Visceral: Essays on Illness Not as Metaphor

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I can’t remember things right now. Some things, anyway, nor can I really remember the order of things or how something began by the time I get to the end. It’s my grasp that’s gone, my ability to hold on and sort things out and remember the things and the sorting. Even these few sentences are getting repetitive because I can’t really remember what I had been thinking to say next. This isn’t the first time I’ve had this complete lack of grasp. The first time was when my cat died and I didn’t even bother trying to read anything in English for days afterward because I couldn’t remember the beginning of the sentence by the time I had gotten to the end of it (that I can remember). I’m not sad, now, and no one’s dead. Now, my grasp is gone because of Amitriptyline HCL 10 mg.

It’s not what you think. While it is true that Amitriptyline HCL 10 mg is a tricyclic antidepressant, it has a long history of off-label usage as a treatment for nerve pain or nerve damage, like nerve damage caused by a chronic illness, and the whole time my doctor was discussing the prescription and its use in relation to the gastrointestinal system with me, I couldn’t tell if he was saying gastroenterology or gastroneurology.
many other people who take antidepressants for sad minds only to find themselves facing physical side effects of which weight gain and constipation are some of the most common, I, instead, am taking it for my sad gut only to find myself with mental side effects which, while not being able to remember things doesn’t make me sad, exactly, do make me absolutely and completely infuriated. I can only say “it’s like” because I don’t have a lot of other information about sad guts, yet, and because, as an off-label usage, it is difficult to find information about Amitriptyline HCL 10 mg and nerve damage, and the whole time my doctor was saying either gastroenterology or gastroneurology, he was discussing Elavil, a version of Amitriptyline that AstraZeneca doesn’t even make anymore.

Tummy on My Mind

The first step in determining whether guts can even be sad (and whether I should continue taking the Amitriptyline HCL 10 mg) is to decide what “gut” means. Because the gut is a complex system or network, including organs all the way from the salivary glands and esophagus to liver and pancreas and anus. It is often characterized, within popular scientific journalism, as a computer system, a little brain or a second brain, because the enteric nervous system, which innervates the whole gut, contains every neurotransmitter that the central nervous system contains; there is nothing peripheral about it. Because there is nothing peripheral about it, the gut is also, more widely speaking, at the center of things: it may not be at the heart of the matter, but it is what runs entirely through it and because it is at the center it provides, in its own way, an answer to or model for an answer, to the question of whether my doctor was saying gastroenterology or gastroneurology, because he and I are still trying to determine what is at the center.

The enteric nervous system is extensive. It is commonly quoted that “the small intestine in humans has as many nerves as the spinal cord.” The gut feels. What it feels, though, is not always obvious.

The enteric nervous system consists of three main kinds of nerve groups, divided between two main networks (called plexuses) which serve to detect thermal, chemical, and mechanical conditions (done mainly by sensory neurons) and augment these conditions by manipulating muscle movements (like of the gut wall) and secretions (like of digestive enzymes, performed by motor neurons). Interneurons facilitate communications between sensory and motor neurons. The little or second brain labels come in because there is, relatively, little communication along the vagus nerve between the gut and the brain. The gut makes its own decisions.

As a somewhat disparate collection of organs whose main functions are best facilitated via muscle movements and secretions, who are you to make decisions of this kind? Doing so would require specific and constantly, minutely, changing information and the ability to make decisions based on this information. For instance, what is the difference between the amount of lipase and amylase, enzymes needed to break down fat and carbs, respectively, in a piece of pizza as opposed to an avocado? How do these amounts change based on the time of day or the temperature or how much water I’ve had to drink or what else I’ve eaten or how much pain I’m in or whether I’ve done my part properly in these decisions by taking Creon, a neatly capsuled dose of amylase and lipase? Maybe a sad gut is one that can’t make decisions. Maybe a sad gut is one that hasn’t been given enough information about what is at the heart of the matter. Maybe if losing my memory is enough to make me angry than being confused is enough to make my gut sad.

This confusion fits neatly into the computer model of the gut, because it depicts a network of nerves and information hubs (organs) in disarray or with crossed connections. One main aspect of the computer-gut model not often noted is how reliant this analogy is on invisibility. Because just as the stuff (hardware) that makes a computer actually compute is hidden within smooth silver surfaces, the stuff of the gut is hidden beneath skin and muscle and a rib cage and other organs. Both computers and guts rely on this invisibility to produce, continually and reliably, seamless interfaces and user interactions. “The portions of the gut innervated mainly by the enteric nervous system tend to remain outside awareness
until they break down.”

Mind on My Tummy

A second model of the gut seems to refute this invisibility entirely. Instead of envisioning the gut as a computer, it can be depicted as another (more apparent) body part, that of the skin. The gut can be seen as similar to the skin because both serve as barriers, with the gut acting as “a tunnel that permits the exterior to run right through us. Paradoxically, whatever is in the lumen of the gut is thus actually outside of our bodies.”

The funny thing about the skin as a metaphor or model for the gut is that the skin is the largest organ humans have and the one that you never think of as being a real organ, so in some ways the gut/skin metaphor doesn’t, actually, move beyond or stop relying on and reinforcing the invisibility of the gut, because it likens it to another object that seems beyond the realm of real organhood.

If the computer model of the gut serves mainly to illustrate the workings of the enteric nervous system, the skin model seems to be more so about the function of the gut (as organs rather than as nerves) as a barrier, as a thing that controls the flow of what enters and is released by our bodies, much as the skin does. Maybe having a confused gut very much on the inside of my body instead of (being able to envision it as) on the outside of my body is enough to make me sad.

Wouldn’t having an external barrier within the body mean that the gut is really just a barrier to ourselves, from ourselves? Maybe being isolated is enough to make my gut sad.

Tummy on My Mind

Maybe a determination of what constitutes a sad gut doesn’t need to be based on, or only on, defining what the gut, itself, is, but on whether the gut is able to experience sadness. As in, if what you are noticing is chemical, thermal, or mechanical, what about

3 Wilson, Psychosomatic, 37.
4 Wilson, Psychosomatic, 44.
this information can cause sadness? But even this question would depend on whether the gut is being defined by what it is or by what it does. Is the gut a collection of organs that do stuff or is it a bunch of nerves that decide stuff? Privileging one conceptualization over another seems to depend on another set of privileges: does your gut work or does it not work? Is your gut a thing that does things for you, that makes its own decisions, or do you have to constantly consider your gut’s needs and decide, for it, what it should do and when? (Keeping in mind that any such decisions are guess work because how can you fix hardware, which inherently requires mechanical repairs, when all the hardware is inside and, anyway, what kind of hardware can be fixed just by putting more stuff, like food or Amitriptyline HCL 10 mg, into it?)

If what you are noticing is your gut’s ability to notice (and regulate) mechanical, chemical, and thermal changes, what about your noticing (or what you are noticing) determines whether you want more skin or an internal computer? When your perception of an object includes “the motor adjustments we made to obtain the perception in the first place and also include[s] the emotional reactions we had then,” does your perception of your gut as either a computer or as skin imply your perception of your gut as a thing you used or a thing that covers you at all times?

Mind on My Tummy

Part of the determination of whether a gut can be sad is related to the question of having either more skin or an internal computer. Because part of whether a gut can feel sad depends on how much it is yours. That is, if “ownership and agency are, likewise, related to a body at a particular instant in a particular space. The things you own are close to your body, or should be, so that they remain yours.” Is your gut a thing, like a computer, that you own and inside you because through this ownership you keep it close, or is it, like skin, which is simply there with this invisible, inherent, always already embeddedness, so close to you that it is like a barrier, like

a second skin, that defies ownership because, really, how do you own your skin? Whether you own it or not matters not only for the objecthood of your gut but because this ownership is related to agency and, therefore, maintains (or consists in part of) a spatial relationship to your body, it also matters in considering whether or not your gut can be sad: are gut feelings ones that your gut has or feelings that you have or feelings that your gut gives to you? And when you stop taking Amitriptyline HCl 10 mg and find yourself much more able to write (because you are much more able to remember), now, is this satisfaction a feeling that you have or one that your gut gave you or one that you are having at the expense of your gut?

Tummy on My Mind

The question of ownership, of how you have (or feel yourself to have) your skin, and therefore the rest of your body, is at the heart of the matter of having a gut that is skin or a computer. Or, more precisely, the question is not so much one of similarity between your gut and skin or a computer, but rather a question of how differently you perceive your gut to be from the rest of your body and whether this difference (or lack thereof) is more like a computer or like skin. Meaning: if your gut is in no way dissimilar from the rest of your body, then your gut is like skin, because having a gut that is skin means having a gut that is more of the same, more of what’s already there. Because your body is not, actually, a computer, having a gut that is a computer means having a gut that is different from the rest of your body.

Different in part, perhaps, because of the kind of thinking (or non-thinking) your gut does. That is, because of the kind of information the enteric nervous system pays attention to, namely mechanical, thermal, and chemical, namely not emotions, the gut as computer model is a way of encasing the gut as a data set. This encasing effects not only the gut but the way the data of the body throughout is thought of as well: if the gut is data, then data is a collection of matter and nerves and organs. Information is mass.

Information is mass and the gut is weight and this is most obviously illustrated by the fact that weight is a number, in pounds and BMI and in 10 mg being an appropriate dose of Amitriptyline HCl.
for a gut my size. Is the preclusion of emotional information from data based on thermal, mechanical, and chemical changes indicative of the way we think about our own emotions, the liveliness of our bodies, or the way that processing is so often portrayed as being at odds with higher level emotional thinking? Maybe being isolated is enough to make my gut sad.

Mind on My Tummy

All of these questions and the perceptual maneuvers they require are because this question of what the gut is is not one easily answered within standard considerations of embodiment. Because embodiment is so often taken to mean the way that we experience and are embodied within our physical bodies. But the question of whether the gut can be sad can’t be answered entirely within such a matrix because it ultimately asks the question of how bodies, how physical matter, is embodied within us. What is it about this question that makes it so difficult to answer?

Consider, for a moment, the way that “stomach” often acts as a cipher for the entirety of the digestive system. Which, in turn, means that a word like “stomachache” can be used to mean anything from nausea to pain to hunger; it becomes not a cipher, exactly, but a way of creating opacity over physical sensations. “Stomach” is the gut/center/tunnel of the matter because a tunnel is a hole and “stomach” is a hole that indicates an inability to completely perceive and account for the complexity of the gut and I say “stomachache” even when I know the pain I’m in is in no way caused by my stomach. “Stomach” is indicative of a hole in embodiment, of a failure in perception that is similar to a kind of agnosia. Agnosia is a neurological condition in which a lack of one specific kind of sensory information (i.e. visual, auditory) prevents the recall of an object. Which, in turn, prevents a current perception of an object because how can you recognize an object if you can’t remember having seen it before and how can you tell if your gut is sad if you can’t even tell what your gut is or recall how it was before?

The gut is a black box that is distinct from the black box that the brain has been thought of for centuries. Because the problem of the brain’s black box-ness was about an inability to access the workings of the brain based solely on physical and visual information. The
problem of the black box gut is not one of mechanics but of mechanism. We know what the gut does: we put things into it and other things come out in ways that are both obvious and invisible (but not insensible). We know what the gut does but not how it decides to do those things. How does a gut determine what to shit and what to distribute? How can you have something if you don’t really know what it is?

Tummy on My Mind

This question can actually be answered by a return to the gut computer model. Because it could instead be asked as: how do you own an unknown (or unknowable) product? And Apple easily answers this question: you buy it for the packaging. And, in turn, you develop that smooth shiny packaging precisely because you are aware of the unknowability of what’s inside.

Mind on My Tummy

In terms of the relationship between forgetting (or an inability to remember) and an inability to recognize an object, does the fact that I stopped taking the Amitriptyline hydrochloride 10 mg two days ago and my ability to remember is returning, somehow mean that I will or should now be better able to recognize my gut? Or, maybe, this inability only ever constitutes itself. Maybe it takes a consideration of what depression is to determine what the (sad) gut is. For example, if depression “is a breakdown not of the brain, per se, or of the liver or of the gut. It is a breakdown of the relations among organs,” then maybe my gut is sad because I don’t even know what it is.

What if my gut is sad not only because I don’t know what it is, whether it is skin or a computer, but also because I never decided what it was before, before now, before I needed to, before it became sad. And maybe this confusion or inability only

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ever constitutes itself because consider the following excerpt from Antonio Damasio’s *The Feeling of What Happens*:

We begin with an organism made up of body proper and brain, equipped with certain forms of brain response to certain stimuli and with the ability to represent the internal states caused by reacting to stimuli and engaging repertoires of preset response. As the representations of the body grow in complexity and coordination, they come to constitute an integrated representation of the organism, a proto-self... But all of these processes—emotion, feeling and consciousness—depend for their execution on representations of the organism. Their shared essence is the body.⁸

What if something happens during the growth in complexity of bodily representations that disrupts both the complexity and ensuing coordination? What if, before you fully realize or decide what the gut is, you are taught (if that’s the right word) that this decision is meaningless or unnecessary because your gut is just a thing you have or a thing you use and what is complex about that? What if the disruption to complexity is the utter simplicity of the gut-computer and gut-skin models? What if the development of complexity or coordination is on some level related to other neurological development, like growing up, and you have been sick since you turned 18? What if these disruptions to complexity, because they create an inability to depict accurate representations of the body, further inhibit coordination because you cannot communicate nothing, or, you can, only this means the communication of confusion. What if this series of disruptions creates a situation of alienation, wherein the gut is neither a skin nor a computer but a different actualization of the gut being external, in that it has become external to the knowing self. And, therefore, because it is within me but without me, the gut has no choice but to have its own feelings.

*Tummy on My Mind*

And, now, what kind of interruption to complexity and coordination is going on when my stomach hurts to the point that it is

distracting and I can barely focus on what I’m reading, let alone write anything? It’s a deceptive interruption because in this situation it only seems like the simplicity of my stomachache is interrupting the complexity of my thinking, because, really, what is going on is a series of disruptions: the simplicity of the pain of my body, followed by an immediate awareness that even as I say “stomachache” I know that it’s not my stomach, so if it’s not my stomach then what is it, and if I don’t know what it is, really, today, then how can I do anything about it, and if I can’t even think straight, now, is this better or worse than not being able to remember anything?

I’m too distracted by this simple pain to continue being able to focus on questions of the embodiment of the gut, so perhaps it’s time to fully, actually, consider sadness now and leave the gut at this: it’s a hole, like a tunnel, but not empty. If it’s a lack, as a hole, that’s only because it’s a lack of awareness; as a body part for which there is no complete awareness, the gut exists in a state of unembodiment. This isn’t the same as disembodiment because the problem is not one of detachment. Rather, the gut is within and without and we are within and without the gut as well.

Mind on My Tummy

So, depression. Allowing for a standard hierarchy of complexity within emotions, it would perhaps be prudent to start with a definition of sadness, as feelings of sadness are the building blocks of depression. In fact, by some accounts, depression is simply sustained feelings of sadness. This continuity of feeling, regardless of other criteria, is always a part of determining (or diagnosing) depression. In turn, this linking of diagnosis and defining raises the question of whether depression can be defined in a way that differentiates depression as only ever active (as in actual) when it is a thing a person is doing from depression as a state separate from a standardized enactment of that state. Or, is there a core quality or state of depression that can be identified through its isolation from the set of symptoms that arises in being depressed? If so, it would seem to be this core depression that the gut is capable of because how can a gut exhibit other behaviors associated with depression like not getting out of bed and substance abuse, and I wonder if it is harder or easier to diagnose depression in a person than it is to diagnose
a physical illness in a gut. The statistics would seem to indicate it’s easier, on the basis that psychiatric medications are some of the most widely prescribed, and I have been sick for years with, in part, the condition of being in a diagnostic “no man’s land,” to quote the same doctor who said either gastroenterology or gastroneurology while providing me with an unpopular usage of a popular drug and I do understand that this is not exactly a one-to-one comparison but how much easier is it for you to think of and know a time when you felt sad than it is to identify, locate, and define what, exactly, your pancreas does?

Tummy on My Mind

My simply painful gut is distracting me again.

Mind on My Tummy

Given the frequency with which gastrointestinal symptoms are reported by people with clinical depression, namely changes to appetite and weight, to the degree that such symptoms are part of the criteria for a diagnosis of depression, it may seem like a sad gut is really just a similar psychosomatic state. But the way that physical symptoms arise in depression is such that they are as a result of an existing emotional state. Which, yes, as a set of neurological characteristics is itself definitely physical, but the point being that the entire concept of psychosomatic illness is based on the idea that the body is entirely under the influence of the mind. A sad gut, a gut that is its own physical symptom generator, as in a gut that is already sick, is not producing these symptoms as a result of existing emotions. This in turn gives rise to two questions: one, what to call or how to consider this kind of anti-psychosomatic or psychosomatic resistant sadness, and, two, addressing the kind of internal anthropomorphism at play here.

It’s an anthropomorphism inherent in the term “sad gut” because a gut is not a person and a person is the only thing that gets sad. Many body parts, though, are subject to this kind of anthropomorphism: the heart’s (or penis’) mind of its own, for example. This kind of part–whole anthropomorphism, wherein a part of us, because it’s us, must therefore be comparable to or simply a smaller
model of the whole of us, is useful to our discussion here, but limited by its unidirectional nature. First, it does provide an existing understandable model through which to think sometimes unintelligible or unknown questions. However, part–whole anthropomorphism fails to take into account how the whole may be, actually, comparable to or a larger model of its part, how, maybe, anthropomorphizing the gut only ever further reinforces a failure in understanding the gut and how much it constitutes us.

Tummy on My Mind

Even when trying to define sadness, its location in the gut (as opposed to “us” or the brain) means that it is always in relation to a physical sensation. Despite that oft-cited figure meant to illustrate the sensitivity of the gut, what it is capable of being sensitive to is still defined narrowly and physically. Can an organ (especially one which is not one, but many) have a feeling that is more than the physical feeling of pain? (Is pain only physical, ever?) More of a feeling meaning exactly that, a feeling that is more like an emotion than a physical sensation. Is it that the physical pain of a sick gut becomes, over time or through interpretation or through interpretation over time, a feeling of sadness?

Sometimes I feel pain but I don’t also feel sick and sometimes I feel sick but I’m not in pain but whether I’m in pain or feeling sick or feeling neither, there is always the physical presence of sickness. There is always a sick gut. There is no clear causation, no psychosomatic linking between psychological emotions and physical symptoms, or things that happen that become symptoms, or things that are felt that become symptoms, because, in this already sick saddened gut, the sheer force of physical fact overrides any attempts at separating the physical from the emotional; pain is pain is sadness is sickness is the gut. Saying that sad guts are always also sick guts doesn’t mean that the sadness is being caused by the sickness, because not all sick guts will be sad and because here, in the gut, sickness and sadness are one and the same. Saying that sad guts are always also sick guts isn’t the same as saying that sick people are always also sad, but that certain physical sensations within sickness are always also emotions. Emotions that organs are having. Consider again the diagnostic criteria for depression set out in the DSM-IV,
and the inclusion there of items like changes to behavior or loss of interest in prior activities, and, alongside this, consider symptoms of a gastrointestinal illness like ulcerative colitis or Crohn’s, which can include alternating diarrhea and constipation, and bloating and nausea and bleeding. Alternating diarrhea and constipation are nothing if not a change in behavior. A sad gut is one that no longer wants to do what it (maybe) used to do. A sad gut is one that can no longer remember how to do what it used to do. A sad gut, in this not remembering and not desiring (because it doesn’t know what to desire anymore) recognizes that sadness is the absence of information. A sad gut, knowing that information is mass, concurrently recognizes that the absence of information has direct physical effects. In this sad gut, alternating diarrhea and constipation become a mechanism for the regulation of or searching for information: holding onto, letting it all out, trying to communicate. Because sadness, any emotion, is not just about having the capacity to feel the emotion but also the ability to communicate it. A sad gut is one that is trying to tell you something.

Upset Stomach

If the gut is a hole in embodiment, and if sadness, or at least the sadness of guts, is a lack of knowledge or information, then these states lead to a third condition of misunderstanding because of too little information: what if I never tell you how it feels? What if, throughout this whole discussion of guts and sadness, I never tell you how my gut feels and all that is really felt, here, is how unfelt, how unembodied, the gut is? Because I can say “pain” and “stomachache” over and over, but what do you actually know? But this is, in a similar but slightly different way, exactly how my gut feels: I feel what I don’t know. I feel, exactly, what I don’t know how to feel, as in how to interpret, except that, also, at the same time, my gut hurts almost all the time and also, at the same time, I know exactly that something is wrong and the core of this feeling is more correct than any specific information (diagnosis, pancreatic physiology) can ever be. This is part of what I mean when I say psychosomatic-resistant, in that it is simultaneously, always, both of these feelings, and there is never really one without the other, and (after years of this shit) it no longer matters which is causing the other. This is
why, in part, continuity is such a main part of the diagnostic criteria for depression: it no longer matters why but that; that it continues; that the gut is a hole, but like a tunnel. Continuity is also important in diagnosing depression because it helps to distinguish between sadness that is related to individual life events and that passes, as expected, and sadness that persists, with or without apparent external causes. But how do you know what’s expected? How can you determine what sadness is if there is no standardized or reliable baseline? Because, maybe, not knowing a baseline, non-sad, gut feeling means that I’m constantly mis-feeling, miscommunicating with my gut. All I remember from before, from before I was sick, was never feeling anything, never knowing, and I still don’t know (that much) now, even though I feel all the time. Maybe this is actually how it’s supposed to feel. Maybe the psychosomatic resistance is all in my head and I’ve begun to think that maybe everyone feels like this, like this is what digestion is supposed to, normally, feel like, and I’m just feeling it wrong. But I’ve been asking, especially after meals shared with family or friends, and it seems like not everyone else is in pain most of the time, though this doesn’t entirely clear up the issue of whether what I’m feeling as pain is, actually, being correctly interpreted as such; maybe everyone else feels what I feel but their guts don’t hurt. And then I was watching television with my parents and we were interrupted (or the show was) by a commercial for Victoza™, a blood sugar-regulating drug, a pancreas-regulating drug, and the commercial, as mandated by law, told us that pancreatitis, a side effect, may be fatal and you may have the worst stomach pain you’ve ever felt (maybe they didn’t say that exactly) that may extend through your back, with or without vomiting, and we were interrupted. What if no one ever tells me how it is supposed to feel?

Mind on My Tummy

This interruption may be telling. Because what it illustrates is the way that a sad (sick) gut makes itself felt and present, or at least one way that it can do this: as an interruption to normal communication, as a break, like a commercial, but one that communicates side effects. Remembering that the key aspect of the gut as skin metaphor was the way that the gut came to function as a place of interaction between the inside and outside of the body, consider the
following description of Andrew Solomon’s depression, mainly the way he dealt with it: “Largely unable to feel or connect with others, Solomon is able to enter into a relation of reciprocated care with his father through the gut.”

Meaning that Solomon, through having meals prepared for and fed to him by his father, is able to find enough support in this relationship to ultimately further his recovery from clinical depression. This would make sense given, again, that the gut is “a vital organ in the maintenance of relations to others.”

The gut is about communication, as a conduit (or barrier) for the weight of information, and if sadness is the lack of information, then this lack disrupts communication between what two things, exactly? It doesn’t have to be more complicated than to say that the sadness of the gut interrupts internal to external, and vice versa, communications: it makes obvious the lack of clarity, the lack of information, between what is apparent and what is in the hole running through what is apparent.

Upset Stomach

Even as I’m writing this, trying to communicate, what I am mostly thinking about (being distracted by) is the way that the pain I’m feeling now (a slight departure from, more urgent than, the pain I usually feel) how it feels almost like hunger pangs except that instead of emptiness I feel a tunneling. And I am still wondering if, maybe, it really could be just hunger pangs. Wouldn’t it be easier if my gut was just irritable instead of sad? Wouldn’t it be easier if I could fully join the IBS masses instead of that pancreatitis interruption which may be fatal? How do I know it’s not just IBS? Even when I am told this is also what it is, under every hypothetical model of IBS, having had acute pancreatitis or having chronic pancreatitis creates the physiological changes thought to be responsible for causing IBS — is this really two diseases, one larger one, or two insurance billing codes? How do you know what a disease is supposed to feel like?

Maybe the memory loss caused by the Amitriptyline HCl 10 mg was never a side effect but a desired and desirable main effect, so that this whole time I could have been forgetting how sad my gut is.

9 Wilson, *Psychosomatic*, 47.
10 Wilson, *Psychosomatic*, 45.
Mind on My Tummy (Again, Differently)

Maybe it would be even easier if there was nothing to remember. Maybe biology is just that scary and the answer to fear like this is to frame ideas like those being articulated here as just trafficking too heavily in biology and biological determinism and the attributing of agency to things that are just things as not only poor (queer, feminist) scholarship, but as trivial. See: “Discussion of the biological causes of depression might be plausible, but I find them trivial. I want to know what environmental, social, and familial factors trigger those biological responses—that’s where things get interesting.” Because it is only within the environmental, social or familial that “things” are interesting? Because the body (as in, biology, not as in the Body) is boring? Because it seems like the problem is not as much one of biological determinism as it is one of biological predeterminism, because the problem is not one of how your body is now but of the (seeming) impossibility (or at least intense undesirability) of your body, as it was or always has been or (probably) always will be, biologically, determining you, or (more threateningly) determining your fate. Biologically predetermined as in, your body, a physical form, existed before you were conscious of it (or conscious at all).

I wasn’t born this way, actually; shit happens.

This biological predeterminism is such a problem because, if true, it would mean that “you” are not better than your body. It would mean being unable to think your way out of a physical form. Not only think your way out of it, but the mind–body separation that is necessarily maintained by a struggle against biological predeterminism means thinking you can overcome your body.

I can’t. (And would I really want to? That would be a lot of effort, for what? Not more life, really, nor even, probably, a more intellectually satisfying one. One less filled with shit? Maybe.)

And, as a side note, how can you find biological relations to depression trivial after, as Cvetkovich writes, having just witnessed multiple friends die of AIDS?

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Full of Shit

Maybe there is something biologically predetermined about the gut that leaves it susceptible to depression. Like the fact that it handles shit all day. The constant presence of or continuous engagement in the process of making shit opens space for another gut–brain connection or point of similarity. Within neuroscience, and the way that neuroscience is written or rewritten within critical theory, the main process that the brain is engaged in and which effects all further possibilities and processes of engagement is plasticity. That is, the brain, like a computer, is open to the reworking of neural networks, the formation of new connections, forged through patterns of behavior and information input, that produce both positive and negative change; plasticity is the quality that allows for everything from the learning of new behaviors to the formation of habits to the personality changes that may come from brain injuries. Everything the brain does is related to plasticity, however circuitously. Because the gut is always full of shit and all behaviors and processes that happen within it are tied to this fundamental engagement, a relationship can be drawn wherein the brain is to plasticity as the gut is to shit. Much as plasticity is the main vehicle for change in the brain, shit is for the gut. Because shit is entirely about repetition with difference. Plasticity is about being open to change, whether positive or negative, through inscription and reinscription. The shitty plasticity of the gut is about repetition as opposed to inscription because inscription implies a continuous or constantly present surface on which things happen, being erased or laid over one another, whereas shit is entirely gotten rid of and started anew; it is both continuous and begins and ends and begins all the time; shit allows for newness (and ongoingness) over habit. Shit is not habit-forming because its main purpose is to find the best in things, to sort through what could go into it and save those things most useful, passing them on; plasticity more or less has to take what it is given, developing habits that may be ultimately harmful or losing traits that were useful. It’s not that shit is above malfunction, either, but even in times of alternating diarrhea and constipation, shit is happening.

Shitty plasticity trivializes mind–body separations. Shitty plasticity trivializes notions of biological responses triggered by a you that
Visceral

is (somehow) separate from your shit(-producing gut). Shitty plasticity illustrates the way that, because determining what is needed from what should become shit requires an orchestrated series of actions across multiple organs, across multiple kinds of cells, even including non-human microbes which reside in the gut, this is more than a reaction. A reaction is a simple mechanism, like an unstoppable Rube Goldberg machine. Shitty plasticity requires communicative decision-making. And emotional variation as well: imagine the difference between the way that intestinal eukaryotic cells must communicate with non-human microbes versus the way that the pancreatic cells negotiate differences in function between endocrine and exocrine portions of the organ. Finding biologically oriented gut–brain or mind–body connections trivial turns all of this into an extended metaphor, but remembering the way that the gut is like barrier or conduit to the outside world means that none of this communication is hypothetical.

The looming specter of the constant reinforcement of the importance and supremacy of the social, environmental, and familial over the biological within critical theory creates the condition of theoretical determinism.

Upset Stomach

I find environmental, social, and familial conditions that may be contributing to my being sick plausible, but trivial, because my doctor and I are no longer, and haven’t been for years, looking for why I got sick in the first place but why I continue to be. As in, it no longer matters why, but that. Like depression.

I cried twice this week. The timing seemed off, because earlier in the week, for days, I was in enough pain that I should have gone to the emergency room, but didn’t, and it was only a day or two after, after I was already feeling better, that I started crying. Maybe, like shit, it takes some time to come to the surface. Maybe I wouldn’t have cried if I was still taking the Amitriptyline HCl 10 mg. Maybe if I wasn’t in the face of others’ perceptions of the trivialness of my gut, I wouldn’t be feeling so defensive, so sad, on behalf of my sad gut.
Full of Shit

Being full of shit, both in the way that the gut is and as an idiomatic expression, is about disbelief. Which is also a reoccurring theme within neuroscience and popular narratives therein, namely the “epistemic shock that is said to accompany trauma.” Earlier I felt conflicted in my decisions to link or not link being sick and being sad, for the way such linking often contributes to reinforcing the presence of epistemic shock after trauma as the (only) appropriate or accurate response. But what if it’s not that the trauma of being sick has caused me to disbelieve my own (perception of) my gut but that the trauma of realizing how little I (am able to) know about my gut causes me to disbelieve that any of this shit could be trivial?

Upset Stomach

A large part of Ann Cvetkovich’s project in *Depression* is to open up the idea that depression is firmly within and constituted by the everyday and the ordinary, a linking that has been taken up and reinforced by many queer theorists’ considerations of queer depression or queer melancholic affect. The thing about Cvetkovich’s efforts in particular is the way that the ordinary and everyday are often, overtly or not, linked to the insignificant (and trivial): for example, her description of “what seemed like ordinary or insignificant activities — going swimming, doing yoga, getting a cat, visiting a sick friend.”

Having a sad gut that is in pain almost all the time means that it is never clear what within the everyday is ordinary or trivial or insignificant and sometimes, like shit, you only know after the fact.

Dead Serious

Even while I’m full of shit, I’m also dead serious. I’m not joking. I take shit seriously. Just because it’s something that seems commonplace, just because you may not want or need to talk about it (when it happens), just because this may seem like an extended joke

12 Cvetkovich, *Depression*, 1.
13 Cvetkovich, *Depression*, 82.
aimed at the shittiness of (some) queer/feminist theory, some jokes kill me. Because what is at stake here, and what is being changed by the work going on here, is my body. Really, physically. This is not theoretical. As much as it may speak to taboos or being anal there is, simultaneously, nothing theoretical about shit. Shit is a fact of life, which is what I mean when I say “shit happens.”

I’m interested in shit and the processes of shitty plasticity it facilitates precisely because it happens every day; it leaves open the most opportunities for gut–brain communication because, as we saw in Andrew Solomon’s negotiation of depression via communication, through the gut with his father, sometimes the answer to sadness is not a “cure,” but to do exactly that: answer it, communicate with it, including any and all internal varieties. This could be made even clearer through my Amitriptyline HCl 10 mg, because the mechanism at work there was one that dealt directly with the communication between gut nerves and brain nerves, disrupting this pathway in an attempt to stop pain. Maybe this disruption was why Amitriptyline didn’t fully work for me; while it did stop (some of) the pain, it failed to provide the communication and information my sad gut sorely needs.

Full of Shit

Maybe it’s unfair to trivialize Cvetkovich’s “trivial.” Maybe it’s unfair because what if a perception of triviality was not a matter of opinion but of experience? As in, maybe Cvetkovich (or others who are firmly in a certain anti-biological determinism camp) just hasn’t experienced the kind of necessity that makes apparent what is and isn’t trivial. What if before you decide what your gut is it’s clear that this decision is meaningless or unnecessary and, therefore, trivial, so that by extension, the gut itself is trivial as a lack of unnecessary information? What if the gut de-trivializes itself, makes itself apparent, through the only mechanisms it really has access to, namely shit and nerves, and therefore through pain and upset stomachs and alternating diarrhea and constipation? What if the comedian Tig Notaro was somehow right when she says that maybe (just maybe) it was all those jokes she made for years about her small breasts that came to result in her breast cancer? What if the sadness of the gut is purely a product of its taken-for-granted-ness, which has resulted in
a lack of information (which no longer seems trivial) that has been shaped by forces of the everyday, the insignificant, the apparently unnecessary?

How do you learn to pay attention?

Maybe my doctor would know better. Maybe it’s called “medical attention” for a reason. Because that’s also about paying for and getting a kind of attention specific to a part you may not know. But medical attention is an oddly circuitous route of perception that is more like a Mobius strip than a straightforward relationship between two separate things. See: a definition of disease as “something which always speaks a language that is at one in its existence and its meaning with the gaze that deciphers it... a language inseparably read and reading.” Medical attention constitutes itself. Disease, to follow Foucault, via its signs and symptoms, communicates its presence to the medical gaze that is, simultaneously, always already seeing disease. What if this same logic applies to the relationship between you and your gut, but in an even more pronounced way? Because in the case of the medical gaze it can be said that, physically, signs (as original, real, signs of symptoms) exist indicating the presence of disease before or regardless of the medical gaze; the medical gaze validates this presence, validates the disease, and constitutes it as such, but it does not (usually) (always) do this in the absence of an original sign. Meaning, there is always already a presence of a physical sign before there is also a gaze; there is an order of events that describes the way medical attention becomes a relationship between two things, between the sign and the gaze; what medical attention truly constitutes are symptoms. But, now, consider the kind of attention you can give your gut: there are no two separate things. In order for you to be a you capable of paying attention, you have to be a you in a body capable of sustaining the physical functions necessary for, in turn, sustaining that attention. You are your gut. It can be shitty. The attention you can give your gut is a form of inseparability. Like the gut is a hole, like a tunnel, but not empty, that is inside and outside at once. Like the gut is a hole, but not empty, heard in a language that is being generated and understood simultaneously, a language “read and reading.” Read and reading as

in a form of attention that is both ongoing and already happened (but not over). What if before you need to or knew you would need to, you decided that the gut is either a thing you use or a thing you have, and now, having read it (but not understood) it is difficult to keep reading?

The applicability of Foucault’s consideration of the medical gaze to the kind of gaze and attention possible within oneself, as constituting and constituted by, illustrates an important point to which we will return, later. Namely, that given the physicality inherent in both the medical gaze and the gaze you can give yourself, while maintaining distinctions between the two, it is clear that the medical model is not nor should it stand as the only (or, as a cipher for) the entire concepts of “biology” or “physical.”

Maybe my gut is already engaged in processes of being read and reading, even if only through the seemingly non-narrative information of chemical, mechanical and thermal changes. Maybe my sad gut is better at paying attention because it’s sad. This is not wishful thinking or unfounded. Because depression is a problem for philosophers and neuroscientists and cognitive psychologists beyond the situation I am articulating here. Because why would depression have evolved? Given that there are accounts of depression and different kinds of melancholy dating back to premodern times, why would evolution select for traits or personality features prone to developing depression? What beneficial purpose could depression serve?

Maybe it’s about attention. Maybe being sad means being able to pay attention better. Maybe “the anatomy of focus is inseparable from the anatomy of melancholy.”

15 The thinking behind this hypothesis is as follows: being depressed triggers processes of introspection, specifically concerning situations that may have given rise to said depression, and that this increased analytical concentration serves to, ultimately, help people find paths out of negative situations. While obviously such an effect does not cancel out the loss of life that clinical depression is responsible for, this doesn’t mean that there is not something useful to take from this, for sad guts. Because


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multiple studies have shown that this increased introspection does, indeed, increase analytical capabilities in depressed persons, to the extent that such introspection is included in diagnostic criteria. The term for such an increased introspection is rumination.

All the gut does is ruminate. Rumination is digestion. Rumination is the reason that children put things in their mouths in order to know them; because it is perhaps implicitly understood, before it is understood that the gut must be either a thing you use or a thing you have, that ingesting an object is critical to understanding. Rumination is a simultaneously physical and cognitive process. Consciousness has physical effects; thought and attention are physical processes; why should this process not take place within a space, like the gut, that has the capacity for endless input and output? Shitty plasticity and unending repetition allow for the temporal differences that rumination may create, the gaps between input and output, or the kind of attention spent on one but not the other. Like that fact that I only took Amitriptyline HCL 10 mg (and it was only 10 mg) for one week but I have spent the past month still with it, here.

Upset Stomach

Who knows better what acceptance means, me or my gut? On the one hand, I understand enough to feel that being in pain every day is actually preferable to being in pain and constantly trying to get better, especially in the face of medical and personal understanding of words like “progress” and “chronic;” because at least just being in pain isn’t disappointing. On the other hand, what is remarkable about this sick gut is the way that there are many ways it could perform badly, be hindered by a couple bad parts, but shitty plasticity allows for the fact that my gut is still doing things, a lot of things, comparably pretty well. What is adaptation if not a form of acceptance?

As rumination is shaped by physical processes of the gut and shitty plasticity, it both relies on and creates a state of flow. By flow I don’t mean flow like being in the zone, like being in a state of easy, fluid attention. By flow I do mean that rumination is about movement, specifically the movement of the gut–brain space, which moves things and is moving. By flow I mean the movement
surrounding and generated by things that have the quality of fluidity. Things that are viscous. Like organs. Like the gut, where everything is visceral.

Visceral, meaning having the qualities of viscera; meaning organs, usually the gut; meaning organs usually in the center; meaning the organs that take up and make up the majority of the space often called the body cavity. Visceral, as in having to do with the center of things. Visceral, as in having to do with the center of the body.

So what if I never tell you how it feels? So what if all I can do is try to say the same thing to you as I say to myself over and over? So what if all I do is say things (maybe the same thing) over and over? So what if over and over is the clearest thing I can tell you about how it feels?

I think you probably already know: the statistics are in my favor. Take, for example, the fact that out of a sample group of fifteen coworkers, expanded slightly to include immediate family members: one has rheumatoid arthritis, one is in remission from lung cancer, one has skin cancer, one has a pancreatic disease, one has a brother dead of brain cancer, one has parents dead (one sudden, young, one of old age), one has a son dead in an accident, one is caring for a mother-in-law with colon cancer (stage IV, advanced, the same one herself in remission from lung cancer). I think you maybe already know. I could go on: one has a father dead, recently, of unknown cause but not old age, one has a mother with double hip replacements, one has an uncle in remission from colon cancer, one has a close family friend with MS. So what if I never tell you how it feels?

These are not things I’ve remembered as much as things I’m coming to realize, or coming to realize that I already knew, too. First, again, rumination is a physical process. Because of this, and because rumination is a way to name both digestion and thinking, rumination and (especially) attending to rumination via practices of attention is about accumulation and absorption. It is a process of becoming through absorption. Because the gut is either like the skin, like a permeable barrier, or like a computer, like a thing with multiple interfaces, or like a hole, like a tunnel, like a space, full of shit: the gut is about accumulation and the absorption of accumulated materials through rumination.
Gut Feelings

When I said “everything is visceral” what I meant was that there is the potential for visceral moments everywhere. I meant that the sample group of coworkers are people both involved in their own visceral moments and capable of producing ones I experience. When I said that one of my coworkers has skin cancer what I didn’t say was that he also has a six-month-old baby at home and I feel this, viscerally, within the possibilities inherent in my own body and in some ways I feel the six-month-old to be within my own bodily possibilities as well.

The accumulation (through a capacity for sensitivity inherent in the gut, through the way the gut is innervated, literally given nerves, throughout) of visceral moments is the process of becoming a visceralized body. Even as I’m remembering things, a few things, now, I’m not quite sure what to do with these things, how to tell you. Because this is simultaneously the easiest and hardest thing I’ve had to learn and it is difficult to articulate because it has been characterized not by a series of articulated realizations but by a series of disarticulations. Such that when I say “the visceralized body is the body in a state of accumulating visceral moments,” I am also meaning to say that the visceral is striking, as in being caught in (by) the gut, as in you feel it being caught, as in maybe this hurts, as in how do you dislodge an object caught in the inside of your body, as in how do you dislodge an object that is really a feeling from the inside of your body, as in maybe this hurts, as in there’s no feeling better because how do you dislodge a feeling that’s really an organ from the inside of your body, as in maybe you already know how this feels (and maybe you don’t): visceral as in a collection of organs that create the body cavity, as in the viscous qualities (related to movement, and therefore space and time) of these organs, as in the things that organs are capable of feeling and being made felt. Visceral as in bodies having feelings. Visceral as in bodies making themselves felt.

The Visceralized Body

The visceralized body is the result of the accumulation of visceral moments, accumulated through the body and specifically through the gut, because the gut is entirely about absorption. Because the
gut is a hole, like a tunnel, it not only is space but creates a path to the brain through rumination: a term for the kind of absorption the gut performs and the process of becoming, through digestion and thinking, this describes.

Even as I don’t know what my gut is, even as sadness is the lack of information in the face of need, the information I need now is not a definition of nor even a definitive perception of my gut. Because I know what I do sense and I know that my gut is sad and that this sadness is like a hole, but not empty. I just need to know how else it could feel. I do and do not need you to tell me how it feels (because you probably don’t know either, because is your gut like a skin or like a computer? You know). Because nerve endings do not in and of themselves create feelings, information (even a lot of it) is not the same as meaning. But what information (especially a lot of it) can provide is context.

Because a cavity is a hole, like a hollow, a body cavity, it is also a kind of decay: a relational kind of decay in which decay is a product of the relationship between your teeth and the bacteria in your mouth. In the visceralized body, this can become a kind of decay that is a product of a relationship between your body and lack of information that comes to constitute and decay the relationship between you and your body. (Even as I’m writing “you” and separately “your body,” I wish I wasn’t. It still feels somewhat true. At the same time, I am my body and my body is me and maybe this is a kind of acceptance that my gut and I can both come to and practice together—only together.)

If you don’t know how this feels, and I don’t know if you do, this may be because the inside of the body is a philosophically-historically inaccessible place, as Drew Leder writes it in *The Absent Body*, wherein “a viscous [internal organ] is largely irreversible with corporeal foci. It cannot be summoned up for personal use, it cannot be turned ecstatically upon the world. It’s recessiveness is not simply a function of a current gestalt but of an innate resistance.”

Really? Tell that to my sad gut. (Asshole).

“Innate resistance” only in an able body. “Ecstatically” being ideal or possible only in an able body. “Irreversible” only in an able body

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not full of shit, continually reversing and releasing. “Recessiveness” only when your gut is only ever a thing you use or a thing you have. “Innate” only when you do not care about this recessiveness; “innate” only when you do not have to care.

Or, in a visceralized body, there is no “turned ecstatically upon” because the gut, like a barrier, like a tunnel, like the skin, is already the inside and outside at once. In a visceralized body, there is no “turned ecstatically upon” unless you consider shitting (or any other form of profuseness and excessiveness) ecstatic. This, even just saying (being able to say) “visceralized body” is a “turned ecstatically upon.” In a visceralized body, there is no “innate resistance” (to attention) because innate resistance to corporeal foci is only possible when there’s nothing to pay attention to. In the visceralized body, there is everything to pay attention to. “Innate resistance” is, really, a misnomer for what is really the most basic and intense privilege of the able body: there is no resistance if there is no need.

The relational quality of the decay at the cavity of the visceralized body extends to an overall externally relational quality as well. The visceralized body is not just about the inside of your own body. In part because the experience of visceral moments includes moments where other bodies make your own body felt, differently. As in my coworker with cancer and a baby; I feel all of this, though differently, of course, than he does. Not only because I am removed from the pragmatics and the daily experience of it but because all I am ultimately feeling is still my own body: within the context of the information of his. Visceralized bodies, characterized as they are by a simultaneously internal–external, relational body cavity, are open to each other. Secondly, being so open, visceralized bodies provide room for feeling the things you don’t have. For instance, consider the term HIV-. Because information is mass, an absence of information about one’s own body and especially information that is or is not determined to be absent in relation to others’ is also a state that can be viscerally felt.

This capacity of the visceralized body, its ability to make itself felt, its felt-ness, can also be put another way: even with centuries devoted to the development of medical imaging and auditory technologies for surveying the inside of the body, the stomach (and other visceral organs, the intestines) is still an organ you can hear
clearly with only your own ears. You can also hear other people’s, clearly, with only your own ears.

The “innate resistance” that characterizes the able body and Leder’s body is ultimately irrelevant to the visceralized body because it’s sickness that begins to diminish any notion of “innate.” It’s sickness that both causes the accumulation of visceral moments and causes the moments themselves; it’s sickness that creates the need that changes a lack of information into such a need, that changes “innate” perceptions only when you become suddenly aware of how much you can’t perceive and why can’t you — and would I feel better if I could?

Maybe a resistance that can be found or felt in the visceralized body is one not about the body itself but of a resistance to resisting: a resistance to getting better, in certain ways, to becoming un- or de-visceralized. Because it’s (almost) easier to be in pain every day than it is to be in pain and try constantly not to be. Because at least in pain, you know how you feel. Because the visceralized body isn’t looking for context that would inform a way out.

Talking about being sick in this way, linking sickness to a visceralized body, is an obstacle for me here and one I’m hesitant to address head on. Because it is one thing to say that sickness can cause visceral moments; it is another to say, or to imply, or to write a definition, that all visceral bodies must be sick. As if there were nothing else visceral to experience. On the other hand, I feel and know these things through and because of a body that is sick at the center, at the gut; I have a gastrointestinal disease characterized in part by malnutrition. Everything I ingest and absorb passes through this, is fully absorbed and passed on or not. Everything else within my body becomes, because of this. The pain, too, travels, encompasses my stomach and back and sides, changes my posture; changes the movements that become available to me. Everything is visceral. And I remember enough from before this happened to know that it is only like this now because of being sick.

And perhaps I shouldn’t worry about defining visceral through sickness because as my sample group shows, there are already plenty here with me.

And in these moments, with others, I do not really mean “moment” as a singular event but as an ongoing time. As in: there was the moment I found out my coworker has cancer, the moment I
remembered that he had a baby, the moment I went home and told my partner about this, as if it were one moment, and the moment after that when I said I was still thinking about it. And, now, much later, when I continue to think it and write it here.

Shit is continuously beginning and ending.

What an ongoing visceral moment includes is the ability for the visceralized body to attend to its possibilities as well as to its present. On the one hand, “my future is written in my body,” and at the same time, “I am not writing a will or medical report.”

What does so much absorption produce? Consumption? Consumption as in all-consuming, but not totalizing. As in, just as the gut constitutes the body through digestion, consuming can include the way the gut can take of even as it is adding to. Because the gut is a hole, like a cavity, and because cavities must always include a relationship between at least two things, and because everything can go in either direction in a gut, the gut can begin to produce a decay through too much absorption as well, not only not enough: the gut can absorb so much it begins to absorb, to consume, the rest of the body. In one way, the gut becomes consuming when, in a visceral moment, I find that I’ve lost weight between doctors’ appointments, despite no changes to diet or exercise; having failed to absorb everything else I’ve put in it, the gut must turn to the rest of my body. In another way, the gut demonstrates its ability to be consuming every time I’m unable to pay attention to the thing at hand. Every day, whether I always realize it or not, my gut consumes my attention. This dual absorbing—consuming quality of visceralized bodies, their guts, makes clear a key aspect about a relationship of decay: while I can decide what goes into my gut, I cannot control what comes out of it nor can I control what it decides to take. A centralized sense of agency, like a brain, like a computer, like a body that doesn’t have parts to which a sense of autonomy are always attributed, like a body that probably doesn’t have a heart with a mind of its own, like an able body, is lacking. Nothing is centralized in a visceralized body. Especially agency, because even though the gut is a tunnel, like a hole, in the center, it is also internal and external simultaneously.

I am not very apologetic about saying things like “Tell that to my sad gut. (Asshole),” because by saying things like that I am also already beginning to articulate a theoretical-political position occupied by the visceralized body. Because it’s not, it can’t be, only about how it feels. Because what do you do with how it feels? Because a visceralized body is open to others and what do you do when you find that so few are open to yours? Because the personal is political, right? Because what is more personal than shit? Because, for instance, when I tell my partner about the weight loss, how it’s tied to shit and being sick, am I not only forging a new openness between bodies but simultaneously occupying a political position that argues for exactly a kind of unapologetic nature that runs counter to existing sexist and heteronormative constructions of femininity (i.e. a feminine body that never shits, let alone tells a partner about it)? Because the visceral is political, right?

Furthermore, by saying things like “Tell that to my sad gut. (Asshole),” and thereby continually reinforcing the feelings my organs are having, by attending to those feelings, and by depicting a body wherein attention and therefore agency is a force subject to both absorption and consumption—because are these gut feelings my organs are having or feelings I am having at the expense of my gut—by ultimately finding the gut–brain space to be a space of decentralization, I am really saying that the visceralized body is not about biological determinism. How could this be possible? How could a physicality-reinforcing body be outside of such reductionism? But consider the following as a definition of biological determinism: “To be determined by biology is to surrender to limitations, to deny the possibilities of change.”

“Surrender” is like “innate resistance.” It is constituted in part by its generation through or in proximity to an able body. “Surrender” is only seen as such when what is being surrendered is a form of ideal, universalized ability. Able bodies are not supposed to have limits; to acknowledge and surrender to limitations is inherently to acknowledge a lack of an able body. Even in theory, this lack should be avoided.

The visceralized body has its limitations.

What, actually, is wrong with acknowledging these limitations? I understand that when the idea of “surrender to limitations” is applied to gendered bodies, when limitations become identity constituting, such limitations or just the idea of them, or when the idea of them is taken as fact, become hugely problematic. But, within a sick visceralized body, when I am reading that sentence I am being asked to think about the limits of my body only in terms of surrender, including a surrender to the fact that this sentence, like so many others, is written in a way that “limitations” is implicitly taken to mean limitations as only applying to a gendered body; an able body, limitless as it is, is never mentioned. The surrender becomes one of a surrender to the limitations of ableism.

The limitations of the visceralized body are “actual” as much as theoretical. Limitations are physical. Like, taking care of baby while receiving chemotherapy must be shaped by limitations like exhaustion or nausea. Like, how I run, but only within a certain radius of my home in case I need to run home. Like, how often I don’t go out. Like, how difficult it is to hold a job. What is really the problem with surrendering to these limitations? What is the problem with surrendering to the difficulties of caring for a newborn while receiving chemo if it means you may receive more support from family or friends? What is the problem with not wanting to find a word other than surrender if this is what feels accurate? Is “acceptance” any better? What is the problem with wanting a sentence about a surrender to limitations in which “limitations” is not inherently negative, surrender feels accurate and realistic, unapologetically physical? And following such a sentence, a moment where surrender, like a coworker’s surrender, becomes visceral and the limitations of other’s bodies become felt as and in one’s own?

“To be determined by biology” can also mean several different things to a visceralized body, most of which depend on what “biology” is taken to mean. If “biology” means the physical body, and particularly the way that the body, the inside of it, is thought of as a separate, purely biological sphere (“purely” separate from the mind) and the way this biological body becomes full of hidden-from-view processes then, yes, the visceralized body is determined by biology. If biology is taken to include medical science and human biology then, yes, the visceralized body is determined by biology. Because if I didn’t follow my doctor’s advice, if I didn’t have advice from
doctors with decades of pancreas-specific training, there would only be a body to bury, not a body to be determined. On the other hand, if biology is taken to mean something purely scientific, as if science was something that just happened, as if biology wasn’t a thing that people do, then the visceralized body is not determined by biology. Because what biology can mean, what it actually must mean, etymologically, is not at all something that can just be discovered: it is a “study of.” Studying, like observation, like thinking, like rumination. The visceralized body is an ongoing study.

I understand the problematic nature of biological determinism, the way that biology is and has been used to make universalizing claims about bodies applied particularly to Other(ed) bodies and the way that disciplines emerging from biology, like medicine and genetics, are used to reinforce norms of Otherness and inferiority. I understand the physical effects this kind of “biology” has on bodies and I am not arguing that a continued interrogation of this form of biological determinism within theory is irrelevant. But the way this form of biological determinism is written into theory such that it is taken as applicable to only racial, gendered, or queer others is itself a determining gesture. Even “disability studies,” with its focus on social construction, tends to downplay or ignore or deny the biology within and behind disabled bodies. Which is to say: the rhetoric of anti-biological determinism gets rid of biological bodies along with biology. It is as if all of this theoretical work takes biology to be a definitive answer.

Because of biology, medicine creates and enforces bodily norms. Because of biology, people of color have been subject to centuries of oppression, fueled by fields like eugenics or phrenology. Because of biology, hormonal and neurological “causes” for LGBTQ people are being sought, because with that kind (any kind) of difference, there must be a locatable source. For a visceralized body, biology is never an answer but a question. The visceralized body is (in) an ongoing study. Is my gut sad because of biology? Does shit happen because of biology? Will biology make me feel better?

Probably not, but neither will structuralism nor social construction.

When I read sentences with words like determined and surrender and limitations, when these words could be about my body but never are, I feel like I’m in a space, like a hole, like a tunnel, that’s
empty. If a fear of biological determinism becomes formulated through an intense theoretical anti-biological determinism, anti-biology, what it has created is exactly this hole: the hole of theoretical determinism. A hole that envelops, tunnels fully around, the visceralized body.

I can understand why biology might be scary, in addition to fueling gender-, race-, or sex-based discrimination. Am I going to get sick suddenly (again) because of biology? Will I die earlier than I would have (if I didn’t get sick) because of biology? How much shit happens because of biology? Is my gut sad because of biology? How much biology can a body take?

Does biology really happen in this way, though? Or is it more like: TBD by biology. More like: it’s up in the air and biology is the question. More like: there are definitely social aspects of being sick that exacerbate it, but in no way did I get sick because of social or external factors alone. Even in cases with clear external causes, a body is just responding, biologically, however it can.

One person who did know how it feels was Oliver Sacks. Writing about a loss of sensation in his leg following an accidental fall and a surgery, he realized that this loss was something many of his patients had similarly experienced: “[E]very single one of them has this fear—known it and been unable to share it.” The fear is one of loss and specifically a loss of “the sense of part of their body.” Oliver Sacks knew how much being unable to know comes to constitute what it feels like.

In writing further about this experience, Sacks pointed to a key part of such a visceral loss. On his own leg he says that “not only was I unable to perceive the leg, I was in some sense unable to remember it.” He uses the term “amnesia.” The temporal relationship such an amnesia describes is one of “having/had.” Like, having/had cancer. Or, for the visceralized body, having/had a sense of a body where nothing was like a hole, like a tunnel, both remembers this sense and feels an amnesiac lack of memory about what exactly this felt like. If you don’t know how something feels, now, how can you remember what it felt like when, before, it felt like nothing? Or, the

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20 Sacks, “The Leg.”
visceralized body having/had the loss of “the sense of part of their body,” now feels everything keenly because in the face of a lack of information every single small piece comes to feel important.

Having/had becomes a temporal relationship useful to clarifying the way I am using the term “loss.” Because having/had is a time frame that includes the possibility of ongoing conditions, the experience and memory of finished past conditions, and imperfect past conditions. A loss of sensation is not the same as an absence of sensation. Having/had does not create only a (permanent) surrender and limitations.

Oliver Sacks, in this same article, also provided the best term for condensing what I mean when I say that the gut is a hole, like a tunnel, but not empty: “negative phantom.” He uses “negative phantom” to describe the way that his leg felt like a phantom limb yet paradoxically was still very much present and attached to his body. The gut is a negative phantom. The gut is a negative phantom and the power of unknowingness it can generate is such that maybe I knew (somewhere—felt) even more than I realized when I said “ghostbody.”

Absent-Minded

Another term I didn’t have yet, when I did have ghostbody, was theoretical determinism. Theoretical determinism: the way that critical theory shapes experiences of bodies. The way that critical theory writes bodies, provides information about bodies, in such a way as to directly affect the experience of readers’ bodies. The way that, because of anti-biological determinism, because of the way this demanded that scholars get rid of biology, with or without deciding whether biology was “purely” scientific or a thing people do or a body, as in physical matter, means that the only body in critical theory now is The Body. The Body is a product of theoretical determinism. The Body is capitalized because it is more like a slogan or a brand name than a body; because it is just a cipher, because it, as a hollow figure, can hold whatever things, whatever things people do, in it.
Gut Reaction

I know I’m not the first to say this, that the body functions as a cipher within critical theory. See James Porter: “The mere concept of the body shields theory from its objects; it prevents us from confronting the body in any other way than as a fascination.” I know that theories of bodies as entirely social constructions are not without their discontents. But I also know that as much as there may be cries about “The Absent Body,” it is still necessary to say (over and over) that it is the sick body that is made especially absent.

It is as if no one will admit to sickness.

Absent-Minded

Theoretical determinism is why I have been saying, here, repeatedly, that there is no information. Because in the same way that biology can be taken to mean the physical body and medicine and the study of both, by information I mean both medical information (like a diagnosis, like what does “damage” mean? Like what does “permanent” mean?), phenomenological information from first- or secondhand sources (like will my coworker tell me how it feels?) and theoretical information (like an analysis of first- or secondhand accounts of the phenomenology of illness, or like Being Sick and Time, or like Illness Not As Metaphor). Theoretical information is a structure that acts as a full realization of the term “framework:” because it provides a frame through which to see (you, your body, your experiences), a support onto which other information or experiences can be put, and it involves a certain amount of work, both the work of seeing as well as the work of building up and experiencing.

When I say that I want Being Sick and Time or Illness Not As Metaphor, I don’t mean to say that I want a readymade framework or one that allows me to not put in any work. I mean: how different my experience of my body (and my time, and my relationships, and my future) would have been if I had been able to read Being Sick and Time years ago, if I had known (more, differently), about how

it could feel. It could have been a framework that could have helped to fill in, in small parts, at least, other medical or phenomenological information that was also (still) missing.

Gut Reaction

At the same time, theory isn’t everything. Maybe I would never have felt I needed *Being Sick and Time* if I had only been a little sick or if it didn’t last. I didn’t, actually, at first, want *Being Sick and Time*. I was content to just read *Being and Time*. Theoretical determinism tunnels slowly. Because it took years of reading, took years of sentences about “surrender” and “limitations” as well as sentences about “impairment” and “disability studies” to realize that none of these sentences described my body. To realize that I in no way have A Body.

Absent-Minded

It took longer for me to see how this failure to describe, to just leave my body out of it, was not a neutral act of exclusion. As if you just didn’t have room in your word count. It was and is an act of exclusion predicated on exactly the same kind of reductionism involved in biological determinism. Because theoretical determinism reduces bodies to The Body, reduces experiences of yourself as/in a body to you as A Body: instead of the “you are your body” of biological determinism, theoretical determinism means that you are what is made of you. You are what is seen of you. You are what cultural factors determine you to be. In a perfect neoliberal shift, you are what you make of yourself.

Theoretical determinism is a hole, like a tunnel, around the body, that mirrors the hole of the gut. Theoretical determinism is a hole because The Body is constituted by cultural factors, because The Body is (only) what is seen, and so the hole is like a trap, one covered by camouflaging ground. Theoretical determinism reduces the body only to its surface. And uses this surface, spreads it, to cover the depth of the hole left in its reductionist wake. Theoretical determinism renders the inside of the body empty.
Gut Reaction

Maybe I didn’t want *Being Sick and Time* at first because critical theory, as strong a framework as it may be, doesn’t exactly make being sick better.

Absent-Minded

The exclusion of the body through theoretical determinism, while in and of itself is not neutral, has, in some ways, passed neutrally through decades of scholarship. That is, both the hole of The Body and the exclusion of other bodies have both passed neutrally, as in with little notice, through those decades. Which is something I’ve been trying to say, more or less successfully, for some time now. Something I’ve tried to say in multiple ways, like when I said “compulsory able bodiedness.”22 It’s not that this was wrong, just somewhat incomplete. Compulsory able bodiedness has also been noted before, by others, as a way to name the ways in which space, cultural and physical, is shaped for and by able bodies. But theoretical space is not without its shaping factors either. It seems like philosophical lineage is something that should be easy to trace, to locate references and vocabulary and the movement of ideas, cohesively; it’s easy to see this as a space more or less shaped freely. That is, more or less unshaped by unacknowledged ideologies.

But see, even now, when I am trying to just say the thing I’ve been trying to say, it’s like I have to, like I can only, tell you through this kind of grounding lineage. Like this lineage is the only thing capable of grounding and validating ideas.

The thing about this lineage, though, and the space it creates, is a feature of its foundation: the entire history of Western metaphysics and philosophy is based on an able body.

Gut Reaction

It’s funny, because in a lot of ways, for years, I have been angrier about this fact than I have been about being sick. It’s funny, because

this is easier to be angry about than being sick. It’s funny, because this is also something that it feels easier to do something about.

Absent-Minded

In her book *Ongoingness*, Sarah Manguso writes about her practice of diary keeping, which spanned decades. She adds to these documents every day, sometimes more. She describes this intensely daily process as “more than daily.”

“More than daily” is how I would describe the able body that is the basis of all metaphysics, of phenomenology, of The Body. This more-than-dailyness is what makes compulsory able bodiedness seem incomplete. Because that concept is taken from the idea of compulsory heterosexuality, which itself depends on the idea that heterosexuality is positioned as “wholly natural.”

What doesn’t fit about this, here, is that able bodiedness is more than natural. The able body is the thing that makes (human) nature possible, the able body is the thing that is more natural than anything else. Compulsory able bodiedness names a condition of invisibility. But the way that the able body is the basis of The Body, the way that this foundational fact has been able to pass neutrally through so much work, is more than invisible. It is a force that I have also elsewhere called a prototype; but the able body, again, is more like the prototype on which all others are based. It shapes The Body because it is (only, always, right?) the body. It shapes The Body, and it is the body, and this seems so neutral because doesn’t “human,” doesn’t the body, only ever mean one that is definitively alive, one that isn’t sick, one whose wholeness is never threatened, one whose mind is and can remain superior, one whose inside is never distracting, one that isn’t stuck in its hole of a gut; a body that is these qualities is never The Body. The Body, in the way it writes the body, in the way it excludes these possibilities, deploys the very idea of the body in an almost absent-minded way. More than daily. More than invisible. More than taken for granted. It’s like no one will admit to sickness.

Gut Reaction

Is biology really so scary?

Absent-Minded

Sickness is something that needs to be admitted. Sickness takes up space. Sickness pushes other things aside; sickness distorts the boundaries of The Body. Sickness is a thing that must have room made for it. Sickness is a thing that pushes aside the more-than-invisibleness of The Body.

No one will admit to sickness because, in a body where the mind is and can remain superior, where embodiment is something that can be studied in way closely bordering on “detached,” there is no room for threats from things, from biology, that theoretical determinism has judged inferior.

The visceralized body, with its holes, like tunnels, but not empty, has room for sickness.

Theoretical determinism has no room for sickness. Theoretical determinism drives theory to tunnel fully around sick bodies, because sickness is too large an obstacle; sickness cannot be reduced. The able body, the way that the able body is a prototype before all other prototypes, is the ultimate reduction. It is the easiest reduction (so clean! so whole! so able!) and therefore the easiest starting point. It is the easiest starting point on which to pile on all those cultural factors. It is the easiest starting point, the most common of common denominators, because it ultimately erases the source of the greatest variation and difference and, simultaneously, same-nesses, among people; it reduces all of this to The Body. It eliminates the problems of bodies. It, more than invisibly, eliminates any notice of this until, suddenly, The Body is no longer possible, until it is no longer possible to imagine yourself in A Body while reading about Bodies; until it becomes clear that the able body is not your prototype. And then where is Being Sick and Time?

Absent-Minded (Again, Differently)

Or: sick is not a quality. Sick is not an aspect or feature or trait. Sick cannot be reduced through theoretical determinism because sick
is a sheer physical fact. Sick is always already in its simplest, essential, form. Theoretical determinism cannot reduce it and so it just tunnels fully around it; by completely excluding sick, by making its absence more than invisible, theoretical determinism neutralizes sick; it makes the absence of sickness (within theory) seem neutral.

Saying “sick” is in its simplest and most essential form is not the same as saying that being sick lacks complexity. If theoretical determinism creates a tunnel, the visceralized body provides a form capable of moving through such a tunnel, provides a way of giving complexity to sickness, to being sick, while never ignoring (because how do you not feel something in your own body, including the absence of sensation) physical fact (which is a fact that announces itself physically, which is why it can’t be ignored, because how do you ignore urgency in your own body).

I’ll admit to sickness.

Just because I asked for Being Sick and Time doesn’t mean that I haven’t been able to find anything else. It’s just a matter of application. Like this, another consideration of the space of “able body,” from Foucault in “Madness, the Absence of Work.” “It will not be said that we were at a distance from madness, but within distance of it.” It cannot be said that we (“we,” able bodies) are at a distance from sickness but always constituted in part by being within a distance of it.

He goes on in that essay to write that, in relation to said distances, there exists “this desire to establish the limit yet at once to compensate for it through the framework of unitary meaning.” The able body is the limit. It sets the limits of The Body. To compensate for this limit, sickness (people who are sick) becomes the object ground down to the anchoring (as in holding in place, deeply, as in suctioning, as in this is not comfortable or comforting, as in weighing down) surface of “able body.” The unification of the able body with its limits is made in the idea (the framework) that sickness is a thing that happens (not that just is), that sickness is socially constructed (that it happens, somewhere else, somewhere at a distance to the

25 Foucault, “Madness, the Absence of Work,” 293.
able body). That sickness is a thing that happens, that it is not an inherent (or natural) flaw in the surface of the able body.

The limit of the able body is also its limited capacity to make itself felt (in all senses).

Gut Reaction

Writing about her experiences caring for her son, who has neurological impairments, Julia Kristeva refers to the urgency and utopian nature of negotiating for disability rights and the day-to-day negotiations of being sick. This urgency can be blinding. This urgency has been a main difficulty in my trying to name the able body and The Body here, the source of so much messiness. This urgency is my limit, though this is really just the product of moving urgently on slippery surfaces; skidding.

Absent-Minded

Theoretical determinism is the compensation for the limits of the able body. Sickness is the only limit that matters. Sickness must be admitted but will, can, never truly be. To compensate, theoretical determinism admits so much else; it admits socially constructed bodies and marginalized identities and systemic oppression enacted through (seemingly) bodiless modes of corporate, governmental, and institutional neglect.

But it cannot admit, cannot reduce to the level of human action, sickness; it cannot admit that sickness is a thing that is.

This has always been about this limit. Not that that has always been recognizable. Not that there have always been the words to name this.

Gut Reaction

It took my sad gut, realizing its sadness, feeling it, not being able to feel it, to come to these words. This seems like the opposite of the popular theoretical rhetoric surrounding pain, the idea that pain is

resistant to language, that it dissolves words. So what does it mean for a sad gut, for a visceral experience, to have actually provided the words “the able body is the basis of Western metaphysics and philosophy”? What does it mean that one (but not singular) personal experience of the limit of perception made clear a much larger limit, a lack of information? It means that maybe the body, maybe pain or sickness, is nowhere near as language-resistant as has been thought. It means that experiencing within a visceralized body opens new areas of knowledge. Because even learning of a lack of information itself generates understanding. Because when there is not enough information about my body, about my sick body, within my body itself, why is it that there is nowhere else to look for and find such information? Why are there no words? Because it is not pain that takes away words; it just makes clear their need. It is not pain that takes away words; it is the able body. The able body is the lack.

I don’t want a medical narrative, I want a theoretical narrative. Even recognizing this grinding, slipping, reducing, reductive, force at the heart of critical theory, why does theory remain desirable? Even before that question, the answer to which is about the work that theory does, it could be asked whether the able body is even a problem for theory at all. Who cares? Who is theory for? (Ask that of my sad gut, asshole.) Why does theory remain desirable even if, as it is now, it is really only for people in an able body (or who want one, or who can think about having one), people who can believe in The Body?

Because I don’t want a medical narrative, I want a theoretical narrative. Because medical narratives are always already filled in but theoretical narratives are open space, space that can open around. Because medical narratives are inescapable. Which I say even though I hate the word “inescapable” but it’s also true; theoretical narratives are open to (for) escape. Theoretical narratives are about possibilities. I don’t want a medical narrative not because I’m opposed to progress or getting better but because I would rather (given the odds, given the day-to-day work involved in a medical sense of better) think about what else “better” can mean. Because theory is easier than being sick. Because being sick makes theory (more) possible, makes theory a possibility. Because being sick and theory both turn everything into possibilities.

Because I have the right to a theoretical narrative.
Because when you are sick and reading and/or producing theory, when everything is a possibility, narratives are never linear. A theoretical narrative both matches the time of a visceralized body and provides a way out of it. Like, is my gut sad because of theory? Do I not know what my gut is because of theory? How can I think about this unknown? How much theory can a body take? How much non-linearity can a body take? How many escapes can a body be provided? If it’s better that pain becomes language-generating instead of language-resistant, how many words must be found to “make it worthwhile?” How much, of what, is “worthwhile”? Worthwhile “in theory” or “in life?”

In theory, and in the lineage that I am thinking of here, backwards from disability studies to queer studies to feminist critical theory to Simone de Beauvoir to Lacan and Freud, is one based on an able body whose main attribute (or defining characteristic) is sexuality. That is, the person’s sexuality, because the main work of feminist critical thought was to separate the biological body from the mind, the mind that produces (enacts) “the female” on/through/upon the body. It is this enactment that ultimately produces The Body. It is this enactment and performativity of such a foundational aspect of identity that makes it seem so obvious that the rest of identity is an enactment as well. This follows through feminist critical theory to queer studies to critical race theory, to examinations of the socially, linguistically, constructed experiences of queerness or race. Which, in turn, continues in examinations of all other aspects of identity, including being disabled.

Enactment is what makes invalids. How can you theorize an enactment of identity when it takes place in a body that itself is enacting both “alive” and “dead”? (Ignore the body.) How can you theorize an enactment of identity in a body that is never in one place long enough for anything to be enacted upon it? (Ignore the body.) How can you theorize an enactment of identity upon a body whose surface is meaningless, when confronted with the even more meaningful meaninglessness of its insides? How do you enact being dead, but still alive, now?

Because being dead cannot be enacted, being sick cannot be either. This is not such a stretch; being sick is not the same as being dead but nor is it ever really very different; it cannot be said that we were at a distance from being sick, but within distance of it. When
being sick is seen as an identity, when disability studies theorizes itself into being, invalids are made. Because it is not enough to talk about sickness as a thing that happens or a thing people do. Because how does it feel? Because having words is not enough without also having information.

The thing about all of this theory, about feminist and queer and disability studies, is that this is not just about a lineage of erasure and no words and non-identity. This is not just about lineage, as if lineage were just a thing that happened, a history. This is not just about lineage because this is also how I was taught. I was taught that this is what critical theory is. I was taught that this is what is included within critical theory. I was taught this lineage. I was given readings. I was not taught about being sick, although I have been sick for six years and could have a Masters by now. It is the lineage of critical theory that is enacted.

Gut Reaction

The ironic thing about a difference constituted by sickness or disability is that this is actually a difference based on the most same of samenesses. The real difference is not the sickness itself but an awareness, even if it’s an awareness of the limits of perception. An awareness of the limits of information.

I also cannot unlearn what I was taught about critical theory and its lineage. It’s a lineage taught and enacted by people who can still think, comfortably, of The Body. What is taught through this Body is a paradigm in which the object of theory is identity, in which identity is constituted as a set series of differences from established norms, and that the most transgressive differences are those concerning sexuality and gender. “Everyone shifted over from production to perversion.”27 Coming out of Freud and Lacan, critical theory is based on The Body as (only ever) the sexualized body.

The visceralized body is not the sexualized body.

27 Terry Eagleton, “It is not quite true that I have a body and not quite true that I am one either,” London Review of Books 15.10, July 22, 1993, http://www.lrb.co.uk/v15/n10/terry-eagleton/it-is-not-quite-true-that-i-have-a-body-and-not-quite-true-that-i-am-one-either.
I cannot unlearn what I was taught about differences and norms, but, within such a system, how can you think about a difference predicated on the most normal norm? Being alive, but dying, is the most basic, unavoidable, norm. Sickness is no different.

When I said that I have a right to a theoretical narrative, what I meant was that I have the right to theory centered not on the sexualized body but on the visceralized body. The visceralized body can serve not only as a way to talk about visceral bodily experiences, it can also be a model for theory; it can be a new paradigm. And, indeed, it would have to be a new paradigm, because how can you write sickness within a theoretical paradigm where sickness cannot be admitted? Only ever partially.

Was disability studies supposed to be the new paradigm? Was crip theory? A huge amount of the work of disability studies has been a “positioning [of] disability as a set of practices and associations that can be critiqued, contested and transformed.” But this work has been exactly the kind of enactment that writes out sick bodies, that is (a) “set,” that’s “practices,” that’s “associations,” but what does this actually mean for living in a body every day? Disability studies has continually pushed aside these issues, pushed aside messiness, to focus on questions framed as (only) larger (more important) political issues. Because theory is easier than being sick. I would suggest that a theory whose object is the visceralized body is less about contestation or transformation and more in line with Being Sick and Time: an elucidation, a phenomenology, a filling in of gaps. Thinking in the gut–brain space. Being aware of the slippery surface of the able body. Being sick.

To not focus on contestation or critique, or at least what critique commonly means, doesn’t mean that a theory of the visceralized body wouldn’t be critical. To inhabit a hyperphysical, fully felt, body in a theoretical context where “bodies are ways of talking about human subjects without getting all sloppily humanist” is inherently a critique of existing theoretical norms. Simply being aware of theoretical determinism is critical. Sloppiness can be critical.

28 Alison Kafer, Feminist, Queer, Crip (Bloomington, IN: Indiana University Press, 2013), 9.
29 Eagleton, “It is not quite true.”
Was disability studies supposed to be the new paradigm? What does it mean to find that this doesn’t include sickness? It begs the question of defining sickness as something opposed to disability, an easy definition to fall into. But my issues with disability studies have less to do with how disability is commonly defined and more to do with how it is written as a “set of practices and associations,” as something that almost always visibly marks a body, something that has more to do with wheelchairs and ramps than shit and guts. Something also generally written as a permanent state, probably something you were born with. Something that feels static, something that never includes or admits to being in pain every day, something that never makes you have to discuss diarrhea with your partner. And no, sickness is not always these (static) things. It is less aligned with the freaks paradigm of disability studies and more about ghosts and the walking dead and the undead; less about obvious monstrosity and more about figuring out what, exactly, is monstrous.

On the other hand, what does it really matter whether sickness and disability are mutually exclusive terms? At least within theory, because there are definite legal implications for how disability is defined, which I don’t mean to ignore and to which we will return later. But, here, within theory, whether sickness can or should be considered a disability should be something of a nonissue. First and foremost because defining bodies, defining bodies by their conditions and practices and associations, will always end up at The Body. By focusing on disability as such, by relying on and reinforcing definitive differences between disability and people with disabilities and impairments, disability studies only winds up writing Another Body. Even (or especially) crip theory, which, in part, seeks to better integrate disability studies with queer theory, to be more inclusive, but must first define that which it includes. All of this defining is an attempt to avoid sloppiness. Or to avoid a confrontation.

Secondly, shifting away from a theory focused on defining categories of identities to one based on the visceralized body also means a shift in vocabulary. This is why it doesn’t really matter, within theory, whether disability and sickness are the same or mutually exclusive; everything is visceral. The visceralized body is open to others to the extent that it is not really necessary to first define what to be
inclusive of. The visceralized body needs a theory understanding of the fact that theory is easier than being sick; why close it off?

Was the category of being sick ever that much of a difference? At first, I thought that perhaps the lack of sickness within disability studies was because, historically, sickness really was that distinct, and so it would, now, be more accurate to say that sickness is no longer a difference. And I could see why this could be true, I could see how the huge rise of conditions like obesity and diabetes make it seem like suddenly everyone is sick; now that so many people are sick, it’s like sickness is no longer a difference. But, on the other hand, people have always been sick. People have always been sick and historically even more people have been sick than are sick now and even more people have died, often at home, from sicknesses the majority of which are no longer fatal. This, actually, is the only real difference, now, that the majority of people no longer expect to get sick and die. Especially given that with so many diseases being made nonfatal, now, many more people will be walking around sick; alive, but maybe already a little dead. Sickness is both not the norm, now, even as it once was, and simultaneously, is still the most basic norm. If the able body is the most natural natural, sickness is the most normal difference. It invalidates itself.

Absent-Minded

I want to return to these legal implications of “disabled” now, specifically to think about obesity. Because it’s not just that with the rise of obesity and diabetes there are suddenly millions (more) sick people. It is also the fact that with the declaration that obesity is a disability, there are suddenly millions (more) disabled people in the U.S. Further, the more or less concurrent passage of the Affordable Care Act included within its provisions ones that directly affect the protection of sick people; in a way, creating legal protections similar to those already in place for the protection of disability rights. For example, the fact that the law made it illegal for insurance companies to refuse to cover or raise charges for people with pre-existing conditions meant that millions of chronically ill people had their right to accessible health care protected.

But what do these legal rights have to do with theory? There is more than one lineage to theory. When looking at a history of
disability studies, there is a remarkable concurrence of successful
disability rights activism with an increase in the popularity of dis-
ability studies. Like how the passage of the ADA in 1990 happened
during a period, from about 1990–1995, that saw a large amount of sociological scholarship about illness and disability produced. This production slowed to a halt in about 1995—more or less the time that the release of protease inhibitors and their success in turning AIDS from a death sentence to a chronic illness (which itself is a kind of right) happened, meaning that there were now very many less sick people. It no longer seemed like a crisis, of health or attention. Now, between crip theory and disability studies, The Disabled are every-
where; this rise seems to have happened within the past 10–15 years, as debates about rights like the ACA raged. Debates, and media sur-
rounding the debates, and scholarship done at the time, brings to
mind Rosemarie Garland-Thompson’s writing about freak shows and their relationship to disabled bodies: “The immense popular-
ity of the shows between the Jacksonian and Progressive eras sug-
gest that the onlookers needed to constantly reaffirm the difference between ‘them’ and ‘us’ at a time when immigration, emancipation of the slaves and female suffrage confounded previously reliable physical indices of status and privilege.” The immense popularity of disability studies between 2000 and 2015 suggests the need to constantly reaffirm the difference between “them” and “us” at a time that’s included the passage of the ACA, the declaration that obesity is a disability and rising rates of autism, diabetes, and auto-
immune diseases (for example): Who’s disabled now?

I am not normally disabled.
The people who are disabled now are not depicted as freaks, but as the direct opposite, as incredibly mundane, unexceptional, because of the huge number of Americans affected. The people who are disabled now are not freaks but they are “the obesity epi-
demic,” which, although not “freak,” has the same effect. “The obe-
sity epidemic” names millions of people, makes it seem like these sick bodies are everywhere, but, by naming these people as singular, renders them invisible. “The obesity epidemic” is everywhere and nowhere at once.

It can’t possibly, really, be your problem.

30 McRuer, Crip Theory, 103.
“The obesity epidemic” is not at a distance from “disabled” but within distance of it. But any distance here is crucial because what would it mean for, suddenly, millions of people to now be disabled? Can you be disabled by an illness? Can you be disabled by an illness that seems to have such clear external causes, causes like food deserts and HFCS and a lack of educational and health resources? An illness that seems to be both physically present, in that it has clear physical effects, and remarkably disembodied. What will these bodies mean for other disabled bodies, bodies whose disabilities seem so physical, so definite, and solid? Sickness can’t possibly be admitted. It can’t possibly be your problem, because with an illness like obesity you can just avoid those behaviors that cause it. And then not get sick. And then maintain your distance. And then.

I am tempted to say: what does it matter what effects obesity will have on the larger category of disabled? It’s not that I don’t understand the fact of limited resources, the distribution or lack thereof of such resources, to all kinds of bodies. But, theoretically, linguistically, (empathetically,) why isn’t there room for admitting these bodies? If your body is legally protected, why can’t it be theoretically protected?

The bodilessness of obesity, the way it is seemingly constituted by only actions, not internal mechanisms, actually makes it a perfect test case for illustrating the possibilities of thinking through and around and with a visceral body. Because obese bodies are bodies that are experiencing the very physical effects of an illness that (they are being told) is a product of their behaviors, of their minds, of the minds and behaviors of those around them. Obese bodies are bodies existing within and experiencing (and exemplifying) the gut–brain space. Obese bodies can make this space apparent in ways that more invisibly ill bodies may not be able to (at first). Obese bodies are visceral bodies. Furthermore, the obesity epidemic has seen a huge rise in nutrition studies, in the evaluation of various diets, in the long-term tracking of various metabolic data. What these data show, and the metabolic data in particular, is concurrent rise of people who have health problems identical to those caused by obesity, despite their non-obese weight: the term is metabolically obese normal weight. Who is disabled now? How is sickness any different?
Gut Reaction

The visceral bodies of the obesity epidemic, and the inherent inseparability of mind and body when considering their illness, coupled with historical concurrence of disability rights activism and disability rights studies, makes clear that now is the time for rights. Not just further legal rights. And it’s not disability studies that’s needed, now, not work that works on definitions, but theoretical rights that collapse definitions and works towards more information. Theoretical rights that respond to the inseparability of mind and body in a visceral body; that recognize that visceral bodies deserve legal rights that attend to physical needs as much as they deserve theoretical rights that attend to the need for information. Rights in theory; rights to a narrative in theory. Rights to Being Sick and Time. And rights to Illness Not As Metaphor but also rights to seeing or doing the rewriting and reapplying of existing theoretical narratives to visceral bodies. Like what if, for once, a discussion of Foucault’s Discipline and Punish was about the different power dynamics within a body, about varying cellular or organ level regulatory mechanisms and what these mechanisms could show about larger political or social systems? What if Kristeva’s concept of the abject was taken to include the things one’s body finds abject within itself, like all that shit or those food intolerances or a faulty autoimmunity? What if différance/difference wasn’t just about the linguistics of terms, the play, but the way the negation inherent in them applies to the non-difference of sickness? What if, to continue with Derrida, an idea of a specter could be used to think about a specter of saturation (as related to rumination)? What if the author is actually dead or dying? What if there was a body of text that was disjointed, tongue-in-cheek, where the argument really didn’t have a leg to stand on; what if there were a sick body of text? What if, these questions answered, these theoretical rights fulfilled, then what? “What should I be cured of? To find what condition, what life?”