TOWARDS A SOCIOLOGY OF LIVED-BODY EXPERIENCE

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ABSTRACT

Sociology has increasingly turned its attention towards the body. One aim of this paper is to explore this by examining a ubiquitous bodily experience namely, somatisation. This paper sets out to address the theoretical issues surrounding the experience of bodily pain, from a phenomenological perspective, and thus drawing on the work of Straus and Merleau-Ponty and their notion of the lived-body. Somatisation, as a Western medical concept, refers to pain within the body which does not fit into a ready-made pathological category; hence, the medical ideological need to invent somatisation as a separate classification. This has resulted in a whole new medical discourse related to chronic pain. There is a growing interest within medicine to try and understand this concept, partly based on the idea that somatisers are costly to health care services provision.

In this paper, I discuss early developmental psychology and the relationship of preverbal communication to the later development of bodily pain. There is a brief examination of how a group of 'pain sufferers' describe their experience, and how discourses such as 'body-as-machine' are used in this process. Somatisation, as a medical construct, highlights the Cartesian mind-body dichotomy. My main argument is that an understanding of somatisation can instead be employed to demonstrate the social context of 'embodiment'.

INTRODUCTION

The body presents peculiar problems for academic disciplines which attempt to study it. Initially, there appears to be a problem of where the body should be located for investigation. It could be situated within the natural sciences, including medicine, psychology and the social sciences - all can lay claim to body knowledge. The natural sciences would appropriate the body on the grounds that only a rigorous examination of bodily parts will yield the body's secrets. Such reductionism, when applied to the body, may well have value within hard-core medical practice, but certainly misses the area of human experience related to subjectivity, with which the body becomes inextricably involved. We should unequivocally echo the sentiments of Shilling, when he says "[The body] *is far too important a subject for sociologists to leave to the natural sciences*" (1993: 204).

The aim of this paper is to argue this point, though from the perspectives of a social phenomenology, and psychotherapy. This is a large task, so I will focus on the bodily phenomena of pain and, in particular, the concept of somatisation. I hope to demonstrate the links between these concepts and thereby move the subject of the body to a sociology of 'lived-body experience'.

THE BODY IN SOCIOLOGY

Currently, there appears to be much interest within sociology on the subject of the body (Featherstone *et al* 1991; Shilling 1993; Synnott 1993; Yoshida 1993; Bendelow and Williams 1995; Sharma 1996). Shilling (1993) points out how we are becoming body conscious. This, he suggests, is an aspect of high-modernity, in that the body becomes more relevant to understanding our self-identity. This is certainly an aspect of modern culture where the body is viewed as a legitimate consumer target by the marketing industry. Such notions as 'body image' perpetuate the mind-body dichotomy; for example, the idea of body maintenance within our culture enhances the 'machine metaphor' (Featherstone *et al* 1991), yet it is a commonly held belief that, *"like cars and other consumer goods, bodies require servicing, regular care and attention to preserve maximum efficiency"* (Featherstone et al 1991: 182).

Sociology is thus increasingly turning its gaze towards the body. It still, however, treats it as separate, as a discrete entity worthy of separate research and enquiry, thus enhancing the mind-body dualism. Sharma (1996) goes on to suggest that there is also a body-culture dualism often underlying the sociological and anthropological approaches to the problem of body investigation. This leads to a difficult tangle of dualisms: mind-body, mind-culture, and body-culture.

This difficulty is currently highlighted by the fashionable notions of cyberspace. In order to participate in this world, it seems all that is required is a consciousness; the body appears to be becoming redundant, regarded by the robotic engineer, Marvin Minsky, as a 'meat machine' or 'wet life' (Webb 1996). One projection of such technology may be the downloading of consciousness (Webb 1996), presumably into 'dry life'. However, cyberspace seems to be a further extrapolation of dualist philosophy; in this case, the duality is solved by removing the body. The mind is projected to some virtual Cartesian co-ordinate, in the liminal world of an electronic machine-generated medium, thereby abandoning the wet meat corporeal machine to tap out the instructions destined for cyberspace.

An important consequence of addressing the body would, therefore, rest on an attempt at corporeal understanding before we are reduced to a state of desiccated consciousness. The problem of the body in sociology is highlighted by Frank when he observes "*It* [the body] *is not an entity, but the process of its own being*" (Featherstone *et al* 1991: 96). A phenomenological perspective may help in the study of such a process.

THE BODY IN PHENOMENOLOGY

The notion of 'lived-body' arose from the work of Erwin Straus (1966) and Maurice Merleau-Ponty (1962). In 'The Phenomenology of Perception', Merleau-Ponty (1962) provides insights into how the body is our means of belonging to our world. We are able to perceive and sense from birth, and the apparatus we have determines the nature of that perception. Both Straus and Merleau-Ponty were influenced by the work of gestalt psychology, which suggests we perceive in groups, in wholes, rather than as discrete entities (Clarkson 1989; Rock and Palmer 1990). In the paradigm of lived-body, they suggest that *"it is the body which first 'understands' the world, grasping its surroundings and moving to fulfil its goals ... the body is not just a caused mechanism, but an 'intentional entity' always directed toward an object pole, a world"* (Leder 1984: 31). The idea of the lived-body allows for an interaction with our environment, and lends a perspective of dynamism to the body.

The body, therefore, does not merely have things done to it, but takes an active part in engaging with the world; it is a lived-body. An understanding of Merleau-Ponty's phenomenology of perception takes us away from the Cartesian dualism, and suggests that the body is "*the very basis of human subjectivity*" (Crossley 1995: 44-45). If we examine the body from this view, we can see that it is not only symbolic of itself, but becomes symbolic for other meanings. It may be a way of bridging the gap between individual and collective subjectivity, since we all have bodies, and come to know of them in both a self-reflexive manner, as lived-body experience, and also in relation to other bodies and their reaction to us.

Drew Leder (1990) has also contributed to the paradigm of lived-body, through his analysis of how we come to know our bodies by their absence. Until we have our attention drawn to our body, it remains, to all intents and purposes, absent from consciousness. An assumption is made that the body will exist from one lived moment to the next. However, this disappearing act poses a problem which Leder (1990: 69) states: "*Why, if human experience is rooted in the bodily, is the body so often absent from experience?*" He attempts to resolve this by taking the disappearance of the body into the background of consciousness as a significant phenomenon. This, Leder suggests, is related to bodily functioning. Body absence then becomes essential to normal body function, the body's ability to conceal itself "*will help account for our cultural understanding of embodiment*" (Leder 1990: 69). Thus, Leder draws our attention to the visceral body; he highlights the notion that bodily perception is not always conscious. Straus (1966) has argued that, phenomenologically, movement and sensation are intrinsically linked. This is contrary to Cartesian thought, which viewed sensation and movement as fundamentally separate.

This argument has relevance here with the concept of somatisation, and the concomitant restriction of movement that pain exerts. Here, we see that sensation and movement are inextricably linked, and the phenomenology of pain breaks down the notion of movement and sensation being separate. It is clear that these phenomenological perspectives dissolve the argument for mind-body dichotomy. Instead,

the employment of phenomenology, when studying the body, brings to the fore subjectivity. It highlights and values bodily perception at different levels, and relates the 'here and now' perception to lived experience. In so doing, it attempts to reach for a deeper level of subjective understanding.

SOMATISATION

The construct of somatisation, within the medical world, refers to bodily pain which does not appear to have an organic physical aetiology. Such pain represents a challenge to medicine, as it defies classification within a discrete pathological category. Nevertheless, the very naming of a specific category, in this case somatisation, does provide a medical label. However, people to whom this label is attributed are often additionally classified by the medical profession as *"crocks, turkeys, hypochondriacs, the worried well, and the problem patients"* (Lipowski 1988: 1361). There is a belief that the pain is 'all in the mind' (Evans 1993). There appears to be an assumption that somatisation and psychosomatic disorders are linked, and of less importance than 'real' illness, where the patient has a demonstrable pathological label.

Somatisation is a ubiquitous phenomenon in primary health care settings throughout Western culture (Ford 1986; Fisch 1987; Coen and Sarno 1989; Lipowski 1988; Barsky 1992; Craig *et al* 1994). Medicine is beginning to view the phenomenon with increasing interest, as the cost of treatment for people who are somatising is called into question (Shaw and Creed, 1991). Other cultures have observed somatisation; for example, shamanism acknowledges the existence of psychosomatic processes (Achterberg 1985). In ancient Buddhism, it was believed that the conversion of psychological pain into somatic pain was an adaptive achievement (Goldberg and Bridges 1988). In other cultures, there is an attempt to link affect to bodily organs, and thereby transcend the mind-body dichotomy; an example here is how Afghanis refer to a 'squeezing of the heart' to denote sadness or depression (Craig and Boardman 1990). In Chinese medicine, somatic changes and emotions are linked by notions of the angry liver and the melancholy spleen (Ots 1990).

Somatisation, as a distinct category, does try to solve the problem of linking mind and body, but does so only within the confines of reductionistic medical discourse. This problem has been noted by Ots (1990), who rejects the notion of somatisation on the grounds that it is embedded in the mind-body dichotomy. In arguing against the use of the term somatisation, he makes the link with the 'lived-body' paradigm, and suggests that the German word '*lieb*' could be employed. This is a 'pre-dichotomatic term that denotes the 'body-mind entity' (Ots 1990), and is used to describe how mind, body and person are considered to be all part of lived experience.

A phenomenological treatment of somatisation may help as a bridge in the analysis of 'lived-body', with differing cultural experiences of the body. It emphasises mind-body unity, since pain is a bodily experience and, simultaneously, a psychological experience. Pain transcends the mind-body dualism at its moment of conception. Once in pain, we are drawn to a 'here and now' moment; what is past recedes rapidly, and it becomes difficult to remember not being in pain; and the goal of life is to be out of pain. Pain, thus, exerts a "*telic demand*" (Leder 1990: 79).

THE BODY IN PSYCHOTHERAPY

There is a need to justify the inclusion of psychotherapy into this discussion of the body. Psychotherapy, which focuses on individuals, and acknowledges societal influences as external, is at odds with the sociological perspective, which tends to look away from the individual. There is, thus, a dualistic problem of how individual subjectivity can be located within a sociological framework, and, conversely, how sociological influences are contained within psychotherapy. As Tolman (1994: 18) suggests, "*the end result is that the human subject is either totally subjectified or totally objectified, becoming abstracted and isolated in either case*". Psychotherapy does, though, offer some important insights into how we may come to experience our bodies.

The particular theories here relate to developmental processes. Since we have all been small, and subject to either benign or malign influences, the common factor involved has been our body, and how it was perceived by other larger bodies, and by ourselves in the early developmental stages of life. Much theorising focuses on how young children respond to such external influences. One particular aspect of interest here is the notion of preverbal communication; that is, the mode of communication employed prior to the cognitive processes of verbalisation (Shaw 1996a). This preverbal communication is predominantly body-orientated, and therefore becomes a means of being able to understand the world via our bodies. It is primarily transmitted via the body, be it as screams, posture, movement, or the contraction of muscle. We feel the world via our body, and then begin to understand and adjust to the environment. There is, thus, a link with the phenomenology of perception and preverbal communication, since it is the body which is first able to perceive the world, and, initially, the communication with that world is preverbal. Various branches of psychotherapy, though by no means all, acknowledge the importance of preverbal communication; those that do include Reichian vegetotherapy, and gestalt.

It is these therapies which advocate the use of touch within therapy. This is a major issue within psychotherapy, and the prevailing ideology is to avoid physical contact. Touch is considered to evoke sexual feelings, and questions arise as to whether the touch involved is the need of the therapist or that of the client. As a consequence, there is a fear of physical contact within the therapy world. However, the controversial debate on touch, and its appropriate place in therapy, also demonstrates that the body is an important part of that world. The touch taboo (Shaw 1996b) is, thus, a means of excluding the body, but, at the same time, an implicit acknowledgement of its existence. Other notions abound, in the therapy world, around those therapists who do not touch, and who regard those who do with disparagement, frequently referring to their model of work as 'touchy-touchy, feely-feely'. Therefore, there would appear to be, along with a touch taboo, a fear of bodies. Psychotherapy, then, acknowledges body processes, but tends to stand back from a deeper understanding, almost in fear of the repercussions that such work engenders.

The significance of addressing psychotherapy here is in the somatic processes which may be being expressed as preverbal communication. It is well known and observed that psychotherapy clients frequently exhibit somatic symptoms (Reich 1983, 1990; Randell 1989, 1992b; Frankl 1990, 1994; Shaw 1994, 1996a, 1996b). However, within psychotherapy, it is the verbalisation of feelings which is paramount. If these bodily phenomena are related to developmental preverbal material, the process towards verbalisation could be very difficult.

An understanding of preverbal communication, with its links to the lived-body paradigm, could, therefore, provide a fruitful area of study for social phenomenology.

METHODOLOGY

The data for this study was collected from eight osteopathic patients. Four osteopaths asked two of their patients to answer three questions, the replies to which were noted by the osteopaths. The questions asked were: [1] How would you describe your pain? [2] How does this pain affect your life? [3] What do you think is the cause of your pain?

Opportunity sampling was used to select patients for questioning. The important factor was that they all attended a consultation with an osteopath at an osteopathy surgery. The sample comprised five women and three men. Their ages ranged from 30 to 70 years, and the type of pain for which they sought osteopathic treatment was low back pain (n=3), neck pain (n=2), headache (n=1), leg pain (n=1) and shoulder pain (n=1). These presentations are typical of osteopathic patients (Thomas *et al* 1991; Pringle and Tyreman 1993).

The questions were deliberately designed to be open-ended. The use of the word 'your' in each question was also deliberate, in an attempt to draw out whether or not the pain was seen as belonging to the patient.

Although only a small sample was used for this study, which could be seen as a drawback if viewed from a hard-nosed scientific perspective, the questions elicited meanings and values of a personal nature which were so subjective that they did not require a large sample (Radley 1989; Yin 1989; Iphofen 1990; Stoeker 1991; Abramson 1992; Yoshida 1993). Furthermore, I make no attempt here to use the responses to represent society's range of perceptions or divisions. The important consideration with this study was to give full attention to the meanings and values of those questioned. Small sample sizes, in this context, can be justified, since they yield rich and insightful data (Radley 1989; Gilfoyle *et al* 1993), which can be useful for relating to broader patterns of meaning within society. Research of this nature thus places importance and value on meaning and subjectivity.

THE EXPERIENCE OF PAIN IN A GROUP OF OSTEOPATHIC PATIENTS

The questioning was conducted within the confines of an osteopathic treatment session. Under such circumstances, there is invariably the patient-practitioner relationship to consider, with its implicit power dynamics (Foucault 1972, 1973; Gilfoyle *et al* 1993). The typical osteopathic set-up mirrors that of a doctor/patient consultation. It is important to recognise this when considering the discourses which might

arise from those questioned for this study, for they were, in a sense, expecting a quasi-medical consultation. This may, in part, account for the prevalence of 'medically' orientated replies. This is not unreasonable, as pain in our society is, after all, perceived as a medical issue. The respondents, however, sought help from outside a traditional medical framework, so one might have expected there to be some disquiet on the part of the respondents about orthodox medicine, or, at least, a certain outward ambivalence. From the results, it seems that the respondents still craved a 'magic bullet' - in this case, the osteopathic manipulation, or the 'quick fix'.

Osteopathy, as a distinct discipline, has its own jargon-laden discourse. This paper is not the place to describe or analyse the specifics of this discourse. It is sufficient to say that it does exist, and that the people in this study were, on the whole, unaware of its existence. Essentially, they sought the services of an osteopath to relieve their pain. In doing so, they were not deserting the traditional discourse on pain - i.e., where pain of a physical nature must be removed physically. Rather, these people simply chose a different type of practitioner, and carried with them into the consultation the dualistic paradigm of mind-body disunity (i.e. the view that their problem was associated with a bodily dysfunction which required a physical remedy).

This is clearly highlighted in the clients' responses to question 3 ('what do you think is the cause of your pain?'). Mr A, for example, was aware that his pain arose from a poor sitting posture, and Mrs E attributed her pain partly to 'wear and tear' and 'past damage'. Mr H had three slipped discs, according to one osteopath. The 'body as machine' metaphor is striking here. The emphasis on something 'not being quite right', or 'being out of place', implies that something can be put right using simple intervention. The clients thus believe that the osteopath's magic touch is what will put the problem right and remedy the situation.

In every case in the study, the word 'it' was articulated to describe the person's pain. The point, here, is that a client's use of the impersonal neutral pronoun, 'it', contrasted somewhat with the language of the question, which emphasised the absolute possessive pronoun, 'your'. The replies therefore seemed to place the pain somehow apart from the person, suggesting a sort of disowning of pain. The pain existed for the client, manifesting as an unpleasant sensation, and registering in the consciousness; within the consultation, this was verified and treated through the skilful touch of the osteopath, trained to identify and feel these painful tissues. However, through the intervention of the osteopath and the beliefs of the clients, the experience of pain and its 'treatment', while highly individualised and subjective, was relegated to a neutral, non-personal level. This, in a sense, demonstrates the entrenched mind-body dichotomy, where pain is perceived as 'separate', a disembodied sensation, having a reality as if seen outside the person. This poses a problem, for how can a sensation, so intensely personal as pain, be simultaneously separate? In Mrs E's reply to question 1 ('how would you describe your pain?'), perhaps we see this idea eloquently summarised as, "I feel I'm in a battle, trying to win it", and also, "*... but it's better to let the body do it - it's a tiring battle*". Her fight against pain was taking place within her body, yet she was able to view her body as a separate entity, as a battle-ground for pain.

Other ways in which pain conveys meaning is through the way the clients perceived that it affected their everyday living. The responses yielded two prominent themes. The first was that of decreased enjoyment, and the second was impaired movement. There is a case for linking these two themes, for movement can be considered to be both enjoyable and it enables people to pursue their lives to the full. Mr A, Mrs C and Mr D each recognised that their movement was somewhat impaired. Furthermore, Mr H said, "*I didn't like to make arrangements to go out*"; here, his pain prevented him from enjoying normal everyday activities made possible through going out. Pain was thus perceived as having an 'enforcement' function, and thereby to blame for its role in confining him. Some of the interviewees were very candid about how their pain limited their enjoyment of life. Mrs B, for instance, said, "*... it doesn't stop me doing anything, it takes the pleasure out of them*", and Mrs E said, "*It ruins my happy mood and restricts my pleasures, e.g., walking ... everything is pain*". This restriction of movement, resulting from pain, denies access to pleasure. Within the context of an osteopathic treatment session, this could be very important, because treatment involves movement, and this movement could be seen as reintroducing pleasure to areas of intense rigidity. It is these rigidified areas that are often painful (Reich 1983, 1990; Frankl 1990; Randell 1992a). Under the control of a therapeutic liaison, these clients were perhaps allowing themselves to move and to be moved. The body might then be viewed as a symbol of this change. Touch used by the osteopath was meaningful to the clients, partly in enabling the client to take possession of his or her pain. The pain became unified with the patient through simple, but important, preverbal recognition, where there was a merging of body and mind and a disappearance of former boundaries.

In such situations, a deep unspoken level of meaning can occur, and, set within the comfort of a therapeutic relationship, the pain is allowed to exist. For a moment, the battle is allowed to ease and an 'osteopathic armistice' occurs. In this context, movement is also related to sensation. Enjoyment is lessened because of movement restrictions; the 'lived-body', at this time, is pain. The telic demand may have encouraged these people to seek help. The pain, in these contexts, cuts across 'normal' lived experience and drives the patient to seek relief. As Leder (1990) suggests, pain imposes a constriction on our being in the world.

It may, therefore, be that these aches and pains are more profound metaphors for underlying dissatisfaction. Indeed, in the case of Mr H, he described how the pain affected his life detrimentally, and also caused him to frequently lose his temper: "*I'm not the sort of person to lose my temper ...* [but it] *affected the relationship with the children. I lost my temper*". This was echoed by Mrs F, who could see how pain affected her cousin's temper, noting, "*I think one gets bad tempered*". The emotions associated with pain were undoubtedly profound and significantly affected the clients' lives and relationships.

Throughout the interviews, there were oblique references to the stresses and strains of life. Mrs C, for instance, said, "*... everyday worries, all help to a certain thing*", while Mrs E, rather less obliquely, said, "*You cannot go out and punch your neighbour on the nose, so you scrunch up your muscles and then you feel pain*". This was probably the most direct response to question 2 ('how does this pain affect your life?'), illustrating how clients' emotions, such as becoming upset, could precipitate physical pain. Mrs G, in response to question 3 ('what do you think is the cause of your pain?'), attributed her pain to her raised emotions: "*I could feel my jaw tighten and clench my teeth*"; the muscular component of pain and emotion is clear here. Also, this reference to mouth and teeth is made by Frankl (1990), where he described the oral aggressive phase of life, where the mouth becomes highly libidinised. Mrs G went on to say, "*It's life, I can't relax, I keep doing things ... Well, it's tension, isn't it - you know that!*". The implication here was that, for Mrs G, stress caused tension, and tension would exacerbate or precipitate her pain. Such pain is clearly difficult to put into words. As these clients were drawn to a body therapist, perhaps the action of approaching the therapist signalled their preverbal intention to speak about the meaning of their pain, by firstly attending to its physical manifestation. The clients expected to be touched, which in itself had a powerful physical impact, but required successive psychotherapeutic intervention.

Several references were made to sleep disturbance by the clients. Mr D, for example, said, "[the pain] *can wake me at night*", and "[it] *distracts me from work and sleep*". Mrs G, similarly, referred to "*pain at night*", and said, "*loss of sleep irritates me*". Also, Mr H said, "*The days are shorter, as I sleep, as it doesn't hurt*". Mr D and Mrs G both reported that the pain kept them awake at night, which was clearly annoying and posed limitations on their daily routines, such as interfering with their work during waking hours. Mr H viewed sleep differently, though, perceiving it as a refuge, a place to escape to from his constant pain. However, this had the effect of making his days shorter, thereby limiting his experience of normal everyday life. Perhaps this represents for him an escape from life, a life he sees as painful and disquietening.

The enjoyment of sleep is described by McDougall (1989) as a psychosomatic experience *par excellence*. This enjoyment was denied among some of the people interviewed; the pain permeated their lives so completely that sleep, a process of mental and physical unity, was disturbed. This is perhaps not surprising, if one views pain from a psychological perspective. However, these people were seeking a physical, rather than a psychological, therapy. It is important, therefore, to acknowledge that the meaning behind this sleep disturbance was of a profoundly psychological nature. It is quite common, within the psychotherapies, to enquire into how clients are sleeping, in order to glean psychological information. It is not common, though, within an osteopathic setting, to enquire about clients' sleep patterns. Yet these people raised the issue of sleep disturbance unprompted. In effect, they offered information about their psychological state; they also verbalised an aspect of this state. So there is meaning behind these sleep disturbances, which may signal underlying unconscious conflicts, which may in turn have a bearing on the clients' pain.

The potential links between social phenomenology and psychotherapy centre around the developmental issues that pain may symbolise, and the effects these have on the lived-body. For this group of 'pain sufferers', it is clear that their lives were deeply affected by their pain; phenomenologically, we can see how their daily existence was affected.

We are also able to see how they sought the touch of a therapist, which may represent a form of preverbal communication. The body is, therefore, powerfully implicated within both approaches.

These case studies provide a glimpse of a small group of people's perceptions of bodily pain. Although the sample cannot claim to be fully representative of all clients who use the services of an osteopath, it provides some evidence to suggest that people in pain view their pain as impersonal, yet, at the same time, they recognise the deeply personal influences pain has on their lives. They seem to demonstrate an adherence to a mind-body dualism in their behaviours and their accounts. This is explained in the way they present themselves to an osteopath in order to seek the exogenous 'quick fix', reflecting the societal belief that physical pain must only be remedied through physical intervention.

CONCLUSION

I have attempted to draw together social phenomenological and psychotherapeutic themes to make sense of a particular experience - namely, pain. The psychotherapeutic constructs of preverbal communication and developmental theory have been employed to link emotional pain to physical pain. This linkage has enabled a discussion around the phenomenological paradigm of the lived-body. Thus, this paper has attempted to draw on multiple discourses to describe, and then contextualise, the concept of somatisation. In doing so, emphasis has been placed on the subjective nature of pain. One of the strengths of phenomenological enquiry, is that it enables subjective phenomena to be contextualised. My attempt, here, has been to try to ground the phenomenon of pain within the sociological and psychotherapy worlds, via the body. It may well be that the body *per se* is phenomenologically irreducible but I hope to have demonstrated that phenomena, such as pain, cut across lived experience and exert a 'telic demand' (Leder 1990: 79); by centring perception to the lived moment, individuals may be able to escape that lived moment.

Sociological constructs of the body need to pay greater attention to the phenomenological perspective, in order to gain a deeper understanding of body knowledge. Pain is an example of a phenomenon which can be used to further this project. The bodily experience of pain also highlights how mind and body are unified, and allows us to perceive further how we might deconstruct this mind-body dualism. The subjective and symbolic nature of the soma is well-documented throughout human history and art (Frankl 1989; Stafford 1991; Synnott 1993). It is the deep meanings and metaphors, which may be uncovered from phenomenological investigation, that, I suggest, make a powerful argument for a movement towards a sociology of lived-body experience.

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