RAGNA WINNIEWSKI
University of Cologne
r.winniewski@uni-koeln.de

WELL-BEING AND MULTISENSORY ENGAGEMENT IN DEMENTIA: AN EMBODIED AND RELATIONAL ACCOUNT[1]

abstract

Aging with a transformative illness such as dementia is – due to a progress of cognitive and sensory losses – often referenced and symbolized as "the social death". Such a predominantly cognitive view posits a challenge to those affected and to those who care for people with dementia. In contrast to this disruptive view, an embodied and relational account of dementia stresses levels of the pre-reflective and relational self that allow for engaging with the world and attuning to the other through various bodily senses. By referring to case studies of multisensory engagement (e.g. Validation, Snoezelen) I show how states of well-being can emerge by turning to someone's affective identity through body memory, interbodily resonance *and* therapeutic atmospheres, *thereby constituting a synaesthetic responsivity. I argue that multisensory engagement contributes to participatory bodily sense-making and well-being within situations of existential crisis, providing possibilities for the "disoriented" self in dementia.*

keywords

synaesthetic responsivity, body memory, therapeutic atmospheres, multisensory engagement

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1. Existential Well-being in Illness and Bodily Doubt

Ageing and illness are experiences that confront us at various stages of our lives, both are transformative experiences that have the potential to unsettle our sense of coherence. Aging with dementia, for instance, seems to emerge as a particular *symbol of a kind of existential discontinuity*.[1] This can lead to feelings of fear, uncertainty, and a loss of control over our lives and future plans. A purely biomedical view, which focuses solely on the physical aspects of illness, such as the loss of specific cognitive functions like the declarative memory in dementia, falls short in providing a comprehensive understanding of what it means to live with an illness such as dementia[2]. Common narratives and metaphors like the "living dead" (Behuniak, 2011) echo this narrow viewpoint and can indeed come across as threatening, solely emphasizing deficits and challenges without acknowledging the broader impact on an individual's life and identity. Living with dementia involves far more than just the loss of specific cognitive abilities. It encompasses a wide range of emotional, social, and existential dimensions that profoundly shape the individual's experience and interactions with their environment. These may include: *1) Emotional impact*: Dementia can evoke feelings of confusion, frustration, and fear, not only for the individual affected but also for their family and caregivers. *2) Social dynamics*: Dementia can strain relationships and social connections, leading to feelings of isolation and loneliness. It can also challenge communication and interpersonal interactions, altering the dynamics within families and communities. *3) Existential concerns*: Dementia can raise existential questions about identity, purpose, and the nature of one's existence. Individuals may struggle to make sense of their changing reality and grapple with feelings of loss and uncertainty about the future. For instance, Käll (2017) claims that by focusing solely on biomedical aspects like memory loss, we risk overlooking these critical dimensions and consequently silence transformations of self-expression into symptoms of cognitive decline.

To consider the broader context in which dementia unfolds, including the emotional, social, and existential challenges faced by individuals living with the condition is necessary

1 In the context of age-related changes to a person's physical and cognitive constitution the notion of ageing and illness become relevant as they refer to a demarcation between a person's former, unimpaired life and a fundamentally different life filled with limitations and impediments. (Cf. Grebe et al., 2014.)

2 Dementia is an umbrella term that stands for a series of neurodegenerative symptoms, which are accompanied by a progressive loss of memory and cognitive abilities (WHO, 2018). However, this predominantly bio-medical view is problematic as it remains one-sided and primarily refers to cognitive deficits and not to remaining potentials of those affected, as has been criticised by Hydén et al. (2014), Kontos (2005; 2014), Käll (2014), Sabath (2006).

for a more integrative and compassionate understanding. A holistic approach to illness and well-being respectively can help foster greater empathy, support, and quality of care for those affected. According to Kontos et al. (2017), embodied and relational approaches to dementia emphasize the importance of understanding the capacities, habits, expressive dynamics, and socio-cultural dispositions of individuals with dementia in their respective environment. As such they are "central to self-expression, interdependence, and the reciprocal nature of engagement" (ibid., p. 183). Dementia is a social disorder that affects our intercorporeal communication as has been argued by Zeiler (2014), Petherbridge (2019), Dzwiza-Ohlsen (2021), Winniewski (2022) or Winniewski and Dzwiza-Ohlsen (2024). That is why, while understanding illness as a fundamental disruption of "being-in-the-world" and an experienced sense of disorder (Toombs, 1993, p. 70), a complementary account of being and sense-making in illness, as I propose here, recognises the lived body`s *pluralistic and social unfolding*. Following this existential and phenomenological assumption, there is evidence that in the presence of dementia it is possible to maintain or improve one's quality of life and subjective sense of well-being[3] (Becker et al., 2010, Fuchs, 2010) meanwhile embracing a *sense of fragmented identity*.[4] I use the term "fragmented identity" in a two-fold manner here: First, it serves to subsume transformative experiences inherent to our lives which we may have undergone due to illness, trauma, migration etc. in order to de-stigmatize the sense of self-alienation or the struggle of re-finding one's identity and to re-integrate sometimes inherent clashing experiences of identity. Second, it shall support those who seek sense but might feel irritated or de-stabilised by the encounter with someone who seemed familiar once but now has become alienated, for instance, through illness.

Well-being, in general, refers to the overall state of an individual's physical, mental, social and emotional situation. The WHO defines well-being as "a positive state experienced by individuals and societies", which is determined by social, economic and environmental conditions. Similar to health, well-being is a "resource for daily life" and "encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose" (WHO, 2021). Consequently, "[a) society's well-being can be determined by the extent to which it is resilient, builds capacity for action, and is prepared to transcend challenges" (ibid). When discussing well-being in illness it is important to distinguish these manifold and intertwined dimensions that feed into the state of a person's well-being in a phenomenological manner. Diener et al. (2009) identify and explain *feelings of well-being* as follows: *Physical well-being* (1) refers to the individual's physical health and how they perceive their body's functioning despite the illness. This not only includes managing symptoms such as pain or losses of former capabilities and senses of orientation, but maintaining a healthy lifestyle as much as possible, and optimizing a sense of physical comfort. Illness, and here particularly dementias, can have a significant impact on a person's emotional state.[5] That means that *emotional well-being* (2) involves recognizing and understanding one's emotions, managing stress, anxiety, and depression, and finding ways to cope with the emotional

3 Note that well-being in illness is a highly individual experience. It is essential to respect individual preferences, choices, and autonomy while supporting someone in their pursuit of well-being. Additionally, healthcare professionals play a vital role in providing appropriate medical care, information, and resources to promote well-being alongside the medical treatment of the illness.

4 This aligns with Jenkins (2014) who claims that the "primary goal of practitioners should not be the fixing, reviving or re-unifying of a pre-morbid self but, instead, enabling a rich and polyphonic montage of selves to emerge" (ibid., p. 125).

5 In frontotemporal dementia, for instance, and also in later stages of Alzheimer dementia, emotional regulation becomes a great challenge for people with dementia but also for the carers. (Cf. WHO, 2018.)

challenges that come with illness. Support from carers, counselling, or psycho-physical forms of therapy can be beneficial in promoting emotional well-being addressing always the relational and social aspect of illness and well-being. That is why maintaining social connections and a support network is crucial for overall well-being. *Social well-being* (3) involves having meaningful relationships, receiving support and understanding from family and friends, and engaging in activities that provide a sense of belonging and social interaction. Since illness can lead to feelings of uncertainty, fear, and loss of control *mental well-being* (4) is equally important: Maintaining a positive and adaptive mind-set, practicing self-care, engaging in activities that bring joy and purpose, and seeking mental health support when needed are signs of mental well-being.

Existential well-being, when considering the dimensions mentioned, adopts a comprehensive perspective on what constitutes well-being *amidst illness*. Such an approach to well-being emphasizes the existential aspects of human experience, including questions of meaning, purpose, and identity, particularly in the face of illness. It recognizes that illness can bring about profound losses, such as physical abilities, autonomy, or life opportunities, while also highlighting the presence of resources, such as resilience, social support, or newfound priorities. This may involve finding meaning in the midst of adversity, cultivating a sense of purpose despite limitations, or nurturing connections with others to foster a sense of belonging and support.[6] It underscores the importance of addressing not only physical symptoms but also the existential dimensions of suffering to promote a holistic sense of well-being. According to Baiasu (2021) existential well-being constitutes a background which renders possible states of happiness, contentment, satisfaction while involving a sense of belonging, home-coming, or turning to the world through bodily certainty.[7]

In illness such as dementia, however, where bodily disorientation and linguistic decline are common symptoms, a kind of *bodily doubt* (Carel, 2013; 2016) seems to be inevitable. For Carel (2013) the three central dimensions in the structure of bodily doubt are: a loss of continuity, a loss of transparency, and a loss of faith in the body (pp. 188-192) which all underlie different degrees, that is, they 'vary in duration, intensity, and specificity' (ibid., p. 181). In dementia, bodily doubt is experienced particularly in the early stages of the disease when people have more awareness of their sudden behavioural changes. As expressed by Hýden et al. (2014), some individuals may articulate a sense of unreality or disconnection from their surroundings, which adds to their distress. It may feel like their grasp on reality is gradually slipping away. In order to ease this bodily felt uncertainty, it has been argued widely that despite their illness, people with dementia can still find ways to pursue their passions and preferred activities (e.g. singing, dancing, exercising, etc.) when they either rely on their formerly embodied habits or engage into building up new ones.[8] Focusing on activities and interests that bring a sense of fulfilment therefore can contribute to overall well-being and provides a sense of purpose and identity beyond the illness. That is why an account of existential well-being addresses the transitional bodily experiences of loss and of change by integrating them in new meaning-making activities. In the following, I shall refer to different forms of multisensory engagement in dementia achieved through multisensory environments, embodied habits,

6 McFadden (2003) draws on the paradox of well-being in illness and old age stressing the importance of a sense of humour as meaningful perspective.

7 Bodily certainty is, according to Carel (2013), pervasive and provides the background confidence with which we perform familiar actions. It is simply the immediacy and automatic manner in which we turn to familiar tasks. It is not optional, but a basic mode of action that takes agency for granted.

8 Cf. Fuchs (2010; 2020) and Kontos (2012; 2021).

and shared practices that help to create interbodily resonances (Fuchs, 2016) and therapeutic atmospheres (Sonntag, 2016) contributing to an existential form of well-being.

2. Synaesthetic Responsivity and Body Memory

Several empirical case studies show that the bodily self is maintained even in advanced stages of dementia through diverse embodied habits as well as through spontaneous forms of bodily interaction which allow for resonance with the social world. In alignment with Hartmut Rosa's concept of social resonance (2019) we can respond to someone withdrawing ('repulsive moments') by bodily resonating with someone's situated being. The affective qualities of a situation or the environment allow for bodily responsivity, be it in the form of sensations, attitudes, expressive movements, gestures or movement tendencies, which allow us to experience the former. Through its resonance and responsivity, the body functions as a medium of affectivity.[9] That is why feelings, moods, emotions, atmospheres and the evocation of bodily-expressive resonances and responses as well as the multisensory design of spaces play an important role in maintaining well-being and the *synaesthetic self* as open to the world.[10]

One way of addressing the pre-reflective self with its embodied habits and bodily responsivity in dementia (particularly in later stages), is to activate the bodily and affective self through multisensory engagement and participatory sense-making (De Jaegher and Di Paolo, 2007). The latter term, while originating from enactive cognitive science and phenomenology, proposes that sense-making—the process of creating meaning and understanding—is not solely an individual cognitive activity but rather a participatory and relational process that occurs within social and environmental contexts. When connecting both processes, that is, through multisensory engagement with the world in a participatory sense-making way we gain higher relational autonomy that contributes to well-being effects on both sides, respectively, on the side of the carer and the person with dementia. Successful examples of these responsive and engaging processes are Validation, Snoezelen, Music, Dance, Theatre, Creative Art Projects.[11] Recent studies by Kontos et al. (2020), emphasize the beneficial effects of *Dance Movement Therapy* (DMT) in dementia highlighting the playful and imaginative nature of how persons living with dementia engage with dance and demonstrate how this has the potential to challenge the stigma associated with dementia and instead support social inclusion and a sense of agency and *embodied interaffectivity* (Fuchs and Koch, 2014).

What seems to be foundational for a sense of self that relates to others and the own history inscribed in the proper body is the implicit body memory (Fuchs 2010; 2020), which counts as form of pre-reflective self-awareness. For the experience of the lived body and particularly for the pre-reflective self, kinaesthesia and synaesthesia are two phenomena that are foundational as pointed out by Shaun Gallagher:

> Kinaesthetic organization operating through the body schema now provides for the organized unity of the synaesthetic field. The visual field, the tactile field, etc., do not become united noetically or consciously; they are already united for consciousness by the lived body [...]. Thus consciousness finds itself already surrounded by a meaningful world, one that is organized by the lived body (ibid., 1986, p. 154).[12]

9 Cf. Fuchs and Koch (2014).

10 Synaesthesia in the Aristotelian sense, i.e., 'sunaisthanomai' stands for 'the social energy of life and friendship' (Flakne, 2005, p. 51) and fosters an intersubjective perspective of dual birth of self and ethical world.

11 Cf. Kontos (2014; 2020), Käll (2017); Nocon (2008); Winniewski and Dzwiza-Ohlsen (2024).

12 I agree with Gallagher's view that there is no isolated datum. He argues that "primarily, before any reflection,

Hence the synaesthetic field is addressing the complex, entangled, intangible, inter- and intrapersonal aspects and mechanisms of perception and sense-making. It becomes "visible" in bodily memory, for instance. It exists beyond explicit memory and narratives we tell about our lives and constitutes the indispensable basis for our self-familiarity. Therefore, synaesthetic experiences and body memory are foundational for our personal identity. Following Merleau-Ponty's concept of *intercorporeality* (1968, p. 180), a horizon of synaesthetic possibilities serves as the intersubjective foundation and dimensions of selfhood and body while opening the structure of experiencing the world and the other, thereby forming a Synaesthetic-We.[13]

Contemporary phenomenological accounts by Shaun Gallagher, Dan Zahavi, and Thomas Fuchs which build upon the work of Edmund Husserl and Maurice Merleau-Ponty stress the *lived body* with its pre-reflective dimensions of self-experience preceding explicit memories and narrative self-attributions. Their concepts emphasise our multisensory anchoring in the world and our bodily perception as existential *modes of relational, interbodily and synaesthetic being.* Following Merleau-Ponty, our perception is commonly synaesthetic but we, however, have "unlearned" this layered, multiple, and yet integrated way of experiencing the world because we direct our attention to either intellectualist or empiricist views of perception, thereby neglecting a crucial dimension of our lived experience (cf. Merleau-Ponty, 2002, p. 266). Synaesthesia conceived as a social phenomenon of bodily resonance and bodily integrity pertains to a broad definition addressing a variety of synaesthetic perceptions and thereby accounting for the fact that each of our senses is modularised and likewise connected to the other senses[14]. Hence, synaesthetic responsivity can be considered as a complementary and diverse way of meaning-making.

The synaesthetic-self is revealed in the body memory. For instance, in the *Proust-effect*[15] our bodily olfactive memory has a strong impact on how and what we remember of our experiences from the past and how they make us feel. In *In Search of Lost Time*, it was the taste of *madeleines* previously dipped in lime blossom tea, which brought back pleasant memories and feelings connected to the familiar place of his childhood. These memories can evoke feelings of well-being if they establish connections to positive experiences in the past.[16] Likewise they offer a form of re-orientation for the self in dementia.

However, dominant cognitivist approaches to personal identity converge in the claim that the brain is the *central organ* for personal identity since it controls enduring memories and the continuous character of the person (Tewes, 2020, p. 371). Such a "cerebro-centristic" view conceives the brain as a self-contained organ separated from social interactions, from the living body, and from the experiential dimension of agency (Brockmeier, 2014, p. 73).To

there is always a field or *Gestalt,* and the field is always a synaesthetic one." (Gallagher 1986, 141) To signify this unitary and synaesthetic field, he proposes the term 'hyletic experience' as opposed to Husserl's concept of hyletic perception.

13 Flakne's ethical interpretation of the Aristotelian concept of 'sunaisthesis' is an important and critical contribution to synaesthesia research as it stresses the embodied, interactive capacity that creates overlapping meanings through the cultivation of a sensibility that is neither purely individual nor communal, but emerges between bodies in motion. (Cf. Flakne, 2005; 2022.)

14 Among proponents of this wider definition are Maurice Merleau-Ponty, Erwin Straus, Shaun Gallagher, Bernhard Waldenfels and Thomas Fuchs. To disentangle the debate between a narrow definition of synaesthesia pertaining to only 3% of the population and general crossmodal associations, see Deroy (2017).

15 Cf. Van Campen 2016.

16 Note that Fuchs counts also the traumatic memory as part of the implicit memory and therefore body memory is not only provoking positive feelings of well-being, but can generate much of the opposite. It remains upon the synaesthetic self in dementia and carers to know what kind of situations and sensory effects stimulate those negative feelings. Sonntag (2016) therefore distinguishes between benign and malign therapeutic atmospheres.

respond to a cognitivist paradigm of personhood[17] and uphold ethical standards in practical care, it's essential to recognize and respect bodily dignity and the notion of personhood on a pre-reflective bodily level, even in the late stages of dementia. Fuchs (2010; 2020) and Tewes (2020) propose an implicit body memory as central for an interbodily communication and orientation. memory. Their suggestions align with an embodied and relational paradigm of personhood which argues against the foregrounding of the progressive loss of explicit memory, usually coined as the earliest and most prominent symptoms of Alzheimer's diseases. On the contrary, it operates on the basic assumption that large areas of implicit memory remain unimpaired even in late stages of dementia.[18] It is important to note that patterns of shared intersubjective social practices are incorporated in the infant's implicit memory system long before they acquire the ability to communicate symbolically.[19]

I argue that the implicit structures of our body memory exemplifies our synaesthetic way of perceiving and remembering the world. For example, familiar surroundings, moods, melodies and sounds not only arouse corresponding emotions but often also the associated autobiographical memories. The familiar patterns of being in the body and in the world are elements of security and support for dementia patients. Finding them confirmed promotes self-confidence in their remaining abilities. This is not only proven to reduce the anxiety and agitation of persons with dementia, but also helps them to maintain their own activities. To a certain extent, the habitual life activities are evoked and confirmed by the environment itself. The bodily, pre-reflexive orientation in the surrounding space is more fundamental than the reflexive orientation in space and time (cf. Fuchs, 2010, p. 239). Bodily sensations or situations experienced in bodily space thus can act as implicit memory cores and release memories and emotions enclosed in them.

To answer the question on how to enhance well-being through synaesthetic responsivity I will now turn to the interplay of body memory, interbodily resonances and multisensory environments that all contribute to creating benign therapeutic atmospheres (Sonntag, 2016) in dementia care.

3. Synaesthetic Responsivity in Validation and Snoezelen

When she moved I moved with her. I matched the intensity of my voice to the intensity of her movement. And pretty soon, for a split second, we became one person' (Feil, 2008). Naomi Feil is the founder of Validation therapy[20] and her well-known video[21] with Gladys Wilson, who is in a later stage of dementia, has been emphasized in view of *primarily intercorporeality* (Käll, 2017; Zeiler, 2014) and on the basis of *embodied vulnerability* (Petherbridge, 2019). This particular case of validation shows how – despite an initial appearance of unresponsiveness – interbodily resonance is achieved through multisensory engagement, i.e. by means of gentle touch, a soft voice, a gradually summoning of rhythmic clapping and singing together. These bodily

17 For a more detailed presentation of the lacunae of cognitivist and narrative paradigms of personhood in dementia, see Tewes (2020) or Hýden et al. (2014).

18 Research in developmental psychology on infants has demonstrated the significance of primordial intercorporeal relations for the constitution of the self and body memories. (Cf. Trevarthen, 1989.)

19 Research in sociology and anthropology has shown that incorporating practices occurring in rituals and commemorations, for example, repeatedly performed social activities embodied in gestures, postures, or speech structure mnemonic systems, contribute in turn to differences in class, gender, and cultural identities in general. (Cf. Tewes, 2020; Kontos, 2005, 2018.)

20 Validation therapy focuses on helping the person work through the emotions behind challenging behaviors by echoing emotions, rephrasing feelings, and using senses. Erdmann and Schnepp (2016) found that agitation levels of residents were decreased with integrated validation therapy and that caregivers felt positive about its use with the residents.

21 Cf. https://www.youtube.com/watch?v=CrZXz10FcVM, retrieved at 20.04.2023.

alignments and attunements entangle present and past experiences, i.e. embodied habits. These, even if rather fragmented habitualisations, do contribute to creating new situational meanings to which openness and spontaneity are important. Accordingly, Kontos and Naglie (2009) frame the tacit knowledge of caring and embodied selfhood as follows: "the socio-cultural aspects of corporeality endow selfhood with the capacity for *improvisation* and *spontaneity*, [...], embodied selfhood [...] permits 'an *element of inventiveness* and *creativity*, albeit within the limits of its structures, which are the embodied sedimentations of the social structures which produced it." A mutual attunement and alignment is thus achieved via habitual and creative, expressive, and affective bodily movements, i.e. through a kind of *synaesthetic awareness* and *kinaesthetic empathy* that can be found in primarily intercorporeality. According to Käll (2017), this kind of social encounter is based on a constitutive openness and accessibility to the other, which is prefigured in the experience of the "double sensation" [22] in which the subject has a double experience, for example, when touching one hand with the other. The self becomes self through the interactive engagement with and bodily presence of the other. Hence, it is possible to communicate with a person with advanced dementia who may not be able to talk and appears unresponsive through music and touch. Consequently, there is evidence that people with advanced dementia do not lose the ability to communicate or face a complete loss of self or identity, but rather that identity and personhood might instead be understood in terms of intercorporeal accomplishments (Fuchs, 2020; Winniewski, 2022; Winniewski and Dzwiza-Ohlsen, 2024), which continue throughout life but take different forms in older age or illness.

As people with dementia are no longer fully able to design their living space to meet their needs, especially the control of sensory aspects such as temperature, visual and auditory design, they encounter difficulties to add atmospheric pleasantness such as appropriate music to a perceived unpleasant environment or to turn off an inappropriate one (cf. Sonntag 2020, 350). A vignette by Sonntag (2016) during a shift as music therapist in a care institution is illustrating what could be framed as synaesthetic responsivity. Sonntag (2016) reports from an encounter with an agitated man who was pacing down the aisle. When deciding what would be the best approach to unsettle his agitation and contribute to a more relaxed state and situated well-being, Sonntag instead of talking to the man chose to take up his pace, chasing down the aisle together with him. The effect was striking: due to the therapist who was bodily resonating with the man and attuning to his pace, thereby mirroring indirectly the bodily expressivity of his agitated mood, the man gradually slowed down to find a more relaxed state of being in the situation. This is another example of how the mutual bodily attunement generates a more relaxed therapeutic atmosphere (Sonntag 2016) and adds to the state of well-being through emotion regulation. In other words, the alignment to the kinaesthetic and synaesthetic affect-laden self by the therapist via bodily empathy and resonance provoked a smooth adaptation and joining into a more pleasant pace, situation thereby providing effects of well-being and constituting a synaesthetic responsivity (*Synaesthetic-We)*.

The above examples of synaesthetic responsivity can be found in various therapeutic forms offered to dementia sufferers. Among others, we find for instance aroma therapy,

22 In following the canonical discussion of the body in *Ideas II* (Husserl, 1989), Merleau-Ponty emphasizes the inevitability of the felt body in all perceiving. The "double sensation" or "touching-touched", especially in his late *The Visible and Invisible*, it becomes the very essence of flesh and our "entwinement" in the world (cf. Moran, 2010).

basal stimulation, which is used in the *Snoezelen* concept[23] to which I will turn now to further demonstrate an increase in well-being through synaesthetic bodily responsivities.[24]

The *Snoezelen* concept combines multisensory activities in a multisensory environment (MSE) in order to activate the *body memory* of a person with dementia and to discover and share the embodied habits as resources of the lived body. In this example, the social assistant in a care home usually conducts a Snoezelen group session of 30 minutes with 2 to 3 participants who are invited shortly beforehand to join the session in the Snoezelen-Room (a nicely equipped and greenish coloured room, simulating a forest on the one side and with an empty screen for video projection on the other side). In the Snoezelen-Room a variety of the bodily senses are stimulated and addressed.[25] She usually prepares the various multisensory items to reactivate embodied habits beforehand, for instance, setting up an aroma lamp diffusing the smell of oranges, chopped fruits and cheese to taste; garlic, cinnamon, or coffee to smell; wrapped household objects such as cork or pliers to touch; pictures of people in different emotional states (joy, sadness, anger) or social situations (classroom), etc. At the beginning of each session, the care assistant has prepared for a printed scale of well-being laid out on the table. Each of the participants is asked to mark the proper state of well-being in the beginning with a small pottery figure. "How are you today?" Options to answer range from bad to very good, when participants are asked to place their figure on the scale. The question is repeated after the session and in 2/3 cases it adds a positive change to the individual mood. In this example session, two ladies (aged 80+) both sitting in a wheelchair were reluctant upon the invitation expressed 2 hours beforehand by the social assistant. One of them wanted to go home, expressing this verbally and the other one refused to put on her shoes before she was brought to the room. However, as soon as the session started they were in a good and excited mood, chatting along and commenting the different multisensory tasks. Both were very engaging throughout the session. One woman, when presented with different multisensory stimuli in the form of tasting and touching different types of food (apple pieces followed by a piece of chocolate she had to unwrap) talked a lot about her childhood experience before she became a migrant. The other named very creative images that she would see in the multi-coloured lava lamp shapes that were projected onto a wall and shown to the group. Both women seemed to be cheerful after the session and answered the question of how they would feel with "very good", marking this accordingly on the scale of well-being in front of them. From this example, it seems as the very diverse multisensory engagement used in the Snoezelen-Room is a welcomed and positively stimulating activity for people with dementia.[26]

4. Conclusion

In this paper, I emphasized a synaesthetic, multisensory, embodied, and relational framework which serves a pluralist view to illness and potentially contributes to a complementary understanding of psycho-physical and social wellbeing in dementia. By turning to an embodied, relational, and meaning-centred account which is supported by therapy examples of synaesthetic responsivity I gave an alternative view to a prevailing bio-medical and cognitive definition of dementia. Such an account stresses levels of the pre-reflective and bodily self that remains key to engage with the world and attune to others through interbodily resonance despite a degree of un-shareability or non-narrativity in later stages in dementia.

23 The word snoezelen stands for doezelen (to doze) and snuffelen (to sniff). It is conceived as a multisensory activity supported by a respectively trained therapist. It usually takes place in specially equipped rooms where the intensity of sensory stimulation can be adjusted in order to find a balance between relaxation and activity. (Cf. Van Weert, 2004.)

24 For a more detailed conceptual explanation of shared responsivity see Waldenfels (2020).

25 All observations and descriptions from this example are taken from proper fieldwork in May 2023.

26 Brettschneider (2009) and Van Weert (2004) come to a similar conclusion.

I argue that the *lived body* in dementia remains a relational self with resources of bodily expressiveness, interbodily resonance, and creative responsiveness.

By means of different case studies of multisensory engagement and phenomenological fieldwork in a multisensory environment (MSE), known as Snoezelen Room in care homes, I aimed to show how *synaesthetic effects* and *affective states of wellbeing in dementia* appeal to a balanced and relaxed mind-body-relation, meliorating the interbodily communication between relatives, caregivers, and those affected thereby reducing bodily doubt. Therapeutic atmospheres are most successfully created in well-balanced multisensory environments (MSE), through multisensory stimulation (MSS) and through interbodily resonances or synaesthetic responsivities. They offer possibilities for sharing embodied habits of people with dementia. By referring to the synaesthetic-self and -we in dementia I have addressed an urgent question of integrated healthcare programmes and the ethical and political dimension of selfhood in dementia beyond a limited view of cognitive impairments.

Synaesthetic tendencies of perception and agency emphasize a multisensory engagement with the environment as vital for our existential being, particularly in illness. These tendencies allow for a variability and openness in engaging with the world and others, thereby providing a gradual degree of bodily stability and re-orientation. Since the synaesthetic bodily self-constitutes a core aspect of vitality for someone with dementia it should be addressed regularly to counteract bodily doubt. By framing synaesthesia as a social and affective phenomenon, I have argued that, this view not only challenges traditional concepts of perception and cognition but also provides new avenues for phenomenological qualitative research and therapeutic practices in dementia. Synaesthesia then is understood as a complex and entangled way of addressing sensory and cognitive needs while expressing the aesthetic and communicative aspects of the body in illness. Such an alternative understanding can break with hierarchical separations and stress a paradigm shift towards a more inclusive, yet complementary, and integrated approach of the lived body in theory and practice, thus contributing to both individual and social well-being.

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