THE EXPERIENCE OF AGONIZING PAIN AND SIGNALS OF DISEMBODIMENT

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(Received 16 November 1995)

Abstract—Philosophical literature discussing embodiment has yet to address the many and multiple modes of disembodiment. The analysis of interviews with burn patients who had experienced agonizing injuries reveals reference to their own body parts using depersonalized language (i.e., it, the, this). The conjectures tested were: disembodiment (1) due to loss of sensation; (2) due to loss of ability to control the affected part; (3) as learned from physicians; (4) as a means to protect the self in an agonizing situation; or (5) as a means of controlling overwhelming pain. These alternative explanations for the use of linguistic signals of disembodiment were assessed by comparing burn patient interviews with interviews of patients who differed by significant characteristics (i.e., patients who had spinal cord injuries, transplants, or myocardial infarction). Thus, alternative conjectures for the use of disembodying language were excluded, and the interpretation is advanced that the use of disembodying language by burn patients points toward a special human capacity to maintain the integrity of the self during prolonged agonizing experiences. The present study thus attempts a phenomenological interpretation of the body and its experience by drawing on otherwise neglected qualitative research data to broaden and deepen our understanding of the experience of excruciating pain. © 1998 Elsevier Science Inc.

Keywords: Pain; Disembodiment; Burns; Spinal cord injury; Myocardial infarction; Transplant.

INTRODUCTION

Following catastrophic burn injuries, individuals arrive in the emergency room suffering from life-threatening trauma. Some patients retain a level of consciousness and are acutely aware of the extent of their injuries. They may have remained oriented and partially lucid while being extricated from an accident scene, receiving emergency care, and being transported to the hospital. For burn patients, their agony can be only temporarily relieved during the most critical phases of injury management. Although the weeks that follow may blur due to the effects of analgesics, their agony continues during the onslaught of “excruciating” and “intolerable” treatments. Interviews with these patients reveal what they later recall as “flashbacks” of extraordinary clarity to many of these devastating experiences. During the rehabilitation period, in addition to managing the memory of pain from the critical phases of illness, these patients have to “come to terms” with the resulting disabilities, losses of body integrity, alterations in their former sense of self, and often the death of other family members involved in the same accident [1, 2].

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How do these patients “get through” such an experience? One aspect of coping with the agonizing physical pain is what we will identify—with reference to the literature on embodiment—as “disembodiment.” Embodiment, as a summary term for the bodily aspects of human subjectivity, emerged as a central term in the French phenomenological tradition as a result of the work of Maurice Merleau-Ponty [3]. Disembodiment entails not so much a change in body image (although that may eventually take place) but a distinct physical distancing from one’s own body. We have noted that such distancing is signaled by the ways in which burn patients spontaneously begin to refer to their bodies.

When analyzing transcribed interviews with burn patients, the senior author noted that, in describing their experiences, the patients regularly refer to parts of themselves as objects: as it, the, this. Yet when these individuals describe the rehabilitation period, they resume using possessive pronouns to refer to the same parts of their bodies. This depersonalized language includes the use of the definite article to refer to self (i.e., the) and also it, this, and that. To further examine the uniqueness and function of such linguistic signals, indicating an experience of disembodiment of the self, and the subsequent linguistic reversion, indicating the self’s re-embodiment, these interviews can be compared with descriptions of pain experienced by persons whose illnesses or injuries differ from burn injuries in important dimensions. Such a utilization of qualitative research interview data can complement and deepen phenomenological reflections on the experience of the body in pain [4–9], which have so far failed to notice this particular phenomenon of disembodiment.

**METHOD**

In this study, the senior author used the qualitative methods of narrative analysis of unstructured, focused interviews to identify the phenomenon of interest; that is, patients’ linguistic transformations that reflected their altered perception of the body. First, patients were asked to “tell their stories” of accidents and subsequent recoveries. The researcher assumed the stance of a reflective listener, only rarely interrupting to clarify or to probe for additional information. While several researchers conducted the interviews, all used this same approach of listening primarily without interruption. Second, from these transcribed interviews, alternative explanations for the use of detached language were developed, and in an effort to go beyond phenomenological description, competing conjectures that could be supported or refuted were identified from the narratives. Third, patient populations, which differed from the original group along various critical dimensions, were identified. Dimensions that enabled the testing of the conjectures included: the loss of control of a body part; the loss of sensation; the need to protect oneself; the opportunity to learn disembodying language from physicians; and the degree of pain. Fourth, the transcripts from these comparison samples were examined for the presence or absence of linguistic signals of disembodiment. This method permits further clarification of the different conjectures, depending on the presence or absence of identifiable attributes in each sample and thus provides a further elucidation of the variable experiences and expressions of disembodiment in response to injury and pain. Moreover, the principle of theoretical sampling for the negative case [10]: that is, rather than adapting a theory to account for an extraordinary single case (as is usual with grounded theory), we sought entire samples who differed from the original sample by important characteristics. Although the confirmability of the findings does not constitute the same hypothesis testing used in experimental design, it does increase the certainty of results. This process, with the findings of each segment, can be sequentially described as follows.

**RESULTS**

*Identification of the phenomenon of interest*

As a part of a research program to examine patient strategies for achieving comfort, patient experiences and capacities for surviving agonizing experiences were ex-
Disembodiment

Disembodiment (see also Morse and Carter [2]). Initially, six patients who had experienced major burns were identified as participants. Patients consisted of two female and four male patients. Their ages ranged from 25 to 35 years, with a mean of 33.17 years, and were identified through a burn clinic in a large Canadian hospital.

All were interviewed after discharge from the rehabilitation hospital, 5–12 months following injury. These participants were asked to “tell their story” in a series of unstructured, focused interviews, and these interviews were transcribed verbatim.

How do patients who experience agony live through the devastating pain? Patients are explicit when attempting to describe the nature and the amount of pain but also state that language is inadequate to describe the experience. The pain was immediate and considered constant, controlling, overwhelming, and engulfing:

I remember having pain. I remember how great the pain was. I’d had four children and every one of them a hard delivery. I remember with this pain, thinking that a baby—that labor pains—didn’t even hold a candle to this pain. This pain is even too great to even try to describe. It’s just solid pain. I’ve never felt anything that comes close to it, since or before. It’s the greatest pain I’ve ever had.

The agonizing pain experience continues throughout the ICU and burn unit experience. Treatments become a devastating experience, feared and dreaded:

. . . The minute you hear those metal trays, you start shaking, your stomach gets all in knots, and you’re scared because you know the pain that’s going to be coming.

Linguistic analysis reveals that as these victims relate the stories of their accidents and hospitalizations, they use depersonalized language in reference to self. Rather than referring to parts of the body in the possessive (e.g., “my hand”), participants often refer to themselves using the definite article (“the hand”). Transcripts appeared thus:

. . . both hands and wrists were burnt, which were the [electrical] entry sites.
And . . . both feet were burnt . . . the right side being the worst . . . right side of both hands and feet because—my right hand was up high—so naturally it entered the right the most . . . whatever was left over came down and went into the left . . . it still sustained some damage . . . the right hand had to be removed . . . And the right leg was burnt quite badly, and the whole outside of the leg was burnt down to the bone—you could see bones and sinews in there, and at the very bottom—it also exited—not on the bottom of the foot—but . . . on the bottom of the leg, like right at the side of the foot was really burnt bad, too.

The use of the definite article when referring to one’s body is taken to be an indicator of detachment from or disembodiment of the injury. However, as might also be expected, this form of speech does not occur uniformly throughout the transcripts and is most evident only during descriptions of the most painful parts of a hospitalization. Indeed, one can note that, in the quotation above, when this participant speaks of a time period that was before the burn injury—even immediately before (“my right hand was up high”)—he reverts to the possessive pronoun. Then as patients tell of their recovery and rehabilitation, their references to their bodies be-
come normalized, and possessive pronouns return as they “take back their bodies.” In the words of one patient, who sounds almost like an objectifying physician:

... hopefully when we get this scar tissue matured, at which point then ... depending on whether the skin can support itself—you also burn out the oil sites ... you have no natural oil going into your skin and if you don’t, it cracks.

Another feature of importance is the content of the patients’ speech: Victims do not disembowel themselves totally but rather relinquish parts of their bodies. In this burn patient’s description of his ICU experience, he uses “I” in reference to himself (i.e., the confusion is still his) but resorts to indicators of detachment when speaking of his injured extremities:

But the time, the month of October was very hazy, I was in and out of it. As soon as I would get better, one limb would turn bad, toxic, and I would get confused; then they would amputate one more, and then it would clear up ...

Examination of six interviews reveals that disembodying language is used by all but two of the burn patients. With the first negative case, the primary difference is that this patient refused to look at her burns or in the mirror—in essence, she refused to acknowledge her burns:

I don’t know what my body looked like because, like I said, I never saw it—I never wanted to look at it. ... My mom was really worried about my face, and she’d mention it to me, and she’d say, “I wish, you know, I hope everything turns out okay for your face.” ... I guess on one side I had a large hole, a deep one on my cheek, so I knew I was bad, but I didn’t realize how bad or anything because I would not, I would not look in a mirror.

In the second negative case, two patients had no recollection of the injury (an explosion), the emergency care or the first week in ICU and, as such, had no recollection of the most excruciatingly painful experience. The other five burn patients were conscious during the emergency care, transportation to the hospital, and, to some degree, were aware of the care provided in the emergency room. Thus, by using the clues in these six interviews, observations of the nature, utilization, and form of linguistic indicators of disembodiment were made, and conjectures were developed.¹

Identification of alternative competing explanatory conjectures

The second step was to consider what this form of detached speech signifies. Our first two conjectures addressed the objectification of the self related to the transformation of body parts into a separated “object” or “thing” because the injury resulted in loss of sensation in the affected part or in the inability to control or to move the body part. These were:

¹ As a methodological aside, one may note that use of the criterion that a phenomenon be present in all cases during initial coding introduces an important standard of rigor required in qualitative work, especially considering the small samples used. But this need not mean that the appearance of one single negative case discounts or invalidates an observation. In quantitative inquiry a score of zero on a scale does not indicate that a phenomenon does not exist—only that it was not present in that particular case. One may thus suggest that these same standards could apply to qualitative inquiry. Yet in qualitative work, when the sample is obtained and analyzed case by case, if the negative case is the first case analyzed, there is a risk that this case could inadvertently redirect inquiry.
1. When individuals lose control of a body part, some disembowel that part to maintain control of the self.

2. When individuals lose sensation in a body part, disembodiment can be a psychological strategy for “disengaging” the body part from the self.

These two conjectures were tested by systematically comparing burn patient transcripts with patient groups who have and who have not lost sensation and control. Support for these conjectures is provided if the members of those populations that have lost sensation and/or control also used the definite article in reference to their bodies and if those who have not lost sensation or control do not use this form of speech.

A third conjecture is that, linguistically, modes of detachment are a normal pattern of “doctor-talk” as a way of objectifying parts of the body. Patients learn these linguistic patterns of speech by hearing physicians discuss themselves as “cases” on rounds, and so forth. The conjecture to consider is:

3. Patients learn disembodying language from physicians.

If this conjecture is accepted, then evidence of linguistic forms of disembodiment should be present in all patient groups.

Next, in the burn patient transcripts, it was observed that the use of disembodying language was not used consistently throughout the transcripts; rather, it appeared most during descriptions of the most acute stages of patients’ injuries, when life was most in jeopardy. Therefore, a further conjecture to be tested is:

4. Disembodiment is used in life-threatening trauma, in an effort to protect the self.

Here disembodiment would be viewed as a strategy encouraged by a threat to life in which removing the injured part of the self could remove the threat to the self. To support this conjecture, linguistic signals of disembodiment should occur in the transcripts during periods when patients face any life-threatening injury or illness.

A final conjecture is that some individuals disembowel parts of the body when pain of the injury is overwhelming and localized to those body parts. Thus:

5. Disembodiment is a strategy used to remove the body part, hence to remove the pain, when the agony is overwhelming.

This conjecture may be tested by comparing the burn patients with comparison groups that experienced varying amounts of pain in the course of their injury or illness.

Identification of comparison patient populations

Patient populations with various characteristics that permit consideration of the above conjectures by exhibiting various degrees of the above characteristics (presence or absence of pain, control or lack of control of their bodies, and so forth) were identified. Using these patients’ stories of their experiences, transcripts from these data sets were analyzed to explore the five conjectures to further understand the linguistics of the disembodied self.

In detail, the characteristics selected were: (1) the loss of control of a part of one’s body; (2) the loss of sensation in the part of one’s body; (3) the opportunity to hear
physicians discuss one’s body with other physicians; (4) the threat to the individual’s survival imposed by the accident or illness; and (5) the experience of severe, overwhelming, and prolonged pain. Three patient populations, each differing by one or more characteristics, were identified to serve as comparison groups for the burn patients. These were patients with a spinal cord injury (SCI), transplant patients, and myocardial infarction (MI) patients. The theoretical rationale for sample selection permitted the systematic support or refutation of conjectures for the use of linguistic signals of disembodiment.

The SCI sample \( (n=11) \) consisted of nine male and two female patients, ranging in age from 18 to 56 years, with a mean age of 27.7 years. This group was identified as a patient population which, similar to the burn population, experienced an instantaneous onset of the condition as a result of an accident. With the paralysis, spinal cord–injured patients had *loss of control of body parts* and *loss of sensation*. If they remained conscious during the accident, during the extrication, and in the emergency department, they were usually aware of the ramifications of their injuries and therefore would experience a *need to protect themselves*. They would have discussed their condition with physicians, overheard physicians discussing their “case” on rounds, and therefore had the opportunity to learn to refer to their own bodies using depersonalized language from physicians. However, the pain experience of SCI patients is qualitatively different from that of burn patients. One patient described her pain as follows (with interviewer comments in brackets):

[You said that you’re starting to get your feelings back. Do you get pain?] Yep.

[What kind of pain?] Burning pain—a burning, tingling pain. . . . Sometimes it’s—I feel good that I have this feeling. Sometimes I think to myself, “Hey! I don’t want this feeling, it hurts too much.” [It comes and goes?] Like, it’s always there—It just gets stronger . . . .

Thus, those spinal cord patients who did report pain, reported pain that appeared to be bearable, and they had an ambivalent attitude to the pain.

The transplant patients \( (n=8) \) consisted of eight patients (six males and two females), whose ages ranged from 25 to 57 years, with a mean age of 45.25 years. Five of the patients had undergone heart transplants, one a heart–lung transplant, one had a kidney transplant, and one a liver transplant. This group was selected because its members experienced a need to protect themselves and maintain hope as their condition deteriorated and as they awaited a transplant. However, personal control over their body part and the amount of sensation of the body part remained unchanged before and after a transplant. As with the members of other groups, these two patients had opportunities to learn the use of depersonalized language from physicians, and their postoperative pain was controlled by analgesic and could not be described as overwhelming.

MI patients \( (n=13) \) consisted of six females and seven males. These patients ranged in age from 43 to 70 years, with a mean of 59.15 years. As with the transplant patients, those who experienced a myocardial infarction had no alteration in the amount of control over their hearts or loss of sensation. The amount of pain experienced with MI was less intense than the burn patients and not described as overwhelming. Indeed, the onset was usually ambiguous, with patients confusing the
pain for indigestion or “a little pain in the chest, but nothing to worry about.” They described the pain as “tightness,” as “heaviness,” or as a “pulled muscle.” Even a patient who arrested later described his pain as follows:

I felt there was something seriously wrong, although I wasn’t in a lot of pain . . . I mean, when they asked me what was the pain level on a scale of ten—that’s what they kept asking you—I suppose five or something like that, was what I had to say.

In contrast, the pain of the burn patients was engulfing and overwhelming. Four of the six burn patients experienced amputations of digits, hands, feet, or legs; two did not. Two of the burn patients had at least one prosthetic limb: This permitted movement but, of course, there was no sensation in the prosthesis. All burn patients reported discussing their injuries with their physicians or overhearing conversations about their injuries during physician “rounds.”

Exploring for signals of linguistic detachment in comparison patient groups

Patients who had experienced spinal cord injury, transplant, or myocardial infarction were asked to “tell their stories” in tape-recorded interviews. The transcripts of illness stories from the comparison groups were analyzed for signals of linguistic disembodiment in comparison with the burn patients’ interviews.

None of the spinal cord injury patients used disembodied language, despite the fact that, similar to the burn patients, they had experienced sudden, unanticipated injury that threatened survival. They experienced loss of the function and sensation of body parts and had the opportunity to learn linguistic disembodiment in reference to their own bodies from physicians. However, although some spinal cord injury patients complained of postinjury pain, their pain experience could not be described as agonizing.

The onset of symptoms in the transplant group was relatively slow compared with burn injuries, with onsets lasting days, weeks, or even months; and their disease eventually threatened survival. However, they did not usually experience severe pain. There was only scant evidence for the use of disembodied language, and this occurred when referring to internal organs (i.e., heart or liver), either at the critical stage of the disease in reference to the organ to be transplanted (i.e., “when I get a heart”) or to a procedure (i.e., “a heart transplant”).

Within the myocardial infarction patient sample, there was no evidence of disembodiment in the transcribed interviews. Although these patients’ survival was often in jeopardy, frequently the onset of the attack was ambiguous, with symptoms not appearing instantaneously. However, the amount of pain experienced by these patients varied, ranging from mild discomfort to severe pain.

Testing conjectures

Transcripts from the four groups of patients were then analyzed to test each of the five conjectures, and these results are summarized in Table I.

Disembodiment enables maintenance of the control of self. A burn patient described his care using linguistic signals of disembodiment in regard to a nonfunctioning hand:
Table I.—Presence of characteristics in four patient samples

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Sample</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Burn</td>
</tr>
<tr>
<td>Loss of control of body part</td>
<td>Some loss of movement</td>
</tr>
<tr>
<td>Loss of sensation</td>
<td>Some loss if prostheses is used</td>
</tr>
<tr>
<td>Need to protect the self</td>
<td>Yes</td>
</tr>
<tr>
<td>Opportunity to learn from physicians</td>
<td>Yes</td>
</tr>
<tr>
<td>Extreme pain</td>
<td>Yes</td>
</tr>
<tr>
<td>Evidence of linguistic signals of disembodiment</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The left hand—the only hand I have left—and she [the physical therapist] goes over the hand, and she bends the fingers and the wrist, you know, because everything's stiffened up.

Thus, the conjecture is supported for the burn patients. However, patients who have an organ transplant, an MI, or an SCI have no control over their diseased organs.

The interviews with the heart transplant patients are extraordinarily interesting, for those patients refer to their original hearts as “my heart,” and one patient was not even able to speak of his diseased heart using the word heart. Rather, he made reference to this period as “before my surgery”; others said: “before I got a new heart.” From these transcripts, it appears that these patients’ use of language in reference to themselves indicates that the removal of one’s original heart was incomprehensible. They tend to refer to both their original heart and to their transplanted heart as my heart.

The MI patients also refer to their disease using the definite article (i.e., the heart attack) rather than “my” heart attack, but they do not use signals of disembodiment when discussing their heart. The spinal cord–injured patients who also had lost control of their bodies did not use disembodying language. Therefore, the first conjecture was not supported.

Disembodiment “disengages” a body part when sensation is lost. Four of the burn patients had undergone amputations and been fitted with prostheses—replacement limbs without sensation. Yet, they tended to refer to their amputated limbs using the definite article (“the leg”) and to their prosthetic limbs using “my.” For example, a burn patient, with a double leg prosthesis and one prosthetic hand, told of his experiences on a trampoline:

So [my wife] said, “Come up there with me.” And I started jumping about a foot, two feet in the air. I was doing fine until one leg pulled out and twisted sideways so I had to hang on to [my wife], and we had to . . . I sat down on the trampoline, and they had to get me off and put my leg back on . . . (laugh-
So that was pretty hilarious. My brother was there, and he was just in tears laughing.

Another group that disconfirmed this conjecture was the spinal cord-injured patients, who had little, if any, sensation, and did not refer to their bodies using signals of disembodiment. Therefore, the second conjecture remained unsupported.

Patients learn disembodying language from physicians. Physicians deliberately de-personalize their patients in order to maintain a detached, professional relationship and to avoid involvement. In particular, Gadow [12] notes how physicians refer to the patient’s body with “complete abstraction.” “Physician-ese” is scripted and learned in the process of socialization into medicine. Thus, it is possible that when physicians talk to or about patients in their presence, patients learn to use the same form of speech to refer to their own bodies. Consider the following report from a burn patient:

He [the physician] came right out and said, “Look, you know, I’m sorry to tell you, but, uh, the hand doesn’t look too good, and we think it might have to be removed.” And I said, “Well, okay, well, if it’s got to be done.” He said, “Well, they’ve tried everything possible, you know, to save the hand.”

Detached language is well documented in medicine as a strategy used by physicians that enables them to protect themselves and give appropriate care. May [13] writes of the predicament of surgeons: “The surgeon must accept that what delights him as technical results may still be a horror to his patient” (p. 139). Does the patient “pick up” the reference to parts of his or her body as the objectified “the” from his or her physician?

All groups of patients were treated by physicians, and all were subjected to physicians’ rounds. Therefore, if this statement were to be supported, some disembodiment should be evident in and relatively stable across all groups. Because the SCI, the transplant, and the MI patients did not use disembodying language, the third conjecture is not supported.

Disembodiment protects the self in life-threatening situations. If this statement were to be supported, disembodiment would occur in all persons who experience a sudden and life-threatening event, and linguistic signals of disembodiment would be present at the time a patient’s life is in jeopardy. This was true for some of the burn patients. A patient with 60% burns (and one of the two patients who did not use disembodying language) illustrated the type of situation that threatens the self and can haunt such patients for months:

I know I could feel a scab coming down over my eye. It was dead and dry and crisp... John’s [her husband] mom and dad had come. They didn’t recognize me. I said it was me. “Do I look so bad you don’t know who I am?” Don, my brother-in-law, was one of the firemen; he didn’t recognize me either. He was walking right by me. I said, “Don, it’s me, Sally.” I remember his voice, “My God, Sally!”

One patient, a lineman who experienced electrical burns described the scene:

... so they energized the line, 14,400 volts, and I was working on it at the time. I remember when I got hit and stuff like that, I didn’t go under very long and
coming back to and stuff like that. [So, what did you feel, do you remember?] At first it was, I could feel myself going further and further away, there was a funny sound, like water, tons of water rushing through my head. [A roar, was there pain?] A roar like water. There wasn’t pain right away, but as soon as I started breathing and a guy did CPR on me, I was conscious but I couldn’t breathe. [Did you fall?] . . . Yeh, in the ditch, on the ground. But then he did CPR on me, and I came back, then as soon as I started breathing and stuff like that, then the pain set in and the pain, it was just like I was on fire, it was just like you couldn’t visually see too much, but it was just like my whole body was on fire and it just burned. All I could do was scream, and I screamed my head off to get rid of the pain.

Among the transplant patients there was weak evidence of disembodiment during the critical periods that a delay in waiting for a transplant threatened survival. This was the time during which the liver transplant patient referred to his diseased liver as “the liver.” Some of the MI patients experienced an ambiguous and slow onset of symptoms, and others quickly recognized their symptoms as a “heart attack”; yet signals of disembodiment were not used by either group of MI patients. If disembodying language were a strategy used to reduce the emotional impact of the injury, it would also be experienced by the SCI patients, although it was not. Therefore, the fourth conjecture is not supported.

Disembodiment is a strategy used to remove the body part, hence to remove the pain when the agony is overwhelming. Cassell [14, 15], Scarry [6], and other pain theorists have noted that pain is considered a phenomenon “outside the body” and referred to by patients as “the pain.” In this article, we suggest that by disembodying the pain, the patient also “removes” the painful limb or organ, detaching “it” from his or her body, and thereby removing the pain. This conjecture is that the enduring of overwhelming pain, which continues over time, results in disembodiment of the affected part. Consider the following:

Oh yeah, I knew right away at the accident location that— I knew—I don’t know how I knew—but [I knew] I’d probably lose both hands and both feet. . . . I knew because there was just too much pain. The extremities were on fire, and it was just like they were burning. Fourteen thousand four hundred volts; they say it’s just like instant microwaving.

In this quotation, signals of disembodiment occur as the patient is describing the overwhelming pain of the electrical burn, a pain that continued throughout the weeks that followed. As disembodiment of the affected part was not evident in groups—such as the MI group, which may have experienced intolerable, short-term pain, for example, “crushing” chest pain— this conjecture is supported.

The conjecture that is the best theoretical match is that which explains disembodiment and relinquishment of the body part experiencing excruciating pain as likely to be a method for controlling agony (see Table I). Further evidence was obtained by interviewing the patient who was burned, but who had no recollection of the most acute phase, who did not reveal disembodiment. The only group that did not fit the model well was that of the transplant patients. However, as stated, detachment was used briefly by one patient, and it only appeared in the most acute phase of the disease when a suitable donor was not immediately available.
In this study, the unstructured nature of the interviews permitted participants to “tell their story” sequentially. All participants chose to begin prior to their accidents or illness. As participants reflect on their experience, to a certain extent they re-lived their experience. Thus, as they described the experience at a particular stage of their recovery, their narrative reflected that their manner of speaking, tone, and expression changed as the particular experience they were describing changed, and their voices and speech patterns reflected the feelings and emotions that were experienced at that particular time. In the sample of burn patients, the changing patterns of detachment of body parts coinciding with the intensity of pain experienced and the absence of this pattern in other groups is used as evidence that the use of de-personalized language is an indicator of disembodiment for the removal of pain. We argue that this detachment and disembodiment during the most severely painful states are not only phenomenological variants of human-body relation but adaptive capacities that enable the physical body to tolerate the intolerable.

Zaner [16], building on the work of Merleau-Ponty [3], describes the process of embodiment as a continuous and more or less automatic process of consciousness that enables one’s body to single out what is peculiarly its own and, at higher levels, to identify and develop a construct of “my own” that is easily grasped. Gadow [12] describes the experience of not being able to act out as desired, arising from an increasing consciousness of ineptness, as incapacity. She ascribes incapacity as arising from an increasing consciousness of ineptness, weakness, and pain. Incapacity gives rise to the internal distinction between the self and the part of the body felt to be the site or the origin of the constraint. The present study shows that the disruptions or changes in the perception of one’s self are not permanent and that there is greater evidence for such disruption in the case of excruciating pain. However, rather than view this phenomenon as ineptness and incapacity, as Gadow does, we suggest its interpretation as an adaptive human capacity.

It is important to note the distinctiveness of the particular form of disembodiment that has been identified. For instance, although Schilder [17] notes that the body responds to pain by isolating the painful part and “pushing it out of the body-image” and concludes that if “the whole body is filled with pain, we try to get rid of the whole body” (p. 104), he fails to describe any concrete mechanisms for this strategy. In other phenomenological discussions of pain (see especially the works of Scarry [6] and Leder [7–9]), pain is described as that which redirects attention to the body. In the words of Leder [8]:

Prior to the onset of pain, the body . . . stands in [a] threefold disappearance. . . . Attention is . . . distributed to distant points. Parts of the body are backgrounded and forgotten. . . . A metabolic machinery supplies . . . energy, without demanding attention or guidance. . . . Yet this structure is lacerated by a single moment of pain. [One] is called back from . . . engagement to focus upon the state of his own body. (p. 71)

With Leder [8], pain is seen as disrupting human intentionality toward the world and redirecting it toward the body—but always on my body:

When in pain, the body becomes the object of an ongoing interpretive quest.
We obsessively probe and palpate even when this increases discomfort. . . . We pose tests to see what diminishes or increases pain. (p. 71)

According to Toombs [18] also, the body becomes an object of reflection or consciousness “in such mundane experiences or fatigue. . . . stubbing one’s toe. . . and feeling the pain in the toe” (p. 59). For her, the moving of the body to the forefront of consciousness arises during “certain ‘limit situations’ such as sickness or pain” (p. 59).

For Leder and Toombs, the “limit situation” of pain is clearly not the agony of burn patients—and the “objectification” of the body does not yet take any part of my body out of the realm of that which is mine. Even when Leder [9] examines the tendency of pain “to establish opposition of duality” (p. 97), the opposition introduced is primarily one between self and others—not between me and my body in a way that turns the body into an “it.” Beyond the phenomenology of pain described by such careful observers as Leder and Toombs is the phenomenology of the intense physical pain known as agony, which overwhelms the self, not just redirects its attention.

Agonizing pain upsets, detracts, overwhelms, and overpowers, reaching levels of intolerance. Interestingly, the language used to indicate disembodiment resembles that used in hypnosis scripts, particularly Ericksonian hypnosis [19, 20]. Hypnosis scripts indicate that techniques move quickly from, “Your eyes are getting heavy,” to the detached, “The eyes are getting heavy.” This is done deliberately on the part of the therapist to deepen the level of hypnotic trance. As hypnosis is frequently used for pain control, it may be possible that the technique has its origins and was initially learned from careful observation of those who were able to control pain using the disembodying language described in this article.

The most difficult time for the burn patient occurs in the periods following discharge from the ICU, when the work of enduring and of reforming the self is achieved. Here the patient suffers and learns to endure pain and decides to begin the work of healing. In her study of chronically ill patients, Charmaz [21] notes that physical pain, psychological distress, and the deleterious effects of medical procedures contribute to suffering. Patients in that study described a “loss of self” as former self-images were undermined without the compensation of the reconstruction of a new and valued self-image. However, Charmaz’s [21] definition of “loss of self” was different from the processes of disembodiment, detachment, and relinquishment of self described in this study.

Although the recognition of this strategy for the control of pain is important, preliminary application as a technique for pain control must be cautioned against. One must be cautious about recommending that those caring for burn patients should encourage the use of disembodiment in patient care by, for example, deliberately referring to the patient’s limbs or injuries using language of detachment as a means to facilitate the patient’s control of pain because it is also possible that the methods of treating a patient objectively may also be harmful. One burn patient who actively resisted using disembodying language felt physicians’ rounds were dehumanizing:

. . . I did feel that it changed me. I would have to put up a little wall so that I

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1 I am indebted to Dr. Ceinwen Cumming for this observation.
could become a little bit colder, a little bit harder, so their words that they were talking to each other or things couldn’t hurt me, couldn’t penetrate me . . . I classified myself as a “piece of meat,” a piece of ugliness, a piece of—I wasn’t human anymore; I was incapable, incomplete of feelings.

Conversely, physicians and nurses may use linguistic analysis as cues or as a means to determine both the phase of patients’ rehabilitation and the degree of their acceptance of their changed selves and their injuries. When patients “take back their bodies” (i.e., when they no longer use signals of disembodiment in reference to themselves), have they incorporated their new injuries, their altered selves, into a new body image? Much additional inquiry is needed to answer such a question. Because the present study represents work still at a preliminary stage, it can only be suggestive. Further interviews must be conducted to determine if there are other reasons for the use of disembodiment and other time frames in which such language occurs.

It is possible that the spinal cord–injured patients and other patients who experience a loss of sensation from their limbs do disembodify, but the onset is much later in the rehabilitative periods than were used in this sample. For instance, in his autobiography, Murphy [22] reported disembodiment several years after the insidious onset of a disabling tumor of the spinal cord:

I have also become rather emotionally detached from my body, often referring to one of my limbs as the leg or the arm. People who help me on a regular basis have also fallen into the pattern (“I’ll hold the arms and you grab the legs”), as if this depersonalization would compensate for what otherwise would be an intolerable violation of my personal space. (p. 100)

This illustration is also extraordinary in that Murphy was aware of his own use of these linguistic signals of detachment. By contrast, in the present study, whereas participants were aware of the objectification of their own bodies by others, they were unaware of their own use of this form of speech. Two burn patients and one transplant patient who were asked directly about their use of the definite article in their speech were surprised to learn that they did this and could not comment. Nevertheless, it is recommended that this investigation be continued with other patient populations and this inquiry of patients’ perception of their bodies as revealed in speech be continued.

CONCLUSION

In this study, the comparison of data obtained from four different populations, each with distinct characteristics, for the presence or absence of linguistic signals of disembodiment, enabled the testing of conjectures. These patient narratives not only enabled the identification of the presence or absence of disembodying language but also located its use when the pain was most intense. Later, in the rehabilitation period, the patient again reverted to using possessive pronouns in reference to self. Thus, this study suggests that in instances of excruciating pain, patients disembodify in order to remove the pain from the self. Extending this database by examining patient narratives from other patient groups at the end of the convalescent pe-
period will add to the insights obtained in this study and to our understanding of patients’ self-management of excruciating pain.

Acknowledgments—This research was supported by a grant from the National Institute for Nursing Research, National Institutes of Health (2 R01 NR02130-07). The assistance of Gwen Anderson, Ph.C., Joan Bottorff, Ph.D., Barbara Dobierneck, Ph.D., Mary Haight, M.A., Joy Johnson, Ph.D., and Sharon Laskiowski, M.N., is acknowledged for their comments on earlier drafts of this article and with the collection of data. A preliminary version of this paper received the International Nursing Research Award, Council of Nurse Researchers, American Nurses Association, Los Angeles, CA, October 23, 1991.

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