Derivative benefits: exploring the body through complementary and alternative medicine

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Abstract
Since the 1960s, in Western societies, there has been a striking growth of consumer interest in complementary or alternative medicine (CAM). In order to make this increased popularity intelligible this paper challenges stereotypical images of users’ motives and the results of clinical studies of CAM by exploring bodily experiences of acupuncture, reflexology treatments, and mindfulness training. The study draws on 138 in-depth interviews with 46 clients, client diaries and observations of 92 clinical treatments in order to identify bodily experiences of health and care: experiences that are contested between forces of mastery, control and resistance. We discuss why clients continue to use CAM even when the treatments do not help or even after they have been relieved of their physiological or mental problems. The encounter between the client and CAM produces derivative benefits such as a fresh and sustained sense of bodily responsibility that induces new health practices.

Keywords: agency, CAM, health practices, responsibility, sociology of the body

Introduction
Since the 1960s, in Western societies, there has been a striking growth of consumer interest in complementary and alternative medicine (CAM), and an increased focus on a variety of therapies such as reflexology, acupuncture, meditation, aromatherapy, osteopathy and healing. Based on a random sample of 14,566 Danish citizens aged 16 years or above, the most recent (2005) representative national Health Interview Survey in Denmark estimates that 45.2 per cent respondents have drawn on the services of alternative practitioners, 22.5 per cent within the preceding year, compared to 10.0 per cent in 1987 (Ekholm and Kjoller 2007). This tendency also seems to be reflected in research results, for example in other Scandinavian countries, the UK, the USA and Canada (Hansen et al. 2005, Tindle et al. 2005, Ni et al. 2002, Eisenberger et al. 1998, Astin 1998, Zollman and Vickers 1999, Ernst 2000, Saks 2001, Thomas et al. 2001, Wiles and Rosenberg 2001). How can we explain this increase in the use of CAM?

Clients’ use of CAM has often been linked to notions of rehabilitation and the minimising of risk and pain (i.e. Ahn and Kaptchuk 2005, Arman and Rehnsfeldt 2003, Baer 2003). The reasons why clients choose to pursue alternative medical practices seem, however, to be more complex. A review of the literature by Boon et al. (1999) indicates that the motives for choosing alternative medicine fall into two main categories: clients have had bad experiences with conventional medicine, or they are attracted to alternative therapies due to a
general belief in the alternative paradigm. In several sociological studies, the increased popularity of CAM has been explained in terms of disenchantment with conventional health care systems that are based on impersonal practices, and the failure of such systems to cure chronic illness and disability (for example, Foote-Ardah 2004). There is, however, some evidence to suggest that users of alternative medicine also make more use of conventional medicine than those who have never used alternative therapies (Ekholm and Kjøller 2007, Ni et al. 2002, Druss and Rosenheck 1999, Astin 1998:1551). Cant and Sharma (1999) discuss the growing popularity of CAM as a new medical pluralism and Sharma (1992:47–53) has described an ‘eclectic’ or ‘consumerist’ attitude to health care among users who mix different forms of treatment. Fadlon (2004) has pointed out that CAM users’ dual use of both systems, CAM and conventional biomedicine, is not perceived as an esoteric choice. Several modalities of CAM have undergone a process of legitimation and she argues that a ‘domestication’ of CAM is now following a pluralistic phase. This is an integration which abolishes many of the original differences between CAM and biomedicine (2004:70–72). However, more knowledge about the specific health strategies of CAM users is needed. The present study seeks to address this need.

The use of CAM as part of individual health strategies has been qualitatively explored in socio-cultural research (Sharma 1992, Boon et al. 1999, Lee-Treweek 2001, Foote-Ardah 2004, Testerman et al. 2004, Sointu 2006), and this research has emphasised that the use of CAM represents a health strategy through which individuals struggle to gain control over their situation. For users, the ‘effect’ of the treatments may be just as important as their reflexive health strategies and self-reported motives for seeking out alternative therapies. Ong and Banks (2003) have in summarising British studies found that CAM is typically used for long-standing illnesses and in conditions recognised as benefiting poorly from conventional treatments, such as musculo-skeletal problems, injuries, bowel problems, indigestion, stress, anxiety, depression, migraine, asthma. However, the way in which CAM users explore the body through alternative therapies, and the meaning they ascribe to this experience, remain to be further explored. This article therefore aims to contribute to and modify the general image of users’ motives and to add to the results of conventional clinical tests through further empirical elaboration and specification of the bodily sensations that CAM users ascribe to the specific treatments.

On the basis of a qualitative study, we examine the various dimensions of clients’ bodily experiences of acupuncture, reflexology or mindfulness meditation in relation to processes of treatment. We focus on the positive benefits described by clients and on the bodily experiences and explorations that they report, including their conceptualisation of bodily sensations. However, we also take our analysis of clients’ use of CAM a step further by investigating their reasons for continuing CAM treatments even when these fail to relieve their symptoms or even after such symptoms have been relieved. In this sense the article is intended to throw new light on the increased popularity of CAM.

One reason for clients’ continued use of CAM seems to be that it enhances bodily awareness. Offering a phenomenological analysis of the way in which individuals experience alternative therapies, we argue that CAM per se profoundly disrupts modes of bodily ‘disappearance’. We also suggest that this disruption results from societal inscriptions upon the body, and examine the role of bodily experience in contemporary health practices. The attempt by CAM clients to maintain and increase their wellbeing while simultaneously contesting their own bodies represents an act of responsibility. In the discussion, our analyses are informed by current debates surrounding individual responsibility for health, and we have attempted to trace the tension in the relationship between the active body (Merleau-Ponty's body-subject) and the regulated body (Foucault's body-power) in the different forms of alternative therapies.
Methods

In Denmark CAM treatments are not officially recognised as legitimate forms of medical treatment. CAM as defined in this study thus involves health care practices that lie outside the officially subsidised health care services. We define CAM as therapies that go beyond the treatments offered by the state-financed health system and as such are not under the control of the Danish National Health Board. Thus the clients who participated in this study used alternative therapies at their own expense.

The study is based primarily on qualitative methods, including in-depth interviews, observations and client diaries. It was carried out in 2006–07 in the Copenhagen area, Denmark, and was approved by the research ethics committee of the municipality. Participants were recruited through collaboration with alternative practitioners, and the sample was strategic, in so far as practitioners were asked to recruit interviewees among clients whom they expected to be able to treat successfully. Furthermore, clients were selected with a view to ensuring as broad a range as possible with regard to motives for seeking alternative therapy, age, gender, and social and educational background. Since the study was designed to show variation, we chose three different kinds of alternative therapies: reflexology, acupuncture and meditation (mindfulness training), all of which are among the most prevalent in Denmark. Clients who had attended CAM treatments within the last year were excluded in order to ensure that participants’ reported experiences were connected to the specific treatment. These sampling strategies were intended to access a wide spectrum of clients’ experiences of ‘effects’ in terms of the bodily experiences and sensations that arose from their participation in a specific CAM treatment.

Each client was interviewed three times during the course of treatment. Interviews varied from 20 to 90 minutes and were conducted in the clinics immediately after the second, fourth and sixth treatments. A few of the interviews were conducted in the clients’ homes. Interviews were supplemented with observations of the second and fourth treatments. Moreover, clients were asked to write diaries in between treatments, and during the second interview they filled in a brief questionnaire on age, family, education, job, and motives for seeking alternative therapy. A total of 46 clients were interviewed (15 acupuncture clients, 15 reflexology clients and 16 mindfulness meditation participants), 138 interviews were conducted, and 92 observations were made of clinical treatments. This article builds mainly on the in-depth interviews.

The participants ranged in age from 22 to 81. Thirty-two of the 46 participants were women (69%). The participants’ characteristics in terms of age, gender and education correspond closely to those of participants in the Danish National Health Survey’s population (2005) who stated that they had used alternative medicine within the preceding year. Women, people aged 25–64, and those with an education just below university level predominated among the recent CAM users identified in the survey population (Ekholm and Kjøller 2007). This pattern is also reflected in the present study of reflexology, acupuncture, and mindfulness-training clients.

The interviews were conducted using a semi-structured interview guide that focused on bodily experiences (Gendlin 1997) relating to the specific treatment or to the treatment course in general. The interviewee was asked to choose a situation or event in the treatment that was particularly memorable. The interview continued by giving the interviewee the opportunity to speak freely about his/her thoughts, emotions, bodily sensations and specific reflections relating to these situations.

All interviews were tape recorded and transcribed verbatim on the basis of a transcription guideline. We used NVivo qualitative software to manage data, and the transcribed
interviews were coded into broad categories deriving from themes in the interview guide such as ‘motives’. We then identified sub-themes within these categories, such as ‘meaningless pain’ and ‘meaningful pain’, without determining any fixed coding themes beforehand within the broad categories. According to Berg (2001:251), the main aim of open coding is to ‘open inquiry widely’ with the aim of identifying themes that are important to the further analysis. Thus interview segments within the broad categories from the interview guide were coded with descriptive phrases or words, including ‘in vivo’ terms. In a second step, all quotations within each coding were bundled together thematically and collected in a matrix. This enabled us to generate more generalised thematic areas (Strauss and Corbin 1990, Charmaz 2000), and to add in references to other literature where specific outcomes were better represented.

In what follows we present both the bodily sensations reported by clients and the theoretical framework that these empirical findings accentuate.

Exploring the body – in practice and theory

Almost 46 different reasons were given by the 46 interviewees for attending reflexology, acupuncture or mindfulness training. Using the coding process, however, we discovered six thematic areas among the motives for attending alternative medicine: (a) relieving stress, depression, anxiety; (b) minimising pain and allergies; (c) solving fertility problems; (d) promoting self-development; (e) improving general health. Whereas (b) and (e) were the motives most frequently reported among clients attending acupuncture and reflexology treatments, (a) and (d) were the reasons most frequently given by mindfulness training participants.

Among the 46 clients, one reported that he had no bodily sensations that could be ascribed to the treatment course. The rest of the clients fell into two categories; (1) they were relieved of their problem or they experienced improvements, or (2) the problem remained but their general wellbeing improved. These 45 clients all reported various bodily sensations while undergoing treatments, including warmth, flushing, headaches, fatigue, feeling tense or relaxed, sweating and pain. Between treatments they variously experienced nausea, dizziness, fever, happiness, energy, initiative, activity, new priorities, bodily attentiveness, reflexivity or the sense of ‘becoming oneself’ again. If they experienced influenza-like symptoms these disappeared within a day or two and were generally interpreted by the clients as processes initiated by the treatment and as ‘proof’ of its effectiveness rather than as negatives.

What struck us in our communication with the clients was that in the course of their treatment they became convinced of the positive benefits of CAM even in cases where CAM failed to relieve them of their symptoms. All the participants in our study felt confident that, at the very least, they would not be harmed by the treatment they received. Thus, they had only money and time to lose. Despite the fact that most clients experienced headaches, fever, colds and fatigue between treatments, none considered that CAM might also have a negative impact on their bodies. Indeed, they considered continuing treatment on a regular basis even when it was no longer necessary in terms of the original complaint. In the following sections therefore we address the empirical questions: what are the ‘derivate benefits’ that make individuals willing to expose themselves to headaches, colds, dizziness and other bodily reactions? What makes individuals use time and money on treatments when they are either in good health or unsure that the particular treatment helps their specific symptoms?
In investigating the derivative benefits of CAM we have chosen a theoretical approach through which we emphasise the bodily experiences that users of CAM describe. In conceptual formulations within philosophy, psychology, and psychotherapy experience is often defined as a construct ‘consisting of all that could be, but is not necessarily, in any sense in awareness’, whereas ‘experience in awareness’ refers to the explicit content of awareness (Gendlin 1997:242). Since we analyse clients’ verbal descriptions in this paper, we will define ‘bodily experiences’ in terms of the individual’s own direct verbal reference to what is phenomenologically presented to him or her, i.e. what s/he perceives (1997: 243). Thus we seek to identify features of the clients’ verbal accounts that indicate what they themselves see as ‘effects’ of the therapy. From this perspective bodily experience is a present, perceived and explicitly meaningful datum to which a client directly refers. We cannot in this study obtain access to implicitly meaningful data or to the ongoing sensory process in an individual’s phenomenal field. Our discussion of the ‘effects’ of CAM is limited to those effects that the clients themselves refer to as meaningful.

Moving on from these reflections, it goes without saying that bodies are not silent, and bodily experiences are mediated by the way in which clients describe their perceptions. In a phenomenologically grounded sociology (Schutz 1973, Berger and Luckmann 1966) language is seen as the fundamental mechanism for legitimising the social world as an objective reality: meaning does not lie in the experience itself but in the way in which it is formulated. In Schutz’s words, meaningful experiences are grasped reflectively. Thus, bodies speak, they are spoken to, and they can be spoken about. Two consequences follow: first, bodies are both active and acted upon; secondly, language is a bodily process (Merleau-Ponty 1998) in the sense that it is produced through the work of the body.

The phenomenological approach taken in this article enables us to bring together phenomenology and sociology in an account of how people understand their CAM experience as a process of embodiment, that is, a process of ‘inscribing in the natural corporeal form specific historical demands and possibilities that arise within a particular “mode of life” ’ (Ferguson 2006:105). As we will see in the interviewees’ accounts, they describe the positive benefits of CAM in terms of maximising or optimising the efficiency and the functioning of bodies. These empirical findings will be discussed in relation to the question of how society can be said to be embodied in the lives of individuals. In discussing the ways in which clients’ experiences are not only immediate, but are also mediated by discourses linked to established forms of health practices, we enrich the phenomenological approach by examining the technologies of the self and of governance from a Foucauldian power perspective.

**Bodily awareness**

Our point of departure in discussing clients’ exploration of their bodies is Drew Leder’s (1990) phenomenological analysis of *The Absent Body*, a study inspired by Merleau-Ponty’s phenomenology of the body. Leder points to a certain phenomenological universality in the human experience of the body in which the latter, in the normal course of events, tends to disappear from view. When our bodies function unproblematically, we tend to take them for granted and they cease to be part of our conscious experience. We will argue that participation in CAM practices increases clients’ bodily awareness, making the body ‘present’ to them even when they no longer suffer from pain or other types of dysfunctions.

Leder is concerned above all with the process by which the body becomes alienated from the self (see also Williams 1998:63 and Scott 1998) and thus focuses on its dis/dys-appearance. The body in pain, for instance, ‘emerges as an alien presence that exerts upon us a telic...

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demand’ (Leder 1990:74, his emphasis). This telic demand includes what Leder terms a hermeneutical and a pragmatic moment (1990:78). Whereas the hermeneutic component involves a quest for the meaning, interpretation and understanding of suffering, the pragmatic component involves action, namely the elimination or mastery of suffering: ‘Instead of just acting from the body, I act toward it’ (1990:79) in the attempt to cope with the pain or in the hope of finding relief. Because the hermeneutic component involves a quest for meaning and interpretation, it goes without saying that a presupposition for communicating this component is that the client is aware of the body:

These [reflexology treatments] have given me what I came for. Because I wanted to find out what kinds of tensions I’m walking around with, [tensions] that I’ve created in my body. I don’t want to have these any more. And I’ve obtained an enormous understanding of what kinds of tensions these are. (reflexology client G)

The body begins to work on what [the practitioner] started up last time, and then chain reactions can happen. Then there are some places that also start working and they become sore. (reflexology client O)

In one place or another it may be that I really like the fact that it tightens up a little, then it disappears, then some time passes again, and then I think that something is happening. Something or other happens. (acupuncture client C)

We understand awareness as the process through which clients give discursive attention to the body in specific circumstances. Clients tend to regard awareness as a means of enacting changes in their personal lives. Their reflections indicate that the treatments play an important role in producing emotions and attitudes that the clients conceptualise as more positive. This may be one reason why clients continue treatments even when the latter fail to relieve them of their symptoms. Awareness is seen as providing guidance in acting toward the body (cf. Williams 1998:62) rather than from the body, and at the same time offering ideals to aspire to. Clients may seek this experience through health practices that go beyond CAM, such as physical fitness training and diets.

Although the client may no longer suffer from any dysfunction, bodily awareness means that the body does not return to being absent (cf. Leder 1990). Thus, through body work (CAM treatments) and body talk (dialogue during CAM treatments), normal modes of bodily ‘disappearance’ become disrupted. The clients’ mode of bodily understanding is transformed from the tacit to the explicit. The body is indeed present.

This increased bodily awareness is described by some clients as a heightened degree of self-reflection. Experiences that clients may formerly have regarded as trivial, such as blowing one’s nose after a biking trip or suffering menstruation pains many years ago, evolve into important elements in a series of corporeal reflections, a coherent body narrative, which the client becomes aware of as a result of the course of treatment. Bodily sensations in the present study, such as a low or high level of energy or changes in mood, and observations of everyday behaviour with regard to health and illness, also become part of the clients’ new awareness, potentially leading them to make changes in their everyday lives.

One consequence of the awareness engendered by CAM seems to be that many clients feel encouraged to continue using alternative medicine regularly as a way of maintaining wellbeing and preventing illness. Thus, clients appear to seek out CAM treatments in order to gain greater control over their health. In what follows we address these aspects by looking at how clients attempt to become masters of their bodies.

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Bodily mastery

The most common reason given by participants in mindfulness courses for seeking such therapy was a distinct feeling of loss of control. Through mindfulness training they sought to regain a sense of control, if not over their lives, then over their minds and bodies. The fit mind, like the fit body, connotes the individual’s victory over problematic situations in his/her family, workplace, or social life. In the following quotations two participants explain how the meditation can be used to control bodily expressions of emotions, such as nervousness or distraction:

When I pause [am mindful] during an argument, I calm down, so I can get control over the nervous bodily sensations such as palpitations, sweat and cold fingers.

(meditation participant K)

I am able to get myself together. Present and past. It is a secure feeling. It gives more clarity so that I don’t get distracted by other thoughts’. (meditation participant F)

Moreover, mindfulness engenders both an increased bodily awareness and a desire for self-care, as expressed in the following quotation:

I’ve had almost no desire to eat white bread and stuff like that. I have also been a casual smoker, but now I don’t have any desire to smoke a cigarette. And I didn’t expect this, because it wasn’t anything I had wanted. I didn’t think, ‘No, I ought to remake my life and live more healthily’. Because I basically eat fundamentally really good food, you know. What is strange is that I mostly notice [the meditation] physically, that’s what I’ve realised. I have developed an enormously great desire to take care of my body.

(meditation participant H)

Performing ideals of control and agency seems to empower clients. The different forms of alternative therapies, and mindfulness meditation in particular, offer scripts for producing desirable emotions, such as a sense of control and calmness and emotions associated with ideals such as freedom and individual agency. Mindfulness training aims to maximise the feeling of psychological centredness and to distance the client from recurrent sources of anxiety and loss of control.

Thus, for many participants, mindfulness training offers what we term bodily mastery, i.e. the client’s developing ability to pay attention to the results of their behaviour and make corrective adjustments as needed. Mastery also implies coming to terms with their personal situations in ways that provide meaning and maximise health. Like physical fitness training, the various meditation exercises (breathing exercises, body scanning, and so on) promote bodily mastery through a pre-established series of repetitions. These repetitions enhance bodily awareness in ways that also produce in participants a sense of psychological wellbeing.

Clients who used reflexology and acupuncture practitioners expressed wellbeing as well:

I had hoped that it [the pain] would disappear. That’s why I came. But although it hasn’t, I’ve at least got something else out of it. I didn’t know it would be so nice. I would like to continue with reflexology once a month, but I don’t expect to get rid of the pain problem. (reflexology client A)

This client expresses a liking for the treatment because it makes her feel ‘healthy inside, psychologically as well as physiologically’ and she aims to use reflexology as a prevention strategy in order to ‘avoid getting ill’. Another client similarly focused on prevention:
Most likely I will have to continue every third month to maintain it [*i.e., maintain the effect of the treatment: the elimination of imbalances*]. . . . I know this would be wisest. Otherwise you have to go through what I’m going through now, where you really need to get to the bottom of it, where sweat is flowing out of you and so on. When [the practitioner] has got to the bottom of it all, [the practitioner] can more easily put things right if we meet regularly and if something [*i.e. a new problem/imbalance*] occurs. (reflexology client O)

Many of the reflexology and acupuncture clients talk about – and write in their diaries about – the feeling of an ‘energy flow’ in their bodies. One of the acupuncture clients puts the feeling as follows:

. . . sometimes you can feel that it [the energy] is flowing around your whole body.
This is such a pleasant sensation. I felt it most distinctly when I was lying there [on the couch] today – as soon as I have got the needles in the skin, then peace and quiet and delight enter in, I get incredibly heavy and relaxed and feel immense pleasure. (acupuncture client A)

Whereas participants in mindfulness training see mastery as an attempt to gain control over the body, reflexology and acupuncture clients see it as an attempt first to achieve and then to maintain bodily wellbeing in general, and to prevent possible bodily imbalances through ongoing regular treatments. Reflexology and acupuncture clients who attended alternative treatments for a more pragmatic reason, such as reducing pain, also saw the treatment as an end in itself. These clients were more inclined to emphasise the pleasurable experience of the treatments as such. Mindfulness participants, by contrast, tend to seek bodily mastery as promising a low-risk course of action and thus seem more inclined to emphasise meditation as a means to help them in their life projects rather than as an end in itself.

No matter whether the treatment is successful or not, most interviewees report an increase in ‘general wellbeing’: an effect that we refer to in this study as a ‘derivative benefit’, because the clients themselves expressed positive surprise at this bodily reaction. The notion of wellbeing encapsulates and reinforces the significance of personal experience and knowledge in social environments in which self-discovery through bodily awareness is emphasised as both normal and morally correct (Sointu 2006:341). However, some clients, particularly those who have attended mindfulness training, also seek more actively to gain control or mastery over their bodies. Thus, the bodily dimension of mastery, as a kind of ‘training effect’, complements the dimension of bodily awareness, in so far as clients work actively to achieve changes in their health practices, rather than passively experiencing wellbeing. From the client’s perspective, the aspiration to achieve bodily awareness and mastery seems to be an important dimension in explaining the increased popularity of CAM.

In what follows we discuss wellbeing and responsibility in explaining the popularity of CAM.

**Wellbeing and responsibility**

In general, the clients in the present study regard the body as a natural phenomenon involving bodily energies, which they regard as potential self-healing resources. They are
convinced that, with the assistance of CAM practitioners, these self-healing resources can create (or restore) the body’s balance and hence cure it of its ills. This naturalistic perspective (see also Shilling 2005:37–61 and Scott 1998) operates within an external/internal dualism with regard to healing. The body per se is healthy, and illness, together with various symptoms such as pain or the feeling of loss of control, are the body’s way of telling the individual that the body needs help in utilising its natural resources. The body thus ‘speaks’ to the individual, and the individual must learn to decipher the body’s ‘signals’. This learning process engenders an increased awareness of the body. While some clients regard the use of pharmaceuticals as an ‘artificial’ impediment and a threat to the healthy body, it does not occur to them that the energy-stimulating processes initiated by the alternative practitioner might have unwanted side effects. Rather, clients see the treatment as positive – even when they experience influenza-like symptoms – because it encourages them to start exploring their own bodies. Unlike Lee-Treweek’s study (2001) the findings in this study do not indicate that increased bodily awareness makes the clients overly careful or scared or create dependency. Instead, in their continous exploration of their bodies, health and well-being become important values that the clients seek to achieve through an activity such as CAM that is supposed to have a restorative effect on their minds and bodies.

As Sointu (2006) has noted, when health is conceptualised as general wellbeing it becomes possible for CAM practices to challenge the dominant biomedical domain. CAM offers clients the experience of returning to a state of wellbeing perceived in terms of harmony, fulfilment and a ‘natural contentment’ (2006:335). Some of the mindfulness clients in our study referred to this process as ‘coming home’. In this sense wellbeing is seen as potenti- ally available, even to the terminally ill. Sointu emphasises that wellbeing is open to personal definition and subjective assessment, pertaining in particular to how the individual feels about him or herself (2006:336). The demand for wellbeing is now articulated in a variety of social contexts, thus contributing to a transformation in our ideas of how health is achieved. Likewise is the issue of the difference between healing versus curing central in CAM treatment and philosophy. For many CAM practitioners they do not expect to cure people and very few CAM users in our study expected to be cured. Thus, they accepted – some even appreciated – it if the treatments hurt or caused some negatives, which they experienced as a part of the healing process.

According to the interviewees in our study, wellbeing is founded both on a sense of awareness that focuses simultaneously on the mental, emotional and physical, and on the sense of becoming a master of one’s self in regard to all spheres of life.

From a historical and societal perspective cultural analysts and social psychologists (e.g. Lasch 1984 and Gergen 2000) have noted that individuals in (late) modern, Western societies find it increasingly difficult to achieve self-mastery. The notion of self-mastery, however, reflects a general tendency in contemporary Western societies in which individuals are accorded greater control over, and responsibility for, their own destinies. In other words, the responsibility for health is decentralised from the state to the individual (Petersen 2007). As a result individuals, subtly influenced by wider hegemonic discourses of health promotion, are more inclined to practise health-surveillance and self-monitoring (McClean 2005). This may be one reason why, as several surveys have indicated, individuals shop around for health advice (Ekholm and Kjøller 2007, Ni et al. 2002, Druss and Rosenheck 1999, Astin 1998:1551).

CAM’s holistic orientation likewise puts the responsibility for health and illness in the hands of the individual, and thus relates to lay concepts of health and illness (McClean 2005:637). As the individual retains ownership over his/her illness, the latter becomes ever more coupled with subjective ideas about illness as an expression of personal identity.
The sense of personal responsibility thus goes hand in hand with self-blame, and is seen as an integral feature of self-mastery. Contemporary Western societies attach a high value to the ability to take decisions, make informed choices and take responsibility: competence in these regards is seen as vital to forging one’s own identity. Exploring and engaging with the personal self has become an important constituent of contemporary identities. Yet such self-exploration implies reflecting on the self and constructing one’s own subjectivity. Foucault theorised this phenomenon in his last works, *The Use of Pleasure* (1985) and *The Care of the Self* (1986), in which he offered a more active notion of subjectivity, focusing especially on technologies of the self that:

. . . permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conducts, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality. (Foucault 1988:18)

In the light of these reflections, the client’s decision to use alternative therapy can emerge as an act of responsibility. Being well implies avoiding letting things ‘get to you’, and upholding a sense of wellbeing involves bringing preventive strategies into play. By taking responsibility for his/her health through undergoing CAM treatments, the client feels able to counter perceived threats to personal health by taking personal action. In this sense the client constructs her/himself as an individual who actively chooses to respond to health threats, even before these are diagnosed. Thus, CAM is chosen by self-responsible individuals in an effort to promote their own health and wellbeing. The clients in this study who continue to seek CAM treatments do not necessarily do so in order to be relieved of specific physiological or mental problems. They do so in order to maintain their health in the sense of wide-ranging wellbeing, even when the treatments fail to relieve them of specific symptoms. CAM both establishes a sense of control and produces individual agency.

Since CAM is not officially accredited in Denmark, attending therapy implies information, initiative and action on the part of the client. Indeed, the behaviour of CAM clients comes closer to reflecting the consumer image promoted nowadays by the conventional health system than that of patients within the established system. As a consumer, the patient is supposed to take responsibility for her/his own health by actively participating in all aspects of the illness trajectory: seeking out information, taking part in conversations with experts, making informed choices about treatment and rehabilitation, and so on. These are precisely the kinds of actions necessary in order to utilise alternative therapies in Denmark. In other words, the CAM client is by definition a responsible health consumer. On the other hand, users of alternative therapies are seeking non-conventional health practices and challenging medical knowledge and expertise. Their concern about their health is not restricted to a particular time and place, as it is in Parsons’ (1951) account of the sick person’s role. Health includes awareness and mastery of the body and self and is managed in various aspects of the individual’s life. These empirical findings suggest new sites for and types of analysis outside the context of clinical diagnosis and assessment, in order to explore how individuals use and modify, and enjoy or suffer from, their bodies.

**Conclusion: the body as a locus of action and a target of power**

In this article, we have explored the ways in which alternative therapy clients describe their bodily experiences of reflexology, acupuncture or mindfulness meditation. In the course of
their treatment clients became convinced of the positive benefits of CAM, even in cases where CAM did not relieve them of their symptoms. Many of the clients therefore considered continuing treatment on a regular basis when it was no longer necessary in terms of their original complaint. For this reason we have termed the positive 'effects' described by clients as 'derivate benefits'.

The analysis of the derivative benefits of CAM as reported by clients has shown a diverse array of bodily experiences, from increased bodily awareness to a sense of bodily mastery. In general, clients in the study seem to regard the body as a natural phenomenon involving bodily energies, which they regard as potential self-healing resources. In this sense the clients appear to adopt the practitioners’ perspective on health and illness. The adoption of this perspective, along with their increased bodily awareness, means that many clients feel encouraged to continue using alternative medicine regularly as a way of maintaining wellbeing and preventing illness. In this sense, clients attempt to gain control of their health through seeking out CAM treatments. We have addressed this aspect by looking at how clients attempt to become masters of their bodies.

A striking difference between the participants in mindfulness training on the one hand, and reflexology and acupuncture clients on the other, is reflected in their differing emphasis on the purpose of treatment, the former seeing the treatment as a means to help them in their daily lives, and the latter as an end in itself. Thus, the mindfulness meditation participants tend to emphasise meditation as a means of achieving bodily mastery, whereas reflexology and acupuncture clients seem more inclined to emphasise the treatments as pleasurable in themselves, helping, for example, to minimise pain. Regardless of the outcome of the treatment, most interviewees reported that they had achieved increased wellbeing through CAM. Some clients, however, especially those who participate in mindfulness training, seek more actively to gain control or mastery over their bodies. Thus, the bodily dimension of mastery as a kind of ‘training effect’ complements the dimension of bodily awareness, as clients actively seek changes in their own health practices rather than passively experiencing wellbeing.

In the discussion, we have attempted to trace the tension in the relationship between the active body (Merleau-Ponty’s body-subject) and the regulated body (Foucault’s body-power). We have therefore focused on bodies in the process of creating themselves, and on how CAM treatments disrupt normal modes of bodily disappearance (Leder 1990). As a result of the treatment the client’s mode of bodily comprehension moves from the tacit to the explicit, and the client acts in a much more self-aware and reflective manner – with bodily awareness and mastery.

The results of this study thus add empirically to – and challenge – McClean’s (2005) study, which concludes that CAM practices are de-politicising and that they manifest a ‘blame-the-victim’ ideology, individualising the approach to health and placing responsibility on the client. In the same vein, Coward (1989) has criticised CAM for fostering conservative ideologies of personal responsibility for health. However, such de-politicisation may also be seen as part of the strength of CAM approaches. Individuals make ‘personalised choices’ (Kelly-Powell in Boon et al. 1999) that are based on past experience, current self-image and images of the future. In this sense, clients’ motives for continuing CAM treatments reflect not only an individualised sense of responsibility towards personal health and wellbeing, but also new, more conscientious ways of living one’s life and imagining one’s life and oneself in the future. Yet the self today is constructed not only as being capable of taking responsibility but as having an obligation to do so. Thus the governing health policy addresses contemporary individuals on the assumption that they want to be healthy and to seek out ways of living that are most likely to promote health.
The empirical findings of this study indicate that the use of CAM may enhance the client's agency and choice. There may be considerable variation in the extent to which clients see themselves as responsible consumers, as is the case among patients within the conventional system. However, the change we have seen in the perception of the body – from a natural, biological object to an experiencing subject – may help to explain the increased popularity of CAM. In seeking alternative therapies, clients are interested not merely in relieving an ailment or reducing pain. The decision to continue CAM treatments represents not only an act of increased individual responsibility towards personal health, but reflects the client’s desire for bodily mastery as well as a recognition of the importance of wellbeing.

The demand for wellbeing is now articulated in a variety of social contexts, thus contributing to a transformation in our ideas of how health is achieved. For the interviewees in our study, wellbeing is founded both on a sense of awareness that focuses simultaneously on the mental, emotional and physical levels and on the mastery of the self and the body in regard to all spheres of life. From the client’s perspective, the achievement of bodily awareness and mastery appears to be an important dimension in explaining the increased popularity of CAM.

**Perspectives**

More data are needed to see how various clients use and respond to specific techniques, since this study draws on interviewees recruited among clients who were expected to be able to receive successful treatments. Clients are not always active agents in their bodily awareness (see also Lee-Treweek 2001, Taussig 1992). There is a danger of self-blaming and some clients look to health care practitioners to provide guidance on how to evaluate and manage their awareness. This might also explain why many clients want to continue CAM treatments and a close client-practitioner relationship. However, our data indicate that, although there are differences between the three forms of alternative therapies, not only in terms of the treatment as such but in the ‘effects’ experienced, a common feature of all three is the supportive attitude of the practitioner as a caring and nurturing individual who respects the integrity and agency of the client: an attitude much appreciated by the participants in this study.

In future studies it must be relevant to consider a wide range of opportunities for and benefits of attending CAM, according to the presenting social conditions. As Sharma has noted, CAM consumers can be considered as a differentiated category (1992:47ff). Our data suggest that particular types of clients seek out particular types of therapies. For example, there are variations in the respective educational background of the groups of clients attending the three forms of alternative therapies (almost 60 per cent of the reflexology participants had little or no further education, whereas nearly 60 per cent of the acupuncture participants had further vocational training but not a university education, and close to 60 per cent of the mindfulness participants had obtained post-secondary school education, mostly at university). The relative importance of various social factors such as gender, age, and education in the use of different forms of alternative therapies is an issue for future quantitative research.

Health care services may undergo fundamental changes in the future, as prevailing conventions are questioned and challenged by informed health consumers. Both academic researchers and politicians and professionals within the health care services need more data from the client’s perspective in order to capture the ongoing nature of outcomes and
'effects'. How do clients gain access to experts within Western medicine as well as within the CAM 'movement'? What kinds of services have been beneficial and from which institutions do the clients prefer to receive these services? It is likely that a more dynamic relationship will eventually develop between Western medicine and the CAM movement. Hence we need more knowledge of how clients integrate conventional and alternative health systems and of their experience of such integrated approaches, since several studies in Western countries indicate that CAM users make more use of conventional medicine than those who have had no experience of alternative medicine.

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Notes

1 Cf. the definition used in the Danish National Health Survey (Ekholm and Kjøller 2007:16). It should be noted that chiropractic treatment is recognised by the official Danish health care system and integrated into publicly subsidised health care practices.

2 A huge amount of CAM treatments are available in Denmark and non-biomedical healers are not outlawed, they are only forbidden to call themselves doctors. However, CAM practitioners are not recognised by the official Danish health care system. The Danish National Health Survey includes 20 different CAM forms among which reflexology (6.1% of the population aged 16+ reported usage within the last year (2005)) and acupuncture (5.4% in 2005) have gained a mainstream user appeal with large and diverse user groups (Ekholm and Kjøller 2007).

References


