Med Health Care and Philos (2008) 11:99–110
DOI 10.1007/s11019-007-9076-0


## Scientific Contribution

# Inscriptions of violence: Societal and medical neglect of child abuse – impact on life and health

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**Abstract**

*Objective* A sickness history from General Practice will be unfolded with regard to its implicit lived meanings. This experiential matrix will be analyzed with regard to its medico-theoretical aspects.
*Method* The analysis is grounded in a phenomenology of the body. The patient Katherine Kaplan lends a particular portrait to the dynamics that are enacted in the interface between socially silenced domestic violence and the theoretical assumptions of human health as these inform the clinical practice of health care.
*Results* By applying an understanding of sickness that transcends the mind-body split, a concealed and complex logic emerges. This logic is embedded in a nexus of the impact of childhood abuse experience and the medical disinterest in subjective experiences and their impact on selfhood and health. Its core is twofold: the violation of embodiment resulting from intra-familial abuse and existential threat, and the embodiment of violation resulting from social rules and the theoretically blinded medical gaze.
*Conclusion* A considerable medical investment, apparently conducted in a correct and consistent manner as to diagnostic and therapeutic measures, results in the complete incapacitation of a young physician.

**Key words:** child abuse, lived meanings, mind-body split, phenomenology of the body

## Introduction

*Katherine Kaplan – re-opening a closed case*

In spring 2000, the following letter concerning Katherine Kaplan was sent from me, her primary care physician, to the local health insurances: "Last autumn, your consultant N. asked me to take charge of the primary care of Katherine K. who, until then, had been in specialist care through years of chronic sickness. Her case was declared as exhaustively explored and her medical treatment as terminated. She had been granted extended rehabilitation funds according to the judgment of specialists in neurology at the University hospital. The neurologists had diagnosed Chronic Fatigue Syndrome following frequent infections. According to their prognosis, Katherine was still in need of 2 years of rest and of gradually increasing physical exercise, before she again would be able to engage in her work as a physician. I was asked to provide her primary care during her recovery, if necessary. Upon my agreement, I received her medical records before encountering her for the first time. After having studied these, I was positive that this 'case' was neither exhaustively explored nor properly understood. My conviction increased when I met her personally.

By now, we have reconstructed her sickness history, which, in every step and detail, reflects a violation history. Katherine has been violated since childhood. Her parents applied kinds of 'punishment' that qualify for the term physical abuse. However, most violent towards her was her

brother Christopher. Katherine tried time and again to tell her parents what Christopher did to her. Yet her parents would not 'hear.' Gradually she learned that telling would not improve but rather worsen her situation, since Christopher would take revenge for her 'slandering.' Even after she had moved from her hometown in order to study medicine at the University of Oslo, he would still come and batter or threaten her in her student apartment.

Until recently, Katherine has kept these brutal attacks concealed due to her childhood experience of not being heard, but also with regard to her family reputation, and of fear. But since she could not speak the violence, it sickened her. Already in early adolescence she became anorectic. But neither her parents nor her teachers saw that she was overpowered. Her proneness to sickness increased ever more after her parents divorced. The year after, she was admitted in emergency with a bleeding gastric ulcer. Nobody was aware that the admission had been preceded by her being gravely violated by Christopher. The next year, she was injured in a traffic accident. While recovering, she gained 60 pounds in weight, a rather paradoxical effect of an accident that ought to have made her doctors suspicious to hidden problems on the background of her previous anorectic phase. But nobody reacted.

Her studies were frequently interrupted due to diseases, among which a prolonged and severe Mononucleosis. All these interruptions caused a considerable postponement of her final examinations. The pattern of apparently incidental diseases continued, comprising a serious bacterial and two viral infections, one of which verified as a meningitis. Her internship, normally lasting for eighteen months, was extended to 3 years before she received her medical license. Although almost continually in medical treatment, none of her medical caretakers suspected grave distress to be the source of Katherine's sickness, since every sickness period was diagnosed as an isolated disease, unrelated to and differing from the preceding.

Upon receiving her medical license after 10 years of study, Katherine broke down and was completely incapacitated. Her state was diagnosed as Chronic fatigue syndrome. This 'diagnosis' is still highly controversial, and as yet, no agreement as to etiology or treatment has been arrived at (Whiting et al., 2001; Taylor and Jason, 2002; Chaudhuri and Behan, 2004). Resulting from her prolonged studies, Katherine has accumulated high debts. Consequently, she still depends on her parents' economical help, which adds considerably to her burden. Still, she keeps silent as to the violations inflicted on her since childhood. Still, she is horrified and distressed. As her primary care doctor I conclude that Katherine K. suffers from hidden and silenced domestic violence.

N.N., M.D., Ph.D., Specialist in Family Medicine''

In response to this letter, Dr. L., senior consultant physician of the insurance, revised ''the recently surfaced nine tenth of an iceberg termed Chronic fatigue'', as she termed it.

## Theoretical framework I

### *Moving beyond the mind-body split*

A frame of references different from the Cartesian view upon the diseased body as it dominates biomedicine is chosen for a further analysis of this violation-sickness-history. Within this framework, thought is not given preference over perception, the rationality of the natural sciences is not given status as the measure that overrules all other rationalities, and not only formal but also perceptual logic is attributed documentary force. French philosopher and phenomenologist Maurice Merleau-Ponty, in opposing the Platonic view of the world of perceptions as representing a lower kind of reality, argues that human existence unfolds precisely within the realm of perception (Merleau-Ponty, 1989). Contradicting the traditional distinction between thinking and perceiving, he claims that a human being does not exist as a self-reflective awareness, but as a *lived body*: both subject and object; both seeing and seen; both sensing and sensed; and both observing the world and partaking in it. Merleau-Ponty emphasizes that humans know about and perceive the world *by means* of their bodies. This implies that being alive means being embodied rendering lived and embodied life the inevitable precondition for both knowing and perceiving. This position grounds subjectivity in the body. Consequently, the subjective body is primary to the object body and qualitatively different from the ''mindless,'' purely physico-material body of the Cartesian legacy as it is integrated into biomedical theory (Thornquist, 2006). ''With incarnate subjectivity having been recognized, it follows that human experience can only be lived in and through the body and that people cannot but express and convey their history bodily. However, phenomenology has to be supplemented by social theories if it is to account for

social and cultural aspects of embodied subjects and human agency. The body can then be grasped as a conveyer of life and history – socially, culturally, and personally'' (Thornquist, 2006: 70).

As the center of experience and a field of expression, the phenomenological body, which means the *lived body*, unites personal experience and the ''material'' body. Applied on the diseased body, the traditional distinction between mind and matter as a basic concept is transcended. This position renders human experience and particularity sources of valid knowledge, relevant for an understanding of the impact of lived life on health. The view of the body as history and memory allows an integration of perception and experience into cognition and meaning. Thereby, an approach to the *lived meaning* of what a person has experienced *and* embodied, is provided. Since lived meanings are central to all incorporation of experiences, they are salient for any exploration of trauma impact. Research in neurophysiology has recently confirmed that trauma-perceptions may engender sensor-motor inscriptions that are cognitively unapproachable yet can be reactivated by ''sufficiently similar'' perceptions regardless other contextual differences (Bremner et al., 1993, 1995; Goenjian et al., 1994; van der Kolk and Fisler, 1995; van der Kolk et al., 1996). Such cognitively and verbally non-integrated perceptive memories are already central in the theories of the French philosopher and psychiatrist Pierre Janet in the 19th century (van der Hart and Horst, 1989; van der Kolk and van der Hart, 1989). He observed that human beings have the capacity to associate, which means to integrate new experiences into their cognition or to dissociate these from cognition and verbal memory. Janet interpreted dissociation as a strategy for survival, shielding or protection of the self in the presence of overwhelming and frightening experiences. He hypothesized the dissociated experiences, not ''remembered'' yet experienced, to represent sources of anxiety and confusions. Therefore he claimed that traumatic memories had to be acknowledged, told and integrated into a meaningful life history in order not to surface in a ''meaningless'' because medically incomprehensible sickness-history. Being a psychiatrist, Janet conceived of unrevealed trauma as the matrix of mental sickness only. And this particular relationship has, by now, been amply documented (Holmes and Slap, 1998; Krug et al., 2002; Amiel and Heath, 2003; Edvards et al., 2003; Arias, 2004; Arnow 2004). However, increasing evidence supports hypotheses concerning an at least equally destructive long-term impact of traumatic experience on somatic health (Stein and Barrett-Connor, 2000; Dong et al., 2003; Dube et al., 2003a, b; Batten et al., 2004; Dong et al., 2004; Goodwin and Stein, 2004; Dube et al., 2005).

The researchers conducting the by now largest study of early trauma impact on health, formulate the essential question engendered by their findings as follows: ''Exactly how are adverse childhood experiences linked to health risk behaviors and adult diseases?'' (Felitti et al., 1998). Based on exploration and calculation on group level, epidemiology of diseases in traumatized people provides no access to an answer that is valid for the process as such in general and in individuals in particular. The path from violation to sickness in a particular person is informed by personal appraisal of experience within a socio-cultural, historical and biographical context. Thus, a theory of the lived body and of incarnate experience is a more adequate means to gain insight into the process of the transformation from violation to disease. A theoretical shift from the body of biomedicine to the lived body implies a shift of perspective: from ''that'' to ''how'' (Kirkengen, 2001).

## Material and method

### *Face to face – encountering Katherine K. as scheduled*

Material and method cannot be presented separately since the aforementioned theoretical framework informed the mode of collecting material, the kind of material gained, and the path of its exploration as to implicit meaning (Mishler, 1986; Kvale, 1996). Katherine K.'s sickness history, as it was provided in her medical records, clearly documented her incapacitation resulting from the accumulated impact of frequent and severe diseases during near two decades. However, this document of sickness was also a document of how the objectifying medical gaze, in the sense of French philosopher and historian Michel Foucault (1975, 2000), reads bodily ailments as apparently representing consecutive yet different states of individual, bodily disease.

However, a different reading grounded, on the one hand, in a theory of the lived body, and, on the other hand, mirrored in epidemiological evidence of trauma impact on somatic health, rendered the same sickness history a document of an implicitly coded, concealed violation history. This reading provided an entrance to a dialogically based,

biographical and phenomenological exploration of Katherine K.'s incapacitation termed chronic fatigue. This different reading was based on two assumptions: firstly, that abuse violates the human right of non-violated bodily integrity; secondly, that violation of any kind is embodied, as is any other kind of experience (Merleau-Ponty, 1989). Violation embodiment presents in a broad continuum of phenomena from medically objectified damage of tissue or function to perceived local or generalized chronic pain and different degrees of dissociation. Such a ''different'' reading of an extended sickness history as testifying to the violation of embodiment *and* the embodiment of violation is in accordance with American phenomenologist Elizabeth A. Behnke and her reflections about the phenomenology of the body (Behnke 1997, 2003).

Consequently, in the course of our first encounter, I presented for Katherine my reading of her records as follows: ''Both volume and content of your records make me confident of the presence of a coded text in your sickness history, of a not-yet-told story, and of non-integrated experiences. According to my knowledge your records bear witness of an overload of something during your lifetime, probably since early childhood. You were anorectic when 14 years old, apparently without preceding, serious events such as death of a relevant person or grave loss, since these most probably would have been reported. Therefore I suggest that something serious must have happened to you over a period of time and hidden for view from outside.'' At that point, Katherine's eyes turned glass-like, her face pale, her breath invisible, and her body motionless. I waited, focusing her intensely for quite a while. Suddenly she breathed deeply, her eyes zoomed me in, and she took eye contact. As she started to speak, her face regained its normal color. That was the opening to a co-operation upon painful memories and bodily ailments such as abdominal pain due to excessive bread consumption, vomiting evoked by distress, serious infections linked to conflicts, and panic associated with feeling trapped. This work, lasting for 4 years, is terminated. Katherine has overcome her conflict-triggered eating problems, whereby avoiding incapacitating nausea, abdominal pain, vomiting and weight changes. She does not panic any more. She has regained normal immunity expressed in freedom from infectious diseases. And she is back in work as a health care professional.

The first Katherine could tell was the permanent war between her parents; her father's high consumption of alcohol; her mother's bitterness for living in arctic Northern Norway instead of her native country Italy, for the sake of a man frequently humiliating her with extramarital affairs. Then, she could tell about some years abroad and the resulting alienation upon the family's return to Norway, followed by her loneliness and everyday harassment at school due to her ''strange'' accent. The next story was about her father's temper tantrums and the horsewhip he then would use on her. Another story was about her mother's frightening change when embarrassed by her daughter's eventual ''disobedience,'' resulting in her beating Katherine with a dog chain. And finally, she told about her brother Christopher and his ways of trapping her in situations where she was injured, apparently due to her own care- or recklessness. This story was told in such a low voice and such a lack of visible emotions that I was confident Christopher to be the main character in Katherine's drama. Thus far had we come in reconstructing the story of a wounded person by the end of the first consultation (Frank, 1995).

### *The body remembers – encountering Katherine K. off schedule*

A few days later, Katherine attended in emergency in order to have me see her left hand. Presenting her hand-back with her fingers stretched, she, instead of seeming plagued, appeared rather triumphant. I could observe a non-infected, cleft-like wound on every finger. Then she turned her hand while bending her fingers towards her palm. ''Look,'' she said, as if what I was seeing was self-explained. The cleft on every finger now added to a line across all four fingers as if cut, or rather, as if erupted from within. Katherine almost shouted the answer to a question I was about asking: ''This was a door!'' Then she told that, the day after our first encounter, she had felt pressure and later some pain in her left hand. The hand had grown red and swollen by the night, but she had nevertheless fallen asleep yet had had several nightmares that night. The next morning, her hand had shown these stripe-like wounds, at first shallow, later deepening, yet without bleeding. She had felt increasingly worried by the sight of her hand until she, all of a sudden, had acknowledged to have seen this hand in this state once before. This particular image recalled a movie-like memory: Katherine, 5 years old, stands in the hall of her home; her parents are out; she is alone with Christopher; he tricks her to place her left hand

around the frame of the entrance door – and then, with all his strength, he slams the heavy door over her fingers, which burst.

Katherine's embodied violation experience surfaced in what almost literally represented a bodily inscription (Kirkengen, 2001). Recently, trauma researchers have characterized such a reactivation of trauma inscription as "site-specific" (Nijenhuis and van der Hart, 1999; Rothschild, 2000). Site-specificity may appear as allergic, inflammatory or other kinds of stigmata referring to traumatic perceptions, such as a skin eruption around both wrists related to certain types of conflicts in a man having been forcibly back-bound (Nijenhuis and van der Hart, 1999, p. 47), or a persistent pain in her right hip in a woman who blamed herself for not having saved her husband's life since she did not reach the hospital in time despite flooring the right (gas) pedal (Rothschild, 2000, p. 118). Norwegian psychiatrist Sol Dahl reported a painful paralysis in a female Bosnian patient attending the center for refugees at the University of Oslo (personal communication). The woman had been tortured in order to tell her husband's hiding place. Her torturers had cut and battered her while she, hanged up at her left arm, had held her baby-boy with her right arm. All her attention had, despite the assaults afflicted upon her, been directed to the baby: Should she fade, she had to strangulate him with her right arm in the last moment in order to prevent him falling alive into her torturers' hands. Thus, her right body had been in a high state of readiness to act. She had neither told nor faded – and had finally been left alone. However, weeks later and upon bad news about her husband, she immediately became painfully paralytic in her right body, especially in her right arm.

## Theoretical framework II

### *Site-specific bodily inscriptions*

The aforementioned examples depict what site-specific means. Simultaneously they show that the "ailing" part of the body not necessarily has been wounded or been the assaulted body part. The entire situation, and particularly its *meaning* for the traumatized person, determines *how* the lived experience is inscribed in the body. Inscribed bodies are, in fact, not only bodies into which painful perceptions have been inscribed. They are even more bodies that are inscribed into socio-cultural contexts such as revenge, war, honor, pride, humiliation, punishment, powerlessness, guilt, and shame (Rothschild, 2000; Kirkengen, 2001). Neurophysiologists and endocrinologists are about to spell out the patterns of neurological impulses and transmitters linked to distressing or traumatic perceptions (Sieber et al., 1992; Bremner et al., 1995; van der Kolk and Fisler, 1995; van der Kolk et al., 1996; Glaser et al., 1998; Kiecolt-Glaser et al., 1998; McEwen, 1998; Sephton et al., 2000; Spiegel and Sephton, 2001). Each current sensory perception is immediately compared to the patterns that have resulted from prior perceptions. Is the "new" pattern identified as similar to one of the prior, the impact is either accept or alarm. Not the pattern as such, but its implicit meaning for the perceiving person informs its particular impact. *Thus, the crucial point is not what kind of event is happening, but: who experiences this event, in what kind of context, and how it is perceived.* If the current perception resembles sufficiently to a previous trauma inscription, the distinction of tenses is extinguished, and sensor-motor trauma-perceptions are reenacted in the once assaulted body (Goodwin and Attias, 1999).

Katherine's hand had "told," enabling her to acknowledge that she knew certain things perceptively, which she had not been able to approach cognitively. She also understood that instead of fleeing reflexively from scaring bodily sensations, she rather might trust such perceptions to bear witness of a "forgotten" reality. The next "movie" she recalled was a dramatic slide head-down a staircase covered with a red carpet while black iron pins passed quickly at the outside of her field of vision, and a head crash on marble at the foot of the stairs resulting in bloody hair. Katherine was now instantly confident that this "movie" represented a true memory. She even perceived, "within this movie," a push at her back from someone behind her, but she could neither remember where these stairs had been, nor whose hand had pushed her. When phoning her mother the next time and interrogating the location of her memory without revealing her purpose, Katherine evoked her mother's immediate confirmation that there had been a black lacquered, iron staircase with red carpets in their house in Milan where the family had lived when Katherine was 2–3 years old. And, without Katherine eliciting further details, her mother added: "You fell down from these stairs once and got a concussion of the brain and a cut. We were not at home and Christopher had to wash blood from your hair."

The third "movie" emerged in a nightmare concerning a stripe of light at the floor and, in it, the shadow of two feet as if seen from an elevated point. Katherine, now relying on lived meanings, decoded the scene the next day: she is seated on top of the water tank, her feet upon the WC, in a toilette room without a window. In her lap, she holds a thermos flask with hot tea. She keeps her breath and stares at the bottom of the locked door that does not reach quite to the floor, thus showing a stripe of light from the hall and the shadow of Christopher's feet, an effect of the roof lamp behind him. He suspects her to be there without being sure since she may have left the house before he came from school. She needs the tea because it is cold in this room, and she may have to wait for hours until one of her parents return and she can sneak out. Only once he has tried to crash the door open with his boots. She even could see the lock move. However, when her parents discovered the traces, he was punished so severely that he never tried again. The toilette had proven a shelter provided she reached it before he entered the house.

## Discussion

### *Empirical evidence – traumatic experience endangers health*

Adverse childhood experiences are shown to have accumulative pathogenic long-term impact on health, resulting in excess adult morbidity and mortality (McNutt et al., 2002; Ehrensaft et al., 2003; Arnow, 2004; Batten et al., 2004; Norman et al., 2006; Surtees and Wainwright, 2007; Weissman et al., 2006). Women and men victimized as children, run a significantly higher risk of being re-traumatized than are non-traumatized persons (Arata, 2000; Classen et al., 2001; Coid et al., 2001; Maker et al., 2001; Silverman et al., 2001; Desai et al., 2002; Thompson et al., 2003; Dube et al., 2005). Women and men abused as children are at high risk of self-destructivity expressed in drug-, alcohol-, nicotine- or food abuse, self-molesting acts, unintended and teenage pregnancies, and attempting and committing suicide (Dietz et al., 1999; Anda et al., 1999; Brown et al., 2000; Dube et al., 2001; Anda et al., 2002; Dube et al., 2002; Dube et al., 2003a, b; Kilpatrick et al., 2003). Among women in psychiatric care, 55–85% report violation experience during lifetime (Goodman et al., 1997; Seeman, 2002; Arias, 2004). Adults who have been abused are at high risk for sexually transmitted diseases due to non-protective sexual practice (Hillis et al., 2000; Augenbraun et al., 2001). Sexual and physical abuse are shown to be positively correlated with a range of ailments: generalized, muscular, low back, facial, gastrointestinal and gynecological pain, neurological dysfunctions and cramps, bladder dysfunction and sexual problems, eating disorders and obesity, fibromyalgia, and chronic fatigue (Golding, 1994, 1999; Boisset-Pioro et al., 1995; Drossman et al., 1996; Laws and Golding, 1996; Harden, 1997; Linton, 1997; Shrier et al., 1998; Goldberg et al., 1999; Finestone et al., 2000; Sherman et al., 2000; Campbell, 2002; Taylor and Jason 2002; Williamson et al., 2002; Davila et al., 2003; Kovac et al., 2003; Lampe et al., 2003; Wijma et al., 2003; American College of Gynecologists, 2004; Gustafson and Sarwer, 2004; Seng et al., 2005; Heim et al., 2006; Kato et al., 2006). In women, growing up in abusive households increases their risk for adverse outcome of pregnancies and neonatal death of their offspring (Hillis et al., 2004).

### *Empirical evidence – traumatic experiences disturb balance*

According to the latest results of neurophysiology, -immunology and -endocrinology, modulations of the hypothalamic-pituitary-adrenal (HPA) axis and of the natural killer cells are the most probable mediators of the pathological or disruptive impact stemming from violation experience (McEwen 1998; Septon et al., 2000; Spiegel and Sephton, 2001; Reiche et al., 2005). The immune-suppressive impact of distress, and especially of continuous distress, has been documented. A decline of natural killer cell activity has, for example, been reported in people exposed to noise, but only in those subjects who perceived themselves as having no control over the noise. Those who were informed that they could switch off the noise if necessary, even if this information was not correct, showed no such a decline despite exposure to an equal amount of stressful noise (Sieber et al., 1992). In other words, it is highly probable that *the particular person*'s perception of disposing self-protective measures or not, of either feeling empowered or powerless, and not objective facts of control or non-control, determines the impact of a "stressor" (Epel et al., 1998). The person's own appraisal of the situation, strongly modulated by previous experience and current context, evokes either protective or destructive bodily responses.

The impact of distressing experience is accentuated by frequency and aggravated by continuity.

The core of a person's bodily response to a sudden event is based on systems that maintain stability by change, a phenomenon termed "allostasis" (McEwen and Wingfield, 2003; McEwen, 2005). The dynamic and complex allostatic response terminates when the event is perceived as non-threatening or has passed. If non-threatening events occur frequently, the consecutive allostatic responses decrease in extent, thus showing the person's adaptation to non-dangerous events. However, this system of dynamic balance can be disturbed when a stressor perceived as threatening and dangerous occurs frequently. Such repetitions tax the allostatic abilities of a person, either as repeated "on-and-off" responses, representing a state of continuous readiness and uncertainty, or as lacking shut off, representing a state of permanent alarm or fright. Both types result in what is termed "allostatic load" (McEwen, 2004). Allostatic load is correlated with decreased immune status, probably mediated by permanently elevated levels of cortisol and other neurotransmitters, resulting in several health risks such as elevated blood pressure, disturbed regulation of blood glucose and lipids, and loss of minerals from the bones. However, a third type of dysfunctional response, a hypo- or even non-responsiveness of the HAP-axis, has been described, presenting in lacking variation of cortisol levels during the day. This phenomenon is, in analogy to processes in the thyroid gland and the pancreas, interpreted as an exhaustion of the body's biological adaptability. Permanently low levels of cortisol and lack of variation have shown to predict both onset of cancer and reduced survival in women with severe states of breast cancer (Spiegel and Sephton, 2001; Reiche et al., 2005). Such an exhausted flexibility has also been observed in people whose sickness has been labeled "fibromyalgia" and "chronic fatigue syndrome" (McEwen, 1998). The latter is even more than the former a highly debated concept of complex dysfunction, and both are correlated with trauma experience (Boisset-Pioro et al., 1995; Finestone et al., 2000; Taylor and Jason, 2002; Lampe et al., 2003; Seng et al., 2005; Heim et al., 2006; Kato et al., 2006).

As to Katherine K., decades with frequent violation by relatives, lack of protection, permeated terror, and perceived powerlessness led first to allostatic load as expressed in decreased immune response, resulting in frequent, prolonged, and serious infections. Later, when the adaptive potential broke down, the resulting state of exhaustion was termed "chronic fatigue" and attributed to the previous infections. The real origin, the long-term immunosuppressive impact of terror, was not identified until an "iceberg" of socially silenced violation emerged. The diseased body of Katherine K. was, according to biomedical theory, conceived as "mindless" (Scheper-Hughes and Lock 1987; Cassell, 1992, 2004; Toombs, 1992; Gallagher, 2001; Svenaeus, 2001). Consequently, it could not regain its mindfulness unless a theoretical split had been transgressed by means of an integrative theoretical framework, revealing the lived meaning of her social world (Bracken and Thomas, 2002).

### *Implications for medical theory, practice, and ethics*

On the background of her livelong experience of being repeatedly and deliberately violated by her nearest family, Katherine K. had felt forced both to tolerate and to conceal her state of being due to loyalty, fear and shame. Being prohibited from speaking, she had nevertheless exposed extreme vulnerability to representatives of the health care system. And she had done so repeatedly, presenting severe and threatening expressions of bad health. Examined and diagnosed according to the criteria of biomedicine, however, Katherine's body had not been considered as the center of her experience and her field of expression. Her chronically diseased state had been interpreted consecutively, as a sequence of independent sickness events, as different health problems requiring different names, consistent with the reductionist, fragmenting methodology and approach in biomedicine. Consequently, the undercurrent of violence exhausting her adaptability had not been identified. Katherine's corporeality of being battered and rejected had not been seen. The evidence of shattered health had not been related to a personal context of destructivity resulting in constant fear and powerlessness. An application of presumably correct knowledge had not done justice to a state of being.

When an approach was applied that was based on an assumption of a continuity of unacknowledged experience, Katherine K.'s life and sickness could be explored as mutually constitutive. An open-ended question arising from information characterized by a certain lack of reasonable aspects challenged Katherine to reflect upon her situation. She became aware that her medical records were suspicious due to a particular absence, and that what was absent might be key to making sense of her sickness history. When

being offered an unprecedented choice, she visibly withdrew from the dialogue. In her acutely established room of introspection, she made her decision. Deliberately she began to tell, and without hesitation yet step by step she then configured the "key" consisting of violation, abandonment, maltreatment, terror, secrecy, and shame. She reconstructed the map of her intertwined biography and sickness history, thereby identifying and naming, disentangling and recognizing how experience became body. Fragments were reconnected, and relations were reestablished. Katherine gradually came to terms with her bodily expressions, in a literal sense, and in her own terms and her own voice. A non-intrusive approach was the only possible way to heal what had been violently disrupted and destructed.

An appraisal of the long-term impact of distressing, abusive, and disruptive childhood experiences on life and health in medical theory and clinical practice is urgently warranted. Empirical data not only document the disturbing amount of violence and numbers of violated people. They also testify, on group level, the powerful pathogenic potential of such experiences in general. This evidence challenges the traditional separation of psychiatric and somatic specialties since the resulting morbidity shows a degree of complexity that defies the divided classifications. The documentation of experience affecting the body shatters the traditional assumptions of the human body and the human mind as different and separable. Latest research in neurology, immunology, and endocrinology accentuates the decisive role of *personal* appraisal. The particular person in her or his particular situation informs the embodiment of her or his particular experience. Consequently, the impact of individual interpretation, the salient influence of biographical context, and the structuring force of socio-cultural values and meanings must be acknowledged.

Integrative medical theories must be developed to do justice to the nature of human suffering, and all practical approaches to complex and chronic sickness must be in accordance with these non-fragmenting theories. The history of the sickness in the body cannot be understood separately from the history of the sick person. Consequently, bodily and verbal expressions of pain and suffering must be seen and interpreted in light of each other. Fragmenting and alienating medical research cannot be tolerated.

At the heart of almost globally acknowledged human rights is the right not to be violated. A medical knowledge production that, due to its frame of references and its methodology explores human bodies as if these were mindless and non-experienced, alienates people from their lived bodies. Implicit in doing so, a violation of particularity, personhood and personal dignity occurs. This means that correct scientific approach, deemed appropriate and justified due to objectification, and presumed to lead to valid results, nevertheless represents ethically untenable measures. Not only is it non-scientific to explore a phenomenon – the lived body – with inadequate means. Such an exploration, grounded in a mistake of category, by formal logic leads to "correctly" collected, calculated and validated results that, nevertheless, are invalid and mistaken as to the nature of the phenomenon explored. An application of knowledge based on this alienation is ethically compromised because it ignores the experience, the meaning and the intention inherent in the life projects of particular people.

Even more problematic is the fact that such "mistaken" scientific knowledge may acquire an instrumental function in the societal control and suppression, in the sense of Foucault, of certain kinds of "deviations" resulting from asymmetries and abuse of interpersonal or structural power. Abuse of power expressing in deprivation, discrimination, humiliation, marginalization, stigmatization, violation and terrorization, when and where ever publicly or privately exercised, and whether tolerated or silenced, represents a strong pathogenic force. The resulting amount of sickness on personal or group level represents the utmost challenge with regard to the ethical standard of the medical profession, and to the moral-theoretical awareness of its practitioners.

## Conclusion

Whenever and however medical treatment contributes to concealment of the destructive health impact of abuse of power, whether this is acknowledged or not, medicine becomes instrumental to an abuse of power itself.

## Acknowledgement

This text is a result of a co-operation between a young woman whom I have named Katherine Kaplan, and myself. She has agreed to the means applied for granting her full anonymity. She has authorized the present version and allowed its

publication. I am very grateful for both her contribution and her permission. In addition, I feel indebted for help and support during my work with this manuscript to Dr. Linn Getz, assistant professor at the Department of Community Medicine, University of Trondheim, Norway, and Professor Jóhann A. Sigurdsson, Department of Family Medicine, University of Reykjavik, Iceland.

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