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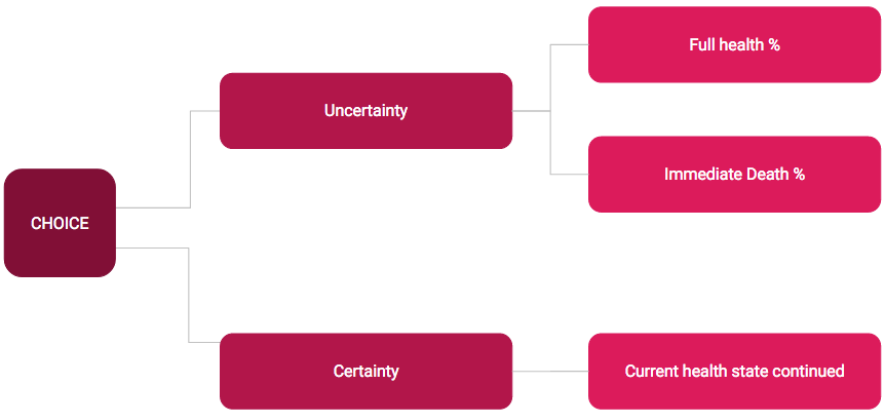
EMBODIED RESTORATION:

THE CULTIVATION OF QUALITY OF LIFE AND DEATH

Gambling with the Sacrum

A major focus point of Ivan Illich's critique is Iatrogenesis, denoting any harm done by medical involvement in health which is often driven by economic interest. The methods used to determine the economic feasibility of new medical interventions tend to be abstracted from reality. They do not consider any possible negative effects besides death, due to the extreme complexity of such calculations. Not only this, but they also do not consider the social differences in values regarding different health states. Different methods used to quantify quality of life, from now QoL, deal with the same absolutes of perfect health or immediate death in one way or another. The time trade-off, for instance, posits a decision between two scenarios, one of which will involve a cure and a reduced number of years left to live in that perfect state and the other a longer perhaps natural lifespan concluded in the current state. Because this choice includes a time factor that cannot be applied to suicidal states, time trade off will not be used below. The only method explored in this paper is the Standard Gamble. Derived from game theory and easily adapted to different patients' situations, it is considered the gold standard.

The Standard Gamble, henceforth SG, asks a simpler question. What is the highest risk of immediate death that you would accept from a treatment which would otherwise grant you "perfect" health, in contrast to the state you find yourself in today? In this way, the highest chance of death accepted in the hope of "perfect" health determines quality of life. From this the utility value is calculated as follows. As the odds given are phrased in percentages, there are one hundred answers to this question. If a patient chooses to accept a risk of immediate death of no higher than 12%, their utility value would fall at 0,88 on the scale of 0 for death to 1 for "perfect health."



The answers of individuals with the same condition, or participants tasked with imagining living with a described health state is often used to assign an average or a range of utility values to a diagnosis. While this is the larger institutional use, the main function of the SG is to help patients make medical decisions under uncertainty. However, there are only very few scenarios, all of them medical emergencies and time bound where odds of complete rehabilitation or immediate death could be given as a ratio as extreme as 50:50. We might think of difficult surgeries, attempted only because the alternative is the patient succumbing to their injuries or disease. Those are not the cases that are relevant to QoL, so going further the framework of the SG will only be used to apply to chronic conditions and other situations where death is not expected to occur soon.

The Scale of Suicidality

In the wide variety of conditions that have been categorised for standard diagnosis that can coincide within the individual, suicidality can be brought about not only through the direct suffering of symptoms but also through social changes and treatments. The SG has known biases affecting the prioritization of treatment development for diseases disproportionally affecting men at the cost of those primarily affecting women. This can be explained by differences in proclivity to risk[1] and by the implications of gender in caretaking and social connectivity.[2]As a completely subjective measure of one's own QoL, the SG can incorporate all these factors and more. For instance, one's assumptions about the future condition based on a diagnosis could become a factor of fear, increasing the proclivity to risk in seeking treatment to prevent this future version of life.

Conditions most associated with suicidality, such as depression and chronic pain disorders, tend to have the lowest utility values across cultures. However, none of them go quite as low as 0,5 which is why it is common for the range of QoL ranking by disease to only go from 0,5 to 1. We can consider this the positive side of the scale. There is an alternative way of arranging probability and choice in the SG for states considered worse than death, SWD for short.[3] This designation is made by people tasked with imagining certain health states. Often these states are so extreme that no discernment's ability can be attributed to the patients, as is the case with irremediable comatose states or the worst of the pain disorders. To contrast, values 0 to 0,5 derived from the baseline SG fall on what will be referred to as the Scale of Suicidality, represent the outcomes of reasoning for or against sustained life.

The assignation of 1 to perfect to health should be free of definition for now. It is only a subjective value which might apply to someone who might struggle to keep going in their current health state but would not accept any risk for fear of death. Extrapolating, everyone with a higher tolerance of risk is tasked with imagining their perfect health state. It should be safe to

[1] See Leath Al Obaldi, and Jörg Mahlich. 2015. "A Potential Gender Bias in Assessing Quality of Life – a Standard Gamble Experiment among University Students", *ClinicoEconomics and Outcomes Research: CEOR* 7 (April): 227–33. https://doi.org/10.2147/CEOR.S84065.
[2] Émile Durkheim. *Suicide, a Study in Sociology: - Scholar's Choice Edition* (Creative Media Partners, 2015).
[3] R. Rosser and P. Kind, "A Scale of Valuations of States of Illness: Is There a Social Consensus?", *International Journal of Epidemiology* 7 (1978): 347–58. https://doi.org/10.1093/ije/7.4.347.

assume that for many this is negatively derived from the restrictions that currently make life hard to bear, in alignment with the common definition of health in bioethics. However, the capability approach offers an alternative, focusing on individual values. For instance, the ability to think clearly could be rated to freedom from pain. Considering this realistic adjustment of the acceptance of 50:50 odds this can be described as not caring whether one lives or dies to escape the current state, marking the beginning of suicidality. Any values below could be interpreted as a preference for immediate death as an outcome. In understanding the approximate attitudes assigned to different values below 0,5 it is important to remember that there are many misconceptions about suicide making invisible the large instance of impulsive suicidal behaviour, exemplifying that a personal QoL value can change drastically from day to day. To make possible the analysis of some mechanisms capable of affecting these changes, it is necessary to abandon the contexts of treatments with known effectiveness and risks.

Good and Bad Dying: From Suicide Temptation to Life Extension

Suicidality, lacking its own history, is best understood in the anthropology of the good and bad death as well as its recent, western history. Philippe Aries having described the shifts in attitudes and rituals surrounding death in Europe as a movement away from it, starts by naming the natural death ritualised: the tame death. Here it will best be described as part of the larger category of the good death. Truly natural in that it is a cross cultural phenomenon, the good death is not caused by human action and is therefore expected, prepared for, socially experienced, and accepted.

Here follows an example of a tame death by Aries:

> "An Uncle of the same M. Pouget was ninety-six. "He was deaf and blind; he prayed all the time. One morning he said, 'I don't know what's the matter with me, I've never felt like this before; please get the priest.' The priest came and gave him all the sacraments. An hour later he was dead." Jean Guitton comments, "We see how the Pougets in those bygone days passed from this world into the next simply and straightforwardly *observing the signs* [italics added], and above all, *observing themselves.* They were in no hurry to die, but when they saw the time approaching, the not too soon and not too late, but just when they were supposed to, they died like Christians." But non-Christians died just as simply. "[4]

In *The Hour of our Death* Aries mentions suicide only as a temptation, at times proposed by a demon, always to be resisted, because though it may end one's current pain it will lead to endless torment. Christian conceptions of punishment after suicide are not unique. Many cultures have similar and often more extensive deterrent mechanisms. In some cases, suicide serves as an explanation for later tragedies befalling

[4] Philippe Aries, *The Hour of Our Death: The Classic History of Western Attitudes Toward Death over the Last One Thousand Years*, trans. Helen Weaver (New York: Vintage, 2008.

the community.[5]Deterrent mechanisms – no matter how strong – cannot work indefinitely or against the most impulsive forms of suicidality. One of the first properly documented phenomena of suicide in Europe is that of people who wished to die but not at their own hand. They preferred the more brutal methods employed to carry out capital punishment, to the sinful death that would deny them entry to the afterlife to which they wished to depart. (Bähr and Medik 2005). Non impulsive, considered, and planned suicides of any kind might not seem to fit into the framework of the SG. Death no longer presents a risk however failure to die would. We must regard these cases as the firm conclusion of long deliberation, during which hope for healing has run out and been replaced by something more definite than even the long-lasting anguish that has led one here. [6] Death is the only true certainty in the standard gamble.

There are of course cases where the sufferer might have felt this same way but did not have the capacity to act on impulse or resolution as nor communicate. If this social death had occurred but the signs of physical death were not observed by those surrounding the dying, they might be faced with the same choice as their relation, as prayer for deliverance from this state could be phrased either for restoration of life or their deliverance – a good death.

"…our lord had answered her prayers and that she was going to die."[7]

Medicalisation established new forms of uncertainty and reversed the mechanisms of control. This does not represent the secularisation of death, but the start of the iatrogenesis resulting from the fight against death in the name of doing no harm.

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[5] The following is an example from the isolated Lusi-Kaliai people living in the West New Britain Province of Papua New Guinea: "A bad death is premature and inappropriate. Even when the dying person seems to acquiesce in his or her death and tries to exert control over it – as in the case of suicide it is a death out of time. It is always seen by survivors as being caused by a human agent. Suicide is always a bad death, for it represents the ultimate expression of the breakdown of social relationships. This breakdown continues into the afterlife where the suicide is excluded from the community of the dead. Invariably, the suicides survivors argue that the person was driven or forced to this extreme action. Similarly, the victim of unrelenting sorcery may beg for death in order to escape the constant pain,

"In its loneliness it may lure away the souls of small children or enchant persons walking alone in the forest and entice them to their deaths. Such a spirit is potentially dangerous to the living because it cannot sever its ties to them. […] It continues to be a social person who cannot resolve its grief and, as such, poses a threat to the living." Dorothy A. Counts and David R. Counts, "Loss and Anger: Death and the Experience of Grief in Kaliai", *Coping with the Final Tragedy: Cultural Variation in Dying and Grieving* (Amityville, NY: Baywood, 1991).

[6] Joseph Andriola, "A Note on the Possible Iatrogenesis of Suicide", *Psychiatry* 36 (1973): 213–18.
Aries, Philippe. 2008. *The Hour of Our Death: The Classic History of Western Attitudes Toward Death over the Last One Thousand Years*. Translated by Helen Weaver. 2nd edition. New York: Vintage.
[7] Ibid.

> "In den Aufzeichnungen des Zürcher Totengräbers Hartmann Wirz über den Tod zweier seiner Kinder tritt der Tod zwar nicht unerwartet auf, aber die Sterbephase verlängert sich quälend. Es herrscht völlige Ungewissheit. Die beinahe Verstorbenen werden plötzlich wieder zu Genesenden, um erneut ins Sterben einzutreten. Ärzte machen Hoffnung, korrigieren ihre Diagnose- und korrigieren ihre Korrektur wieder. Man erwartet ‚alle Minuten sein [eines Mädchen, Anm. S.L.] seliges Ende'. Aber: ‚Wer Hätte doch immer Denken sollen, Daß dies ausgemergelte Gerippten, einen solchen harten Kampf […] aushalten Könte.» Doch das Mädchen ‚Kame […] Wieder ein Wenig zu sich Selbst'".[8]

The extension of life by any means, especially in the case of illness that might be defeated, starts to take hold here. However, in case doctors conceded that their methods could not have any effect to win this fight, they would still refer them to the church, be it for the last sacrament or forms of healing inexplicable to doctors. This is true to this day. Curiously, the other type of case referred to the church by the new medical profession was due to the hardly understood bodies of women and the mysterious caves they were said to contain. The following sections will focus on gendered experience, due to the gender paradox in suicide.

Schluckbildchen: Image as Remedy

For those reliant upon divine intervention, rather than the medical and crude intrusions into the body at the time, there was another way of taking matters into their own hands. "Pilger wiederum suchten Gnadenbilder wie auch Reliquien nicht nur zu schauen, sondern selbst zu berühren, zu küssen, oder gar in den Mund zu nehmen, bisweilen sogar in sie hineinzubeißen und sie zu schmecken."[9] Interactions with both primary and secondary relics were intimate in nature. Touch and its more extreme forms described above, starting from kissing to biting, involving ever more senses seems private but the experiences derived from such intimate encounters with the saints' bodies were widely discussed. "The odor of sanctity" is one such phenomenon, which Illich comments on in his conversations with David Caylee[10]. The poor handling of the relics, as well as other attempts to permanently take up healing energy, one such practice "Einheilen" or "Verheilen," involving the inclusion of the consecrated communion wafer into a wound before sutured or bandaged, eventually led to a change in accessibility. In 1215 the Fourth Council of the Lateran decreed that all relics

[8] Sebastian Leutert, "Geschichten vom Tod: Tod und Sterben in Deutschschweizer und oberdeutschen Selbstzeugnissen des 16. und 17. Jahrhunderts," Basler Beiträge zur Geschichtswissenschaft (Basel: Schwabe-Verlag, 2007).

[9] Schaller, Maria. 2021, "Bilder essen? Einverleibte 'Schluckbildchen' und 'Schabmadonnen'", in *Einverleibungen: Imaginationen – Praktiken – Machtbeziehungen*, Schriftenreihe der Isa Lohmann-Siems Stiftung (Berlin: Reimer, 2021).

[10] "But what was important was that the people themselves smelled the sanctity of a relic, the odor of sanctity. I'm not joking, I have too much evidence of this. You asked me to tell you about a foreign world. The odor of sanctity was so much perceived by everybody that, at the beginning of that century, there was one bishop in Milan who claimed that he didn't feel it, and people asked themselves, Why did God so punish him, or what sin did he commit that he couldn't feel the smell of relics?" (Cayley 1992)

may only be displayed inside their cases, reducing the experience from the multisensory to the visual. To reinstate all the senses and intimate contact with these holy objects a more complex process using images emerged. One of the reported healing miracles popularizing images is of difficult birth, during which the laborer swallowed a pendant of the mother Mary. As her prayers were answered and the child born, it was discovered that it held in its right hand the swallowed pendant.[11]

Retellings by Jacob Vorhof among others speak of the pendant's passage through mysterious caves, which circumvented the problem of digesting and excreting the tertiary relics and communion wafers. Also of note is that stories of children born with the swallowed images were numerous, while in others the image exited the mother's body through her mouth.

> "Suggeriert wird eine Passage durch die geheimnisvollen »inneren« Höhlen des weiblichen Körpers, der Bilder an verschiedenen Stellen dauerhaft aufbewahren oder verbergen, sie aber auch eigenmächtig gebären kann."

This symbolic association of caves to the feminine[12] seemed to have kept the medicalization of women at bay, although the same cannot be said for pathologies. This new pilgrimage rite involved all the markers of magic in anthropology. Votive offerings carved from wood or made of red wax cast into the shape of the affected body part were taken to the holy site and left at the altar. These mimetic magical artefacts functioned as an invitation to the deity to enter the ailed body. Contagion was implemented prior to sale by touching the "Esszettel" or "Schluckbildchen" (edible leaflets) to "Gnadenbildern" (depiction of a saint, painted or plastic which can be asked for miracles or intercession), thereby turning the papers into a tertiary relic. The stamp-sized images which were torn from the slips one at a time sometimes depicted saints, usually Mary, but just as often showed other relics. These were depicted to engage the *sensus interni*, that is the full imagination, using the lower senses of touch, taste, and smell. For this purpose, the drawings were as interactive and suggestive as possible, showing details from creases to textures that one's body might feel in the interaction that the image seems to invite. Additionally, the journey to and from the "Walfahrtsort" showed veneration to the spirit. Upon return the

[11] „Gertrudis Pichelmayrin, Tagwercherin zu Oberstaetten naechst Abensperg, bekennte muendlich, und mit einem Ayd, das als sie Anno 1747. in Monat Octobris nacher Alten-Oetting Wahlfarthen gegangen, sie unverhofft unter Weegen in die gefaehrliche Kinds-Noethen gekommen, also daß sie zwey Taeg sehr schwaerlich von disem Ubel geplaget worden; in diser Gefahr dann erinnerete sie sich, von ihrer verstorbenen Mutter öffters gehoeret zu haben, daß die allhiesige Gnaden-Mutter sich in dergleichen Umstaend sonders huelffreich erzeuget habe. Weil sie nun kein anders Bildlein [der Landshuter ‚Muttergottes mit dem geneigten Haupt'], als einin Messing eingefaßtes und an ihren Rosenkrantz angehaengtes bey sich hatte, nahme sie solches herab, und in einen Wasser ein; worauf sie gluecklich Kinds-Mutterworden. Dabey aber Insonderheit zubewunderen, daß, als man das Kind gebaadet, und ihre Haendlein gereiniget, selbiges in ihrer Rechten das eingenommene Bildlein haltende ist befunden worden. Besagtes Bildlein nahme die Mutter hernach zusich, und ueberbrachte es in unser Closter, allwo es noch biß anheunt aufbehalten wird."

[12]Johannes Mattes, "Unter Der Haut Der Erde – Geschlechter- Und Körperbilder Des Unterirdischen von Der Antike Bis Ins 20. Jahrhundert", *Mitteilungen Des Verbandes Der Deutschen Höhlen- Und Karstforscher e.V*. 59 (June 2013): 60–68.

Esszettel are consumed, meaning part of the deity's power is given to and absorbed into the body, completing the exchange.

Whether the conditions sought to heal could be affected by trust in a higher power, as in the case of a long labor or made bearable in case of chronic suffering through positive sensual experience, images and the pilgrimage rituals surrounding them were a useful practice for healing. Considering Esszettel to be an early example of a placebo,[13] the "papierene wundertätige Pille" (Schaller 2021, 142) is not a reduction of the complex practices developed by communities of women. Instead, it shows the efficacy of non-materialistic healing modalities, despite obviously requiring adjustments in a post-secular world. Their popularity in the eighteenth century implies a certain efficacy as a technology to strengthen belief and improve the individual's relationship to their body. This positive feedback effect is something adjustments made should aim to reinstate, generating awe of human physicality. Given the assignation of the body and the intimate senses of touch, taste, and smell as feminine and ratio along with sight and hearing as male, it stands to reason that those being granted access to the full sensibility of their body could have an advantage in healing.

The Vulnerability of Gendered Bodies

While connection to the body, as well as the social tolerance of sensitivity and therefore higher utilisation of healthcare might be greater for women, when it comes to low quality of life, time to heal is the bigger advantage. While women tend to report experiences of suicidality, encompassing ideation, behaviour, and failed attempts more frequently, men conversely have higher rates of mortality. Without making any further claims on impulsivity, it is important to explore the differences in relating to the body due to forced modes of intersubjectivity and (suicidal) behaviour prescribed on the basis of sex.[14] The split of the "Leib," the body and mind as one, along the gender binary appears contradictory, marking it as one of the weaker narrative points upholding the dichotomy.

The boundaries of male and female senses, capabilities, ills, characteristics, etc. blur the main differentiation of the woman as body and the man as mind. Only in considering the violent constitution of gender on the body (of the child), does it become clear that this split has as much phenomenological merit as gender singly. The divide is simply between internal (embodied) experience of the self and the external (instrumental) wielding of the body. This is exemplified by different forms of violence that aim to disembody, either the other or the self, completely.

Disciplined Embodiment

In the military academies of the Freikorps where suicide was common, bodies of boys were reconstructed so that they might one day move with the other cadets as the troop machine. Constant surveillance made any other form of connection impossible. Any failure to discipline oneself to work as part of the machine, was punished. The dual numbing strategy often included further isolation, but mainly relied on physical pain which only

[13] Duane J. Corpis, "Marian Pilgrimage and the Performance of Male Privilege in Eighteenth-Century Augsburg," *Central European History* 45 (2013): 375–406. https://doi.org/10.1017/S0008938912000337.
[14] S.S. Canetto, S. S. I. Sakinofsky, "The Gender Paradox in Suicide," *Suicide & Life-Threatening Behavior* 28 (1998): 1–23.

ceased once it was accepted and desired[15], completing the reversal of the pleasure principle.[16] "The soldier's own body is purged of sexuality, its erogenous zones cordoned off, deadened."[17] Awareness of vulnerability closes the body to distance itself from femininity. "The raped and rapeable body, the body vulnerable to sexual assault, is a woman's body, whatever its genitals may indicate. A man is not merely the one with a penis. A man is the one who can use his penis as a weapon, who can rape."[18] What other body could be more femininely vulnerable than a dead woman's body? What other body could offer a boy such assurances of his invulnerable sexed status? What other body offers such protection from the risks of the erotic? […] In enacting the fantasy of their invulnerable imaginary bodies, the rapists abandon the *jouissance* of the lived body's passions. Mechanical ejaculation with a "dead" woman is a poor substitute for the fleshed intimacies of erotic sexuality.

Corporealized Vulnerability

„It is his body on/in hers that robs her of her right to be in a world of her making. Whether she sees him looking at her or whether he blindfolds her, it is his body entering hers, that makes her into the sex that can and will be used as a thing. […] Where Witness 1 France speaks of her rape as transforming her into an object body, Susan Brison speaks of her rape as transforming her body into an enemy body. For her, it was not a matter of being objectified, but of becoming an intensely vulnerable body whose vulnerability makes it an enemy to herself. This enemy body poses no danger to others. It only threatens her. Louise de Toit describes the body transformed by rape into an enemy body as treacherous. She writes, "For the duration of the rape, the body with its pain and humiliation, and the body as a thing causing that suffering becomes the victim's only experience of herself...With trauma enhanced clarity a new despicable treacherous version of herself is burned into her consciousness."[19]

In all cases of alteration described above, the body is easier to kill. The object body cannot be regarded sensitive even to mortal wounds. The enemy body can be managed, or its power taken away completely by absolving the connection between the body and self through physical death. As in the last case the newly constituted betraying self can be undone if the death of the familiar self is completed by physical death. Both examples of violence constitute gender on the sex of the body. It is not necessary for each body to experience sexual violence or to penetrate others. The threat alone inscribes gender into the body along lines of vulnerability. However, the

[15] "No feeling or desire remains unclarified, all are transformed into clear perception: the desire for bodily warmth into a perception of the heat of bodily pain; the desire for contact into a perception of the whiplash. "

[16] Klaus Theweleit, *Male Fantasies, vol. 2,* Theory and History of Literature, 22-23 (Minneapolis: University of Minnesota Press, 1987).

[17] Jonathan Kemp, *The Penetrated Male* (Santa Barbara CA: Punctum Books, 2013), 44.

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[19] Debra Bergoffen, "War-Like Violence: Violating the Ontological Contract," *Labyrinth: An International Journal for Philosophy, Value Theory and Sociocultural Hermeneutics* 23 (2021): 117–29. https://doi.org/10.25180/lj.v23i2.268.

trauma of experience takes more than *jouissance*, it can cause a loss of all enjoyment of the body, numbing everything down from warmth to relief.

The Rational Diseases

The loss of hedonistic function, indeed any capacity for positive experience of stimuli, is so common it is named and its many forms welldescribed, Anhedonia. Therein lies an opposed form of disembodiment in relation to pleasure and pain, to that of the Freikorps, who while substituting pain for pleasure after it's eradication can still experience pain positively. For sufferers of Anhedonia, however, the remaining range of sensation is numb to negative.

The loss of emotional resonance, described by patients as a "feeling of not feeling"[20] is the furthest extent of disembodiment. Self-harm beyond pain becomes the guiding principle of sensitivity and relationship with one's self exactly because the usual instincts for self protection become inverse. This experience and the mental as well as physical pain it entails temporarily forces a reconnection between the body, the psyche, and the world. Although these states are not likely to be perceived as having a physical origin, the body is where interventions intuitively occur. (Numbness experienced while the pleasure principle is intact offers more options for escape from desensitised states, such as hallucinogens or sex.)

Although seemingly counterproductive, both disembodiment and reactions of self-help/self-harm should be understood as a coping mechanism. As coping is a central concept in Illich's definition of health, it must be clarified that these are time sensitive. And any attempts at self-help within a personal rational response to specific circumstances, including personal beliefs, will require additional healing. Increased likelihood of suicide attempts through the wearing down of bodily protection instincts in self-harm can only be said to involve a decreasing utility value, varied by the frequency and severity of harming behaviour, already on the scale of suicidality and prone to fluctuations. As self-harming behaviours can be part of many disembodied rational strategies, all individually susceptible to environmental impacts on QoL, the perception of time and change has to be explored in another context. For severe depression a common phenomenology is desynchronization. This altered perception of time influences the rational consideration between enduring low QoL states and immediate death.

"Corporealisation thus means that the body does not give access to the world any more, but stands in the way as an obstacle. The exchange of body and environment is inhibited, drive and impulse are exhausted. […] The excretions cease; appetite and libido are reduced or lost. […] In the worst cases the weight loss may progress to the point of cachexia, and the regulation of the blood circulation gets disturbed. All this litterally means a corporealisation, namely in the sense of coming nearer to the corpse, the dead body." "The patient is forced to identify with his present state of bodily stasis and decay, with his state of feeling guilty as such, or, in nihilistic delusion, with his state of not feeling alive any more. He is no more able to keep his situation in

[20] Thomas Fuchs, "The Phenomenology of Body Space and Time in Depression." *Comprendre* 15 (January 2005)): 108–21.

perspective, and to relativize his convictions. It has always been like this, and it will stay the same for ever – all reminiscence or hope different from that is deception."[21]

The phenomenology of severe depression above, is opposed to the view that embodied cognition is a form of bounded rationality, which if freed from the body could be perfect. Instead, the questions asked by the SG are agued internally, and whether the conviction of the state being irremediable is the conclusion or in much the same way that death will occur and until then life can be endured, the thoughts surrounding suicidality are rational. It can be hard to argue against such deeply personal and meaningful arguments, showing a need for proof of improvement in persons who were once in a similar position. If successful, the movement from corporealization, with its clear convictions derived from incredibly limited evidence, to embodiment first through the experience of others and then one's own senses, is what we can consider the base movement of healing.

Within a phenomenology of depression, it is equally clear that treatment should be sensory in order to reconnect the body to the world. If instead treatment for suicidality consists of more interventions into the Leib, this can act as a deterrent from seeking help, as all iatrogenesis can. It should be clear that the explanation of one's attitude toward death needs to be respected and worked with in any medical setting rather than condemned and pathologized. Returning to the SG, if the conception of treatment for suicidality is violent and having low efficacy, this can further the idea that healing is impossible and drive suicidal persons to attempt to take one's life rather than seeking help. If however, help is given on the sensory, bodily, and mental levels, wishing for death will not be forgotten. Instead, a resolution of postponement might carry forth the positive attitude towards or perhaps even anticipation of death into old age.

Death as Capability

Only opposed to the death caused by human action can death be natural. Beyond natural causes it must be assigned to a diagnosis and localized to a failed organ system. Reducing death to a failure of the body to sustain life is possible only in a society where death is made invisible. Observing the process of a slow death, as in palliative care, reveals two phenomena which meet the criteria of a natural death. The rally, a sudden increase in vitality shortly before physical death occurs, restores the passing person to their old self. If correctly understood as one of the signs, it provides opportunity for a last goodbye. Holding on at the hour of one's death, be it for minutes or hours to elongate the window of opportunity for such a goodbye, suggests that a good death is a capability. Notably, excitement at the release of preliminary results of the Aware II study of cardiac arrest, using both brain scans as well as interviews revealing a positive phenomenology shared by the 11 patients that retained memories of their near-death experience (NDE), shows that all death might soon be equalised. Regardless of one's last moments, a complex neurochemical process that is reported to include a feeling of coming home by those who after all did not die, accompanies the physical death. More research coming to similar results could appease the atheist's fear of nothingness and make it altogether more attractive. While

[21] Ibid.

offering comfort for those grieving after a sudden death or afraid of one's own passing, positive conceptions underscore a need for deterrent mechanisms apt for a secular modernity. The following is a proposal for a new deterrent strategy, strengthening belief in healing as well as recovering the ability to observe the signs and die a good death.

Interoception

In the Leib, self-awareness of the mind as introspection has a physical pendant: interoception. The space bordered by one's skin is where direct experience occurs most intimately. Akin to touch, emotion, affect, and pain/pleasure, interoception combines and localises physiological information. While awareness of these internal perceptions automatically embodies, there is a danger that negative interpretation of sensation induces anxiety and leads to self-pathologizing, especially in those afraid of death. To this day interoception lacks a secure place in the doctor patient relationship. This is an issue of communication and bias. In the perspective of a medical professional, sensation is not rational. The patients do not know their own body. They do not understand the specific ways that pain is splayed across their skin. They might not even know the direction in which their bowls are arranged and should be externally stimulated. As a result, subjective experience is often ignored as soon as the most likely and fatal causes are eliminated.

This focus on fatality excludes risk of suicide. Medicine lacks a consistent phenomenological vocabulary to bridge the gap between the expert of their body and the expert of disease. For example, rating pain on a scale of 1-10 is ineffective without a measure, while terms like "treatment resistant depression" or "failed to respond to treatment" places blame on the body. Patients are often forced to become lay experts, potentially reaching a diagnosis that fits onto their broader life experience, which might be confirmed or eliminated by lab work or imaging. Beyond self-assessment, methods like imaging open new doors for healing in professional settings. Risk free options utilising the placebo effect demonstrate that if it works, the mechanisms need not be understood. Healing experiences that are sensual, spiritual, and interpersonal in nature have been clearly shown to take effect. Seeing these black box methods as a continuation of religious healing experiences, it should be clear that benefits of belief can be expanded into the post-secular.

As Tanya Luhrmann has shown in her absorption experiments,[22] learning to pay close attention to all internal phenomena is necessary for religious experience. It follows that the body can support other systems of belief, including that of its own capacities. Whether wound and wonder share a common origin, they should be linked in the individual's relationship to the body. Supported on a societal level the evidence of this could come in the form of discourses on brain plasticity or images of livers regrown after donation for transplant. Although medical technology has played a part in the creation of life as sacrum, as in the case of intrauterine life starting at conception, it can now help create the new sacrum – the Leib, as the foundation enabling all experience, before it is transcended.

[22] Tanya Luhrmann, *How God Becomes Real: Kindling the Presence of Invisible Others* (Princeton NJ: Princeton University Press, 2020).

Conclusion

Aries concludes *The Hour of Our Deat*h with a pessimistic outlook on the future of death in the west with medicalization rendering it invisible, while the image of the dying entangled in machines present a new savagery. A shameful end. "Père Ribes in 1973 when he was lying in an intensive-care unit with tubes all over his body: "They are cheating me out of my own death!"[23]

The failure of the body controlled in this setting, is ignored, because according to Aries neither the individual nor the community can comprehend its enormity or personal significance. However, Aries did not account for growing parts of any community that had previously experienced suicidality. Given an opportunity to publicly address the experiences and resulting fearless attitudes towards mortality without risk of being pathologized, previously suicidal persons might accomplish an unveiling of death from behind the hospital curtains. Doing this in tandem with stories of regained *jouissance* could showcase that the quality of death is within reach as well. In this sense approximate value meanings can be assigned to a scale of quality of life and death (QoLaD) utilities.

-1 to 0: The true negative scale only applies to persons dependent on life support with a condition confirmed to be irremediable. The SWD formula, wherein immediate death and current health state are in reverse positions, of the SG is applied. Suicide is not possible, instead euthanasia might be sought. The withdrawal of life support can be seen as a natural death. A release long overdue. The assumption in these states is that solely negative experience is possible.

0: Corporealization. All intersubjectivity is lost, representing a social death. There is hardly any sensitivity. Healing is still possible. Physical death would merely complete the social and psychological death. Through the loss of all affects, this completion might naturally occur, unless the minimal requirements for sustaining life in stasis are met by someone else.

0 to 0,5: The scale of suicidality. While the current condition might fluctuate widely, the uncertainty, reduced sensitivity and impulsiveness can be encompassed without conflict. Escaping this general instability includes a lot of internal deliberation to find a strategy strong enough so that it can be relied upon to get through setbacks and implement systems of prevention and care.

1: Perfect health. A state of wanting to live to the body's full ability and deriving enjoyment from it without holding out hope for serious improvement. While discomforts might be present both mentally and physically, positive experiences exceed them. At this level death can be accepted, anticipated, and even experienced positively. Relationships can be brought to a good end.

The gender gap exists in suicidality, as well as many of its risk factors like depression or domestic violence. Realizing the full capabilities of the body as a malleable organism shaped by environment is significant because the limits of subjectivity are lifted. In gender affirming health care, the body is transformed, different trajectories of its development revealed, and ambiguity reinstated. As with other healing experiences, hormone replacement therapy and elective surgeries create a new set of cultural values that are not bound to the therapies but to the possibility of

[23] Aries, op. cit. 567.

transformation. Ambiguity in self-determination is crucial for healthier modes of intersubjectivity within current protector-protected societies. "The deconstruction of gender enacted by those who refuse to be identified with any gender, by those who identify as trans-gender and by those who speak of themselves as bi-sexual, creates a unique opportunity to re-imagine the category of gender. These challenges to fixed gender identities align gender with the realities of ambiguity. They are a dramatic way of signifying the fluidity of the intertwining of consciousness and bodied existence that defines us as subjects."[24]

However, the idea of the human body, spanning all categories and their corresponding abilities, is far from being supported by medicine. Medical misogyny clearly devalues the lives of menstruating and birthing people. Ignorance spans from physiological birth processes well known in indigenous cultures, to accepting severe pain as a normal component of the hormonal cycle and once more discounting suicide as a fatal risk factor. The leading direct cause of death (pregnancy related) in the year following birth is suicide.

What has been called a capability so far could also be called a technique of the body. Taking the cultural body (including the gendered body) to presuppose the natural body which it has overwritten, the intertwined being can be investigated only if the cultural categories are removed and their prescriptive techniques unlearned. Then interoception might reveal better ways of suffering, as through medicalized culture iatrogenesis has seeped into our self, where it can cause greater harm by corrupting even the most basic of functions of the body. This social and cultural iatrogenesis can reach from stomach gripping (sucking in) weakening the pelvic floor, which might lead to incontinence and organ prolapse, as well as altering breathing to a lung perforation cause by heavy panting due to pain.

Currently the most pressing application of the QoLaD scale, which considers the number of treatment options offered, would be to create an accurate picture of suicidality in patients with different diagnoses and comorbidities. This would include tracking the changes in utility following news such as "another treatment failed" as well as simply analyzing seasonal changes. Seeing as reduced treatment options along with general support and accessibility lower QoL, health services need a more accurate and expansive data pools apt at displaying the complexities of a system in which the service is itself a major actor.

[24] Debra Bergoffen, "The Flight from Vulnerability," in *Dem Erleben Auf Der Spur: Feminismus Und Die Philosophie Des Leibes*, eds. Hilge Landweer and Isabella Marcinski, 137–51, (Bielefeld: Transcript Verlag, 2016),150-151.