Body Praxis and Networks of Power

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Departing from what has in medical anthropology been termed the individual body, the social body and body politics, actor-networks in medical pluralism are investigated on the basis of a study of complementary and alternative forms of medicine (CAM) in Denmark, including participant-observation in 12 clinics of reflexology, biopathy and kinesiology, as well as interviews and informal conversations with more than 40 alternative practitioners and 300 patients of CAM clinics. In this study, several actor-networks that connect metaphorical models of the body, clinical technology, social relations and political structures of the Danish society are revealed: a technocrat network, a social-democratic consultancy network and a neo-liberal network. The co-existence of several actor-networks has phenomenological as well as structural implications. The implications for patients using several forms of therapy is important insofar as the patients’ move between different actor-networks of healing implies switches between different experiences of body and self. Each of the actor-networks at the same time implies different positions in relation to the public healthcare system, and some actor-networks appear to be more compatible than others with the generalized and technical properties of public healthcare.

During the last decades of the twentieth century, two major theoretical approaches co-existed within medical anthropology without much reference to each other. One was a discussion of medical pluralism with a focus on structural aspects of the plethora of healthcare offers found in any one locality. The other was a discussion of experiences of body and self.

The notion of plurality in medical systems gained importance during the 1970s and 1980s as a concept that encompassed medicine as social and cultural systems implying certain forms of practitioners that share titles and explanatory models as well as educational and professional organizations. From the onset, the idea of medical pluralism was central in studies from Asia and Africa (i.e., Leslie 1975;
Janzen 1979; Kleinman 1980; etc.). Later the focus on a plurality of medical systems in co-existence was also applied in studies of European and North American healthcare (i.e., Baer 1984; Sharma 1992; Johannessen 1994), although this approach never had the same impact on the overall conceptualization of healthcare provision in the West as it had on the understanding of healthcare in Third World countries.

Another major approach in medical anthropology—as well as in anthropology at large and in other disciplines—was a preoccupation with the experience of body and self (i.e., Csordas 1999, etc.). Heterogeneity in conceptualizations of body, self and the closely related issues of health and healing was widely acknowledged, but as the reference point of most studies within this approach has been subjective experiences, not much attention was paid to relations between subjective experiences and larger social and cultural patterns.

Time has come to combine the two approaches in a socio-cultural contextualization of subjective experiences in pluralistic medical setting. A contextualization that does not imply notions of independent and distinct medical systems, but allows for flexible and situated networks of experiences, social relations, praxis and power.

Three Body Perspectives

We need not go far to find a theoretical framework suitable for understanding experiences of bodies and selves in the context of pluralistic medical settings, as the well-known model of the three body perspectives provided by Nancy Scheper-Hughes and Margaret Lock (1987; Lock & Scheper-Hughes 1996) is good to think with in this respect. Most readers of medical anthropological literature are probably well acquainted with this model of three perspectives on the body, but for those who are not I shall provide a short introduction to the model.

The first perspective implies a focus on the individual body and refers to a phenomenological perspective on subjective experiences of bodies and selves as entities separated from others. Such experiences of oneself as a distinct being are anticipated to belong to all humans although particular forms vary from one society to another and imply different experiences of the body as organism and as person, i.e., of the corporeal body, as well as of self, soul, spirits and other entities considered as parts of the human being. The variety of subjective body experiences has been amply demonstrated in research from many different places, and the relations between body and mind has been characterized as either that of the person having a body or being a body (cf. Turner 1992). The individual body perspective is very closely linked to the second body perspective, that of the social body, which according to Scheper-Hughes and Lock refers to the symbolic representation in and of the body as implied in praxis, idioms and metaphors of the body shared by members of the same community (Lock & Scheper-Hughes 1996). Mary Douglas pioneered in this field by pointing out that in most cultures, the body is conceptualized as a symbolic representation of social hierarchies and roles, as well as openings and transgression of borders, or is likened to technologies well known in the society in which it is situated (Douglas 1966, 1975). Numerous other studies since the time of Douglas have explored the variety of cultural models of bodies, sickness and treatment, and it is
now generally accepted that a plethora of models and metaphorical representations exist. I would, however, propose to include in this perspective also the social relations that bodies engage in when they turn sick. All sickness is dealt with in social relations and these relations of the clinical practice constitute a representational praxis of bodies as they provide for different kinds of bodies to emerge, so to speak. Clinical relations may thereby also be considered an expression of the social body and in considerations of this analytical level, one should pay attention to the social roles, rights and obligations attributed to the sick persons as well as to the practitioners. The social body, with a focus on discursive and relational constructions of the body, is closely connected with the third body perspective, that of body politics, which refers to a critical-interpretive view of social, political and economic regulations of bodies. This is a structural perspective focused on various forms of governance of the body, i.e., on power, policies, political institutions and organizations concerned with bodies. Michel Foucault was a pioneer in conceptualizing connections between bodies and politics by pointing to the privilege of nation states to dispose of the bodies of citizens in times of war and to choose which forms of aid to provide in cases of poverty and sickness. He demonstrated the regulating power over bodies and subjects performed by regimes of knowledge through a consideration of legal rights and institutional priorities in medicine as well as in prisons and sexuality (Foucault 1975, 1977, 1978).

Over the years, this three-perspective model of the body has been discussed in medical anthropology and used as a theoretical frame for research and analysis of praxis in health and sickness in different localities. It has thus provided acknowledgement of the plurality in medicine on a global scale. I propose that it will also serve studies of the medical plethora in any one locality, but before we can proceed to a demonstration of that, we must explore the interconnections of the three analytical levels of the body.

Lock and Scheper-Hughes (1996) propose body praxis as the link between the three levels, and I would like to elaborate a bit on this. Body praxis includes, inter alia, discourses, relations and technologies of body and self employed in clinics and is the nexus where plurality in medicine is disclosed. It is through the representational praxis that certain body-self experiences and certain forms of body politics are engaged. I propose that the link is provided through affinity in organizing principles identifiable at all three analytical levels insofar as founding principles of the organizational logic of subjective experiences and clinical representations, as well as, of body politics establish connections between specific elements. At the same time the organizing principles exclude elements based on incompatible forms of organizational logic (see Lyng 1990 and Turner 1992 for further discussion on affinity between the social body and body politics). In the optic of Bruno Latour’s (1993) actor-network theory, one may speak of actor-networks that emerge through affinity in the organizational principles of the individual, the social and the political levels of the body and become part of everyday reality through praxis. In any one locality a plurality of actor-networks co-exist, and persons, artefacts and ideas link up with these networks momentarily, which implies that such networks are not to be conceived of as firm and closed systems (as the traditional conception of medical
systems implies) but as fluid and open networks momentarily supported by organizing principles in the events taking place. This fluidity further implies that stable and loyal populations of patients, practitioners, technologies or discourses never inhabit networks, and networks are merely to be conceived as ideational structures supported by objects and actions.

In spite of the fluidity and openness of networks, this multi-level perspective of connections may help us understand interconnections in medicine from the individual to the political level and provide an analytical grip on the connections between body, self, clinical representation and power structures that are obviously at play. Second, this approach may provide a tool for analysis and explanation of inequality in status and official recognition of different kinds of medical practitioners and forms of praxis—a question that cannot solely be answered with reference to the therapeutic efficacy of the therapies.

In the following, I will present some actor-networks encompassing the individual body, the social body and body politics based on my own fieldwork in Denmark.¹

A Technocrat Network

Much body praxis in Danish complementary and alternative forms of medicine (CAM) clinics has been centred on a metaphorical representation of the body as a series of hollow cavities connected with one another and with the body’s orifices by a series of pipes. This metaphorical representation has been labelled ‘the plumbing model’ and been proposed as a common body model among lay people (Helman 1990, p. 21). It is not a new model, as it can be dated back at the least to the eighteenth century when the British physician George Cheyne described the body as a hydraulic machine, a contexture of pipes filled with liquids (Turner 1992, p. 184). However, as Cecil Helman has pointed out, the plumbing model with its emphasis on pipes and circulation in the body is a metaphorical representation that reflects technologies of drainage systems, circulation of water, heat and electricity in the house so familiar to contemporary people (1990, p. 21); I would like to add that it also reflects community circulation of resources such as the pipe- and wire-based distribution of clean and dirty water, gas, electricity and telephone calls (Johannessen 1994, p. 147). This model is thus an excellent example of the social body as a representation based in metaphors referring to technologies of the society in which the body is situated.

In Danish clinics of CAM, the plumbing model was supported by praxis, both in explanations and in therapeutic interventions applied. This was particularly the case in reflexology, where the massage on reflex zones on the feet was a multiple manifestation of the plumbing model. The treatment was based on the idea that physical nerves (pipes) connect zones of the feet with organs and other tissue in the body at large; and in clinics, literature and educational institutions of reflexology, this model has since the early days been the most prominent model providing a rationale for effectiveness of this form of treatment. The American masseuse Eunice Ingham, who was the founder of foot reflexology, thus used the metaphor of a blocked garden hose in an explanation of reflexology: ‘We are all familiar with what the effect of sand...
or gravel would be in a garden hose, yet we expect our body to function properly regardless of obstructions in the delicate nerve endings. We forget that our body is supposed to contain about 22 miles of tubing’ (Ingham 1966 [1938], pp. iv–v). This metaphor was also used as explanatory model among the reflexologists in my study along with explanations of the importance of ‘flow’ in the different ‘pipeline systems’ of the body. The necessity of ‘circulation’ of blood, of lymph fluids, in the digestive system etc., was repeatedly mentioned in conversations between reflexologists and their patients. Furthermore the massage was applied in a systematic way that reflected the pipeline representation, as it was generally applied to all zones referring to organs of the digestive system one after another, to organs associated with the lymph system one after another, and to organs of the blood system in a row etc. The importance of drinking large amounts of water (approx. three litres per day) in order to ‘cleanse out’ pollutants and other obstacles of circulation and body functioning, as emphasized by all of the CAM practitioners that I observed, also represents the plumbing model in a close association with drainage systems of the house.

The clinical technology of reflexology as based in the plumbing model implies that the practitioner is ascribed the role of a craftsman or technical expert, somewhat like a plumber or an engineer, who knows how to re-establish circulation in the various pipes of the body. This praxis thus implies social relations positioning the practitioner as an expert one can call upon to fix the problem and the patient as a passive receiver of expert interventions. In regard to the individual body, this praxis provides for an experience of the body as an object separated from the self. The body is something that you have and something that can be fixed in a technical way by implying the knowledge and craftsmanship of the practitioner. The practitioners become experts that provide generalized and technical treatments, and the education of practitioners as well as regulation of praxis is compatible with policies and technical procedures formulated in general terms.

In the affinity between the experience of the individual body as an object that can be fixed, the social representations referring to craftsmanship and technical solutions, and the technical and generalized political governance of bodies that these elements invite for, an actor-network emerges. As this actor-network is expert based, generalized and technical in its approach to bodies, sickness and healing, it is characterized by an organizing principle of ‘technocracy’, and thus links very well with a public healthcare system in which generalized, technical and science-based solutions are basic criteria for inclusion of therapies.

**A Social-democratic Consultancy Network**

Another important actor-network of CAM in Denmark emerges around a metaphorical representation of the body as a nation state. This metaphor relates closely to Mary Douglas’ thesis of the body as a symbolic representation of society, but was more recently formulated by Emily Martin who suggested that within immunology the body is likened to a nation state. Martin observed that researchers and clinicians of immunology in the USA attributed characteristics known from the military to the immune system that was often labelled a ‘defence’ system and its parts
described as ‘defence troops’, ‘infantry’, ‘mines’ and ‘bombs’ (Martin 1994); and a conception of the immune system as a defence of the territory of the body implies a symbolic connection between the body and the nation state (Martin 1990, p. 415). The metaphorical representation of the body as a nation state within immunology has close resemblance to a body model emerging in the CAM focus on homeostasis and balance of the body, although there are also marked differences.

All of the CAM practitioners, that I observed and talked with, emphasized ‘balance’ as very important in health and healing, and ‘imbalance’ as a characteristic of all sickness, and this concept of balance may hence be considered common in much of CAM. Several axes of balance are considered and one of them concerns a balance among major body organs and a joint effort of all organs in keeping the body going. According to biopathic practitioners, for example, this inter-organic balance is disrupted if one or more organs malfunction. This conception is a symbolic representation of society as interconnected and interdependent, where all parties are obliged to fulfil their functional roles for the benefit of the whole, and where dissatisfaction with the social order may be expressed through strike or other forms of resistance. Cecil Helman finds that body models with an emphasis on internal balance can be viewed as ‘somatic democracies’ where all members must be provided with essential needs and may express their dissatisfaction through symptoms (Helman 1991, p. 99). In much CAM, the idea of internal balance is, however, complemented by a widespread belief in the capacity of one organ to take over the functional roles of another in case of malfunction (e.g., if the liver shows a low energy level, the kidneys are believed to demonstrate a heightened energy level). In elaboration of Helman’s suggestion of somatic democracy, this idea can be viewed as a symbolic representation of communism where any member of a society is obliged to give according to his ability and may receive according to his needs. In that connection it is interesting to notice that biopathy, in which much emphasis is placed on this idea of internal balance, emerged in the early 1980s in Denmark, where the political milieu has been dominated by social democracy from the 1930s to the late 1990s.

The focus on internal balance among body organs is complemented by an emphasis on the importance of balance between the body and its physical environment. In this the border between body and environment is crucial as balance between external disease agents (such as allergens, pollutants, bacteria and viruses) and the body’s defensive capacity is stressed. This model bears strong resemblance to biomedical ideas of agents of disease, but biomedicine and biopathy pay attention to and intervene on different sides of the border, so to speak. While biomedical treatment aims at elimination of the external agents, for example by providing antibiotics that attack the bacteria or viruses like an automatic missile (Helman 1991, p. 35), biopathic treatment aims at strengthening the body by natural medicine or diet in a symbolic resemblance of nourishment to internal troops.

According to Helman, the idea of balance between body and environment is a symbolic representation of the nation state constantly under attack (1991, p. 37), and the borderline separating the body from environment is analogue to the border separating a nation from the rest of the world (cf. also Martin’s 1990 interpretation.
of immunology). This metaphor suggests that the body, like the nation state, has enemies—micro-organisms may invade the body like offensive troops may invade the nation state—and Helman suggests that the popular conception of bacteria as attacking the body is a symbolic representation of external dangers threatening to destroy the order of society (1991, pp. 35–36). The CAM focus on strengthening the body and rebalancing body organs internally may, along these lines, be seen as a symbolic representation of the importance to maintain a healthy population and social order as a means of defence.

Balance also emerges as important in the social relations evolving around the clinical technologies of biopathy. I have often observed how the clients engage actively in interpretation of the results of the clinical test that is performed with an electrical apparatus showing signs of light and sound very easily observed and interpreted. Exclamations such as ‘Uh, I surely need that medicine’, or ‘Oh, my liver surely doesn’t have much energy’, were quite common responses to the signs of the apparatus. Experienced clients actively participated in discussions with the practitioner about the relative importance of the test results and thus about which medicines to take. The technologies applied in biopathy in this way implied shared responsibility and cooperation between the practitioner and the client, and balance in the relationship was further emphasized as the practitioner provided substances and medicines to be tested, while it was the responsibility of the client to follow the prescriptions and carry out the treatment. The metaphorical representations and technologies of biopathy thus provided to the practitioner the role of a consultant that can help one find solutions, while the client was the active part in the therapeutic interventions.

This form of praxis implies that at the individual level the body emerges as a subject capable of voicing needs through symptoms and showing the way to restoration through the test results. In this respect, the body is not conceived as something separate from the person, and it may thus be claimed that the self is the body. As test results are, however, plentiful and ambiguous, the body and the signs it provides also become objects of the subject who must interpret and prioritize the many suggestions, and a separation between body and self is maintained. This way the self also has a body.

The organizational logic in the praxis of clinical discourse, relations and technology connected with a metaphorical representation of the body as balance in a nation state is characterized by principles of democracy, consultancy and uniqueness, and we may thus label the actor-network as a social-democratic consultancy network. The sick person depends on a consultant to reveal the causes of disorder in the body’s territory, but also has responsibility in decisions and interpretations of the test. This is not a case where an expert does something to a passive patient, rather each depends on the other in order to make the treatment successful, and as the sick person carries out the treatment in his home the principles of democracy and consultancy are further enhanced. With the praxis of individualized prescriptions that reach beyond the symptoms and seek to strengthen the balance of the particular body in question, generalized education and evidence of efficacy are not possible in regard to the relevance of specific treatments for
specific diseases. This feature makes this praxis incompatible with current trends in public healthcare with an emphasis on evidence-based medicine and formulation of standards for the provision of treatment and care based on scientific evidence of the efficacy of specific interventions in regard to specific health problems (Trinder 2000). It does, however, show affinity with the idea of personalized medicine acknowledging that a specific medicine may evoke different responses in different bodies that was created in relation to the Human Genome Project and thus shows affinity to emerging trends in biomedicine.

A Neo-liberal Network

Yet other forms of CAM-praxis have the computer as metaphorical point of reference; a model of the body that, according to Cecil Helman, has become widespread in Western society in reflection of the increased use of computers in everyday life (1991, pp. 88–89). In this metaphorical representation the corporeal body is conceived of as hardware and ‘...ideas, feelings, and the webs of memory have become merely the “software” of the human spirit—a set of ghostly patterns within the soul’ (ibid., p. 89), and in concordance with this, treatment is often explained as ‘re-programming’ and deficiency in the ‘hardware’ as repairable through work on the ‘software’. Repeatedly have I heard kinesiologists explain to patients that ‘the body is governed by the brain’, which is ‘like a computer’, and that the ‘treatment is like re-programming the computer’. Treatment interventions aim at restoring order at a mental level and thereby also on physical problems.

The main technology involved in kinesiology is a test of muscle strength, and it relies on the idea that the patient’s body knows the answers to whatever questions the practitioner poses. These questions can refer to anything from experiences in childhood and previous lives, to substance intolerance, malfunctioning of organs, problems in relations to family and others, and to relevant therapeutic interventions. Some kinesiologists refer to the very system of questioning as ‘a computer’, and the way in which they pose questions is analogous to the organization of folders of the computer. Kinesiologists thus typically ask first for relevance of treatment in different main categories (folders), in for example ‘food, medical substances, mental techniques, manipulative treatment’, and test the relevance of each category on the relative strength of a muscle. After identification of the main category, they repeat the procedure by asking for the relevance of different subcategories (sub-folders), in for example various kinds of medical substances like ‘homeopathy, flower essences, herbal medicines’. Eventually they end up asking for the relevance of a specific treatment (a specific document in a specific sub-folder), in for example ‘five drops of Chestnut Bud, six times a day’.

This praxis implies that the practitioner is attributed the role of a technician, who knows how to operate and reprogram the computer, while the patient or rather the patient’s body-mind becomes the expert, who knows what is wrong and what can be done about it. This provides for a subjective body experience of being a body, of oneness of the corporeal body and the mind (I am a body). The body as an organism is collapsed with the person and the particular life of this being is acknowledged as
embodied. The body becomes a communicating subject and symptoms as well as muscle strength constitute its language. This gives the patients a unique feeling of being in control, which all patients of kinesiology, that I interviewed, stated to me; for example, one woman, whom I asked whether she believed what the test showed, said with great passion: ‘Yes, because it is my arm that tells it.’

At the political level, this form of praxis implies that the patient becomes a sovereign expert in control of diagnosis and treatment options. Practitioners cannot diagnose or prescribe treatments based on generalized knowledge of disease and treatment, but must ask the patient’s body-mind for the relevance of various possible solutions. At a first glance, this praxis thus implies autonomy of the sick person who can choose freely among causes and treatments of disease. But at a second glance it also implies governance because questions—and thus also possible answers—are calibrated by the practitioner. The body-mind cannot improvise or express itself freely; only questions posed to it can be answered, and the answer can only be a ‘yes’ or a ‘no’ as the muscle will either prove strong or weak when pressure is put to it. This praxis may hence be conceived as an example of governmentality in post-modern healthcare, as described by Nikolas Rose (1992), where regulation of bodies are not performed through external coercion, but is exercised by the individuals who believe they choose freely what to do, but in reality conduct in accordance with ideals proposed by experts. A major point made by Rose is that the perceived autonomy and free choices are illusions, as we all choose according to what we have been told to do (p. 160).

A form of praxis like that of kinesiology implies that education of practitioners must ideally be very extensive as to the questions that could be relevant to ask the patient’s body-mind. The technology of testing the strengths of muscles is general and simple, but the questions are not—at the least only on a classificatory level—and as questions range from biochemical matters, through emotional and social matters, the range of topics that the practitioner should be familiar with is quite large. Furthermore, the lack of generalized connections between ailments and treatments implicit in this praxis makes it impossible to document effects of specific interventions in regard to specific diseases. This technology does therefore not show affinity to the demands of evidence-based medicine and public healthcare.

To conclude, the organizational logic of this actor-network is at first sight based on principles of autonomy, individualism and existentialism, and thus shows affinity with current neo-liberal ideals of the free and sovereign individual. At a second glance the principle of governmentality, however, seems to be at play in so far that practitioners provide the options available for patients’ free choice and thus set the frame for what can actually be chosen. As the principle of governmentality has been demonstrated to penetrate much healthcare of the contemporary world, and furthermore to go hand in hand with neo-liberal ideals of autonomy and free choice, this network can be labelled a neo-liberal network. With these affinities to neo-liberalism, this network is not compatible with the generalized and technical properties of most public healthcare systems, but demonstrates affinities with ideals and the organizational logic inherent in private healthcare and the emerging ideas of a patient-driven healthcare system.
Networks of Power

The actor-networks of individual, social and political issues of the body presented previously do not belong to specific medical systems. Practitioners sharing titles as well as educational and professional organizations tend to focus on selected metaphors and forms of technology, which implies that some actor-networks are dominant within specific educational and organizational structures, but they are never exclusive. Individual practitioners mix metaphors and technologies and thus align with several actor-networks in each their own specific pattern.

Patients neither confine themselves to any one of these actor-networks. They may prefer one to the other, but they walk in and out of networks and their experience of themselves and their bodies change according to the metaphors, technologies and social relations they encounter. Some patients use different forms of therapy for different ailments; others have hierarchies of resort, usually going from the technical fix to more existentially oriented forms of therapy; yet others use many therapies simultaneously for one ailment in order to deal with the problem in as many levels and ways as possible. An implication of this patient mobility is that experiences of body and self are flexible and link to different networks of praxis, knowledge and power, and, as mobility and flexibility in bodies and healthcare seem to be universal (cf Johannessen & Lázár 2006), a reconsideration of body and self is needed. It seems relevant to replace the concept of the body per se with a concept of the complex body that incorporates the gaze, the discourse and the technology in which it is articulated, as well as, the body praxis performed by patients and practitioners. Likewise, the self must be considered as flexible and in constant negotiations regarding its relations to the complex body.

The actor-networks and the fluidity in the complex bodies and flexible selves question the relevance of current trends of evidence-based practice and quality control in public healthcare systems. If bodies and selves are flexible and complex—even in connection with specific diseases in biomedical terms—it makes no sense to standardize treatment and search for the one treatment that is the best. Rather, one could think of different kinds of treatment as structures that provide different spaces, or different halls of mirrors, that people inhabit in their agency to improve their situation in the way that suits them the best.

These halls of mirrors do, however, have implications far beyond the phenomenology of body and self. As demonstrated earlier, some clinical discourses, relations and technologies are more compatible with current ideals of evidence-based medicine and public healthcare than others, and therefore some actor-networks more easily than others imply official and political support. The various clinical representations of the body interplay with—at the same time depending upon and enhancing—specific power structures in healthcare, and the political innocence of any form of therapy is thus dismissed.

Acknowledgements

The fieldwork providing data for this paper was financed by the Danish Research Councils of Medicine, the Social Science and the Humanities. Participation was
voluntary, and all participants could withdraw from the study at any time. I am grateful to my colleagues Lisbeth Rostgaard, University of Southern Denmark, and Giovanni Pizza, University of Perugia, as well as a critical referee of *Anthropology & Medicine*, for constructive comments on earlier drafts of the paper.

Notes

[1] The material was generated through fieldwork (1988–1992) in the folk sector of the Danish healthcare system (cf. the three-sector model of healthcare by Kleinman 1980), including among others participant-observation for several weeks in each of 12 clinics of reflexology, biopathy and kinesiology, as well as interviews and informal conversations with more than 40 alternative practitioners and 300 patients of alternative clinics (see also Johannessen 1994, 1996, 2001).

[2] Biopathy is a treatment form established by the Dane Kurt Winberg Nielsen in the years around 1980. Winberg Nielsen drew heavily on German technology of measurement of the electrical energy of meridian points etc., and on American theories on the importance of vitamins and minerals, when creating the explanatory models and technology of biopathy (see also Johannessen 1994).

References


