

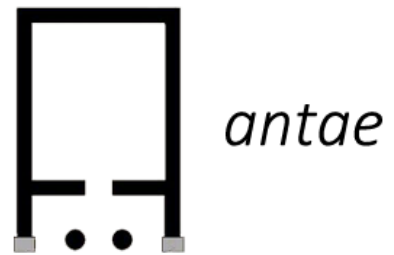
Trespassing the Boundaries of Flesh: Exploring wounded embodiment through artistic practice

Pamela Baldacchino

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Trespassing the Boundaries of Flesh: Exploring wounded embodiment through artistic practice

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The continuously shifting, 'in flux' position of the reflecting, ill body as it enters into dialogue with itself, seeks always to uncover or hide meaning as it negotiates its boundaries with other relating bodies and with its context. This is in contrast to the unquestioning way the healthy body takes its wellbeing for granted. A simple model of space, as seen below, provides the corresponding structure for the conceptual development of this paper. The model is based on the relation of three spaces: the space of interior reflection or the reflecting body/state; the space of exterior relation or the relating bodies/states; and the space of revelation or the context where the process of reflection or relation unfolds.

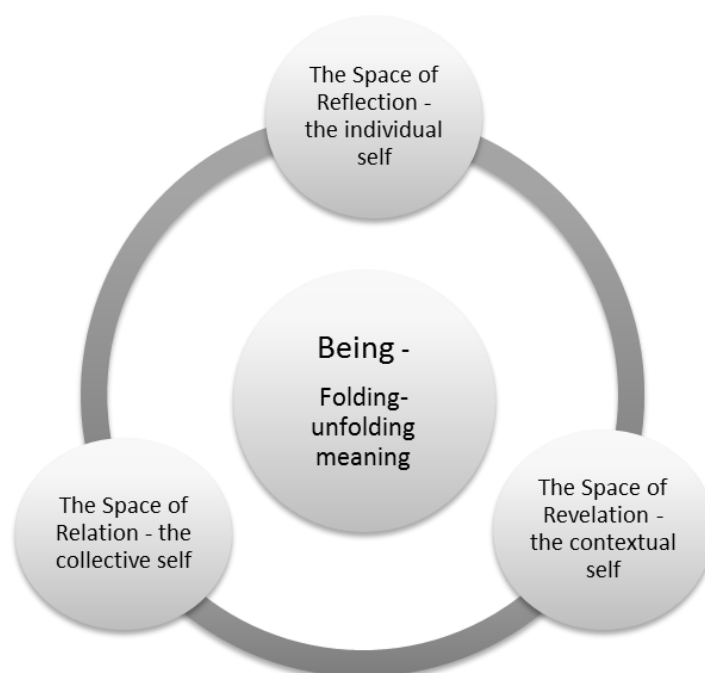


Figure 1: The 3R Model of Space

With this as a starting point, the theoretical and conceptual underpinnings to this paper will be explored in relation to the creation of an audio-visual tool, called *Sanctuary*, to be used within the hospital or clinical context. The project, *Sanctuary*, can be defined a virtual shelter where the viewer is immersed in digital art content whose narrative is based on

simple metaphorical interpretations of illness as compared to natural world cycles and ideas of journeying. The visual and auditory content aim to trigger or compound the empathic response as a way of sustaining therapeutic dialogue between the healthcare professional and the patient or client. By establishing a link between the viewing of artwork and an empathic response, one aims to encourage the process of reflection, relation and revelation (of meaning) through therapeutic dialogue and narration.

When considering the ‘3R Model of Space’ and its relation to illness, one needs to bear in mind that the human body, being subject to ‘disease whose spatial requisites are not necessarily those of classical geometry’, is invested by a level of spatialisation that is not just subject to that which is visible on one bodily plane and at one moment in time.¹ Michel Foucault describes how secondary spatialisation (the invisible, spatial depth that comes with the intersection of the peculiarities of disease with the individual body) and tertiary spatialisation (the locus of all social, political and economic dialogue related to illness and disease) affects our understanding of illness and its spaces.² It is in this light that one seeks to understand the relation between these spaces and how such a relation allows for the negotiation of meaning within the ill body. This knowledge can then be applied therapeutically within wards and clinics.

The person going through the biomedical process risks being turned into a passive recipient whose agency and autonomy are neglected. The institutional spatialisation of disease is done through a process of depersonalisation and objectification that involves a lack of personal care and emotional support, manifested in a lack of touch and human warmth; an emphasis on instrumental efficiency and standardization; the technological orientation of the biomedical process; and neglect of the patient’s individuality and his subjective experience.³

One observes a basic separation between disease and illness, characterised by the distinction between explanation and understanding. Whilst the medical doctor explains disease through the use of scientific methodology so as to identify the relationship between cause and symptom in order to prescribe treatment, illness is explained as its subjective, experiential twin sister. However, such a dichotomous view also needs to take into account the point of interaction between the opposing sides that constitute it, as clinical observation and investigation of disease must also involve human understanding of such experiences.⁴ There is in fact an ‘urgent need for a richer and a more complex understanding of the illness experience, of how illness breaks into our lives [...] to change, derange and deform’ the meaning-making structures of our human experience.⁵

¹ Michel Foucault, *The Birth of the Clinic* (London: Routledge, 2003), p.2.

² *ibid.*

³ *ibid.*; Nick Haslam, ‘Dehumanisation: An integrative Review’, *Personality and Social Psychology Review*, 10 (2006), 252–264 (p. 253).

⁴ Rolf Ahlzén, ‘Illness as unhomelike being-in-the-world: Phenomenology and medical practice’, *Medical Health Care and Philosophy*, 14 (2011), 323-331 (p. 325).

⁵ *ibid.*

Whilst phenomenological theory seeks to redress the imbalance inherent within the prevalent biomedical understanding of illness, artistic practice—being rich in symbolic language—can prove to be an invaluable, therapeutic tool within such a context. Through its use of visual metaphor, art can aim to sustain not only all that can be communicated verbally but also all that resists coming to light and to expression. Investigating other artists' relation to these three spaces reveals insights into how these artists engage with these spaces in a tangible way and how such engagement reveals layers of enquiry that seek to conceal or to reveal.

The Lived Body and the Experience of Illness

When examining the embodiment of illness, Martin Heidegger's phenomenology provides an insightful explanation as to why one observes a change in the way the ill body relates to others. He analyses 'being-in-the-world' as a space of meaning-making within the experience of the lived body: in other words, how a human being can 'be' in the world, or 'be' in the defined space around him and how this 'being' relates to this space and functions within it. Humans do not just occupy space like a simple object does; rather they can realise needs, desires and goals within such a space.⁶ In his book *The Visible and The Invisible: The Intertwining—The Chiasm* (1968), Maurice Merleau-Ponty calls this 'body intentionality' or 'life-world', referring to how man inhabits the world and gives it meaning.⁷

Heidegger goes on to describe the human body as a tool whose totality of relevance is the web of meaning acted out by a human being. He talks of a being thrown into the world, in a kind of random, haphazard movement. Central to this motion are three intertwined 'existentials'; these are understanding, attunement and language. Fredrik Svenaeus suggests that the lived body is the fourth 'existential'.⁸ These four aspects are interlinked in such a way that a change in one 'existential' will invariably affect the other, leading to a consequential change in the individual's meaning-making patterns. If these tools are broken, this will affect the 'projection' of the self in the creation of meaning through the way the self thinks, feels and acts.⁹

Health is explained as a 'homelike being-in-the-world', a 'non-apparent attunement, a rhythmic, balancing mood that supports our understanding in a homelike way without calling for our attention'.¹⁰ 'Being at home' is analogous to 'being healthy' because they share the same characteristics, such as familiarity and being in tune with the different

⁶ Martin Heidegger, *Being and Time*, trans. by John Macquarrie and Edward Robinson (San Francisco: Harper & Row, 1962), Sections 22-24.

⁷ Maurice Merleau-Ponty, *Maurice Merleau-Ponty: Basic Writings*, ed. by Thomas Baldwin (New York: Routledge, 2004), pp.247-257.

⁸ Fredrik Svenaeus, 'The Body Uncanny: Further steps towards a phenomenology of illness', *Medicine, Health Care and Philosophy*, 3(2000), 125-137.

⁹ Heidegger, *Being and Time*.

¹⁰ Kay S. Toombs, *Handbook of Phenomenology and Medicine* (Alphen aan den Rijn: Kluwer Academic Publishers, 2001), p.95.

aspects of your home and your body (being-in-the-world is the primary home).¹¹ Vincent Descombes identifies the character of home as being a place where one is ‘at ease with the rhetoric of the people with whom he shares life [...] the ability to make oneself understood without too much difficulty and to follow the reasoning of others without any need for long explanations’.¹² This leads to rhythm, balance and flow.¹³

Heidegger proposes that ‘Being-there’ (*Dasein*) is open to the world, consequently disclosed and makes itself at home in it, but only to a certain extent, because ‘to this very *mineness* belongs otherness’.¹⁴ He proposes that *Dasein* suffers meaninglessness on encountering the absurd in life. Svenaeus extends this theory to the area of disease and illness. He explains that illness has an illogical quality that leads to the individual experiencing a rupture within. This prevents the self from balancing the ‘otherness’ of the body.¹⁵

In fact, current phenomenologies of illness include the interpretation of the body as:

- An alien and uncanny entity,¹⁶
- An independent or absent entity that goes against the ill person’s will, and¹⁷
- A gradually objectified entity that stops belonging to the person but starts belonging to science.¹⁸

There is a consequential breakdown in the individual’s meaning-making structures. A senselessness in the world-structure itself triggers an indefinite anxiety as ordinary understanding and activity collapses.¹⁹ Such a turn of events does not allow the self to feel at home in his/her own body and thus all harmony is interrupted with illness. Illness is therefore defined as ‘an unhomelikeness of this structure of *being-in* [which] can be thematised as a peculiar kind of attuned understanding or as a breakdown in the tool structure related to the self’.²⁰ This leads to the ill person experiencing a change in the experience of embodiment involving a loss of control over the body, helplessness, and resistance to the illness experience.²¹

This change, in fact, pushes the self to a heightened attunement or an increased sensibility or feeling. Heidegger explains that when a person is experiencing alienation or

¹¹ See Ahlén.

¹² Vincent Descombes, ‘Proust: Philosophie du roman (Critique)’, in Marc Augé, *Non-places: Introduction to an anthropology of supermodernity*, trans. by John Howe (London: Verso, 1995), pp.75-115 (p.108).

¹³ See Ahlén.

¹⁴ See Svenaeus.

¹⁵ See Svenaeus.

¹⁶ Richard, M. Zaner, *The Way of Phenomenology: Criticism as a Philosophical Discipline*, quoted in Svenaeus, p.131.

¹⁷ Drew Leder, *The Absent Body*, quoted in Ahlén, p.335.

¹⁸ Kay, S. Toombs, *The meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient*, quoted in Ahlén, p.335.

¹⁹ See Heidegger, *Being and Time*.

²⁰ Toombs, *Handbook of Phenomenology and Illness*, p.100.

²¹ Svenaeus, p.130.

'homelessness', he is leaving the familiar boundaries of the self and entering into a process of further negotiation with the world and with the earth, creating new meaning. The world, by resting on the earth, enters in a relationship of tension as it tries to bring to light all the meaning it attaches to itself while the earth resists it by its nature which is self-secluding or concealing. Together they enter into a process of folding and unfolding meaning. The self, by sharing its flesh with the world, is also subject to this unrest by being part of this process that oscillates between revelation and hiddenness.²²

In the play *Side Effects*, the scholar Alberto Sandoval-Sánchez describes the alienation he felt when he faced the monstrosity of his illness. He writes, 'It is a feeling of terminal loss for what is left behind [...] You are in eternal estrangement.'²³ There is a strangeness that extends 'far, far away into the horizon' where 'you see your body wandering,' lost in a penumbral zone of homeless suspension.²⁴ This can be related to the Freudian analysis of the term '*unheimlich*'. Being a negation of the term '*heimlich*'—that is, the familiar, the intimate, a 'being at home' implying a degree of protectiveness and concealment (even from the self)—the '*unheimlich*' brings into being all that is uncanny or alien, all that should be concealed but is unwittingly revealed.²⁵ During illness, this self-revelation can in fact be carried out unwillingly, leading to a forced displacement or transgression of boundaries.

At this point, it is also necessary to distinguish the unconscious transgression of boundaries (I/Other, Inside/Outside) that comes with a dialectic of denial or negation (Freud's theory of the unconscious), from the process of exclusion that involves 'a separation from' rather than 'a negation of' desire.²⁶ Serious illness becomes a dance with death characterised by a degree of physical abjection that exposes one's weakness and mortality and threatens exclusion. Julia Kristeva writes,

There, I am at the border of my condition as a living being. My body extricates itself, as being alive, from that border. Such wastes drop so that I might live, until, from loss to loss, nothing remains in me and my entire body falls beyond the limit – *cadere*, cadaver.²⁷

She asks how the "I" that is expelled to a world without borders, becomes itself without borders; the ultimate transgression of boundaries, concerned more with expulsion rather than negation.

The abject thus becomes neither subject nor object, neither here nor there, but a fluctuating entity whose sole defining quality is 'that of being opposed to I', an engulfing space where meaning collapses and from where the self is finally to be excluded.²⁸ In this way, Kristeva

²² Heidegger, 'The Origin of the Work of Art', in *Poetry, Language and Thought*, trans. and intro. by Albert Hofstadter (New York: Harper & Row, 1971), pp.15-86 (p.47).

²³ Alberto Sandoval-Sánchez, *Politicizing Abjection: In the Manner of a Prologue for the articulation of AIDS Latino Queer Identities* (Oxford: Oxford University Press, 2005), pp.542-549 (p.545).

²⁴ *ibid.*

²⁵ Peter Gay, *Freud: A Life for Our Time* (London: Anchor Books, 1989), p.200.

²⁶ Julia Kristeva, *Powers of Horror: An Essay on Abjection*, trans. by Leon S. Roudiez (New York: Columbia University Press, 1982), p.6.

²⁷ *ibid.*, p.3.

²⁸ Kristeva., p.1.

distinguishes abjection from uncanniness and refers to its more violent quality as being the inability to recognise the familiar, that is, all that previously created meaning and value. In his paper on the crises of presence, anthropologist Ernesto De Martino similarly writes,

Anguish signposts the attack on the very roots of human presence, the alienation of oneself from oneself [...] [it] underlines the risk of losing the distinction between subject and object, between thought and action, representation and judgement, vitality and mortality-it is the scream of someone tottering on the edge of the abyss.²⁹

The sick person becomes anguish itself when faced with the loss of presence, leading to a ‘laceration in the structure of personality’³⁰. The ultimate threat is not the threat of being reduced to the absolute nothing (not-being or negation) but the threat of not being part of culture and history (not being-there or exclusion).³¹ The presence of the self is in fact defined by De Martino as being one’s capability to be an active mediator in the world and in its unfolding.³²

Conclusively, whilst illness intertwines its ‘mental’ and ‘somatic’ aspects to produce an ‘unhomelike being-in-the-world of *Dasein*’ characterised by displacement and transgression of boundaries leading to a traumatic loss of meaning, one need also consider how medical science intensifies the process of objectification and alienation.³³ This factor, together with the effect of hospitalisation on the individual and the potential presence of chronic pain, can make it very difficult for the ill person to re-embrace the body as home, thereby allowing the body to ‘come back to meaning’.³⁴

Revealing Spaces of Relation

This process of thought leads one to question what an individual’s prospect of adjusting to illness is and in what ways the individual can be encouraged to do so. Maria L. Honkasalo looks at the diverse ways people deal with uncertainties associated with chronic pain that is consequential to chronic illness and how they are pushed into action.³⁵ She talks of agency as a way of acting in the world so as to cope with indeterminate circumstances, identifying engaging tactics such as controlling, resisting, embracing and enduring. The idea of enduring as agency is itself strengthened by the development of meaning-making techniques.³⁶ Other studies have shown the value of creativity and habituality in encouraging or mediating the agency of the ill person.³⁷ This in turn brings together two polarities: being an agent, a form of proactivity, on the one hand, and being a patient, a

²⁹ Ernesto De Martino, ‘Crises of presence and religious reintegration’, trans. by Tobia Farnetti and Charles Stewart, *HAU: Journal of Ethnographic Theory*, 2 (2002), 431-450 (p.439).

³⁰ *ibid.*, p.440.

³¹ Kristeva, p.440.

³² De Martino, p.439.

³³ See Svenaeus.

³⁴ See Toombs, *The meaning of Illness*, and Maria L. Honkasalo, ‘Enduring as a mode of living with uncertainty’, *Health, Risk and Society*, 10 (2008), 491-503.

³⁵ See Honkasalo.

³⁶ See Honkasalo.

³⁷ See Hans Joas, ‘The creativity of action’, and Pierre Bourdieu, ‘The logic of practice’, quoted in Honkasalo.

form of inactivity, on the other. This paradoxical idea leads one to acknowledge the possibility of the agential patient as a way of being ill.

The chronicity of illness and associated pain becomes a mediating platform where control is exerted through a dialectic process that involves the nurse's negotiation of two continuums:

- a closeness – distance continuum
- a presentable – unrepresentable continuum

The presence of a closeness-distance continuum between the nurse and the patient can be balanced using Edith Stein's concept of empathy based on intersubjectivity.³⁸ By using the concept of alterity where the "I" is allowed to transcend boundaries that separate, the nurse is also able to explore the presentable-unrepresentable continuum of illness.

Brenda Cameron identifies the weaving of a 'co-text', such as the elemental acts of care that allow the nurse to bear witness to all the narrative being enacted: that which is being revealed, as well as, concealed.³⁹ One asks, what tools do nurses have at their disposal that encourage the co-textual reading of the patient's story? In a literature review of the patient's use of metaphor in palliative care, David Southall concludes that metaphor is used by patients as a tool for innovation and creation whereby they can construct a new understanding of the world in the immediate present.⁴⁰ This helps them create a new perceptual structure that supports them when seeking to visualise new solutions to the challenges they face. Southall classified the metaphors used by patients into various domains:

- military – as in a battle occurring within the patient's body,
- journeying – captures the movement within a patient's illness narrative,
- personhood – as in a change in identity, such as when a patient's body starts to feel alien,
- natural world – captures the cyclical rhythm of life or the unyielding nature of the elements, and
- existential or ideological – related to concepts or abstract ideas such as freedom and safety.

The metaphor is in fact a way through which people may gain a more in-depth understanding of the persons or things that surround them, and further insight into ideas

³⁸ Edith Stein, *On the Problem of Empathy*, trans. Waltraut Stein (The Hague: Martinus Nijhoff, 1964).

³⁹ Brenda Cameron, 'Towards understanding the unrepresentable in nursing: some nursing philosophical considerations', *Nursing Philosophy*, 7 (2006), 23-35.

⁴⁰ David Southall, 'The patient's use of metaphor within a palliative care setting: Theory, function and efficacy. A narrative literature review', *Palliative medicine*, 27 (2012), 304-313 (p.309).

and concepts.⁴¹ It is defined as ‘understanding and experiencing one kind of thing in terms and concepts of another’ to the extent that it produces ‘an identification or fusion of two objects, to make one new entity partaking of the characteristics of both’.⁴² Paul Ricoeur pointed out that metaphors are in fact ways of creating new realities whilst V. Haworth concluded that art works within wards or clinics help the exploration of perception and interpretation, thoughts and emotion through the narrative created by the artist.⁴³ Using art as a metaphorical language within the ward can thus counteract the dislocation imposed by illness and allow the nurse to read in between the lines of a patient’s story.

Some artists use this sort of dialogue to understand their own brokenness as wounded beings, so as to create art that provides insights into both spectator and author.⁴⁴ This provides context for Joseph Beuys’s observation that ‘Suffering and compassion should not arise in man because of biographical events, but every person should in himself be able to suffer and show compassion, that is, he should be so penetrable and open that he can’.⁴⁵

The artist approaches intra-personal space (Reflection), inter-personal space (Relation) and territorial space (Revelation) through practice. Boundaries and thresholds are interpreted in a way so as to finally get to the interstitial spaces between. This is done on two continuums:

- a ‘being with’ (relation) - ‘being without’ (exile) continuum
- a ‘homelike’ (relation) - ‘unhomelike’ (alienation) continuum

One can then observe the artist’s relation to these spaces and to the forms of connection or absences that infiltrate them. The artist Ana Mendieta, who worked with a Heideggerian vision to reveal spaces that fluctuate between a spectrum of relation and alienation, represents spaces which are both present and absent, and possibly fuelled by nostalgia.⁴⁶ Mendieta’s treatment of exile implies and is reflective of an exile from the spirit within the body itself.⁴⁷ Jane Blocker describes how ‘Siluetas disclose the earth in such a way that it

⁴¹ See Ahlzn.

⁴² George Lakoff and Mark Johnson, *Metaphors we live by*, 2003

<<http://www.sociosemiotics.net/files/Cognitive%20Linguistics%20-%20Lakoff,%20G%20&%20Johnsen,%20M%20-%20Metaphors%20We%20Live%20By.pdf>> [accessed 15 August 2014] p.5; *Encyclopaedia Britannica*

<<http://www.britannica.com/EBchecked/topic/377872/metaphor>> [accessed July, 2014]

⁴³ Paul Ricoeur, ‘The Metaphorical Process as Cognition, Imagination, and Feeling’, *Critical Inquiry*, 5 (1978), 143-159; V. Haworth, ‘Opening Doors: the art gallery as a resource for working with service users’, quoted in Kathleen Hammonds and Margaret F. Hammond, ‘How can visual arts help doctors develop medical insight?’, *iJade*, 31.1 (2012), 78-89.

⁴⁴ Eva Marxen, ‘Pain and knowledge: Artistic expression and the transformation of pain’, *The Arts in Psychotherapy*, 38 (2011), 239-246.

⁴⁵ Gunter Wolf, ‘Show Your Wound, Medicine and the Work of Joseph Beuys’, *American College of physicians of Internal Medicine*, 133 (2000), 927-931 (p. 930).

⁴⁶ Mendieta had been torn from her county, Cuba, at the age of twelve and sent to America through the operation Peter Pan with the intention of helping young children escape Fidel Castro’s regime; Mariana Ortega, ‘Exiled Space, in-between space: existential spatiality in Ana Mendieta’s Siluetas Series’, *Philosophy & Geography*, 7 (2004), 25-41.

⁴⁷ John Perreault, ‘Mendieta: Artopia’, *Arts Journal* (2004)

<<http://www.artsjournal.com/artopia/2004/07/mendieta.html>> [accessed 2 January 2013]

is always hidden [...] a world that for the exile is and is not always there'.⁴⁸ Ortega clarifies that Mendieta's art reveals a being in search of home. Her female form, in the process of being reclaimed by the earth, is symbolic of the home one belongs to. To reveal and to seclude are antagonizing movements, one against the other.⁴⁹ By laying submissive claim to space and abandoning herself to this process, Mendieta acknowledges all that is hidden within her and fulfils Stephen Levinson's comparative observation that 'every animal needs to find his way home'.⁵⁰

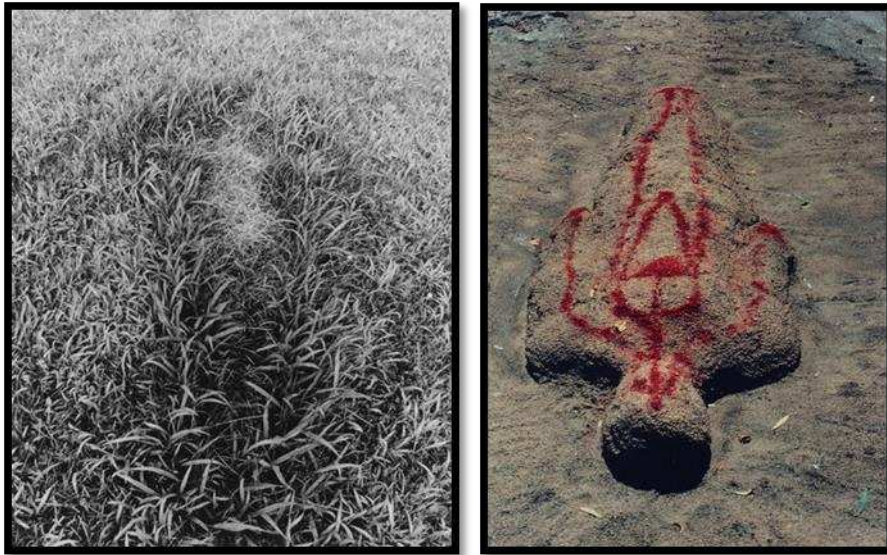


Figure 2: 'Untitled 1', *Silueta Works in Iowa*⁵¹

Figure 3: 'Untitled 2', *Silueta Works in Iowa*⁵²

Presence and absence, subject and object shift with the passage of all that is ephemeral. Photography and film capture her shadow fluctuating in-between blades of grass or partly submerged in sand, mud and water. Susan Best concludes that analysing an object with unspecified boundaries is the result of a 'desire for boundlessness (that) suggests not interminability but a desire for infinite extension and variability, like the appearance of nature'.⁵³ Mendieta's discourse challenges the intertwining duality of transcendence and objectification by controlling and leaving a temporary, volatile mark on the earth, not so

⁴⁸ Ortega, p.32.

⁴⁹ Susan Best, 'The serial spaces of Ana Mendieta', *Academia.edu* (2007)

<http://www.academia.edu/230543/The_serial_spaces_of_Ana_Mendieta> [accessed 6 October 2013]

⁵⁰ Stephen C. Levinson, 'Place and space in the sculpture of Anthony Gormley – an anthropological perspective', *Max Planck Institute for Psycholinguistics* (2001) <<http://www.mpi.nl/publications/escidoc-66471/@@popup>> [accessed on 12 September 2012]

⁵¹ Ana Mendieta, Ana, 'Untitled 1', *Silueta Works in Iowa* (1978), Estate of Ana Mendieta Collection, Courtesy Galerie Lelong, New York.

<<http://www.sfmoma.org/explore/collection/artwork/9151>> [accessed on 28 July 2004]

⁵² Mendieta, 'Untitled 2', *Silueta Works in Iowa* (1976 - 1978/1991), Estate of Ana Mendieta Collection, Courtesy Galerie Lelong, New York.

<http://artandwomenfa2012.blogspot.com/2012/11/ana-mendieta_18.html> [accessed on 15 August 2014]

⁵³ Levinson, p.64.

much as to dominate nature, but to reactivate the ‘dialectic relationship between humans and the natural world from which we cannot be separated’.⁵⁴



Figure 4: ‘Cripplewood’⁵⁵

Figure 5: ‘We are all flesh’ Installation views⁵⁶

Another artist who engages with such relations is Berlinde De Bruyckere.⁵⁷ Memories from her past resurface in the multi-tiered meaning of her sculpture. Her intense need for hope, security and comfort—qualities so intimately associated with home—are probably a vestige of a lonely childhood spent in boarding school.

One can imagine this artist as a child being impressed and maybe upset by carcasses of pigs and shanks of meat hanging from steel hooks in her father’s butcher shop. The raw muscle and fine capillaries, the bruised appearance of broken veins, the creamy deposits of hardened fat and opaque fibrous tissue give her sculptures an unsettling feeling. Branches, twigs, and horns seemingly growing out of broken bodies are covered in layers of melted

⁵⁴ Levinson, p.71.

⁵⁵ Berlinde De Bruyckere. ‘Cripplewood’, *The Venice Biennale* (2013) <<http://theculturetrip.com/europe/italy/articles/the-best-of-the-2013-venice-biennale/>> [accessed on 30 June 2014]

⁵⁶ De Bruyckere, ‘We are all flesh’, *Installation Views* (2012) <<http://www.abc.net.au/arts/blog/arts-desk/berlinde-de-bruyckere-we-are-all-flesh-acca-120706/default.htm>> [accessed on 30 June 2014]

⁵⁷ See De Bruyckere, ‘Sculpture: Berlinde De Bruyckere Interview at ACCA, We are all Flesh’, *YouTube* (2012) <<http://www.youtube.com/watch?v=ffzINEejOs0>> [accessed on 30 October 2012]

wax, bandaged at joints and laid out to rest in a funerary arrangement or immersed into a lovers' embrace. Fragile entrails and guts spill out like poetry over lines, comforted and swallowed by large pillows and supported by rope.

Through the interpretation of these artists' work, it becomes apparent that the reflective/relational state of the artist fluctuates between wholeness and brokenness, between *being part of* (within the boundary) and *exile* (out of the boundary), and between *being at home* (health) and *not being at home* (illness). This discursive orientation allows one to engage in artwork that resides within spaces that are difficult to reach and at times even inaccessible.

Development of *Sanctuary*

How does one start on the process of overcoming boundaries for therapeutic benefit? Within the hospital and clinical context, patients or clients need to share the physical, psychological and emotional suffering being faced so as to bear witness to their life story whilst making sense of and validating their suffering. The ill person, whilst negotiating internal boundaries associated with the condition of being ill, need also overcome boundaries so as to communicate effectively with the nurse, doctor or therapist.

Both theory and practice work in unison to explore boundaries in relation to flesh. If flesh is the common denominating factor of existence, then it should unify body with body, and these bodies with the world. If this were the case, boundaries would be mere technicalities that exist to define one entity from another. However, we know from experience that flesh is not simply homogenous. Your body is not my body even if I would or would not like it to be, your pain is not my pain even though empathy allows me to experience it to a certain extent, and your death is not my death although I might wish it or fear it to be. As Merleau-Ponty explains, the world, like the body, is made of flesh. This relationship is, however, always in the process of becoming but never fully realised.⁵⁸

Further insight into the phenomenology of the body as a *chiasm*, an intertwining of the subjective and objective experience of the human body, was given by Merleau-Ponty exactly before his death. He conceived this phenomenon as a way of revealing the two dimensions of our *flesh*, seen as an *element* of being. He looks to the essential human experiences, the tactile and sensory experiences that are subject and object, existence and essence. The bi-dimensionality of our flesh, as is exemplified by our being able to touch one hand with the other, leads to both tactile and tangible experiences. According to Merleau-Ponty, this reversibility of flesh is the only way I have at my disposal, as a human being, to 'go to the heart of things, by making myself a world and making them [all that is outside the self] flesh'.⁵⁹ Thus, there is a 'reciprocal insertion and intertwining of one in the other'.⁶⁰

⁵⁸ See Maurice Merleau-Ponty: *Basic Writings*.

⁵⁹ *ibid.*

⁶⁰ *ibid.*, p.255.

The reversibility of flesh, the fact that we can touch and be touched at the same time, presents a sort of osmotic boundary that allows and encourages the empathic process at work. Michel Serres suggests that the skin is the border where world, body and senses meet by contingency (mutual touching and caressing). The world, which is apprehended as a kind of flesh, mingles with skin which in turn mediates the world through its senses.⁶¹ This empathic process, however, is disturbed during illness. Arthur Frank notes that trauma, whether visually experienced as art work or witnessed in traumatic situations such as war or illness, elicits different empathic responses and disturbs one's mental wellbeing. He ties this in with the concept of vicarious traumatising where the individual experiences traumatic stress by simply witnessing the trauma narrative, such as observing a state that is engaged in war.⁶²

Serious or chronic illness can in fact be compared to a state that is at war, albeit with the self. This metaphor brings with it a perversion: invasion is no longer an exterior process but an interior one. The cultural theorist Paul Virilio talks of war that brings about a destabilization of the familiar environment including one's pace of life and one's relation to people. When experiencing war, the living space stops being secure and becomes a space of fear. Borders become subject to the *Blitzkrieg*, the war of speed (same as for medical intervention).⁶³ He brings in the terror of collective fear (versus individual fear as in the case of serious illness) and he identifies the total mobilization machine where 'everyone's set in motion'.⁶⁴ This can also be extended to the health care environment where a professional team works in unison to *fight* illness.

Virilio analyses what he calls the aesthetics of disappearance, where objects are present but are visually concealed or camouflaged. Not only do these objects merge with nature but are designed aero-dynamically, which means that during an invasion, their organic, rounded boundaries protect the physical body from damage.⁶⁵ Virilio compares the bunker to the monolith, 'an object that isn't grounded in the earth but centred in itself and capable of resisting the tremors to which the terrain is subjected.'⁶⁶ It is consequently more likely to resist what, according to Heidegger's theory, is the concealing/secluding nature of the earth.

⁶¹ Michel Serres, *Les Cinq Sens* (Arbor: University of Michigan Press, 1998), p.97.

⁶² Arthur Frank, *Letting Stories Breathe: A Socio-Narratology* (Chicago: University of Chicago Press, 2010).

⁶³ Paul Virilio, *A Winter's Journey, Four Conversions* with Marianne Brauch, trans. by Chris Turner (London: Seagull Books, 2011).

⁶⁴ *ibid.*, p.11.

⁶⁵ *ibid.*, p.42.

⁶⁶ *ibid.*, p.43.



Figure 6: 'Iron Cupola on an observatory'⁶⁷

Figure 7: 'Individual Shelter on the North'⁶⁸

One can easily compare the visor to the bunker, which provides a specific type of shelter from war. Morphologically, the forms are similar, being designed to provide protection; the bunker from exterior, physical threat whilst the visor, whose use has been misappropriated from the gaming industry, provides shelter from interior threat posed by illness. The element of camouflage aims to hide what is being unwillingly exposed. It allows for the negotiation of the '*unheimlich*'/'*heimlich*' relation within the self. It can protect to a certain degree from interior threat associated with the witnessing of the body's higher level of abjection during procedures such as wound care change, colostomy care and drainage procedures or during treatments such as chemotherapy.

The bunker presents the notion of magnified presence as the interior space of the bunker is small in relation to the physical self which is immersed in the experience of shelter. Similarly, the visor allows the self to enter a space and be engaged in it by the act of *looking out* whilst sealing off the actual space outside one's auditory and visual threshold. It then presents a virtual shelter with a screen or portal into another world. There is a sense of voyeurism and detachment from the intimate self, allowing an element of respite where the self can watch the war unfold exterior to itself in this machine designed for survival. If one had to for example imagine a contemporary situation where the Libyan patients received within a local hospital and needing to undergo major lower limb amputation are given the tool immediately prior to the surgical procedure as way of offering a life belt when one is drowning, this would allow one to 'hang on' to something. Contemporary research points out that a hospital achieves an optimal healing space when it balances 'shelter-respite' with the 'active treatment-related functions' of medicine.⁶⁹

⁶⁷ Paul Virilio, 'Iron Cupola on an observatory' (1958-1965) <<http://www.themorningnews.org/gallery/the-frightening-beauty-of-bunkers>> [accessed on 20 March 2014]

⁶⁸ Virilio, 'Individual Shelter on the North' (1958-1965) <<http://www.themorningnews.org/gallery/the-frightening-beauty-of-bunkers>> [accessed on 20 March 2014]

⁶⁹ Marek H. Dominiczak, 'The art of medicine of wandering doctors, cities, and humane hospitals', *The Lancet* (2011)

Through my project I seek to find a means to reveal the illness narrative, to encourage the ill individual to unearth the memories and feelings that lie hidden within. Considering the ill body as homeless, *Sanctuary* aims to create a mobile space of shelter and protection where this homeless body can find refuge. When illness can be seen as the temporary or extended condition that favours new meaning formation when previously constructed meaning collapses, the visor becomes the in-between space that facilitates such a process. The importance of enabling connection so as to reveal new meaning becomes the primary focus of the tool. This necessitates the creation of a space where empathic dialogue with the homeless self and with relating others can take place thereby allowing the negotiation of boundaries both within and external to the self. The unbounded self, emerging from ‘the abyss beneath illness, which was the illness itself, has emerged into the light of language’.⁷⁰ In this way, the tool hopes to contribute to the ‘syntactical reorganisation of disease in which the limits of the visible and the invisible follow [such] a new pattern’.⁷¹



Figure 8: ‘Heartbeat’, from the series *Sanctuary*⁷²

The project looks into the external and internal temporal processes associated with Heidegger’s notion of *Dasein*.⁷³ The audio-visual imagery incorporates the circadian

< <http://www.thelancet.com/pdfs/journals/lancet/PIIS0140673610623276.pdf> > [accessed on 16 October 2013]

⁷⁰ Foucault, p.242.

⁷¹ *ibid.*

⁷² Pamela Baldacchino, ‘Heartbeat’, *Sanctuary*, St. James Capua, Sliema (2014), photographed by Anna Runefelt.

⁷³ See Svenaeus.

rhythm as the basic structure of the day. The presence of an external temporal process is a reference to Heidegger's belief that when nature keeps to its temporal rhythms, it helps to organise the temporality of *Dasein*. It is a way of exploring the temporality of illness and not a direct attempt to mend any rupture the patient may have from the past and possible future.

The internal temporal processes associated with one's body are captured by the rhythm of the client's or viewer's heartbeat. The continual rhythmic sound of one's own heartbeat places the whole of the person within the context of the film and encourages one to connect empathically with the self. All the body feels immersed in this experience and in this way the visor becomes a 'bunker' experience. The bunker experience, conceptually derived from Virilio's aesthetics of disappearance, triggers both the tension and security that go hand in hand with standing in a solitary shelter whilst being assailed.⁷⁴



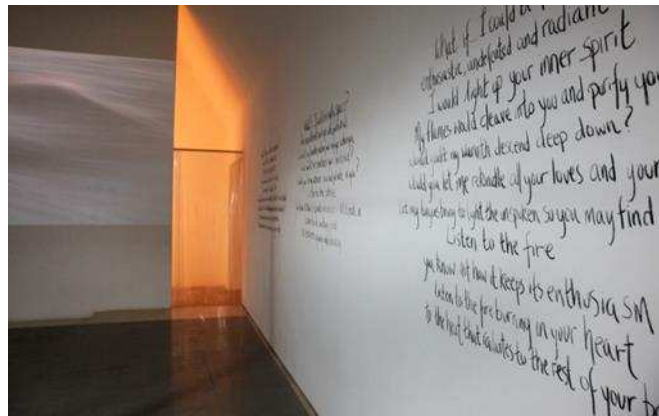
Figure 9: 'The desire for infinite extension', from the series *Sanctuary*⁷⁵

The visual imagery captures the sea and its boundaries as flesh of the world and metaphor of one's own flesh, compounding the empathic response. The sea is the broadest metaphor of existence because its singularity seemingly leads the eye beyond the borders of what we

⁷⁴ See Virilio, *A Winter's Journey*.

⁷⁵ Baldacchino, 'The desire for infinite extension', *Sanctuary*, St. James Capua, Sliema (2014), photographed by Anna Runefelt.

know.⁷⁶ Although its nature is quantifiable, it is also contemporarily ageless, timeless and endless. Its pervasive and silent qualities give it an immanent nature. This makes it encompass within it ‘the sum of all diversities’.⁷⁷ Its language is thus understood by all.



Figures 10, 11, 12: Installation views from *Sanctuary*, Propolis exhibition⁷⁸

⁷⁶ Friedrich Ratzel quoted in J. A. Tillmann, ‘I Have Seen The Sea’, *Acta Universitatis Sapientiae, Philologica*, 4 (2012), 5-13.

⁷⁷ J. A. Tillmann, p.5.

⁷⁸ Baldacchino, ‘Installation views from *Sanctuary*’, *Propolis exhibition*, St. James Cavalier, Valletta (2014), photographed by Anna Runefelt and Justin Gatt.

Conclusion

Embodiment allows one to use the mediatory senses, such as touch, as places of interaction. The physical closeness and intimacy between nurse and patient helps the patient overcome issues of trust. It allows them to engage in dialogue with the nurse present whilst revealing their thoughts and fears.⁷⁹ Physical acts such as the giving of bed baths, the holding of a patient's hand and active listening allows for boundaries that separate to be overcome. The audio-visual tool *Sanctuary* aims to sustain this empathic process whilst acknowledging all that is unrepresentable in illness through the visual use of metaphor.

The nature of serious and chronic illness can thus lead to a mediation between boundaries that fluctuate between hiddenness and revelation. The process of reflection, relation and revelation, the project's conceptual framework, becomes a process whereby these malleable boundaries enter into a dialectic relation through the attraction and negation of forces, resulting in movement between interior and exterior flesh, self and other. When a person's meaning-making structures collapse with the onset of illness, it is the negotiation and transgression of boundaries that encourages new meaning formation. Such meaning allows for the visualisation of new possibilities and, new ways of overcoming adversity. Thus, a fluidity of movement between internal and external boundaries engages the ill self in a revelatory process. Morris identifies the plasticity of space and argues that,

... the sense of space does not belong to a being who can be bounded or protected by limits, but belongs to a moving being who crosses limits and in doing so has a sense of space that always implicitly signals the limits of death, signals something that is there before us that can be neither encompassed nor sealed off.⁸⁰

This crossing-over between body, other bodies, space, place and world, whilst allowing us to explore the body's depth as it relates emotionally and expressively to all that it is immersed in, is not limited to a specific point but is a 'stretching across space and time'.⁸¹ Body-world movement leads to a place of interaction that has a texture of envelopment which stretches to accommodate our sense of depth. This movement is the 'movement of a social body, and takes our study of depth into the ethical'.⁸² Morris concludes that our sense of space is linked to our ethical relation to people and to the place we inhabit.

The wounded body is realised through the act of storytelling which in turn becomes a kind of transformative performance.⁸³ Art works concerned with spaces of relation within the hospital ward allow the flesh of the patient, the flesh of the nurse and the flesh of the artist to intermingle with the flesh of the world. This merging of boundaries, one into the other,

⁷⁹ See M. Rittman, P. Paige, J. Rivera, and I. A. Godown, 'Phenomenological study of nurses caring for dying patients', *Cancer Nursing*, 20 (1997), 115-119.

⁸⁰ David Morris, *The Sense of Space* (Albany: State University of New York Press, 2004), p.178.

⁸¹ Morris, p.126

⁸² *ibid.*, p.24.

⁸³ Arthur Frank, *The Wounded Storyteller: Body, Illness and Ethics* (Chicago: University of Chicago Press, 1997).

is what makes flesh the place where the story of this mediation unfolds, leading to the revelation of new stories.

As we turn to face each other in our quest to *be there*, be present for each other, ‘the ethical and the spatial cannot be prised apart [...] this gives us our initial sense of a responsibility to something beyond us,’ leading us to go out of our way to show care, concern and feeling.⁸⁴ Through the negotiation of boundaries, new meaning is generated both for the ill self and for the healthcare professional. The individual patient’s story will become part of the nurse’s empathic structure. It is in this commonality that life stories are recycled and become an intangible part of something bigger.

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⁸⁴ *ibid.*, p.176.

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