, the key factors include examining actions that support dialogue in conversation, constructing a shared emotional experience, creating community, and creating a new shared language. Through dialogue, feelings of love, manifesting powerful mutual emotional attunement in the conversation are made possible.

When people experience chronic illness or serious injury, changes occur not just within their physical bodies but also in their embodiments, that is, how they view the world through their bodies. Wilde (2003) examines how nurses

guide people with illness or injury to wellness by examining theoretical bases of embodied knowledge drawing on Merleau-Ponty and Polanyi. Understanding the body as a “silent partner” fosters an appreciation of the body’s own subjectivity that can be enhanced in nursing care through sensitivity, listening, and creative coaching. The body as “informant” holds much promise for solving some of the everyday problems that people with chronic illness or injury experience. Recent scholarship is moving beyond conventional familiar Western worldview thinking to invite forms of inquiry and embodied moral action to address social justice that encourages to honor nursing’s focus on whole person-environment-universe as one (Watson, 2018). In this vein, Khong (2013) advocates for health care settings that go beyond patients and individuals to forms of relating that include discussion of difficulties and experiences, and chart their personal journey. By bringing together Heideggerian, Buddhist, and daseinanalytic ideas of being-in-the-world, openness, being-with, anticipatory care, meditation, mindfulness practice, meditative attitude, a beginner’s mind, aspects that are critical to the chronic illness experience can be experienced through letting be and letting go.

A large part of patient-provider communication work involves listening, attending, and responding. Here the Buddha’s teachings on meditation, mindfulness, quiet listening, and letting go are relevant. The Buddha recommends two types of meditation, namely tranquillity (*samatha*) and insight (*vipassana*) meditation. The latter is commonly referred to as mindfulness practice. Briefly, term or concentration meditation involves sustaining attention on one object, such as the breath, a mantra, a candle, etc., to the exclusion of other stimuli, allowing the mind to settle down. As Kabat-Zinn (1994) explained, with continuous practice, the mind becomes better able to stay on the object of focus, and to notice “the earliest impulse to become distracted by something else.” Although the Buddha recommends tranquillity meditation as a way of calming and stabilizing the mind, he emphasizes the importance of insight meditation or mindfulness practice as a way for individuals to get to in touch with and understand the nature and workings of their own minds.

In the embodied relationship between nurse and client, these subjective relations come into play in the ways we frame the encounter and in the ways that religious perspectives can shape the way it is experienced. Groenhout et al. (2005) offer an explanation of how the embodied encounter between nurse and client can be interpreted through a theologically reformed perspective. In thinking through how the practice of nursing can be both a place where different theological perspectives can meet, and also a place where both nurse and client can meet as whole persons, the challenge is not to see each as divested of communal and social meaning. Groenhout et al. (2005) explain that embodied experience can be understood as either set in opposition to

spiritual experience or as integral to it. Characterizing the ordinary aspects of the socially informed relationship between nurses and patient as reflective of a sacramental practice of empathy and trust building requires the envisioning of embodiment in care through spiritual training in being in the moment. Understanding principles from Vedic philosophy, for instance, can integrate embodiment in/as food and nature with sustainability and co-constitutive ethics of the other, to envisage a health care context characterized by a meeting of whole persons, and oriented toward the idealized goal of healing.

I conclude the book's arguments on the third environmental layer by proposing the development of the ecological model of wholeness with the discussion on food, nature, and body/self integration, the final arguments reference the principle of connectivity of body/self through awareness, embodiment, and discursive and material nourishment (figure 9.2). The idea of being whole is the idea of relating and giving back. Chronic illnesses fragment, dissipate, and make dissolute the human capacity to embody tranquil equilibrium and cultivate wholeness. A journey to wholeness begins with self-reflexive and embodied awareness of body/self, the material/discursive body, and its dialogic relationality with time, change, and nourishment. In this cyclical model, then, food, from its role in sustenance, constitutes the idea of sacrifice in conceptualizing integrative modes of relating and otherness. Food constitutes body/self integration in the idea of letting go, in the idea of nourishment as cultivating a eco-sustainable heterodox vision of food in relationship with/as self.

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