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When bodies 'fail': illness and incarnation

Charity Hamilton

THE REVD CHARITY HAMILTON is a presbyter in the Methodist Church who currently works in learning and development. She is a PhD student at Leeds University researching embodiment and incarnation.

charity.hamilton@yahoo.co.uk
Yorkshire, UK

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Bodies: success or failure?

I can remember clearly the first time someone pointed out that my body had 'let me down' or failed. I remember because I was at the time marvelling at the way in which my body had responded to the demands of medical treatment. I was frustrated by the observation in a way that lingers sometime later. My body had not let me down; it was neither faulty nor defective. In fact my body was ill, I was ill, and the body being referred to was indistinguishable from the whole of me, so the inference that I had let myself down seemed to me to be an odd attempt at shaming me as a presumed failure.

To suggest that a body has failed or 'let you down' is a common phrase of the onlooker or even the person who is ill, and the feeling is understandable in terms of vulnerability, sadness and being at a loss for other words. However, it comes from two assumptions which I want to explore and redress: the assumption that the body is somehow separable from the self; the assumption that the body can fail and that illness is such a failure. Beyond the assumptions, I want also to suggest that there is in bodily illness the potential for transformative incarnational narratives.

Into popular culture has leaked a polluting duality surrounding the nature of the body and the spirit/soul/self, a process as old as Plato and one that seeped into modernity through the dualism of Descartes, in which one part is often set up against the other; the body is a cage or a prison which can be overcome by the self, the body hinders the self, the body is to be tamed. While such duality is a common feature of twenty-first-century culture, and a feature which the Church has in part written the narrative of, it is time to reclaim and redeem the holistic self as embodied, incorporated and incarnational without demonisation of any aspect in the salvific effort of another aspect. It is time to reclaim the body as liberative and not as a cage imprisoning a separate self.

Historically, the Western Church has had a troubled dualistic approach to the body; it has persistently attempted to separate the body from the 'soul' or spirit. Tara M. Owens sums up some of the troubled approach towards the body in the life and doctrine of the Church when she writes of the dualistic inhabitation of corporeal reality:

> In our silence, we damn our bodies as peripheral to life with God at best and an impediment to redemption at worst. In our silence, we refuse to live in the corporeal reality of humanity, we pretend as if we can be human without being incarnate.[1]

The early Church Fathers espoused a message that emphasised the need to 'overcome' the body. The Christian Church reproduced Greek theology and biology in its biased and therefore flawed form, whether related to the gendered body, the sexual body, the black body, the disabled body; the problem was inherently and indistinguishably the body and its relationship to the 'soul'. Set into that context is the pejorative fear of bodies, which is embedded in a culture that seeks to tame, to shape, to manicure and conform the human body to a set of ever-changing prescriptions of physicality and success. Alongside this runs the latterly adopted taboo surrounding death and the related fear of illness of the body as a harbinger of mortality.

It is not in spite of but rather in light of this background that Christian theology finds its physical feet embodied, because the fear of embodiment in Christian history is juxtaposed with the centrality of the body in the Incarnation. Tertullian wrote that 'the flesh is the hinge of salvation';[2] it is in the Incarnation that we understand the body as redemptive, healing and salvific of humankind through the nature of a God who makes a choice to be fully human (embodied) and fully divine. It is in the Incarnation that we understand the body as 'mattering' in God's story and most importantly we understand the body as overcoming death, both incarnational and soteriological. It is the centrality of the body that has an echoing significance throughout Christian history. The body is not an external meaningless diversion from the spiritual path; rather it is an incredibly important recurring theme both biblically and in Christian tradition and history.

The ill body has a particular nuance in any theological discourse of embodiment and incarnation because of the false notion of failure as a bodily and embodied state.

The *good news* is that 'God has no fear of bodies. This is the truth at the heart of the incarnated God. The idea of God emptying him- or herself into fragile flesh is one of the great shocks of Christian theology.'[3] However, the good news of the body is also bound up in the body's ability to point us all towards death in its degeneration and change over time, and importantly in its illness. The societal fear of death leads to a fear of illness as the mortifier, which in turns suggests that everything can be easier to cope with if only we separate the body from the self or soul; that way we can package up the difficult stuff in the flesh and call it a failure, which we may try to overcome or at least partition off. The nature of our embodiment, however, is such that despite these strategies to ameliorate the body's significance, it is impossible to disentangle ourselves

from our bodies. Stanley Hauerwas expresses the anxiety around such somatic experience:

> We are our bodies and, as such, we are creatures destined to die. The trick is to learn to love the great good things our bodies make possible without hating our bodies, if for no other reason than that the death of our bodies is our own death.[4]

The problem is that such a fearful approach towards the body incapacitates us as fully embodied and integrated people, and allows the body and therefore the whole self to be first perceived and then experienced as the very cage that is the kindle to this incarnational liberative struggle. Elizabeth Moltmann-Wendel declares that 'I am my body',[5] a declaration of both the inseparability of the body from the self and of the intrinsic self-identity found in the embodied state. Moltmann-Wendel interprets some of the fear around bodily illness, which reinforces our personhood reporting as embodied, by reminding us that ill bodies make those around us insecure because we are our bodies. The direction that Moltmann-Wendel's idea that we *are* bodies, inseparable and situated, takes is one that must raise a number of questions about how identity that is not perceived as failing is created, particularly if we *are* ill bodies.

Illness: embodied identity

Rather than approaching the body in ill health as a body that is somehow failing or outside of that which is acceptably normative, perhaps theologically we can begin to understand illness as a form of embodiment that enables the Church to more fully embrace incarnation, even perhaps as a place of incarnational dialogue. Illness is not a metanarrative to the story of the body, but rather is the refining of the value of that story and therefore of identity, both ours and God's. Recognised as one of the leading figures in a movement of narrative medicine, Rita Charon writes:

> Although illness might trigger dissociation from life, it can also distil the life, concentrate all its deepest meanings, heighten its organising principles, expose its underlying unity. This is not to say illness is a gift … rather that, as it takes away, illness also gives searing clarity about the life being lived around it.[6]

It has been my experience that illness is the tumult into which you never imagined yourself being thrown, the sense of being repeatedly pulled under the waters, a lonely walk in which the road often sharply turns. For some of us, illness is frightening, isolating and confusing. Illness is not a blessing, nor a gift, it is not a good road which any of us would choose to trudge. Physical illness has the potential to diminish us, to accentuate our psychological wounds, and it often alters the map by which we have so far navigated. Rachel Mann, in her autobiographical writing about her gender, sexuality, Crohn's disease and faith, explores what it means to be a person of hope while highlighting the importance of recognising reality: 'Only a fool would deny that chronic illness is corrosive and vile … my life has generally been a slow erosion of strength and often a feast of pain.'[7] There is nothing good about illness, and attempts to create a dialogue between illness and faith should never result in erasing the story of suffering in favour of a more palatable retelling; rather, an incarnational story expresses such suffering in the light of love. As earlier discussed, the body and the self are fully incorporated. Thus, despite recognising the reality of illness, illness is not a failure of the body for it is not and can never be a failure of the person. There are circumstances in which clinicians may use the word failure – heart failure, kidney failure, intestinal failure. Something in your body isn't working in the most effective way, it is ill and you are ill; the failure of a part of your mechanism is no failure of the whole self. Your body has not failed nor let you down, for you have not failed nor let yourself down. However, the illness you experience is important in clarifying and articulating something of your identity and personhood. Charon suggests illness relates to more than the physical experience – it relates to the whole experience of life, it offers a particular lens through which to view and narrate the experience of the world; in essence it clarifies and enables an identification of personhood in creation. Charon goes on to describe it thus: 'Illness intensifies the routine drives to recognize the self. It is when one is ill that one has to decide how valuable life is.'[8]

While in pastoral practice, I have often heard people state very clearly that they wish not to be defined by their illness or trauma. They express a strong desire that I hear and understand that there is more to them than the very immediate and present condition. I have some sympathy for such a view, for who of us wants to be defined or identified by a single experiential strand of our lives, particularly if that strand indicts us as vulnerable. The desire not to be defined solely by illness is part of the struggle to integrate difficult experiences with a previous identity, and it is important for pastoral practitioners to hear this

struggle in an attempt to help the person who is ill to construct an emerging reconstructed reality of being. The difficulty arises if we begin to deny the experience of illness as part of clarifying and shaping that changed identity. Elizabeth Moltmann-Wendel attempts to highlight something of that struggle:

> In a variety of situations we can distance ourselves from our bodies, but at some point they get hold of us and will not let go. 'I am my body.' … A dark world shapes us, whereas normally we allow ourselves to be shaped by so many more welcome events. It is not only my body that is sick; I am sick. I am my body. I have no other identity.[9]

Incarnation: the clinician–patient relationship

From the relationship between embodiment and illness come a number of potential incarnational stories. The one example of such a narrative that I want to explore further is that of the clinician–patient relationship, for it is in this relationship that I understand the bearing forth of the story.

In the Incarnation we recognise that God chooses to dwell among humankind as both fully human and fully divine in the person of God. We understand that this act is continual in the living and breathing of all creation and in the resurrection of the body; we understand that incarnation reveals love. The Incarnation is an act of the compassion of God born out of God's desire for humankind, in which God is revealed in the perceived weakest and most frail, turning all assumption of power and authority on its head. In the same way the Incarnation is daily experienced as God's breaking through in the most unlikely and yet powerful places, spaces, peoples and ways.

Imagining illness as a place of incarnational story is one of the ways in which we can understand the body not to have failed but to have experienced the darkness into which light dawns. That imagining is important if we are to enable the telling of the story as liberative praxis. To align illness with the Incarnation is not to make illness into either a victorious event nor a candyfloss-coated, easy-to-navigate journey. In liberation there is always great cost and never an attempt to deny the truth of experiences of suffering, but rather to interpret those experiences for the whole people of God.

One of the incarnational narratives of illness is found in a good clinician–patient relationship. This is not to suggest the oft-quoted medic's God-complex, nor is

it a simplistic and clichéd notion of healing or redemption, that a medic comes like a shining knight in a fairy tale and rescues the situation. There are bad clinician–patient relationships in which patients feel unheard and clinicians feel unvalued. There are unhealthy clinician–patient relationships in which there are attachment issues poorly dealt with or too much professional distance. There are clinician–patient relationships in which physical healing cannot be the aim. In the good clinician–patient relationship the incarnational narrative of illness is represented and based in a dynamic of mutuality. Carter Heyward, the radical theologian, writes about *mutuality* as being in right relations with others beyond the confines of heterosexist normative boundaries; *mutuality* brings about justice while taking into account power.[10] In his recent work exploring mental health and mutuality, Simon Mainwaring summates Heyward's *mutuality* thus: 'This notion of connectedness has profound implications for her doctrine of God such that "God" is "the movement that connects us all"; God is not only in the "relationality" between us, God is our power in mutual relation.'[11] The virtues of the good clinician lie in their ability to be with the patient even at those times when 'cure' is not an option, but care becomes part of the healing (and incarnational) dynamic. The dynamic is reliant, however, upon a mutuality, in the same way that the Incarnation is made possible in the cohabitation or mutuality of divinity and humanity, not as dualistically juxtaposed identities but as integrated into the *Logos*. The patient–clinician relationship is a two-way one in which the predicators of assumed power can shift according to the coherence of mutual relation. Good clinical care echoes a theological nuance of theotokos, a God-bearing in the midst of suffering and incompleteness in which the body is central in that bearing, both in the body of the patient and that of the clinician. The natural focus on embodiment in the setting of illness lends itself to an a posteriori understanding of the centrality of the body in God's love drama. Rita Charon writes:

> When patients try to tell their doctors about their illness, they are attempting to represent something personal, frightening, meaningful, death-related[12] … If the professional listens stereophonically for what the person says and also what the body says, he or she has the rare opportunity not only to hear the body out but also to translate the body's news to the person who lives in it.

The clinician's role as listener and translator of the body echoes very clearly the role of the whole people of God in disseminating and interpreting the

testimony of any person of faith and incorporating it into the whole people of God – or the God story. Such a form of accompaniment between the clinician and the patient will enable the patient *and* the clinician to inhabit fully an embodied state as incarnational. Tara Owens describes what a lack of habitation looks like when she writes that 'alienation from our bodies is a form of alienation from God, one that we … seem to accept as simply normal, the way it is'.[13] This alienation simply cannot occur in a state of illness, for either the patient or for the clinician. However, the clinician clearly has a role in eschewing such alienation. In my early twenties, when working in university chaplaincy, it was the custom of the chaplains to accompany first-year medical students as they encountered their first human dissection through to the end of the year when we held a service of thanksgiving for those who had donated their bodies for this purpose. It always struck me as a profoundly privileged position to be accompanying invariably young medics as they began to shun such alienation and absorb the importance of the human body as the locus of personhood in medical practice and in life more generally. The recognition of the importance of the human body as the 'self' effects change in the clinician as equally as in the patient. Charon describes the shift in emphasis for clinicians as bodies as places of 'self' and therefore of more than mechanics: 'Accepting the power and privilege of touching another's body, interfering with it, hurting it, perhaps healing it incurs in health professionals profound duties to acknowledge the inviolability of the patient's body as a locus of the person's self.'[14] There can be no space for bodily alienation in a clinical setting; bodies matter, and through such a focused and sharpened lens it becomes clear that the body intensely experienced is both experienced as and experiencing of something of an incarnational narrative. It is in the reading of the body and the listening to the body that clinicians are able to enable a mapping forward of a journey for the patient.

> The nature of the body is such that patients cannot ordinarily just *tell* in words what needs to be heard about it. Instead, patients convey through all sorts of ways what a good clinical listener should be able to cohere into corporeal truth.[15]

The story is not told simply through verbal or written articulation but through the cues of the body; it tells a story, and it is in the recognising, the telling, the hearing and the standing with that the incarnational narrative unfolds. Such a narrative cannot unfold in isolation; the ability to shun alienation of the body requires koinonia or community. The transformative narrative is birthed in the

opportunity to be interpreted, reinterpreted, it is born in the trust proffered through vulnerability and the permission to be both weak and strong, the willingness to express and to hear self; the narrative comes alive in shared decision-making about the body and ergo the self. There is privilege, power and responsibility for a patient who experiences a good clinician–patient relationship as equally as for the clinician. The mutuality of a good clinician–patient relationship in which co-interpretation of the body as the ground of identity allows for shared decision-making and shared health care is thus one of the communal places in which the incarnational narrative exists, for such mutuality is the heart of Christian understandings of the divine/human coalescence.

Despite the ease with which the phrase rolls off the tongue of seemingly well-meaning acquaintances, my body has not failed. I am my body. I have not failed. Illness is not a symptom of my body's failure but rather it is story of a God who chooses to break through and dwell among a suffering people, not in a glib or clichéd way but in the dynamic of co-authoring, relationship, mutuality. One of the ways such a breaking through is experienced is in the good patient–clinician relationship, which reveals the inseparability of the body and the self.

Notes

1. Owens 2015
2. Tertullian, *De resurrection carnis* 8.
3. Mann 2012.
4. Hauerwas and Pinches 1996.
5. Moltmann-Wendel 1995.
6. Charon 2006.
7. Mann 2012.
8. Charon 2006.
9. Moltmann-Wendel 1995.
10. Heyward 1982.
11. Mainwaring 2014.
12. Charon 2006.
13. Owens 2015.
14. Charon 2006.
15. Charon 2006.

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