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Chapter 1

Toward a Phenomenology of Abnormality

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Introduction

The contrast between health and illness is often equated with the contrast between normal and abnormal, where health is seen as the normal state and illness as the abnormal one. In contemporary health care, what belongs to the domain of the normal is determined based on scientific insights, consensus within professional groups, and social and political norms. Against the background of current health policy that emphasizes a commitment to early and preventive treatment, it makes sense that the American Heart Association in November 2017 changed the standard for high blood pressure from 140/90 mmHg to 130/80 mmHg. The consequence of this adjustment is that 46 percent of the American population now suffers from hypertension.¹ This example shows how changeable standards or norms are, while at the same time making it clear that abnormality—not meeting the standard—is not necessarily equivalent to illness. Most people whose blood pressure is just above the new standard do not suffer from anything at all. Doctors may want to treat them, but if we label all these people as “ill,” we end up with very few healthy people.

For most people, being ill or sick means suffering from something, experiencing pain or discomfort. If we limit ourselves here to somatic



1 complaints, we could say that illness, as demonstrated by the blood pres-
2 sure example, usually goes hand in hand with a certain form of bodily
3 abnormality; however, bodily abnormality does not always go hand in
4 hand with illness. In the same vein, having a genetic abnormality does not
5 necessarily mean that you are currently ill, or will ever become ill. Other
6 cases in which abnormality and illness do not always coincide include a
7 range of physical limitations as well as visible physical abnormalities. If,
8 after a diagnosis and successful treatment of cancer, you continue to live
9 with one breast or without a nose, you are not sick, but you are abnormal.
10 In addition, people with impairments can be said to deviate from the
11 norm of normal functioning, but, very often, this is not seen as a disease
12 but rather as a disability.² Perhaps even more importantly, a person with
13 an impairment is often directly identified by others as abnormal. If you
14 have only one leg, you are not sick, but you are abnormal.

15 In my previous research project *Bodily Integrity in Blemished Bodies*,
16 I studied physical changes that occur as a result of cancer and cancer
17 treatment and how people handled these changes.³ Central to this
18 research was the question of how people experience their visibly changed
19 bodies. In order to understand these experiences, it was critical to see
20 the individuals in their social context. These people did not only have to
21 deal with a changed body but also with the fact that others might see
22 them as abnormal because they are, for example, missing a breast, have
23 a visible scar, or use a facial prosthesis. It will come as no surprise that
24 the phenomenology of the body was at the heart of this research, for
25 indeed, a phenomenological approach greatly facilitates the interpretation
26 of embodied self-experiences. However, during this research project it
27 also became clear that conventional phenomenology has its limitations.

28 Phenomenology is well suited for interpreting the phenomenon
29 of illness, of being ill from a first-person perspective. Yet it provides far
30 fewer tools for analyzing the phenomenon of bodily abnormality. Indeed,
31 a sociological and/or social constructivist approach might seem more
32 suitable for understanding abnormality. Yet, as I have suggested elsewhere,
33 phenomenology can account for third-person perspectives on the body if
34 it is developed in the direction of a sociophenomenology.⁴ In this chapter
35 I will elaborate on this suggestion and show how phenomenology can
36 account for both illness and abnormality.

37 For my analysis, I will first return to the most important source
38 text for contemporary phenomenology of health and illness: Maurice
39 Merleau-Ponty's *Phenomenology of Perception*. In the first part of this
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chapter I will explain why, according to Merleau-Ponty, illness cannot be equated with abnormality. The distinction between illness and abnormality, I will explain, stems from the phenomenological methodological consideration of putting scientific knowledge and prejudices in parentheses. Merleau-Ponty was also profoundly inspired by the work of the German neurologist and psychiatrist Kurt Goldstein, who in *The Organism* writes, “It may be stated as certain that any disease is an abnormality, but not that every abnormality is a disease. No matter how we may define normality, there are certainly many digressions from the norm that do not mean being sick.”⁵ Merleau-Ponty’s contemporary Georges Canguilhem also bases his main work, *The Normal and the Pathological*, on the work of Goldstein. Since Canguilhem discusses the distinction between the normal and the pathological much more explicitly than Merleau-Ponty, I will discuss their work in parallel.

From my analysis of these three authors, it will emerge that the use of statistics plays an important role in the distinction between illness and abnormality. According to phenomenology, statistics as a form of scientific knowledge must be bracketed. However, while following Merleau-Ponty’s remark that the most important lesson to be learned from the phenomenological reduction is the impossibility of a total reduction,⁶ I will, in the second part of this chapter, show that statistics should not be banned from our understanding of the lifeworld nor simply put in parentheses. I begin by reviewing Ian Hacking’s analysis of how the rise of the concept of “normal” occurred at the same time as the rise of statistics in the nineteenth century.⁷ Even though statistics is inherently descriptive in nature, Hacking asserts that it soon acquires a normative, prescriptive function. Our world is largely made up of “averages” that are considered to be normal *and* normative. Physical deviations from an average not only imply a statistical observation but also give rise to a judgment of some kind of failure. Thus, I will argue, physical deviation directly affects embodied subjectivity and agency.

Illness in the *Phenomenology of Perception*

In his philosophical analyses of the body, embodiment, and perception, Merleau-Ponty (1908–1961) makes extensive use of pathological cases. Let us first have a look at why he uses cases of illness within his philosophical analyses of embodiment. Since he contrasts the sick person

1 (*le malade*) with the person who is normal (*le normal*), it seems that
 2 he uses illness to explain what is normal, that he understands normal
 3 embodiment or perception on the basis of pathological cases. Yet, this is
 4 too hasty a conclusion; his use of pathological cases needs to be placed
 5 in the context of his phenomenological approach. As Merleau-Ponty
 6 clearly describes in the preface to the *Phenomenology of Perception*, the
 7 phenomenological reduction and the eidetic reduction (or variation) are
 8 crucial methodological steps for phenomenology. The use of pathological
 9 cases fits within the design of the eidetic reduction; these cases serve as
 10 the variations necessary for finding the eidetic or the invariant of the
 11 embodied existence. In Edmund Husserl's view of the eidetic variation,
 12 intellectual imagination plays the most important role. In order to be
 13 able to determine the eidetic nature of something, we need to think
 14 up or imagine all possible forms of a particular phenomenon and then
 15 examine what cannot be omitted without the phenomenon ceasing to be
 16 the phenomenon in question.

17 For Merleau-Ponty, however, the eidetic variation is not just an intel-
 18 lectual exercise in which everything possible is first thought or fantasized
 19 to see what cannot be omitted. He uses factual variation and factual cases
 20 in order to arrive at something like the eidetic or the essential. In the
 21 preface, Merleau-Ponty describes this seemingly contradictory idea of a
 22 philosophy that focuses on the essential or essences while connecting to
 23 the factual as follows: "Phenomenology is the study of essences . . . [and
 24 yet it] is also a philosophy that places essences back within existence
 25 and thinks that the only way to understand man and the world is by
 26 beginning from their 'facticity.'"⁸

27 According to Merleau-Ponty, the normal cannot be derived from
 28 the pathological because illness is not the same as the loss of normal
 29 functions. Pathology and normality are different modalities of the same
 30 underlying phenomenon.⁹ What the underlying phenomenon is becomes
 31 clear when we focus on the case of Schneider, first described by Gelb
 32 and Goldstein in 1920. This case plays a crucial role in Merleau-Ponty's
 33 conception of embodiment, and he describes it vividly in "The Spatiality
 34 of One's Own Body and Motricity" in the *Phenomenology of Perception*.
 35 Johann Schneider was a World War I veteran who suffered brain damage
 36 as a result of shrapnel. Due to this brain damage, his way of perceiving,
 37 orienting, and moving was considerably affected. Psychiatrists at the time
 38 classified his case as one of "psychic blindness."¹⁰ Schneider was not blind,
 39 but with his eyes closed he was unable to perform so-called "abstract
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movements,” movements that are artificially elicited. For example, when requested by his doctor, Schneider was not able to touch his nose (with his eyes closed) or to bend or stretch his limbs on command. However, if his nose was itchy, he could immediately touch his nose (with his eyes closed), and he could also find the handkerchief in his pocket to blow his nose. These kinds of movements are called “concrete movements;” though they are mechanically and physiologically the same as the abstract movements, they differ from abstract movements because they do not exceed a person’s actual situation.

The fact that Schneider could not point to his nose on command should not be explained in terms of a defect in the sensory-motor system, as if something were wrong with a sense organ or a muscle. Pointing (*Zeigen*, abstract movement) and grasping (*Greifen*, concrete movement), although they have the same underlying anatomy and physiology, are two different intentional actions. The difference between the two forms of movement shows a variation in how we can relate to the world. Whereas concrete movement is primarily a way of dealing with our actual situation, abstract movement is about transcending that situation. The difference between the two forms of movement also shows a variation in the extent to which motor actions take place in a reflective or prereflective manner. Concrete movements generally take place without reflection or thought, whereas abstract movements require one’s awareness of what one is doing. If you are asked to point to your nose on command, this is a movement that you think about for a moment; yet when your nose itches, you scratch it without reflection. It should be noted, however, that a concrete movement is not the same as a reflexive movement, such as moving one’s lower leg when the knee is tapped with a reflex hammer. Whereas a reflex cannot be controlled, concrete movements can be controlled. You can become aware of concrete movements and reflect on them. Normally, though, this is not necessary, and the movement takes place in the flow of the situation.

Considering these two different forms of movement as possible variations of the phenomenon of embodied existence, we find motor intentionality as the invariant underlying both. According to Merleau-Ponty, motor intentionality is founded in what he calls the “intentional arc.”¹¹ Our entire conscious life is underpinned by this arc, which contains a projection of our past, present, and future as well as of our social environment and our physical, moral, and ideological situation. This intentional arc allows us to situate ourselves somewhere and in a certain way(s). Yet in Schneider’s case, Merleau-Ponty argues, his intentional arc is weakened

1 (*se détend*) and its span into the future is diminished.¹² The metaphor of
 2 tensile strength and span refers to the possibilities, or the existential “I
 3 can” that people have. Our consciousness, says Merleau-Ponty, is not first
 4 of all an “I think,” as Descartes and Kant said, but an “I can” (*je peux*).¹³
 5 The consequence of Schneider’s injury, therefore, is not just a matter of
 6 his being unable to perform tasks because of his defects. It is also matter
 7 of what possibilities he experiences the world as offering him. Both the
 8 environment and the situation in which a person finds themselves and
 9 the physical functioning of that person determine together, as if in a
 10 dialogue, what that person’s possibilities are. For Merleau-Ponty, having
 11 fewer possibilities, having a flaccid arc, is what is most characteristic of
 12 what we call illness. Schneider, the sick person, has fewer possibilities.
 13 The way he deals with his world and environment is characterized by
 14 a high degree of awkwardness. Illness, so we can say, affects his entire
 15 being, his existence.

16 In *Phenomenology of Perception*, Merleau-Ponty does not elaborate
 17 on how the dividing line between normality and illness is drawn. By
 18 taking a pathological case from clinical literature, he appears to assume
 19 unreservedly that medical literature defines where the line between the
 20 healthy and the pathological should be drawn. In addition, because he
 21 does not give a description of what is normal, he could be accused of
 22 a rather naive idea of normality: that normality is that which is not
 23 described in the clinical literature and is something that is given natu-
 24 rally. However, this is not the case. Merleau-Ponty describes illness as
 25 affecting a person’s intentional arc. This description implies a dynamic
 26 understanding of both normality and pathology. In Merleau-Ponty’s own
 27 work, this dynamic concept is not really made explicit—illness and nor-
 28 mality are by no means the main themes in his work. In order to make
 29 it clear how we can interpret illness and normality as dynamic and as
 30 nonnaturalistic, I will now briefly discuss a number of elements from the
 31 work of Goldstein and Canguilhem.

32 33 34 The Normal and the Pathological According to 35 Goldstein and Canguilhem 36

37 Kurt Goldstein (1878–1965) was an important inspiration for Merleau-
 38 Ponty’s analyses of embodiment. From 1916 onward, he worked as a
 39 neurologist and psychiatrist in Frankfurt, where he saw many World War
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I veterans with brain damage, including Johann Schneider. According to Goldstein, health represents the most adequate way in which the organism deals with its environment. Health, therefore, consists mainly of “preferred behavior” or “orderly behavior.”¹⁴ By this, he means that the way the human organism acts is based on all kinds of habits (and skills) that have been acquired through time, tradition, and education. From this, it immediately becomes clear that health or healthy action is not something universal but is instead always bound to a certain time and place in which preferences have been developed. Normality or health is therefore not based on a predetermined scientific or moral norm but is formed within a process of habituation. In other words, according to Goldstein, there is no such thing as a supra-individual norm that prescribes what normal or healthy physicality is. The norm that determines whether an individual is healthy or ill is formed by the individual organism while it relates and responds to its environment.

It is precisely this idea of health and normality that Canguilhem (1904–1995) further develops in his main work, *The Normal and the Pathological*. According to Canguilhem, the most important characteristic of health is a flexibility of standards or norms.¹⁵ The healthy person or the normal person does not so much meet a predetermined standard of health; rather, the person’s health consists of having the possibility to set new norms or standards over and over again. Therefore, he says that being healthy means “being normative,” that is, being able to change and set norms. Whereas Goldstein states that normal physical action is based on a norm-producing process of habituation and adaptation, on an interaction between the organism and the environment, Canguilhem emphasizes that this is an open and infinite process in someone who is healthy.

According to Goldstein, illness or disease manifests itself in disturbed, disorderly behavior that goes hand in hand with a loss of skills (both cognitive and motor). His ideas about health and illness were crucially developed through the examination and treatment of many World War I veterans. These young soldiers suffered from all kinds of devastating health problems, including wound shock and shell shock. These symptoms typically could not be explained by the degree of the soldiers’ physical injuries.¹⁶ Goldstein, therefore, considered illness or disease not simply as a matter of organ or tissue failure but as a total body (or total organism) response. What he observed in injured veterans was that the loss of skills could trigger intense experiences of fear and uncertainty. He called this experience the “catastrophic reaction.”¹⁷ Merleau-Ponty and Canguilhem

1 both take up Goldstein's idea of illness.¹⁸ Illness manifests itself in a
 2 person's having fewer possibilities. Merleau-Ponty describes this in terms
 3 of a flaccid intentional arc or a reduced "I can." Canguilhem describes
 4 the pathological as an inferior norm of life (*norme de vie*). It is a norm
 5 but an inferior one "in the sense that it tolerates no deviation from the
 6 conditions in which it is valid, incapable as it is of changing itself into
 7 another norm."¹⁹ According to Canguilhem, being ill is not the same as
 8 being non-normal or abnormal. The sick person is not ill because they
 9 deviate from a given norm; the sick person is ill because they "can admit
 10 of only one norm."²⁰ As he states, the sick person "is not abnormal
 11 because of the absence of a norm but because of [their] incapacity to be
 12 normative."²¹ This means that they are not able to create other norms
 13 in other situations. A sick person is thus "normalized in well-defined
 14 conditions of existence and has lost their normative capacity, the capacity
 15 to establish other norms in other conditions."²²

16 Health or normality, therefore, means that the organism is capable
 17 of more than just adapting to the environment. When an organism can
 18 only adapt to its environment, it only follows that specific situation and
 19 is not able to exceed the norm of the situation. It then remains bound
 20 to that specific environment and is not normative. Just being able to
 21 adapt indicates pathology.²³ We also saw this in the case of Schneider.
 22 Because he is capable of making concrete movements, Schneider is per-
 23 fectly capable of coping with the given situation, but he is not able to
 24 play with or transcend the situation.

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27 The Silence of Health

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29 Goldstein, Canguilhem, and Merleau-Ponty all emphasize in their analysis
 30 of pathological cases the subjective illness experience, that is, the experience
 31 of illness from a first-person perspective. Referring to the then well-known
 32 statement of the French surgeon René Lérique (1879–1955) that "health
 33 is life lived in the silence of the organs," Canguilhem states that illness
 34 is always related to the *experience* of the sick person.²⁴ A person who
 35 only feels the silence of their organs is not sick in Canguilhem's opinion.
 36 This seems to be an easily refuted claim since diseases do not always go
 37 together with an experience of being ill: for example, early-stage cancer
 38 can still be categorized as being within the "silence of the organs." In such

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cases, people often do not feel anything is “wrong” or “abnormal” in their 1
 bodies. To diagnose a physical abnormality, physicians cannot trust patients’ 2
 experiences but must rely on all kinds of medical diagnostic equipment. 3
 Canguilhem would reject this objection while claiming that contemporary 4
 medical knowledge and equipment that allows us to diagnose a disease 5
 without it having been “heard” by the patient can ultimately be traced 6
 back to patients’ experiences. Medical knowledge, however disconnected 7
 it may now seem from patients’ experiences, has been able to develop 8
 only on the basis of a rich history of patients who have shared their 9
 experiences with doctors. In other words, a device that measures blood 10
 sugar levels, even at a level where people have no symptoms, has been 11
 developed only because people with actual symptoms of low blood sugar 12
 went to their doctor. That is why Canguilhem writes: “*there is nothing in* 13
science that has not first appeared in the consciousness.”²⁵ 14

It is interesting to note that Canguilhem uses the terms “pathology” 15
 and “pathological” when he talks about the experiences of sick people. 16
 In contemporary parlance, pathology refers to “disease,” and “disease,” 17
 according to medical sociology, involves the biomedical perspective on an 18
 ailment, and should be distinguished from “illness” (the person’s experi- 19
 ence of that ailment) and “sickness” (the social meaning of being sick).²⁶ 20
 Canguilhem, by contrast, suggests that pathology is not necessarily the 21
 same as some localizable defect in the body (disease) but rather has its 22
 origin in the experience of illness. Only when doctors have developed all 23
 kinds of diagnostic tests to determine a possible somatic cause of those 24
 complaints does it become a disease. At the beginning of this chapter, I 25
 referred to high blood pressure and mentioned that even if people have 26
 an abnormal blood pressure value, they do not necessarily feel sick, and 27
 probably do not say they are sick. Symptomless high blood pressure is 28
 indeed not an illness, but it might be considered a disease or a precursor 29
 of disease since something is measured as being wrong or abnormal. 30

While Merleau-Ponty, Goldstein, and Canguilhem all emphasize 31
 the patient’s first-person perspective, they criticize the prominence of the 32
 “disease-model” in contemporary medicine. This model, first developed in 33
 the eighteenth century and also described, for example, by Canguilhem’s 34
 student, Michel Foucault, in his *Birth of the Clinic*, meant that doctors place 35
 increasing emphasis on research into underlying defects and abnormalities 36
 in anatomy and physiology for understanding, diagnosing, and treating 37
 patients’ complaints. At the beginning of the nineteenth century, Bichat 38

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1 wrote that corpses had to be opened up in order to understand diseases
 2 better, thus creating a happy marriage between anatomy and pathology:
 3 anatomy becomes pathological while pathology is “anatomized.”²⁷

4 Before the eighteenth century, medicine focused more on the com-
 5 plaints and symptoms that patients reported to a doctor. In the modern
 6 era of medicine, the anatomical body became the focus. A disease, a
 7 pathology, is what you can locate somewhere in the body. Hence, as Drew
 8 Leder argues, the body that is central in modern medicine is actually
 9 the dead body, the corpse of pathological anatomy.²⁸ This emphasis on
 10 pathological disease, which in our time is increasingly reinforced by all
 11 kinds of diagnostic (imaging) technologies that make it possible to locate
 12 inconsistencies in the body without cutting it open, means that in clinical
 13 practice the patient’s story disappears into the background. Goldstein,
 14 Merleau-Ponty, and Canguilhem, by contrast, want to centralize the
 15 patient’s experience of illness.

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Quantification of Pathology

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20 In addition to the emergence of the so-called disease model in medi-
 21 cine, Canguilhem describes how in the nineteenth century a shift also
 22 occurred from a qualitative to a quantitative concept of disease. In his
 23 historical analysis, Canguilhem shows how the definition of health as
 24 “normal,” introduced by the physician-physiologist François-Joseph-Victor
 25 Broussais (1772–1838), has led to the idea that the difference between
 26 disease and health is a quantitative difference.²⁹ According to Broussais,
 27 every organ has a “normal state.” A deviation from this normal state
 28 implies illness, and this deviation occurs when an organ is, for exam-
 29 ple, too much or little stimulated by irritation or inflammation. In his
 30 time, Broussais was not taken that seriously and was even caricatured
 31 in Honoré de Balzac’s work. Balzac ridiculed Broussais because, at the
 32 beginning of the nineteenth century, Broussais was still a fervent advo-
 33 cate of bloodletting. Balzac wrote that just as much blood had been
 34 shed under Broussais’ hands as during the Napoleonic battles.³⁰ Hacking
 35 states that it is because of Balzac’s parodies of Broussais that the term
 36 “normal” appears in the French language.³¹ And Canguilhem claims
 37 that it is mainly due to August Comte (1798–1857) that the idea of
 38 health as a “normal state” eventually became a widespread idea. Based
 39 on the “eminent philosophical principle” of Broussais, Comte argues
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that the pathological and the normal state do not differ substantially, 1
 or qualitatively, from each other. The pathological state is nothing more 2
 than too much or too little compared to the normal state.³² This idea 3
 of disease is by no means foreign to us. Just think of the examples of 4
 normal and abnormal blood sugar levels or blood pressure. More sugar in 5
 the blood indicates a problem with an organ, and thus, a disease. With 6
 hypertension, or high blood pressure, the pressure of the blood on the 7
 wall of the blood vessel is so high that over time it can cause damage 8
 to the blood vessel wall. 9

In his analysis, Canguilhem criticizes this quantification of disease. 10
 First of all, he shows that both Broussais' and Comte's reasoning is not 11
 entirely consistent and that their determinations of "too much" or "too 12
 little" call for a qualitative, normative perspective: "To define the abnormal 13
 as too much or too little is to recognize the normative character of the 14
 so-called normal state."³³ For Canguilhem (and also for Goldstein), the 15
 pathological cannot be seen as a condition that differs only quantitatively 16
 from the normal condition. When your blood pressure is higher than 17
 130/80 mmHg, you are not necessarily ill. Illness implies a *qualitatively* 18
 different state than health: you feel different; you are no longer able to 19
 do things the way you did before. 20

Canguilhem and Goldstein's criticism of the idea of disease as a 21
 quantitative difference also goes hand in hand with their view that a 22
 statistical perspective does not contribute to the understanding of whether 23
 an individual is ill or healthy.³⁴ A norm based on a statistical average does 24
 not do justice to the experience of the individual; such a norm cannot 25
 determine whether an individual is ill or healthy.³⁵ At forty beats per 26
 minute, Napoleon's pulse, compared to the average of seventy, is far too 27
 low, but the man was in good health. Apparently, those forty beats of his 28
 heart were sufficient to cope with the demands of life.³⁶ 29

Merleau-Ponty's work does not provide a comprehensive analysis 30
 of the meaning of statistics, but it is clear that, for him, a statistical per- 31
 spective on the body is associated with the idea of the body as an object, 32
 the objective body. Such a perspective is not compatible with what he 33
 calls one's own body (*corps propre*), lived body (*corps vécu*), or the body 34
 as a subject (*corps sujet*). The bodily subject experiences themselves as 35
 embodied from the first-person perspective, which involves experiences 36
 of the body through localized sensations such as touch, pain, propriocep- 37
 tion, kinesthetic sensations, warmth, and cold. Statistical measures of the 38
 body, like the medical gaze of a doctor, form an external perspective, a 39
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1 third-person perspective that concerns the objective body (*corps objectif*).
 2 Because Merleau-Ponty is not explicitly interested in the question of what
 3 is normal (and what is not), as Canguilhem and Goldstein are, he does
 4 not spend many words on statistics. It is, therefore, even more interesting
 5 to focus on a passage in which he mentions the statistical perspective in
 6 relation to human characteristics.

7 At the beginning of the chapter on freedom in the *Phenomenology* (in
 8 which he enters into a discussion with Jean-Paul Sartre), Merleau-Ponty
 9 explains that one cannot have an awareness of one's own qualities such
 10 as being jealous or being hunchbacked when one is restricted to a
 11 first-person perspective, a perspective *pour soi*. Let us consider here the
 12 reference to the hunchback (*le bossu*). The figure of the hunchback is an
 13 interesting one because—certainly after Victor Hugo's novel *Notre Dame*
 14 *de Paris* (1831) in which the hunchback Quasimodo plays the leading
 15 role—it is exemplary of abnormal embodiment in European culture.
 16 Merleau-Ponty describes the hunchbacked person as becoming aware of
 17 being hunchbacked only by comparing themselves with others, by seeing
 18 themselves through the eyes of someone else with whom they then take
 19 on a statistical or objective perspective on themselves.³⁷ Statistically, most
 20 people have a fairly straight back and no hunchback. The hunchback is,
 21 therefore, a statistical deviation from the average.

22 What is interesting about this incidental remark about the hunchback
 23 is Merleau-Ponty's claim that it is partly due to statistics that people
 24 become aware that they deviate from the norm, that they are abnormal.
 25 Yet, this is not the same as an awareness of illness. Like Goldstein and
 26 Canguilhem, Merleau-Ponty assumes that statistics—which set supra-
 27 individual norms—do not help to determine whether an individual is ill
 28 or not. For all three of them, awareness of illness is based on the patient's
 29 own experience, on the first-person perspective. This means that being
 30 hunchbacked is not really considered an illness because the person who
 31 is hunchbacked does not experience it from their first-person perspec-
 32 tive as such. Here it becomes clear how we can interpret the difference
 33 between illness on the one hand and abnormality on the other hand in
 34 Goldstein, Canguilhem, and Merleau-Ponty. Illness is the lived experience
 35 of having fewer opportunities to deal with the situation and environment.
 36 Abnormality can exist without being “heard,” whereby it remains hidden
 37 under the “silence of the organs,” as long as it is not confronted with
 38 others and thus with a comparison with others.

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Statistics and Abnormality

Abnormality, or abnormal embodiment, therefore, appears only within a framework of comparison. In medicine and public health, this framework is formed by large-scale biomedical, epidemiological, and statistical measurements. Goldstein and Canguilhem were both trained as clinicians, and their criticism of the statistical approach should thus be seen in the light of their view that this approach does not do justice to the experiences and stories of their (individual) patients. This is, of course, different for Merleau-Ponty. He was not a physician, and his criticism of a statistical approach to the body was not inspired by the wish to improve clinical practice. His criticism is philosophical in nature. Putting the statistical perspective on the body in parentheses in order to gain a better understanding of the embodied existence fits within the phenomenological exercise of “returning to the things themselves.” The proposal for such a return implies that we should bracket our science-formed knowledge and prejudices as much as possible. Since the term “abnormal embodiment” is a result of statistics, it must be bracketed in the phenomenological interpretation of the embodied existence. In that sense, a phenomenology of abnormality seems to be a contradiction in terms. It is, therefore, no wonder that Merleau-Ponty does not use the term “abnormal” in his analysis of Schneider. Schneider, the patient (*le malade*), is contrasted with the normal (*le normal*). Nowhere is the normal (*le normal*) contrasted with the abnormal (*l’anormal*).³⁸

In the remainder of this chapter, I want to show, however, that it is also possible to develop a phenomenological approach to abnormal embodiment. I will explain that the statistics of abnormality are not just a neutral form of scientific knowledge that exists peacefully and independently of the way people experience their bodies. Even though we intend to bracket statistical knowledge for our phenomenological analysis of lived experiences from a first-person perspective, such a bracketing, or such a phenomenological reduction, can never be complete. Our world is permeated with statistics. Most of our daily activities are dictated by statistical norms. In order to clarify how statistical knowledge infiltrates the lived experience of people, I will now take a trip outside phenomenology to discuss Hacking’s analysis of statistics. In his historical analysis of nineteenth-century statistics in *The Taming of Chance*, Hacking establishes a direct link between the development of statistics and the emergence of

1 the concept of “normal.” According to Hacking, the concept of “normal”
2 in the sense of “usual,” “ordinary,” and “common” originated in the nine-
3 teenth century.³⁹ Before that time, when it came to people or bodies, one
4 did not speak of something like a normal person or a normal body but
5 of “human nature.”⁴⁰ The term “normal”—derived from the Latin *norma*
6 and Greek *ortho*, which means “right angle”—takes on the meaning of
7 “usual” through developments in statistics.

8 One of the most important statistical ideas is that most charac-
9 teristics or properties are “normally distributed” within a population. The
10 term “normal distribution,” expressing this symmetrical distribution of
11 properties, was introduced by Francis Galton (1822–1911) at the end of
12 the nineteenth century, but before that it was already thought of in terms
13 of the so-called Gaussian curve, which was used in the calculation of
14 probability and named after the German mathematician Carl Friedrich
15 Gauss (1777–1855). If properties are normally distributed, this means
16 that the mean or average coincides with the median (the value that is in
17 the middle) and the mode (the value that occurs most often). A normal
18 distribution curve looks like a so-called bell curve that is completely
19 symmetrical.

20 Typical examples of normally distributed properties include biometric
21 properties (weight, height) and also students’ grades. A typical normal
22 distribution emerges only when the statistical calculation of mean, median,
23 and mode is based on a large sample. The normal distribution and the
24 mean are descriptive models that give us insight into the variation of
25 properties within a certain population. Hacking, however, shows that as
26 soon as the normal distribution appears on stage as a descriptive model, it
27 also immediately acquires a normative function. The work of the Belgian
28 statistician Alphonse Quetelet (1796–1874)—according to Hacking, the
29 “greatest regularity salesman” of the nineteenth century—is exemplary in
30 this respect.⁴¹ Quetelet, who was very interested in all kinds of measures
31 and calculations of the human body—thanks to him we also have the
32 still widely used Body Mass Index (BMI) or Quetelet Index—managed
33 to obtain a biometric dataset from the Scottish army that was remarkably
34 rich for the nineteenth century. The chest size of about 5,000 soldiers
35 was measured, probably to determine measurements for new uniforms.
36 According to Quetelet’s calculations, the chest size values are “normally”
37 distributed. He did not yet call it a normal distribution—since that
38 term was only later on introduced by Galton—but used the term “error
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curve,” which Gauss used to represent the values of measurement errors in astronomy.

According to Gauss, the error curve showed that the values that occur most frequently and are concentrated in the middle are the least false values. The measured values further from the center and that occur less frequently are—most probably—erroneous. By means of this curve, Gauss could indicate, based on many measurements, which measurement of a certain planet was most likely correct. When Quetelet uses this error curve—which has the same graphical form as the normal distribution—to calculate the average chest size of the Scottish soldier, something remarkable happens, as Hacking indicates. Whereas Gauss based the average or mean and, therefore, the most correct measurement on multiple measurements of one and the same planet, Quetelet calculates the average size of the chest on the basis of measurements of many different soldiers. Quetelet seems to see the measurements of many different thoraxes as a multitude of measurements of one and the same body—the “average body.” Quetelet thus approximates the average chest, or the average body, in the same way that Gauss considers a planet. Whereas a planet is a real entity, an average is not. Therefore, as Hacking writes: “Quetelet changed the game. He applied the same query to biological and social phenomena where the mean is not a real quantity at all, or rather: he transformed the mean into a real quantity.”⁴²

This specific interpretation of the mean implies that values that lie (far) from the mean are considered to be errors, as actual deviations and not just as a statistical deviation. This means that if the average chest size is thirty-nine inches, then someone with a chest size of forty-seven inches is abnormal, a deviant. From the idea of the error curve, the average is equated with a standard or norm. A soldier with a chest size of forty-seven inches does not meet the standard. What we see in these analyses by Quetelet is that the average is not *only* a descriptive model of how the biometric values of chest size are distributed. The average itself becomes normative or prescriptive in the sense that it indicates how the chest of a Scottish soldier *should be*. For Quetelet, the statistical average is ideal. Based on his conviction that the natural and social world is structured and organized according to certain laws of regularity, he assumes that the statistical average is the expression of the ideal type within a given population. Quetelet, therefore, like most of his colleagues, agrees that statistics are of great importance to

1 identify and improve the qualities of a population. Statistics were indeed
 2 considered an important tool for what Galton called “eugenics”: the
 3 theory that a population could be enhanced through the elimination of
 4 inferior (hereditary) characteristics while embracing one specific (racist)
 5 idea of humankind. Interestingly, whereas most eugenicists considered the
 6 above-average person (i.e., the person endowed with exceptional strength
 7 or intelligence) as ideal, Quetelet considers the average person—*l’homme*
 8 *moyen*—as ideal. The average person is not only a statistical construct
 9 according to Quetelet, but also an actual entity. He does not see the
 10 average person as a mediocre person (as Galton did after him). No,
 11 for him the average is the ideal. He literally says: “An individual who
 12 epitomized in himself, at a given time, all the qualities of the average
 13 man, would represent at once all the greatness, beauty and goodness
 14 of that being.”⁴³

15 Hacking’s analysis of Quetelet’s work shows how the seemingly
 16 neutral and descriptive statistical mean becomes directly normative.
 17 Although nowadays we do not directly link mediocrity to the greatness
 18 of mankind, even in our time the ideal of the average is often embraced
 19 when it comes to appearance. In the 1990s, psychologists established that
 20 a beautiful face is nothing more than an average face.⁴⁴ Kathy Davis,
 21 who researched the motives of women who undergo cosmetic surgery,
 22 also observes that averages are more important than diversity.⁴⁵ Most
 23 women who underwent cosmetic surgery indicated that they wanted to
 24 be “ordinary” or normal in the sense of ordinary. They did not neces-
 25 sarily want to be more beautiful; they wanted to be more normal. So
 26 here we can clearly see how the idea of an average can easily ensure
 27 that individuals who, outside the scope of the statistically normal, regard
 28 themselves as different in a negative sense, and, therefore, even feel the
 29 pressure to adapt more to the norm, to normalize themselves, to belong
 30 more to the average, to be within the scope of the normal.⁴⁶ When you
 31 are average or normal in a certain population, you do not stand out, and
 32 you do not attract attention. However, if you are not average, then you
 33 stand out and are confronted with the comparative views of others that
 34 may hinder you. In addition, our entire living environment is geared to
 35 averages: architects, designers, and tailors use sizes that suit the majority
 36 of the population. If you fall outside the bell curve of the normal, most
 37 things do not happen automatically. This point can help us to integrate
 38 the abnormal into phenomenology.

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A Phenomenology of the Abnormal 1

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 3 Merleau-Ponty argues that the hunchback needs the third-person per-
 4 spective if they are to become aware of the fact that they are “different”
 5 from others. This is true, but this third-person perspective, which is fed
 6 by ideas about averages, is also part of our living environment. When
 7 Merleau-Ponty indicates that someone is not aware of their own char-
 8 acteristics, such as being hunchbacked, it means that this form of being
 9 embodied for that person, without the gaze of the other, has something
 10 in itself that is self-evident. We can also say that when the hunchback
 11 is not aware of their hump and experiences their body as a matter of
 12 course, their body forms the obvious zero point of action and orientation.
 13 This zero point coincides with the above-mentioned “I can.” Therefore,
 14 we can say that the “I can” of the hunchback who is not aware of their
 15 hunchback is not diminished.

16 Based on his analysis of Schneider, Merleau-Ponty defines illness
 17 as a disruption or reduction of the “I can.” This is also in line with
 18 Goldstein’s view on disease in terms of a total body response resulting
 19 in “disordered behavior” and sometimes a “catastrophic reaction,” and
 20 Canguilhem’s idea that pathology goes hand in hand with the loss of
 21 normativity, that is, the capacity of setting norms. What I want to add
 22 here is that disturbances of the “I can” are not only provoked by illness or
 23 pathology. As Merleau-Ponty points out, there is a disturbance of the “I
 24 can” when the natural way to deal with your environment and situation is
 25 disturbed. But this disruption of the “I can” also occurs when people feel
 26 that their embodiment, their way of being embodied, is not self-evident
 27 within a specific social group. In his chapter “The Lived Experience of
 28 the Black (*le Noir*),” in his book *Black Skin, White Masks*, Frantz Fanon
 29 states that being black in white France in the 1950s has a direct impact
 30 on his body schema and thus on his physical subjectivity. According to
 31 Fanon, the body schema—which for Merleau-Ponty forms the basis of
 32 the “I can”—must be exchanged for a “racial epidermal schema” (*schéma*
 33 *épidermique raciale*).⁴⁷ In *Queer Phenomenology*, Sara Ahmed elaborates on
 34 this: “For bodies that are not extended by the skin of the social, bodily
 35 movement is not so easy. Such bodies are stopped.”⁴⁸ Being black in a
 36 white world means that you stand out, that your being embodied as “black”
 37 is never self-evident, that instead of being a zero point of orientation, you
 38 often become a point of attention for others. In this sense, being black

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1 in a white world leads to an inhibition of intentionality and possibilities;
 2 it leads to being arrested both figuratively and literally.

3 Merleau-Ponty, as we all know, makes no reference to skin color and
 4 argues that physical characteristics that are noticed from a third-person
 5 perspective belong, phenomenologically speaking, to the “objective body”
 6 and not to the lived body, the body as subject. Fanon and Ahmed show
 7 that skin color and racial characteristics have an enormous impact on
 8 the body as a subject, the body as the incarnation of the “I can.” This
 9 observation can be extended to the domain of abnormal embodiment, that
 10 is, embodiment that statistically differs from what is considered normal
 11 within a social group, such as that of the hunchback. Because not being
 12 average within a social group often goes hand in hand with being different
 13 in a negative sense, it makes you stand out in this group, protruding so
 14 that you cannot pass for normal.⁴⁹ If that is the case, being nonaverage
 15 can have an impact on the lived body.

16 When Merleau-Ponty talks about the hunchback, he states that this
 17 person will experience themselves as different only from the perspective
 18 of the other. Perhaps it is true that a hunchback who lives in total social
 19 isolation or in a community with only hunchbacked people does not
 20 experience their hunchback as something different. In real life, however,
 21 this is never the case. In real life, we are always confronted with the
 22 comparative views of others. This gaze can affect someone’s embodiment
 23 by transforming the self-evidently embodied zero point of action and
 24 orientation into a body that stands out to others. The gaze, therefore,
 25 directly affects the lived body because it breaks the self-evidence of it.
 26 Those whose physical appearance is statistically different can, therefore,
 27 experience a disturbance of their “I can” without any pathology as described
 28 by Merleau-Ponty, Canguilhem, or Goldstein.

29 Goldstein wrote that pathology always goes hand in hand with
 30 abnormality, but that abnormality does not always go hand in hand with
 31 pathology.⁵⁰ We can agree with this viewpoint of Goldstein if we think
 32 back to the example of high blood pressure. Blood pressure higher than
 33 130/80 mmHg is currently considered abnormal in the United States,
 34 but, as mentioned above, most people with such blood pressure do not
 35 feel ill and would probably not say they are ill. Goldstein would indeed
 36 say these people are not ill. We could, therefore, say that Goldstein’s
 37 distinction between disease and abnormality can very well be used to
 38 counteract contemporary medicalization.⁵¹

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The norms and standards that Goldstein and Canguilhem are talking about are mainly physiological standards, standards that, according to Broussais, indicate the normal state of an organ or tissue. In this chapter, however, I am talking about norms or standards of how bodies appear. As I indicated above, standards of what a body should look like often correspond to average values within a population. Based on my explanation of the effect statistical reasoning can have in today's societies, I have put forward the suggestion that the mere fact of being physically abnormal can also lead to a distortion of the zero point of action and, therefore, to a reduction in possibilities. This applies to any physical characteristics that can be observed by others; it applies if you are black in a white society, you have a hump in a society where the majority do not, you are much taller or smaller than most, you are missing a limb, your breast is amputated, or your face is damaged.

In the phenomenology of the body, this variation in physical characteristics is very often considered to be characteristic of only the objective body and, as such, is usually bracketed and kept out of the analysis. What I have just shown is that perceptible physical differences—abnormality according to statistics—do not necessarily mean that someone is ill, but they should be included in the phenomenological analysis because they also concern the lived body. A phenomenology of abnormality integrates the third-person perspective, the perspective from the outside, into the first-person perspective. A phenomenology of abnormality can thus help us to describe and interpret how being physically different is experienced.

Notes

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33. Canguilhem, <i>The Normal and the Pathological</i> , 56.	2
34. Canguilhem, <i>The Normal and the Pathological</i> , 181.	3
35. Goldstein, <i>The Organism</i> , 326.	4
36. Canguilhem, <i>The Normal and the Pathological</i> , 181.	5
37. Merleau-Ponty, <i>Phenomenology of Perception</i> , 497.	6
38. Merleau-Ponty uses the term “abnormal” in the <i>Phenomenology of Perception</i> only when he refers to the experiments by Stratton which incite “abnormal perception” in the chapter, “Space” (p. 248, note 4).	7
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