

## Commentary

### **Nursing and the Body**

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In this short paper I will argue that "psychosocial" nursing research is premised on a mind/body split that disembodies persons and fragments the representation of health and illness experiences. I will also argue that this disembodiment has created a rift between nursing research and nursing practice.

When I review the nursing research literature on acute care, I am struck by the scarcity of attention to the body. Nursing researchers seem to have left the body to the biomedical investigators, concentrating their own efforts on the psychosocial dimension of acute illness.

Psychosocial nursing research is based largely on notions of stress and coping; it examines constructs such as stressors, perceptions, appraisals, needs, beliefs, adaptation, and coping responses of persons "managing" their health and their illness. These constructs "frame" health and illness experience in cognitive terms – presuming that people know what is distressing them, that they think about these things, that they can talk about these things, and that they consciously decide what they will do about these things.

Contemporary notions of "stress" are very much rooted in a biomedical framework. Hans Selye is renowned for having highlighted the physiological manifestations of excessive demands on the body; he referred to the manifestations as stress, to the demands as stressors. Selye characterized the overall response of the body to stress as a process of adaptation.

Subsequent researchers in psychophysiology and psychosomatic medicine discovered a link between mind and body. Psychological distress became recognized as a cause of physiological disorder. Yet

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human experience was characterized in linear terms: a person (1) encounters stressors, (2) becomes stressed, and (3) adapts.

In the late 1960s and the 1970s these universal claims were largely refuted. Linear models of stress were supplanted by more "psychologically sophisticated" frameworks (Young, 1980). The stress, appraisal, and coping framework articulated by Richard Lazarus became particularly prominent in the nursing research literature. In this model, the person faced with stressors engages in a complex cognitive appraisal of "what's at stake." This appraisal shapes the person's subsequent stress experience and his or her "coping response." This stress and coping paradigm has been further elaborated as a way of understanding the experience of families.

The psychosocialization of nursing research seems rooted in the disembodied rationality that is prevalent in Western psychology. Mind/body dualism can be traced to the 17th-century thesis of Descartes, "*Cogito ergo sum*" (I think, therefore I am). This ideology presumes that cognition can be disengaged from the realm of the body and serve as the "site" of human experience.

A number of social studies have further examined the ethnocentricity of this dualism. Several ethnographies suggest that the presentation of illness (including bodily symptoms) is shaped by cultural views of health, illness, and healing (Kleinman, 1988). The body can also be an object of social domination, wherein bodily expressions are interpreted as a form of social dissent (Lock, 1993). Culture determines what is construed as "normal" and what is construed as "pathological."

Thus the dualistic view that the body can be separated from the mind is a highly contestable one. The bodily manifestation of illness is expressive of human physiology as well as of cultural context. Similarly, the psychosocial separation of the mind from the body is problematic. The mind is embodied, and it is inescapably expressive of bodily experience.

A stress and coping framework for nursing research requires that the researcher construct a cognitivistic, disembodied representation of human experience. However, much of health and illness experience is broader than what a cognitivistic framework can accommodate, and it frequently lies outside the realm of articulacy.

During the course of several studies, I have interviewed and administered questionnaires to a number of patients and their families, as well as nurses, with the aim of having them describe their "stressors" and how they "cope" with them. My informants have consistently

exhibited discomfort representing their experiences in these terms. Often they find it difficult to present their experiences in words at all.

For example, the death of a child affects a complex constellation of elements in a parent's life. Asking a bereaved parent to list what is stressful about such an experience, and to rank the stressors and describe how he or she copes with each of them, results in a fragmented representation of a grief experience.

On the other hand, when I speak "freely" with bereaved parents in my clinical practice they frequently speak of feeling empty, hollow, tormented; they may have a loss of appetite and sleep disturbances; their whole body seems to be grieving. Also, they typically say that words simply cannot do justice to what they are going through.

The proliferation of nursing research on pain further illustrates nursing's disembodiment of acute illness. Although I recognize that pain research has advanced our understanding of nociception and how it can be effectively mediated, I object to how this has fostered a fragmenting of human suffering.

The dominant trend in nursing research is to frame suffering in dualistic terms: (1) there are nociceptive pathways in the body that are activated by physical events, and (2) there is a perception of pain in the mind. Working within the psychosocial tradition outlined above, nursing researchers have been interested in how we perceive our pain and how we cope with it. Whereas medications affect how pain is transmitted, cognitive strategies (such as imagery or self-control techniques) affect how it is perceived. Ultimately, injury is seen to be in the body and pain in the mind. This dualistic framework perpetuates the disembodiment of suffering.

In my clinical practice, I have found that persons express suffering in holistic terms, through words, silence, moans, movements, physiological fluctuation – suffering involves the whole person. Suffering is existentially "thick," in that bodily experience is deeply rooted in the larger significance it has for the person. The suffering that accompanies illness threatens the integrity of a person's sense of self and life.

Dualistic models of pain contribute to the disintegrating and compartmentalizing of human experience. I have found that I can comfort a person's suffering best when I try to understand "what it is like" for the whole person, without imposing my pain dualisms. I use my understanding of pain but I am not centred on it. I realize that the language of pain is part of *my professional* language and does not sufficiently represent the patient's broader suffering experience.

Embodiment is also relevant for the clinical expertise of nurses. Clinical expertise seems rooted in practical, embodied "know-how" that is beyond the grasp of rationality (Benner, 1994).

I propose that we turn to the practice of nursing for guidance on how to embody nursing research. As I understand nursing practice, an expert nurse directs her efforts toward "getting to know" the patient. This involves getting a grasp of how the patient is construing the situation, discovering what matters to him or her, and becoming familiar with the patient's ways of doing things. Throughout this process, the nurse draws on her current understanding of physiology as a framework for interpreting bodily function – this is elaborated into an understanding of the patient's particular bodily function and an ongoing revision of the nurse's general understanding of physiology. The same process holds for the nurse's understanding of psychology, spirituality, social systems, and other relevant domains, and how these pertain to a particular patient. Over time, the expert nurse comes to a holistic understanding of the patient within which to interpret his or her expressions (including bodily expressions).

My portrayal of expert nursing characterizes the practice of nursing as a process of "thick" interpretation (Benner, 1994). Thick interpretation is dependent on a thorough understanding of what is significant to a particular patient, within the context of the culture and community that largely shape how things matter to him or her and how these are expressed. Within this framework, I recognize that much of my a priori research knowledge is fragmented. I recognize that human experience is enmeshed in the webs of meanings and practices that shape a person's way of life. Whereas the dominant psychosocial nursing paradigms disembodied human experience, an interpretive framework seeks to embody patient accounts – representing the body in whatever way it presents in a particular encounter.

In light of the complex ways in which context shapes the experience and expression of illness, I would like to see a more vigorous promotion of interpretivism in nursing research. This would also foster a harmonizing of nursing research with nursing practice.

## References

- Benner, P. (Ed.) (1994). *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness*. Thousand Oaks, CA: Sage Publications.
- Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.

- Lock, M. (1993). Cultivating the body: Anthropology and epistemologies of bodily practice and knowledge. *Annual Review of Anthropology*, 22, 133-155.
- Young, A. (1980). The discourse on stress and the reproduction of conventional knowledge. *Social Sciences & Medicine*, 14B, 133-146.