The Paradox of Illness: Why me? Why not me?
Chronic Illness and Disability as Developmental Opportunities in Adults.

Human life is a developmental process biologically, psychologically, and socially from infancy to adulthood to senescence and death. Human nature is constantly evolving. Some researchers formulate the changes in form of life cycles (Levinson 1996), developmental stages (Erikson & Erikson, 1997), or within a spiritual context of the Great Chain of Being (Wilber, 1998). Daniel Levinson proposes a model in which adulthood is characterized by alternating periods of stability when individuals solidify their life structure and periods of transition when that structure is reexamined and modified. Roger Gould (1989) develops a model comprising six stages of adulthood in which individuals progressively abandon one childhood myth after another, manage to confront reality to a greater degree than before, and eventually succeed in raising their levels of consciousness.

Some scholars classify schools of adult development into three basic models, the ontogenetic, sociogenic and liberative (self-development) models. Ontogenetic models, illustrated by Erikson's stage theory, are rooted in a biological metaphor. They suggest a universal sequence of normative adult development. Vaillant (1993) describes Kohlberg's and Loevinger's ontogenetic view of adult development as "increasing differentiation of self from others and a progressive freeing of self from contextual and social constraints" (p. 161). Sociogeneic models emphasize the social determination of behavioral change. On the basis of social learning theories and role theories they view adult development organized around satisfying social roles (e.g. those of spouse, parent, worker etc...), social norms and practices (Dannefer, 1984; Elder, 1998; Neugarten, 1984).
Self-development and liberation models regard adult development as teleological or goal-oriented that is not entirely influenced by biological or socio-environmental forces. Kegan (1998) stresses the self-authoring and self-transforming potential of the adult to move beyond the socialized self.

In the more conventional kind of developmental psychology we are taught how people develop from genetic roots and in interaction with family, school and society. By adulthood, although refinement might occur and wisdom increases, identity is largely formed. As the individual grows older and integrates life experiences he or she matures. These approaches to development see development as a process of increasing emotional, cognitive, and moral complexity (Labouvie-Vief, 1990). Although identity formation is completed, the adult self becomes increasingly differentiated internally and more distinct from its environment. The objective of development is to strengthen the self through increasing mastery, experience, and knowledge.

William James introduced, in his book on religion (1902) the idea of a second phase of development: the possibility of *transformation* of identity during adulthood. Faced with the evil and misery of the world and in search of meaning a new life trajectory begins. This second phase often starts with some sort of a conversion experience, when the individual realizes that there is more to experience that waking life suggests. This reorientation may be precipitated by an emotional crisis. Intense love, jealousy, fear, despair or loss propels people into a new life trajectory and the recognition of the inadequacies of their old self. They question everyday experiences and aim at a deeper meaning of their life. James concept of identity transformations of adulthood was later followed by Jung's (1939), Erikson's (1959) and Levinson's (1986) investigations of crises of adulthood during development through the life span.

C.G. Jung (1933), one of the first theorists that studied self-development in adulthood, especially stressed the appropriateness for middle age adults of liberating themselves from biological and social determinants. He focused on adult development as a psycho-spiritual path towards individuation. In his view individuation was characterized by constant conflict of archetypical opposites which had to be integrated and assimilated in order to succeed in individuation (e.g. the union of anima and animus, the male and female aspects of the unconscious). He often used allegories from the medieval science of Alchemy to describe the individuation process. He saw the alchemical attempt to transmute base metals into gold as a metaphor for the psyche's unconscious effort to develop and learn from opposing tensions. According to Jung, libido, or psychic energy is the vital impulse of human life; it is the energy behind growth and development. It is created by tension between conflicting forces or opposites. These constant conflict of opposites produce psychic energy; they are the motor of development or individuation. Jung stressed that individuation must not be understood as a linear process, but as a "circumambulation of the self," a circular and self-contained movement towards a center. One of the symbols in alchemy which represents this process is the Ouroboros, the serpent which devours its own tail. Jung viewed the adolescent and young adult phases as developmental stages in which the focus is on the development of ones "Persona." The persona is that aspect of the self that is identified with worldly characteristics (e.g. name, sex, nationality, family ties, work identities etc...) and oriented towards conforming to adult social roles and conventions. Later in life the task of development is to transcend the externally oriented self or, in other words, to add deeper layers to the socially conditioned self.

Erikson proposed that emotional tasks remain to be faced throughout adult development. Adults are revisiting inner conflicts left unresolved in earlier stages and in addition are confronted with new distinctive challenges. For example: conflicts between intimacy and isolation, between generativity and self absorbtion. Erikson describes the psychosexual crisis of middle age as a polarity between generativity and self-absorption (Beckmann Murray & Proctor Zentner, 2001). A generative middle-aged person reconciles personal needs and the needs of others. He or she expands personal interests with efforts for the community with the goal to leave the world a better place in which to live. "If the developmental task of generativity is not achieved, a sense of stagnation, or self-absorption, enshrouds the person....This person hates the aging body and feels neither secure nor adept at handling self physically or interpersonally (Beckmann Murray & Proctor Zentner, 2001, p. 729)."

With James', Jung's and Erikson's concepts of a transitional or transformational phase in middle adulthood came the idea of the mid-life crisis. Gail Sheehy (1976) performed one of the best known studies of the phenomenon. In her book *Passages* she describes stories of men and women who came to find that although they had accomplished what was culturally expected from them, their goals and ambitions had lost their meanings and they found themselves dissatisfied with their life, depressed, empty, or restless. As if something crucial was missing. Correspondingly, Levinson (1986) in his study of men found that as individuals age, if their concept of themselves relies primarily on body functions and external social success, it will become less positive over time. Concerns about the natural decline in body functions and the frailty of social success call for a new foundation of the self in a new set of meanings. A culture that overemphasizes body shape, juvenile sexuality, and anti-aging promotes self-absorption and impedes psychological growth and maturity. Concerns about health and body image, the understandable desire for a fulfilling and meaningful sexuality in every stage of adulthood needs to be adjusted with an adequate perception of one's finiteness in death. The changes in bodily function and shape, the impermanence of social

achievements are a reminder that death is a natural and inevitable part of the life course. A society or person stuck in self-absorption and anti-aging experiences death as an affront to the self. Eastern philosophy where life and death are all part of a continuous cycle and other spiritual practices teach us that death and life are inextricably woven together and the "self" continues throughout.

For Baltes, Reese, and Lipsitt (1980), all development consists of both gains and losses. Most developmentalists focus on gains and mitigating or coping with losses. For them the central task of coping with loss is to overcome it and return to the former state of self. However, from another perspective loss is an integral component of life and a challenge to transcend the self. With age and the possibility of increasing illness loss and bereavement become the most challenging aspects of development. Death, the ultimate loss or transformation, rises into the foreground of our awareness and challenges all our preconceived notions of being in the world. Illness is the harbinger of death, the herald that calls us to reinterpret our state of self oblivion, the illusion of a life without death and illness.

My thesis for this paper is that illness can be an opportunity for change and development on the path towards individuation. From that perspective the challenge of illness creates psychic energy for growth, and illness as a "wound" can transform into strength and paradoxically might empower the person that is afflicted by it. Jung believed that through the use of myths, symbols, and archetypes, we, as individuals, can understand difficult experiences like illness and make them part of our own lives. Bolen (1996), a Jungian analyst claims in her book *Close to the Bone: Life-Threatening Illness and the Search for Meaning* that the search for meaning often takes us beyond our everyday boundaries and requires new tools. Using myth and metaphor she develops a new language that helps us relate to our illness experience and enhances our understanding of what is happening. She believes that we can find metaphors in ancient myths that provide meaning and understanding to the illness experience. For example, she likens the myth of Demeter and Persephone in which Hades, the Lord of the Underworld, seizes Persephone out of the blue and forces her down into the Underworld, to the experience of being diagnosed with serious illness. One day, life seems fine, normal and good, and suddenly, a test result comes back indicating a life-threatening illness. Persephone represents the innocent part of us, who lives in the land of health oblivion and one day encounters Hades as the perpetrator of the unexpected and unforeseen. The encounter with him disturbs our illusion of wholeness and good health and startles us into an awareness of our emotional and physical vulnerability and the uncertainty of life. The myth of Inanna and Ereshkigal describes Inanna, the Queen of Heaven and Earth in the Upperworld, as she decides to visit her sister Ereshkigal, the Queen of the Underworld who suffers and is in pain. For that Inanna has to pass through seven gates and surrender symbols of her Upperworld identity, status, and security. This myth represents what many who confront serious illness go through: namely pain, dying, fear of being abandoned and being changed. The confrontation with serious illness some times makes it possible for us to reach depths within ourselves that we other-wise might not reach.

Let me clarify this critical point. Kay Toombs (1995) writes of giving a speech about her illness experience with multiple sclerosis and being asked by audience members "to state explicitly those things that I find 'good' about my situation. Is it 'enabling' rather than 'disabling'? Has the experience caused me to 'grow' in certain ways?" To these questions Toombs answers, "Harsh tough the reality may be, there is nothing intrinsically good about chronic, progressive multiple sclerosis. Nothing" (19-20).

Yet Toombs also writes of what she has gained through illness – empathy for others' suffering, friendships, and "a clearer view of what is really important in my life" (20). There is nothing "good" about illness and no one living in even moderately good health wants to imagine ceasing to be the person they enjoy being. Nevertheless there are some developmental opportunities and personal powers that confrontation with illness can trigger. Illness can be excruciatingly painful and difficult and we all hope to be spared some of its pain. But at the same time individuals confronted with serious or life-threatening illness often achieve deep and meaningful levels of psychological awareness. In Greek mythology, if you were on the road to Athens, the center of all commerce, politics and art, you had to pass by Procrustes and his bed. Procrustes would place you on the bed and cut off any part of you that did not fit. If you were too short for his bed, he would stretch you until you fit (Bolen, 1996). This myth represents what happens to all of us as we go through life trying to fit consensus reality[1] expectations and goals. Parts of us get cut off so that we may meet certain expectations. To fit in consensus reality some of us disassociate ourselves from the parts that are less consensual, more oriented towards creativity, dreams and spirituality. The diagnosis of a serious illness challenges many consensus reality views and values. This process may transform our identity and reconnect us with the forgotten parts. The descent into the underworld of a serious illness may allow us to see ourselves from a new perspective and may lead to life altering decisions and relationships. Priorities may shift and change and new, deeper, more creative and more interesting lifestyles may surface.

Of course, all of us like our bodies to allow us to do certain things, to give us some minimal degree of comfort, or absence of pain. Nobody looks forward to being ill. Up until middle adulthood development centers on getting a life in every day consensus reality, securing a social status that allows us to live and provide for our families. This focus can entice us to think that consensus reality is the only reality that counts. We have a tendency to imprison ourselves in an identity that confines us to fulfill certain expected roles, like if you are a man for example, to think that your main role in life is to look after a family. Many of us have no other choices than to follow the roles that society intends for us. We are forced to do so by our social, cultural, or economic situation. And for others it is also the way we like to live. An illness can be a chance out of these collective roles.

Again for others illness leads to a marginalized position in society that is deprived of minimal social and economical security. Their inability to continue to fulfill valued and expected social functions and roles makes them feel excluded and deficient. Besides their physical pain their social suffering adds an extra burden. Eachus, Chan, Pearson, Propper, & Davey Smith (1999) and Brekke, Hjortdahl, & Kvien (2002) found an SES[2] gradient for illness in general, illness severity and the severity of pain experience. They speak of the "double suffering" of the less affluent. Individuals on the lower rungs of society not only suffer more illness but also a greater symptom intensity. When illness forces individuals into a marginalized and deprived social position they experience "triple suffering." Their suffering from social degradation is aggravated by the fact that the probability for them to experience more illness and more pain is increased and their chance to heal is impeded by their marginalized social position. For them to think of illness meanings is often impossible and

[1] The term consensual stresses the notion that reality is a cultural concept, not an absolute truth. Arnold Mindell (2000) adds a concept of non-consensus reality that encompasses all spheres of experience that get marginalized (e.g. altered states of consciousness and foggy dreamlike states) in the process of shaping consensus reality by the more dominant parts of society.
[2] Socio-economic status (SES).

inappropriate. Nevertheless, some individuals can make choices that brings meanings to their experience even in the most terrible situations. How we respond when suffering shapes who we are can make a difference for us as individuals and for those around us. It might increase some spiritual dimensions to our experience as human beings.

An important relationship exists between adult development and adult education. According to Merriam (2001), one of the best-developed theoretical links between adult development and learning lies in the theory of andragogy. Andragogy is based on the assumption that, by and large, adults are self-directed beings who are the products of an accumulation of unique and personal experiences and whose desires to learn grow out of a need to face the tasks they encounter during the course of their development. Illness and death may be the most challenging tasks we all have to confront. The different stages of illness (Crisis Phase, Transition from Crisis to Chronic Phase, Chronic Phase, and Terminal Phase) harbor many developmental tasks. Examples are:

- psychosocial understanding of the illness
- crisis reorganization
- create meaning for illness that promotes family mastery and competence
- grieve loss of family identity before chronic disorder
- acknowledge possibility of further loss while sustaining hope
- develop flexibility to ongoing psychosocial demands of illness
- maximize autonomy for all family members given constraints of illness
- balance connectedness (time together) and separateness (time apart)
- completing process of anticipatory grief and unresolved family issues
- help dying member/survivors live as fully as possible with time remaining etc...

Probably the most difficult demands on the individual confronted with illness and on his or her environment is to envision growth despite uncertainty, fragmentation of being, incompleteness, sketchiness, and conditional health. Uncertainty, not knowing, the unpredictability of one's illness course, and loss of control and powerlessness can result in feelings of meaninglessness. On the other hand, uncertainty can force us to relate to our feelings and emotions and opens us to aspect of life that aren't yet controllable and solvable. It is a powerful connector and makes us all more humane.

Let me now explore the concept of health. The words "heal" and "health" go back to the root word "*heilag*" or "whole." Healing and health are related to the concept of wholeness physically, mentally and psychologically. Implicitly, health practitioners, are supposed to work towards a state of wholeness and help patients attain it. The philosopher Ian Hacking (1990) postulates that the idea of normal currently contains both the meaning of an existing average and a state of perfection towards which individuals or societies can strive. Normal now comprises not only the concept of an objective average but also the notion of good health. Diseases have become part of a moral dispute about the boundaries between normal and abnormal and their social significance. Individual health, wellness, the avoidance of disease and illness are part of a new health morality and have become ends in themselves rather than means to some other objectives. The resulting virtue of health improvement strongly contrasts with the fact that we are never completely whole, despite our desperate urges toward wholeness, which we hope to achieve by healthy life styles and diets, by exercising, and by going to therapies of all kinds. Physical and emotional symptoms are always part of our lives. Wholeness, unimpaired health, is an illusion; symptoms are a basic aspect of our lives. Functional impairments and symptoms are a basic phenomenon of life and a "developmental stage"

that everybody goes through, at least at the end of life. Health as the state of self oblivion and unawareness of being healthy, and our focus on consensus reality life projects that presupposes a taken for granted state of good health is incomplete. Accordingly a cure oriented medicine that limits its goal to the restitution of that state of oblivion ("restitutio ad integrum" and "normality") will fault many aspects of the lived experience of illness.
Guggenbühl-Craig (1999) speaks of a basic phenomenon of life that defies all healing efforts. He calls it the "archetype of the invalid." Deficiencies, functional impairments and symptoms are always part of ourselves. He regards health and invalidity as complementary archetypal fantasies and reproves the fact that wholeness has been identified one-sidedly with health. He argues that the prevailing idea that health is wholeness in mind and body ignores the archetypal invalid within each of us. Splitting health from invalidity leads to a health and wholeness moralism and to negative stereotyping of people with symptoms. Illich (1992) further suggested that well-being as virtue is being transformed into a dangerous fetish, while little is done about the social determinants of ill health, in particular about discrimination and poverty. The body becomes a symbolic field for the reproduction of dominant values and conceptions. In Guggenbühl-Craig's opinion it may also be a site for resistance to and transformation of those systems of meanings. Sickness may be an unconscious expression of a struggle to resist and defend ourselves from the moralistic call for good total health. The strive to heal everyone and everything forces a counteraction that resists the expectations of wholeness and good health.

Furthermore, Kleinman (1997) claims that monotheism has had a determinative influence on the way health and medicine is viewed in Western cultures. The idea of a single God and Augustinian imperative of a universal moral order led to the dominance of rational principles, the idea of a single objective truth. It also fostered a single-minded approach to illness and care with an extreme insistence on materialism as the foundation of knowledge. Medical orthodoxy developed, on the base of Cartesian materialism, very strong value orientation, seeing nature as physical and bare of any teleological meaning. That serious illness may involve a quest for meaning got disavowed. The emphasis on quantitative data and the rejection of qualitative interpretation led to an objectivistic worldview bare of any moral purpose. The positive aspect of this reductionistic approach has been the development of biochemical-oriented technology and its many successes in the treatment of acute pathology. But in proceeding within this cultural logic of dualistic value opposites between male and female, mind and body, hard and soft, strength and weakness, technology and human experience biomedicine, warrants marginalization of the "softer" side of the poles. Following that logic, 'soft' medical procedures and specialties, which concentrate on the human practice of medicine and understand its social, psychological and moral aspects have low value, provide the lowest incomes, and attract more women practitioners.

"Illness in its complexity cannot be reduced to its conception as a pathoanatomical and pathophysiological fact" (Toombs 1992, p. 42). The prevailing biomedical model that focuses on the dysfunction of the biological organism and a medicine that is based on the exemplary type acute illness with the primary goal of restitution is incomplete. The scientific account of a disease state clashes with the lived experience of illness. Most of us like many medical professionals conceptualize illness as a disease state that needs fixing and restoration. But from a phenomenological point of view illness and symptoms are part of a story and embedded in a particular lifeworld. They have specific significances and are interpreted according to distinctive environments shaped by class, ethnicity, age and gender. "Healing" in contrast to "curing" requires

an understanding of the lived experience of illness, an empathic listening to the story told by illness and an interest in the meaning that the ill person assigns to her experience.

The first characteristic of the living body is that of sentience. The very meaning of our bodies is that they are animated by sensations. These subtle sensations of pressure and tension give us a sense of where one's body is in space, as well as an immediate sense of connectedness to the body. These sensorimotor experiences also distinguish the lived body from all other physical objects. They provide us with a primary "knowing" that is a "knowing" through the body. "Because our normal state of consciousness marginalizes sentient, reflective processes, we become uncertain about the nature of reality (Mindell 2000, p. 197)." But this subtle "knowing" from within is what connects us to the sentient world ("the Tao that cannot be spoken") as basic reality. The subjective reality we experience through body sensations helps us to transcend consensual aspects of ourselves and observe something much more basic about ourselves as subjects, not as objects.

In recent times some physicists and astrophysicists tend towards a sentient view of life, one which gives meaning and direction to evolution, and its self-regulating creativity. The metaphysical and teleological conceptualization of life that opposes entropy and gives meaning and direction to evolution has managed to go on despite materialism and scientism. In physics Newton determined the forces controlling the fate of objects and saw them as lifeless. Leibniz disagreed and insisted upon an inner force, the "vis viva," the mover of matter, for only matter can move matter, and the spirit or energy which is able to move it is necessarily part of it. History has for a certain time decided in favor of Newton. Einstein's relativity theory ($E = mc^2$), on the other hand, asserts that every material object has an energy which is inherent within it. But as Mindell (2000) observes: "Newton's idea of lifeless matter still prevails in science, since energy is defined mechanically. Yet Leibniz's "vis viva" hovers in the background, behind the new tendency of scientists on the cutting edge of physics who are exploring where consciousness enters matter" (p. 134).

With the rise of genetics and evolution, ideas about sentience disappeared almost completely except inside some departments of theoretical physics and philosophy. Modern molecular biology ascribes life to an emergent property of biochemical processes and any vitalistic life force or energy field is deemed unnecessary and unacceptable. Nonetheless functional descriptions still fail to capture the organizing principle present in living systems, the kind of inherent wisdom which fuses together amino and ribonucleic acids into proteins, molecules, and organisms. New concepts of quantum theory (quantum coherence, quantum entanglement, quantum state reduction) are drawn to explain basic intercellular and intermolecular dynamics and to revise macroscopic physical systems. They form the new fields of quantum holism[3] and quantum vitalism (Esfeld 1999 & Hammeroff 1997). The question is still open as to which quantum holism can be regarded to be universal in the physical realm or limited to the microphysical level. For Hammeroff (1998) life is a macroscopic quantum state: "Life is an emergent phenomenon involving macroscopic quantum superpositions which are, in reality, self-organizing blisters in fundamental spacetime geometry" (p. 1).

At the quantum level where the existence of particles is determined by the presence of an observer, one is confronted with a subjectivity which makes possible a new type of knowledge that transcends

[3] The description of quantum states as superposed and entangled possibilities or tendencies that actuate by virtue of observation. All the possibilities that can happen to an observed system when it interacts with an observing system are described by the quantum wave function, a mathematical equation that englobes all actualities.

the phenomenal. Mindell (2000) relates the indeterminacy of a quantum state, the unobserved state of a particle, to a dreamlike non consensual experience of reality: “The important point is that reality rests on interactions between the observer and the observed at levels of experiences we do not always normally notice” (p. 197).

From Mindell’s standpoint the most marginalized aspect of today’s discourse about life and experience of life is the realm of sentience. Materialistic views dominate our current perception and experience of reality. From quantum physics he extrapolates a dimension of experience in which time is non linear and parts, events and ideas are entangled and non local. In this sentient dimension basic tendencies, moods, and atmospheric changes reign. Subtle influences and energies resonate throughout our bodies and manifest in slight discomforts and symptoms at the fringe of our awareness. They can later develop into full blown symptoms and diseases. A quantum or sentient medicine’s aim, says Mindell (2000), is to discover the origin of problems before they manifest as symptoms.

Concepts of sentience defy the philosophical prejudice of the scientific community against such vitalistic concepts as guiding entelechies, élan vital, and final causes. Yet they rest, as we have seen, on modern physics and are needed to understand and treat diseases and to accommodate facts that don’t fit the old models of a physicalistic and mechanistic view of humankind. Current medical views overestimate the importance of objectifiable cause and effect relations. In so doing they disavow influences of psychology, dreams, and non-local field effects.

One aspect of every disease process is that it interrupts our sense of integrity, the taking for granted of the body. The body part most affected by the process receives a more material and object-like quality. An example of this sensory disturbance and disruption of the “sense of ownedness” (Toombs 2001) of the sentient body is when you wake up in the middle of the night and discover that your arm has ‘gone to sleep’. In those instances you most likely experience your arm as profoundly other, an object that is no longer part of your body. Likewise illness draws attention to the material nature of the body. Besides that illness is also experienced as a disruption of the sentient body – a disruption that includes an altered experience of space and time, changes in self image and self-identity, and threats to social roles and status.

Many sick people feel victimized and preoccupy themselves with the question “Why me?” “What have I done to deserve this fate?” As Taylor (1983) reported in a study of women with breast cancer there is a need to restore some sense of certainty as to the cause of one’s disease. For many sick people the uncertainty of not knowing the cause of their affliction makes it difficult for them to cope. In an attempt to regain mastery over the events of their lives and to restore their self-esteem they look for meaning and construe causal connections to reinterpret reality and answer their original question “Why me?” The search for meaning is a way to regain control and recreate a sense of a coherent world in which personal tragedies are experienced within a larger meaningful context. Antonovsky (1979, 1987) showed that women with a high sense of coherence (a global orientation and feeling of confidence that life’s challenges are predictable, explicable, and meaningful) were more resilient to extreme health challenges.

On the other hand Toombs (1995) found the opposite question “Why not me?” liberating. She experienced her Multiple Sclerosis as an unlucky break for which nobody was responsible. The

experience of meaninglessness can be a liberating and joyful experience and give people a feeling of creative power. However, finding meaning in traumatic and highly stressful life-events is positively related to psychological and physical well-being (Debats, Drost, & Hansen, 1995). Thus, in addition to logotherapy (Frankl, 1965), there have been many efforts to make meaning-finding or -making a more central aspect of therapy (e.g., Carlsen, 1988). One example is Sherman's (1987) work, which explores mid-life crises and transitions by focusing on the meaning of the crisis or transition to the individual. Unfortunately, there are not many therapeutic concepts which include meaning-finding in their approach to body symptoms and illness.

For Barnard (1995) the existential paradox of illness is the tension between hope and despair. In illness humans are faced with the boundary between finitude and transcendence. The dialectical nature of illness challenges us to defy our limitations in order to realize greater life possibilities, and to accept limitations in order to avoid enervating struggles with immutable constraints. Meaningfulness can be a helpful adaptive mechanism in the face of threat. The uncertainty of illness is replaced with a meaningful explanation and a way out of hopelessness is achieved. The diseased person is no longer only a prisoner of her illness. Her hope promotes the energy for persistent striving. But, the process of finding meaning in an illness crisis, the ability of finding the good in what is a painful and terrible experience, is a privilege that not everybody can achieve. Some illnesses, of course are simply too powerful and pervasive in their impact to be dealt with meaningfulness and hope. These illnesses are stories that need to be told and empathetically heard.

With his "Dreambody" concept and his incorporation of quantum physics into conceptualizations of medicine Mindell (1984, 2000) developed a treatment modality that integrates meaning-finding. He differentiates between the everyday world of practical activities in which consensual views of reality reign and a more symbolic numinous realm that is governed by more dreamlike events. Symptoms are seen as an attempt to compensate the one-sidedness of consensual reality and as a link to the world of sentient experiences. Mainstream views structure our experience of normality, what we perceive as functional or dysfunctional, normal or deviant, healthy or unhealthy. It influences the way we feel about certain group of people (e.g. the elderly) and various types of bodies (e.g. the thin and the obese body, the ill or diseased body). The doctrines that arise from the social discourse are subjected to power struggles within competing social groups and interests with some dominating over others and defining what counts as 'truth' or 'reality.' These mainstream value orientations dominate many individual's development and act like Procrustes. They force us to marginalize disapproved parts of our personality.

Mindell (1984, 2000) proposes a new holistic approach to medicine and body experiences. He developed many tools and skills for unraveling the subjective meanings underneath our bodily complaints which I cannot describe here in detail. Illness from this perspective can be viewed as an attempt to fight against Procrustes' one-sided demands. Illness is an opportunity to reconnect with the parts that we were forced to disassociate ourselves from.

It seems clear that Western health sciences offer powerful tools for understanding and treating a lot of different conditions and opens up new possibilities for positive change. On the other hand, dominant scientific and medical language reinforces dualistic worldviews and devalues patients' sense of wholeness. Biomedical materialism got rid of God and the soul and views matter as being inert. It disproved the concept of vitalism, a vital power or life force. This thinking has proved

enormously successful for certain purposes in certain areas. But in this disenchanted worldview there is no place for mystery and magic. With the demise of the divine and the numinous realm, with the denial of sentient experiences and our dreaming nature, all our inner experiences, which follow alternative values to those of objective materialism, are marginalized. With the denial of the idea of a force of life that animates our bodies and selves, there is no room for the therapeutic powers within ourselves, which help us regain strength and overcome fatigue and sickness.

To conclude I would like to focus on the question of how an integrated view of health translates into our own lived experience of everyday? Most of us will, while we are healthy, direct our attention outwards towards our involvements in the world and our bodies will remain largely unnoticed and taken for granted. Our bodies stay in the background of our awareness. Our conscious focus is towards meeting the challenges of everyday and we marginalize the subtle dreaming aspects of our living bodies, their primarily sentient characteristics. In sickness, when our symptoms submerge us, the body then suddenly becomes the foreground. When faced with symptoms most of us will probably display a biomedical reflex in which we seek restitution and cure. I am not saying that this is wrong but that in so doing we remain unaware of the lived experience of our own bodies. I suggest a culture in which we relearn an empathic understanding of our bodies and an experiential awareness of the sentient feelings that animate our bodies. One way to enhance experiential consciousness of the bodies' 'dreaming ' is by engaging in embodied practices such as sentient propioceptive inner work. Sentient meditation on the body brings the lived body into conscious awareness. In this practice we are directed to turn our attention to the immediate experience of the body and to discover the subtle feelings that permeate our bodies. This sentient symptom work is a way to tune into the 'dream-song' of our bodies and to explore the essential life force that gives our lives meaning and direction. Empathic listening requires that we give our bodies' stories ongoing attention and not exclusively when symptoms overflow our awareness.

Furthermore, everybody's lived experience is complex and multifaceted. It doesn't just abide to an either/or approach nor to a rational and objective truth stance of Western medicine, science, and conventional concepts of development. In our lived experience many perspectives are all true at the same time and the interconnectedness is a basic reality. From this perspective every disease is spiritual and material. There is no separation between a sentient and material realm. Reality has a material foundation and a non-visible and non-visualizable dimension of pure generative power. Symptoms in their material and subjective expression are, from that perspective, not only a source of suffering and pain, but an unseen ocean of creative potentialities.

References:

Antonovsky, A. (1979). Health, Stress and Coping; New Perspectives on Mental and Physical Well-being. San Fransisco: Jossey-Bass.

Antonovsky, A. (1987). Unraveling the Mystery of Health. How People Manage Stress and Stay Well. San Fransisco: Jossey-Bass.

Baltes, P.B., Reese, H.W., & Lipsitt, P. (1980) Life-Span Developmental Psychology. Annual Review of Psychology, 31, 65-110.

Barnard, D. (1995). Chronic Illness and the Dynamic of Hoping. In S.K. Toombs. D. Barnard, & R.A. Carson (Eds.). Chronic Illness, From Experience to Policy. Bloomington: Indiana University Press.

Beckmann Murray, R. & Proctor Zentner, J, 2001. Health Promotion Strategies Through Life Span. Upper Saddle River, New Jersey: Prentice Hall

Bolen, J. S. (1996). Close to the Bone: Life-threatening Illness and the Search for Meaning. New York. Scribner.

Brekke, M., Hjortdahl, P. & Kvien, T.K. (2002) Severity of Musculoskeletal Pain: Relations to Socioeconomic Inequality. Soc Sci Med; 54(2). 221-228.

Carlsen, M. B. (1988). Meaning-making: Therapeutic Processes in Adult Development. New York: W. W. Norton & Co.

Dannefer, D. (1984). The Role of the Social in Lifespan Developmental Psychology: Past and Future. American Sociological Review, 49, 847-850.

Debats, D. L., Drost, J., & Hansen, P. (1995). Experiences of Meaning in Life: a Combined Qualitative and Quantitative approach. British Journal of Psychology, 86, 359-375.

Eachus, J., Chan, P., Pearson, N., Propper, C., & Davey Smith, G. (1999). An Additional Dimension to Health Inequalities: Disease Severity and Socioeconomic Position. J Epidemiol Community Health 53(10). 603-611.

Elder, G.H. (1998). The Life Course and Human Development. In. W. Damon & R.M. Lerner (Eds.). Handbook of Child Psychology, Vol. 1. New York: John Wiley.

Erikson, E.H. (1959). Identity and the Life Cycle. Psychological Issues, 1.

Erikson, E.H., & Erikson, J.M. (1997). The Life Cycle Completed /ext. version). New York: W.W. Norton.

Esfeld, M. (1999). Quantum Holism and the Philosophy of Mind. Journal of Consciousness Studies, 6, No. 1, p. 23-38.

Frankl, V. E. (1965). Man's Search for Meaning: an Introduction to Logotherapy. Boston: Beacon Press.

Gould, Roger L. (l989). Adulthood. In Kaplan, H. I., M.D. and Sadock, B. J., M.D. (Eds.), Comprehensive Textbook of Psychiatry, Vol.1, Fifth Edition, Williams & Wilkins, Baltimore, Maryland.

Guggenbühl-Craig, A. (1999). The Archetype of the Invalid and the limits of Healing. In: Guggenbühl-Craig & J. Hillman (Eds.). The Emptied Soul. Woodstock, CT: Spring Publications.

Hacking, I. (1990). The Taming of Chance. Cambridge: Cambridge University Press.

Hammeroff, St. (1997). Quantum Vitalism. Advances: The Journal of Mind-Body Health 13(4):13-22.

Hammeroff, St. (1998).What is Life? Quantum Vitalism. Quantum Approaches to Consciousness. QUANTUM-MIND@LISTSERV.ARIZONA.EDU. Fri, 6 Nov.

Illich, I. (1992) In the Mirror of the Past: Lectures and Addresses 1978-1990. New York: Marion Boyars.

James, W. (1902). The Varieties of religious Experiences. New York: Longmans, Green & Co.

Jung, C.G. (1939). Conscious, Unconscious, and Individuation, in The Archetypes and the Collective Unconscious. Princeton, NJ: Princeton University Press.

Kleinman, A., Das, V. & Lock, M. (Eds.) (1997). Social Suffering. Los Angeles: University of California Press.

Labouvie-Vief, G. (1990). Wisdom as Integrated Thought: Historical and Developmental Perspectives. In R.J. Sternberg (Ed.), Wisdom: Its Nature, Origins, and Development (pp. 52-86). Cambridge: University Press.

Levinson, D.J. (1986). A Conception of Adult Development. American Psychologist, 41, 3-13.

Levinson, D.J. (1996). The Seasons of a Woman's Life. New York: Knopf.

Merriam, S. B. (Ed.). (2001). The *New* Update on Adult Learning Theory. New Directions for Adult and Continuing Education, No. 89. San Francisco: Jossey-Bass.

Mindell, A (1984). Dreambody. London: Routledge & Kegan.

Mindell, A. (2000). Quantum Mind: The Edge Between Physics and Psychology. Portland, OR: Lao Tse Press.

Neugarten, B. (1984). Interpretive Social Science and Research on Aging. In A. Rossi (Ed.) Gender and the Life Course. Chicago: Aldine.

Sheehy, G. (1976). Passages: Predictable Crisis of Adult Life. New York. Dutton.

Sherman, E. (1987). Meaning in Mid-life Transitions. Albany, New York: State University of New York Press.

Taylor, Sh. E. (1983). Adjustment to Threatening Events: A Theory of Cognitive Adaptation. American Psychologist, 38(11): 1161.

Toombs, S.K. (1992). The Meaning of Illness. A Phenomenological Account of the Different Perspectives of Physician and Patient. Dordrecht: Kluwer Academic Publishers.

Toombs, S.K. (1995). Sufficient Unto the Day: A Life with Multiple Sclerosis. In: S.K. Toombs, D. Barnard, & R.A. Carson (Eds.). Chronic Illness: From Experience to Policy. Bloomington IN: Indiana University Press.

Toombs, S.K. (Ed). 2001. Handbook for The Philosophy of Medicine, Volume One: Phenomenology and Medicine. Dordrecht: Kluwer Academic Publishers.

Vaillant, G.E. (1993). The Wisdom of the Ego. Cambridge: Harvard University.

Wilber, K. (1998). The Marriage of Sense and Soul: Integrating Science and Religion. New York: Random House.