The Uncanny of the Illness Experience: Can Phenomenology Help?

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Keywords

Uncanny · Psychopathology · Phenomenology · Illness · Medicine

Abstract

The illness experience encompasses not only several changes in bodily processes but also the very feeling of becoming ill. This seemingly non-scientific aspect of being sick is characterized by forms of uncanny body experiences and an unhomelike *being-in-the-world*. Both include disconcerting phenomena, feelings of fear, restlessness, and inexplicability. In this paper we discuss some contributions aiming to understand the illness experience, focusing on the concept of the *uncanny*. This life event brings changes in the familiarity of our world, revelation of what previously was and should have remained hidden, loss of control, and the certainty of mortality. The experience of uncanniness is here conceptualized as a psychopathological phenomenon that should be regarded as a general symptom of diseases and should be identified and approached. We discuss the impact of these considerations on medical practice, focusing on the role of physicians and ultimately on the purpose of medicine.

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Introduction

To start exploring the range of phenomena involved in the illness experience we will review the concept of *uncanny*, the nature of the uncanny experience during disease processes, and how these notions could orient interventions in clinical practice. Etymology and translation as well as the conceptualizations of this concept by Freud, Heidegger, and Svenaeus are amongst relevant contributions to the understanding of *uncanny*. We discuss the ontological changes of the embodied and narrative self-experience as well as the engagement, enactment, and attunement to the world during illness. Lastly, we will focus on how the clinical encounter and the practice of medicine presently dismiss these aspects and how relational frameworks addressing patients may be re-established, ultimately reducing the overall uncanniness of the experience of being ill.

Making Sense of the Concept of *Uncanny*

Firstly, we address the concept of *uncanny*, exploring its etymology in English and in German as well as some proposed translations to French. Secondly, we show its universality as a human experience by acknowledging how it reflects on the Arts, particularly from the post-

World War period onwards. Thirdly, we explore the psychopathological nature of this phenomenon by understanding how this concept was introduced to Psychology and Psychiatry by Freud and explored under the light of Philosophy by Heidegger. Lastly, we discuss how the *uncanny* is a central concept in the phenomenology of becoming ill by detailing the contributions of Svenaeus.

The concept of *uncanny* and its meaning have evolved in the English language. It was originally used to designate the one who was not *canny* – an adjective employed to characterize someone who is astute and prudent. Later, the semantic halo was widened to other meanings, *nuances*, and metaphysical connotations. Today, *uncanny* refers not to a person, but to a phenomenon or a meaningful experience of restlessness lived with fear and perplexity [1].

The works of Jentsch and Freud have been at the basis of conceptual and operational definitions of *uncanny*. Jentsch defined *uncanniness* as a feeling of strangeness and fear that comes from intellectual uncertainty and disorientation [2], which is prototypically highlighted by the doubt arising from what appears both animate and inanimate [3]. Freud proposed an etymological analysis of the word *unheimlich* – the German word for *uncanny* – as a concept opposed to *heimlich*. In German, *heimlich* stands for familiar, intimate, domestic, but also secret, hidden, and clandestine. Conversely, *unheimlich* accounts for all phenomena that have become strange, sinister, unsettling and for things which were secret, hidden, and private and that have now become exposed. Freud seems to explicitly disagree with Jentsch's concept of *uncanniness* as only bearing the novelty of the unknown, emphasizing the aspect of alienation of something previously familiar to the subject. He further sustains that Shelling's definition of *unheimlich* is also vital for the characterization of the phenomenon – the sudden open display of things that “should have remained hidden, but which came to light” [4].

The translation of the German word *unheimlich* is challenging since there are meanings that can only be partially grasped in other languages. For instance, the English word *uncanny* does not include the fundamental aspect of *Heim* (home), which seems central to Freud's conceptualization of the term. Sandberg points out that *heimlich* could be linked to the words “cosy” or “comfortable,” conveying the sense of shelter, protection, and therefore of *home* [5]. Hence, *unheimlich* could be defined as opposed to such meanings, which means losing the “feeling of being at home.” In line with these contributions, Vidler chooses the neologism “unhomely” [6].

The meaning of “home” has been his starting point to analyse the *uncanny* in architecture, its role in modernism and on the contemporary metropolis, where people lost the feeling of having a place [5] – we will discuss this later.

The French translation of *uncanny* is also pertinent for a thorough understanding of the concept in Latin languages. A relevant input to the concept by Lacan in 1969 is the neologism *extimité*, the direct opposite of *intimité* (closeness or intimacy) [7], representing a condition “where interiority, which is most intimate, coincides with the exterior and becomes threatening, provoking horror and anxiety” (Mladen Dolar as cited in [7]). Also in French, Certeau proposes that *uncanny* describes an “*inquiétante familiarité*” (disquieting familiarity). However, he further suggests that the present conceptualization is flawed since Freud's *unheimlich* only “circumscribes the inexplicable; does not explain it” (Certeau as cited in [8]).

Unheimlich is a universal and fundamental experience of one's being in the world but remains a subjective feeling that has resisted all attempts to be defined – both ineffable and intangible [4]. For this reason, some have recognized and listed situations where this feeling arises, in an attempt to formulate an approximate definition. Royle offers a few examples of circumstances in which the feeling of uncanniness may emerge: curious coincidences, automata, inanimate objects that seem alive, reminiscences of the past misplaced in time and place, or the sense of estrangement of something belonging to the self. All of these seem to share the sense of doubt that disturbs the subject, blurring the boundaries between what is familiar and what is unknown [5].

We find innumerable examples of uncanny experiences in various social domains such as Literature, Fine Arts, Cinema, Architecture, Politics, and Finance [9]. In Literature, Hoffmann's and Allan Poe's tales accurately illustrate *uncanniness*. Hoffman's stories, for instance, were regarded by Freud as a paradigmatic example of this concept [10], as they portray the contrast between a safe and familiar interior with a feeling of a strange presence [6].

Modernism encompassed a change in architectural settings which is also considered to bring the experience of the *uncanny*. In the nineteenth century, the sheltered and familiar countryside environment is replaced with that of a bursting metropolis, where the subject feels displaced, no longer recognizes his origins, and loses himself to social and institutional roles [6]. Marx regards capitalism as a motor of alienation, in which (1) the worker does not recognize himself as a person, but only as a mere tool without freedom or free will [11] and (2) houses are no

longer owned (or felt as such) but leased or rented [6]. Unhomeliness is then a condition of the modern man, emphasized by the historical analyses of both post-war periods, characterized by the nostalgia for the true, familiar, and undamaged homeland.

In the mid-twentieth century, the concept of *uncanny* is largely presented in Fine Arts by the hand of expressionists like Kubin, who aimed to convey a dimension of uncertainty between dream and reality, or Kirchner, who painted the frenetic pace of contemporary life where people are packed together and yet isolated from each other. In Cinema and Architecture, through the visual experience, we are offered similar contributions: “Twin Peaks,” by David Lynch, has the most varied baffling scenes which elicit the feeling of *uncanniness*, by making use of dopplegangers or repeating its iconic triumphal music in paradoxical contexts, sounding strangely familiar. In Berlin, we experience the *uncanny* at the Jewish Museum, where passageways gradually narrow and dead ends convey a sense of dislocation, disorientation, hopelessness, and *homelessness*, re-enacting the trauma of World War II [6].

Today, the *uncanny* is studied in robotics and user-computer interface series where the concept of *uncanny valley* emerged. This represents the paradoxical feeling of revulsion that arises when a given robot or computer game figurine becomes too similar to humans. In other words, initially these figures seem strange for their inhumanity, but as graphics and interfaces progress they suddenly look too human – that is then experienced with a disturbing and uncomfortable familiarity [1].

Freud’s essay “Das Unheimliche” is seminal for the introduction of the *uncanny* concept in Psychology and Psychiatry. Here the *uncanny* is first defined as a form of anxiety – an expectant state of preparation for an unknown danger [12], which is triggered by ambiguity and strangeness [11]. This is different from fear, that “always comes from entities (things or events) within-the-world,” whereas anxiety comes from “nothing and nowhere” (Heidegger as cited in [13]), being considered the fear of an unknown object or source. Anxiety is the expression of the complex emotion that human beings experience when confronted with ontological insecurities and with questions about the meaning of life [14]. Freud also sustains the necessary change in familiarity, providing a personal example when he once experienced his reflection in the mirror as a person he could not recognize [10, 15]. Freud postulates the *uncanny* as part of the ontology of consciousness, preceding all experiences after the formation of the ego: a state of *homelessness* arising from the impossibility of returning to the womb. The *uncanny* is

not simply “feeling strange;” it reflects the awareness that what once was the most familiar condition – being an extension of the mother – is and will forever be endowed with strangeness [12].

Homelessness as a human condition is also a recurrent theme of Heidegger’s work. He defines “Existence” – *Da-sein* – as an ontological category characterized by *verstehen*, *befindlichkeit*, and *rede*, which in English can be roughly translated to *thinking*, *feeling*, and *speaking*. These three features together allow the creation of a *pattern of meanings* that binds the man to the world (Heidegger as cited in [16]). He employs the term *Dasein* as not referring to a *static being* defined by “what is it?” but rather to a situated and self-interpreting being that can only attest for “how is it?” [13]. This *being-at-home* of *Da-sein* is, strictly speaking, a *non-being-exactly-at-home* – as the world does not belong to the subject and is neither controlled nor fully understood by him [12]. In our everyday life we tend to create *inauthentic* states so that we can hide ourselves from the violent *unhomeness* inherent to our condition. According to Heidegger, the *uncanniness* emerges when this veil of the apparent familiarity of the world falls and suddenly this world reveals itself as it really is – a strange and mysterious place that can never be fully grasped. Heidegger states that *uncanniness* is a form of anxiety, describing both a fear of nothing concrete and a fear of the whole world. After all, there is no home in a world with no intrinsic meaning and in a never intelligible and comprehensible existence and body [12]. For Heidegger, uncanny situations are the paradigmatic mirror of Freud – moments in which reality stands out as it is, when one is led to feel an uneasy realization about one’s own solitary and homeless existence without any immanent meaning [11]. Such familiar strangeness of the human condition also elicits the *certainty of death*. Differently from Jentsch, who regarded the *uncanny* as the *uncertainty* between what is living and dead, Heidegger’s conceptualization suggests a disconcerting anxiety that comes with the awakening to the *certain* finitude of life [12]. Such insight about the human condition, in particular that of death and unchanging *homelessness*, may represent a turning point in the subject’s life, reflecting not a physical death but the death of the previous *Da-sein* with consequent limitless ontological possibilities. In other words, the *uncanny* can provide a key awareness regarding the finitude of our capacities, roles, functions, and practices, which then allows for a delineation of a new identity. The resulting unique opportunity of growth is terribly frightening as the previous inauthentic notion of an infinite existence is replaced by the experience of being

alive and fragile. Only through such uncanniness can the subject embrace true freedom and contemplate his existence, and adjust himself to the endless new interpretations ahead [13].

According to many authors the experience of becoming ill is uncanny in its essence, as the subject faces his physical nature and consequently his fragility and the finitude of life.

Falling Ill as an Uncanny Experience

The uncanny is a key aspect to characterize the event of falling ill, as changes in the body and in the bodily experience turn what was previously pre-reflexive, intimate, and familiar to something exposed and fragile.

In this paper we explore the concept of *illness*, which is distinct from *disease* or *sickness*. *Illness* is defined as the self-reported mental or physical symptoms that characterize the subjective loss of health suffered by the subject himself. This is a wide concept which ranges from reports of minor and temporary difficulties to severe health problems or acute suffering. *Disease*, on the other hand, is the biological process or state of the body that tends to cause the suffering that illness carries – often diagnosed by a physician or other medical expert. *Sickness* is a concept, mostly used in social sciences, related to the role a person with illness takes or is given in society – and therefore the notion of “*sickness absence*” from work [17, 18]. We will focus on the first – the feeling of falling *ill* that limits the person’s ability to lead his regular life, many times permanently [17, 18].

Svenaeus in his major contribution portrayed the “process of falling ill” in a similar way to Freud’s and Heidegger’s *uncanny* [11]. A simplified (perhaps even simplistic) view would be to regard the effect of illness on the body as similar to the breaking of the hammer in the paradigmatic case of Heidegger’s work [19]. The body, or the hammer, has a meaning not intrinsic but arising from the relationship it establishes with the subject regarding its representation and usefulness. Such meaning (*utilization behaviour*) is implicit and unavailable until the hammer breaks or the body sickens, and the user is deprived of its use [20]. However, the body has unique qualities and is, in itself, part of what provides the subject with meaning and therefore cannot be reduced to a mere tool – the body is “our expression in the world, the visible form of our intentions” (Merleau-Ponty as cited in [21]).

This leads us to the concept of embodied existence – a body that provides me with more than sensory inputs and

from which I can be estranged. Husserl distinguished between the objective body, *Körper*, and the body as lived, *Leib*. *Körper* is the living body, the flesh, and therefore the object which appears to be targeted by surgeons and the interest of technological medicine. *Leib* is the lived body – the first-person experience of the physical body. In a healthy state the two bodies are aligned and implicitly united [21, 22]. A disease may produce the necessary distance so that the experience of the duality of the embodied nature emerges – we are a body (*Leib*) but we also have a body (*Körper*). This means that the body that I embody can become alien or other in the illness process when it is “influenced, threatened, inhibited, altered or benefited” (Zaner as cited in [20]). There, the subject perceives that the body belongs to him in the same way as he belongs to the body in a twofold equilibrium that could be lost estranging the body from subject. Secondly, the body is not merely a sensory apparatus capturing external stimuli processed in the brain but it also provides us with the pre-reflexive sense of presence and understanding of the world. The very basic sense of being in the world describes the immediate and implicit engagement, enactment, and attunement to the world. According to Thomas Fuchs’ stance, the brain, mind, and context should be considered under an ecological perspective – neither is consciousness entirely located in the brain nor does the context-driven mind survive without an embodied existence or subjectivity. Only the human being, as a whole, in the world, can become aware, perceive, and act. This means that he is not a mere spectator but a bodily living being who experiences the events in the world [22].

In the illness process, the *uncanny* has two dimensions: (1) the loss of familiarity of the body and the world and (2) the consequent new perception of the body and the world that was previously concealed and now came to light [23]. The painful, heavy, nauseated, feverish body, now alien and out of control, is no longer *home* and restrains the access to an also no longer familiar or safe world [24].

An operational *definition* of the *uncanny* experience of the body was defined by four criteria by Zaner [25]: (1) the “inevitability and restraining” character of my embodied condition – my body determines the range of experiences I can have and I cannot choose not to have my body; (2) the “fear/terror” of relying on a physically confined body and depending on a suffering body; (3) the “hidden presence” as my body operates through biological processes beyond my control which I cannot feel; and (4) the “strange presence” of a body regulated by natural rhythms proper to a biological organism [24].

Other than the uncanny body, the illness experience entails further ontological and social changes that add to its uncanniness. These include the reorganization of the temporal structure, with the autobiographical narrative now built over a form of “presentification” (understood here as the hegemony of the present). This means the subject now visualizes his healthy past as unrecognizable and his prospective future as impossible [26]. When this personal temporality forcedly changes, the ontologically established identity disintegrates and whatever had existed or was to exist no longer makes sense.

Warsop stresses that the realization, often for the first time, of the eminence of death is what contributes the most to the uncanny character of falling ill. He challenges Svenaeus’ theory – the uncanny arising from a diseased, broken, and alien body – arguing that experiencing the body as different from the *self* (e.g., when checking the heartbeat rhythm, regularity, and frequency) is not a sufficient condition for the *uncanny*, as it can even be a comforting finding. For Warsop, it is the realization of the finitude of my organic presence that is truly responsible for the perplexity of being ill – in other words, the awareness that “the flesh will fail us and how we have been wrong to think otherwise.” [24].

Lastly, social contexts, both historical and cultural, also impact on the experience of being ill – and on what is, in fact, a disease. A paradigmatic example is homosexuality and gender dysphoria, which once figured in the *Diagnostic and Statistical Manual of Mental Disorders*. On a broader note, the mere “becoming ill” represents a detachment from the goals assigned by society [27], which further contributes to the alienation and strangeness felt by the subject when his body weakens and he is no longer in the position to fulfil what was expected from him [11].

Taking into consideration the experience of uncanniness rising both from disturbances of (1) the embodied existence and its engagement, enactment, and attunement to the world and (2) the narrative and social construct provides therapeutic targets. We address some interventions which are believed to reduce the feeling of *unhomelikeness*, anticipating that the clinical relationship may be the place *par excellence* to do so.

Reconsidering the Model of Care

In recent years, the experience of *becoming* and of *being* ill has been studied and new, personalized models of health care [28, 29] have been conceptualized, incorporating principles of social aesthetics in medicine [30]. In

this section we will discuss some of them and how the phenomenological method may enhance experiences of understanding, closeness, and well-being to the patient. These interventions aim at providing *homelikeness* to patients and to mitigate the experiences of displacement, difference, and strangeness already discussed.

Health professionals benefit from acknowledging the impact of illness addressed above and valuing the gulf inherent to interviewing someone who is ill. This gulf bears two aspects – one that exists *a priori* (being ill distances the patient from the healthy interviewer) and another built over the present way that medicine is taught and practiced (objectified and technological medicine). The first is represented by the *radical* distance between doctor and patient – illness bears a “*decisive gap*” “between the physician’s conceptualization of a disease and the patient’s way of experiencing it” (Baron as cited in [31]). There are new meanings and basic changes in the transcendental structure of consciousness that evade everyday experience and therefore to which we do not have access and that require detailed attention in the patient’s rapport [32]. The awareness of this distance might allow clinicians to build a new communication model that (1) relocates the patient closer in the therapeutic relationship and (2) aims at building new bridges over this gap. The doctor and the patient should then meet with an *ethos of approximation* – a radical difference to be gradually bridged by means of actively listening. Such *ethos* is not favoured by the current conceptualization of diseases nor the methods of diagnosis and treatment in medicine, all subsidized to an *ethos of explanation*. Moreover, Karl Jaspers provided an accurate account of the threat of treating such subjective experience not as “*difference*” but as “*sameness*,” stating that “in all lucidity we can choose a false road. Even the certainty of decision, in so far as it is manifested in the world, must retain a certain element of suspension. For the most devastating threat to truth in the world is the overweening claim to the absolutely true. In the certainty of the moment, the humility of the enduring question is indispensable” [33].

The second aspect, more subtle, has risen through the introduction of new techniques and technologies (e.g., instruments, imaging, computer interface) which have furthered the patient-doctor gap by adding another obstacle to medical encounter. An example of such is how we identify heart murmurs – they were first detected by placing the head onto the chest while today the pursuit of scientific accuracy favours the stethoscope [16]. Other techniques attempt to reify illnesses (e.g., MRI studies

that aim to locate depression in the brain), exploring the biological nature of medical diseases and distancing the doctor from considering subjectivity as relevant. By focusing solely on *what* characterizes a disease – the pattern of signs and symptoms – the doctor neglects the *how* it is – core features that the condition imposes on the patient while becoming ill. First, keeping with divergent conceptions and purposes, health professionals and patients might never collaborate in the encounter as what is relevant to one is deemed irrelevant to the other (life changes are considered core features to the definition of the disease for patients but seem meaningless for medical nosology). Second, though our paper explores the *uncanny* as a general experience of falling ill, this last argument suggests that research into the phenomenological properties of the experience could provide insight into the unique features that could characterize each disorder. Indeed, literature on the *self* and world experience suggests key features of schizophrenia, mania, and melancholia [34] – disorders where the uncanniness of the illness experience could be unique and therefore relevant for diagnosis, prognosis, and treatment. Therefore, attending to such changes means valuing important subjective experiences for patients, promoting and restoring their congruence and well-being, and allowing the identification of phenomena unique to each disease process.

Toombs' contribution seems relevant when she described five patient-related *eidetic* aspects of illness which are transversal to any disease: (1) *loss of wholeness* – the body becomes “another,” detaching itself from the *self*; (2) *loss of certainty* – the realization that one is in fact not indestructible; (3) *loss of control* – a previously familiar world becomes unpredictable in the hands of others, such as doctors and technical devices; (4) *loss of freedom to act* – no longer relying on one's understanding for decision making and having to follow advice from others whom, despite their scientific knowledge, might not share personal values; and (5) *loss of the familiar world* – a distinct way of *being-in-the-world* must be adopted, as the previous one feels unavailable or disturbed [31].

Looking back on the definition of *uncanny*, we realize how it clearly characterizes at least two of the *eidetic* aspects set forward by Toombs – the feeling that the body becomes “another” and the “loss of the familiar world.” Deconstructing the particulars of falling ill as detailed above allows a better understanding of this complex though otherwise apparently uniform experience. This leads us to the challenge of assessing subjective phenomena. The phenomenological method aims at offering a

systematic appraisal of experience while valuing, at the same time, some of the above-mentioned relationship features often dismissed [16]. This method, originally a philosophical approach for collecting subjective phenomena, was introduced in medicine by Jaspers for the investigation of psychopathological phenomena [35]. It includes a predisposed attitude – *epoché* – of bracketing previous personal viewpoints of the world and adopting an opened and neutral position [36]. This method aims to comprehensively describe culture-bound human experience “inserted into a given culture and having a certain meaning based on the concepts and values of that same culture” [21]. This approach provides an explanatory framework of how an individual actively attaches meaning to his experiences [31]. As previously described, disturbed meanings and processes of meaning attribution appear central to the experience of falling ill. There is a loss of the previous relationship with the world and the rearrangement of the “patterns of meaning that formerly (inter)connected the individual with the objects and made the objects appear in a certain way” (Svenaeus as cited in [37]).

Today, dominant paradigms in medical care dismiss the role of health care in encouraging patients' identity redefinition and the recovery of a homelike body and world [20]. Medical professionals offer structured interviews focused in clinical anamnesis, physical examination, laboratory and imaging tests, along with drug prescriptions and a prognosis. We therefore see how patients are given a diagnosis and left alone with a fragmented existence to face such a large part of being ill. Indeed, an “ontological death” [13] of the previous narrative seems to take place, along with uncanny changes in “body disposition, a change in the experience of time and space, a frustration of corporal intentionality, social changes and challenges for personal identity and integrity” [21]. If we go back to Husserl's concepts of *Körper* and *Leib*, we see how present-day practices identify disorders as features of the *Körper*, that is, the sick body as a broken object, and provide interventions to clarify and correct such disorders – further dismissing subjective experience. Then a paradox ensues in these new technological health sciences – although we treat biological diseases with a growing effectiveness, the illness experience increasingly draws from the amplified disconnection between *Leib* and *Körper*. The burden of the uncanny experience for which our present practice is responsible is now even more overwhelming, if we reflect upon how we can detect diseases that are yet asymptomatic and identify risk factors that may lead to a future disease. We have

redefined the experience of health and illness which might further tear apart our *Körper* and *Leib*, making us vulnerable to the uncanniness in new previously comfortable situations [38]. A balance of the *Körper* and *Leib* disturbances is the key to offer patients new, ego-syntonic ways of experiencing their identity and their world. Only by approaching the experiential and subjective dimensions of illness through touch and empathy could we attend to the *Leib* dimension of the body, which is damaged and needs care [12].

Other ontological changes should also be addressed. As for the temporality disturbance, interventions should focus on “reconceptualising the present, the relation with the past and the future, by favouring the structuring of a narrative of experiences” (Ricoeur as cited in [26]). These interventions can enable the narrative’s rebuilding under illness and reintegrate coherent new ways of being [20].

Recovery from illness means allowing for a communion between body and identity, regaining control over the body, and readjusting the world’s pattern of meanings to the new reality. Several qualitative studies that assess interviews, self-reports, video recordings of behaviours, and the aesthetic expression by patients (such as music, writing, dancing, or movies) highlight the above-mentioned difficulties experienced by patients. Moreover, these studies identify changes specific to each disease, allowing therapeutic behaviours to be adjusted to the patient’s real needs, rather than focusing solely on those thought to be more frequent in a disease or group of patients [21]. For instance, in stroke rehabilitation centres, patients underlined the loss of control, boredom, and frustration as uncanny features of their experience, suggesting investing in physical rehabilitation, patient autonomy, and clear communication as interventions to a more homelike recovery [39].

The phenomenological method provides tools to explore how one falls ill and assess its ontological features. We must stress that what is claimed here is not the absolute *subjectification* of the diagnosis or that we should disregard the objective dysfunction, but rather the acceptance that the two dimensions coexist and that a complete *objectification* ignores (and increases) core experiences of illnesses [21]. The inclusion of this approach in the qualification of health services and professionals and in the formulation of health policies could provide a better care system for patients. Furthermore, these skills can provide new data for nosology and for more relevant and effective treatment plans [35]. Doctors’ engagement in the field of medical humanities (e.g., psychopathology, phenome-

nology, or phenomenological-existential psychotherapy) could provide them with an insight into how to approach the *uncanny* and the radically unique existence of patients. The clinical encounter is the ideal place to a “communion that appears impossible between life companions,” by creating a “tension to build” and ultimately allowing the patient “a return to freedom” (Jaspers, adapted from [35]).

Conclusion

An analysis of illness as an *uncanny* experience and the role of phenomenology in addressing such experience could provide new procedures for medical practice [13]. Emphasizing the value of subjective experience in parallel with objective disturbances is central to increase the detail and validity of medical science and to address what patients consider the core of their disorders. We suggested that several contributions from social and human sciences have a role in addressing subjectivity and should be considered in future health practices [15]. As these are essential and transversal elements and skills to any professional working with patients, they might be deemed relevant in all undergraduate and postgraduate health sciences curriculums. Attending the being-in-the-world and its disturbances could be a therapeutic measure that promotes the dissolution of the uncanniness of falling ill and ultimately brings the patient to a new home.

Disclosure Statement

The authors declare no conflicts of interest.

Funding Sources

This paper was not funded.

Author Contributions

Luís Madeira and Beatriz Leal contributed equally to this paper (joint first authors). Maria Luísa Figueira, Teresa Filipe, and Madalena Ferro Rodrigues were reviewers of content and form.

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