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Rivista della Società italiana di antropologia medica / 11-12, ottobre 2001, pp. 191-209

Stories the body can tell [1]*.*

On bodily perceptions as a link between alternative medical technologies and illness narratives

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One day in March 1989, I was driving along the main street of a small town in Zealand, Denmark. With me in the car was Julie, an alternative therapist, a reflexologist, in whose clinic I was at that time doing participant observation. We were on our way to Julie's yoga class, which she had invited me to join as part of my enquiry into her life as an alternative practitioner. Suddenly Julie pointed to a man walking along the street with a baby carriage. "*There goes one of my babies*", Julie claimed, and then she told me about the man and his wife, whom she had both been giving treatment to cure their infertility. According to Julie the new father was convinced that the reflexology treatment had caused their happy conception.

Julie then went on to tell me about other cases of infertility she had been treating, and elaborated on a case in which she was involved at the time. This case concerned Rebecca, a woman in her late twenties. According to Julie, Rebecca had had very irregular or missing menstruation since the age of 14 and had been told by the medical gynaecologist that her ovaries were all "dried up" and her body like a female body in the menopause. Julie did not believe this was true, since Rebecca had not had any excessive sweating. Julie herself was a woman of 56 and she knew from her own experience what it was like to be in the change of life. She rather suspected Rebecca's long time use of "the pill" to be the cause of the damaged ovaries.

Two months later I met Rebecca in Julie's clinic, where I observed her treatment and interviewed her. Before Rebecca arrived, Julie told me that they had had good results from the treatment: Rebecca's ovaries had been

pulsating during and after treatment sessions and Julie interpreted this as a sign that the treatment was effective.

When Rebecca entered the clinic, Julie asked how she felt, and as Rebecca had not experienced any symptoms since last time, they proceeded to the examination of whether needles should be set in acupuncture points of her ears. For this, Julie used an electrical apparatus, which looked like a pen and sometimes made a sound when put to the ear. The sound was interpreted as a sign, that a needle could be appropriate at that point. By itself, however, it was not valid; it had to be coupled with Rebecca's feeling of pain at the particular point before a needle was inserted. The apparatus thus made sounds when put to the points believed to correspond with the uterus, the pituitary gland and the ovaries, but as Rebecca only felt pain in the points corresponding to the pituitary gland and the ovaries these were the only points to which needles were applied.

After this, the reflexological treatment began, or rather, the combined examination and treatment by foot reflexology began (see below for a further introduction to the philosophy behind this practice). Julie started by rotating her fingers gently on Rebecca's ankle joints in order to "make contact". She continued until Rebecca reported that she could feel a buzz in her fingers. Then Julie started the reflexological massage of the feet, and while doing this, she jokingly told Rebecca to take care not to walk into a pole. Then they joined in telling me that they had discovered that a fierce blow to her head caused Rebecca's menstruation cycle trouble when she was 19 years old. Thereby, they believed that her pituitary gland was damaged so that it was no longer able to properly control the hormonal production in the body. During that day's treatment, they also agreed that Rebecca still had problems with this gland. Julie recognised that «*it feels like there are three grains of rice [in the reflex zones] in the right side while there is only one in the left*», and Rebecca experienced considerable pain in these zones. Likewise, Rebecca felt pain in the zones corresponding to the ovaries. Julie asked whether they were painful, and Rebecca answered: «*Yes, in the foot, but not in the abdomen. And my hands are sweating terribly*». – A little later Rebecca reported to be able to feel her ovaries in the abdomen, they were pulsating, and curiously enough mostly in the left side.

When the treatment was over and Rebecca had rested for 15 minutes, I interviewed her in the clinic while Julie was busy elsewhere in the house. Rebecca told me of the disappointment she felt when a gynaecologist told her that she was not able to have children. After that message «*I was rotten for a week, I cried all the time, because, all the time I hoped that I could have children. It has almost become an obsession to have children. ... That may be why I*

protect myself, by not having too great expectations [to the reflexology treatment]».

We talked about Rebecca and Julie's idea of the blow on the head as the cause of her infertility, and I asked Rebecca if she believed that to be true. She answered: «*Yes, I do. We reached this conclusion by joint effort. She could feel that the pituitary gland was sore and damaged... Then we also talked about when my menstruation stopped, and all of a sudden I remembered that I had a minor concussion the summer my menstruation totally messed up. So I believe in that*.» I then asked Rebecca if she had any idea of what happened in her body at that time, and she answered: «*Yes. It so happened that my pituitary gland produces hormones, and that is what I do not produce. Nothing is wrong with my ovaries and uterus. They send out a lot of signals, and at the moment I walked into the pole, I pushed something in my hormonal system out of balance*.» When I enquired about what effects she has experienced from the reflexology treatments she said: «*In the beginning my ovaries gave a lot of reactions – they started to beat and pulsate, I felt sudden pains, and I felt a pressure. Those things are more rare now. But then I started to get acne, hormonal acne, in the chin area, and I have not had that since my teen years*.» She told me that she never felt any sensations in her ovaries prior to taking up reflexological treatments: «*I have not felt anything in my ovaries the last 10 years. And that is why it is something I notice when it comes*.» Rebecca believed the acne to be a good sign, partly because it is located in the chin area. Julie has told her that in traditional Chinese facial diagnosis, the chin area was believed to correspond with the abdomen and the reproductive organs. «*I have also started to be more hot-tempered*», Rebecca continued, «*which I never used to – normally I am very balanced. But all of a sudden, some reactions have come that I just cannot understand. That is why I believe that something must have happened.*»

Alternative patients

The above case stems from a study based on fieldwork in alternative healing clinics of reflexology, biopathy and kinesiology in Denmark. This study includes information elicited through participant-observation during healing sessions, workshops and educational classes, and qualitative interviews with patients and healers. The fieldwork was conducted from 1988 to 1991 and covered 12 clinics and 286 patients from these clinics. In some ways Rebecca's case is not very typical – infertility was not among the most common problems brought to the alternative clinics, though I

did meet other persons with this problem as well. In other ways it is very typical and it serves as a good illuminating case for the questions to be explored below.

A prolonged illness implies a long-lasting disordering of the life worlds of the patients. Several scholars have demonstrated that suffering of any kind implies a disruption to the "normal" life and life worlds of the persons involved (i.e. Good 1994; Kleinman, Das & Lock 1997) and this is certainly also the case when the suffering is bound in the body in the form of sickness. In sickness the body plays, in Donna Harraway's terms, the role of a "witty agent" or "trickster" who in very concrete and often painful ways disturbs the normal pace and doings of a person's life (Harraway 1991 in Lykke 1999:158). Much effort is put into silencing the trickster and returning to normality, whatever that may mean to the individual. Consulting a medical practitioner and receiving treatment are important strategies in this striving for a return to a normal life, and in Denmark – as in most other Western countries – the biomedical doctor (the GP) is the first resort. For many, one or more visits with the biomedical doctor, or the hospital, solves the problem; the sickness is cured or the symptoms repressed, suffering ceases and normality is resumed. But for some, this strategy does not work, and they are the persons most likely to try out alternative treatment.

Most people who go to an alternative therapist have already consulted various practitioners within the established health care system in search of a cure for their ailment. A representative survey among Danes receiving reflexological treatment showed that 85% had consulted the established health care system prior to the alternative. This seems quite logical as the same study revealed that 45% of the reflexology patients had had the particular health problem for 5 years or more, and 28% had suffered from this problem for 10 years or longer (Geil 1989: 7-8). In my study, 45% of the patients reported that a biomedical doctor had previously treated them for the particular health problem they now sought to be relieved through alternative therapy. 18% reported to have been examined by a biomedical doctor but either did not follow a suggested treatment or were not offered any treatment; and 16% reported to be in biomedical treatment simultaneously with the alternative treatment (Johannessen 1994: 191).

Many reasons could probably be given to explain why the strategies of resort are expanded from biomedical to alternative treatments. A very pragmatic one is the fact that many of the patients in the above mentioned studies suffered from ailments for which a successful biomedical treatment does not exist. Among the 286 patients included in my study, 24% suffered

from chronic pain in the muscular-skeleton system or the head, 19% had allergic reactions in the respiratory system or the skin, 8% had digestive problems, and 7% reported psychological problems or stress as the problems they tried to eliminate through treatment (Johannessen 1994:190). All of these diagnoses refer to health problems for which no effective biomedical cure exists. Closely related to the pragmatic explanation of unmanageable diseases are, however, existential and cultural explanations referring to the recurrent state of chaos and anomaly in the lives of persons suffering from sickness incurable within established medical settings.

Therapeutic technologies

Whatever problem a person brings to a clinic of reflexology, biopathy or kinesiology the treatment involves an exploration that touches on a wide range of elements including bodily function, behavioural, emotional and social aspects as well as life events. At a phenomenological level, three aspects are important in the examination and conclusions reached. The first aspect is the therapeutic technologies applied, the second aspect is the perceptions and senses involved in the diagnostic process, and the third aspect is the extended talk on life, self and action that are involved.

In the three alternative systems to which the clinics I studied were attached, three different technologies were used, each involving certain practices of examination and treatment and ways of reading the body. In reflexology, both of the patient's feet were examined closely at every clinical encounter, no matter where in the body the patient experienced symptoms. During this examination, colours, tonus and sensations of pain or tickling in the feet were interpreted as signs of dysfunction in other body parts as well as the lives of the patients. The feet were believed to hold a map of the whole body and were divided into zones – reflex zones – each supposed to correspond to specific parts of the body as a whole. As a consequence of this belief, abnormalities in a specific reflex zone were interpreted as signs of dysfunction in the body part corresponding to this zone and indirectly as signs of improper behaviour or maladjusted emotions. The treatment consisted of massage of the feet, and changes in colour, tonus or sensations in the feet appearing after treatment were interpreted as signs of change in other body parts, signifying the effectiveness of the treatment.

In biopathy every clinical encounter involved examining electrical resistance of acupuncture points on hands and feet by the use of an electrical device called a "biotron". Based originally on Chinese models of correla-

tion between specific acupuncture points, meridians and specific organs of the body, the relative skin resistance in meridian points was interpreted as a reflection of the "energy level" in meridians and organs. By measuring the skin resistance at points on all of the twelve main meridians an individual pattern of energy level and functional ability in the major organs of he body was created. The electrical apparatus showed the level of electrical resistance in three different ways: by a tone increasing in volume analogous to an increase in resistance; by a pointer moving up and down a scale; and by a green and red light interchanging. Anomalies in skin resistance were interpreted similarly to anomalies in the feet within reflexology, as signs of dysfunction in body parts, emotions and behaviours corresponding to the particular acupuncture point showing an abnormal level of resistance. The treatment consisted of dietary advice, herbal medication and homeopathic remedies, the relevance of which were verified by the use of the same electrical machine.

In kinesiology the relative strength of various muscles was given the same signifying importance. There were two basic systems of muscle testing within kinesiology. One system (Touch for Health) involved testing the relative strength in 14-48 muscles, supposedly corresponding with specific meridians, organs, biochemical processes and emotions. During the test, an image of energy levels, functional ability in major organs and mental dispositions and conditions was created. In the other basic system (One Brain) the whole test was performed on one muscle and variations in the relative strength of this (arbitrarily chosen) muscle were interpreted as digital answers (yes/no, well functioning/malfunctioning, enhances/debilitates, and so on) to questions formulated by the kinesiologist. Prescriptions were determined by giving remedies to the patient and retesting the strength of formerly "weak" muscles. If the muscles became "stronger" it was interpreted as a sign that this remedy strengthened the patient. Remedies could be food items, herbal medicines, homeopathic remedies or mental affirmations and visualisations. For testing affirmations, visualisations and emotions, the patient was asked to hold certain mental pictures, or say certain statements, while the strength of the muscle was being tested.

All of these technologies are practised within specific alternative medical systems, each centred on specific techniques and explanatory models. In Denmark, these alternative medical systems are made up of associations of practitioners and schools where the techniques and philosophies behind them are taught. With this close relation between associations, schools and technologies I believe that it is appropriate to talk about communities of alternative healing practice when referring to therapists applying the same

clinical technologies. Such communities of alternative healing practice can be considered as contexts for what Lave & Wenger have called "situated learning". A fundamental assumption behind the notion of situated learning is that learning is a way of being in the world, and that learning can be viewed as a feature that is potentially present in all social activity (Lave & Wenger 1997:18-24). This further implies that knowledge and learning are relational features – that learning takes place in relations between people, and in terms of learning potential whatever is demonstrated in practice is more important than what is verbally expressed (ibid: 22).

The people that consult alternative therapists engage in social relations in the clinic and the technologies applied demonstrate ways of reading the body that differ widely from the ways biomedical doctors observe and read the body. During alternative clinical encounters, patients thus learn new ways of understanding their bodies and relatedness in body and life. This learning process is facilitated by the participation in a community of practice involving experts with close relations to schools and associations as well as by clinical demonstrations. I would, however, like to add to this perspective that whatever is *perceived* in practice is most conducive for the learning process.

Perceptions and senses in the body

The joint effort of therapist and patient in perceiving bodily signs and interpreting these in a wider life perspective was central to all three forms of alternative therapy although the kind of perceptions involved differed. In reflexology, the perceptions of patient and practitioner are of quite different kinds but supplement each other. Reflexologists perceive colours and tonus of reflex zones of the feet. The patients perceive pain and tickling in the feet, as well as heat, beats and buzzing sensations in the body at large. In the introductory case, Rebecca reported several sensations in her body: buzzing in her fingers, pain in reflex zones and acupuncture points, sweating, pulsation in the ovaries, acne and hot-temperedness. These sensations were very convincing to her, making her believe that the treatment was setting processes in motion in her body and that the explanations for her infertility explored through reflexology were true and trustworthy.

In kinesiology the perceptions of the patient and the practitioner were closer to each other in that both perceived the relative strengths of the same muscles at the same time. The difference lay in their respective access to the phenomenon: the patient perceived that she could not hold her

arm up (or that she could), while the practitioner perceived her own ability to either suppress the arm or not. In biopathy, the patients and therapists perceived the same: the change in sound, lamplight and pointer on the scale. All of the perceptions in the biopathic test were one step removed from the patient's body, they appeared on the electrical machine, but they were supposed to stem directly from the skin resistance of the acupuncture points measured on the body.

Patients readily learned what to perceive and how to interpret the signs of the feet, the muscles and the biotron, and eagerly engaged in negotiations with therapists on whether a particular sign was significant or not. For patients in all of these forms of therapy, the bodily sensations and the direct perceptions were most important, and gave them a feeling that this was a true communication with their body. As one woman, seeking biopathic treatment said: «*Of course I believe in it. One can hear when there is something wrong*». And another woman in kinesiological treatment responded to a question of what she found best about consulting a kinesiologist by saying: «*I feel secure in knowing that it is MY arm that is narrating.*» The trust in these bodily perceptions is reflected in that some patients brought medicines prescribed by biomedical doctors to have them tested by the biotron or kinesiological test in order to see whether this medicine was appropriate for their particular bodies.

Talks about life and behaviour

Common to all of the treatment sessions I have witnessed in alternative clinics is that the perceptions of bodily abnormality are linked to the lives and behaviours of the patients in a broad perspective. The examinations of reflex zones, acupuncture points or relative muscle strengths were never confined to conclusions only involving these particular points of examination. Each anomaly was interpreted first as a sign of an abnormal condition in a corresponding body part in the body at large. Secondly, it gave rise to a discussion of emotions, social relations and personal behaviours associated with the organ or body part in question.

In Rebecca's case, the pain in the reflex zone corresponding with the pituitary gland started a process of exploration in which she and the reflexologist tried to find out when and how some damage could have been done to this gland. Both agreed that this gland plays an important role in governing the hormones of the body and, thus, that it could be central to the fertility problems experienced by the patient. They engaged in a verbal

search of other signs of trouble in the hormone system, and Rebecca recalled how her never regular menstruation totally "messed up" after she had been hit on the head by a pole at the age of 19. As the pituitary gland is situated in the head, they readily agreed that this gland was damaged when her head was hit, and that her infertility originally stemmed from this incident.

It is not always the case that such clear connections between events in the past and contemporary perceptions of the body are stated. But it is general to all cases of these forms of therapy that any perception of anomaly in the reflex zones, acupuncture points or relative muscle strength gives way to a conversation on events, habits and relations in the lives of the patients. Any abnormality corresponding to the stomach thus caused the therapist to ask about eating habits of the patients. Abnormalities believed to correspond to the kidneys or liver gave reason to talk about drinking habits and social aspects related to the use of alcohol. Abnormalities corresponding to hormonal glands gave rise to talks on psychological and social aspects, etc. As the examinations covered zones, points or muscles corresponding to all major parts of the body, a large number of habits, emotional and social patterns and events were included in the clinical conversation between therapist and patient. As in Rebecca's case, the conversations most often involved a search for causal relations in a narrative plot leading to the present condition.

All of the therapists I studied had forms of practice that gave way to perceptions in and of the body. The kinds of perception varied from one form of therapy to another. However, all were directly accessible to patient, practitioner or both, and all were connected to the functions of the body at large as well as to social, psychological and habitual aspects of the patient in a wider perspective including events of the present as well as the past. To the patients and therapists, the perceptions in and of specific body parts became a key to knowledge of the body at large and the body was readily read as a medium carrying messages of the selves and lives of the patients.

A different way of knowing

There are no scientifically or biomedically proven connections between colour and tonus of specific areas of the feet and functional ability of specific organs in the body; in particular there are no links to aspects of self such as memories or emotions. Likewise, neither the electrical resistance

of specific points on hands and feet nor the relative strength of muscles can scientifically be explained to connect to organs, memories or emotions. And yet these ways of reading the body were highly meaningful and logical to the patients and therapists involved. At a hermeneutic level these phenomenological aspects can be understood as implying forms of knowing and knowledge that resemble what Lévi-Strauss (1969) calls "the science of the concrete".

In a classic paper from 1962 Lévi-Strauss discussed different ways of knowing in a comparison of what he called mythical and scientific ways of producing and constructing knowledge of the world. He argued that two different forms of science which represent different strategic levels of epistemology – and not different stages in the evolution of thinking – are concurrently practised. The one, mythical thinking, is somewhat adapted to interplay between perception and imagination and thus labelled the science of the concrete. The other, so called rational scientific thinking, is displaced from direct perception, trying to get beyond immediate sensations to underlying messages and processes, and thus labelled the science of the abstract (Lévi-Strauss 1969:26ff). Both strategies involve exploring nature, but in different ways, one based on direct perceptions of signs, the other on concepts one step removed from direct perception.

In this paper Lévi-Strauss drew on examples from ethnographic research that described indigenous ways of categorising plants and animals and related these to humans and different forms of suffering. He showed that in the science of the concrete, congruence in form and colour are interpreted as signs of connections and therapeutic relevance. Opposite to this Lévi-Strauss situated the categorisation and ideas of relevance of plants and animals within the natural sciences, where direct perceptions of form and colour are subordinate to more subtle similarities i.e. of chemical substances in plants (Lévi-Strauss 1969:20-23).

The similarities between Lévi-Strauss' concept of the *science of the concrete* and alternative therapeutic technologies are obvious. The alternative philosophies of congruence or correspondence between observable and perceivable abnormalities in specific visible body parts and inner body parts as well as life events, emotions and actions provide explanatory systems that connect concrete perceptions with ailments in the body and life of the patients. If attention is paid to concrete perceptions in and of the body, information is produced on the sickness, its causes and potential ways of alleviating it. Another similarity between the science of the concrete and alternative therapy is the way that information is construed into knowledge. According to Levi-Strauss the science of the concrete focuses on

collecting and interpreting whatever signs there are into a bricolage. Like the handy-man who uses whatever is available to construct a device, a therapeutic science of the concrete collects whatever signs the body may give and constructs out of this – in combination with what is revealed in conversations between patient and therapist –, an explanation and a strategy for the healing problem. In Rebecca's case, the perception of abnormality in the reflex zone of the pituitary gland was combined with abnormalities in other reflex zones and her memory of a bump on her head and a concussion. This complex of perceptions and memories led to an understanding that her infertility was caused by a damaged pituitary gland that led to a malfunction of the reproductive organs. The treatment sessions focussed on restoring the functional ability of the pituitary gland and reproductive organs by restoring the corresponding reflex zones.

Contrary to this *bricoleur* approach to the construction of knowledge, the science of the abstract follows certain lines of investigation according to a conceptual plan or some abstract ideas of underlying connections. Lévi-Strauss compares this approach with the way an engineer plans a construction and purchases whatever is needed according to the plan of construction (Lévi-Strauss 1969: 30). In biomedicine, where explanatory models of disease are ideally based on principles from the science of the abstract, the practitioner explores the body according to a preconceived idea of what the cause of the symptoms experienced by the patient could be. Atkinson (1988) has convincingly pointed this out in a study demonstrating that whatever is perceived or told by the patient that does not fit into the conceptual framework of the medical doctor is discounted. The approach is engineer-like. Many of the patients whom I met at the alternative clinics had experienced that the biomedical doctors were not able to give them a clear diagnosis or explanation of why they suffered the symptoms they had, just as Rebecca had experienced with the gynaecologist. Apparently the particular configuration of symptoms and clinical findings (if any) did not fit into patterns connected with specific biomedical diagnoses or explanations.

Patients and alternative therapists do not seem to be as selective and engineer-like as biomedical doctors in their search for explanatory models and diagnoses. On the contrary, there are obvious analogies between the knowledge bricolage described by Levi-Strauss and contemporary forms of thinking among patients and alternative therapists. A study of the psycho-social aspects of having and treating cancer within the biomedical system in Denmark showed that while the medical staff had an engineer-like approach to cancer and its treatment, the patients' way of thinking was much more like

that of a handy man. Patients collected sensations in and of their bodies, and combined these with information from the media, friends and medical staff and memories of their lives. All in an attempt to create meaningful answers to why they had such a disease as cancer and why it should happen to them at this particular point in time (Jensen *et al*. 1987). The ways patients and therapists of alternative clinics strive to create meaningful narratives out of health problems is similar. Perceptions of pain and other bodily sensations interplay with mental processes of recalling events, emotions and actions and all of these elements are combined into disease explanations and illness narratives in a *bricoleur* way. A significant difference between biomedicine and alternative medicine seems to be that alternative therapists are much more *bricoleur*-like in their approach to the sickness and suffering of patients than the biomedical staff. In fact, the various alternative practices of reading the body facilitates such body-self-life bricolage building based on whatever is perceived.

The Danish philosopher Søren Gosvig Olesen goes one step further along these lines of thinking. He states that in alternative therapy we find not only a different way of producing and construing knowledge, but a totally different kind of knowledge that can not be subsumed to the scientific, mathematical rationale, and thus not be judged within or by the scientific epistemology. He argues that while biomedicine, ideally based on the natural sciences, aims to dominate nature on the basis of a truth that depends on the accuracy of mathematical calculation, alternative therapy "constitutes an attempt to let man reach an encounter with himself or his nature" (Olesen, 1995:154). According to Olesen alternative therapy seeks to realise that moment of truth where "I Express Myself – expresses that which the whole conversation has led to but which was inexpressible until now" (citing the Danish psychologist Søren Willert Olesen, 1995:156). This kind of truth is in opposition to scientific epistemology but, nevertheless, Olesen argues that it is a kind of truth and he finds that it can very well be "determined by shifting facial expressions, a shrug of the shoulders or by a sudden grin. Or by a sudden pain, tension or tickle; or by a yielding arm, or an erecting torso" (Olesen, 1995). Along similar lines of thinking, the American anthropologist Meredith McGuire states that such aspects as bodily features, emotions, memories, relationships, imaginations and spirituality all interpenetrate each other. In recognising this, we should be aware that there may be bodily ways of knowing that challenge many assumptions implicit in the established science and research of the body, health and healing (McGuire, 1995: 28).

Body as meaning and narrator

Based on a study of ritual healing in suburban areas of Boston, Meredith McGuire, concludes that to the respondents of the study «health and wellness was not merely – indeed not mainly – a physical condition; real health required closely related mental, emotional, social, and spiritual aspects» (McGuire, 1995: 18). In continuation of this conception of health, the issue of meaning evoked by illness, pain, disability and suffering was central to the respondents of McGuire's study. While the issue of meaning is generally not addressed in biomedicine, the body and illnesses are assumed to be laden with meaning in many alternative forms of treatment. As McGuire states, «part of the healing process [in alternative practice] consists of 'discovering' the meaning for each person and each illness and addressing that meaning through healing practices» (ibid: 20). For those I met at alternative clinics in Denmark, the body itself became most central in the process of creating meaning and illness narratives.

To Rebecca, bodily infertility obstructed her self and the meaning of her life. She had consulted biomedical experts regarding this problem but they were neither able to help her find out why her reproductive organs had ceased to function normally nor to help her overcome the problem. With the reflexologist, she learned to pay attention to the sensations of her body and they both collaborated in interpreting these signs and combining them with life events in a narrative that made the infertility meaningful and understandable to her.

Like Rebecca, narratives were important in the process of creating meaning for most of the patients suffering from chronic ailments and seeking alternative treatment. This aspect of narratives is not peculiar to the patients I have met; on the contrary, anthropological literature abounds with examples of the meaning creating function of narratives for persons suffering from diseases or other life disrupting phenomena. As Cheryl Mattingly has pointed out, life itself is without plot. But in narratives, a plot with a beginning, a middle and an end incorporates selected experiences and events of life and imposes meaning on the seemingly chaotic flow of events (Mattingly 1998: 28-29). One of Mattingly's major points in her research on occupational therapists is that the clinical practice implies narrative structure and points to future end points, and she has coined the term "emplotment" to signify this process of creating narratives for and with the patients through practice (ibid: 20). In the alternative healing clinics I have studied, emplotment also takes place. And in this context the emplotment is aimed at creating narratives that give meaning and expla-

nations to ailments that can not be defined, explained or cured within the biomedical system. The emplotment in alternative therapy is embedded in the clinical practice of linking perceptions of anomaly in specific body parts to events and experiences in the patient's life. This way a plot is created that determines physical, social or emotional patterns that are believed to cause the ailment as well as point to ways to overcome it. In this process, perceptions of pain and tickling on the feet, the strength of muscles and shifting lights, sound and pointer movements on the biotron become bridges that link alternative healing technologies to narratives of the sickness embedded in the patient's life.

In order to reach beyond a conception of the body merely as a tool for creating narratives and meaning the body itself can be conceptualised as meaning, and in this connection several philosophers of phenomenology provide useful ideas and assumptions. Maurice Merleau-Ponty explored the phenomenology of the body and its spatiality and concluded that perception, action and conscience was an inseparable whole. He argued that the body is not an object, and that the consciousness one has of the body is not a thought. The wholeness of body and consciousness is implicit and unclear, and no matter whether it concerns one's own body or another body, one can only get to know it by living it, by taking over the drama permeating the body and uniting with it (Merleau-Ponty 2000: 169). He thus distinguished sharply between the reflexive idea of the body, involving a separation between subject and object and the experience of the body in reality (Merleau-Ponty 2000: 170). Based on the philosophers Løgstrup and Heidegger, the Danish philosopher Sune Frølund argues similarly that the body is not an object or a thing, but rather it is meaning and that meaning is timely-dynamic, as meaningfulness is an activity, is something *happening* (Frølund, 1993: 99-100). Frølund distinguishes between the body (as meaning) and the corporeal (as an empirical object located in time and space) and says that we do not *have* a body, we *are* not a body, but rather we embody our existence. Our bodying forth existence aims at the future and is based on the past and present and thus unites past, present and future in an inseparable meaningful whole (Frølund, 1993: 103).

It seems to me, that the arguments about the truthfulness of a different kind of meaningful and existential knowledge are based on a different way of knowing that is tightly bound to experience and perception in and of the body. This knowledge provides a conceptual ground for an understanding of therapeutic processes in alternative therapy. It moves beyond an understanding of alternative ways of reading the body as superficial

and "just" symbolic to an understanding of these technologies as means for bodying forth experience, self and life through perceptions transcending space and time in a meaningful whole. This conceptualisation of therapeutic processes is a serious challenge to dominating scientific and medical thinking. It thoroughly dismisses the traditional Cartesian dualism that separates body and mind and the scientific focus on accuracy in the mathematical sense. It also challenges the ideas of those who are "experts" on sickness, as this understanding gives prominence to the patients' lived experiences of bodying forth existence. The practitioner is thus relegated to the status of a technician who knows how to make the body narrate about existence, while the patient ultimately is the only one who knows exactly what incidents from her life should be related to particular bodily symptoms and perceptions (Johannessen 1994: 136).

Highly respectable people who are deeply involved with scholarly and scientific thinking, and practised by patients as well as therapists in alternative medical clinics formulate this challenging position in scholarly terms. But the patients and practitioners of alternative therapy do not necessarily explain alternative practice along these lines of thinking. Rebecca and Julie had never read Levi-Strauss, Merleau-Ponty, McGuire or the Danish philosophers. Neither had any of the other patients or therapists I met, I suspect. At least they never referred to these scholars' ideas of the inseparability of body, meaning, life and emotions when telling me about sickness and therapy. But they all believed in the close relation between apparently separate body parts, and between body, life and emotion, because they perceived and experienced such connections. Many said that they could not explain how these things were related, others had ideas of physiological body connections through the nerve system or blood vessels or in the form of meridians as "energy-channels". Connections between emotions, behaviour and body were either conceptualised in rather mechanistic ways, in spiritual ways stressing the interrelatedness of everything in the universe, or not explained at all. The idea that connections in the body are physical and supposedly objective mirrors the dominant positions of biomedicine and the epistemology of the natural sciences in Denmark as elsewhere. Many alternative therapists and patients thus subsume their practice and knowledge to the epistemology of the rational mathematical science of the abstract and this could very well be done in an effort to give credibility to the therapeutic practice. The more spiritual explanations transcend the boundaries of scientific and scholarly epistemology, and thus render the phenomena to the realm of the unscientific. The spiritual explanations do, however, tend to acquire credibility (to the patients and

practitioners involved) by being based on what is believed to be an "ancient" truth from before the world went rational and disenchanted (Wackerhausen, 1994). A third way of explaining alternative medical technology could, however, be based on existential and phenomenological approaches and on the philosophy and anthropology of the body. This approach seems fruitful for understanding the relatedness of self, life and body and what is going on in the alternative clinics. Though it is as abstract as explanations aimed at a mathematical truth it permits the subjective, fluid and individual experiences of patients and therapists to be taken serious within a scholarly epistemology.

Wider perspectives

Sickness involves much more than objectively observable bodily processes and is imbued with social, psychological, cultural and spiritual meaning. This implies that research on sickness and healing must also address this wider perspective in listening to the sick persons' whole and contextualised narratives of their experiences of bodies, healing and what they find significant in their lives (McGuire 1995: 20). Anthropology has a strong tradition in research of this kind, and can thus complement traditional biomedical research in an understanding of the processes involved in sickness and healing by providing theoretical and methodological approaches to investigate such embodiment of the self and embeddedness of the body in the self.

In regard to biomedical treatments, such anthropological research can provide deeper understandings of the processes involved in sickness and treatment. This research reaches beyond the observable changes in the body by relating them to processes of the self. Much medical anthropological research has already worked along these lines (conf. Quaranta, this volume). But since many biomedical treatments are prone to traditional biomedical research in regard to their effects, anthropological research is often considered to provide interesting perspectives that are, nevertheless, without importance for understanding why the particular treatment brings about a therapeutic effect. When turning to alternative treatments the picture looks quite different.

A major problem in the evaluation of the efficacy of alternative medicines has been the discrepancy between subjective and objective evaluations. Most studies including patients' subjective evaluation of treatments reveal that 60-80% of patients suffering from non-life-threatening diseases report on

positive effects of the treatment, bodily as well as emotional and social, while the objectively registered effect is either totally absent or much less significant than the effect experienced by the patients (Launsø, 1995: 54; Johannessen, 1998). In these cases, traditional biomedical methodology does not seem adequate for researching effects and processes of the treatment, and other kinds of research are needed to provide explanations of what is going on. Investigations of the processes of interrelatedness of practice, body and narratives in alternative therapeutic ways of reading the body, along the lines sketched out above, provide venues for a deeper understanding. Although such close-up perspectives are by no means the only ones relevant for the study of alternative therapy, I believe that they offer understandings of processes that are implicit in the patient's subjective experience of the positive effect in alternative therapy. As such these perspectives supplement biomedical exploration and research, which does not always seem to be able to show what is going on and therefore seriously lacks explanatory power.

Although an analysis like this is appropriate in the study of therapy it is by no means the only contribution medical anthropology has to offer in this field. In a review of papers presented at international seminars during a four-year network project for research on alternative therapies, the American anthropologist Mary Ryan-Thorup provides a list of perspectives and methodologies applied to the field. Besides perspectives that focus on measuring efficacy on the basis of purely physiological definitions, as can be done by traditional biomedical controlled clinical trials, the list covers:

- measuring efficacy with quality-of-life methodologies;
- physiotherapy measures, dealing with physical movement and ability in household tasks;
- inter-subjective measures of experience related to everyday life from the perspectives of patient-, family- and practitioner satisfaction;
- financial cost-benefit analysis;
- political-economic concerns;
- measures based on entities recognised in medical systems other than the biomedical (such as vital energy, yin-yang balance, chakras and auras); –
- ecological analysis focussed on effects on the environment;
- aesthetic evaluations focussed on issues such as the intrinsic, felt value that goes beyond measurement (Ryan-Thorup 1997: 168-9).

It seems obvious that medical anthropology can provide contributions to most of these perspectives, and can thus play a major role in future research on the efficacy and implications of alternative therapies in a wide

sense. As far as I can see, such approaches are relevant in the evaluation of biomedical treatment and therapy as well. Some of these perspectives are presently involved in biomedical technology assessment but most often they are mathematised in the processing. A more phenomenological and existential approach could turn the discussion on biomedical therapy and effect upside down and thus provide space for the patients' perspective in a way that is not found today.

In regard to anthropology in general, this essay points to medical anthropology as a field where many current theories and perspectives in anthropology can be synthesised into a meaningful coherent pattern throwing light on i.e. interfaces between the individual and the group, learning, knowing and knowledge, narrative, body and life. A synthesising focus on human bodily suffering, and therapeutic efforts to overcome it, also provides a way in which anthropology can re-centre as a science of man (in the West as well as the Rest). By providing research that may actually help people in their concrete struggle to get a decent life, anthropology reaches beyond the post-modern position of telling stories about other peoples stories so far predominantly offered to (or taken by) the discipline when applied at home. Anthropological research in this field can thus make a difference to the research field as well as to the mother discipline – and by synthesising the many current stances in anthropology it may even be a difference that makes a difference.

Acknowledgements. I would like to thank colleagues at the second conference on *Medical Anthropology at Home*, Tarragona, Spain, and at the Institute of Anthropology, University of Copenhagen, for comments on an earlier draft of this paper. Special thanks for extended comments go to Francine Lorimer, Vibeke Steffen, Susanne Reventlow and Sylvie Fainzang.

Notes

(1) A book on foot reflexology published in the USA in 1963 inspired the title of this paper. The American masseuse Eunice Ingham, who developed the first reflex zone map of the feet, published as *Stories the feet can tell*, wrote the book.

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