BABEȘ-BOLYAI UNIVERSITY, CLUJ-NAPOCA
FACULTY OF EUROPEAN STUDIES
PHD PROGRAM: ”EUROPEAN PARADIGM”
RESEARCH FIELD PHILOLOGY

PHD THESIS

THE BODY IN AN “ALTERNATIVE” MEDICAL PRACTICE: AN ANTHROPOLOGICAL PERSPECTIVE

SCIENTIFIC COORDINATOR:
PROF. UNIV. DR. ION CUCEU

PHD STUDENT:
COLOPELNIC NICOLETA-ILEANA

CLUJ-NAPOCA
2012

KEY-WORDS: the anthropology of the body, medical anthropology, embodiment, narrative, "alternative" medicine, food

TABLE OF CONTENTS:

SUMMARY

The aim of this thesis is to explore several aspects of the lived body in relation to a healing practice. The research question of this inquiry is the following: how is the body lived by those who are involved in the so called "alternative" healing practices? In Romania, as Simona Drăgan and Odde Madsen notice, there is a wide range of such practices, especially in the big cities, and in 2009 a study revealed that 7% of the whole population used "alternative medicine" in the last 12 months[1]. By focusing on one such healing practice that positions itself outside the official biomedical establishment, my aim was to bring into discussion a series of aspects regarding the body and embodiment, through the means of an anthropological inquiry. This research was based mostly on semi-structured interviews I conducted with those involved in the practice. Thus, this thesis consists of two main parts: in the first one I outlined the theoretical and conceptual framework of my research, while in the second part I provided an analysis of the way embodied experience is constructed in the healing practice that I focused on.

1. Socio-cultural perspectives on the body

Noticing an increased interest in the body and embodiment in the most recent developments of social science research, my aim in the first chapter was to offer a starting point in the analysis of the way the body is constituted as a research object. A first question I sought to answer was: why this interest in the body now? Then I highlighted the most important theoretical approaches of the body in social-science research, by focusing on the symbolic approach, the discursive one, and then on the phenomenological and narrative ones. Several factors were considered by many authors as having had an influence in this increase of academic interest towards the body: economic factors, the politicization of the body and the development of the feminist and civil rights movements, the demographic transition and the proliferation of chronic illness, technological developments and last but not least, the reconsideration of embodiment as a methodological and conceptual resource in several disciplines. In its search for the universals of man-kind, anthropology was interested in the body since its beginnings, and thus long before the body became an issue in relation to the socio-cultural structures of westerns societies. Notwithstanding, this interest was at first directed mainly towards the body of others, considered to be more embodied. In 1935 Marcel Mauss published his

[1]Simona Dragan, Jesper Odde Madsen, "CAM in Romania - a Brief Overview," http://www.cambrella.eu/home.php?il=150&suchhigh=romania&l=deu, viewed 23.07.2011.

study on "techniques of the body"[2], in which he argues that there is no "natural" way in which we use our bodies, but that all the ways of body "utilization" are informed by culture. This study, along with those of Mary Douglas is often regarded as the pioneer of the anthropology of the body and is still very influential today. In 1966[3] and 1970[4], Mary Douglas published two books in which she also analyses the body as a natural social symbol for all socio-cultural structures.

Taking as a starting point the assumption the body is a socio-cultural construct rather than just a natural object many authors have considered the place the body holds in western thought. There is a propensity towards the analysis of the religious, philosophical and medical conceptions of the body. Thus in the Christian tradition some have noticed an ambiguous stance toward the body: on the one hand, as the body of Christ, through which he suffered and then resurrected and raptured, the body becomes the sole means for salvation; on the other hand, the body as flesh must be subdued and overmastered in order for the soul to be saved. The philosophical discourse regarding the body is, starting with Plato, determined by a somatophobia: "the body is the betrayal and the prison of the soul, mind or rationality"[5]. Centuries later, Rene Descartes conceives an irreconcilable distinction between the mind and body – the body-mind dualism that is so often criticized today. The mind is the *res cogito*, having the certainty of its own existence, while the body becomes part of the *res extensa,* of natural things. The border between the two is sharp, as the body and mind are conceived as different ontological categories. This conception is supplemented by a mechanist model of knowledge that regards nature, thus including the body, as functioning according to a mathematical schema that can be discovered by the rational mind. The Cartesian dualism plays an important part in western conceptions of the person that considers the mind as a location for the self, rationality, thought, language, knowledge and agency. Furthermore, each mind corresponds to a single body. A critique of this dualism is brought forward for example by Drew Leder who argues that the Cartesian split is a reification of an incomplete phenomenological analysis[6]. A different sort of critique is that this split also implies a hierarchical relation between the two components of the dualism. Thus the mind is the valued component, while the body is the undervalued one. Other dualist models are similar to this Cartesian split: nature – culture, woman – man, private – public, colored – white, animal – human. A consequence of this model on the structure of knowledge is the

[2] Marcel Mauss, "Techniques of the Body", in *The Body: A Reader*, ed. Monica Greco and Mariam Fraser (New York & London: Routledge, 2008).
[3] Mary Douglas, *Purity and Danger*, 3 ed. (New York & London: Routledge, 2001).
[4] Mary Douglas, *Natural Symbols. Explorations in Cosmology*, 4 ed. (New York & London: Routledge, 2005).
[5] Elizabeth Grosz, "Refiguring Bodies", in *The Body: A Reader*, ed. Mariam Fraser, Monica Greco (New York & London: Routledge, 2008.
[6] Drew Leder, *The Absent Body* (Chicago, London: The University of Chicago Press, 1990).

incommensurable distinction between the knowing subject and the known object. Knowledge is conceived as dis-embodied and as belonging solely to the mind[7]. The Cartesian dualism determined the constitution of the body as a research object for natural science, paving the way for the emergence of the autopsy and the clinical gaze. The body became an object of anatomic and esthetic display, in the name of knowledge – "anatomic object to discover its inner structure, esthetic object to define its ideal proportions"[8]. In Western Europe, the medical-anatomic perception of the body became widespread with the Enlightenment and the "birth of the clinic", disseminating after biomedicine, as a state institution, became a characteristic structure of every western society.

The most important theoretical approaches of the body can be divided into: the symbolic approach, the discursive approach and the phenomenological approach. Nancy Scheper-Hughes and Margaret Lock suggest an analytic framework that consists of three different levels: *the individual body* that implies a phenomenological analysis of lived experience, *the social body* that implies an analysis of the body as a symbolic system and *the body politic* that implies a post-structuralist analysis of the body as a discursive construction[9]. These three levels presume distinct methods and epistemologies, as they deal with different aspects of the body. The symbolic analysis seeks to reveal how the body is a powerful social symbol, and that the way it is conceived in a particular historical or cultural context reflects essential aspects of society. Thus, social order and disorder, as well as transgression are represented on the body, and this representation helps to legitimize a certain vision about society. The symbolic inscription of socio-cultural categories on the body takes place through ritual. One major criticism against this symbolic approach is that it reduces the body to a semiotic issue, and the analysis focuses only on deciphering its meanings. The body as lived experience is left unquestioned.

The discursive strain of analysis seeks to show how the body is a result of the power relation within society. These are mainly post-structuralist theories that see the body as "an object produced and regulated by political, normative and discursive regimes"[10]. Thus, the body, the way knowledge about it is structured and the way it is disciplined through various regimes are in correlation with the power relations in a certain society. This connection can be deciphered using a genealogic approach

[7] See Elizabeth Grosz, "Refiguring Bodies".
[8] David le Breton, *Antropologia corpului şi modernitatea*, trans. Doina Lica (Bucureşti: Amacord, 2002).
[9] Nancy Scheper-Hughes, Margaret M. Lock, "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology", *Medical Anthropology Quarterly* 1, no. 1 (1987), Margaret Lock, Nancy Scheper-Hughes, "A Critical-Interpretative Approach in Medical Anthropology: Rituals and Rutines of Discipline and Dissent", in *Medical Anthropology. Contemporary Theory and Method*, ed. Carolyn F. Sargent, Thomas M. Jonshon (Westport, Conneticut, London: Praeger, 1996).
[10] Chris Shilling, *The Body in Culture, Technology and Society: Classical Debates & Current Issues* (London: Sage Publications, 2005).

as Michel Foucault suggested. This implies a close historical reading of the body and the ways it became an object for inquiry in different fields of knowledge. In the constitution of the modern discourses about the body and about the population together with the need for surveillance, regulation and discipline, an important role was played by the clinical gaze and biomedical knowledge. The main constitutive power of these discourses is not their ability for repression as is their ability to produce new subjects of power. As was the case with symbolic analysis, a main criticism of this approach is that it leaves lived experience unquestioned. Furthermore, this approach does not explain agency and resistance adequately enough.

In a move to overcome the shortcomings of the symbolic and discursive approaches, there is a growing interest in the phenomenological strain of thought that does not focus on the body as a cultural object, but on embodiment in an effort to transcend the body-mind split. From a phenomenological perspective the starting point in the analysis of culture is that one does not only *have* a body, but one also *is* a body. Being-in-the-body as part of being-in-the-world is the philosophical assumption of a phenomenological analysis of embodiment. A starting point for such an approach is represented by Maurice Merleau-Ponty's phenomenology of perception[11] and also by Drew Leder's theory of the absent body and of its dys-appearance in pain and illness[12]. Embodiment is regarded as the "condition of possibility for our relation with the world and with others"[13], and has profound implications for the way culture and society, intersubjectivity, intentionality and agency are conceived. Thomas Csordas argues in favor of considering embodiment as a starting point for the study of culture[14]. The relation between culture and the body is no longer regarded as one in which the body is a *tabula rasa*, as a passive ground for culture to inscribe its symbolic categories and power relations. In this strain of thought, the body is regarded as an active source of culture, just as it is an active source of the self. Hence a series of studies focus on the dynamic body, the body as process, flux, actively incorporating and creating the world around it. Embodiment is ambiguous, irregular, without the possibility of drawing clear-cut borders between self and body, body and world; it is an active process of engagement with the world, of perception, and of producing the world, not by a rational mind, but by a lived body, always dynamic, always becoming, incorporating the world it opens onto. This ambiguous and dynamic character of embodiment entails

[11] Maurice Merleau-Ponty, *Fenomenologia Percepţiei*, trans. Ilies Campeanu and Georgiana Vatajelu (Oradea: Aion, 1999).
[12] Drew Leder, *The Absent Body*.
[13] Kate Cregan, *The Socology of the Body. Mapping the Abstraction of Embodiment* (London: Sage Publications, 2006).
[14] Thomas J. Csordas, "Introduction: The Body as Representation and Being in the World", in *Embodiment and Experience. The Existential Ground of Culture and Self*, ed. Thomas J. Csordas (London: Cambridge University Press, 1994).

a focus on narratives of the self as embodied narratives, in a quest to uncover lived experience as it is perceived by those who live it. This pursuit of narratives comes in a time that is marked, as Arthur Frank notices, by a preoccupation with an ethics of voice[15]. This narrative approach is not a step towards relativism, but calls for a focus on the particular, and for an acknowledgement of the specific character of each voice, depending on its location is a network of interdependency and in a social and cultural context.

2. The body in plural medical contexts

In the second chapter of my thesis I presented a theoretical model for analyzing the body in plural medical contexts. By plural medical context I refer to specific socio-cultural contexts that are characterized by the existence of more than just one health care provider. In Western societies, these usually consist of one "official" medical practice – namely a medical practice recognized by the state and having a somewhat privileged status in society (in anthropological research this is usually referred to by the term "biomedicine"), and several other practices that are deemed "alternative", "complementary", "unofficial", "unorthodox" etc. By medical practice I understand a complex configuration of symbols and practices, situated in certain socio-cultural, economical and historical context, which has as its main purpose the management of illness. Therefore every such practice offers a definition of illness and a set of actions that are considered appropriate for the alleviation of human suffering.

As a starting point I considered the theoretical stance of medical anthropology and in particular the concept of medical pluralism to figure out how plural medical contexts can be analyzed in western societies. Then I used the theoretical model of the three bodies put forward by Margaret Lock and Nancy Scheper-Hughes in what they term a critical-interpretative approach to medical anthropology, to explore some of the main issues regarding the body in medical practice. I believe that this theoretical model is very useful in the analysis of plural medical contexts as it allows for the illustration of different aspects regarding the three levels of analysis in a certain practice. Furthermore, it permits the interconnection of a macro, structuralist perspective, with a micro, phenomenological one. In any medical practice, the three levels of the body are interconnected: a phenomenology of the ill body – the lived experience of illness with its two demands for interpretation and action; a symbolic dimension of illness – explanatory models and conceptions that help in finding an answer to the hermeneutical demand of illness (what does it

[15] Arthur W. Frank, *The Wounded Storyteller. Body, Illness and Ethics* (Chicago & London: The University of Chicago Press, 1995).

mean?), as well as to the pragmatic demand (what must I do?) in culturally sanctioned ways; a political dimension of illness – the power relations that infuse the social organization of a certain medical practice.

As a subfield of anthropology, medical anthropology is preoccupied with the way in which human communities, in varied socio-cultural contexts, conceptualize health and illness and deal with human suffering. Thus, the scope of this subfield is to describe, interpret, and critically asses the relationships between culture, behavior, health and illness by regarding them in the larger context of social, cultural, political, economic and historical processed. Medical anthropology is preoccupied not only with ideas and conceptions about health and illness but also with the social structures deployed to deal with these aspects of human existence. Lately several issues that have gained ground in this subfield are those regarding the ill person's perspective, the illness experience, the way illness and the actions aimed at alleviating suffering are conceived by the ill person, but also by those who belong to his social network. Although in its beginnings medical anthropology was concerned mostly with "exotic" medical practices that it approached from a symbolic perspective, gradually the main assumptions of the western medical system came into question. A handful of inquiries from different perspectives led to a destabilization of the, until then, unitary concept of "western medicine" or "biomedicine"[16].

The concept of "medical pluralism" tries to address the plural nature and the diversity of health care in a given society. Thus, this concept pertains to the existence in a given society of more than one group of persons that provides health care services. Gradually medical pluralism was recognized as a feature of western societies. In the U.S. and Europe, the existence of a plural medical context is regarded as the result of a "re-emergence" of "complementary and alternative medicine" – a set of practices that are in one way or another positioned as outside the biomedical framework. When giving a definition to these "alternative and complementary" medical practices, a first thing one must consider is the legitimacy given to these practices by the state. From this perspective of legitimacy, the state plays an important role in the distinction between different medical practices. A second thing none must consider is related to the perspectives on the body, health and illness that can differ from those of biomedicine. From this point of view, "alternative and complementary" medical practices are regarded as cultural phenomena that share certain concepts and systems of meaning. The most appropriate way to consider these practices is to start from a fluid or flexible definition that takes into account the fact that a diverse range of practices is

[16] Annemarie Mol, Marc Berg, "Differences in Medicine: An Introduction", in *Differences in Medicine*, ed. Marc Berg Annemarie Mol (Durnham and London: Duke University Press, 1998).

gathered under such umbrella terms as CAM[17], "alternative medicine", "complementary medicine" etc., in different geographical areas and historical periods, and in different social, cultural and political contexts.

In their article, *The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology*, Margaret Lock and Nancy Scheper-Hughes start off with the assumption that the way the body is conceived is crucial not only for the whole discipline of anthropology, but also for the way health care is planned and deployed in western societies. To show how this takes place, the two authors set forth the theoretical model of the three bodies I mentioned earlier.

The individual body entails a phenomenological approach that takes as it´s starting point the embodied nature of human beings. One question regarding this level of analysis is how do illness and the search for good health, articulated in a specific medical practice, influence the parameters of our embodiment – the lived experience of illness and the body, intentionality, body image, lived temporality and spatiality etc.? In order to understand this approach in relation to a certain healing practice, the relation between embodiment and the social body must be analyzed. As far as biomedicine is concerned, several phenomenological writings have criticized the way the Cartesian body-mind split led to an inadequate vision regarding the embodied nature of ill persons. In the clinical encounter, between doctor and patient, the dualist model is the salient one, and lived experience is overlooked. The body is objectified. For several reasons, this approach is problematic. As many other aspects of our lives, illness is embodied, it resides neither completely in the mind nor in the body, but in the embodied mind, leading to a disruption of the lived world of the ill person. Many "alternative" or "complementary" medical practices use different models of the body, some of which highlight the unity between mind, body and spirit, and thus imply a different paradigm of embodiment from that of biomedicine. Furthermore, in the diagnosis process, many of these practices rely on a biographical form of knowledge and the illness experience is taken into account to a higher degree. The diagnosis may entail the integration of bodily perceptions with bodily signs and biographical events[18].

The social body entails a different level of analysis: a symbolic or structural exploration of the models and conceptions that in a certain socio-cultural context, determine the way people think about their bodies. In putting forward certain conceptions of the body, health and illness any medical

[17] CAM is an increasingly used acronym (Complementary and Alternative Medicine)in the Anglo-Saxon literature, but also in the rest of the European Union to refer to those medical practice that are situated outside of the official biomedical framework.

[18] See Helle Johannessen, "Stories the Body Can Tell. On Bodily Perceptions as a Link between Alternative Medical Technologies and Illness Narratives", *AM Rivista della Societa italiana di antropologia medica*, pp. 11-12 (2001).

practice – "conventional" or "alternative", resonates with other cultural structures. In western thought, the most influential conception of the body is defined by the Cartesian body-mind split. This dualism has a series of profound implications for the way biomedical knowledge is structured. One such implication is that the foundation of biomedical knowledge is based on the inanimate body understood in mechanist terms – the body-as-machine that functions according to the laws of physics and chemistry, and that can be known, controlled and treated in isolation. Many practices defined as "alternative" or "complementary" entail different models of the body. As a general observation, it can be said that there is a plurality of representations: the energetic body (the body as a fluid and open system of vital energies); the bio-holographic principle (according to which the whole body and its organs and parts is projected in discreet parts of the body like the foot, the iris, the ear etc.); the homeopathic body (as a sum of features and tendencies that also includes psychological traits of the person in a temporal dimension). In many such practices one can find a principle of "holism" according to which the person is regarded as a whole – body, mind and spirit. Illness metaphors have a great capacity to speak both to the individual body and to the social one by providing a connection between individual experience and the wider cultural field. As for the metaphors of the body and illness entailed in "alternative and complementary" medical practices, some resonate to a smaller or greater degree with other cultural structures. Nonetheless, all of them are grounded in the socio-cultural context and are related in one way or another with different models of nature and society. In some of these practices the same metaphors that permeate the biomedical discourse can be found.

The body politic primarily refers to power relations. It entails a post-structuralist analysis of the ways in which bodies are disciplined and regulated by different political, discursive and normative regimes. Health and illness are medical labels that have profound implications for the normalization of the body, thus having a social control function. Michel Foucault draws a distinction between the anatomo-politics of the individual body – the way individual bodies are disciplined and transformed in docile bodies that can be subdued, modeled, transformed – and the biopolitics of the human race – the regulation of populations by a concern for general life processes (birth rate, death rate, longevity etc.)[19]. An important aspect of anatomo-politics is the therapeutic relationship, because in it the ill person is individualized under the careful examination of the clinical gaze, and the body is compared to the norm. Some studies have shown that many "alternative and complementary" medical practices entail a more embodied form of diagnosis that gives a greater

[19] Michel Foucault, *Society Must Be Defended* trans. David Macey (New York: Picador, 1997).

consideration to the illness experience and that incorporates along with it other biographic events and bodily signs. The therapeutic relation is egalitarian in some practices by giving the ill person a bigger part in the therapeutic process, both in finding the diagnosis and it the treatment of illness. This greater participation involves also a greater responsibility for one´s own state of health. Related to the aspect of biopolitcs is the process of medicalization of western societies but not also of societies in other parts of the world. Medicalization is a process through which more and more aspects of life come under the incidence of medicine and are defined and managed from a medical perspective. Mainly the concept of medicalization refers to the extension of the social control function of biomedicine by the definition in medical terms of social deviance or life processes – like birth, old age, death etc. But in plural medical contexts one must also consider the social control function of the so called "alternative and complementary" medical practices. These practices also participate in the panoptic vision of the state. Even if they are not institutionalized, they also represent articulations of power-knowledge that produce docile bodies, especially by the many aspects that they consider as important for health (diet, spirituality etc.).

Margaret Lock and Nancy Scheper-Hughes suggest the notion of *body praxis* as a way to tie the three levels of the body together. This notion invites researchers to start their analysis of health and illness from the vantage point of the "individual who lives and reacts to the place assigned to him in the social order"[20], and from this starting point to uncover the complexities and interconnections of the three levers of the body.

3. The narrative body

Considering the fact that this research is based primarily on semi-structured, qualitative interviews, in the third chapter of my thesis I explored the opportunity of narrative analysis for researching issues concerning the body and embodiment. Besides this I argued in this chapter that the concept of *narrative body* can be considered as an extension of the concept of *body praxis*. If we consider narrative to be much more than simply text, to be a performance, than we can talk about narrative practices that include both text and context, both language, action and embodiment. I argued thus for considering narrativity as an embodied practice that constitutes a link between the three levels of the body: individual, social and politic. When I talk about the narrative body I am not referring to stories about the body, but to embodied stories. Thus I am not talking about the body as

[20] Margaret Lock, Nancy Scheper-Hughes, "A Critical-Interpretative Approach in Medical Anthropology: Rituals and Rutines of Discipline and Dissent," p. 65.

a described object, but about the way in which the body, or rather embodiment contributes to the formation of stories[21].

The narrative turn in social sciences is linked to a questioning of the nature of language and of its function of representation that took place in the 60s and 70s. This questioning led to a shift from the notion of language as perfectly transparent to a notion of social reality constructed through the use of language[22]. Despite the polyphonic nature of this turn, its coherence is given by the preoccupation with experience, temporality and the process of narrative production both by the research participants and the researcher him/herself. Furthermore, in considering all these aspects there is a considerable amount of reflexivity aimed at illustrating the means through which narratives are produced in a certain context, including the context of academic research. The narrative turn, in its different forms, by being concerned with local stories, by its affinity with marginal groups, by bringing under close examination the academic means of production comes as an answer to the call for giving a voice to those whose voice was silenced either by illness or by other sufferings.

To answer the question concerning the link between the body and narrativity, I started out by providing a definition of narrative. This definition is not intended to refer to narrative as a literary genre, but it does share some of its features. A determining element of any narrative is the plot, and a feature determined by it, is coherence. A narrative is a way of giving a meaningful order to events that happen in time, mainly by an omniscient narrator. This ordering takes place by the emplotment of events, that is, by creating a temporal space for their meaningful unfolding. Without emplotment the events would be a simple chronological succession. Through this process a circumstantial causality is assumed between events, in close correlation with the idiosyncratic features of time and space of the act of storytelling. Also, the plot confers narrative coherence, due to the fact that the storyteller knows the whole line of events, thus including the resolution of the story. This puts him/her in a position that grants the possibility of giving the narrative a certain meaning and moral orientation. Taking this definition as a starting point I then proceeded to analyze the relationship between narrative and experience to see whether one can say or not about life that is has a narrative structure. Arthur Frank argues that the relationship between life and story is mutually mimetic[23]. Thus, the story does not represent experience, but contributes to its constitution. On the other hand,

[21] Daniel Punday, *Narrative Bodies : Toward a Corporeal Narratology* (Palgrave McMillan, 2003).
[22] Lars-Christer Hydén, "Narratives in Illness: A Methodological Note," *Qualitative Sociology Review* IV, no. 3 (2008): pp. 49-50.
[23] Arthur W. Frank, *Letting Stories Breathe. A Socio-Narratology* (Chicago and London: The University of Chicago Press, 2010), p. 21.

stories do not exist in void but in a close relation with actual experience that can influence the course and meaning of the story.

One way to conceive this mutually mimetic relation between life and story is by using the concept of "narrative unity of life" put forward by Alasdair MacIntyre. In his line of thought, the narrative unity of life is the unity of a narrative quest. At the beginning of this quest there is a telos that is in fact a conception regarding "the good for man"[24], and is constantly redefined by the narrative quest itself. Paul Ricoeur explores the ways in which the self requires a *narrative identity*. By using this concept, Ricoeur argues for a departure from the conception of identity in substantialist terms, as an unchangeable essence, by introducing in the definition of identity of a dimension of historicity. He does this by using such concepts as emplotment and character that are characteristic of a narrative analysis. But if identity can no longer be conceived as an unchangeable essence, it cannot be conceived as an incoherent series of events either[25]. For both MacInyre and Ricoeurthe narrative unity of life is a fundamental issue and identity can only be conceived in relation to it. For Ricoeur, emplotment is a process of structuration that is an intermediary between permanence and change. As for the body, in Ricoeurs conception, it is much more than a criterion for identity, and even much more than part of an identity project[26]: embodiment is the existential condition of identity.

On a different level, the link between the body and narrative can be explored as mediated by metaphor. As a simpler structure – A is B – the metaphor can be used to illustrate the way in which the relation between experience and language is being forged. Laurence Kirmayer argues that the metaphor" occupies an intermediate realm, linking narrative and bodily-given experience through imaginative constructions and enactments"[27]. By the study of metaphor one can highlight the way in which the body or rather embodiment is a source of meaning and not just an object to be signified. What Kirmayer pursues in his argument is to illustrate the relationship between the body and cultural narratives through metaphor and its origin that is both bodily and social. Narratives are more complex structures of experience that presume a meaningful temporal ordering of events. By the use of metaphors, individual or collective narratives are grounded both in bodily experience and in culture.

---

[24] Alasdair C. MacIntyre, *After Virtue: A Study in Moral Theory* (London: Duckworth, 1985), pp. 218-19.
[25] Paul Ricoeur, "Life in Quest of Narrative," in *On Paul Ricoeur. Narrative and Interpretation*, ed. David Wood (London and New York: Routledge, 1991).
[26] See Anthony Giddens, *Modernity and Self-Identity: Self and Society in the Late Modern Age* (Stanford: Stanford University Press, 1991).
[27] Laurence J. Kirmayer, "Healing and the Invention of Metaphor: The Effectiveness of Symbols Revisited", *Culture, Medicine and Psychiatry* 17, no. 2 (1993), p. 161.

Narratives are not built in isolation, by always involve the existence of a reader or of an audience, be it present or absent. Narrative analysis argues for a departure from a mere linguistic analysis of text, towards a consideration of its production circumstances as part of social interaction. Thus, we must ask ourselves not only what a story means, but also what it means to tell a story, as the act of storytelling is an integral part of the narrative. It is a matter of concern not only what is being told, but also how, where, when and to whom. Stories are not individual, but they are social, they are not constructed in isolation but always in a certain interaction and a certain socio-cultural context. Narratives are thus social acts.

Taking notice of this narrative turn, in medical anthropology there is a growing interest in illness narratives and in illness experience. Illness, as Laurence Kirmayer argues, is a disruption of both bodily and textual order[28], and thus it represents a unique opportunity to explore the ways the two intertwine. A series of researchers have argued that in illness, narrative (re)construction becomes compulsory because of its ability to construct both meaning and experience. Felt at first as an embodied individual experience, illness affects not only the individual but his/her entire social network. Thus illness narratives are not constructed in isolation but in interaction; they are performed and polyphonic, and they draw on different cultural resources to give meaning to lived experience. These narratives are not outside power relations that articulate themselves through the legitimating of certain stories and the silencing of others. Illness narrative mediate between the three levels of the body suggested by Nancy Scheper-Hughes and Margaret Lock[29], the individual phenomenological level, the socio-cultural level of symbols and cultural structures and the political level of power relations. Illness narratives, in as far as they not merely about the body, but embodiment represents their existential condition, can be seen as an instance of the concept of body praxis that the two authors put forward as a mediator between the analytic levels of the body.

The study of illness experience implies a focus on the biographical context of the ill person, on his/her perceptions of the illness, on the ways his/her existential condition as an embodied person has changed as a result of illness and the ways in which his/her identity has changed. From a theoretical perspective, the concept of narrative slowly became a central one in the study of illness, some other concepts like, for example that of identity are subordinated to it[30]. From a

[28] See Laurence J. Kirmayer, "The Body's Insistence on Meaning: Metaphor as Presentation and Representation in Illness Experience", *Medical Anthropology Quarterly* 6, no. 4 (1992).
[29] Vezi Margaret Lock, Nancy Scheper-Hughes, "A Critical-Interpretative Approach in Medical Anthropology: Rituals and Rutines of Discipline and Dissent", Nancy Scheper-Hughes, Margaret Lock, "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology."
[30] Lars-Christer Hydén, "Illness and Narrative," *Sociology of Health & Illness* 19, no. 1 (1997): p. 52.

methodological standpoint, by recognizing the situational factors that play an important role in the construction of narratives, there was a shift from a unitary concept of narrative to a focus on narratives[31] that are diverse in different interactional circumstances. Also, there has been recognition of the role played by the auditor or by the researcher in the production of these narratives that are not already out there waiting to be picked up, but are produced in the interaction between storyteller and listener.

4. Methodology

Considering the fact that the main objective of this research has been to illustrate how the three levels of the body put forward by Margaret Lock and Nancy Scheper-Huges[32] are constituted in a healing practice that is situated outside the official biomedical framework the research is based primarily on a series of semi-structured interviews with persons who resort to a healing practice that I encountered in the town of Cluj-Napoca. By using a semi-structured interview I tried to highlight the ways in which this practice is conceived by those who are actively involved in it, taking as a starting point the assumption that the interview method is the most appropriate for tracing the hermeneutic process of meaning creation in a certain socio-cultural context. I thus focused on the experiences that determined the search for a healing method situated outside the biomedical framework; on the experiences with a particular healing method; on the ways this healing practice influenced the lives and the world view of those who I´ve interviewed, but also their relations with others; and last but not least on the way they define illness and health.

For carrying out the interviews I decided to focus on a single healing practice that I encountered, with the help of a friend, in Cluj-Napoca. After gaining the practitioners permission to start the research, the selection of the participants in this study took place exclusively by approaching them directly in the "waiting room". The fieldwork took place between July 2011 and June 2012, and in this timeframe I conducted one recorded interview with the practitioner, as well as several unrecorded ones and semi-structured interviews with 21 persons (4 males and 17 females, with ages between 26 and 76 years old), who at the time of the interview were actively involved in the practice. Besides interviews I also used participant observation in the "waiting room" as a research method, and in a couple of cases, direct observation during consultations. This latter kind

[31] *Ibid*.
[32] See Nancy Scheper-Hughes, Margaret Lock, "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology", Margaret Lock, Nancy Scheper-Hughes, "A Critical-Interpretative Approach in Medical Anthropology: Rituals and Rutines of Discipline and Dissent".

of observation was possible at the bid of the practitioner, but without obtaining the consent of those who came in for consultation. This situation raised some questions regarding research ethics that determined me to focus mostly on the observation in the waiting room. A limitation of this present research is that it does not include the potential negative experiences with this healing practice that some persons might have had.

The main research method used was that of the semi-structured interview. The interview guide was conceived starting from the McGill interview guide for eliciting illness narratives[33] and from the interview guide used by Meredith McGuire in her study on healing practices in suburban America[34]. Taking these two as a point of departure, I conceived my own interview guide, focusing on the following issues: demographic information, the personal experience with an "alternative" healing practice, the illness explanatory model, conceptions of health and illness, the therapeutic relationship, the impact on the participants life of his/her participation in the healing practice. Before commencing the interview the participants were asked to read and sign an informed consent form that included a short presentation of the subject matter and purpose of the research, and the confidentiality of the "data" obtained during the interview, as well as the anonymity of the participants were guaranteed. In some instances, either before the interview, or after it, I was asked to give further details regarding the purpose of my study. The interviews were recorded with a digital recorder, and then transcribed. After transcription, the analysis was based mostly on identifying some common tropes and themes.

5. The narrative body and the construction of meaning

Before commencing this thematic analysis, in the fifth chapter of my thesis, by focusing on a couple of individual interviews, I illustrated the way meaning construction, as well as emplotment takes place in the narratives about the experiences with this healing practice. These commence during the interview in the interaction between the interviewer and the interviewee and they regard the organization of experience in a meaningful whole through emplotment. A narrative represents a way of meaningfully ordering of events in time by a narrator who, by having a retrospective gaze also has a reflexive distance that allows him/her to give the narrative a certain meaning and moral significance. In close connection with this process, the construction of the narrative identity of the

[33] Danielle Groleau, Allan Young, Laurence J. Kirmayer, "The Mcgill Illness Narrative Interview (Mini): An Interview Schedule to Elicit Meanings and Modes of Reasoning Related to Illness Experience," *Transcultural Psychiatry* 43, no. 4 (2006).
[34] Meredith B. McGuire, *Ritual Healing in Suburban America* (New Brunswick: Rutgers University Press, 1988), pp. 283-88.

storyteller takes place, but this process is not limited to the narrator, as it also includes the audience – either an active interlocutor, or a passive audience, that is involved in the process of emplotment. From this perspective, the research interview becomes a location for the creation of meaning, for what Jaber F. Gubrium and James A. Holstaein call "narrative work"[35]. The particularities of time and place that define the narrative event have an influence on the way emplotment takes place.

As I noticed earlier, the hermeneutical process of enplotment implies a reflexive distance that makes the meaningful ordering of experience possible. This distance is often in relation with the retrospective gaze involved in the narrative process, a gaze that determines a constant (re)signification of past events and experiences in the light of the present. This retrospective gaze of the narrator makes possible the integration of certain experiences, that at the time of their passing had a disrupting effect on the storytellers identity, into the narrative configuration, making them part of the narrative necessity. Both Paul Ricoeur and Jens Brockheimer argue that one of the central aspects of the plot is the way it transforms contingency into necessity by presenting the events from the perspective of how the story ends[36]. The teleological nature of life stories is in close connection with their moral dimension and the attempt to define "the good for man", as Mark Freeman and Jens Brockheimer argue[37]. Considering the moral-religious dimension of the healing practice that my interlocutors are involved in, in the analysis of the interviews I assessed the way "the good life" is defined at the level of the individual biography and its particularities.

The process of signification is in close connection with the temporal modalities of past – present – future within a narrative. Arthur Frank defines his three illness narrative types (the restitution narrative, the chaos narrative and the quest narrative) according to the ways in which this temporal ordering of events takes place, but also according to the ways these narratives address what he calls the issues of embodiment. From the five narratives that I analyzed in this chapter, four can be defined as quest narratives in which the experience of illness determines a reconfiguration of identity by taking on the illness. This, in the view of my interlocutors, presumes a changing of their life style that is regarded as a main cause of illness. The quest narrative is different from the other narrative types in that in it the illness is accepted and regarded as an occasion for a rediscovery of the self and a reorganization of meaning. It´s temporal structure opens towards a future of new

[35] Jaber F. Gubrium, James A. Holstein, *Analysing Narrative Reality* (SAGE, 2009).
[36] Paul Ricoeur, *Oneself as Another*, trans. Kathleen Blamey (Chicago & London: University of Chicago Press, 1992), p. 142.
[37] Mark Freeman, Jens Brockmeier, "Narrative Integrity. Autobiographical Identity and the Meaning of the "Good Life"", in *Narrative and Identity. Studies in Autobiography, Self and Culture*, ed. Jens Brockmeier and Donal Carbaugh (Amsterdam/Philadelphia: John Benjamins Publishing Company, 2001).

meaning, the illness representing a turning point in the life of the ill person that cannot forget what he/she has been through[38]. The narrative that does not fit into this pattern of the quest is broad terms a chaos narrative, in which the attempts to construct meaning are constantly frustrated by irruptions of disorder caused by a misfortune (the death of a child) more specifically than by an illness.

At the origin of the narrative process there is the illness experience. Much more than a pathology of the biological body, illness represent a disruption of the life world and has a deep impact on the embodied self. In analyzing the interviews I pursued the following aspects: how are the illness experience and the therapeutic process accounted for in the narrative process of meaning construction; how this process takes place and what is my role in it; what are the particularities of the narrative event and how are these narratives performed during the interview. The first interview is focused on an illness experience determined by the onset of cancer. My actual input in the form of question was very low in this interview as the interviewee recounted her experience with cancer and the healing practice of T. with very few interventions on my part. In the second interview my input was again very little, but in this case the narrative was focused on a misfortune that this person went through and that was correlated with different illness episodes. In this case the meaning construction process was a difficult one, as the life of my interviewee was laden with hardship. The third interview represents a story about a new beginning in the search for a way to deal with an undefined health problem. In this instance my input during the interview was more consistent than in the first two ones. The same can be said about the forth interview in which the narrative process is focused on the narrative reconstruction of identity in the light of a clearly stated life telos. The last interview is more of a narrative about an initiation as a practitioner, than about an illness experience, even though illness is positioned as a turning point. Through this analysis of individual interviews I aimed at showing how the three levels of the body intertwine at a micro level, and how this is profoundly marked by the biographical particularities of each interviewee.

6. **Healing through food: an embodied perspective on a therapeutic practice**

The last chapter of my thesis is intended for the presentation of a general view on the healing practice, through a thematic analysis of the ethnographic data. This analysis was focused on the three levels of the body established by Margaret Lock and Nancy Scheperd-Hughes. The healing practice I focused on takes place in the urban area, and most of the participants in this study live in the urban area.

[38] Arthur W. Frank, *The Wounded Storyteller. Body, Illness and Ethics*.

The state regulations concerning different healing practices determine the retrieval of many of them in different surgeries that offer "alternative medicine". Most such practices suppose the acquirement of a practice certificate after a course had been completed. The healing practice that I focused on is characterized by an irregular spatial arrangement, as the practitioner comes to the town where I conducted my fieldwork, every sixth week, and the place he uses for consultations can vary from one visit to another. These aspects concerning the spatial arrangement and what goes on at an interactional level in these spaces were closer analyzed in the second section of this chapter. In that section I focused on "the waiting room" and the observations I made in this space. Another particular characteristic of this healing practice concerns the way the practitioner (mister T.) conceives the knowledge transmission process and presents the story of his own initiation and also concerns the way he conceives the diagnosis and treatment methods he uses, and his conceptions of the body, illness and healing. His approach to healing and his conceptions about health and illness, and about individual responsibility in the process of regaining one´s own health, have both an experiential and a theoretical dimension. The experiential dimension refers to his own experiences of illness and healing that are presented as the impetus, or as the starting point in the process of his formation as a therapist. This process of becoming a therapist is presented as an initiation rite that is based especially on an illness experience and on self-healing. As for the theoretical dimension one can speak about a worldview in which illness and health are regarded in relation with other notions, like religion and nation. At the same time, his practice is presented as the result of an eclectic combination of diagnosis and treatment methods. Thus, this healing practice is constituted around the diagnosis method of iridology – the reading of the iris, where the iris becomes a location for defining the state of health or illness of the individual. The diagnosis is not focused on the identification of a disease – in the sense of discreet categories of physical pathology that manifest themselves in similar ways in different individuals, but it is focused on constructing an individual profile of the ill person including physical aspects – in terms of affected organs or body parts, and also personality features, genetic background and spiritual aspects. Health problems are defined as a result of the accumulation of toxins in time, due to a life style that is considered unhealthy and whose change becomes an imperative in order for the evolution of the health problems to be halted and for the toxins to be eliminated in a reverse process of purification. This purification – "*a clean living*", implies a spiritual dimension as well as one related to food intake. Mr. T. defines his practice in medical-religious terms and uses as a main therapeutic method, what he calls "food therapy". This is based on a list of allowed and forbidden foodstuffs, and on the construction of a

new way of eating considered in relation to a temporal organization based on the orthodox calendar. Moreover the healing practice is presented as a practice that is characteristic of the Romanian cultural space defined by the Christian-orthodox religion and nationalism.

After presenting the perspective of the therapist, in the remainder of the chapter I focused on the experiences of my interviewees with this healing practice. In this analysis I took, as a starting point, the illness experience, and I considered it from a phenomenological perspective. In most cases, an illness experience, either one's own or of someone close was the impetus for the search of a healing practice situated outside the biomedical framework. Drew Leder argues that in suffering the body dys-appears, namely it is perceived as an obstacle, as distinct from the true self and as frustrating the intentionality of this self and its involvement in the world[39]. In other words, the readiness to involve in the world is disrupted by pain or illness, as they "bother you", in the words of one interviewee, transforming the ailing body into an obstacle between self and the world. The possibilities of engagement in the world, that before illness were taken for granted, are now restricted. In the accounts of the participants in my study, illness appears as something that disrupts their whole existence, and also the one of their closest relatives and friends. To describe this disruption they most often use the metaphor of the "fall". The disruption of the life world in some instances is not determined only by illness but other biographical evens can determine a rupture that has an impact on the modalities of individual embodiment. One such example can be found in Ana's story: after the death of her son in an accident her whole world plunged into chaos.

Confronted with this disruption of the life world determined by health problems the individual tries to find an answer regarding their meaning but also regarding the course of action necessary for restoring health. In the search for this understanding the individual affected by illness or pain appeals to the available cultural resources that help him/her in interpreting his/her phenomenological state in a certain way. This search for meaning is not restricted to the afflicted individual but it also includes the members of his/her social network. The interpretations are based on culturally salient knowledge and also on the former experiences of the individual and of the social network. The hermeneutic moment, as Leder calls it, continues with the recourse of the afflicted person to those who, in a certain society, are considered certified in interpreting the sings of bodily distress. Most of the participant in my study, in their search for a diagnosis, turned to the biomedical framework, but often this had proven as problematical. The search for a diagnosis and the impossibility of finding one in the biomedical framework was often invoked by the interviewees

[39] Drew Leder, *The Absent Body*, p. 73.

as the reason they turned to "alternative" methods. The main way that information about this particular healing practice is transmitted is through the social network in which several stories about positive healing experiences are circulating.

As for the diagnosis procedure, through the reading of the iris, this is often presented by the participants in relation to the way the consultation and diagnosis takes place in the biomedical setting. Regarding the diagnosis process, Meredith McGuire argues that this is always transformative, as "the signs or biophysical expressions are transformed into symptoms – socially intelligible markers of a category of illness"[40]. In this process some signs are ignored in the detriment of others that are used for constituting the diagnostic[41]. The diagnosis is appreciated as a good one by the persons who go to this healer if what he reads in their iris corresponds to a certain degree with what each knows about his/her own body and the problems he/she has. What takes place is the construction of an individualized profile of the ill person. After identifying some organs or body parts that are in the present affected, the diagnosis also implies the layout of a direction of further evolution of these affections. By relating the health problems of the individual with those that run in the family, or by postulating a relationship between psychological and spiritual aspects and health problems, in this healing practice, the signs that the practitioner reads in the iris, as indicating a present problem or a predisposition towards illness, are situated in a frame of reference that includes the personal, as well as the social and cultural.

After the diagnosis, the treatment prescribed by mister T. implies a change in the eating habits based in a first instance on the banning of all foodstuffs of animal origin – meat, milk and dairy, eggs – of salt and sugar, of all processed foodstuffs, of coffee, alcohol, tobacco and of some vegetables and fruits. Changing the eating habits is perceived as the main means through which healing and preventing illnesses takes place. The main idea that lies at the basis for this change is that the previous eating habits led to the accumulation of toxins in the body and these led to illness, or, if the eating habits are not changed, will lead to illness. In order to be healed or to avoid falling ill, the foodstuffs that determine this accumulation of toxins must be eliminated from diet, and a new way of eating must be pursued, as the healer recommends. The purpose of this change in diet is the purification or cleansing of the body that implies a reversed process of healing in which older illnesses are relived in a lighter fashion as they mark the evolution of the body in the process of detoxification. This care for the body and what goes into it is related to the awareness my interlocutors have of different discourses that underline the importance of food in the healing

[40] Meredith McGuire, *Ritual Healing in Suburban America*, p. 34.
[41] *Ibid*.

process or in maintaining one´s health, and also of a series of discourse the determine an insecurity regarding processed foodstuffs and the effects of certain substances (food additives, Es) on the body.

From a phenomenological perspective, eating in a sensory experience that engages first of all taste, but also the other senses. Moreover, eating is an essential act for the survival of man, and thus for his engagement in the world. Changing their eating habits and applying the indications of the healer is felt by most of my interviewees as a sensory provocation. I used Pierre Bourdieu´s concept of taste to analyze the ways in which following the diet prescribed by the healer implies the changing of the gustative habitus. This change is made in the name of health and is related to defining certain foodstuffs as unhealthy and regarding them as having negative effects on the body, and it includes both the abnegation of certain foodstuffs and the introduction of others in their diet. From a phenomenological standpoint this change also implies a constant management of the sensation of hunger. Considering that the diet prescribed by mister T. does not imply quantitative limitations[42], hunger is often correlated in the accounts of my interlocutors with feeling the need to eat certain foodstuffs. Whereas those who have just started the diet feel hunger as a challenge, those who are on the diet for a longer period of time, no longer feel hunger as a problem. In time the control exercised on hunger and food cravings is internalized and transformed in disgust.

The effects and the efficiency of the diet are felt by my interlocutors at the level of embodied experience as changes that affect their modalities of embodiment. After changing their diet, a series of bodily changes are felt and perceived as allowing an opening towards the world that in illness was missing. Some describe the disappearance of the symptoms of illness, but also an increased vitality that allows the individual to engage in the world in new ways. At the same time the healer asks about the bodily signs and symptoms at each visit and the ill persons are required to carefully notice their evolution from one visit to the other. These signs are interpreted as what the healer calls "healing crisis" that marks a reversed evolution of the body to an earlier state of purity. Even if they are felt as negative, resembling illness, their meaning is a positive one indicating the course of healing and of purification.

Anthropology regards food and foodstuffs not only as "raw material" for the body, but also for thought through its symbolism. The act of eating, of incorporating food is a complex socio-cultural act that implies a whole system of symbols. Changing the eating habits that this healing practice presupposes has at its basis the main distinction between two categories of foodstuffs: forbidden and allowed. This distinction conceptually overlaps the one between unhealthy and

[42] The diet is mainly based on the qualitative distinction between allowed and forbidden foodstuffs and the quantity of food that is to be consumed is not an object of regulation.

healthy. In the accounts of my interlocutors there is a representation of food, especially of processed food as a pathogen that can lead to illness caused by the accumulation of toxins. A way of dealing with the anxieties determined by this representation, especially regarding the chemical substances that food can contain, is the distinction between processed and natural foodstuffs. The distinction between healthy and unhealthy foodstuffs positions certain foodstuffs as having a healing potential, and others as having a harmful one. Deborah Lupton argues that an effect of considering certain foodstuffs as pathogenic is the construction of others as medicine and thus the opening of a conceptual space for "functional foodstuffs"[43]. These foodstuffs are considered not only much healthier than others, but as also having a healing potential. Moreover raw food is (re)signified as "living food" that incorporates the essence of being. Because it is living just as our body, it is conceived as having the potential to transfer this prosperity of "living" to the body and thus to keep it healthy or to heal it. In antithesis to living food is dead food, whose prime materialization is meat.

Eating is a deeply social act that in some way always involves the others: "eating is at the basis of social relations; during meal time we create the family and friends through the sharing of food, tastes, values and ourselves"[44]. Considering the role food has in the construction of both personal and collective identity, a part of the interview for this study focused on the way in which changing one´s diet and adopting the diet prescribed by mister T. influenced the relations my interlocutors had with others, from family and friends to the larger communities they were a part of. The reactions of family members range from rejection to acceptance and even to changing their diet. In the family, the preparation of food is closely related to gender roles and to the power relations they imply. In many cases, for my female interlocutors, changing one´s diet involved a double burden of cooking. Outside the family, the reactions of others regarding the different way of eating of my interlocutors are described as emerging especially in different social contexts in which food plays a part. Such contexts are either special occasions – birthdays, weddings, christenings, funerals – or in day to day life during mealtime at the office or during visits or going out with friends. In such cases my interlocutors either request a special menu, thus having to explain their food choice to others, or at times they are bound to concede and eat foodstuffs that are forbidden.

The conceptions about food are closely related to those about the body, illness and health. Through the study of metaphor one can highlight the ways in which the body or rather embodiment is an active source of meaning and not just an object that is given meaning to. Through metaphor a

[43] Deborah Lupton, *Food, the Body and the Self*, (London, Thousand Oaks, New Delhi: Sage Publications, 1996).
[44] Carole M. Counihan, *The Anthrolopology of Food and Body. Gender, Meaning and Power* (New York, London: Routledge, 1999), p. 6.

(re)signification process takes place in the quest of the individual to understand his/her own experience. But this process does not take place outside cultural structures, but on the contrary it is deeply influenced by them. The individual appears as a *bricoleur* who "thinks with things to create an order based on the logic of the concrete"[45]. Amongst the metaphors encountered in the accounts of my interlocutors one can notice the mechanist metaphor of the body-machine, and also the computer metaphor that illustrates an informational logic in the conception of the body. In most instances the mechanist metaphor is regarded as an erroneous way of conceiving the body that is specific to a medicine that resembles an assembly line. The critique of the body-machine metaphor opens up a conceptual space that allows for a (re)signification of corporeality that highlights certain abilities of the body that make it different from a machine. Thus the body is unlike a machine because it has a self-healing power that is a proof of an intelligence of the body. The body has a kind of intelligence that certifies that it is a divine creation. Another way of conceptualizing the body is with the use of a concept of energy. "To have energy" is presented as an essential quality of life. But, at the same time, energy can also be a cause of disease in the form of a negative principle – "negative energy". Energy is conceived as having these two sides and sometimes even the theological principles are presented in energetic terms. The energy metaphor is used by tying it to an experiential base where having energy is felt as a good thing, as a state of wellbeing of the embodied individual who is thus capable of orienting itself towards the world and of acting in it. The conceptions of health that I encountered in the accounts of those interviewed also have as a starting point a critique of the mechanist metaphor and assumes more defining aspects in the conception of health than the "physical body" – usually psychological and spiritual aspects. There is also a re-conceptualization of illness in terms of the possibility of its materialization from the ambit of the mind – negative thinking patterns or emotional states, in the "physical body". Stuart McClean, in his study in a spiritual healing center, notes that what happens through the consideration of negative emotions or thoughts as a cause of illness is that illness is regarded as part of the person and not just as something that affects him/her[46]. Another widespread conception in the accounts of my interviewees is that of illness as a result of sin that implies a re-signification of illness and etiology in religious and moral terms.

Starting from these conceptions of the body, health and illness, in the accounts of my interlocutors there is a distinction between what they call "allopathist" or "classical" medicine and

[45] Laurence J. Kirmayer, "Healing and the Invention of Metaphor: The Effectiveness of Symbols Revisited", p. 170.
[46] Stuart McClean, "'The Illness Is Part of the Person': Discourses of Blame, Individual Responsibility and Individuation at a Centre for Spiritual Healing in the North of England," *Sociology of Health & Illness* 27, no. 5 (2005), p. 636.

"alternative" medicine. This distinction implies an allopathist medicine that is more aggressive, treats only the effects of illness and not its causes and often uses medicines that have harmful side effects, and "a different kind of medicine", more gentle, natural, and that can identify and treat the cause of illness, not only its effects. However, biomedicine is not fully rejected, from the interviews I can conclude that all my interlocutor either at some point used the services of biomedicine either they still do – for diagnosis or treatment.

In the last part of the chapter I focused on the body politic and thus I pursued the modalities in which power relations are constituted in this healing practice, highlighting the following aspects: who is responsible for health and what is the relation between the way knowledge is produced in this practice and this responsibility; the therapeutic relationship and the ways power is distributed in this relationship; the domains of surveillance that are articulated in this healing practice, taking notice especially of the spiritual and food dimensions and the ways they are related. In all the accounts, illness, whether an experience that the person went through, or something that must be prevented, is seen as the result of a certain life style for which the individual is held responsible. Changing this lifestyle becomes the only option for these persons to construct themselves as moral agents that do everything they should for their health, but also for the wellbeing of those around them. The new lifestyle that the healing practice implies has two important dimensions: a spiritual one and a food related one. Both are regarded as equally important, and in most cases the spiritual aspects of life were considered as important even before becoming involved in this practice. In the accounts they told me, an outsider, this change of lifestyle is integrated in a narrative structure as follows: illness, as a disruption of the life-world, or perceived as having a disruptive potential (in the case of those who attend the practice mostly for preventive reasons) is the plot that was at the basis of the quest for a therapeutic method; the visit to T. and the decision to follow the diet are presented in the narratives as another turning point, that leads to a break in the temporal flow of events. Confronted with illness, or with its possibility, changing the lifestyle that led, or could lead to it becomes a moral imperative. By this choice, the fact that they used to have a lifestyle defined as unhealthy and therefore immoral is redeemed, and this includes the promise of a future without illness. This lifestyle change is regarded as an individual choice, that everybody has the possibility to make and that constitutes the person who makes it as responsible and good from a moral standpoint. In a culture that is more and more preoccupied with health and the messages regarding the preventive measures that each individual should take are increasingly common, I argue that my interlocutors are conforming to a cultural imperative that positions health as an essential value for the individual.

But, although at a first glance the responsibility for one´s health is considered to belong just to the individual, there is to be found also a conception of this responsibility as related to the existence of a superior divine will that can influence the state of health of a person.

Furthermore, the way the role of the healer is conceived in the healing process contributes to considering the individual as the most responsible for his/her own health. Due to considering the healing capacity of the body as an intrinsic characteristic, the role of the healer becomes that of an "intermediate", who, by using his specialized knowledge, can guide the ill person on the way back to health. The individual must take an active part in this process. Many of my interviewees perceive the role that T. plays in their life as much more than that of a doctor because the advice that he gives during consultations are aimed at various aspects of one´s life. The therapeutic relationship is perceived by some as more egalitarian because during the consultation many aspects of personal life are discussed and the advice that T. offers concerns not only the way the body works, but also spiritual life. Moreover, because for each consultation the ill person must keep track of the things that happened since the last visit, my interlocutors feel that they have a more active role in the healing process. Nonetheless some perceive the therapeutic relationship as a power relationship, as a dependency on the expert knowledge of the healer is created. This dependency is accentuated by the fact that in the way this healer presents his practice it cannot be encountered anywhere else.

In the last part of the chapter I focused on the ways in which the domains of surveillance are constructed in this practice, taking into account the spiritual and the food dimension of the practice and the ways in which they are related. These domains of surveillance concern what Michel Foucault calls the anatomo-politics of the individual body and this refers to the ways in which the individual bodies are disciplined and transformed into docile bodies that can be "subdued, used, transformed and enhanced"[47]. In this healing practice, the domains of surveillance are constituted in relation with, on the one hand, food – what goes into the body, and on the other hand, spiritual life. These two, both in the healer´s perspective and in that of my interlocutors are not distinct, but closely related. Quite often the concept of diet is overlapping that of fast in the accounts I heard, but even more so in the conception of the healer. A couple of researchers have noted the fact that in western societies between the science of nutrition and religious ascetism there are several conceptual links. The purification of the body and spiritual purification are conceived by most of those I interviewed as a function of the diet perceived as a form of fasting. Bryan Turner argues that what the concept of medical regimen and that of religious ascetism have in common is the notion of

[47] Michel Foucault, *A supraveghea şi a pedepsi*, trans. Bogdan Ghiu (Piteşti: Paralela 45, 2005), p. 175.

program, namely the establishment of some rules according to which the disciplining of the body takes place through what goes inside it – "from an empirical stand point, both focus on diet and imply a governing of food"[48]. But what distinguishes one from the other is that along with the development of the science of nutrition, the diet was conceived starting from a mechanist model of the body that implies the possibility of calculating "the necessities of input and output that can be mathematically quantifiable"[49]. In the conception of my interlocutors, changing their eating habits supposes a constant monitoring of what goes into the body, as they are careful to consume only those foodstuffs that are on the list of those allowed. Being on the diet is perceived as an act of will or as a result of ambition most of the time presented as a conscientious effort of abstinence. This control exercised over food cravings implies for many of the interviewees some transgressions that are perceived as having an important role in keeping the cravings under control. Bryan Turner and Deborah Lupton argue that western modern societies are characterized by an asceticism/consumption dialectic. In her study, Lupton notices that there is an oscillation between control and release presented in the following way: it is important to exercise discipline in order to be healthy and attractive, but at the same time it is necessary to be able to enjoy life, and even to eat "bad" food[50]. The necessity of control conveys a logic of asceticism while the necessity to enjoy life conveys a logic of consumption. In the accounts of my interlocutors there are two forms of this dialectic. First of all there is the fear of transforming the care for what they eat into an obsession, thus they say, food is only an aspect of life, not necessary the most important one, and the fact that they exercise a strict control in its regard, does not avert them from enjoying life in other ways. Moreover, this control/release dialectic implies in many instances a concession in favor of the craving. Through these practices of self-surveillance and self-control – that imply will, but also motivation and a control over food cravings that sometimes can imply a concession to them – what takes place is the construction of an identity of "good eaters, in the sense that the individual choices regarding food good from a scientific perspective and therefore right from a moral one"[51]. Moreover, this control exercised over the body can be a source of empowerment.

[48] Bryan S. Turner, *Regulating Bodies. Essays in Medical Sociology* (New York & London: Routledge, 1992), p. 178.
[49] *Ibid*., p. 182.
[50] Deborah Lupton, *Food, the Body and the Self*, p. 148.
[51] J. Coveney, "The Science and Spirituality of Nutrition," *Critical Public Health* 9, no. 1 (1999): p. 36.

7. Conclusions

Considering that contemporary society is more and more preoccupied towards the body and the possibilities of its re-creation through different technologies or through self-control and self-discipline, the spread of "alternative" or "complementary" medical practices must be considered from this perspective of the increased concern towards the body as an identity project. Chris Shilling argues that, in consumer culture, the body becomes a reflexive project par excellence and people must work for its realization[52]. Moreover, in contemporary society, this body project is reflexive and individualized and it implies choices made by the individual from the available cultural resources. Part of this project is not only the body form, size, or appearance, but also its interior that can be modified by different "technologies of the self"[53] that involve self-regulation. In contemporary society the preoccupation with the body is also one that concerns its health not only its appearance.

One limitation of the present research is that it focused on a single healing practice. Thus it is impossible to draw some general conclusions regarding the phenomenon of "alternative medicine" in general. A further line of research would concern the analysis of several such practices from a comparative perspective so that a series of general characteristics could be highlighted regarding the ways several aspects of the body are (re)constructed in these healing practices in the geographical space of Romania. An anthropological approach of "alternative medicine", especially a narrative one, that focuses mainly on experience and on the meaning making process is useful because of its focus on the perspective of the ill person and because it highlights the hermeneutic process from a micro level of understanding.

[52] Chris Shilling, *The Body and Social Theory* (London: Sage Publications, 1993).
[53] Michel Foucault, *The History of Sexuality: The Use of Pleasure*, trans., Robert Hurley, vol. 2 (New York: Vintage Books, 1990), pp. 10-11.

Selected References

1. Breton, David le (2002), *Antropologia corpului şi modernitatea*. Translated by Doina Lica. Bucureşti: Amacord.
2. Counihan, Carole M. (1999), *The Anthrolopology of Food and Body. Gender, Meaning and Power*. New York, London: Routledge.
3. Coveney, J. (1999), "The Science and Spirituality of Nutrition." *Critical Public Health* 9, no. 1:23-37.
4. Cregan, Kate (2006), *The Soc iology of the Body. Mapping the Abstraction of Embodiment*. London: Sage Publications, 2006.
5. Csordas, Thomas J. (1994), "Introduction: The Body as Representation and Being in the World", in *Embodiment and Experience. The Existential Ground of Culture and Self*, edited by Thomas J. Csordas. London: Cambridge University Press.
6. Douglas, Mary (2005), *Natural Symbols. Explorations in Cosmology*. 4 ed. New York & London: Routledge.
7. Douglas, Mary (2001), *Purity and Danger*. 3 ed. New York & London: Routledge.
8. Drăgan, Simona, Jesper Odde Madsen. "CAM in Romania - a Brief Overview." http://www.cambrella.eu/home.php?il=150&suchhigh=romania&l=deu, viewed 23.07.2011.
9. Foucault, Michel (2005), *A supraveghea şi a pedepsi*. Translated by Bogdan Ghiu. Piteşti: Paralela 45.
10. Foucault, Michel (1997), *Society Must Be Defended*, (trad.) David Macey, New York: Picador.
11. Frank, Arthur W. (2010), *Letting Stories Breathe. A Socio-Narratology*. Chicago and London: The University of Chicago Press.
12. Frank, Arthur W. (1995), *The Wounded Storyteller. Body, Illness and Ethics*. Chicago & London: The University of Chicago Press.
13. Freeman, Mark, Jens Brockmeier (2001), "Narrative Integrity. Autobiographical Identity and the Meaning of the "Good Life"", in *Narrative and Identity. Studies in Autobiography, Self and Culture*, edited by Jens Brockmeier, Donal Carbaugh, pp. 75-99. Amsterdam/Philadelphia: John Benjamins Publishing Company.
14. Giddens, Anthony (1991), *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Stanford: Stanford University Press.

15. Groleau, Danielle, Allan Young, Laurence J. Kirmayer (2006), "The Mcgill Illness Narrative Interview (Mini): An Interview Schedule to Elicit Meanings and Modes of Reasoning Related to Illness Experience", in *Transcultural Psychiatry* 43, no. 4: 671-91.
16. Grosz, Elizabeth (2008), "Refiguring Bodies", in *The Body: A Reader*, edited by Mariam Fraser, Monica Greco, New York & London: Routledge, 2008.
17. Gubrium, Jaber F., James A. Holstein (2009), *Analysing Narrative Reality*: SAGE.
18. Hydén, Lars-Christer (1997), "Illness and Narrative", in *Sociology of Health & Illness* 19, no. 1:48-69.
19. Hydén, Lars-Christer (2008), "Narratives in Illness: A Methodological Note", in *Qualitative Sociology Review* IV, no. 3: 49-58.
20. Kirmayer, Laurence J. (1992), "The Body's Insistence on Meaning: Metaphor as Presentation and Representation in Illness Experience", in *Medical Anthropology Quarterly* 6, no. 4: 323-46.
21. Kirmayer, Laurence J. (1993), "Healing and the Invention of Metaphor: The Effectiveness of Symbols Revisited", *Culture, Medicine and Psychiatry* 17, no. 2: 161-95.
22. Leder, Drew (1990), *The Absent Body*. Chicago, London: The University of Chicago Press.
23. Lock, Margaret, Nancy Scheper-Hughes (1996), "A Critical-Interpretative Approach in Medical Anthropology: Rituals and Rutines of Discipline and Dissent", in *Medical Anthropology. Contemporary Theory and Method*, edited by Carolyn F. Sargent, Thomas M. Jonshon, 41-70. Westport, Conneticut, London: Praeger.
24. Lupton, Deborah (1996), *Food, the Body and the Self*, London, Thousand Oaks, New Delhi: Sage Publications.
25. MacIntyre, Alasdair C. (1985), *After Virtue : A Study in Moral Theory*. London: Duckworth.
26. Mauss, Marcel (2008), "Techniques of the Body", in *The Body: A Reader*, edited by Monica Greco, Mariam Fraser, 73-77. New York & London: Routledge.
27. McClean, Stuart (2005), "'The Illness Is Part of the Person': Discourses of Blame, Individual Responsibility and Individuation at a Centre for Spiritual Healing in the North of England." *Sociology of Health & Illness* 27, no. 5: 628-48.
28. McGuire, Meredith B. (1988), *Ritual Healing in Suburban America*. New Brunswick: Rutgers University Press.
29. Merleau-Ponty, Maurice (1999), *Fenomenologia percepţiei*. Translated by Ilies Campeanu and Georgiana Vatajelu, Oradea: Aion.

30. Mol, Annemarie, Marc Berg (1998), "Differences in Medicine: An Introduction " In *Differences in Medicine*, edited by Marc Berg, Annemarie Mol, 1-12. Durnham and London: Duke University Press.
31. Punday, Daniel (2003), *Narrative Bodies : Toward a Corporeal Narratology*: Palgrave McMillan.
32. Ricoeur, Paul (1991), "Life in Quest of Narrative", in *On Paul Ricoeur. Narrative and Interpretation*, edited by David Wood, 20-33. London and New York: Routledge.
33. Ricoeur, Paul (1992), *Oneself as Another*. Translated by Kathleen Blamey. Chicago & London: University of Chicago Press.
34. Scheper-Hughes, Nancy, Margaret Lock (1987), "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology", in *Medical Anthropology Quarterly* 1, no. 1: 6-41.
35. Shilling, Chris (1993), *The Body and Social Theory*, London: Sage Publications.
36. Shilling, Chris (2005), *The Body in Culture, Technology and Society: Classical Debates & Current Issues*. London: Sage Publications.
37. Turner, Bryan S. (1992), *Regulating Bodies. Essays in Medical Sociology*. New York & London: Routledge.