

THE UNIVERSITY OF HULL

“We’re all individuals”: postmodernity and alternative
health practices in Northern England

being a Thesis submitted for the degree of Ph.D

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by

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A spectre is haunting scientific medicine: the spectre of alternative approaches to health and healing.

J.W.Salmon *Alternative Medicine:
Popular and Policy Perspectives*

The power of crystals is upon us and cannot be denied... use your own intuition as you explore the resources of this phenomenal world of light.

K. Raphaell *Crystal Healing:
The Therapeutic Application of
Crystals and Stones*

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Abstract

This thesis explores the use and practice of crystal and spiritual healing – therapies located on the fringe of complementary and alternative medicine (CAM) - and what these ‘represent’ in the context of a profound socio-cultural transformation, characterised by the shift in Western societies from modernity to postmodernity. I explore this theme in relation to the empirical example of a healing centre in the North of England. The methodological stance I took was that of ethnography; data was largely gathered using participant observation.

A central theme is that healing practice and ideas which emerge at the Centre reflect individual concerns, and therefore healing practices themselves are often highly personalised. In addition, I explore how, from a Centre that celebrates highly personalised practices, healing knowledge becomes institutionalised and consensus emerges. Furthermore, I explain that the Centre collectively sanctions this personal expression. This tension between individual expression and the formalisation of group practice is, I argue, indicative of our times. Therefore, what emerges from this study is that the Centre fosters an ethos of the individual, but it is a collective ethos.

In addition, crystal and spiritual healing usage and practice reflects levels of dissatisfaction with biomedicine, the medicine of modernity. Though challenged by these healing practices, biomedicine has not been significantly weakened by this emergence. Even within the more esoteric healing practices, I point to the continuing influence of materiality, science and biomedicine. The appropriation of biomedicine can be witnessed in the Centre’s attempts to professionalise and systematise practices, but it can also be seen in less obvious ways, in that healers seemingly infuse their practice with some of the language and science of biomedicine. This throws into question the conventional biomedicine/alternative medicine interface, and offers some insight both into the common metaphorical basis of healing and medicine, and biomedicine’s continued hegemony.

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Crystals and Stones: formative experiences

As a young person (early to mid 1980s) I recall being particularly fascinated with crystals and stones. For example, on school visits to places of cultural and historical interest I would ensure that I had spending money for the small bags of stones that the tourist shops sold in cheap plastic presentation boxes with the label describing their 'precious' contents. Despite appearances, they were neither expensive nor rare gemstones, just rocks that were often indigenous to the region, and in abundance. As far as I can recollect, my primary interest in these artefacts was aesthetic – the crystals could be smooth or craggy, opaque or cloudy and they exhibited beautiful colours. The hobby, not necessarily unusual at the time, lasted perhaps two or three years, or at least until more typically teenage pursuits took over.

It wasn't until 1991 that crystals moved back into my social sphere. Returning home from university during the Christmas and Easter vacations, I was conscious of a significant change in the 'spare time' activities of some friends. Before leaving for university, these friends became interested in meditation, yoga practices, and tai-chi. These are bodily regimes that help to focus the mind and are used to alleviate stress, amongst other things. I thought it was nothing exceptionally unusual, perhaps another middle-class lifestyle preoccupation. It was not expensive to undertake, unlike other therapies such as acupuncture. The emphasis was on self-help. Furthermore, it seemed that there was no right or wrong way of healing your body - you chose the type of healing that worked for you.

On returning home during the summer vacation at the end of my first year studies, my friends' interests were taking a new and unexpected turn. Now they were buying crystals and stones and saying they healed the body. For some inexplicable

reason this excited me in a number of ways, and perhaps it validated my earlier fascination. Although the tourist shops in areas of geological interest still sold rocks and stones in abundance to hordes of school children, the crystals that we sought were of a 'higher' order. By this, I mean they were more 'exotic', more expensive, from all regions of the world, and were sold in 'New Age' shops along with books on self-help and healing. In short, a very different set of meanings were attached to the crystals sold in these shops in comparison to those that I bought as a child.

During a period of experimentation with these unusually mundane objects, some close friends and I began to use crystals to heal the body. It was thought that they could be used for self-healing, though in practice it was not that easy. For instance, if you were lying down, listening to calm and relaxing music on the cassette player, it did not help when the stones that you placed on your body kept falling off. Each time you picked one up that had fallen and replaced it, another would topple. So, we started practising on each other. This occurred on an ad hoc basis, in that it depended on who could give up their bedroom to being an alternative medical centre for the afternoon.

This was how our activities continued for a few summer months: surreptitious visits to each others' houses, each carrying bags full of crystals and gemstones. We would take it in turn, one healing the other, and then alternate, until we had all healed and had been healed. I did not think then that four years later I would witness similar routines, though with very different meanings attached, being carried out at a healing centre in the North of England.

Returning to University for my second year, the healing routine slipped somewhat. I suppose the gap between academic study and crystal healing was too large and, besides, outside of the narrow social space of some old friends nobody that I knew seemed to be interested. The time for personal and social experimentation was coming to an end, and the crystals were packed into boxes. I wasn't to take them out again until

my finals were over and I'd decided to embark on a Ph.D. This time, they became the serendipitous inspiration for the subject matter of my study, rather than as a tool for healing - though this was soon to change.

Crystal and spiritual healing:¹ background and context

As expressed in the preface, my experiences using crystals to heal the body became an inspiration for my PhD. By the time of the research I felt I had ‘distanced’ myself from ‘believing’ in the healing properties of the stones. Nevertheless, I thought that it would be worthwhile to consider why individuals practised a therapy that is located on the extreme fringes of mainstream health care. However, I thought that the issue would have been addressed copiously within the social sciences (sociology and social anthropology), not least because the practice and usage of therapies like crystal healing were increasingly ubiquitous. Therefore, I go on to argue that aspects of alternative medicine have been insufficiently explored within social science.

Crystal healing and healers were (and still are) the subject of mocking broad-sheet newspaper articles. Crystal healers are perceived as ‘crackpots’ espousing ‘mumbo jumbo’ and ‘silly nonsense’ for astronomical fees (Moir 1993). However, it is not alternative medicine *per se* that the journalists want to discredit, but individuals who are seen as ‘charlatans’ and ‘quacks’ – a throwback to the 18th Century when people were perceived as peddling harmless but expensive ‘cures’ and ‘potions’ for a particular demographic in British society (Porter 1993). For my own part, I felt that the situation was more complex than this, and that the healers in contemporary society are deeply involved in a coherent belief system or ‘world-view’ that social science could help to articulate.

To an extent this attitude has been mirrored in academia. Accounts of what is currently referred to as complementary and alternative medicine (CAM) (Kelner *et al* 2000) within

the social sciences have grown exponentially, and certainly at the rate of increase in the practice and usage of CAM itself. However, the range of alternative medicines explored, and the issues they were explored in relation to, consumerism and professionalisation and the like, were very limited. In their fairly recent book on the social and political context of CAM, Cant and Sharma state: “We should remember that the story of alternative medicine is not just the story of the major therapies” (1999:186). In some ways the issue of marginality in medicine has provided a point of departure.

Very broadly, the substantive issue in this thesis is the contemporary usage and practice of alternative medicines. More particularly, I address alternative medicine that is marginal to both mainstream medicine (biomedicine) and other forms of alternative medicine that in recent times have gained a degree of visibility and respectability. This issue of respectability is certainly a timely issue in British society and in the wider context of the European Union, where concerns about the regulation and control of CAM have become almost commonplace (Stone 1996).

However, the thesis does not just address this particular substantive issue in isolation. Its aim is to take stock of these changes and examine what they ‘represent’ in the context of recent and profound socio-cultural transformation, characterised by the shift in Western societies from modernity to postmodernity (Bauman 1992, 1995; Harvey 1990; Jameson 1991; Lyotard 1984) or ‘late modernity’ (Giddens 1990). I return to this central theme in chapter two. In addition, this thesis explores the CAM and postmodernity/modernity issue via an empirical example of a healing organisation and Centre in the North of England. I return to this empirical context shortly. First, however, I situate my research focus in the context of influential studies and key research.

The academic context: exploring complementary and alternative medicine (CAM)

Over the past decade a number of studies have addressed a range of different issues on CAM, both in the UK and the US. For example, in the UK Sharma's *Complementary Medicine Today* (1992) was timely, in that it examined the exponential rise in alternative medicine during a particular social and political milieu that spurred the rise in middle-income household budgets – Thatcherism. The text also gave space to contemporary sociological concerns: consumerism; medical pluralism; patient and practitioner knowledge and responsibility; and professionalisation. It also explored fairly mainstream and respectable therapies such as osteopathy, homeopathy and reflexology.

In contrast, Saks' *Professions and the Public Interest* (1995) focused mainly on the case of acupuncture, and the book was set against the backdrop of increasing professionalisation amongst the medical profession. More recently, Cant and Sharma's (1999) study of medical pluralism raises the 'tripartite' relationship between alternative medicine, biomedicine and the state. Cant and Sharma argue that the form that medical pluralism takes in the late twentieth century is of a different order from the medical pluralism in the seventeenth and eighteenth centuries. During the late 1980s to the late 1990s other significant books, journal articles, and edited volumes have been produced on this substantive area in the UK (e.g. Bakx 1991; Budd & Sharma 1994a; Cant & Sharma 1996a; Coward 1989; Saks 1992a; Salmon 1984a).

Across the Atlantic concerns also focused on the above issues, as well as the more marginal and esoteric healing practices concerned with spirituality, particularly within the context of what was being termed the 'New Age'. The issue of spirituality is central in this

thesis and I go on to expand on its place in the field of alternative medicine. McGuire's *Ritual Healing in Suburban America* (1988) for example, explored healing groups in suburban New Jersey, and is a good example of how the 'exotic' can be found in middle-class America. Other texts such as English-Lueck's (1990) *Health in the New Age*, Hess' *Science in the New Age* (1993), and Brown's *The Channeling Zone* (1997) made important in-roads into understanding the nature of 'New Age' healing practices in American society. Here the 'New Age' can be defined as a social movement incorporating "diverse goals", but which may be likely to promote a variety of personal and interpersonal values such as self-responsibility, psychological growth and creativity (English-Lueck 1990:1).

The 'New Age' movement also attracted the attention of the social sciences in the UK (Prince and Riches 2000). Also, this burgeoning of 'New Age' activity was clearly reflected in magazines in the UK that offered a forum for such phenomena. Typical examples are *Kindred Spirit* and *Caduceus*. Additionally, such growth in 'New Age' concerns could be witnessed on the shelves of bookshops which had whole sections devoted to esoteric, healing and self-help literature.

The use of crystals to heal the body is typical of such 'New Age' healing activity, and other sociologically-minded researchers are in agreement with this statement (Brown 1997; Fuller 1989; Hess 1993; Sharma 1992). However, what has not been sufficiently addressed beyond what I believe is a superficial reading, is the meaning of those healing practices for the healers, patients, and other routine participants. Too much attention is given to 'generalising' the phenomenon by relying on 'expert' New Age writers and neglecting the issue of local variation (see for example, English-Lueck 1990). Therefore, we need to consider its meaningfulness in the contexts in which it emerges and is practised, which is the main focus of the thesis.

To paraphrase, during the late 1980s and early 1990s we can simply note that the usage and practice of CAM had grown apace, and so too importantly, had the proliferation of so-called ‘New Age’ or spiritual activities that explore healing as an aspect of spiritual growth. I expand on this issue in chapter one. Also, alternative medicine generates and maintains a particular relationship with orthodox medicine, which I refer to in this thesis as biomedicine. Again, this is an issue I explore in more depth in chapter one.

Aims and research questions

As I have intimated, the aim of the research is to explore local participation in crystal and spiritual healing activities, and examine what it signified in the context of a profound and ongoing socio-cultural transformation in Western society. In this way, although the thesis addresses issues surrounding CAM, it is not concerned exclusively with this substantive area. A number of research questions guided my thesis inquiry:

- How and why do individuals use and practice crystal healing and other spiritual-based healing practices?
- To what extent does this usage and practice reflect failings in biomedicine?
- What kinds of ideas and concepts do healers propagate about health, illness and the body? How do these ideas and concepts differ from biomedical ones?
- To what extent do healers’ ideas and concepts of healing form a cohesive practice? Is there any significant difference between individual healers’ practices?
- What kind of relationship is fostered between these therapies and other medical practices? Furthermore, what does this tell us about the boundaries between

biomedicine and CAM, and more specifically, between biomedicine and spiritual healing?

- What facets of the well documented socio-cultural transformation (modernity to postmodernity) does the usage and practice of crystal and spiritual healing illustrate? What are the features of this transformation, and what can this tell us about the individual meanings behind spiritual healings increased ubiquity?

The ethnographic context: avoiding the road to Taos, New Mexico, USA.

Without doubt, the mid 1990s seemed like a key time to be involved in researching crystal and spiritual healing activities, though during the early stages I was undecided as to the setting that I would 'immerse' myself in. My concern was to ensure that the chosen context would typify particular and salient facets of this social phenomenon. In the following therefore, I offer extended access accounts. Drawing attention to the field setting allows me to consider its wider significance, which extends beyond the normal methodological considerations. Sociologists have commonly viewed 'New Age' healing practices as the exclusive preserve of the middle-classes and middle-income households (Brown 1997; English-Lueck 1990; Hess 1993; Sharma 1992). I wanted to demonstrate that this is an unwarranted generalisation and is not universally applicable. The setting that I came to research, though not drastically untypical of other contexts where New Age healing flourishes, is far from middle-class in social composition.

However, my thesis does not explore the relationship between the locality and the individual healers in the way that has characterised much 'traditional' anthropology.² Healers' activities, as I came to understand them, did not necessarily exhibit local concerns (besides, many of the healers I approached for the research did not live in the local area).

Primarily, I was interested in how the Centre and the healing activities practised therein contained features that were representative of a wider social and cultural trend.

Selecting the field: from the 'exotic' to the mundane

Taos, New Mexico, USA is nestled comfortably at the foot of the Sangre de Cristo Mountains, about 100 miles north of Albuquerque. The nearest large town - Sante Fe - is 60 miles south. During the 1980s 'The Crystal Academy of Advanced Healing Arts' - a small, but well publicised crystal healing organization, was located in this small town in the semi-desert environment of New Mexico. For a short while this was to be my chosen place of fieldwork, but for both practical and personal reasons this became increasingly unlikely.

First of all, in considering Sante Fe as a location I had to consider what other additional meanings, perhaps superfluous, might be attached to this field location. A study of healing in Sante Fe might not offer a new or contrastive angle. Besides, at the time of my search for a suitable field setting anthropological research into the New Age was being conducted in Sante Fe (Brown 1997), an area which Brown describes as one of the foremost 'Centres' of alternative spirituality in the US (ibid:viii). After deliberation, I decided that Britain would be my focus (and not the US). There was an equally well-documented increase in spiritual healing in the UK (Fulder 1996). Also, it is argued that a particular rise of CAM practices could be noted in the South of England (Sharma 1992), and initially I considered this to be an important area for these activities.

Secondly, I was aware (post-1993) of the growing interest in CAM from biomedicine. The date 1993 is significant, in that it was the year in which the British Medical Association (BMA) declared in an official report their interest in and support for alternative medicine that had embarked on a professional project – therapies they referred to explicitly as 'complementary' (e.g. osteopathy, acupuncture). This was a notable ideological shift

from the previous report on 'alternative therapies' (British Medical Association 1986), but the more favourable treatment was reserved for particular therapies. The BMA argued that practices like chiropractic were legitimate because they had embarked on a project of professionalisation to bring them in line with patient expectations.³ Most importantly, the BMA argued that 'complementary' medicine was rooted in medical science (British Medical Association 1993:6). In this way we can see that 'complementary' medicine was grabbing respectability when it could. For most therapies this was deemed achievable, as there was no perceived tension between the nature of these practices and the professional agenda put before them by the BMA.

With these changes to the legitimacy of alternative medicine in mind, I wrote to a number of healing centres that specialised in crystal healing, the 'New Age' practice *par excellence*. The majority of Centres practising crystal healing are located in the South and South West of England - places like Exeter, Ilminster, Glastonbury and Bath. Some wrote back with details of courses that they ran on crystal healing, but I then reconsidered my choice of location.

Cant and Sharma state that much of the empirical focus on CAM has been in this area of the UK (Cant and Sharma 1999; Sharma 1992), although they also state that this statistic may be skewed due to the higher numbers of training colleges and the supply of practitioners in the South. Such activities have not been so widely studied in the North and particularly not the North East of England, an area of high unemployment, poor health, and high levels of socio-economic deprivation.

However, this socio-economic and geographical focus ignores the greater socio-historical context and tradition of religious and 'spiritualist' healing (such as Mesmerism), which has its origins in the North and North-east of England during the Victorian period (Barrow 1986; and Owen 1989).⁴ Such 'spiritualist' practices were also prevalent in the

United States during this time (Braude 1989; English-Lueck 1990:85-88). They are based on the idea that entering a state of 'trance' allows the individual a form of communication between the living and the dead. This practice was deemed spiritually meaningful by its proponents, though it also reflected materialist (social and scientific) concerns of the Victorian age (Owen 1989).

Consequently, I began to look further afield until one day a postgraduate student at my University commented on my project saying that she knew a crystal healer who lived in a village on the outskirts of 'Broadville'.⁵ The healer happened to spend much of her week practising at a beauty clinic in the town centre. Eventually I met up with this healer – her name is Jenny – at her 'clinic' in Broadville, to talk about my interests. This encounter with Jenny also led to my introduction to the owner of a healing centre close to Broadville – the Centre that is the empirical focal point of this thesis. Jenny is also frequently mentioned in the thesis and, hence, I include a brief discussion of this meeting.

The 'Complementary Therapy Clinic', Broadville

The 'Complementary Therapy Clinic' is located on the first floor of a Victorian terrace in Broadville. Jenny shares the first floor with a hairdresser, a beauty centre, a reflexologist, a chiropodist and an iridologist. The room Jenny practices in is self-contained, barely decorated with white walls that exude a slightly clinical feel. Inside the room there is minimal furniture – a biomedical-style couch at one side of the room, and a small table and two chairs in the corner. On the far wall is a bookcase with a tape recorder on top of it, which is used to play relaxing 'New Age' style music during the curative sessions. On another shelf is a selection of aromatherapy oils housed in small and carefully labelled bottles. Two white coats hang from a brass peg on the back of the door.

During this visit Jenny and I discussed a number of different subjects: how she became involved in healing; the nature of the healing; and the clinic and her patients. For example, she explained how she became involved in healing: “I started in wholefood interests and after going to America I got into oils (aromatherapy) and then crystal healing. So I started from the quite physical to the more ‘subtle’.⁶ I want to explore this side much more now.”

By the end of the interview Jenny explained that I should talk to Teresa - her tutor at the ‘*Vital Energy Healing Centre*’ in Granby: “Teresa’s really nice, I talk to her a lot about what I do...she knows a lot.” Also, she said that Teresa would be able to introduce me to others with similar interests in healing.

The ‘Vital Energy Healing Centre’, Granby

Granby, East Riding, is located at the far western end of an estuary, approximately 30 miles from my university. Aside from the town of Granby, the area is predominantly rural. Indeed, in the local area Granby is commonly referred to as ‘Sleepy Hollow’, as though the town functions merely as an extension of the rural scene. Some of the surrounding rural area is quite prosperous, but there are notable pockets of deprivation and poverty, particularly in Granby itself.

The principle form of economic activity in the area has been and continues to be port-related. Indeed, Granby emerged as a key town in the region of East Riding for the purpose of moving goods and passengers between the local canals and the nearby estuary. More recently, however, Granby has experienced high levels of unemployment, substantially higher than the national average, particularly for the under 25s. Granby faces the kind of problems associated with high levels of deprivation. For example, it has the highest rate of heroin-related deaths in the UK per head of the population.⁷

The *Vital Energy Healing Centre* (VEHC) is a short five minute walk from the centre of Granby and is located in a three storey Victorian terraced house situated on Lowland Road, a bustling high street. The Centre also shares premises with a trophy shop, a fish and chip shop and a carpet salesroom. On arriving at the Centre for the first time I met a young woman whom it later transpired was Emily, Teresa's daughter. Sitting down in the middle of the reception room, Emily was pricing up some crystals for sale. Before long Teresa appeared and invited me into the downstairs healing room, the 'front room' as I came to know it.

Teresa and I discussed a number of things at this meeting: her involvement in healing; the VEHC; Granby; and her 'students'. After this discussion, she provided a demonstration of a crystal healing, and then took the opportunity to show me around the rest of the building. She showed me the 'sanctuary', a room that acts as the focal point for group meditation every Wednesday evening, an issue I explore in chapters six and eight. Across the landing on the first floor is the 'pink room', another healing room. Upstairs is an 'office', which she said was being renovated, and a guest room/library, which contains her esoteric books.

Before I left I asked her if I could come along on Wednesday evenings to the group meditation. She said that that wouldn't be a problem. As she was heading off she turned and asked me if I had meditated before. I admitted that I hadn't, so she said that to start with I should only observe.

The 'VEHC': preliminary research concerns

The healing centre was home to a number of healers, male and female, of various ages and backgrounds. Yet, a methodological issue that I raise here, and reiterate throughout the thesis, is that this research project focuses on the healers whose lives are a significant,

routine and everyday part of the Centre.⁸ At an embryonic stage in my research I had surmised that the healers were attending the Centre for reasons that were perhaps unique to them, and reflected personal and individual concerns.

Methodology and context: participant observation

The ethnographic fieldwork for this study took place for a total of twelve months between February 1996 and April 1998, and it focused almost exclusively on the VEHC. My description of entry to the field outlines how my involvement started. After a while, however, Teresa and the other healers started to take my presence for granted and were not particularly interested in my ‘university’ involvement. Before long I was an established figure at the Centre, and my routine participation as a crystal healing trainee of ‘good potential’ was an ordinary fact of life at the Centre. In short, I was accepted as just another healing trainee.

The methodological stance I took was that of ethnography, data was largely gathered using participant observation, although the extent to which I utilized either observer and/or participant roles varied over time. These and other methodological issues are explored in greater depth after the Introduction.

The organisation and structure of the text

In Chapter One, following the methodology, I provide some scene setting in relation to some of the key debates within social science on the subject of CAM. I critically examine some of the key issues surrounding social scientific writing on complementary and

alternative medicine. First, I consider the social and historical context in which biomedical orthodoxy emerged. This sets the scene in terms of the more recent ‘resurgence’ of healing practices.⁹ In particular, I argue that the spiritual healing practices evident today are a resurgence of particular phenomena which have their roots in former spiritualist healing, but with features that are unique to their current manifestation.

In chapter two I explore the wider social and cultural transformation that frame both the ‘crisis of biomedicine’ and orthodox systems of knowledge and the resurgence of spiritual healing. I go on to define what I mean by ‘crisis of biomedicine’ and its features in chapter one. In chapter two I identify a tension between individuation and systematisation within approaches to healing knowledge. In addition, I examine the wider significance of the lay challenge to expert knowledge as further indication of this wider social and cultural transformation, and I explain that spiritual healing forms of knowledge are a reflection of the lay approach.

Chapter three expands on some of these themes. I introduce the reader to the individuals who routinely contribute to life and the social reality of the healing centre. In particular, I offer a number of extended individual healer subject accounts - Teresa, Charlie, Stella, Sally and myself. I include these because the healers’ narratives exemplify key themes in the thesis. In this chapter I explore individual healer identities and intimate that these identities are crucial to understanding and making sense of healing practice and ideas.

In chapter four I focus on the boundaries and ritualised actions healers employ in order for the healing to be carried out efficaciously. In particular, I emphasise two themes in relation to these pre-healing rituals. First, the space of the healing is both physical (material) and a non-physical (spiritual/immaterial), and the interplay between these is central to the way that the relationship between biomedicine and emergent forms of spiritual healing is perceived.

In the following chapter (five) I offer a descriptive account of twelve healings, which are a mixture of hands-on and crystal healing. I consider the ways in which healer and patient roles at the Centre are largely interchangeable. That is, the healer is often the patient and vice versa. Secondly, these descriptions of healer practice help us to engage with the issues of healer competency and the nature of contemporary ritual innovation. That is, how healing is learned and performed, how individual innovation is highlighted as a central healing tenet, and how these multiple ritual forms become normalised through the process of routine self-reflection and interpretation.

Chapter six explores the nature of the healing process, and reflects primarily and in further depth on the descriptive examples of healing offered in chapter five. I explore the relationships between different ways of looking at the healing process. For example, I examine such topics as healing space, performance, the use of crystals, and the role of intuition and the senses in healing diagnosis. In essence, the chapter characterises healing as a dialectical process, one that oscillates between structure and improvisation.

Chapter seven examines the diverse ways that healers at the VEHC classify the individual and the human body. I consider the nature of the boundaries between biomedical and alternative medical knowledge, and in particular I examine the ways in which spiritual-based healing mimics and parodies biomedical discourse and what this means in relation to wider themes. Central to this chapter is the notion that spiritual healers combine cultural discourses such as those of science and spirituality.

In the final chapter – chapter eight – I consider the nature of healers' varied and contested views of health, illness and disease. In this chapter I explore the relation between spiritual healing and biomedicine, in terms of their perspectives on health and illness, and I argue that there is a degree of interplay between these apparently contradictory and contested forms of knowledge.

¹ 'Crystal healing' refers to the use of stones and crystals (mostly semi-precious) to heal the physical and spiritual body. It is a 'fringe' and esoteric therapy primarily used in conjunction with other spiritual healing practices. I use the term 'spiritual healing' in a very broad sense to mean those practices where the individual is conceived as having a spiritual body that requires healing in the same way as physical body; also that healing normally involves the intervention of spirits. Spiritual healing is thus inclusive of a diverse range of practices, such as crystal healing, hands-on healing and Reiki.

² Such studies reflect traditional anthropology's concern with the localisation of the object of study; and what we often see is the essentializing of the individual to a particular locale (Clifford 1997:24). See also Rapport & Dawson (1998) and Gupta & Ferguson (1997) for a critique of these approaches.

³ Other significant (post 1993) articles from the medical profession include a British Journal of General Practice editorial by Brewin (1994) and by Ernst (1996); also see Ernst (1995).

⁴ 'Spiritualist' is the name given to individuals interested in all aspects of the spiritual (not just healing), and although not a religion in the conventional sense, these activities still tend to be tied to spiritualist churches.

⁵ In order to protect the privacy of individuals, fictional names have been given throughout the thesis, to key places in the field locality and to individuals themselves.

⁶ In healing circles 'subtle' denotes the spiritual domain.

⁷ The town's actual name derives from 'hole' or 'open sewer'.

⁸ This has important implications with regard to the individuals I include in the individual subject accounts in chapter three.

⁹ The term 'resurgence' can be found in other texts that interpret the recent rise of CAM and 'New Age' healing. See for example, Cant & Sharma (1996a:2) and Saks (1996:35).

Introduction

In this, the methodology, I define and explore a range of issues that were central to my ethnographic study. I reflect on the reasons for adopting particular methods in the project, and consider how ethnographic debates can illuminate fieldwork issues. Some fieldwork experiences are not always ones which the ethnographer can add insight to, so I have produced an indicative selection. Here, then, I take some comfort from Clifford's (1990) assertion that the experiential aspect of fieldwork is more complex than the accounts of it: "[fieldwork] is a complex historical, political, intersubjective set of experiences which escapes the metaphors of participation, observation, initiation, rapport, induction, learning, and so forth, often deployed to account for it" (ibid:53).

The Setting: the *Vital Energy Healing Centre*

This is a qualitative study, consisting largely of participant observation that totalled approximately twelve months in one setting, a healing centre. I attended a range of different activities and healings at the Centre, and the healers' perception of my status altered over time as I changed from initially being an interested observer and patient (asthmatic) to becoming a healing trainee. As well as the owner and figure-head, Teresa, other individuals played a key role in the Centre's development and culture, including Charlie (a male healer in his late twenties), Stella (a female healer in her fifties) and Sally (a female healer in her early fifties). The Centre also played 'home' to a number of other visiting healers and trainees, some of whom I refer to in the thesis.

All data presented and analysed in this thesis has been drawn from events, activities and conversations that took place within the ‘institutional’ confines of the *Vital Energy Healing Centre* (VEHC). The Centre is a focal point for healers in the local area, and for healers and related practitioners from further afield. However, from this setting, I offer more general comments and suppositions about the nature of CAM in Western society. In order to generalize, I draw on a variety of theory and data from other, mostly Western contexts. This is a key feature of much anthropological research. As Hastrup explains, the nature of the anthropological endeavour is “...to provide ground for comparison and generalisation of social experience on the basis of concrete ethnography” (1995:x).

Use of the autobiographical mode

In the thesis I make use of the autobiographical mode, partly because of my personal involvement in spiritual healing.¹ Furthermore, autobiography is justified because I became an active part of the healing centre, contributing towards the construction of healing knowledge within a local setting. As such, I am embedded in the social reality of the Centre. For example, I include myself in the individual subject accounts (see chapter three) and the healing accounts (chapter five). Therefore, in the words of Okely, my past is relevant “...only in so far as it relates to the anthropological enterprise, which includes the choice of area and study, the experience of fieldwork, analysis and writing” (1992:1).

I do not use the autobiographical because I wish to make a statement about the importance of the anthropologist’s identity per se, or to explore the boundaries of postmodern ethnography. This postmodern approach has been variously described as ‘navel gazing’ and/or narcissism, although these are two interpretations that Okely criticises (1992:2).

Access: entering the field and key settings

In the main Introduction I offered extended access accounts of my initial involvement in the field, and here I make some additional comments regarding these experiences. Access issues are central to the success of ethnography (Burgess 1982:17). However, access does not just apply to the embryonic stages of the fieldwork process; access-related concerns are embedded in all stages of the data collection process (Hammersley and Atkinson 1983). I reflected upon and routinely negotiated access throughout the research. For example, I had to gain regular access to sensitive and private curative sessions in order to obtain relevant data, and this was not automatically granted by the healers and/or patients involved.

One key issue surrounding access concerned my negotiation of 'role', which was an ongoing preoccupation during the research. Another issue was the negotiation of access to curative healing sessions. In practice these concerns were interrelated. However, I consider the issue of 'role' negotiation first.

First, in the preliminary stages of my fieldwork I decided that I would present myself to the healers as a university researcher exploring alternative medicine. I was aware that healers may have interpreted the 'researcher' role as a position of 'authority', and that this would perhaps influence the ways in which respondents spoke about healing, though I do not believe this was the case. This risk was mitigated by introducing myself as someone who also had a long-standing interest in healing, and who required some healing for a particular condition: asthma. Although my feelings about this initial and rather clumsy introduction changed rapidly during the fieldwork, my identity as apprentice healer and asthmatic did not change significantly over time. Through time the healers accepted me and wove my identity into the routine life of the Centre, making me less conspicuous. As I spent more time at events and in discussions

at the Centre as an individual interested in healing, I was drawn more explicitly into the healing activities.

In many ways this raises some fundamental issues and ambiguities regarding the supposedly 'intrusive' nature of ethnography. Rather, I suggest that through my routine and everyday involvement at the healing centre I became inevitably drawn into the philosophy and culture of the Centre, in which healing is highly personal and healers' practices reflect individual concerns. This engagement led to an appreciation and frequent assessment of my future, as healer or anthropologist – from intruder to insider.

Secondly, my primary research focus was aimed towards the practitioners of healing and not patients. This decision arose during the course of the research. I felt that social scientific debates surrounding the issue of CAM paid scant attention to the practitioners of healing modalities, what takes place in a healing centre, and the ways in which healers influence the world-view of their patients.

During these preliminary fieldwork stages I witnessed key practitioners' healing sessions by acting as the patient, which I did willingly, as the healing sessions were always very relaxing. This is an important point to make, as my role at the Centre could only be legitimate by being someone who was open to healing. To have not wanted any healing, or to have been lacking 'knowledge' about healing ideas, would have effectively precluded me from being a part of the Centre, for central to crystal healing is the idea that the healer always requires some form of healing, as repair and rejuvenation. Nevertheless, initial access to the Centre was gained by being someone who had an interest in healing and not just one who was carrying out 'research', even though, as I was to learn, healers also promote the notion that they do 'research'.²

The Centre has a focal point, which is the reception area, and on another level, this too was helpful in fostering relationships with others. It gave me a place to legitimately 'hang-out', as just being present is not acceptable in many situations. In such

circumstances I would sit and read from the books available for sale, and talk to others who were passing through. This occasionally awkward initial involvement led, in time, to my participating in the group meditation sessions that are carried out in the sanctuary room. Before long it seemed as though I was someone who was debating the pros and cons of being a healer, rather than just someone who was 'at university'.

By the time I started healer training I was able to have access to a wide variety of curative sessions. Nevertheless, attending healing sessions that were carried out with many of the paying clients was more heavily restricted, which I assumed to be primarily due to legal and insurance reasons. Negotiating access to healing sessions was therefore an ongoing process, and I was aware that the rules would change from day-to-day, in that Teresa would make *ad hoc* decisions as to whether to invite me into a healing. I became used to attending healings as and when Teresa requested me, rather than actively soliciting my own attendance. Teresa often seemed more acutely aware of my 'dual' status. However, I could also attend healings in order to learn specific techniques, an important part of the healer training.

This research took place within a 'familiar' setting, a situation that has been increasing due to a realisation that Western societies consist of a diversity of world-views (Jackson 1987).³ By familiar, I mean that I did not have to work very hard at understanding the intricacies of social life in order to gain a basic level of acceptance, and this had advantages. As Rapport (2002) explains:

...an anthropologist thoroughly at home in linguistic denotation, and familiar with behavioural form, is more able to appreciate the connotative: to pick up on the niceties of interaction and ambivalences and ambiguities of exchange, where the most intricate (and interesting) aspects of sociocultural worlds are constructed, negotiated, contested and disseminated." (Rapport 2002:7).

The field site was close to my university and, in addition I had already established a good degree of knowledge and understanding of what healing involved in Western contexts – a situation that, as outlined in the preface, arose from my personal interest in the subject. Thus, all in all, acting ‘competently’ (Hammersley and Atkinson 1983:93) and without making the usual ‘social blunders’ (Rapport 1993:58) was not an issue in the early part of the fieldwork, when negotiating access. Besides, I go on to argue (see chapter six) that some degree of inadequacy was not necessarily questioned in the way that it would be in a more orthodox medical context, because the signs that healers demonstrate when healing are perhaps more opaque and more open to a range of interpretations than those a medic might display.

Wider access issues: gatekeepers.

Negotiating access to certain activities at the Centre such as curative sessions was gained primarily through Teresa, who acted as the conventional gatekeeper. While there are gatekeepers, healing is not, in fact, always shrouded in secrecy. For example, Charlie and Stella are often happy to heal someone spontaneously in the reception area in front of an audience, if restrictions of space and time dictate that they must. Therefore, access was mainly related to the patient’s wishes and not the healer’s, although I believe that Teresa undoubtedly steered my attention towards performative actions and contexts that she wanted me to be witness to. As Hammersley and Atkinson make explicit: “Gatekeepers may therefore attempt to exercise some degree of surveillance and control” (1983:65). And it was certainly the case that Teresa, perhaps during my initial involvement, wanted to limit my observations.

A good example of this ‘steering’ took place after I had been visiting the Centre for about six months. On one occasion, Teresa introduced me to Charlie’s ‘spirit doctor’ healing (see chapter three for a more detailed explanation of this healing). I had

intended to have a ‘conventional’ healing with Charlie, but Teresa ensured that I would experience Charlie’s new healing practice. Besides, she was curious about my reaction to this kind of healing, and so she asked me a number of questions afterwards, perhaps in order to seek my own opinion as to its legitimacy. Teresa may have been undecided as to the ‘authenticity’ of Charlie’s performance; perhaps she wanted to see if I was able to corroborate its level or lack of innovation and legitimacy (in Chapter Six I consider how authenticity may be measured in the healing context). Also, Teresa often questioned whether potential healing applicants were suited to a healing course. For example, in the Centre’s official brochure for the course it states that prospective individuals are chosen on the basis of their “compatible energies”, and that this may result in precluding certain individuals.

Participant Observation

My methodological involvement in this particular setting can be broadly described as ‘participant observation’, the stock-in-trade of social anthropology, although I am aware of the enormous variations in the field role that the approach may involve (Hammersley and Atkinson 1983). For example, Gold (1958) outlines and describes four levels of personal involvement in participant observation, ranging from complete observer to complete participant, with the majority of researchers’ roles being located in between these extremes. Furthermore, participant observation involves in-depth research over an extended period of time. As Agar explains, “...ethnographic relationships are long-term and diffuse” (1980:70), but they also vary in their intensity in that some periods of the fieldwork seemed productive in terms of data, whereas at other times the participation seemed uninspiring and uneventful.

My involvement stretched over a longer period of time than I initially anticipated as I found myself participating more during times of intense activity, such as when training for the crystal healing diploma. In addition, as I was researching curative practices at the Centre I did not involve myself in other aspects of the healers' lives, although, I concede, as a research focus it may have helped because healing practice as highly personal and informed by healers' everyday concerns turned out to be a central finding that could be explored further. As such, the four walls of the healing centre became the 'artificial' boundary for the research, and this was useful in helping me to demarcate and provide a rationale for the data collection.

It is argued that participant observation is always 'somewhere' – there is always, despite the postmodern ethnographic enterprise and calls for multi-sited ethnography (Marcus 1995), some degree of localisation (Clifford 1997:21), and in this case the setting is a healing centre in Northern England. However, as I pointed out in the main Introduction, the local area does not feature significantly in terms of the thematic concerns of the thesis. Locality is significant more generally in terms of the socio-demographic usage and practice of CAM, but it carries less significance in relation to the activities carried out in this locale (the healing centre). This is partly because the healers' and the healing centre's sphere of influence extends beyond the local area, but it is also because I was interested in how the activities at the Centre brought to light wider themes about the use and practice of CAM that were not confined to specific localities.

Participant observation has been described as a form of "mini-immigration" (Clifford 1997:22), in that the anthropologist immerses themselves into the socio-cultural sphere of the participants, in order to minimize the distinction between anthropological self and ethnographic 'other'. This is largely true, but as I have already noted, prolonged periods of participant observation problematise the social identity of the ethnographer.

In my case, I began to perceive myself over time less as anthropologist and more as crystal healer, as if these respective identities could not be coterminous. In order to reflect and write about the field of study and bring into play theory, one must return to being the anthropologist.

This complex interaction between two respective identities was reflected in the change of identity I had to effect on my travels to and from the field setting. On occasion I stayed at the Centre as they had a spare bed upstairs in the 'library'. I used a desk upstairs to write out full notes of the day's activities and observations. More commonly however, I'd return to the place I was living which was a short train journey away. As I would often travel to Granby from an insurance company that I was doing some temporary work for, I would have to go through a clothes change on the train over to the Centre; a sort of mini *rites-de-passage*. I'd carry 'healing' clothes in a small rucksack to work, and then change on the train, in order to minimise my 'temporary insurance clerk' profile. This made me reflect on Clifford's term 'mini-immigration', as the local train transported me between two transitory forms of social identity (in this case, healer and insurance clerk). Yet, the experience evoked something more than Clifford's 'mini-immigration', as the type of ethnography I experienced, which is common when working 'at home', is more a series of entries and exits. In this respect, it is more difficult to sustain a traditional 'anthropological' role, as one is routinely fluctuating between various 'personas'.

Data Collection

Before exploring some of the representational issues, I want to make some notional remarks about the data collection process. Data collection was perhaps more straightforward than in most observational contexts, as the process of 'taking notes' is fairly common at the VEHC. For instance, healers invariably record details of patient

contact following a healing and jot down nuggets of received wisdom from Teresa and other visiting healers. I tended to write down conversational details in depth either after a visit to the Centre, or when I had some time on my own. This was made easier during the diploma training when I was able to write down both issues of cosmology and conversational snippets. It was sometimes noticed by others that I wrote more than other participants on the healing course, which Adele (another trainee) put down to the fact that I wanted to write about how mad they all were! This was a throwaway comment, but highlights my identity as constantly betwixt and between - healer and distant observer. Self-consciously, in response, I tempered my inclination to write on every possible occasion.

Presentation of Data

The ethnographic present

Taking Davis' (1992) perspective on the use of tense in anthropological writing, I adopt what he terms the 'observational' present. I use it because it "...reflects the reality of fieldwork" (Hastrup 1995:20). Also, it is true that through the use of the present the ethnography is given a more timeless quality, although Fabian (2002) suggests that the anthropologist should be wary of this as he sees its usage as an authority trope. Nevertheless, as Hastrup explains, the reality of the 'cultures' we write about depends on the "...discursive present" (1995:21).

Creating and representing the social reality

Texts like *Writing Culture* (Clifford and Marcus 1986) document the background to and use of experimental ethnography. In providing an appraisal of this 'postmodern-turn' in ethnographic writing, Berger (1993) argues that the supposed involvement of the

anthropologist in the social fabric of the world of the 'other' is a myth, and that much of the dialogue is not with the individuals in the field, but with the ethnographic self. As he explains, "Even the attempt to converse with the "Other" – the great redemptive gesture of interpretive anthropology – collapses into a narcissistic enterprise in which the ethnographer is essentially talking to him or herself" (ibid:184). However, Berger neglects to consider that the so-called 'Other' may not be significantly different from the ethnographer. In addition, Berger's statement assumes that individuals have immutable social identities, and that they are brought into social encounters, rather than arising from them.

I do not subscribe wholeheartedly to the postmodern experimental movement in ethnographic writing, but agree with some of their findings. In particular, through the impact of the ethnography on the social reality of the healing centre, I am a maker of the social reality as much as those that I choose to write about. Here, I refer to Hastrup: "By her presence in the field, the ethnographer is actively engaged in the construction of the ethnographic reality or, one might say, of the ethnographic present" (1995:16).

Use of the dialogical mode in the representation of social reality

Rather than take on-board experimental ethnography, it is important to be ethnographically creative, in order to show self-awareness and reflexivity. An example of this creative stance is reflected in my use of dialogue. In presenting a variety of data I have made some use of the dialogical mode, in which as Clifford explains, "Many voices clamor for expression" (1986:15), and in which the ethnographer "...seeks to share ethnographic authority with the voices of informants" (Sanjek 1990:406). Clifford's main point, as I see it, is that new forms of writing and representing social reality may provide a movement towards the dialogical in anthropology. Rapport and Overing (2000) describe this anthropological dialogism as the knowledge which

emerges from local dialogue and conversation, as opposed to the analogic anthropology in which ‘others’ are understood “...via *a priori* reasoning” (ibid:116).

In its extreme, dialogical anthropology is not a representational anthropology. In view of this fact, some writers have provided a clear case for the continued use of traditional ethnographic authority as arguments surrounding polyphony for example, are viewed as ‘mystifying’ and ‘opaque’ (Sangren 1988:407). However, the key point to make here is that texts that integrate some dialogic dimension are still representational texts: “The anthropologist retains his or her authority as a constituting subject and representative of the dominant culture. Dialogic texts can be just as staged and controlled as experiential or interpretive texts. The mode offers no textual guarantees” (Rabinow 1986:246). Hastrup reiterates this point in explaining the obvious limits to this usage, “...no dialogue can overcome its own textualisation” (1995:151).

Therefore, use of the dialogic in anthropology needs to have a rationale. I use it because it has implications for the way we construe the healers’ sense of individuality and potential for innovatory healing knowledge and practice. In order to make statements about the highly personal nature of healing one must provide dialogic instances of the healers’ conversation. As such, I go on to argue throughout the thesis that the healers’ sense of individuality is not ‘carried into’ the Centre, rather it emerges and is fostered by the specificity of the ‘relations’ between individuals. In this sense I wanted to foreground dialogue over monologue, as Tyler insists (1986:126), and to demonstrate the emergent quality of ethnographic knowledge.

¹ Various positions regarding the role of the autobiographical have been established. See for example, Okely & Callaway (1992) for an exploration of these positions.

² That I was doing ‘research’ was largely irrelevant, as Teresa would argue that all healers are researching the spirit in some way. See Cant and Sharma (1998) for an example of how mentioning ‘research’ to healers/therapists can be ambiguous. A similar remark is made in Brown’s (1997) study of spirit mediums in the US. He remarks how the research subjects felt that his research was a stage in his movement

towards greater spiritual awareness, "...channels viewed the project as a stage in my own spiritual growth" (ibid:viii).

³ For further discussion around the scope, history and legitimacy of anthropology in the British context see Rapport (2002).

The contemporary resurgence of alternative medicines: from biomedical hegemony to plural health care

Introduction and background

The last two decades in the UK have witnessed a burgeoning use, practice and variety of CAM (Fulder 1996; Saks 1992a; Sharma 1992; Zollman and Vickers 1999). As Cant and Sharma explain, it is best to talk of alternative medicines rather than alternative medicine (1999:5). The rise in spiritual healing is particularly pronounced. There have been significant increases in other parts of the Western world, notably Western Europe (Cant & Sharma 1999) and, particularly Canada (Wiles and Rosenberg 2001) and the United States (Astin 1998; Eisenberg *et al* 1993; Eisenberg *et al* 1998), where increases have arguably been more pronounced than in the UK.

This transformation happened against the background of ‘crises’ in established, scientific systems of knowledge and practice (Lyotard 1984:37), of which biomedicine was one. Importantly, it has been argued that alternative medicine has emerged as a response to the failures of biomedicine (Bakx 1991). For example, biomedical knowledge and practice has failed to resolve chronic degenerative illnesses (Kleinman 1988; Salmon 1984b), in particular the AIDS epidemic (Sharma 1992). Contemporaneously, there has been increasing sociological awareness of the substantial changes occurring in social and cultural life, now represented by theoretical debates surrounding postmodernity (Lyotard 1984).

Rapid growth in the field of CAM constitutes, I would argue, both a cause of and a response to these twin crises/transformations. CAM has been loosely described as inhabiting either of two contrastive positions of compatibility and incompatibility with biomedicine (Coward 1989), and I have shown how this is reflected in its differential treatment by the BMA.¹ Some therapies are perceived as more suited to being used alongside biomedicine and have gained a degree of respectability, though not in the way that biomedicine claims state legitimacy. Other more esoteric therapies may be antagonistic to, and hold a radically different perspective on health, illness and the body, to that of biomedicine (Bakx 1991). At the extreme end of CAM, we can see how 'New Age' therapies or spiritual healing are radically alternative to biomedical knowledge and practice.²

There is an unexpected definitional ambiguity that should be explained here. 'Complementary' medicine draws upon manifest professional and biomedical strategies in order to attain popularity and gain state recognition. Therefore, 'complementary' therapies have been able to promote themselves as an adjunct to biomedicine.³ This is not something that we would expect from very esoteric and radical healing systems. However, though very unlike medicine, in fact healing practices such as crystal healing also draw upon perceived biomedical-type practices and ideas, and as such consist of a curious blend of material and spiritual idioms. It could be said that these crossovers reflect the continued hegemonic influence of biomedicine, although I go on to explore a range of explanations.

This opening chapter explores a number of issues in relation to the interplay between the emergence of alternative medicines and the continued influence of biomedicine. First, issues regarding terminology are discussed. Secondly, I consider the socio-historical context in which biomedical orthodoxy has emerged, which is often a starting point for discussion of CAM (Sharma 2000). This sets the scene in terms of the

background to the recent resurgence of CAM, and the varied responses from the practitioners. Thirdly, I explore the notion that our consumer-driven society has helped to foster a plural health care market. Fourthly, I explore some of the criticisms of biomedicine, and CAM's multifaceted response to these criticisms. For example, I consider the patient-practitioner relationship. I then proceed to discuss one of the drivers behind this change in relationship: the rise of the lay perspective in health matters (Blaxter 1983; Calnan 1987). Finally, I consider the divergent trends amongst alternative medicines. Healers either strive for professional status and wider cultural legitimacy, or they aim at countering biomedicine's hegemonic position within the panoply of available healing practices.

Questions of terminology: 'complementary' Vs 'alternative' medicine

In referring to 'alternative medicine' the key question I ask is, 'alternative' to what and to whom? In social science, the term alternative refers to the practices' marginal standing in the health care system. Moreover, 'alternative' denotes those practices not officially recognised by the state, and thus not given the privileges associated with such state sanctioning. One of the main proponents of this view is Mike Saks, who states: "[They are alternative because of] their socio-politically defined marginal standing in the health care system" (1992a:3).

The term 'alternative' is not without its critics. For example, Sharma criticises its use, firstly, because therapists do not necessarily express an 'alternative' outlook in terms of 'lifestyle', and secondly, because the term does not reflect the 'demand' side of alternative medicine. What Sharma means is that patients/users may not necessarily choose alternative medicine out of either disillusionment with biomedicine or because of a lifestyle which encourages engagement with activities that come under the umbrella

term - 'alternative'. It is certainly true that the structural marginality of CAM within the wider health care system does not necessarily reveal anything significant about the usage of therapies. For instance, as I make clear in chapter three, the healers at the *Vital Energy Healing Centre* did not feel that they exhibited an 'alternative' lifestyle.

More recently, sociologists (and therapists) have termed these therapies 'complementary' - that is, they are complementary to the dominant system of healthcare (see Cant & Sharma 1999; Sharma 1992). There is an increasing trend for these practitioners to establish complete bodies or 'systems' of knowledge to be used alongside biomedicine. A 'complementary' philosophy of the body, health and illness does not stand in marked contrast to biomedicine: 'complementary' implies the possibility of co-operation with biomedicine (Sharma 1992).

In addition, the term 'complementary' implies that the users of CAM should be the focus of sociological study, and that additional analytical interest should be accorded to the 'demand' and not the 'supply' side of these practices. I agree that 'complementary' is a more satisfactory term regarding the majority of usage of CAM in the UK. Also, the term 'complementary' does resound more appropriately with those therapies that are seeking wider recognition and legitimacy.

However, the term 'complementary medicine' has been accepted rather uncritically by sociologists. For example, Sharma's (1992) position underestimates the importance of practitioners fashioning practice and discourse partly in accordance with their subjective evaluation of biomedical practice. In essence, the healer's identity may emerge in relation to their understanding of orthodox medicine and what marks it as different to, or the same as healing. By considering practitioners, and not just users, we can comment more pertinently on knowledge systems in Western society, rather than solely on patterns of consumer activity and patient decision-making. This focus on practitioners is particularly meaningful if we recognise that patients may become

practitioners through, in particular, their dissatisfaction with biomedicine (see chapter three).

The subject of CAM as a distinct field of social scientific enquiry has a relatively short history. There could be a number of reasons for its recent emergence as an issue for sociological attention. The specialist field of medical sociology has mostly concerned itself with the subject of biomedicine and its dominating presence in the social relations of health. As such, the role of the biomedical practitioner and his/her patient has held centre stage. Medical anthropologists on the other hand, have largely been interested in 'traditional' healing and indigenous forms of 'folk' or 'ethno' medicine in non-Western societies, categories and classifications that bear a tentative resemblance to the subject of alternative medicine in Western society (Bakx 1991). However, since the 1980s a small but emerging body of literature has considered CAM, or what Kleinman (1984) refers to as 'local health care systems', healing practices located outside of orthodox medical services.

The emergence of biomedicine as recent orthodoxy

In this section I consider the socio-historical context in which biomedical orthodoxy emerged, which is important because it is against this background that CAM has itself ascended. I ask the question, what is the nature of biomedical dominance – is it clinical, socio-cultural, and/or symbolic/ritual? Addressing biomedicine is necessary for a number of reasons. Indeed, as I go on to show, the healers at the VEHC engage constantly with biomedical/scientific forms of discourse and imagery. Inevitably therefore, CAM is invariably approached by social science in the context of biomedicine's dominance. Biomedicine is firmly entrenched within Western society.

Until the 1790s a complex array of healing knowledge and practices flourished in Europe, and could not be distinguished in the eyes of the public as any better than other ones (Bynum and Porter 1987; Harrison 1987; Neve 1987; Porter 1993). This had implications for the way that so-called 'fringe' practices and miracle cures were perceived: "...fringe practitioners in the seventeenth and eighteenth centuries were not practising radical alternatives to orthodoxy; there was no one medical orthodoxy" (Stacey 1988:51). Arguably then, a form of 'pluralism' in medicine existed in Europe during this time, in that diversity in health-seeking behaviour was the norm.

In this way we can view the emergence of scientific biomedicine as a uniquely Western cultural trend. As Lupton states, while 'healing' powers are valued in most societies, the emergence of scientific 'medicine' is a more recent phenomenon in the West (1994:83). The period is perceived as significant in that biomedicine, through various processes that I identify later, managed to secure its hegemonic position:

...spanning roughly one hundred years between the late seventeenth century and the late eighteenth century, is believed to be the period in which many of the ideologies, discourses and practices surrounding contemporary biomedicine developed and became dominant (Lupton 1994:83).

Since the mid to late 19th century, biomedicine has achieved considerable social, economic and ideological dominance within the health care domain. The historical set of circumstances within which this dominance had been achieved has been well-documented (Lawrence 1994; Porter 1993; Stacey 1988), and I only touch upon this evidence here. Importantly, legislation has played its part. The most important piece of legislation was the 1858 Parliamentary Act, calling for the compiling of a medical register that would list those doctors who were allowed to call themselves such (Saks

2001:121). This represented, in effect, “a recognition, in law, of [the] relationship between orthodox practice and the state” (Lawrence 1994:56). As a consequence of this and various other medical acts and legal jurisdiction that took place during the middle of the nineteenth century, coupled with the increase in the processes of the professional project, certain kinds of practitioners were increasingly marginalised from the newly created dominant system of medicine.

Despite the help given by the legal system, biomedicine has never achieved absolute governance over health care (Cant & Sharma 1999). Nevertheless, and despite the persistence of a diverse array of therapies, biomedicine’s formally sanctioned position within health care has not been significantly challenged (Saks 1994), and the most likely scenario for the near future is the continued dominance of the medical profession (Saks 2001:129). For example, Fairfoot writes: “consumers have continued to indulge in covert resistance to medical monopoly in ways which essentially do not threaten the hegemony of the orthodox” (1987:389-390). Indeed, as mentioned in preceding sections, the legitimacy of any particular therapy is contingent upon its relationship to biomedicine. Therefore, exploring how alternative therapists legitimate their healing practice has become increasingly important in the study of alternative medicine (Bombardieri & Easthope 2000).

Sociologists point to a variety of reasons for biomedicine’s privileged place in Western society. Two key factors certainly were the emergence of the hospital and the emphasis on laboratory science as the biomedical knowledge base (Cant & Sharma 1999; Kelleher *et al* 1994, Salmon 1984b; Scott 1998). Beyond this, examining the effects of Enlightenment medicine on medical pluralism in the eighteenth century, Stacey (1988) argues that a variety of inter-linking processes led to its hegemonic position in health care. These included secularisation in modern society, philanthropic tendencies in medicine and the health care shift from ‘care’ to ‘cure’.

Others placed emphasis on the support and legitimacy that derives from biomedicine's association with the state. For example, Easthope (1986) describes how core members of the medical profession during the late eighteenth and early nineteenth century formed a social group in London that established contact with the political elite. Inevitably this led to a number of health acts from parliament which secured biomedicine's formally sanctioned position, and had the subsequent effect of disengaging it from other practices which were equally prevalent at the time (Cant & Sharma 1999; Saks 1991). From another perspective, Lupton argues that biomedicine's dominance had been established through its emphasis on scientific bases and science's association with authoritative expert knowledge (1994:107-108), a theme I consider in the next section.

Biomedicine, expert knowledge, and the de-personalised body

Biomedical knowledge reflects a society that valorises specialised knowledge systems, which are a particular feature of 'modernity'. Biomedicine had become an intrinsic part of the Enlightenment project and the project of modernity - indeed, biomedicine has been referred to as the 'medicine of modernity' (Stambolovic 1996:602). Freidson (1986) refers to the term 'formal knowledge' rather than specialised knowledge, which he contrasts with the everyday informal knowledge of lay people. In chapter two I explore modernity and its relationship to issues of knowledge and identity. In this chapter I comment on the expert basis of biomedicine, and consider the implications of this for its objectification of disease.

First, until the 1980s biomedicine was part of a rising tide of commitment to expert-defined and specialised/formal knowledge systems: "Orthodox medicine venerates the expert" (Taylor 1984:196). The increasing prominence of expertise perhaps also heralded the decline of the close relationship between patient and doctor (ibid). In

particular, this applies to the role of the general practitioner in the formal British health care system. As Kelleher *et al* explain, the local GP held “access to knowledge which transcended local concerns and was unavailable to ordinary people” (1994:xii).

Secondly, biomedicine also became more systematically focused on the biological aspects of human disease, and not on the need for holistic care. As Salmon states, “[medicine] continued with an ever-sharpening focus on anatomy, physiology, biochemistry, microbiology, molecular biology, surgery, pharmacology, genetics” (1984b:3). This has had the concurrent effect of alienating patients from the nature of their complaint.⁴

In the institution of biomedicine doctors are ‘socialised’ into valuing expertise and the subsequent objectification of disease (Good 1994; Kleinman 1980). As Sharma states: “Doctors are socialised into a scientific culture which makes an absolute distinction between their own systematised knowledge and the medical knowledge of the ‘lay’ person” (1992:121). Biomedicine generally neglects the personal meaning of illness for the patient. In chapter two I consider this theme of objectification in-depth, examining it in relation to a socio-cultural transformation in Western society and, in particular to the movement towards the personalisation of health and illness.

Nevertheless, there are both cultural and clinical variations in biomedical science, and counter-moves within biomedicine have been aimed at re-addressing the issue of the individual experience of illness (see Kleinman 1980; 1988). Also, in recent years, people’s trust in their own ideas about health and their bodies have accumulated, and a critique of the de-personalisation inherent in expert knowledge systems is now commonplace. This may be indicative of a wider crisis in scientific knowledge *per se* (Lyotard 1984:39) (see chapter two). For example, due to the greater accessibility of medical knowledge, patients are increasingly involved in the studying-up of their condition (Taylor 1984). Certainly, this may provide one reason why many people

increasingly decide to use CAM, and why there has been a change in the boundaries between lay and expert knowledge in Western society (Giddens 1991; Popay and Williams 1996; Popay *et al* 1998).

Biomedicine and the body

I now turn to consider biomedical concepts of the human body. In examining some of these concepts social scientists have focused particularly on biomedicine's association with the material/physical. I note that this materialist focus stands in direct contrast to therapies such as crystal and spiritual healing, with its emphasis on the importance of immaterial bodies. This issue is further examined in chapter seven.

There has been a notable emergence of interest from social science in the body and the theme of embodiment more generally (Csordas 1994a). Some of this has addressed medicine and its understanding of the body. Exploring the body in society helps us to understand current bio-political discourses and values in contemporary society (Lupton 1994). For instance, Foucault (1973) argued how practices such as the medical examination, the use of the microscope, and the various specialisations (anatomy, surgery, radiology), serve to exert power on the body and subject it to increasing regulation and surveillance. Investigation of the body has also considered issues of gender and sexuality (Arthurs and Grimshaw 1999; Watson 2000), discourses of the 'healthy body' and 'individual responsibility' in the 'new' public health (Peterson and Lupton 1996), discourses of disease and hygiene (Douglas 1966), consumption (Featherstone 1991) and commodification (Sharp 2000).

Within biomedicine the body can be regulated, manipulated and controlled. As Saks explains, "the body tends to be viewed as a machine whose parts can be repaired on breakdown" (1994:85). The prevailing metaphor is of the body as 'machine'.⁵ Samson (1999) and Synnott (1992) argue that this machine-based metaphor has its origins in

Cartesian reductionism, in that bodies are disconnected from the individual's sense of self. In contrast, Lupton (1994:59) explains that mechanical metaphors are a product of the industrial revolution, the critical time of biomedicine's emergence. According to Lupton, locating biomedicine in this era helps explain biomedicine's technological imperative, "the dependence on machinery to fix machinery" (ibid:60). Due to this physical reductionism, the biomedical body is a fragmented one – a body whose parts are treated in isolation. As a result, biomedicine dismisses questions of embodiment.⁶

In chapter seven I go on to explore how CAM's approach to the body differs from the biomedical one. In particular, I examine how the healers at the VEHC utilise a classificatory system where the physical body exists alongside a spiritual body. Furthermore, I show how the spiritual body is a conduit for self-identity. It is easy to see how biomedicine's pathological interest in the inner workings of the body represents an epistemological right to control intimate space: that of the topography of the physical body. These metaphorical issues are further discussed in chapters four, six, and seven.

Biomedicine and professionalisation

I now address the issue of professionalisation in relation to biomedicine. The question, 'To what extent does the medical profession distinguish itself from alternative medicine in terms of maintaining a unified approach?' is a current concern amongst social-scientists, and has also informed how CAM organises its activities. For instance, Saks (1992a) argues that biomedicine owes its hegemonic position to processes of professionalisation. It is not that biomedicine is wholly standardised or its practices unambiguously unified. Rather, because of its strong institutional and politically sanctioned position, it is able to rely on complex processes of professional closure, and also act as gatekeeper to valuable resources (Freidson 1988:304).

Cant (1996) argues that these processes are evident today. Biomedicine maintains an ideology of professionalism, and does so at a time when 'trust' in forms of expertise is said to be diminishing (Giddens 1990), and when the subject of the medical profession has increasingly turned to issues of 'professional decline' (Annandale 1998:223). Therefore, the perceived lack of 'standardisation' and 'systematisation' in CAM is one reason why the medical profession does not grant it widespread recognition. As Fulder states, "The lack of standardised training in the complementary therapies has given, and still gives, the medical profession ammunition with which to criticise the therapies" (1992:175).

However, some writers warn of the dangers of homogenising biomedicine. For instance, Helman states that biomedicine is distinctly cosmopolitan and has cross-cultural applicability: "There really is no such thing as a uniform 'Western' or 'scientific' medicine...there are enormous variations in how Western medicine is practised in different parts of the world, in different Western countries, and even within those countries themselves" (1994:105).⁷

'Medical pluralism' and consumerism in Western societies

In this section I address the issue of medical pluralism and the importance attached to the consumer in forging plural health care. It has been argued that medical pluralism in one form or another in Western societies has always existed (Bakx 1991; Cant & Sharma 1999). Also, Bakx (1991) states that there has always been a choice between orthodox and alternative practitioners and despite a short period of 'eclipse', the state of the health services in the Europe is again in a period of plurality. Nevertheless, contemporary healing practices are not a residual category of a pre-enlightenment period (ibid:28). That is, although we can talk of a 'resurgence' of healing practices, these are

distinct from those practices that manifested during the eighteenth century. Cant & Sharma's (1999) distinction between pre-modern medical pluralism and the 'new' medical pluralism of industrial capitalism is therefore a useful one. Also, if we accept Frankenberg's (1980) assertion that medical pluralism is an inevitable feature of class divided societies, then pluralism has always been extant in European society, and is unlikely to diminish in the foreseeable future.

The extent of medical pluralism has been considered cross-culturally (Crandon-Malamud 1997; Frankenberg 1980; Koss 1980). For instance, Cant & Sharma (1999) compare medical pluralism in the 'West' with non-Western contexts and explain that making cross-cultural comparison is rather fruitless and that our situation of supposed equality between medical practices is only apparent. CAM is not therefore the Western equivalent of traditional ethnomedicine or Shamanism (Sharma 1993). Equally, Bakx (1991) argues that the contemporary resurgence of alternative medicine in Western society has only tentative similarities with the traditional and indigenous medicine in other societies. In contrast, Helman (1994) states (like Frankenberg) that all modern societies exhibit health care pluralism, although he acknowledges that biomedical interests are controlled through the field of expert knowledge.

Various arguments have been compounded to account for this re-vitalised medical pluralism. First, Sharma argues that we need to take into account the role of the household in the consumption of CAM (1992:59). She explains that health care choices are heavily influenced by the actions of the other household members, a situation known as the 'lay referral system', a concept I return to in addressing lay perspectives on health. Furthermore, Cant and Sharma (1999) argue that health care choices are based on the same principle as any other consumer-based decision-making. Indeed, for Sharma, accounting for why people choose CAM is the same as asking the question, "Why do

people seek the services of plumbers or accountants?” (1992:24). Decision-making is, in fact, largely pragmatic.

In returning to Sharma’s first point, she states that the increased availability of CAM is not exclusively the result of a cultural shift to a consumer-based society. Sharma (1992) implies that usage is largely a matter of an individual choosing between an ‘x’ and ‘y’ product. The patient’s increased knowledge and access to media information are seen as pivotal. For Sharma, such pragmatism demonstrates that CAM users act as consumers exercising choice. Moreover, Cant and Sharma (1999) argue that the practitioner is chosen on the basis of the patient’s medical problem and not on any preconceptions they may have about the philosophical bases of the therapy. So, ‘users’ are perceived by Cant and Sharma as shoppers: “consumers of alternative medicine do gather advice and shop around...consumers are knowledgeable about appropriate care and in effect choose between practitioners on the basis of their medical problem” (ibid:37).

Secondly, in recent years the state has been instrumental in fostering a plural health market (ibid). The ‘state’ has promoted ‘self-responsibility’ for individual health care needs, an ideology that encourages individuals to seek advice beyond the financially stretched NHS. The state fosters many new enterprises which promote the new ideology of healthcare. I address the issue of ideology further in chapter two.

Thirdly, Cant and Sharma (1999) state that CAM will only be used widely if reasonably priced and popular. For example, they explain that crystal healing is only based in areas which have a wealthy clientele: “If spiritual healing or crystal healing or Reiki are as good as their proponents wish us to believe, what are the professional groups doing to see that they are available in every town and rural area, and not just in the areas that are close to training colleges or where the local population is wealthiest” (ibid:199). In direct contrast to this situation, I show how Granby’s impoverished socio-

economic condition (see the main Introduction) has not been any barrier to the establishment of a healing centre and a local network of healers.

In considering these individual points, I agree that the individual has increasingly had to make wider choices about health care, choices which are limited in the first instance by socio-economic factors. As Sirois and Gick explain (2002), on the whole CAM users tend to have higher incomes. In addition, I agree that some 'users' of CAM are just 'shopping around' (Sharma 1993). For instance, I go on to show in chapter three how the VEHC carried a range of eclectic practices under one roof, and healers and patients did not see this as a conflicting arrangement.

Also, the division drawn between the 'demand' and 'supply' of CAM implies that its usage and practice are separate issues - that practitioners maintain one agenda and that patients are just making choices about products. In chapter three I go on to show how patients/users of the VEHC are often encouraged to believe in their healing abilities, and that they also become healers. This is a moot point and a source for criticism of much social-scientific writing on CAM. Due in part to social sciences' need for generalisation, it could be argued that the local contexts in which healing is practised (a specific healing centre) are largely disregarded.

In the next section I address the issue of patient-practitioner relationships and lay perspectives on health - two major themes in relation to the critique of biomedicine. I consider how understanding these themes can help us to further contextualise the emergence of CAM.

Patient-practitioner relationships

Since the 1960s medical sociologists have been focused on the significance of the patient's role and the process of illness behaviour, such as understanding how the patient reached the doctor (Armstrong 1989). This role is more commonly referred to in medical sociology as the 'sick role' (Parsons 1975). Moreover, sociological studies have explored the relationship between doctor and patient, and the power dimension between them (Budd & Sharma 1994a). This theme has particular resonance in the UK where the doctor-patient relationship is synonymous with general practice (Bury 1997:77). Perhaps these studies merely confirmed what GPs already knew – that patients approach their doctor with subjective preconceptions about health and their body which have to be 'decoded' to make a diagnosis.

In this section I consider how the turn to CAM represents on one level key shortcomings in the biomedical encounter. First, Taylor (1984) points to the declining authority of doctors in Western society. He argues that the decline came about partly through the increased specialisation of medicine, a trend which represents a departure from the 'holistic' model of health held by ordinary people. For Taylor, at the heart of the biomedical relationship, "[is] an authority relationship which depends for legitimation on the sanctioning of the profession's claims to knowledge and skill" (ibid:210-211).

Secondly, in the first British Medical Association report (1986) on 'alternative medicine' a number of reasons are given for the turn to alternative health practices. Unsurprisingly, many of these reasons focus on the doctor-patient relationship: "An intimate bond between physician and patient has always been a hallmark of good medical practice" (ibid:74). Indeed, the medical profession focused on the quality of this relationship as being a key factor in alternative medicines' popularity (Brewin 1994;

BMJ 1983; Sharma 1994). As Furnham and Smith point out, “[people] who choose alternative medicine may do so from disenchantment with, and bad experiences of, traditional medical practitioners” (1988:685). In chapter three I explore how this dissatisfaction with biomedicine can be located in the narratives of two female healers at the VEHC.

A key feature of this relationship is the time the practitioner spends with the patient (Fraser 1981; Fulder 1985). Consultation time with a CAM practitioner is notably higher than with a biomedical practitioner, although regional differences exist (Fulder 1985) as well as important differences both between and within therapies. Also, the interest in the patient’s view of the illness has been perceived as a key factor in CAM’s popularity (Christie 1991; Murray and Shepherd 1993). It is argued that in CAM the patient’s view of their condition is taken into account, allowing the sufferer to maintain a “sense of control over the condition” (Murray and Shepherd 1993:987), prompting sociologists to explore issues of ‘client control’ (Budd & Sharma 1994b). This term signifies that ‘lay’ concepts of health are closer to the diagnostic and aetiological theories of CAM practitioners.

Thirdly, as patients develop greater knowledge about health they may share this information with a practitioner. Johannessen clarifies this issue, “Many patients explain that they have gained insight into new areas of health and healing and, thus, have gained a new perspective on their own health through consultations with complementary medicine” (1996:127). As such, it is possible that particular types of CAM are more likely to be seductive to users, for example those that maintain a more flexible idea of who is the expert. Johannessen suggests that the patient can empower him/herself through this mutual sharing and, indeed, constituting of knowledge. She calls this the ‘structuration’ of healing (ibid:120).

However, empowerment only relates to the claims about their own body. It does not, as Johannessen implies, come from a need to empower in the traditional 'expert' led manner. As such, patients do not seek general knowledge about bodies *per se*; rather, they merely seek greater knowledge of themselves and their own bodies, an issue Prior refers to as being experts, "by virtue of 'having experience'" (2003:53). Furthermore, this 'openness' to knowledge seems barely apparent in some CAM practices (e.g. osteopathy, acupuncture). Many therapists still prefer a hierarchical relationship. Nevertheless, as Sharma (1992) points out, practitioners may have to share knowledge in order to retain patients.

Fourthly, diagnosis and treatment within CAM can be highly individualised, and this is clearly one of its strengths (Fraser 1981; Johannessen 1996). Johannessen explains that such individualisation of treatment helps the patient to imbue a chaotic illness event with meaning: "individualised explanations hold great potential for meaning in treatment...it is likely to create order in the personal chaos accompanying sickness" (1996:117). Becker (1997), in a study of the disruption to self identity brought about by life-altering crises such as ill-health, also underlines this point.

Finally, concerns regarding the patient-practitioner relationship have led a re-evaluation of biomedicine in certain quarters, particularly in relation to the role that health professionals can play. Nurses and midwives encourage increased knowledge of the patient's point-of-view in order to help with their own health care regime (Rankin-Box 1988; Stanway 1979; 1994), and CAM practices are generally more popular amongst these health workers, a shift which is reflected in the newly emerging study guides to CAM for these professionals (see Rankin-Box 2001; Trevalyan and Booth 1994). Health care workers utilise 'complementary' methods in order to help both patient and professional share information and education: "sharing power, information and responsibility, exchanging views and comments" (Rankin-Box 1988:4).

The patient-practitioner relationship is an important issue in understanding and locating the boundaries between biomedicine and CAM. In chapter five I go on to demonstrate that inherent in the healing relationship at the VEHC is a deconstruction of the traditional schism between users and producers of healing knowledge. Relatedly, I consider below the ways in which healers' activities are representative of the changing boundaries between lay and expert knowledge.

Lay perspectives of health, illness and the body

In explaining the patient's explanatory model of health sociologists developed an interest in lay concepts. More recently, debates that address 'expert' and 'lay' knowledge have emerged within the social sciences (Popay *et al* 1998; Williams and Popay 1994) and these have been summarised by Prior (2003). These debates have led sociologists to develop both a critique of expert knowledge, and an appreciation of the distinctiveness of ordinary individuals' accounts of health and illness. As Stacey explains:

Ordinary people... develop explanatory theories to account for their material, social and bodily circumstances. These they apply to themselves as individuals, but in developing them they draw on all sorts of knowledge and wisdom, some of it derived from their own experience, some of it handed on by word of mouth, other parts of it derived from highly trained practitioners (Stacey 1988:142).

Within the sociology of science the prevailing 'deficit model' of lay knowledge of science, in which the public's understanding of scientific knowledge is perceived as limited, has been widely contested (Shaw 1999). The problematisation of medical and

scientific ‘expertise’ can also be witnessed in wider society, reflected in public responses to specific failures of the medical profession. For example, this can be seen in the scandal at Alder Hey hospital in Liverpool, where dead children’s organs were retained for research purposes without parental consent. Also, recognising the value of lay knowledge is increasingly becoming a part of mainstream health policy, reflected in government-led public health initiatives such as the ‘Expert Patient’ (DOH 2001).

A key issue I consider here is the importance individuals place on the use of lay networks or what are often termed ‘lay referral networks’. This refers to a process whereby people rely on recommendations from friends and kin in guiding their search for alternative health advice and information (Fulder 1985, 1988; Furnham 1994; Macfarlane & Ginnety 2001; Sharma 1992; *Which?* 1986). Based on an extensive survey of their readers, the consumers association *Which?* (1986) states: “Most people in our survey had chosen who to see on the basis of a personal recommendation from a friend or relation” (1986:444).⁸ The underlying reason for this behaviour seems to be the shared lay perceptions of illness experience: “These lay theories may also dictate who people turn to for advice, help and information when faced with illness” (Furnham 1994:715).

In addition, certain CAM practices demonstrate considerable sensitivity to lay concepts of health, due in part to the ‘shared’ nature and construction of alternative medical knowledge (Astin 1998). In chapters seven and eight I offer examples of CAM’s sensitivity to lay concepts in relation to the VEHC. A key example I give here is that of the existence of immaterial bodies, a concept that lay people often believe in, and which certain therapies explicitly address. But there is also a shared nature to this knowledge, a theme which I addressed in the previous section on patient-practitioner relationships. Healer and patient may be perceived as co-creators in the production of healing knowledge.

What, then, are lay perspectives of health, illness and the body, and how do these relate to CAM? First, lay concepts are bound up with the individual's complex (and not necessary logical or indubitable) understanding of the cause and effect of illness. In other words, other aspects of the person's life are often embedded into the narrative about illness causation. As Blaxter explains, "These lay theories can be very individual" (1983:59); and as such illness experience and the narrative recounting of illness can be highly individualised. In particular, lay people emphasise behavioural explanations in the event of them suffering certain illnesses. This increasingly becomes the case when the disease is named (Blaxter 1993; Sontag 1991); and more importantly when the name of the disease has connotative (metaphorical) implications (Sontag 1991).

Secondly, lay concepts of health and disease causation are therefore biographical (Blaxter 1993), and the patient account is necessarily subjective. Again, this can infer that ordinary people are more likely to individualise the disease. As Fraser explains, "patients want to be recognised as individual people with problems and preoccupations uniquely different from every other person" (1981:12). Lay perspectives are free from the constraining notion of 'objectivity' that permeates expert and scientific thinking, as Williams and Popay argue, "they are expressions of personal experiences which remain outside the worlds of science and politics" (1994:118). I go on to demonstrate in chapter eight that in the healers' classificatory system disease originates in the domain of the spiritual body, the seat of personal identity. Illness is considered to be a part of the person.

Thirdly, lay knowledge is bricolage. Busby *et al* explain what this refers to, "Such reflexively constituted knowledge is syncretic, developing from a process of 'bricolage' rather than any formal training" (1997:82). In considering the lay person as bricoleur certain writers claim, "Lay knowledge...has always been post-modern" (Williams &

Popay 1994:123). Yet, it is also true that this increased knowledge about health matters suggests that the patient is acting as their own expert – a ‘lay expert’ (Kerr *et al* 1998).

Fourthly, the emergence of lay-inspired therapies can therefore be viewed in part, as a challenge to expert knowledge. Such lay-inspired challenges can be witnessed in the range of public-led reactions to contemporary health issues and in particular health risks. For example, these reactions have been noted in the scientific inconsistency over messages concerning food scares (Shaw 1999), and in environmental health issues (Yearley 1991). More precisely, these challenges and critiques represent “a refusal by lay people to see knowledge as something that should be defined by experts and limited to the controlled spaces of laboratories, seminars, and peer-reviewed academic journals” (Busby *et al* 1997:81).

However, it is the insistence by biomedical clinicians that a boundary is maintained between expert and lay knowledge that accounts for the documented ‘dual allegiance’ people are reported to keep with their GPs and CAM practitioners (Sharma 1992). This parallel usage of biomedicine and alternative medicine has also been noted in key research studies (Furnham and Forey 1994; Thomas, Carr and Westlake 1991).

Finally, I commented in the previous section on the patient-practitioner relationship about the sharing of information and knowledge from healers. It has been noted that the democratic nature of this relationship has much in common with other therapeutic and self-help groups (see Edgar 1995; Vincent 1992), groups that are equally driven by lay agendas. For example, Vincent explains how these groups challenge expert knowledge “...through the recognition and celebration of the knowledge and experience that members bring to the group and are invited to share with others” (1992:148).

Professionalisation: CAM and the clamour for respectability

The question of legitimacy

CAM can be divided into those practices that seek wider cultural legitimacy and therefore gradual incorporation into the biomedical world-view, and those that remain on the margins of this process. Saks (1994) refers to these 'positions' alternately as 'incorporationists' and 'separatists'. Despite the schism, I emphasise that these diverse practices are part of the same phenomenon, the wider agenda of professionalisation in the field of health.

The aim of this section is to consider the extent to which CAM practices have sought legitimacy, and the social, economic and political benefits this can confer (Cant and Sharma 1999:80). Biomedicine does not solely confer legitimacy, legitimacy can be associated with the effects of the therapy (clinical efficacy) and in relation to the knowledge and ideas fostered within the local setting (in this case, the VEHC). All healing/medical practices seek some degree of legitimacy, but the question is how healers go about achieving this.

In considering the question of legitimacy I emphasise two key sources of legitimisation, which I have termed 'internal' and 'external'; the classifications draw attention to differential approaches to healing knowledge. I suggest that 'internal legitimacy' is normally generated through the context in which healing practice emerges. Internal legitimacy is conferred through the 'individuation' and 'personalisation' of healing practice and ideology. As such, legitimacy is conferred on the basis that the practice holds personal relevance for the healer – I go on to examine the wider relevance of these concepts in chapter two.

However, this source of legitimacy may be insufficient by itself. Hence, 'external legitimacy' refers to the process whereby healers emphasise/reproduce modernist

strategies such as ‘professionalism’, ‘systematisation’, ‘standardisation’, and the appropriation of scientific discourse as the benchmark of legitimacy. In addition, healers refer to concepts and ideas common to many medical practices. For example, in chapter four I explore this context in explaining what healers mean by concepts such as spiritual ‘hygiene’, a term that has medical connotations.

Within the heterogeneous field of CAM, practitioners differ in their approach to legitimacy; even within therapies there exists some ideological friction over their direction. Some therapists clamour for respectability, while others position themselves as critical of this process and of the orthodox medicine in relation to which legitimacy is sought. This tension can be identified through the emergence of particular therapies, and in their multi-faceted response to ongoing professional agendas. It is further exacerbated by the medical profession who have long adopted CAM for their own ends (Baer 1984), and that biomedicine may legitimate itself by non-scientific means (Lyotard 1984) – a key focus of chapter eight. In addition, therapists invariably downplay original and/or ‘esoteric’ practices from ‘charismatic’ early proponents in the search for wider acceptance (Baer *et al* 1998a; Cant & Sharma 1996b). Professionalisation, therefore, is a key issue within the study of CAM (Cant and Calnan 1991). In the following section I raise a number of themes: the professional ‘status’ of the healing practice, organisational issues such as regulation and training, and the demarcation of practice, all of which highlight the features of professionalisation.

The features of professionalisation in CAM

First, striving for professional status implies that practitioners have had to jettison ‘esoteric’ aspects of the therapy, such as particular knowledge claims. For example, consider the name changes that therapies have initiated – ‘Mesmerism’ has more recently become ‘Hypnosis’ (Bakx 1991; Easthope 2001). As Easthope explains: “[the

incorporation of alternative practice] may involve reformulating them or renaming them so that they can be seen as medical rather than non-medical practices” (2001:76).

This elimination of controversial naming of a therapy can be seen in the changes to homeopathy. Cant (1996) and Cant & Sharma (1995; 1996b) argue that since the 1970s, in contrast to medical homeopathy, there has been a dramatic change in the knowledge base of lay homeopathic practice. During the 1970s lay homeopathy was perceived as highly individualistic, even disorganised, and relying on the haphazard teachings of its charismatic early proponents. Cant and Sharma (1995; 1996b) state that the lay homeopaths they researched erect a firm boundary between themselves and the lay person. Although these practitioners wanted to emphasise their non-authoritarian relationship with the patient, they had to distinguish themselves from the patients’ lack of expertise, thereby emphasising a ‘deficit model’ of public knowledge.

Professionalisation therefore has the effect of de-radicalising. For example, Cant and Sharma (1996b) argue that homeopathy, despite its marginal beginnings, is now perceived as ‘complementary’ to biomedicine. Here, they state that professionalisation “de-emphasised controversial elements of their teachings, preferring instead a staunch commitment to the tenets of scientific medicine” (ibid:586). Moreover, Sharma explains that “professionalisation involves the consolidation and systematisation of knowledge” (Sharma 1996:169). This means that therapies have had to utilise orthodox methods on the road to acceptance, ‘borrowing’ their structures from the medical profession (Cant & Sharma 1999:64).

Secondly, on one hand an increasing number of practitioners make competing knowledge claims, such that there has been some fragmentation of knowledge. Yet on the other hand an increase in CAM practitioners adopting/appropriating science as a source of legitimacy has been noted (Cant 1996). This appropriation of science can be witnessed in other emerging, though formerly radical social movements, such as

environmentalism (Yearley 1991). Biomedicine has therefore managed to maintain an ideology of professionalism, even when trust in generalisable expertise is said to be diminishing (Cant 1996).

A key issue raised here concerns the standards CAM therapists bring into their practices to appeal to their 'consumers/users'. It has been noted that conflict arises between healing organisations over how to create a unified and standardised practice (Fulder 1992). Such standardisation would help non-medically qualified therapists to protect their interests and gain wider recognition (Saks 1991). Therefore, umbrella groups have now been established in CAM partly to induce the formation of codes of practice and ethics, but also to work towards demonstrating effectiveness (efficacy) to the scientific establishment (Sharma 1990:129). In chapter three I go on to explain how in crystal healing, quasi-authority groups have been established nationally by practitioners to perform these functions.

In the desire to professionalise, CAM practitioners increasingly draw professional boundaries around their activities. For example, discussing reflexology, homeopathy and chiropractic, Cant and Sharma (1998) argue that this concern for professionalisation led to the practitioners asking the researchers advice about how to professionalise their courses and liaise with universities. The main thrust of the article is significant in highlighting the process of gaining legitimacy and status through the acquisition and development of a common, unified approach and systematised body of knowledge:

The groups saw their future security and acceptability as lying in the development of a common body of knowledge accepted by all members of their professional community which would form the basis of training and the acquisition of educational legitimacy (Cant & Sharma 1998:248).

In contrast, Saks (1992b; 1995) explores the gradual inclusion of acupuncture into orthodox medicine during the period 1960s to the 1990s. Saks identifies a tension between the medically qualified and the lay acupuncturists. Much of this tension arises because biomedicine sanctions selected 'medical' features of acupuncture. For example, the ability to alleviate pain "[is] legitimated by orthodox neuro-physiological explanations" (1992b:197). This is another consequence of the de-radicalisation of therapies. Easthope (2001) makes a similar point, but adds that key tenets of acupuncture lend themselves to an orthodox explanation: "The adoption of acupuncture consequently does not cause any challenge to, or reappraisal of, the fundamental assumptions of the biomedical paradigm that sees disease as a malfunction of the body's biological mechanism" (ibid:76-77).

In addition, Baer (1984) outlined how lay osteopaths have attempted to gain legitimacy against the backdrop of increasing medical interest in the therapy. Lay osteopaths have pursued "[an] active policy of seeking state recognition" (ibid:719). Baer considers how striving for legitimacy was blighted by the formally sanctioned position of medically qualified osteopaths who were keen to retain a sense of dominance over the market and who achieved this through the deployment of various professional strategies. Miller (1998:1746) also witnessed these strategies in the credentialism of modern osteopathy that seeks to combine the statuses 'medical' and 'osteopathy' in their formation of a particular identity, exemplified in the use of the letters D.O.M (Doctor of Osteopathy) and M.D.O (Medical Doctor Osteopathy).

However, biomedicine has denounced some healing tenets that lay practitioners consider important. Saks (1996) argues that this is done so that biomedicine can retain its professional integrity and autonomy from CAM, particularly in the context of increasing discussions about CAM's incorporation into mainstream health care.

Biomedicine acts as a gatekeeper over the label of 'science', a strategy which helps to defend the self-interests of the profession and achieve professional closure.

Professionalisation: comparative issues in the US

The situation regarding professionalisation has been mirrored in the US. CAM practices like osteopathy and chiropractic have gained some wider acceptance amongst the medical profession, though more marginal therapies remain largely rejected in US society.

Baer *et al* (1998a) explore the crisis surrounding the status of non-medically qualified acupuncturists in the US. This crisis had been exacerbated by decisions taken on the issue of whether they should they act as generalists and say they can heal all conditions (thereby remaining marginalised but true to their original teachings), or conversely, whether they act as specialists by locating the therapy within a biomedical curriculum. Baer *et al* explain, "schools have been forced to place a heavy emphasis on biomedical concepts and procedures in their curricula" (ibid:534-535). These changes took place in order to cultivate a professional image and to ensure acceptability by the wider medical community and the US state laws. For example, in one case Baer *et al* (ibid) argue that biomedicine tried to make lay acupuncture illegal so that they could monopolise the services amongst their own staff. This was despite acupuncture being more commonly referred to as Traditional Chinese Medicine (TCM) both amongst practitioners and patients.⁹

However, Baer *et al* (1998b) explain that such de-radicalising has been resisted in certain quarters, and this is an issue I consider briefly in the following section. For example, in discussing the 'holistic health' movement in the San Francisco Bay area of the US, Baer says that certain factions of the movement wish to retain their counter-cultural tradition. Baer's findings are particularly applicable to homeopathic groups in

that area of the US, as the San Francisco Bay area is often cited as unusual in its atypical representation and distribution of alternative therapists.

The resistance to biomedical hegemony

Clearly, therapies that utilise orthodox models produce a more certain case for their inclusion into mainstream health services. However, in contrast to the assimilation and incorporation noted above, some social scientists have brought our attention to resistance to these modernist strategies: professionalisation, standardisation and systematisation.

The critical response to biomedical hegemony can be seen in a number of studies and for a number of reasons. First, Baer (1998a) demonstrates that Asian acupuncturists and healers using TCM ignore the call to introduce biomedical concepts and procedures into their curricula. In an analysis of TCM Patel (1987) explains that homeopathy and acupuncture hold a substantively different world view to biomedicine, thereby representing a key threat. Busby (1996) makes a similar point in relation to TCM approaches to medicine and, in particular with regard to their understanding of the workings of the physical body, an issue I return to in chapter seven. In the same article by Baer *et al* (1998b) on the holistic groups of the San Francisco Bay area, a similar theme emerges: that many therapists wish to remain as counter-culturalists.

Secondly, resistance to orthodoxy may feature because the processes of systematisation embedded in medical orthodoxy differ fundamentally from the healers' ideas about expertise. For example, Cant and Sharma discuss how a sector of the lay homeopathic community in the UK remained strictly opposed to the developments of most lay homeopathy, believing in the practice as egalitarian and democratic, "a radical health movement which distrusts 'experts' and expertise" (1995:752). Other writers have followed-up these issues in explaining that certain healing practices represent a

critique of biomedicine, a challenge to professionalisation and the biomedical model (Kelleher *et al* 1994; McKee 1988; Saks 1994). Further, McGuire writes that health seeking behaviour which acknowledges certain alternative health options represents an outright challenge to biomedical hegemony in health care systems: “the health-seeking patterns and attitudes toward the medical profession exhibited by many of the respondents can be understood as a counterassertion of power against the dominance of the medical profession” (1988:201).

Thirdly, in explaining the growth of naturopathy and homeopathy in the US, McKee (1988) argues that the criticisms are not just aimed at biomedicine, but at the nature of capital accumulation in general. Certain alternative practitioners, McKee explains, articulate a critique of economic capitalism. Kelleher *et al* (1994) on the other hand, have paid attention to the wider issues linked with this rejection of professional paternalism, arguing that the explosion of interest addresses wider social and cultural changes: a freedom of expression and a new exploration of self and body, a theme I give weight to in chapter two. As such, in particular contexts CAM represents a backlash against conventional models of expert authority and legitimacy: “From this standpoint the challenges to the expert system of modern medicine could reflect the breakdown of legitimised authority, permitting any number of challenges to be made” (ibid:xxii).

Finally, self-help groups also share the appeal to non-expertise and the use of democratic knowledge, a challenge to the idea of expertise and knowledge of a profession. Hence, as many marginalised alternative therapies consist of individuals who are disillusioned with orthodox biomedicine, the challenge to biomedicine can be seen as one that is a representation of the ‘folk’ inspired challenge to the institutional nature of biomedicine (Williams & Popay 1994).

Conclusion: exploring the continued influence of biomedicine in the use and practice of CAM

In this chapter I have achieved the following. First, I have examined the issues surrounding the emergence of a varied field of alternative medicines. This emergence or 'contemporary resurgence' has been located against the backdrop of a period of biomedical hegemony, which continues to re-assert itself within CAM ideology. Secondly, the issue of medical pluralism is important, and we can argue that the UK is currently experiencing a period of plural health care activity. The issue of consumerism has been addressed, and the pragmatic explanation for rising usage, although I explain that patients may choose healing practices such as crystal healing for reasons that extend beyond the pragmatic. Thirdly, I have pointed to the changing role of expert and lay knowledge as being a contributing factor in the popularity of CAM. In particular, I have noted that lay concepts of health and illness are invariably closer to CAM concepts than biomedical ones, and that lay concepts are biographically embedded. Finally, I have argued that therapies are divided over the degree to which they seek cultural legitimacy through strategies of incorporation, and I go on to explore in chapter four, five, six and seven particularly, how the hegemonic influence of science, and more specifically biomedicine, continues to reassert itself through even esoteric therapies.

The resurgence of a varied field of alternative medicines has mainly been attributed to the changing public response to biomedicine, which has experienced various crises. Furthermore, most researchers exploring CAM have taken medical dominance as a starting point (Sharma 2000:211), so this requires further elaboration. Therefore, what I go on to explore in the following chapter is the relationship between biomedicine, CAM, identity and knowledge in contemporary society. In the following chapter, then, I

locate the changing fortunes of biomedicine in a particular socio-historical period – the movement from modernity to postmodernity.

Rather than seeing alternative medicine as an unproblematic category in terms of the consensus that is seen to exist, I explore alternative medicine as a contested ground, and one which is constituted by a plethora of individual and sometimes incommensurable narratives. In particular, I explore tensions and paradoxes within healing. For example, as I have explained, I demonstrate how healing at the VEHC emerges as a critique of biomedicine, but that participants also find themselves reflecting and mimicking its strategies in the healing context.

¹ Early criticisms from within biomedicine were not authored solely by the BMA. Significant articles appeared in a number of BMJ editorials (1980) and (1983).

² For example, McGuire (1988) argues that biomedicine and forms of alternative medicine operate within totally different paradigms of health and illness.

³ In relation to acupuncture in the UK, see for example Saks (1995), and in Australia, see Easthope (2001).

⁴ For example, Synnott (1992) states that the American Medical Association (AMA) recognises twenty four distinct medical specialisations.

⁵ Miller (1998) notes that biomedicine does not have a monopoly on this metaphor; CAM practices such as osteopathy have also perceived the body as a machine.

⁶ Biomedicine's understanding of the body is forged through the epistemology and ontology of materialism, and such concerns can be located in philosophical discussion. For example, in defending the individual as a critical and constituting subject (one who has agency) Sartre provides a blunt critique of materialism: "All kinds of materialism lead one to treat every man including oneself as an object – that is, as a set of pre-determined reactions, in no way different from the patterns of qualities and phenomena which constitute a table, or a chair or a stone" (1989[1948]:45).

⁷ For a clearer analysis of the complexity of biomedicine, see Good (1994); Good M-J D (1995); Hahn and Kleinman (1983); and Helman (1994).

⁸ Survey based on a sample size of 1,942 readers.

⁹ TCM: a variety of practices brought over to the US, and without a standardised set of healing principles.

The rise of individuation: knowledge, the body and identity in postmodern society

Introduction

In this chapter, and throughout the thesis, I argue that the emergence of a varied field of alternative medicines reflects a profound socio-cultural transformation, conceptualised by some social theorists as the move from ‘modernity’ to ‘postmodernity’ or ‘late-modernity’ (Bauman 1992, 1995; Giddens 1990; Harvey 1990; Jameson 1991; Lyon 1999; Lyotard, 1984; Smart 1993).¹ In this chapter I refer to both postmodernity and late-modernity – indeed, Bauman’s reading of these terms is that they can be used interchangeably (1995:6).

Postmodernity denotes those changes or tremors in ‘late-modern’ society that represent the privileging of the ‘subjectification’ and ‘personalisation’ of public life. Primarily this movement towards such personalisation infers that social life is characterised by a plurality or multiplicity of discourses, and that any interpretation of social reality must maintain an “incredulity towards metanarratives” or grand narratives (Lyotard 1984:xxiv). In this chapter I locate what this subjectification and personalisation signifies in terms of CAM. Therefore, the aim of this chapter is to further contextualise the emergence of alternative medicines and their relationship to the postmodern era.

First, in this chapter I begin by further exploring the hegemonic rise of biomedicine in the field of health, but in the wider context of modernity. Key features of modernity

such as the ‘systematisation’ and ‘de-personalisation’ of biomedical knowledge are discussed. In the thesis ‘systematisation’ refers to the standardisation of knowledge through specialist fields, training, accreditation and codification. It also draws attention to the ways in which knowledge becomes formalised as orthodoxy. ‘De-personalisation’ refers to the ways in which expert knowledge eschews the individuality of the person.

In addition, I go on to explore a tension between individuation and systematisation at the healing Centre. Here, individuation refers to the process of becoming individual, and the ability to distinguish one’s sense of individuality from others, through agency. It also denotes the individual’s unique capacity to relate health, illness and body to the place of the self. Thus, individuation is the process whereby individuality can be expressed and difference asserted. I also explore this process in the context of debates about the nature of individuality and the ideology of individualism.

Secondly, I explore the apparent ‘blurring’ of the boundaries between ‘lay’ and ‘expert’ knowledge, and the supposition that knowledge, in its differing forms, is perceived as having a ‘reflexive’ quality. In chapter one I explored how the critique of medical expertise can be witnessed in wider society, reflected in public responses to high profile failures of medicine. I argue that the contestation surrounding the role and individual usage of knowledge is additionally illustrative of the move towards postmodernity.

In conclusion, I summarise the implications of this socio-cultural transformation for the emergence of crystal and spiritual healing practices in a particular setting – the *Vital Energy Healing Centre*.

Modernity: the growth of (bio)medical expertise

In chapter one I described how biomedicine, though a peripheral player in the development of crystal and spiritual healing, is nevertheless an important concern of the thesis. Indeed, the emergence of a wide field of alternative medicine has been broadly contextualised in relation to biomedicine. With regard to this study, such a focus is important for two reasons. First, it has importance because individual healers at the VEHC appear to position their healing practices in relation to the biomedical paradigm, and secondly, because of the socio-cultural prevalence of biomedical science among Western concepts of health and illness. However, the phenomenon of CAM is much wider than the relationship it has with biomedicine, therefore broader statements can be made regarding its recent emergence.

In this section I outline the key features of modernity and how these are synonymous with the rise of biomedicine. Here, I address the following questions. What is modernity? In what ways did modernity allow for the emergence of a biomedical hegemony in the field of healing in Western society? In what way does the biomedical principle of the 'systematisation' of knowledge alienate the person from their body?

Modernity, in the guise of biomedicine, is undoubtedly global in its influence and consequences. For example, Stacey (1988) argues that biomedicine has a global influence, despite the continued importance of indigenous medicine in many parts of the world. This global feature informs us about the hegemonic influence of biomedicine. These features of modernity are also wide ranging in terms of the institutional aspects of social life that have come under its influence - not just health, but also the family, work, politics, and education.

Arising from the intellectual and cultural crises in Europe (and America) in the fifteenth and sixteenth centuries, and crystallised later as a kind of intellectualised and elitist 'project' of the Enlightenment between the late seventeenth and early eighteenth century (Scambler and Higgs 1998; Lupton 1994), modernity has been viewed as bringing the principles of truth, universality, rationalisation, objectification, expertise and specialisation to the domain of public life (Fox 1993; Harvey 1990; Scambler and Higgs 1998; Lyon 1999; Smart 1993). Enlightenment medicine (later biomedicine) therefore, with its roots in Cartesian mind-body dualism, sought to promote the values of empiricism, rationality and secularism, with the broader aim that it should "[look] to science to produce transformations in health" (Porter 2000:153).

This emerging world-view helped to overturn prevailing perceptions of humanity common with the late-medieval era: a period of history that has been associated with superstition, primitivism and unreason (Hatty & Hatty 1999; Samson 1999), although it is important to note that reason and purposeful, secular rationality had either replaced or had sanctioned the moral guidance of religious faith. As Porter (2000) explains, modernity did not necessarily equate with the total rejection of religion. In addition, Giddens (1991) argues that modernity brought about a heightened sense of exclusion, marginalisation and feelings of difference and dependency. For example, witness the marginal status of CAM in Western societies.

Biomedicine and the systematisation of knowledge

In addition, biomedicine produces and maintains medical specialities that generate a systematised body of knowledge (for example, immunology, neurology, and oncology). In turn, these control the trajectory that biomedicine takes and maintain its hegemonic status in the field of healing. Moreover, CAM is invariably examined in relation to this systematised quality of scientific medicine, with the verdict that no other healing

practice has come close to repeating its totalising body of knowledge: “no competing system has systematically assembled a body of knowledge expressed more fully in texts, refereed journal articles, and clinical studies than scientific medicine” (Salmon 1984b:2).

To recap, since the mid to late nineteenth century, biomedicine has achieved social, economic and ideological dominance over healthcare in Western societies (Cant & Sharma 1999:1), the various features of which I explored in chapter one. As such, the emergence of biomedicine as *the* globalised and formally sanctioned medical system has its roots in a very ‘modern’ phenomenon. Here, I refer to modern in the sense of modernity and the processes whereby the industrialised world has been transformed from its “post-traditional order” (Giddens 1991:1).

Modernity and the ‘dis-enchantment’ of knowledge

In addition to the systematisation of knowledge, the ‘project’ of modernity justified and legitimated certain social practices and policies in terms of what people saw as morally right, and for the benefit of social progress. Furthermore, this pace of change experienced through economic orders such as industrialisation was justified in terms of ‘natural’ progress, and one that had at its core a process of rationality. As Bauman observed, modernity has always been concerned with “making a virtue out of necessity” (1995:107). In this case the necessity was that modern medicine, through the dual process of intellectualisation and rationalisation, would help to improve health in industrialised societies. As Smart explains, “Since the eighteenth century there has been a prominent assumption that increasing rationality is conducive to the promotion of order and control, achievement of enhanced levels of human understanding, moral progress, justice, and human happiness” (1993:91). The emergence of biomedicine illustrates an aspect of this increasing rationality.

The process of rationalisation and intellectualisation led to the break-up of established ways of thinking and acting. The notable increase in rationality was synonymous with the destruction of 'magic' and 'irrational explanation' from the world and social thinking (Gijswijt-Hofstra *et al* 1997; Macfarlane 1978:49). Further, as Lyon explained in a more recent cultural analysis of postmodernity (and quoting Weber): "[the] reign of rationality...would produce the 'disenchantment of the world'" (1999:37). This idea of Weber's regarding the 'dis-enchantment' of the world is emphasised in an equally persuasive manner by both Macfarlane (1978) and Smart (1993), and referred to the notion that 'non-rational' acts would be increasingly marginalised in a techno-rational world.

Modernity and the 'depersonalisation' of knowledge

In chapter one I explained that biomedicine is perceived as existing independently of those who choose to use it: "scientific medicine has been given a life of its own apart from the human actions and the power of the vested social interests that create and maintain it" (Salmon 1984b:4). Biomedicine is therefore considered to be a 'depersonalised' form of knowledge. It objectifies disease, thereby eschewing the individual from any diagnosis. Biomedicine therefore enhances bodily alienation or anomie in the individual, for this model denies making the disease 'meaningful' for the patient, as Good explains, "[A clinician] assumes that diseases are universal biological or psychophysiological entities, resulting from somatic lesions or dysfunctions...[hence, diseases] transcend social and cultural context" (1994:8). Moreover, it is this increasing depersonalisation that Weber would have associated with modernity (Smart 1993). The de-personalisation of biomedicine is a cross-cutting theme, and I go on to explore how therapies such as crystal healing are illustrative of contrastive processes towards the 'personalisation' and 'individuation' of health, illness and the body.

However, I should place these assertions in the context of the ‘ideal type’ notion of biomedicine, as it is perhaps the ‘myth’ about biomedicine that it is de-personalised. For instance, I also noted in chapter one that there have been moves within biomedicine to address the individual experience of illness. Nevertheless, I consider this feature to be an important preconception, which can affect ordinary people’s views about medicine.

In exploring biomedicine, I have explained that its influence should be located in the context of modernity. Biomedicine’s continued influence and power must also be interpreted in this way. A key thematic strand that runs throughout the thesis is the way in which we see the continued influence of biomedicine even in the most esoteric and non-medical healing practices and ideologies. A key question I ask is – are these healing practices an unwitting deference to science and biomedicine, or do they constitute a creative and individual ‘play’ with the available (though restricted) cultural codes and discourses? These issues are further elaborated upon in chapter five.

‘Lay’ and ‘expert’: blurring of the boundaries between personal and professional knowledge

Since the 1960s and 70s scientific knowledge and expertise has experienced criticism from various quarters. In addition, social scientists have given considerable attention to lay classifications of health, and the implications these have in terms of individual health and responsibility in constructing and maintaining the ‘healthy body’ (Blaxter 1983; Herzlich 1973). Indeed, medical sociology textbooks now provide whole chapters that explore lay knowledge (see Bury 1997; Nettleton 1995). Furthermore, the sociological critique of expert knowledge emphasises the importance and distinctiveness

of ordinary people's knowledge for understanding the body, health and illness (Stacey 1988).

'Expert' knowledge for example, is seen as having somehow fed back increasingly into everyday life. This has occurred in two distinct ways. First, in what is often referred to as the 'medicalisation' of everyday life (Zola 1972) and, in Habermasian terms a 'colonisation of the life-world' (1975), medicine has encroached its forms of rationality into key areas of personal and social life. With regard to Habermas' concept of 'colonisation', we see how medicine, through its close relationship to the state and the wider economy, forces individuals to think about illness in ways that are inextricably and unavoidably linked to the public sphere, which is seen as being controlled by money and power (Scambler 2002).

Secondly, this encroachment can be located in terms of ordinary people absorbing expert knowledge. Therefore, increasingly we see 'lay expertise' (Kerr *et al* 1998; Popay *et al* 1998), but we can also note 'expert uncertainty' (Shaw 2002). So, the division between 'lay' and 'expert' has been increasingly 'blurred' and greater attention is given to the range of knowledge that may exist. However, it is important to note that the shift in the relationship between lay and expert knowledge is also linked to more mundane developments such as the increase in self-help groups and literature (Vincent 1992) and internet websites about health (Hardey 1999).

Bury (1998) argues that two issues are central to the issue of lay and expert knowledge. One issue concerns the importance of the reflexive quality of 'late-modern' life (Giddens 1990, 1991), in which as I have explained, expert knowledge is seen as encroaching on ordinary people's everyday life. The second issue concerns the changing boundaries between lay and expert knowledge, a boundary which Bury explains has become more contestable. This contestation highlights the social and cultural transformation from modernity to postmodernity: "These [lay experts] transform

modernity's reliance on expertise and the 'docile' body into a more fragmented and less authoritative scientific voice on the one hand, and a more active and sometimes resistant stance of the lay person on the other" (Bury 1998:11-12). Therefore, this blurring of the boundary has implications for scientific biomedicine as well as the lay person.

The key question that I address here and that informs later chapters is: does the blurring of the boundaries further illustrate the crisis in modernity in which personal and individualised discourses are re-asserted into the public domain, or is it a sign of an impending 'postmodern' era where we have a 'contestable culture'?

The ideology of 'responsibility' for health

In foregrounding the newly established 'expertise' of the lay person, individuals are persuaded to take individual responsibility for their health. The theme of individual responsibility is central in understanding the political and ideological features of modern health-care and has been a prominent issue in the social scientific study of health (see Aakster 1986; Becker 1997; Blaxter 1983; Bury 1997; Cant and Sharma 1999; Coward 1989; Furnham & Bhagrath 1993; Helman 1994; Kronenfeld & Wasner 1982). Yet, does this ideology have empowering or dis-empowering consequences? One way of looking at this issue would be to consider another manifestation of empowerment, such as for example self-help groups, the 'confessional' arena and other experiential group pursuits, such as dreamwork analysis (Edgar 1995). These newly established groups involve "processes that permit individuals and families to take initiative and responsibility for their own health" (Kronenfeld & Wasner 1982:1120). Embedded within their philosophy is a belief in the process of self-healing and self-assessment, and those individuals make their own health-related decisions.

The ideology of individual responsibility for health has particular salience in the US. In this context, placing the onus for health on the individual is perceived as part of an

over-arching ideology of self-control and self-mastery: “In the United States, personal responsibility for health is paramount, and people feel a keen sense of responsibility for regaining their health when they become ill” (Becker 1997:45).² It has been argued that this is one reason why people may ‘shop around’ for health advice. Baer (1998b) is highly critical of this situation, arguing that highlighting responsibility fosters a ‘victim-blaming’ ideology. Such health ideology de-politicises the socio-economic origins of ill health such as income and housing.

In the UK such health ideology that focuses on ‘blame’ has gained similar ascendancy in analysing the socio-political background of the 1980s – i.e. Thatcherism and the ideology of self-blame and responsibility (Hall & Jacques 1989). Some sociologists argue that this political ideology has played a contribution in the increased popularity of CAM (Bury 1997; Cant & Sharma 1999) and also self-help groups in the UK (Vincent 1992). Sharma (1992) for instance, highlights the ideology of consumerism and individual responsibility as significant in helping to foster a plural health market. More currently, the emphasis on individual responsibility for health is a key part of the ‘new’ public health policy in the UK, advocated by the present Labour government.³

In addition, this focus on the consumer-led culture is particularly convincing when applied to health care. For example, witness the demand for off-the-shelf complementary remedies which pharmacies such as Boots have capitalised on, and in the ‘shopping around’ that the behaviour of the majority of ‘complementary’ medicine users seem to demonstrate (Cant & Sharma 1999; Sharma 1992). However, as I demonstrated in chapter one, not all CAM practices owe their use to a consumerist approach to healthcare. A myriad of therapies flourished in the seventeenth and eighteenth centuries, long before the advent of consumerism (Stacey 1988). I return to

the issue of individual responsibility later in the chapter in discussing the ideology of individualism.

The advent of postmodernity: the ‘subjectification’ and ‘personalisation’ of social life

Further along the road of blurred knowledge systems and the fuzzy boundaries of expertise lies a new ‘peril’ - that of postmodernity. Postmodern society is seen as the result of the increasing importance placed on lifestyle. In particular, it is argued, consumption of material goods involves a re-assertion of the subjective and the individual within social reality. As a consequence, the world appears to be a pool of choices in which people act as ‘*bricoleurs*’: i.e. individuals fashion a cosmology or world-view in order to make sense of their own biographical situation and personal concerns. In postmodernity the motto is “anything goes” (Gitlin 1988; Smart 1993:103), and there is a place for everyone (Gitlin 1988). More specifically, in postmodern society individuals experience a wider range of choices over the way they understand and creatively construct ideas about health, illness and the body.

Postmodernity or (post)modernity: a contested concept

Postmodernity is viewed not only as a ‘contested concept’, but also internally conflicting and contradictory (Jameson 1991:xxii). More generally, social theorists are divided over how the two sets of social, cultural and economic arrangement (modernity and postmodernity) are to be classified (Bauman 1992, 1995; Featherstone 1998; Giddens 1990; Harvey 1990; Lyon 1999; Smart 1993). A central question becomes: is this profound transformation in modern society an example of a change within

‘modernity’ but not a departure from it (Giddens 1990), or is it a sign of an epochal break (Lyotard 1984)? Smart has characterised the debate thus: are we witnesses to postmodernity or *postmodernity* (1993:12)? This debate has a significant application to my argument as I go on to argue that the healing practices I observed and participated in are illustrative of a particular socio-cultural phenomenon, which I suggest is illustrative more of postmodernity than *postmodernity*.

Featherstone (1998) argues (*per* Lyotard 1984) that postmodernity represents a new era, a period that symbolises and eulogises a complete shift in values and principles: “to speak of postmodernity is to suggest an epochal shift or break from modernity involving the emergence of a new social totality with its own distinct organising principles” (1988:198).

In contrast, Giddens (1990) explains that situating the historical place of postmodernity and the changes it portends is contradictory, as the situating is contrary to postmodernism’s emphasis on anti-foundationalism. As Giddens explains, “giving some coherence to history and pinpointing our place within it” (*ibid*:47) has been seen as impossible by theorists of postmodernity, so it is perhaps contradictory to situate a socio-cultural movement that renounces the whole idea of situating.

Interesting as these debates are, they are slightly beyond the boundaries of the thesis. However, I argue that it is the former - that the characteristics identified with the term ‘postmodernity’ (and not *postmodernity*) are perhaps an inevitable feature of the globalising effects of ‘late modernity’ (Giddens 1990, 1991). Furthermore, postmodern analysis relies on modernist principles in language and writing, strongly suggesting that such a transformation is part of and integral to the same economic and socio-cultural phenomena. My only additional thought on this matter is that postmodern theorists tend to take no account of the socio-cultural features of capitalism, implying that a postmodern age is a capitalist age, no less. Specifically, this is a criticism levelled at

Lyotard (Saks 1998), although writers such as Jameson (1991) have produced a more in-depth materialist account as to why postmodernity is the emergent product of a modified capitalism.

The socio-cultural features of postmodernity

What, then, are the socio-cultural features of postmodernity? First, Bauman (1995) argues that under modernity, expressions of individuality and the community were stable and fixed and gave the individual little room to manoeuvre between different and sometimes opposing 'life-worlds'. In postmodernity these relations and notions of belonging are loose and disposable so that identity becomes a 'DIY' creation: it is individually crafted and fashioned to the personal project.

Secondly, postmodernity is characterised by the privileging of subjectivity and indeed represents an increasing trend towards a plurality of subjective discourses. As Smart says, "We find ourselves living amidst a plurality of doctrines and styles of reasoning" (1993:120). Giddens too emphasises this point and outlines the implications for scientific knowledge: "The post-modern outlook sees a plurality of heterogeneous claims to knowledge, in which science does not have a privileged place" (1990:2). Although science is the most culturally embedded and reflexive system of knowledge in modern society, I note that changes to the public status of science has fundamental implications for the legitimacy of knowledge in the postmodern era.

Saks continues this theme: "[postmodernity] is normally conceived as being characterised by a plurality of cultures of social groups, with a tolerance of minorities and a willingness to combine multiple discourses" (1998:203). Saks' sentiment is echoed by Thompson who explains that newly established forms of social identity and social groups, "represent new and often surprising combinations and crossovers of codes and discourses" (1992:247). Therefore, new social groups seek to *combine* the

institutional features of modernity alongside those values that seem to have been hitherto excluded. For example, “The kinds of phenomena include some that modernist thought would have regarded as marginal or antithetical to modern life: the sacred, charisma, passion, spirituality, cosmic meaning and unity, enchantment, community” (ibid:247).

I go on to demonstrate in chapter four, six and seven key examples of these ‘combinations’ and ‘crossovers’. For example, I point to the ways in which crystal and spiritual healing practices embrace perceived biomedical idioms and symbolism, and engage with concepts that are common to both healing practices. In addition, the ‘crossovers’ and ‘combinations’ demonstrate that such healing practices cannot escape or work outside of the hegemonic discourses of science and biomedicine, discourses that are woven into the fabric of Western society. As Lyotard adroitly explains in his analysis of the postmodern condition, “the weight of certain institutions imposes limits on the games, and this restricts the inventiveness of the players in making their moves” (1984:17).

Postmodernism, consumerism and the body

One of the defining postmodern ‘experiences’ is the existence of a proliferation of discourses surrounding the subject of the body: “Attention to the body has turned into a supreme occupation” (Bauman 1995:119). In her book on the rise of a new philosophy of the body and health, Coward (1989) argues that the fact that CAM practices draw attention to health and the body does explain some of the reasons for its popularity.

Health practices represent a turn to seeing the body as an individual project, where notions of fitness and healthy living are tied up with keeping the “sensations gathering body” satisfied (Bauman 1995:118). For example, the symbiotic relationship between CAM and fitness practices more generally has been noted (Goldstein 2000). Bauman

(1995; 1998) explains that the postmodern body emphasises the 'receiving of sensations'. The postmodern body, like the patchwork construction of an individual identity, is a DIY creation. The body is therefore a symbolic space where people take up personalised/individual concerns. As Coward explains: "Health is now a goal to be actively pursued, if rarely achieved, and it has become indelibly linked with individual attitudes, and individual commitment" (1989:46).

In contrast, Cant and Sharma argue: "This interest in the body may be seen as a matter of personal choice in a world of expanding consumption possibilities, offering scope for playfulness, creativity and jouissance" (1999:193). Furthermore, they state that the idea of individualised solutions to health reinforces ideological individualism of the 'new right'. Similarly, Coward (1989) explains that the notion of being 'fitter' (physically or spiritually) is linked to people being able to produce and consume more, thereby promoting a capitalist ideology. This idea has similarities with Talcott Parsons' notion of the 'sick role' (1975), in which he argued that individuals who are ill are treated as deviant as they are temporarily suspended from the economic processes of production and consumption in modern capitalist society. As such, in order to avoid 'blame' or 'responsibility' for their condition, the patient must have the 'sick role' conferred upon them by an orthodox medical practitioner.

Individualism, individuality and the rise of individuation

Other explanations for the emergence of CAM have included the rise of individualism, which is one of the arguments suggested by Cant and Sharma (1999). Certainly, the use and practice of alternative medicine can be attributed to a *kind* of individualism: notably, that CAM's main tenets often reinforce self-responsibility and control over

health and, further, that CAM encourages individuals to see themselves as autonomous actors in health care. In particular, the relation between a 'modern' individualism and the emergence of 'New Age' healing in particular can be seen during the influence of Thatcherism in the 1980s. As Sharma argues:

I view both New Age rhetoric and Conservative ideology as modern transformations of an individualism which is very fundamental to English cultural life, but the renewed expressions of this individualism is certainly having an important effect on current public discourse about health (Sharma 1992:203).

Sharma's conjunction between the modern Conservative ideology of individualism and the emphasis on self-responsibility for health is an important one to make, but as she suggests there is a more fundamental and culturally embedded sense of individualism and it is this concept that I draw attention to below.

What is individualism? In making a comparison between the Western idea of the individual and the notion of 'holism' in Indian society, Dumont shows us that individualism, as a form of nominalism, "grants real existence only to individuals and not to relations" (1986:11); meaning that it is only through the 'relations' between individuals that people establish their sense of individuality.⁴ For example, at the VEHC I go on to show how the individual healer's sense of individuality emerges from the points at which their ideas and values contest with others. Furthermore, individualism refers to the person who can cut him/herself off from a "proximity to and relationship with others" (Strathern 1992:13). As Strathern states, it is important not to look at individuals in isolation:

English ideas about the value of individualism and the individuality of persons are not to be understood simply in terms of what they describe, namely by documenting people's solitude or resistance to taken-for-granted relationships – any more than ideas or concepts exist on their own! They co-exist with others. The observer must consequently look at the management of relationships and at the relations between ideas (Strathern 1992:14).

However, Macfarlane (1978) has argued that the Anglo situation regarding individualism is unique, which I believe may account (in part) for this profound social and cultural transformation. For example, Macfarlane presents an illuminating account of the unique qualities of English individualism, and the extent to which individualism is embedded at an earlier stage of English history than had previously been suggested by writers such as Dumont (1986). Indeed, he contends that it was during the thirteenth to eighteenth centuries that England moulded itself into a highly developed and individualistic market-based society. Furthermore, Macfarlane argued that since the fifteenth century England acted separately from the rest of Europe in terms of legitimising the rights and liberty of the person against those of the social group or state. The absence of social barriers had set England apart from its European compatriots. For example, these rights are embedded at a legal level in Common Law: "The strong sense of individualism was likely to be found embedded in the laws in the concept of individual rights and independence and liberty of thought and religion" (1978:165). Quoting Montesquieu, Macfarlane propounds the notion that England is passionately involved in liberty. We can see that the notion of liberty is currently being addressed on a national level, particularly in the debate on the future regulation of CAM.

So let us return to Dumont's argument. I agree with both Cohen (1994) and Rapport (1997) that a key distinction should be made between individuality and individualism. Individualism refers to a political ideology - the ideological assertion of the individual

over the group; self over society. Individualism refers to a historical and pan-European phenomenon, moreover, “[a] particular historico-cultural conceptualisation of the person” (Rapport 1997:6). On the other hand, individuality is a universal, and concerns the incontrovertible essence of the person, and suggests that a person is always capable of agency because of their unique cognitive perception of the external world.

However, in line with Macfarlane’s observation, I suggest that the foregrounding of individuality in the construction of social reality should still be treated as a ‘discourse’ of individualism. By discourse, I mean the story or narrative construction that arises out of the specific ideological situation of socio-cultural marginality. In other words, I go on to argue that individuals gain their sense of distinctive agency through an unofficial ‘credo’ at the Vital Energy Healing Centre – that everyone is an individual and therefore everything is different. Therefore, the Centre fosters an ethos of the individual, but it is a collective ethos.

The individuation and personalisation of healing

Individuation, the process whereby healers distinguish their healing practice and ideas from others, is also therefore the means to innovation and improvisation. The capability for individuation is an essential part of the person. Yet, it is also a construction and a result of the ‘relations’ between individuals, because the healing centre necessitates a structural demand to formalise shared practices, although it is an ideology that ultimately respects and rewards the assertion of individuality and agency. Individuation is a central philosophy at the Centre, and expressing agency (being individual) is institutionalised at the Centre as a form of collective ideology.

In CAM there is an extensive choice of therapy and healing philosophy - a person can choose a therapy which suits them. Yet, how do we make sense of a situation where the therapist or patient can choose whichever diagnosis, healing treatment, or explanation of

the illness that suits them? One consequence of this extreme personalisation and individuation is that spiritual healing enables the healer to have the potential to develop their own distinctive style of healing. Crucially, this individuation provides its own legitimacy (referred to in chapter one as 'internal' legitimacy), and represents a move away from the kind of legitimacy conferred by science and/or medicine.

Accordingly, in relation to the life of those that participate in the healing Centre, this individuation means three things. First, healers recognise and celebrate the individually constructed nature of health, illness and disease. Second, healers (and patients) create, adopt and utilise healing practices and diagnostic procedures that are also individually constructed. Finally, their understanding of health, the body and illness also manifests in individual and highly personalised theories.

The emphasis on individuation is particularly prevalent in a form of CAM that engages with spirituality, such as crystal healing. Therefore, I go on to show how healing practices that engage with spirituality make personally meaningful and resonant, what are sometimes barely comprehensible experiences and feelings. In particular, I go on to explore aspects of this in discussing the legitimacy of a spiritual reality (chapters four, six and seven), the performative context of healing practice (chapters five and six), concepts of healing diagnosis (chapter six), and the interpretation of healing meditation (chapter eight).

Conclusion: individuation and individuality in the postmodern era

In this chapter I have discussed the key features of the socio-cultural transformation from modernity to postmodernity, which led to new preoccupations with the body as a site for articulating ideas about the self and the world, evident in the prevalence and

visibility of jogging, weightlifting, yoga, dieting, consumption of 'exotic' foods, meditation, and alternative medicine - notably in Western society. In particular, I have highlighted a central feature of postmodernity, which is the subjectification of and personalisation of public life. At the VEHC, this means essentially that healers celebrate highly personalised forms of healing practice, and this is fostered by the unofficial ideology at the Centre.

I now go on to demonstrate that the hypothesised tensions between individuation and systematisation (orthodoxy) materialise in the construction and maintenance of routine social reality; in this case, the social 'reality' of the *Vital Energy Healing Centre*. The reliance on the individuation and personalisation of healing raises key questions, particularly the extent to which the healing centre (consisting of a 'core group' of healers with different degrees of influence), through the meeting of emergent individuation (multiple healer world-views), develops forms of orthodoxy in healing practice and ideology. In particular, a key issue which is addressed in subsequent chapters is how, from individuated practice, sedimentation of collective practice emerges. In other words, how, from a Centre that celebrates highly personalised practice, does healing knowledge become institutionalised and consensuses emerge?

In chapter three I explore how the institutional credo at the *Vital Energy Healing Centre* is based on fostering individuality and the acceptance of personal agency. Also, I go on to demonstrate how the healers at the VEHC experimentally and routinely explore what constitutes spiritual healing through the processes of innovation and improvisation, and these innovations are encouraged by the institutional ideology of the healing centre. There are wider 'structures' (ideology) that healers have to contend with that impact on the VEHC. For example, healers confront standards that are set by the fact that the VEHC belongs to a national body (of spiritual healing). Yet, the healers work with these institutional structures/constraints, and on a more local level (the Centre), are helping to

create new orthodoxies, orthodoxies that arise from the contestation that occurs within the four walls of the Centre.

¹ A parallel debate focusing on 'reflexive modernity' provided by Beck (1992); Beck *et al* (1994); and Giddens (1991), has examined how this socio-cultural change is representative of a new stage of modernity, and not a distinct era.

² Further discussion of this ideology in the US is noted in Baer *et al* (1998b); Becker (1997); and Goldstein *et al* (1988).

³ The government White paper *Saving Lives: Our Healthier Nation* (DOH 1999) emphasises people taking responsibility for their own health and their lifestyle choices.

⁴ See Morris (1991:262-274) for an in-depth analysis of Dumont's writings on modern ideology, such as individualism.

The VEHC: exploring healing practice and its relationship to healers' everyday concerns

Introduction

This, chapter three, marks a shift in focus – from wide-ranging debates about CAM, biomedicine and postmodernity, to a specific locality, the *Vital Energy Healing Centre* in Granby. To recap, in the first two chapters I demonstrated that crystal and spiritual healing practices stand in contrast to complementary therapies that are fast becoming mainstream. Spiritual healing, in spite of being 'marginal', engages the individuality of the person. It is significant that some very marginal cults actually eschew the individuality of the person, whereas at the VEHC the healers' marginality seems to be a prerequisite for exploring their everyday individual concerns. I describe how feelings of individuality and difference can arise from experiences of marginality, and also from being a part of a healing centre that fosters the contested nature of knowledge.

In addition, in the social scientific study of healing some writers have tended to obscure the diversity of healing practices and what they represent in Western society. For example, English-Lueck (1990), Hess (1993) and Brown (1997) each engage in the words and opinions of so-called 'experts' in the healing field, but they neglect the question of how these ideas and practices filter down, emerge and are contested within more local contexts.

In this chapter I argue that healing in the VEHC incorporates a set of heterogeneous practices, in which healers link their innovatory practices with something meaningful to

the self. Where consensus emerges it is always 'local' – it is shaped by individual expressions. As such, I state that it is through the 'relations' between individual healers at the Centre that each healer establishes the individual meaning of their healing practice and values.

This chapter begins by offering a number of extended individual healer subject accounts. These include the healers Teresa, Charlie, Stella, Sally and I. I include these accounts as the healers' stories allow us to see the ways in which they develop very personal healing practices, ones linked to their everyday concerns. Furthermore, issues such as professionalisation, marginality and individuation are assessed in relation to these healer stories. I summarise each healer biography with some concluding thoughts. First, I begin by considering the issue of dialogism (see methodology), and I state my position on the question of how healing knowledge emerges and is constructed over time within one locale.

A key theme in this chapter is that individuation is sanctioned by the healing centre as a routine approach to knowledge and discourse regarding health, illness and the body. Therefore, the tension and dissension that emerges from interactions between individual voices is actively encouraged - indeed, this tension is normalised as an inevitable consequence of individual expressions. The strength of individual voices and the relationship between this and the Centre's ideology of individuation emerge in the biography sections in this chapter, but I also note the ways in which a degree of consensus and orthodoxy is reached despite individuation.

Dialogism: exploring the emergent quality of social life

The 'story' of the VEHC is a multiple one as its social reality is the product of multiple voices – those of the people who routinely contribute to the Centre. Therefore, I employ Bakhtin's (1981) concept of the dialogic to illuminate issues of meaning in the

construction of this social reality. This dialogism best encapsulates the contested nature of individual healers' conversations, and that these healer positions cannot be seen in isolation. As Holland *et al* explain, dialogism presents social life as the co-existence of various voices and discourses: "Dialogism pictures social and cultural activity as a manifold phenomenon, of a variety shaped by the juxtaposition of incommensurate voices" (1998:238).

I make use of this dialogicality in two ways. First, I include conversation and dialogue between healers, as it was remembered and recorded. Secondly, emphasising the dialogicality places emphasis on the notion that the healers' "identities are constructed reciprocally" (Hastrup 1992:126). This has implications for the way we construe their sense of individuality and agency. As such, healers' sense of individuality is not 'carried into' the Centre, it emerges and is fostered by the specificity of the 'relations' between individuals.

Healing knowledge is not just there to be learnt; the production of orthodoxy is processual, a product of social relationships that are played out at a local level. More importantly, I imply that there is no such thing as crystal or spiritual healing in the sense of a systematised, cohesive, and organised body of knowledge. Healing knowledge is created *in situ*; it is a product of these social relationships, and is perpetually emergent. Moreover, dialogism emphasises that individuals can hold ideas together irrespective of whether they are in tension or are paradoxical: "Dialogic perspectives, such as Bakhtin's (1981), explicitly free us from the idea that we as a group of individuals can only hold one perspective at a time" (Holland *et al* 1998:15). Likewise, the individuated nature of healing and healing knowledge suggest that as new healers enter the Centre and others leave, the knowledge and practice will change.

Teresa: owner and principal healer of the VEHC

Don't be bothered with trying to prove anything with, I don't have to prove anything, it is important not to imitate the medical services... primarily, it is important to present yourself as professional and you should not forget this. (Teresa)

Teresa is the owner and principal healer at the *Vital Energy Healing Centre*, a business she established in 1981. Her position encompasses a number of key roles. First, as she is the owner she has to organise the business side of the Centre. Secondly, she teaches crystal healing and runs a diploma-level crystal healing course. Thirdly, she is active in the establishment of national standards through her participation in a national healing organisation, which I describe in more detail below. Fourthly, in addition to the training programme, Teresa oversees the other healers who use the rooms at the Centre, and she keeps a watchful eye over the healers who teach in other linked Centres of which she is patron. As Teresa has taught healers that subsequently set up their own healing centres, she oversees their activities on behalf of a national body.

The VEHC is the institutional foundation for the Association of Spiritual Explorers (ASE)¹: a national body and quasi-religious healing organisation formed in Brighton in the 1970s by Teresa's mentor and 'spiritual teacher', Ronald Edmundson. In 1981 Teresa was the secretary for the ASE, now she continues this work by organising speakers and workshops devoted to Ronald's founding principles. Teresa met Ronald many years earlier, back in 1970. A charismatic forerunner of crystal healing, Ronald brought ideas about crystal healing to the UK after living in the US. Teresa described her relationship with Ronald as based on long standing friendship and business. For instance, Teresa sells Ronald's healing books at the Centre; in exchange he offers guest talks when staying in England.

Activities that take place at the VEHC are manifold. In addition to arranging guest speakers, Teresa organises healing workshops and events, which are staged at regional and national healing fairs and exhibitions. She ensures that she attends national healing fairs “to keep an eye on what her competitors are doing.” Local fairs are not such a priority. For instance, she explained how she would like to support them but they generate little income for the Centre.

Teresa allows other healers to use the facilities of the Centre. She then takes a percentage of what they charge for each healing. She practices aromatherapy, crystal healing and her own ‘unique’ form of healing called ‘healing sleep’. In addition, Teresa practices massage which she cheerfully admitted is her ‘bread and butter’ in terms of income. Massage also attracts more of the local population than the specialised therapies.

Each Wednesday evening from about 5pm the Centre is open for free healings, conversation and support to those in need, although patients often provide small donations in exchange for a healing. Also, on the same night a group meditation is held upstairs in the ‘sanctuary’. The group meditation is by invitation only, invariably involves no more than a dozen people, and is used for the purpose of ‘absent’ healing. Teresa directs the meditation and provides the healing ‘visualisation’. I go on to discuss significant aspects of these sessions in chapters six and eight.

In addition to healings and workshops, Teresa attends to the crystal healing course, which was set up in response to the interest crystal healing practice has received over the years. Significantly, much of this interest stemmed from ex-patients. I make this point because through a period of treatment patients are often encouraged to discover healing ability in themselves. This is no surprise, as a key healing tenet at the Centre is the notion that the patient holds important individual knowledge about their own body.

This emphasis on the ‘personalisation’ in healing stands in sharp contrast to the ‘de-personalisation’ evident in biomedicine.

Professionalisation: internal regulation and the ‘CCHI’.

Since 1981 Teresa has created a profitable healing centre, and it is clear that she values the business as well as the spiritual ethic. Her single-mindedness and enterprise has also enabled her to form alliances with ‘professional’ organisations, in particular the Confederation of Crystal Healing Organisations (CCHI).²

The CCHI was formed in 1988 by a group of crystal healing organisations to promote training in crystal healing and to ensure that their courses “adhere to the minimum training standards set by [CCHI]”³, and that regulatory standards are met by the affiliated schools. Its existence suggests that esoteric healing activities are closely regulated and standardised by a national body. For example, Teresa is keen to point out that the CCHI and the ASE are ‘bona-fide’ organisations, unlike the other “quango” groups that she argues can be set up at any time. Identifying the role of the CCHI is significant as many therapies are conceding to these forms of systematisation, a key feature of biomedicine’s hegemonic position within the field of health. The CCHI reflects Teresa’s commitment to this ‘professional’ project.

The issue of regulation also reflects, more generally, national-level debates on CAM. For example, in a British Medical Journal (BMJ) article responding to the recent House of Lords Report, Mills (2001) argues that the situation regarding regulation is unique to the UK, as CAM is unrestricted. As he explains, “the lack of proscription has meant that there are few formal obligations to meet any particular standard, and individual practitioners have been able to pursue their own path, even set up their own training programmes or professional body” (ibid:158).

Teresa is the first spiritual healer of the ASE to establish a crystal healing course, and many of the healers she trained went on to organise their own courses. She intimated that she has taught over a hundred crystal healing trainees over the past ten years, though perhaps only twenty are now 'officially' practising. For Teresa, 'officially' practising means that the individual is insured and their details are placed on the national register organised by the CCHI. It is Teresa's responsibility to oversee these courses and to ensure that training standards are being set. For example, the offshoot courses have to be based on Teresa's model, and she checks-up on their trainees' practice and assignments. As Teresa explains, this involves a lot of work:

It just gets busier. I don't know how I'm going to cope with all the work. I've got tutors working for me now, one in Newcastle, one in Sedgefield, Beth in Northamptonshire, and Jane in Malvern. They're all over subscribed on their courses. I have a little arrangement with all of my tutors. I give them a syllabus - the tutors are part of my group by appointment only, they have to be just right - I tell them how to structure the course and once they start I visit them once in the two years and assess how the course has gone. If it's all okay I'll give them a lovely little certificate. In return I ask for 5% of the course fees that they receive. I like them to teach a course that is similar to the one I designed, but obviously they make it theirs, otherwise it would lose its spontaneity.

A significant point made above is the insistence that the healing tutors make the course their own. As individuation is a central dictum of the VEHC it is no surprise that this institutional ideology is applied to the other linked Centres. However, this may result in a conflict of interest for Teresa between her institutional ideals and business interests.

Furthermore, Teresa emphasised that linked healing centre's tow the line when it comes the message they communicate publicly. For example, on one occasion I asked Teresa:

“Do you have any conflict with any of the healers, over difference of opinion or anything like that?”

Teresa replied: “Well, we have a tutor who I’ve got to go and talk to Jane about, as she recommended her... she is cutting corners with the course. I don’t think she is doing it right, she won’t do the work for the course so we are going to have to talk to her to sort it out.”

Teresa stressed the level of organisation that her diploma demands. This issue and what it signifies in terms of ‘professionalism’ is an important part of the Centre’s legitimacy – i.e. the way ‘significant others’ (patients, regulators, CAM therapists) may perceive and comment on these regulatory activities. A good example of this foregrounding of ‘professionalism’ can be seen in the way Teresa distributes certificates to newly qualified crystal healers. These are awarded on completion of the first and second year of training, and another is given once the tutor is capable of conducting their own courses.

However, although healing trainees said they didn’t care much for the certificate, they admitted that its presence would help legitimate their practice to prospective patients.⁴ Another key example of this professionalism lies in the metaphorical link Teresa makes between business and spiritual techniques. For example, she identified certain ‘visualisation’ techniques that are capable of generating business:

You can imagine, if you like, certain doors opening. Visualise the area and concentrate on yourself opening the door, and your managing to get an opening with regard to clients. It can

be very useful to use spirit to help you to establish your healing. I find the visualisation of doors opening very useful for this purpose.

In this quotation Teresa describes the use of 'doors opening' to denote the opening of opportunities, in this case the number of paying clients. We can see, therefore, that Teresa is not just a healer but a businesswoman, and her move towards forms of systematisation in healing is also driven, in part at least, by the profit motive. This awareness of healing as a business showed through in other attitudes she expressed:

As a healer you should always have one eye on the clock. I know it's a terrible thing to say but you will be running a business as well, and once people start talking they will go on talking about themselves. People may cry after a healing as this is a release of emotion, but once they have cried, that's it, more crying is always a repetition of the same thing and you have to know when to, as an American friend of mine would say, "cut out the trauma".

The routine day-to-day running of the Centre is carried out with her daughter Emily. As well as a practising iridologist, Emily uses crystals for healing.⁵ She provides assistance with the business side of the Centre: taking stock of crystals, cards and gifts in the reception area; booking exhibitions; and acting as general factotum for Teresa.

'The Viking and the Priestess': exploring the tension between material and spiritual worlds

Teresa's husband Derek is a farmer, and his work led to some tension with Teresa, particularly as it impacted upon their lifestyles. Yet, both are individuals with their own businesses and they seemed like-minded to respect that. Importantly, Teresa's

relationship with Derek allows us to make pertinent comments about the interface between the material and the spiritual.

Teresa spoke about Derek's hostility to her spiritual beliefs and the Centre. Her spiritual activities seemed to be a source of conflict, one that Emily was also a part of. For example, Emily discussed how her father was disparaging of their activities. As Teresa explained, "Derek doesn't really believe in what he calls all this rubbish. He's a business man."

In avoiding having to reflect on this part of their incompatibility Teresa pointed to the non-material and spiritual side of their relationship. For example, she recognised Derek as a figure from a past life, and therefore both had much to learn from problems in their relationship. In the past life Derek was a Druid Priestess and Teresa was a Viking. At the heart of the problem was the feeling that Teresa (as the Viking) had done terrible things to Derek (as the Priestess), such as beating him and locking him up. She said that this treatment stunted Derek's latent spiritual abilities, and because of the past cruelty she has to be there to help him during difficult times. Nevertheless, she remains ambivalent: "He still calls me a charlatan and that we are robbing people, and that hurts a little bit."

Teresa believes that Derek's connection to farming, and through his working of the earth, to the material, is a result of his disengagement from spiritual matters. Her interest in crystals represents a compromise between materiality and spirituality. The crystal (a stone), a most mundane object and part of the earth, is imbued with qualities that supersede the material (see chapters four and eight).

‘Earth changes’: identifying the causal relationship between the material and the spiritual

Teresa admits that Granby is not an ‘ideal’ location for a healing centre, but the rent is cheap. Because of the issues surrounding its location (a situation I described in the main Introduction) the Centre only recently received attention from the locals. In further exploring the interface between the material and the spiritual we can make sense of Teresa’s discussion about the Centre’s locality. For example, on one occasion I asked Teresa whether she would move the Centre, and she replied:

Oh yes, I hope so. Somewhere residential so that I can have all my crystals just sitting around, especially with the earth changes happening. This area will be about four feet under water. Ronald came to stay a few years back and he came for a bit of peace and quiet, when we were at the farm. He didn’t get any peace and quiet of course, because of all the low flying planes in our area and the tractors, but while he was there he said to me... “You do know this is going to be underwater soon?”, and I knew of course but was just waiting for ‘upstairs’ to tell me to move.⁶ The sea in the west will rise, the land in the east will fall, and the south will sink. You will not find much high ground until about Peterborough. Scotland will break off from the mainland completely, Ireland will become the new spiritual centre for the Aquarian age, as will Russia and India, though there will be a lot of changes that they will have to go through first, a lot of cleansing. The south coast of Australia will be gone and the central area will remain as an oasis as there is water underneath the ground in that area. France will be in a terrible state due to having to go through a lot of karma after what they have done to people in the past; it will be a time of tremendous upheaval. A saviour in the Netherlands will do his best to help Europe but when he dies it will all go back to being the same again.

On another occasion she explained how the South of England would be washed away by floods, and, as a consequence Doncaster, only a short distance from Granby, would emerge as England's capital city. A central 'New Age' issue is that the planet will go through apocalyptic 'earth changes'. This issue has currency in other sociological research about 'Millenarian' and/or New Age groups (Brown 1997; English-Lueck 1990). For example, in his research on 'channellers' in the United States, Brown (1997) argues that the obligatory information channellers receive is about natural disasters. Brown states that the US will lose certain cities and states during these changes (ibid:45-49). In contrast, Teresa's story about the potential earth changes is a very personal one, one intimately linked to her everyday concerns.

In addition, Teresa identified these future material/geographical changes as a contributing factor for her wanting to move the Centre in the near future. At the heart of Teresa's story is a critique of orthodoxy, which is further emphasised when she claims that although many earth changes will be material and structural, the most profound will be emotional and spiritual. In this way, the spiritual maintains a direct causal relationship to the material world. For example, in the quotation above Teresa draws attention to France and its 'karma', and she mentions Russia and India having to go through some 'cleansing'. In this respect the geographical upheaval is a direct result of the spiritual upheaval. I go on to show how this issue about causality also correlates with the healers' ideas about health, illness and the body (see chapter seven and eight) - physical illness is perceived as resulting from neglect in the spiritual bodies.

Teresa: individuation as healing ideology and systematisation as business necessity

There are two key dimensions within Teresa's narrative, both of which resonate with the central thematic concerns of the thesis. First, there is the issue surrounding her sense of control and gate-keeping over the financial and business aspects of the Centre. Such control manifests in her developing systematised practices. Notably, this can be seen in Teresa's involvement in regulatory activities; in ensuring standards for the healing trainees; and in the way that she took over professional functions of a national healing organisation. Second, Teresa's story draws attention to the issue of spirituality and the material-spiritual interface.

At the VEHC Teresa's organisational activity is a central component of professionalisation. A question we may ask is whether she'd like to see a greater sense of professionalism amongst her fellow healers. Further, is she looking for additional legitimacy that comes with these organisational and bureaucratic practices? Coward has argued that 'alternative' therapies tend to foster a discontent with professionalism and the image of professional expertise (1989:8). Furthermore, Coward argues that more 'complementary' therapies are more at ease with the processes of professionalisation, as opposed to fringe therapies (ibid:9).

In an analysis of the way homeopaths and chiropractors have professionalised in the UK, Cant and Sharma (1998) emphasise the ideology of standardisation and commonality that is at the heart of this 'external' legitimacy, an issue I highlighted in chapter one. Saks demonstrates how therapies that have undergone a process of professionalisation (regulation, training, etc.) have tended to adopt a biomedical model: "Professional associations of therapists have usually borrowed a structure from medical

associations” (1992a:8). Further, he argues that this is ironic, for therapies initially resisted this change with their hitherto individualistic approach (Saks 1999). We can see how Teresa’s work carried out under the auspices of the CCHI is an interesting case in point.

In relation to the second theme, consider the way Teresa talks about Derek and the geographical locality of the Centre. In both cases, she self-consciously chooses not to privilege the material and physical domain over the spiritual domain. Furthermore, I examine the relationship between Teresa and Derek in the context of Skultans’ (1974) study of spiritualists in South Wales. One of Skultans’ key points is that the principles behind spiritualism are coping techniques for women who are embedded in a “traditionally feminine role” (ibid:45). Despite retaining a position of relative power in terms of healing knowledge, women experienced feelings of inadequacy which were fostered by their relationships with men outside of the healing circles. Moreover, “many of their complaints are interwoven with difficult social and marital status” (ibid:29). In this sense, in Skultans’ study the healing rituals carried out enforce women to accept and legitimate this marginal role.

Skultans’ point is supported by Hess (1993), who argues that female healers’ problematic relationships with men are a key factor in their developing an interest in ‘New Age’ practices. I noted some tension between female healers and their partners in a number of the stories from female healers, and from patients. Although this was not an issue exclusive to female healers, it is however significant that the healers’ wider relationships with others can inform their practice.

Charlie: novice to fully fledged healer

Yeah well, I used to have voices in my head before I started coming here. It's to do with healing ability and the spirit guides. (Charlie)

I first met Charlie, a local person in his late twenties, a month into the fieldwork. The healers that I had spoken to at the Centre by the time I met Charlie were, apart from Jack - a reflexologist and tutor on the VEHC diploma in his late 50s/early 60s - all women. Apart from Jack, Charlie was the only male healer who played a key role in the life of the Centre.

From bodybuilding to spiritual healer: marginal and stigmatised identities

Charlie is perceived as a maverick figure at the Centre, constantly testing received wisdom and pushing the boundaries through his innovative healing practices. His biography is also somewhat unusual. As well as being a healer, Charlie is also a bodybuilder. Before attending the VEHC as a patient Charlie used steroids to build his muscles for lifting weights. This led to both physical and emotional difficulties. In order to counteract the pain that the steroids were causing he took painkillers. Charlie explained, "I was in a real mess", and added; "I'm now going to look at how crystals can help me in weight training, you know, doing it the natural way." Though rarely reluctant to talk about these experiences, he tends to shrug them off or distract attention from them by laughter. On one occasion, Teresa put some of his past problems into perspective:

Charlie has been coming on very strong at the moment, although I do think he can be a little naive sometimes. If you think of where's he's come from though, he used to be one

of the local heavies. He was always getting into trouble with the police and had violent mood swings because of all the steroids he took. Stella helped him off all the drugs with healing and hypnotherapy and eventually he started to get interested in what she was saying about the healing. Once Charlie gets interested he puts everything into it, whether it's bodybuilding or healing.

Though small in terms of height, Charlie is physically imposing, mainly because of the lasting effects of the steroids. He seemed like an impostor hiding behind a costume. This often worked to his advantage, as in addition to healing he works as a bouncer outside some of Granby's pubs and clubs. Due in part to his involvement in two quite distinct social activities, bodybuilding and healing, he appears to suffer uncertainty about how he should carry his masculinity in a town like Granby. Although this uncertainty also arose from what could be described as a 'stigmatised' identity.

Here, I refer to the 'stigma' that is attached to his biographical past (see Goffman 1963), such as his use of steroids. This is not a stigmatised identity *per se*, but in relation to his current role as a healer it becomes problematic. As Goffman states, "...the more there is about the individual that deviates in an undesirable direction from what might have been expected to be true of him, the more he is obliged to volunteer information about himself"(1963:83). For example, Teresa states that Charlie had spoken frankly to her and other healers about his past, and she feels that his bodybuilding activities had been developed in reaction to abuse he suffered from his father, as a result of certain bodily inadequacies in childhood. As she explains:

He started off as a very aggressive and difficult person, and he's turned out to be a very mild and nice individual. He used to be a seven stone weakling you know, and that's why he started bodybuilding. His father used to beat hell out of him and his mother would get it as

well. He also came to us because after his first child he was told by the doctor that the steroids had made his testosterone levels very low, and he wanted to get off the drugs.

However, these early experiences are important, not only to Charlie, but also to Teresa because they signify what you have 'to go through' in order to heal. Teresa explained that the early experiences made him a stronger healer. In this respect, the 'stigma' of the past is offset against the efforts Charlie is making to alter his sense of self. Teresa's perceptions mirror those of counsellors and psychiatrists who argue that in order to be able to deal with those who are suffering it helps to have experienced similar problems oneself. As Teresa explained:

To understand something like this, you need to experience it. Charlie has had various experiences in his life that will help him understand various people, which is very important. You have to understand what people are experiencing to heal them...this helps you become more sensitive to the healing energies, both of the crystals and other people.

Here Teresa alludes to the movement from treatment (as patient) to the development of healer ability. This shift is similar to what social anthropologists describe as the 'cult of affliction', in relation to healing groups in Africa.⁷ Sharma also noted that patients of spiritualist groups often discover healing ability in him/herself (1992:132). I return to this theme in the concluding section, in which I draw upon the concept of the 'wounded healer' (Nouwen 1979; Fox, 1993; Brown 1997).

Generally speaking, Charlie's participation in healing is indicative of his marginality as a whole. He is drawn to healing because of the degree of autonomy and control it allows him to maintain over his body. Healing adherents are invariably those who feel, in the 'real world', in a position of social marginality and powerlessness (Skultans 1974;

Glik 1988). For example, Glik argues that socially situated vulnerability often leads to interest in spiritual healing, “healing group participants were peculiarly vulnerable to social and economic changes in the larger society, at the same time lacking sufficient social or economic power to change their personal situation” (1988:1198).

For Charlie, this marginality manifests in the developing of his spiritual body (through healing) and physical body (through weightlifting). Bodybuilding therefore complements his healing work. Nevertheless, Charlie also claimed that there was a genuine physical reason for the healing interest. As he says, “before I started coming here I used to feel my hands burning up all the time like they were on fire. When I came here and asked Teresa what it was that I was feeling, she said it was because I was a healer and have also been a healer in my past lives.”⁸

Healing ability is generally seen by the participants at the VEHC as a feminine quality that stands in contrast to the traditional qualities of masculinity. Charlie confronts this by maintaining an interest in bodybuilding. Others recognised this complementarity in Charlie. As Sally explained:

The healing works on different levels, the physical, psychological, emotional and spiritual. It's easier to for me to give help on the emotional side. Because I'm a woman, my emotions are more highly developed. Charlie is also developing that side. Before, when he was a bouncer, that side was withdrawn, but now he's slowly starting to merge the male and the female side.

Spirit doctors: enlisting the help of experts

Furthermore, this stigmatisation that I referred to in the previous section manifests itself in the existence of Charlie's ‘spirit guides’, or ‘spirit doctors’ as he prefers to call them (see chapter seven for a further discussion). It will suffice to say at this point that the

guides are seen as non-physical/immaterial entities that aid the healer. Charlie enlisted the help of his 'doctors' approximately one year after he started his healing training. The healer invokes the 'spirits' through the process of entering a trance or altered state of consciousness. Hence, anthropologists have variously termed the use of these 'entities' as 'trance healing', 'shamanism', or 'divination'. The activity of communicating the thoughts and actions of the dead has also been called 'mediumship' and 'channelling' (see the main Introduction). Charlie's spirit doctoring reflects concerns that are linked more to his everyday life, and his sense of control over his feelings of stigmatisation is played out through the use of the 'spirit doctors'.

In addition, changes to Charlie's life since becoming a healer, such as the nurturing of his spirit healing, has impacted on the way he perceives other people's life situation. Sometimes he exhibits contempt and arrogance towards local people who do the things that he did. For example, Charlie views the healers and patients at the main spiritualist church in the local area - 'Firs' - as stuck in the rituals they regularly enact:

"I can't believe what has happened to me in the past year. I mean, look at those up at 'Firs', those that go to that spiritual development meeting every week. Some of those have been for years and they go every week. They're not doing anything there are they? I don't understand why they don't want to do what I'm doing - travelling, and seeing people all over and that."

Teresa intervened... "Yes, but Charlie, that's because they like that. You see, all people are different and some of those people like doing the same thing week in week out, because they enjoy that and that's all they want. If you look at the Catholic rituals, they enact the same things each week, they like it because they know what they are doing. Not everyone is like you."

Humour as contest: additional responses to stigmatisation

Finally, Charlie's stigmatisation manifests in his alternation between seriousness and humour when discussing healing matters, and this further highlights the debate surrounding the contested nature of healing. For instance, Charlie rarely uses crystals in his healing practice, partly because he perceives their usage as feminine, though primarily because they are not a part of his healing repertoire. On an occasion when Charlie was talking to Stella and I, Stella remarked:

"How are you feeling Charlie? What crystals are you drawn to at the moment?"

"Oh, I don't waste me money on crystals" he said. He looked up at a large clear quartz crystal resting on the top shelf. "I tell you what, I like that one over there. Yeah, I'll have that one. That'll do me."

Emily looked up at Charlie and said... "It's the bigger the better with you, isn't it?"

Charlie laughed, "Yeah, you know I keep asking spirit guides to de-materialise it so it can then re-materialise in my front room."

Charlie uses humour as a way of normalising his healing activities and of contesting healing ideology he disagrees with. A typical example of this was when Charlie was talking to a group of healers in the reception area about a trip to the dentist. He recalled having a filling in which he was given a local anaesthetic in the jaw:

"It were terrible", Charlie told us, "cos I 'ad to come 'ere to do an 'ealing and of course you start talking right funny to people and I don't want them to think that this is my trance healer voice or something. I also went into the garden centre to check out price of these wooden Buddhas, not the sitting down short ones, but the tall thinner ones. Of course, I said to the woman "How much for your Buddhas?", and what she heard was "How much for these, you bugger?" which didn't go down very well."

We all collapsed into laughter.

Charlie continued: "Of course, they were seventy two pounds each, so I rang up somebody in Sheffield, says he can get them for just eighteen pounds each, so I'm going over at some point to get those ones."

Stella asked Charlie where he was going to put them.

"Somewhere indoors really, I haven't thought about it that much" Charlie replied.

"Not in the garden then?" added Stella.

"What, Buddha's? No, I'm not going to put them in the garden, am I", he laughed.

However, even though Charlie can be humorous, this often borders on being inconsiderate, where he makes jokes at people's expense. Yet, he is a very contradictory person – a Jekyll and Hyde type of healer. For instance, he is very considerate and will come to the Centre at the slightest notice if a patient needs his help. For spiritual healers this is an important quality, and a sign of taking the principle of 'service to spirit' seriously, an issue I develop in a later section.

Charlie: the personal 'project' of healing and the response to bodily stigma

First of all, Charlie's attachment to the Centre makes sense partly in relation to his stigmatised identity, which is mainly connected to the past. Emotionally and physically weakened by the relationship with his father and his steroid dependency, Charlie's preoccupation with healing both the physical and spiritual bodies represents his commitment to the individual 'project' of the body (Shilling 1993; Bauman 1995). For instance, Shilling argues that in late modernity the body is a project that can be nurtured through particular 'regimes': "Self-care regimes require individuals to take on board the

notion that the body is a project whose interiors and exteriors can be monitored, nurtured and maintained as fully functioning” (1993:5).

For Charlie, this body project contains physical and spiritual manifestations. His attempt at reconciliation seems to represent a compromised masculinity. He expresses masculinity through bodybuilding, and yet he takes crystals with him to the gym to aid his physical and spiritual development. This situation can seem somewhat paradoxical, although it makes sense in the context of a Centre that seeks to re-draw the relationship between the material and the spiritual.

Secondly, Charlie’s interest in healing developed through his time as a patient, which draws attention to the problem with the usual boundary that is drawn between practitioner and patient interest. Frankenberg argues that this collective of similarly afflicted people in healing groups is not surprising, as “part of the treatment is to be initiated into a fellowship of the similarly afflicted” (1986:621). In a study of ‘dreamwork’ groups, Edgar (1995) explains that the participants were often propelled to be a part of the group as a way of reflecting on more general life crises or transitions: “Almost all the members who stayed through a group term of ten weeks disclosed either to the group or in the follow-up interviews that they were going through a period of their life which involved, in their eyes, great change or considerable crisis” (ibid:10).⁹ In a similar vein, Glik (1988; 1990) notes the similarities between healing and the initiation into Shamanic traditions:

“Many of those who were in the process of becoming healers had experienced a dramatic healing or improvement in some condition or illness prior to trying to heal others... Sickness of the healer prior to initiation is similar to the process of shamanistic initiation in other cultures (Glik 1988:1200).

In drawing on the work of the psychiatrist Glin Bennet, Fox (1993) makes a comparable point. He argues that healers embody a dual attribute, in that they may have recovered from a wound or have learned to live with it, and through the experience of the wound they learn to heal. Placed in an ambiguous situation, the healer is weak but is imbued with power. Quoting Bennet, Fox refers to this as the ‘wounded healer’.

Finally, arising from these feelings of stigmatisation, we can examine Charlie’s use of spirit doctors. Charlie uses the spirit doctors partly as a way of dealing with his problems of articulation, in that they provide other ‘voices’ and are experts in specialised medical fields, and partly as a way of legitimating his healing innovations (see chapter five and six for a further discussion of these innovations). The existence of ‘doctors’ also reflects the way that spiritual healing incorporates material and spiritual worlds. I now go on to explore the relationship between Charlie and Teresa, and how we can identify tension and contested ideas about the value of spiritual healing and its meaning for the participants at the Centre.

Teresa and Charlie: locating the tension between spiritual status and spiritual service

The assertion of personally meaningful healing practices is the norm at the Centre. Furthermore, these practices arise from the relations and tensions between other key individuals at the Centre. Teresa and Charlie most clearly exemplify these tensions. As ‘leader’ of the group, one of Teresa’s roles is to cement a common ideology at the Centre, so that it embraces solidarity and group purpose. Somewhat paradoxically, this ideology is based on the primacy of innovation and individuation in healing practice. Also, Teresa suggests that the healer’s role is incompatible with any desire to possess

status or money. For example, Teresa states that healers are not highly remunerated, as the higher spiritual authorities or ‘upstairs’, as she referred to them, ensured that healers had just enough money to work. She warned the healing trainees about abusing this dedication to a spiritual purpose, while equally emphasising that the healer charged a fair fee.

While Charlie is undoubtedly attracted to his new-found status and self-worth, Teresa ensures that this does not translate into an incompatible obsession with money, although financial concerns were often high on her agenda. For example, on one occasion Charlie had returned from Germany, where he had been invited by a ‘trance channeller’ to conduct a guest healing:

“Ah Teresa, it was amazing what he was saying about my life and all, and what I was going to be doing. He said that after he dies I would inherit everything, he would give me all he had...” said Charlie excitedly.

“Yes well...” Teresa tried to interrupt.

“Yeah, I mean I don’t think that has anything to do with him giving me all his money, although he has no family. What I think he meant is that I would inherit all his healing energies and...”

“Yes, I know but you must be careful about this business concerning money, because as Ronald says, he gets a number of people saying they’ll give him a lot of money for healing projects and all they want to do is buy him and he won’t have any of it, so you are going to have to be careful as you will get a lot of tempting offers that will test you. Also, his guides will help and protect you. I think it is important not to get too excited about all this and take it in your stride.”

Material gain carries strong disapproval for those working on the spiritual aspects of health. This is reflected in Teresa’s comment above about temptation, a notion that is

evident in Christian ideology. As Douglas explains, “by the logic of opposition spiritual is incompatible with accumulating power or wealth” (1994:26). Skultans (1974) makes the point that the acquisition of power and prestige are not central goals of spiritualism, but may be incidental to it. Therefore, I don’t believe that this is disapproval in a counter-cultural sense – that is, disapproval at the life-style aspects of a materialist Western society. Teresa’s disapproval should be seen in terms of the fact that materialism is associated with egotism, and that Charlie’s ideas could act to subvert Teresa’s professional project. Furthermore, Skultans (1974) argues that spiritualism is emblematic of the conflict between the quest for personal salvation, which is seen as for the good of the group, and the pursuit of personal power, which is seen as destructive of the group. Spiritualism confers the promise of high ritual status when it is carried out satisfactorily, and it is this promise which increases the competition for status amongst a healing group.

Charlie believes in doing his own thing, which manifests in both his healing practice and in his critical attitude towards Teresa’s vested interest in professionalism. Here, his individualism is allowable as the Centre sanctions this approach. I have discussed the ways in which Teresa standardises the course, but Charlie neglects the organisational side of the Centre. For example, Teresa proudly informed me that the Centre was starting a crystal healing diploma that would run in conjunction with a course in CAM at university. Charlie was singularly unimpressed: “Part of a university degree, eh, oh yeah right!” This shows significant opposition towards Teresa’s approaches and its inherent professionalisation agenda.

Stella: established healer

If you listened to what everybody was telling you, you wouldn't eat anything, or do anything, would you, and then you'd probably spend all of your time worrying about it. (Stella)

Stella, a woman in her fifties, has been involved in hands-on healing for approximately eight years. Like Charlie, Stella ventured into healing after visiting the VEHC as a patient. Stella experienced lower back pain for many years - a form of osteo-arthritis - and biomedical treatment was unable to help. As she explained:

I was told I had osteo-arthritis and the GP said that I had to go and learn to live with it. Now, I wasn't going to do that, I'm not like that. So, I started coming here and seeing Teresa, which helped, and then I became a healer. I started with crystals and then later learned hypnotherapy.

Although primarily a hands-on healer, Stella also practices crystal healing. Much of her free time is spent at the Centre's open session on a Wednesday evening. Her husband Roy (see chapter five) also makes the odd appearance at the Centre.

Stella's healing combines 'spiritual' and 'common-sense' conceptual frameworks. Here 'common-sense' denotes an attitude that encompasses both pragmatism and scepticism. These seem to fit together and make sense in terms of Stella's everyday concerns. On the spiritual side, Stella emphasises the personal and biographical base for the existence and continuation of illness conditions (an issue further addressed in chapter eight). For example, during the first healing I received from Stella she said she'd picked up that my heart 'chakra' was slightly blocked.¹⁰ This intimated that my worries

and feelings of being 'below par' were a manifestation of my inability to deal effectively with my emotions. For Stella, this area of my life needed more work.

In contrast to this 'spiritual' approach, when Stella and I were discussing some of Emily's ideas (see below) about new household technologies, Stella's reaction reflects a lay or common-sense response. In the following dialogue, Emily turns her attention to the subject of advances in washing-machines:

"They've developed this new way to do your washing. It's supposed to change the positive aspects of the water to negative, and this cleans your washing" said Emily.

"Oh golly, I'm not quite sure about that", said Stella, "I'm very sceptical about these kinds of things."

"It's like a disc or something that goes into the washing and it will last up to 700 loads", Emily pointed out.

"Oh my!" Stella exclaimed.

Emily continued, "It's about thirty pounds and I thought that's an awful lot of money for just that but if it lasts that long then...I wish I could just see the evidence of what it's like."

"What, you'd like some trials or something", I asked.

"Yeah, I'd like to just see something scientific about it", Emily replied, "they could use magnets as well, which they've been using on cars to make the fuel last longer. You can do anything with magnets, also they can strap a rose quartz crystal to them which helps."

"Rose quartz!" cried Stella. "Oh no, I'm not too sure about that. I think you believe what you want to believe, don't you think, with those sorts of things."

Healers' explanations for the existence of ill health are invariably a response to and a critique of biomedicine. Yet, they also draw on commonly-held understandings and assumptions about the world, partly because these are based on a lay response to the

issues. The common-sense view is one area where some consensus between healers can be reached. As such, healers at the VEHC do not hold 'counter-cultural' ideologies as their views and lifestyles may be considered too 'ordinary' and de-politicised to merit this explanation. In this respect, I agree with Sharma that the lifestyle of those involved in healing does not have to be 'alternative' (1992:18). Also, Stella is concerned that I should try to become a healer. One day Stella spoke to me about the reasons for her becoming a healer:

"You cannot rush into it, it has to take time and if you are a healer then you will know it, whether that is in one year, five years or twenty years time. I think you could be a good healer." she told me.

"He does look like he could be one." Charlie interjected.

"Yes, but that's not the point Charlie. You have to know, feel the right energies." explained Stella.

"You've got to clear a lot of stuff," added Sally, "you know, negative energies. You have to work on your self first." She glanced over to Charlie, "You're an unusual case."

The healer has to go through 'stuff' before he or she can practice. The 'stuff' and 'negative energies' that Sally refers to are the experiences of having been in a position of physical, mental and/or emotional vulnerability, a position I have already referred to as the 'wounded healer'.

Sally: established healer

You have to keep asking them all the time, as sometimes they may want to work with you and sometimes they won't. (Sally)

Sally, a woman in her early fifties, is an established member of the Centre. A good friend of Teresa's, Sally helps out at the Centre on Wednesday evening. By day she is employed at a residential care home in Granby. However, the care home has become the source of a number of problems. Sally takes pleasure in looking after those around her, but over two years of employment, the care work has become physically and emotionally draining. As a result, she suffers frequently from the physical and emotional effects - colds, feeling 'run-down' and emotionally distraught. Teresa explained the frequent physical illness comes about because she gets too involved in patients' lives. For example, on meditation night Sally normally asks Teresa to 'send out' healing energy to her patients at the care home.

One day Sally came into the Centre seeming quite upset. Five patients at the care home whom Sally had become quite attached to had died over the space of a few weeks. Teresa admired Sally's compassion, but felt that she should retain more distance from the patients, as this would affect her health: "The problem is, Sally gets too emotionally involved, and they (the care home staff) have told her not to but Sally will do what she wants. I think they want you to be a compassionate person without being involved."

These events were repeated in one way or another over the period of my fieldwork. Sally often rang in to say she couldn't heal because she wasn't feeling very well or she was too tired. Sally is a very sensitive and fragile person, both physically and emotionally. She also has extreme and quite possibly painful difficulties with her eyesight, and as a consequence has to wear glasses with very strong lenses. This is

something she is self-conscious about, as she has a habit of taking her glasses off and cleaning them when engaging someone in conversation. More importantly, this vulnerability crosses over into and informs her ideas about healing and crystals.

Probably more than the other healers, Sally imputes to the stones agency: that the crystals play a part in the healing process and they help the healer. For example, once I explained to Sally that a crystal I had bought years ago had broken not long after purchase, which I speculated was a bad sign. Sally said that as the crystal had broken into two clear quartz pieces, and that it was originally a twin crystal that had two pieces branching out independently, then maybe the portent was a good one. As she says:

...perhaps they may work together, but with one in each hand. You will have to ask them separately and if they don't want to work together then that doesn't mean that they will always be like that. You have to keep asking them all the time as sometimes they may want to work with you and sometimes they won't.

Sally explained that a healer learns by close association with the crystals. She is particularly attached to her personal collection of crystals, calling them her 'friends', and she carries them around with her in a velvet pouch. Like Teresa, Sally said her husband didn't care for her interest in healing. Similarly, Sally feels that her husband is actually a sensitive person in the spiritual sense, and that he is reluctant to show interest because of a fear of ridicule. In addition to providing healing, the majority of Sally's time at the Centre is given over to healing Stanley, a long standing resident of Granby and a regular participant at the Centre. In exchange, Stanley brings over vegetables from his allotment for Sally, and some flowers for Teresa.

Stella and Sally: the individual response to dissatisfaction with biomedicine

Stella's and Sally's involvement at the Centre is a consequence of their experiences with biomedicine, and it conveys a larger story about the lack of control that ordinary people face in the context of their experiences with biomedicine. For example, Stella often makes allusions about how older people are not treated seriously by the medical profession, and that this attitude impacted on the way she was treated by doctors. As a lay person she did not wield the power and autonomy that expert-based knowledge confers upon the individual. As a consequence, her healing practices and ideas are a unique combination of the spiritual approach and the lay-inspired common-sense ones.

Like Stella, Sally's attachment to the Centre also arises from being able to generate individual control and autonomy in healing practice. For example, I demonstrated how this manifests in Sally's personal attachment to the crystals, and in her belief in the stones' agency. To conclude, Stella and Sally earn back the legitimacy and right to treat themselves and others in a manner which is linked to their everyday lives.

Stuart: participant observer and novice healer

<p><i>You are going to be learning about others' emotions and feelings, and your direction will be motivated towards compassion. (said Teresa)</i></p>
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In the Preface and Methodology I highlighted a few personally meaningful reasons why my interest in crystal healing emerged. In this section I draw upon my own personal reflection and comments from other healers in order to locate my position in the Centre.

As Okely explains, fieldwork is about relationships and relations with others, and the established relationship between the anthropologist and subjects is no exception (1992:2). My inclusion is necessary as I trained as a crystal healer and was identified by Teresa, Stella, Charlie and Sally as having potential. I also featured prominently in other trainee healers' stories.

In similar ways to Stella and Sally, a considerable proportion of my interest in crystal healing stems from my dissatisfaction with biomedicine. Asthmatic from an early age, I was described as a "sickly child", and spent lengthy periods of time in the company of doctors. My asthma is still an issue and I found that healers at the Centre helped me to deal with it.

In addition, along with six other novice healers I attended the crystal healing diploma. I attended partly in response to other healers at the Centre who said that I should get more involved. In particular, Charlie, Stella and Sally all approached me about my healing potential. For example, during a healing one of Charlie's 'spirit doctors' had told me that I should get more spiritually involved and that when I felt a 'tingling in the hands' I would be ready.

Views about my emerging spiritual status had been aired at various stages in my participation at the Centre. On one occasion a healing novice interpreted the contents of a meditation they had conducted on a 'time-link' crystal. The crystal is used to facilitate a meditation and, it is suggested, helps people to remember 'past lives' - events from previous existences. Yet, this had more far reaching implications in terms of my relation to other individuals. In the example below Elsie (a novice healer) offers her interpretation of this meditation on the 'time-link' crystal:

"It was lovely. Stuart was this baby in a well off family, but not really well-to-do. And he rose from being this baby into a powerful leader of the people, and he went to a palace of

learning – I think we were Egyptian. And I asked what we had to learn from him and it (the crystal) said that he had a powerful heart, but he was very gentle and that he could do healing through this heart.” explained Elsie.

Sarah looked over, “So what were you then? Were you related at all to this person?”

“I was his mother.” Elsie replied.

“Oh, I see!” exclaimed Sarah.

“Yes, and he was a very good, very kind leader. I was very proud of him.” Elsie added.

Another issue I raise in relation to my own participation was my feeling that individuation is routinely inscribed into the embodied actions of the healing. That is, healers learn to innovate and modify existing methods of healing. This is one part of the process of moving from being a novice healer to a fully-fledged one. In chapters five and six I go on to consider aspects of this performative context, partly as it pertained to my own learning of individual healing styles.

Conclusion: healers as exemplars of key themes

The aim of this chapter was to explore the ways in which healing practice and ideology emerges and is contested within a local context, the VEHC. In addition, I aimed to explore the ways in which (and reasons why) healers develop very personal healing practices, and how these are linked to their everyday concerns and values.

First of all, I have considered the individuated and contested nature of healing practice and ideology. I have drawn attention to the interplay between the multiplicity of voices that constitute the social reality of the Centre, and that emerge through specific encounters. Although I have also shown how consensus is evident in the healers’ fundamentally lay response to certain healing issues. In this way, the spiritual healing

that I speak of is the spiritual healing that arises from Teresa, Charlie, Sally, and Stella. The healers produce and shape this knowledge.

Secondly, spiritual healing seems paradoxical in a number of ways. This is evident particularly in the Centre's unofficial dictum that healing practices should be personally meaningful. Healers bond and consensus is formed around the individuated nature of healing. Also, paradox is extant in the interface between materiality and spirituality, a theme that expresses the wider socio-cultural issue of the boundaries between biomedicine and spiritual healing. For example, crystals are imbued with material and spiritual qualities. Furthermore, there is a paradox in the conflicting aims of the Centre: the desire to commit to spiritual service against the drive to make the Centre a profitable business. For instance, the tension between Teresa and Charlie encapsulates the differential responses to expertise and the importance of spiritual devotion, which inevitably conflict with 'material' concerns. This paradoxical nature draws attention to a postmodern explanation, in which what we see are combinations and crossovers of multiple and sometimes contradictory discourses asserting themselves in the healers' practices and conversation, an issue I raised in chapter two (see Thompson 1992).

Thirdly, I argue that the healers' participation in the Centre is indicative more generally of their marginality in wider society. However, as I stated, unlike cults which tend to eschew individuality through their marginal status, the VEHC celebrates the assertion of individuality through recognition of the importance of the healers' individual concerns. This theme draws attention to the dissatisfaction with biomedicine, and the notion that patients and healers can be seen as having stigmatised identities. For example, witness Charlie's steroid dependency.

In the following chapters, therefore, I unravel the various contexts in which we can observe and comment on the individual and contested nature of healing practice and ideology. I go on to describe and interpret some of the concepts and procedures that are

central to the everyday practice of crystal and spiritual healing, and demonstrate the ways in which these practices are illustrative of the profound social-cultural transformation in Western society, alluded to in chapter two.

¹ A fictional name.

² Again, in order to protect patient and healer confidentiality, this is not the real name for the organisation.

³ From a pamphlet distributed by the 'CCHI'.

⁴ Dr Norma Daykin, Reader in Social Policy (personal communication), suggests that this may have just as much to do with risk and safety at work, and that the certification may be a requirement. I think this is true, but the variety and number of certificates signify a great deal about demonstrable expertise and legitimacy.

⁵ Iridology is an alternative system of diagnosis in which the iris of the eye is said to indicate the condition of other parts of the body.

⁶ The word 'upstairs' denotes spiritual influences.

⁷ Most cite Turner (1968) *The Drums of Affliction*, as the originating work.

⁸ It is not uncommon for those who claim healing ability to argue that there are physical manifestations of this ability (see chapter eight for a further discussion of healing sources).

⁹ Schneirov and Geczik (2002:211) also note that these difficult personal experiences led to people developing an interest in alternative medicine. In addition, Warkentin (2000:214) highlights recovery from cancer as being the personal motivation for one particular healer in Canada.

¹⁰ 'Chakra': where an element of energy in the spiritual bodies intersects with the physical body.

Healer classification of ritual space: exploring the spiritual and material realities

Introduction

The aim of this chapter is to discuss the use of ‘preparatory’ events in various healing practices. Two ideas underpin these preparatory events. First, the ‘space’ of healing is both physical (material) and non-physical (spiritual/immaterial) in nature. Secondly, the relationship between biomedicine and esoteric forms of CAM is understood as involving interplay between materiality and spirituality.

This chapter begins by exploring the healer concepts of healing space, and in particular I consider the differential treatment towards material and spiritual space and explore the issue of how healers innovate and personalise practices in various healing contexts. Healing concepts such as ‘spiritual hygiene’, ‘spiritual dirt’, ‘risk’ and ‘protection’ are discussed. Furthermore, I explore how, from individuated practice, a sedimentation of collective practice unfolds.

The ‘dramatic’ context of the healing environment

I begin by highlighting the ‘dramatic’ context of healing practice. Medical and healing encounters are also ‘performances’ in which healers articulate certain identities, and draw attention to the legitimacy of the act. As Laderman and Roseman explain:

All medical encounters, no matter how mundane, are dramatic episodes. The protagonists, often without conscious thought, play out their respective roles of patient and healer according to their society's expectations. In some cultures, the dramatic aspect of healing is overt. Performers' costumes can add to the specialness of a healing encounter, ranging from obviously theatrical dress to a medical white coat, or a stethoscope around the healers neck. Foods may be forbidden or necessary; odours of perfumes and flowers or the medicinal fumes of herbs or anti-septics may be used; sounds may be hushed, seductive, triumphant, mechanical. The treatment of the patient may be judged as a scientific procedure, appropriate or lacking, or as an art form whose elements are all working toward a specific end (Laderman and Roseman 1996b:1).

Crystal healing is no different, a performance that, as Laderman and Roseman imply, relies on ideas about the symbolic properties of the objects and props used. A key part of this process is the systematisation of the physical setting.

The systematisation of the physical setting

Preparation of the healing setting involves the deployment of culturally embedded symbols of expertise and professionalism. At the Centre Teresa reinforces the systematisation of healing through a uniform approach to the physical layout of the room. As I explained in chapter three, for Teresa this standardisation ensures that the Centre remains financially viable, in that the patients trust the motives of the healers, but it also ensures some degree of orthodoxy. Other healers, unable to innovate and be creative with the physical layout of the healing room at the Centre, concern themselves mostly with fashioning the room in an immaterial sense.

Issues of professional competence: mimicry and parody

A key concern for the healer is displaying competency, although competency may be defined differently to the way an orthodox medic might think about it. Yet, it is important to note that there may be parallels, as these contrasting systems of healing draw upon practices and ideologies that are common to both. Nevertheless, creating the impression of competency is particularly interesting when it is defined in relation to the healers' assertion of individuality. In this way, competency is also a form of 'internal' legitimacy, which in chapter one I stated is where legitimacy is conferred on the basis of the practice having personal relevance for the healer.

In order to reinforce the 'dramatic episode', healers incorporate differential imagery in the healing acts. For instance, Teresa emphasises that a healer should make herself "neat and presentable", as this is perceived as an important signifier of professional competence. Teresa often wears her white coat and white trousers at the Centre as she explains that "some like that kind of reassurance", although I did not notice this sentiment myself. Also, in the main Introduction I noted that Jenny has two white coats at her healing business in Broadville. She too emphasises the professional context of the Centre by admitting that healing attire is situational: "I wear the white coat here, though at home I don't. I just have what you see me in." In drawing attention to the healers' appearance Teresa and Jenny establish the 'pseudo-medical' undertones of the healing act. Such medically-laden imagery may provide some reassurance for the patient, but it is significant that the garments are worn in the organisational context of the Centre.

In chapter one I intimated at how therapists adopt professional 'markers' in order to further legitimate their practice. Adopting ritually significant markers such as the 'white coat' is one way of achieving this legitimacy (Easthope 1986; Kleinman 1984). In examining Chinese and Ayurvedic systems of medicine, Kleinman (1984) points to this particular 'mimicry' of biomedicine: "Many of the borrowings – white coats,

stethoscopes, laboratory apparatuses, etc. – are somewhat crude attempts at status enhancement by copying the symbolic trappings of biomedicine” (ibid:148). Mimicry refers to the straightforward and non-judgemental representation of the practice (biomedicine), but some healing acts (Charlie’s) are also suggestive of ‘parody’, which reflects a more critical and subversive stance towards medicine (see chapter six).

The symbolism of ritual objects

There are various methods for systematising the physical environment, which may depend on whether the healing takes place at home or at the Centre. Healers at the VEHC may also conduct healing at home, and Teresa ensures that her healing trainees consider the impact of the domestic environment on the healing. For example, the healer should be more sympathetic to the perceived symbolism of specific objects displayed in this context. At the Centre displayed objects are mostly those chosen by Teresa (e.g. large crystals and ‘New Age’ paintings). For Jenny, the ideal healing environment is one that embraces both the ‘professional’ with the ‘individual’, but there are obvious advantages of using a Centre. As Jenny explains, “The healing room at home is the living room, so I have a lot of preparation to get everything right. Ideally I would like a place with a separate healing room and a recovery room as well.”

Teresa argues that the healing environment should be clear of ‘artefacts’, particularly objects that have ‘domestic’ connotations, such as pictures of family. Also, there should be no ‘personal symbols’, as patients may not agree with the healer’s sentiment. My interpretation of this restriction is that Teresa believes that innovation of the physical environment reduces patient confidence in the healer’s abilities. More significantly, personalisation in this context may pose a serious threat to the income of the Centre, particularly if patients disagree with or dislike the symbols and/or the ritual objects. For example, Elsie, another healing trainee, offered an amusing and yet embarrassing

account of the kind of problem that may arise from the encroachment of the personal into healing space:

I have to take my patients upstairs as it's one of the upstairs bedrooms. I change it to my healing room you see, and it feels a bit funny especially when you're taking strange men upstairs, but it's alright. Usually, once they go in the healing room I leave them there so that they can just take it all in... Well, I just remembered. The room that I do my healings, it's my daughter's old room and I remember after one healing a patient said to me that they enjoyed the healing and everything, but there was just one thing that they said they could have done without, and I said "What's that?" and she said that she was just waking up from the sleep state in the healing while I was out of the room, and as she sat up she looked straight at the poster that I never brought down and it just had a picture of a young man with the caption – 'A hard man is good to find'!

Such objects may undermine the patient experience. Furthermore, healers are also encouraged to reduce the ambiguity of object symbolism. For example, Teresa explains that there should be "no wicker...witchcraft" or anything that pertains to a belief in magical arts, as this may conflict with patient beliefs. Therefore, although personalising healing rituals is an accepted practice, we can see how Teresa censures certain practices and the use of some objects because the patient may end up confusing healing with any of the other types of therapy. Limiting the ambiguous nature of the practice is one of the ways in which some formalised healing practice develops.

Also, Teresa describes the best kind of environment to conduct healing, which includes, "candles, joss sticks, flowers, soft music, a warm comfortable room are all important in a healing room, and somewhere to talk and take case histories after. Not just a couch, but a couple of chairs and a coffee table, a place set aside where you can

chat.” The use of these kinds of objects has been noted in other research on healing groups (see Skultans 1974:81).

Evoking the interface between medicine and healing

The physical design of the two main healing rooms at the Centre, the ‘front room’ and ‘pink room’ respectively, blends both ‘medical’ and ‘spiritual/religious’ symbolism. For example, each room contains a biomedical-style couch for patients to lie on during healing; rolls of ‘Kimberly Clark’ paper towels are fixed to the wall. The ‘hygienic’ paper towels are used each time a patient gets on to the couch (though fully clothed), as it is argued that during the healing process patients shed their ‘psychic debris’ (spiritual dirt). These terms draw attention to concepts that have biomedical connotations, although it is important to note that ritual cleansing is an integral part of healing practices whose origins pre-date biomedical hygiene.

A small hand basin is located in the corner of the ‘front’ room. This is not used for washing or sterilising medical equipment, but for ‘cleansing and purifying’ the healing crystals. Conversely, the use of flowers, candles, joss sticks, ‘New Age’ type paintings of Jesus and other religious figures, and the coffee table, all denote a curious blend of medicine and healing. Teresa’s construction of a ‘standardised’ healing environment draws attention to this interface.

The medical and spiritual/religious theme has been noted in relation to other Western healing groups. For instance, in discussing folk healing circles within small villages in Central Italy Romanucci-Ross highlights the adaptation of religious iconography and scientific language. She argues that this combination is a feature of the “syncretic revolution” (1997:11) in which folk healers’ practices have been variously affected by the media, producing a syncretic tradition linking religion, medicine, science and technology. In a discussion of healers in Southern England, Easthope (1986) examines

the combined use of religious and scientific symbolism, arguing that this combination is procured by healers in order to generate a greater authority and legitimacy in the healing process. As Easthope explains, "...healers tap a symbol system and a language that already has an air of authority. For some healers this is religion and they use the language and symbols of religion. For others it is science and they use the language and symbols of science" (ibid:125).

However, it is perhaps not so much that the spiritual has followed the medical, but that these contrastive systems of healing draw upon culturally embedded practices and metaphors common to both. For example, in drawing a distinction between the 'folk' and the biomedical model of health, Helman (1986) posits the notion that although the folk model differs from the biomedical one, it is also significantly influenced by it. Similarly, biomedical practices are influenced by and draw on the folk model. For instance, Helman describes the ways in which the GP colludes with the folk model in order to make the diagnosis more palatable for the patient. This is no surprise as it is clear that spiritual healing represents more of the lay experience of health and illness, as these ideas regarding the body and health arguably have greater congruence with patient values (Astin 1998). The relationship between medicine and healing is therefore two-way.

Preparation of the spiritual environment

Attention given to the healing environment does not just reflect material concerns. The spatial environment in which healing takes place is regarded as having both a physical (material) and an immaterial (spiritual) dimension. Likewise, Teresa explains that in the healing room attention to the 'subtle' and 'imaginary' level is required. 'Subtle' denotes the spiritual domain, and by 'imaginary' I mean that the immaterial nature of healing

reality allows the individual recourse to certain 'imaginings' within the healing practice. For example, during healing the healer can 'imagine' that a ray of sunlight enters the body of the patient through the healer's hands. This is perceived as an 'imagining' that may provide important healing effects. By definition these 'imaginings' are highly personal, and therefore healer innovation is the norm. Indeed, in order to express the 'inchoate' and immaterial nature of the act, healers have recourse to a range of descriptors/metaphors including 'spiritual', 'subtle', 'imaginary', 'light', and 'etheric'.

Healers are given licence to be more creative and express their individuality at the level of the immaterial. The following is a good example of this creative expression. Teresa explained that after a healing the room is enveloped by 'psychic debris', a form of negative energy or spiritual dirt emitted by the patient during the healing. Teresa's use of Kimberly Clark is an entirely symbolic gesture. It draws attention to the removal of the debris.

How do healers achieve the neutralising of the psychic debris? Teresa lights incense sticks in the kitchen before a healing, which are then taken through to the 'front room' when a patient is ready. The incense sticks are supposed to alter the 'subtle' atmosphere of the room from a 'negative' to a 'positive' one. Other methods for neutralising the negative energy include opening windows and lighting candles, utilising objects with spiritual/religious undertones. In addition, providing gentle music and other media that appeal to the senses are said to amplify the healing effect.

The routine nature of individuation: choosing crystals for healing

Responsibility for choosing healing crystals may fall to the healer, the patient, and other significant people (family, friends, etc). At the Centre crystals are scattered around the

reception area, the healing rooms, and the sanctuary. There seems an infinite choice, and it is in the choice of crystal for healing that individuation plays a routine part. Teresa chooses from the large numbers of crystals on display in the front room. Conversely, Sally chooses from her private collection, which she carries around with her in a small velvet pouch. However, the choice does not just reflect the practicalities of availability. Just as important are the meanings attached to these choices, but healers offer different explanations for their choice.

Expert-based crystal choice

Healers often make an 'expert-based' judgement about the appropriate crystal to use. Crystal choice corresponds to parts of the body and to particular conditions that require healing. These decisions tend to be based on healing texts that list the kinds of ailments that certain crystals treat. For example, amethyst is widely presented in these texts as good for the overworked and stressed (see Raphaell 1987). Moreover, there are broader crystal typologies. For instance, Jenny argued that "Some are stimulants and others are relaxants." As an aside, it is worth pointing out how such comments demonstrate that healers draw on medical metaphors in explaining the healing act. Here, crystals are likened to biomedical drugs with definite curative properties.

Additionally, links are made between specific ailments and the physical structure of crystals: shape, colour, and special markings. As Sally explained: "The crystals work on two vibrational levels, the colour and the shape. These are the two basic ways in which they act upon us. This is what attracts us to them and makes us choose a particular one." Teresa frequently adopts this 'expert-led' approach to crystal selection. One day I asked Teresa why she chose certain stones. She explained that a wand crystal was used for spine work.¹ A rose quartz, held in her left hand, generates a calming effect. Based on the properties that key healing texts describe, both crystals are used 'acceptably'. It is

worthwhile noting how in such instances Teresa's professionalism takes precedence. As figurehead of the Centre, she is the most responsible for establishing a systematised set of ideas regarding crystal properties.

Intuitive-based crystal choice

However, the crystal may not be right for a particular patient. Crystal healing textbook descriptions of crystals list 'ideal type' properties, but these may not suit the individual. As Raphaell states, "[crystals] may be different for you than for anyone else" (1985:15). Each healer then extracts something unique from the crystal. Healers hold the view that crystals have no intrinsic qualities, but that instead, their quality changes according to both the healer and the patient. As Holbeche (a writer on crystal healing) explains:

Therefore for me the most vital factor in choosing a crystal for my personal use is how I feel about it...crystals speak through feeling and intuition...By trusting your feelings and intuition, when you hold a crystal, you are speaking the same language (Holbeche 1989:79).

In this way healers make intuitive and individual choices over crystal selection. For example, we can see this in Charlie's statement: "You usually know what to do at first with a healing. You pick the stones you want by trying to think of what they've said they're feeling (the patients) - sad, tired, unloved - and then you choose the crystals that you think you need." Similarly, Jenny retains a looser definition of what is acceptable when choosing crystals, perhaps mostly due to the fact that she is sole practitioner:

Often the properties in the books for each stone are all vastly different, so you have to go by what you think. There are guidelines with the colours of the chakras though...the

chakras are divided by colour, although you can place a crystal from one area into another if it feels right.

The general guiding principle is 'if it feels right', which reflects the core idea of intuitive-based rather than systematised healing. Another good example of this was when Stella and I were healing Cara in the 'pink room'.² Having neglected to bring any crystals up to the room, Stella made her selection from those that had been left by the small basin. When Cara came downstairs after the healing, she questioned Stella about the crystal selection:

"The crystals you picked, did you pick any particular ones for a reason, or did you just sort of choose them intuitively?" asked Cara.

"Yes, intuitively," said Stella, "I mean, the celestite for the crown and the hands would have been very calming for your stressed state of mind I think. Did you find so?"

"Oh yes, it was very relaxing. I just wanted to be there all night." exclaimed Cara.

Stella could only choose from a limited number of crystals, but her point was that they were still used intuitively. The question at the end prevents any further interrogation into the healer's choice of crystal. Cara's reaction thereby legitimates Stella's initial response.

Sally chooses from her own selection which she calls her 'little friends'. These are tucked away in a velvet purse, referred to unambiguously as her 'medicine bag'. By selecting intuitively from her own set she is safe in the knowledge that she is familiar with the crystals. Sally is seen by those around her as often emotionally vulnerable, and is therefore more comfortable with her own selection.

Pre-operative rituals: purifying and charging crystal instruments

Both healing and medical acts employ pre-operative processes. The crystal is comparable to any other medical instrument in that it must be checked and ‘cleansed’ (the terminology of biomedicine) or ‘purified’ (the terminology of healing) in order for the patient to receive its full benefits. In healing, ‘purifying’ and ‘charging’ refer to the different symbolic acts that can be applied to the crystal, usually prior to healing. What is clear is that, discursively at least, the boundaries between these contrastive forms of medicine, biomedicine and crystal healing, are loose, and through individual healing rituals healers reflexively and creatively play with this boundary.

For example, crystals are perceived similarly to the way that the clinician views his/her surgical instruments. Likewise, the purification rituals seem to mimic the healers’ perception of surgical healing. Healing acts may mimic or appropriate symbolic gestures contained within biomedicine in order to make a statement about the legitimacy or professionalism of the healing.

First, ‘purification’ is similar to ‘cleansing’, indeed the terms are interchangeable. Healing terminology is semantically slippery, the meanings multi-faceted and multi-layered. Sally, Stella and Teresa utilise different techniques for purifying crystals. Crucially, the Centre sanctions the ritual content (i.e. what is enacted) if the healer says that this process ‘works for them’. That is, individuation is a reflexive process, and points to the centrality of self-sufficiency in the healing performance. As such, healers do not necessarily rely on ‘conventional’ or expert-based ‘rules and procedures’. Let us consider a few of these methods.

Following purchase, healers can bury the crystals in sea salt, sometimes for a few days. In one of Teresa’s crystal healing texts it states that this method helps “draw out impurities” (Raphaell 1985:30). The molecular structure of sea salt, similar to that of the

crystals, lends it this ability. Teresa argues that sea salt is also a 'natural' form of cleansing. Other methods include washing them in water, leaving them out in the sun, and then placing them on top of a larger quartz crystal cluster. Teresa explained that all the VEHC crystals are regularly purified. "I wash and bless them" she said. Small hand basins are positioned in the two healing rooms and the sanctuary. The healing crystals are washed in the basin, 'blessed', and then left out to dry. The blessing is a simple command uttered verbally or non-verbally, and should be unique to the healer. In contrast to the above, Sally argued that the crystals can purify themselves: "The crystals heal each other, so it doesn't matter if lots of people are touching them, even if they do put a lot of negative energies into them."

Such ritualised behaviour surrounding 'purification' or 'cleansing' can be observed in the clinical environment. For example, Katz describes how certain acts amongst surgeons in the operating room are more symbolic than others during the "restrictive entrance procedures" (1981:336). Katz argues that pre-operative rituals such as the 'scrubbing up' of the surgeon are 'non-essential' to the clinical task, and these rituals are adopted in order for the surgeon to be perceived as clinically competent. For Katz, these biomedical rituals demarcate boundaries of expertise - those of higher clinical status endure more thorough and intensive purification. Such rituals of cleanliness are therefore essential to all healing modalities.

Secondly, the crystals are occasionally laid out on large quartz crystal clusters, in order to 're-energise' them. This method is normally referred to as 'charging'. Crystals need re-charging as they can be depleted after absorbing patients' 'negative' energies:

When crystals and stones are used for healing purposes, they become very receptive to the vibrations of the individuals that they are working with. They can pick up and retain their energies and therefore should be cleansed after each treatment...As you work with crystal

healing and get to know the unique energy of each of your healing stones, you will be able to easily tell which stones need more intense cleansing (Raphaell 1985:27-8).

Teresa explained that crystals absorb a lot of the 'negative' energies of a person. Having said this, for Teresa, all crystals are different and react in a unique way to patients' energies. Therefore, some need more intensive cleansing and re-charging than others.

'Risky' crystals: the process of programming and 'tuning-in'

However, the crystal is not just a healing instrument. On one level, it is like a medical scalpel: it cuts, divides and draws out the impurities from the spiritual body. The crystal epitomises both the medical and healing instrument, and because of this it embodies some of the risk elements of many biomedical instruments.

In addition, it is a precondition of a successful healing that the healer is able to 'tune-in' with the 'crystalline reality' of the crystal itself. What does this mean? 'Tuning-in' refers to the healer's ability to connect and 'align' their inner being with the inner reality (i.e. the immaterial nature) of the crystal. McGuire (1988) also notes the use of 'tuning-in' as a term 'psychic healers' use. Interestingly, McGuire notes the technological and electrical imagery the term conjures up, and that this applies as much to the relationship between the healer and patient as it does between healer and crystal:

The role of the healer in groups using "expert" healers was often interpreted in terms of these technological images. Psychic healers spoke of becoming "charged up", of "tuning-in" to the person needing healing and of "finding what frequency they are on." Similarly, the healer's energy was transmitted "like radio or TV waves." (McGuire 1988:174).

In this way, 'programming' a crystal imbues it with a particular purpose. If the healer wants to give a crystal as a gift they can programme it with a message. The idea is that the message is then embedded in the crystal. Yet, the 'risk' element is that the crystal can be programmed with negative thoughts, such as a subversive message not conducive to the healing. For example, in answering my question as to whether there can be a negative side to healing, Jenny explained: "There is a dark side. It really depends on who has programmed the crystal and what they have programmed it with."

Therefore, crystal usage can also be risky and fraught with 'danger'. The healing effects are not unconditionally positive, and here the healers draw parallels with the dangers of biomedicine. In addition to the technical skill of the healer, healing efficacy depends on the healer's personal involvement in the healing - that they are 'tuned-in' to both the properties of the crystal and the needs of the patient. For example, the patient may not want certain feelings to surface during a healing, an issue that also raised concerns about the risks of healing. As Teresa explained:

You should be careful of how much energy you put into the healing. Some of the early pioneers of crystal healing would over do it a little, they would just want to do the healing in one go, but you need to be more gentle than that, you don't want to blast the patient.

Healer and patient protection from spiritual dirt

I described how negative energies (spiritual dirt) are dispelled into the atmosphere during healing.³ After a healing the healer can feel quite weary and drained. It is not easy for the healers to protect him/herself fully. Indeed, healers are like magnets; due to

their trained 'sensitivity', they can become channels for absorbing other people's energy in many situations. Sally explained this further:

You have to learn to protect yourself all the time, because people with little energy will be drawn to those with greater energy and they can drain you physically. Your body finds many ways of feeding itself energy, whether by food, or the sun, or the air. It will always fight to survive, to keep its energy. That sort of energy is essential, and it can be accessed in different ways.

Again, healers demonstrate personalised methods for doing this. Methods of protection create a 'barrier' between the healer and the negativity drawn from the patient's body. If not adhered to the healer may be contaminated with the patient's ailments. Teresa calls these forms of protection 'spiritual hygiene'. Again, this concept draws heavily on medical terminology although, as I have stated, concepts of ritual hygiene are embedded in healing practices that predate biomedical concepts of hygiene.

In the following I describe two key methods that healers employ for protection. These methods inform us about the healers' individual perception of healing space and their sense of what constitutes risk in the healing act, both in terms of how the healer can be contaminated by spiritual dirt and how they can protect themselves.

Method A: closing the chakras to repel 'negative energies'

Stella explains that certain methods are effective before healings and also in everyday social interaction, for example, in preparation for going shopping. Unconsciously, people, even those one simply meets on the street, 'rub-off' their negativity onto others.

Healers must be protected from this possibility. This idea is illustrated by Stella in the following passage:

The problem is, you see, we need to protect ourselves during the day, because there is so much negativity, you know, negative thoughts that you can pick up. I mean you can get all sorts of nasty things from people and of course it gets into your chakras and then you wonder why all of a sudden you start being miserable or something, and it's just because you are taking in everyone else's energies. Also, I expect you know but you should always close your chakras before you go out as you don't want to pick up other people's negative thoughts.

This image of something from someone else 'getting into' their chakras is a poignant one. The 'health' of the physical body has a corresponding relationship to the chakras, and so the healers' description of the chakras seems quite physical. The 'nasty thing' that Stella speaks of is a curious thing to say because it seems that Stella is saying that 'people get you down' or something similar, a phrase that may arise in everyday conversation. Instead, Stella identifies that 'thing' that makes people inexplicably miserable as a physical entity. One method she recommends is 'closing' the chakras so that the healer is not leaving themselves 'open'.

This is something which Sarah, another trainee healer, grappled with when Teresa tried to get us to 'measure our auras'. The 'aura' refers to the spiritual energy field that surrounds the body (see chapter seven for a fuller definition). Sarah said she felt her aura was unusually large, and asked Teresa whether she should be concerned about being exposed. Teresa explained that there was nothing to worry about as long as the healer adheres to the protection methods, but this did little to appease Sarah's worry that her spiritual body could be naked and exposed to the negative emotions of complete

strangers. However, at another level we can see that this was about Sarah feeling that by being open in this context, you leave yourself emotionally vulnerable. After her second divorce, she did not want her inner self to be revealed to those around her.

Being vulnerable to the outside 'invasion'/'contamination' of negative energies evokes the way Sontag (1991) talks about the prevailing kinds of metaphors people adopt when discussing their illness. Descriptors such as 'invasion', 'infiltration', 'protection' and 'exposure' are highly military in their imagery. And, we know there is nothing unusual about the way these metaphors are used to draw attention to the similarity between war and disease as figurative and institutional domains. As Sontag explains:

...military metaphors have more and more come to infuse all aspects of the description of the medical situation. Disease is seen as an invasion of alien organisms, to which the body responds by its own military operations, such as the mobilising of immunological 'defenses,' and medicine is 'aggressive,' as in the language of most chemo-therapies (Sontag 1991:95).

According to the healer, individuals are therefore partly responsible for their health, and they can do something about it through the use of personal protection. The burden of responsibility provides the healer with a legitimate reason to modify and provide innovations of prevailing methods so that they are individually suited.

Method B: the visualised construction of healing boundaries

Another method is the 'visualisation' technique. For this, the healer constructs an imaginary/visualised boundary of protection, similar, metaphorically at least, to the way

a surgeon uses a mask to keep patient 'germs' at bay and to keep him/herself from infecting a patient. Both Sally and Stella use visualisation in order to stamp their mark of individuality on the process. Indeed, this tends to be actively encouraged. Images used for the boundary of protection must take on a symbolic resonance; they should be perceived as in some way applicable to their own biography. This form of protection can be done before the start of the day and/or before each healing. For example, Stella describes her method for carrying this out:

I find in the morning that what I do is I find some time to just sit down, with my feet firmly on the ground and my arms by my side and I just imagine that my feet and my energies are going down into the Mother and I send out a thought of love to Mother Earth and imagine all this wonderful light ushering down my body into the ground and then, you'll feel the love return with this wonderful heat rising up through your feet and into the stomach, and while you do this, if you can just imagine your energies reaching out from your heart through your head and up into the heavens above, the Father. Imagine it is a beautiful light, and with that light send out a thought of love to the Father and then you will feel that love return. Now, when those feelings meet, from the Mother and the Father, they will meet here at the centre of the soul and this will give you protection throughout the day. If you do this then you will feel much better to go out and deal with the day.

Stella visualises protection in the form of a light. The two spiritual realms, 'Mother Earth' and the heavens - the 'Father' above, are perceived as a whole when they meet at the centre of the body, the soul. The image of the 'light' is significant and is present in much of their description of cosmology. Again, the imagery is not altogether unusual, though its spiritual/religious emphasis is significant in relation to the medical/healing context. For instance, Glik (1988) also notes that the metaphors of light are used to

emphasise healing. Further, Stella describes the physical nature of the protection in the use of a 'cloak':

I also imagine having a cloak of protection on, and as I pull the zip up I imagine one by one the levels of the aura are encapsulating my auric body and inner centre. Imagine as well, the chakras as a flower, and slowly the flower closes up, the petals clasp tightly across a film of aura that makes up your being. Sometimes when I am feeling particularly vulnerable I do this twice a day.

Stella imagines being wrapped in a 'cloak of protection', which she perceives as a barrier against the outside world of 'negative' energies. Stella says that this cloak encapsulates her 'auric body and inner centre'. The 'inner centre' embodies the realm of inner identity. It is perceived as the pure self that is an essential part of every person, untouched by the imperfections of the material world. The inner centre thereby equates with the spiritual realm, and is therefore of a different nature to the material. Now let us turn to Jenny's visualisation, which is similar in the imagery used:

To prepare I have to tune-in, then I just ask for guidance. I cover myself with white light. I close all of my chakras before a healing. To protect myself I need about half an hour before the healing to go into myself. I imagine a white circle of light going around me that protects my aura. Also, I picture a large blue velvet coat that I put on, and as I zip it up I stop at each chakra and say "I close this light with a lock" and then go onto the next one. I do the same with each chakra. I don't think I could go straight into the healing, I need those little rituals, they are very important. They help me to go into myself, to go within.

In Jenny's visualisation the coat is velvet. The chakras correspond to areas of the coat that she can lock like the twisting action of a duffel-coat button. Closing and locking the

chakras prevents 'psychic' debris from entering these spiritual vortexes. This helps her 'go within': the visualisation offers a clear direction into the healing self and the habitat of intimate space. To go within is the same as becoming 'in-tune' with one's spiritual body. In contrast, Stella describes the chakras as a flower, which fold up once the cloak of protection is pulled on. The aura is held in by the chakras that protect this inner space, which as Stella says, helps her overcome her vulnerability during the day.

Despite the Centre's informal sanctioning of individuated protection methods, the two approaches have their similarities. From individuated practice, we can see how collective practice unfolds. Stella and Sally draw upon common metaphors – the 'light', the 'coat', the 'locking' of the aura – which suggests that these are common and shared symbols both within the healing centre, and within the healing/spiritual community at large. Thus, there are perhaps self-imposed limits to the expression of individuality, and despite the 'freedom' that the healers have, they clearly utilise quite conventional imagery.

Conclusion: managing individuation in the material and spiritual domains

In this chapter I focused on the various ritualised actions the healers carry out in order to prepare for the healing. I argued that the pre-healing rituals illustrate key themes in the thesis. For example: the primacy of the spiritual in healing discourse, and the interplay between spirituality and materiality in healer practice and ideology. In addition, I have explored the ways in which individuation (the means to innovation) plays a key part in a range of contested healing rituals. In raising these themes I explored different

preparatory acts. These included: the concepts and orientation towards healing space; selecting crystals; purification issues; and methods of healer and patient protection.

First, in addressing spirituality these healing practices are very different from those that engage solely with the material body. A conventional reading of this situation may infer that crystal healing illustrates a 'counter-cultural' message (i.e. the assertion of spirituality over materiality) (Fuller 1989:116). Yet, there is greater interplay between the spiritual and the material in the healers' concepts of healing reality. I also demonstrated how healers draw attention to the relationship between medicine and healing in their mimicry of biomedicine. I shall offer other examples of this in later chapters.

Crystal and spiritual healing are part of the growth in 'syncretic' healing practices, where healers 'mix and match' both healing traditions, whether these be influenced by predominantly medical or spiritual activities. In chapter two I explored the wider socio-cultural transformation in which various new social identities and groupings have emerged. The emergence of a wide range of healing groups whose practices and discourses explore the nature of this interplay has been viewed as a particularly postmodern concern:

One of the most distinctive aspects of the interconnections between postmodernity and the personal domain, though certainly one of the most neglected in recent discussions, is the capacity of human subjectivity for imaginative elaboration, symbolised by new representations of self and world (Elliot 1996:33).

Secondly, I introduced a key concept in the healers' cosmology: that healing space is both material and spiritual, and that the process of individuation allows the healer to demarcate the boundaries between these domains. Furthermore, the fluidity of the

boundary that demarcates formal from informal healing is equally instructive in helping us to see how the interplay between individuation and systematisation is played out. That is, where the healing setting is more formal, healing tends to be more systematised.

Individuation can be seen in the numerous ways healers justify the importance of 'intuitive-based' action. For example, we see this in the use of protection methods, where the emphasis is on constructing a unique method that suits the healer. The emphasis on the intuitive means that healers see diagnosis and healing success as being in flux, and that healing procedures can change over time. This emphasises the subjective nature of the process, and places more responsibility with the patient. We see this in relation to the healers' perception of the illness, as the patient is perceived as the 'owner' of their condition, an issue I go on to address in chapter eight.

Nevertheless, I also noted that over time healing practices and techniques are being cemented through the process of routine self-reflection. In the case of the protection methods this is partly due to the commonality of the symbols and metaphors being used. This may tell us something about the sedimentation of structure, in that individual actions reproduce social forms over time. Equally, this may also tell us about the relationship between different forms of ritual and the construction of orthodoxy at the level of the local.

Finally, I draw upon a few key points made by McGuire (1988) to further illustrate the key themes arising from this chapter. McGuire conducted a study on healing groups in suburban Baltimore in America and she argues that the healing that individuals were involved in became a routine part of their everyday life. The healing was not something people participated in only if they felt ill or unhappy, it was embedded in the life of the group as normal activity. As McGuire explains:

...several members requested healing at each meeting of their group; they would simply mention, as needing healing, whatever particular problems they experienced recently... seeking healing was often a routine part of participating in the group and engaging in its beliefs and practices (McGuire 1988:186).

From the outside, the VEHC can be seen as a formal health care setting, but within those four walls the individual healers make varied contributions to the everyday life of the Centre. Informal, innovative healing occurs within the 'formal' healthcare setting. Healers and patients alike perceive healing as spontaneous, improvisational *and* routine activity. For example, this interplay can be observed in relation to the choosing of crystals. I explained that healers can make their own interpretations regarding what crystals to use. Crystal healing texts are merely one method of supporting but not legitimating these choices. For example, note Jenny's biomedical sounding rationale in her choice of crystals in the section on 'expert-based' choices, in that crystals are either 'stimulants' or 'relaxants'.

However, this routinisation did not remove creativity, informality and individual expression from the healing preparations. Rather, I have noted how the systematised aspects of the healing process are tied to particular domains of action – specifically material and mundane ones, such as the physical organisation of the healing room. This is partly due to Teresa's insistence on keeping appearances similar for the patient, such as in the use of the 'white coat'. Innovation in pre-healing rituals is evident in more subtle areas of the healing such as protection methods, choosing and cleansing crystals.

McGuire (1988) notes this use of individualistic creativity in the symbolism of the healing rituals in her study, but implies that this can be perfectly in tune with the group's philosophy. As she explains, "Rather than an entire group gathered to celebrate its unity and focusing upon central symbols, these groups often gathered to encourage individuals

to create and explore their separate symbols and world images” (ibid:237). In other words, McGuire states that either individual expressions and symbols are constrained by a ‘group philosophy’, or they are given free licence to develop their own with little sense that consensus may be reached over the meaning of certain symbols.

¹ A long, thin, striated quartz crystal, which is ‘terminated’ (the sides of the crystal come to a point).

² Described more fully as case 12 in the following chapter.

³ One interpretation is that this represents a contemporary version of the miasma theory of ‘bad air’, where decay is transmitted through the air and is therefore contagious.

The orchestration of healing I: innovation, performance and role.

Introduction

The aim of this chapter is to provide a descriptive account of twelve healings. The healings I chose are a mixture of hands-on and crystal healing, and they best illustrate the interplay between uniformity (standardisation) and individual creativity in spiritual healing practice. I provide these descriptive accounts of both healing practice and dialogue about the healing as they encapsulate how healers' ideas are reflected in their practice. They also allow us to explore ritual modifications over time.

Unsurprisingly, the nature and function of healing has generated considerable interest amongst social anthropologists. In particular, they have explored a number of issues related to the ritualisation of healing (Benor 1984; Frohock 1992; Glik 1988; McGuire 1988; Skultans 1974). As such, in the concluding discussion of this chapter I discuss a number of related themes. First, I consider the nature of individual practices and healing innovation and the process by which orthodoxy of practice emerges. Secondly, I explore how healers create the sense that a healing 'works', and how the healing is legitimated. Thirdly, I consider the following question: are these varied healing practices creative acts, or do they reflect a reliance on more conventional medical ideology? Finally, I note the ways in which the changing nature of 'expertise' in Western society has an impact on the healers' perception of patient and healer roles. More substantial reference to the case studies is also made in the following chapter, particularly in relation to the nature of healing performance.

1. Charlie healing Stuart (the anthropologist)

Charlie led me into the front room and dimmed the lights. I took off my shoes, while Charlie, somewhat self-consciously, circled the room doing his preparations. I climbed onto the couch. Charlie was standing by the crystals that were laid out on a pine shelf on the far wall. Pondering over his selection, he picked a few up and rubbed them in his hands.

“What crystals would you like?” he asked me.

“Um, I don’t...,” I said before he interrupted.

“...or do you want me to choose them for you?”

“Yeah okay, you choose them.”

While I turned over onto my back, Charlie adjusted the shape of the couch, and I felt him move my feet apart and place a crystal in between them. Then, he laid a crystal in the palm of my hands. With my eyes closed I sensed him moving around the room. I heard the click and whirr of the tape-deck followed by Gregorian Chant music. The tape-deck clicked again and the music stopped - Charlie was changing the tape. I heard a click a third time and then a more sedate and relaxing kind of music could be heard, echoing sounds of sea animals. It was not very audible. He then said, “Alright Stuart, I’m going to start from the head and slowly move down the body to your feet and then finish back at the head again. I’m sure you know.”

Without further warning he placed his hands on my head. He pressed down firmly with the whole of the hand as though he was supporting it. He held this position for a few minutes, then slowly lifted his hands off and repeated the movement by placing

them on my shoulders. I hardly felt the releasing pressure of his hands on my head, as this was replaced by equal manipulation focused almost simultaneously on my shoulders and upper back area. This lasted for a minute, and then he lifted his hands again, re-positioning them on my lower back area. His hands were intensely warm at this point. After another minute he moved his hands off, and placed them just above my hip bones, and applied pressure again.

Slowly, carefully, he moved his hands off again and I became aware of his presence at the foot of the couch. Finally, I felt his hands press onto my head for the second time. Then, there was a silence before I heard him whisper... "I'm finished now Stuart, I'm going to leave you to get up when you're ready, alright mate?" I heard the door close behind him as he made his way back into the reception room.

2. Stella healing Stuart.

For this healing Stella suggested that we use the sanctuary. I sat down on a chair positioned in the middle of the room. Stella asked me a few questions about what I needed work on, so I told her that my insurance job had been stressful recently. Sitting back on her chair, she nodded her head very calmly and listened.

"Would you like to sit on this comfy chair over there, or would you prefer to sit in that one, so that you are upright?" she asked me.

"I don't mind really, I suppose..."

Stella continued, "Well, if you sit on that one first, then if you are needing some more (she paused and smiled at me) inner depth work, then you can move onto that comfy chair over there. Is that all right for you? I like to work on this chair so that I can get to your back, do

you see? The back is very important, in fact the back is everything, it holds everything together. It is very important to work on this with the rest of your body.”

Stella moved the chair, and I faced the window with my back to the door. I sat down again, my hands placed palms down on my knees, and my feet rooted firmly on the floor. At first her attention was focused on the volume control of the cassette player, but after a little adjustment she returned to where I was sitting. With my eyes closed, I felt her stand close behind me as she placed her hands gently on my shoulders. Then, whispering slowly, she began:

“Our Father, please provide me with the healing energy so that I can help...” she broke off. “I’m sorry I’ve forgotten your name.” I whispered it, hoping that this hadn’t broken her concentration, and she continued, “...so that I can help Stuart to forget about his troubles and stress and so that he can feel at ease and also at peace with himself. Stuart, I want you to relax your mind. I want you to feel every part of your body and feel them getting heavier and heavier, and as you move from your fingers to your hands and then your arms, your whole body will feel heavier and you will want to relax. Then let your mind go off to its favourite place. Breathe in deeply, hold this breath for a moment and then breathe out very slowly, moving further and further away to your favourite place with each breath.”

I breathed slowly and my body started to relax. Stella lifted her hands off my shoulders and placed them over my head for a few minutes, then moved her hands very slightly so that they were resting over my ears, a hand placed either side of my head. Repositioning again, her hands glided towards the back of my neck: the left hand passed down the back of my neck and the right hand down the front. Then, both hands were placed on my chest and upper back area respectively. The touch was gentle and light. For about five minutes her hands were directed towards my back and chest area.

Occasionally she moved them in a circular, coiling fashion: moving them around and out from my body before drawing them back in.

After some time she moved her hands away, and I sensed her move in front of me, redirecting her focus to my lower body. I felt her hands drift along my shin and calf muscle, gently touching the surface of the body as if mapping out the area of my lower leg. With renewed interest she then focused on my chest again, just pressing on my chest and back area with her hands as if supporting the rib cage. At this point the healing came to an end, and I heard her walk back to her chair. Gradually I opened my eyes, and Stella asked me what impressions I received during the healing.

3. Teresa healing Philip (a).

Philip is a crane operative in Granby, and has been visiting the VEHC for the past few years. Teresa explained further: "Philip is a 'sensitive' and because of this he finds it difficult. As one between heaven and earth, he needs a little more grounding."¹ Teresa enquired as to how Philip was feeling that week. He said he didn't feel too bad, although he'd been to the doctors recently because he'd noticed a lump under his left arm. The doctor said he couldn't do anything about it, adding that as it was a soft and not a hard lump there couldn't be anything wrong. Teresa replied: "Yes, they can be hereditary, those things. My father had one and he's passed it on to me, a great huge thing on my shoulder area."

Teresa moved around the room, picked up various stones and placed them on or near different parts of Philip's body - the neck, under the pillow by the head, down the spine (Philip was lying on his front) and at the feet. She took her time, carefully feeling the stones. As she worked she identified the stones for me that were being used and explained the logic behind her selection. Once this stage was completed she moved

around to the other side of Philip, turned down the lights and put a cassette in the tape machine. With her right hand on his shoulder, she voiced her invocation: "In the name of the Father Mother, I ask for love, light and healing for Philip. Bring down your healing rays and wrap him up in your curtain of rainbow light..."

The invocation continued for a few minutes. She asked Philip to feel warmth and light enter every part of his body, and she described the light and energy entering his body and moving sequentially through the major limbs and organs. Following the invocation she took a pendulum crystal from her pocket and suspended it approximately three inches above his head.²

Her eyes closed, Teresa circled the suspended pendulum around Philip's head. Then, the pendulum was dangled down his spine, to his feet, until finally she moved it back to the head. The pendulum swayed gently, and at other-times erratically in both a clockwise and anticlockwise direction. Occasionally it stopped altogether. For the second time, she followed the pendulum over Philip's head. This stage of the healing took about five minutes.

She then replaced the pendulum with a laser crystal,³ which she moved around the shoulder and spinal area in long stroking actions. This action was repeated for a few minutes, and she then moved the laser down the spine, stopping intermittently at selected areas of the body.

After using the laser crystal she returned to her collection and selected another crystal that she placed in her left hand. She held this gem above Philip's head, but this time she moved it slowly across to the other side of the body, and as she walked down from his head to his feet she drew the crystal across his body, at a distance of about three inches from his skin. At the end of the feet she twisted the crystal in a small coiling movement.

Returning to the head, she repeated the movement - five times in total. Each time she moved the crystal higher and further from the body, from three inches to about three

feet. The healing was completed at the feet, and as she held the crystal up to her mouth she blew into her hands, released the crystal and then placed it on the shelf. She then opened her eyes and whispered to me to follow her out of the room.

4. Teresa healing Philip (b).

This was a follow-up healing several weeks later. As Philip lay face down on the couch, Teresa asked how he had been feeling that week. She then played the cassette in the tape machine. She selected some crystals (danburite and malachite) and placed them down Philip's spine, from the neck to the area just above the coccyx. A crystal was placed under the pillow and a small crystal bowl by his left shoulder. Following this she rested her hands on his shoulder and exclaimed:

"In the name of the Father Mother, I ask for love, light and healing for Philip. Bring down your healing rays and wrap us up in your curtain of rainbow light." Teresa told Philip to visualise the healing as energy moving within his body. "Feel your feet in the earth and let the healing energies rise up into your toes and through your feet to your ankles. Also let the rays of light from above your head come in, bringing peace and tranquillity to your self, the rays move into the crown and into the brain, then move down from the neck, into the spinal area, spreading out to give light to all the vital organs: the kidneys, liver, spleen, and then feel it move around the hips..."

Following the visualisation, she gripped her pendulum: "First, I cleanse the aura", she said. She moved the pendulum from his head, down the spine, then along the side of Philip's body, to the soles of his feet. She brought the pendulum back up to Philip's head, stopping at intervals before moving on. Then the pendulum was replaced by a

clear quartz crystal and a malachite wand. Closing her eyes, she held out the wand in her right hand. She pointed the malachite towards his shoulder for a few minutes before replacing it with the quartz wand. On completion she held the quartz wand up to her mouth and blew, releasing the 'auric debris'.

Handling the quartz wand once more, she held it over Philip's head. She then simultaneously brought it across the body and then back, edging towards the feet each time. She repeated this several times, moving the crystal further from the body each time. Holding the same crystal, she passed her hand down the body in long striations, as if drawing lines the full length of the body. She then repeated this action on the other side of the couch. At the end of the healing she stepped over to the sink and held the two wand crystals under the tap for a brief cleanse.

5. Charlie healing Sally.

Charlie was upstairs in the 'pink room' giving Sally a healing, and Ruth and I went to observe. Sally had visited the optician for an eye test and was very annoyed because he said she should have been prescribed an additional pair of glasses. Sally requested to see one of Charlie's 'doctors' for their expert opinion, so she got onto the couch, while Charlie stood by her at the head end, and told her that he would let the 'optician' see her. Then, he went into his trance.

Charlie closed his eyes and, after a momentary lowering of his head, he opened them again slowly, blinking and making exaggerated expressions with his face as he gradually took on the appearance of one of the 'doctors' – this time the 'optician'. He still looked very much like Charlie, although his face was more contorted and he narrowed his eyes slightly. He squinted and looked over to Sally, pressed his right hand against her eye and asked her some questions. In exaggeration of a doctor's paternalistic style, Charlie asked

Sally what the other optician's opinion was on the eye. After Sally told him, Charlie (speaking in the Asian tones of the 'optician') responded... "Yes, yes, I know what kind of man he is. Right, let's see what we can do for your eyes. I think we can make them better... yes?" Sally, her eyes closed, exclaimed in compliance, "Yes Doctor."

First of all, Charlie moved his fingers around Sally's right eye, pressing gently with the finger tips, moved them a few centimetres and pressed against the eyelid as though removing something just above the eye. At times his hand moved around the eye, gently massaging the area. Sally made some barely audible remarks about how the optician she saw previously did something to annoy her. "I trust you more than him", she exclaimed. Charlie grunted, concentrating on this most delicate operation, "Yes, but it is not just about trust. I think you also get second opinion. Yes, it is very important that you seek second opinion from your Doctor." "It's very warm in here", Sally noted. "I know, there are a lot of us in here (Charlie surveyed the room, his eyes narrowed as though trying hard to focus on someone who had just entered), about fifteen." Ruth tried to hold back a slight giggle as she looked over at me. Charlie seemed to notice the awkwardness of his previous statement, and added, "Of the spirit world, of course." Realising he had smoothed over this minor distraction, Charlie returned his attention to Sally. "Your eyes are okay. I think we can make them better. You do not need other glasses. You should use your glasses less", he explained.

His face contorted once more, this time looking at the side of her head, near the temple. At one stage he moved his head to the right and nodded towards a space, as though he was agreeing with someone who was not physically present in the room. Towards the end of the healing he said he thought her eye would improve and she would eventually be able to use weaker glasses. Sally thanked the 'optician' for his help. Then, after Charlie closed his eyes again, he opened them fully. This seemed to take a little

adjustment, and it was at this stage that Ruth and I followed him out of the room leaving Sally to rest.

6. Charlie healing Teresa.

Charlie was healing Teresa in the 'front room'. He began the healing at the right side of Teresa's body with his hands placed on her shoulders, palms down. He had his eyes closed. After a minute he gradually opened his eyes again, his face taking on the appearance of one of the 'doctors'. Once again, Charlie enacted distinguishable physical changes so as to locate the identity transition. Here, Charlie tried to make himself look older by stooping slightly and mumbling.

He kneaded his knuckles into the protruding lump on Teresa's back, as though he was trying to poke something into it. Using his other fingers as a scoop, he scraped at the lump, which I interpreted as the removal of unwanted 'spiritual dirt' that had enclosed the lump. Then, swapping to the other side of the couch, he repeated these movements. At one stage he asked Teresa whether the lump hurt when he pressed into it. Teresa whispered that she was fine, so he kneaded the area once again. Then, he appeared to grasp what seemed like an imaginary hypodermic needle, and started to enact the filling of it and the subsequent injection of the imaginary substance into the lump. This was performed in an exaggerated manner and was repeated three times. Each time he pulled the needle away he seemed to empty its contents on the floor, before refilling it and pressing it back into the lump.

Following this, he shuffled to the foot of the bed and although I could not see his actions too well at this point, his image was reflected in the mirror on the wall above the shelf. From this angle I saw him nod into a blank space - supposedly to one of the spirit doctors who are present in the room with him when he conducts a healing. Finally, he

returned to his original position next to Teresa's head, and placed his hands on her shoulder. He opened his eyes and signalled me to leave the room with him. Teresa was left dozing on the couch.

7. Teresa healing Sarah.

On this occasion the crystal healing trainees were upstairs in the sanctuary with Teresa.

Teresa wrote the following on the whiteboard:

Resonance Therapy

Everything resonates at a different rate

Everything has a vibration

She then explained how the flow of energy can transfer from the resonating object to what she called the 'generator' (the healers' hand). Here, Teresa demonstrated one of her styles of crystal healing called 'resonance therapy' (described in more detail in chapter eight). The purpose of the resonance therapy is to enable the patient to maintain a semi-alert state of mind, so that the healer can carry out 'deep work'. Out of our group (Elsie, Sarah, Margaret, Anne, Katie and I) Sarah volunteered and got on the couch. Teresa then explained the healing:

When you are healing somebody it is important to use visualisations when you can. These can be guided visualisations in that you can take the patient through it and this helps the patient to release anything that is inside them. I think it is important for you to develop your own kind of guided visualisation. Try to vary it as well from time to time, depending of course on what you want to open the patient up to.

Teresa started the healing and described her actions as she progressed. "You should place - as you know - one clear quartz at the feet pointing up, one at the crown pointing down and one in each of the palms of the hands." She asked Sarah whether she was left-handed, which she wasn't. "First, you ask for guidance, and then you ask for a blessing for your healing." She grasped her crystal pendulum and moved it nonchalantly over each chakra point, remarking that as it swings wildly you take that as a sign of an imbalanced chakra,

You balance each chakra as you move the pendulum down the body. The pendulum will go from spinning fast and with a wide arc, to circling slowly. Once the pendulum reaches the feet so as to check the 'earth star', it can be moved up again through each of the chakra points to check that they have been balanced okay.

Teresa then explained that she was going to 'channel' the energy of a 'tumbled 'turquoise crystal.'⁴ The energy of the turquoise was channelled through Teresa's body (from the left arm), over the head, down the right arm and out of the right hand. With her hand above the 'soul star', she said that light would usher in at this chakra point. The 'soul star' refers to a chakra point that is extended approximately six inches above the top of the head (Raphaell 1990:29). She moved on to the crown chakra, then the brow, each time asking Sarah questions related to the sensations she experienced. She used open questions such as, "Where would you like to go with [such and such a colour]?", "What do you want to do with that sensation?", and "What are you feeling with this energy?" However, she said the questions should never be too specific: "Counselling is not giving advice. It's letting them go with what they are experiencing." Furthermore,

You need to question the patients very gently, to ask them what they are experiencing. Whether, if they see a golden light, they want to wrap themselves in it or breathe it in, or anything else. This is very important. Also, they may experience visualising pictures, memories of their childhood or a painful memory. If you find that you have hit on a difficult memory then you can leave it if they don't really want to explore it, and then you can return to it at a later stage if you can take a note of it. You should ask them what they want to do with the picture or the memory or the object or whatever, and don't forget to do that. You are the instrument, and you should fine tune the instrument for what you are doing, whatever the purpose of the healing is.

At the brow chakra Teresa explained, "It is important to give them plenty of space at the brow chakra. Don't press too heavily." She held the crystal about six inches above Sarah's brow point and asked her if the energy was too strong. It was, so Teresa moved her hand up until Sarah was more comfortable, about twelve inches above the chakra point. Teresa continued, "That is very important for the three higher chakras, but for the lower chakras you can sometimes find yourself wanting to press right in so that it feels like you are almost touching them." As Teresa reached the throat chakra, Sarah said she was experiencing a rush of golden light:

"What do you want to do with that light?. Do you want to wrap yourself in it?" asked Teresa.

"I am the light", Sarah replied matter-of-factly. "I feel like I am the universe. It's a wonderful feeling." she added.

"Good." said Teresa. "Stay with the golden light for a while."

At this stage Teresa's hand shook slightly. She explained later that she received very strong vibrations from the throat and heart chakras. At the end, Teresa said you can place a few drops of oil (she used jasmine) onto the palms of your hands and wave it into the patient's aura, as this establishes calmness after the healing. With the oil in her hands, she moved them around the contours of Sarah's aura, making flat stroking actions as if straightening out a tablecloth. An alternative, she said, is to hold the bottle of the oil in the left hand along with the crystal. The crystal should point into the bottle of oil. This channels the vibration of the oil through the palm of your right hand. She later added that you should not channel more than three things during a healing: the crystal, an oil remedy and a flower would be sufficient.

8. Stuart healing Margaret.

On this occasion Margaret and I elected to practice a healing on each other. Margaret chose to go first, and so jumped onto the couch. Meanwhile, I started fiddling with the tape machine. "Do you like music with your healing?" I asked her. She did. I proceeded to take the four quartz crystals that we had chosen downstairs and I placed them in their corresponding areas. The larger crystal was placed between her feet. Another was placed by her head, underneath the pillow. The other two were placed in the palms of her hands. I took hold of the pendulum, stepped closer to her and took a deep breath. I said to Margaret, in a hushed voice:

Okay. Concentrate on your breathing. Imagine as you inhale, a brilliant white light entering your crown chakra. It moves down through all your chakra centres, through your brow chakra, down to your throat chakra, slowly moving through all these points, and as you exhale you breath out this light through your feet, feeling your self grounded in the earth.

Imagine at the same time a myriad of colours entering and following this white light through the chakra centres, taking you to a place of beauty, protection and light, a place where you can relax and be at home.

I grasped the pendulum and held it above her head. Her breathing was noticeably heavy now, though not irregular. I was a little uncertain as to what should happen at this stage and so I just suspended the pendulum. Slowly, it started to swing in an anti-clockwise direction. I was not conscious of making it move this way and observed with interest. As I moved the pendulum down the body it started to rotate wildly. Margaret twitched and her eyes darted around under the eyelids. I described my actions as I moved the pendulum from one chakra to another. As I moved on to the lower chakras, Teresa entered the room. She offered a brief smile and a nod and then went out of the room again. I was under the impression that Teresa was checking on the healings in each of the rooms.

On reaching Margaret's feet I moved the pendulum back up and along her body, and when I felt I was rushing I made myself slow down and took more time to concentrate. I then placed the pendulum on a chair behind me. I wanted to move on to the 'soul star' chakra that Teresa discussed, but I couldn't remember how far up above the head it was, so I selected the quartz crystal generator and the piece of tumbled rose quartz that Margaret and I chose together. I placed both crystals in my left hand, with the clear quartz pointing into the healing crystal in the direction of my arm. After a little adjustment I held out my right arm and opened the palm of my hand. Then I tried to 'channel' the energies of the rose quartz through my body, out of my hand and into Margaret's aura.

However, the tape I had absent-mindedly selected earlier on became a little irritating, and was distracting me. I did not want to change it as I was concerned about disrupting

the continuity of the healing or disturbing Margaret. Spanish style guitar music, played at fast tempo and to the accompaniment of a horn and synthesiser did not help my concentration, though luckily at this stage Margaret seemed unconcerned. I re-focused my mind on the energies of the rose quartz: “Okay. I’m now going to channel the rose quartz energies into the chakras. I shall start at the crown chakra.” I said.

As I reached the base and sacral chakra, Teresa entered the room again. Quietly, she mentioned that I should really have been sitting on the chair while healing, rather than standing-up and leaning over. I finished this stage of the healing at the base chakra. Placing the rose quartz back on the chair, I told Margaret that I was going to go over the aura with some extra healing energy. I continued to move the crystal back and forth across her body, ‘cleansing’ the aura, an action I had seen Teresa carry out many times previously. I repeated this twice, and thought of some words to bring Margaret out of her rest: “Okay. Try to feel yourself grounded again and just open your eyes when you are ready” I said. I sat back in the chair and let Margaret wake from the healing.

9. Jack healing Elsie.

On this occasion the trainee healers were upstairs in the ‘sanctuary’. Jack joined us for the day to teach some healing techniques. Jack, as I mentioned in chapter three, is a healer and reflexologist in his late fifties.

The first healing Jack demonstrated was the ‘aura scan’. We moved through into the pink room and Jack asked who would like to volunteer. “Who would like a bit of a boost this morning?” he said merrily. Elsie seemed keen, so she climbed onto the couch. Jack then placed a crystal in the palm of each of her hands, the left hand crystal pointing to the heel of the hand and the right towards the tips of the fingers. The healer holds the same crystals in his/her own hands in this manner. Jack then went through the

invocation with the rest of us, which we repeated together. "I invoke the light of the Christ within. I am a clear and perfect channel. Light is my guide" we said in chorus.

This was repeated three times. Then he placed his right hand on Elsie's hand and his left hand on her brow. He called this 'bridging', explaining further:

Which hand goes where depends upon which side of the client you are on. If you are on the left side, your left finger would be on the wrist and the right finger on the brow. You will then feel immediately a tingling sensation as the patient's energy field attunes to you and your crystals.

Jack said that the crystal in the right hand should be placed loosely between the thumb and the fingers with the point towards the thumb. This crystal is then passed through the 'etheric energy field' (the aura) surrounding the body, and scans the body for imbalances. These imbalances or what are sometimes termed 'blockages' create 'signals' which individuals detect in individually unique ways. As he explained:

Slowly move the crystal over the body from one side to other. Now, feel any difference. These differences are signals of problem areas, energy blockages or weaknesses. They may be very subtle. Some detect the sensation as resistance, some a heat. Other people feel it as a sensation of cold. Don't worry if you feel hot and I feel cold. It doesn't then mean that I'm right and you're wrong – we're all individuals. Some people receive these signals fast and their conscious mind can't interpret them. It doesn't matter. They just know there is a blockage at that spot.

Jack pointed out that when a 'signal' is detected, you should stop at that area. At this point he directed the tip of the crystal to the place where he had stopped on Elsie, the right shoulder. He explained that you then circle the crystal from right to left until a

strong pulling sensation is felt, drawing the crystal towards the body. He circled the crystal towards Elsie and then touched its tip on her shoulder. He said that this action grounds the change you have been making in the spirit body down to the physical body.

He continued to 'scan', moving down the body, repeating the process each time he picked up on a blocked area. As he moved the crystal down the body he scanned side to side, but explained that you can scan in any direction. Once he reached Elsie's feet he said he was re-scanning the body, which is designed to go back and check on any particular areas that you may have missed. He termed this process the 'onion peel effect'. By this he meant that the layers of suppressed emotions which can surface during healing are removed once the healing is complete.

At the end of the healing he smoothed out the aura by moving his hands over the body with the crystals in either hand, a process he called 'smoothing the feathers'. This was achieved by moving the crystals with both hands down the body, starting at the head and descending to the feet. Following this Elsie got up off of the couch and the crystals were 'purified' in the basin.

10. Sarah, Katie, Anne, Elsie, Margaret and Stuart heal each other.

Jack explained the key principle behind most healings, was that the healer experiences similar sensations, but that these may be interpreted individually. For most of the healings there is a seven stage cycle of sensations, which infers that each sensation usually progresses to the other. According to Jack:

The first stage is a tingling sensation. Stage two is an uneven pulsing. Now, these sensations can be felt at the fingertips, the hands, the face, neck, or chest, or maybe a combination of these. The third stage will be a strong sense of heat, usually felt in the face, or it may be felt

in the whole body. The fourth stage, one of the crystals will change temperature, it will usually get colder. Stage five brings back a feeling of heat, less intense than stage three. An even pulse is felt at stage six, different to stage two, and at stage seven you should get a feeling of calm. It isn't always necessary to detect all seven stages. Most people don't feel the first two stages as they are busy reciting the light invocation. So don't worry. Remember, seven stages: tingling, uneven pulse, heat, cold, heat, even pulse, calm.

This became particularly relevant when Jack introduced the trainees to the 'Four-Square' healing technique, which brings four healers working together on one patient. Each healer holds two crystals, one for the left hand and one for the right. The left hand crystal points in towards the patient's body, whereas the right hand crystal points away from the body. The patient also holds two crystals. We each took it in turns to be the patient. Elsie went first and I stood at the head, with Anne at the feet, Margaret and Sarah stood on either side.

Then Jack told us where to place the crystals. Anne, stood by the feet, held her left hand crystal against the patient's right foot, pointing it towards the toes. The right hand crystal was held against the arch of the other foot, pointing towards the left heel. The healer on the left side of the patient (Sarah) pressed the tip of the right hand crystal against the left hip, a soft hollow spot near the ball joint of the leg and the hip. The healer on the right side (Margaret) placed the base of the left hand crystal against the same spot on the right hip. At the head, I placed my left hand crystal against the left temple, pointing up at the back of the head. The right hand crystal was rested against the right temple, pointing down towards the shoulders. Unsurprisingly, these separate actions took some time to organise.

We then repeated the light invocation three times whilst standing in our positions. "I invoke the light of the Christ within. I am a clear and perfect channel. Light is my

guide” we chanted in unison. We were then supposed to observe the sensory changes during the healing. Each crystal was held still in its respective place, and we tried to identify the tingling, the uneven pulse, a rush of heat and so on. The healings were completed when all of us had opened our eyes to indicate that we had gone through all the stages. We then opened our eyes at different times, which Jack interpreted as confirmation that healers experience individually unique timings. After Elsie got up off the couch we took it in turns to be the patient. Sarah then asked Jack more about the uses for the ‘four-square’ healing.

“The four square is an emergency treatment, for those in shock.” Jack explained.

Sarah was curious. “What if you’re out in the street and you need to do the four-square on somebody, say in a road accident. Can you just grab anyone off the street to help you? Don’t they need to know what they’re doing?”

“Oh no,” said Jack “you could do that, just use anyone. They don’t need to know what they’re doing, so just tell them where to stand and hold the crystal. As long as you say the invocation together.”

11. Charlie healing Roy, Stuart and Stella.

In the ‘pink room’ Charlie was healing Roy, Stella and I. Roy was the first to get up on to the couch. He said earlier that he needed some healing on his eyes. Stella moved down to stand at Roy’s feet, while Charlie sat on a stool by Roy’s head. At this point Charlie went into his trance. Re-emerging as one of his ‘doctors’, he established that Roy’s eyes needed examining. Initially, Charlie looked at Roy’s right eye first, inserting his fingers into the eye socket, enacting a variety of movements: pulling, scraping,

sewing, injecting, and tearing. Each time he pulled out from Roy's eye what I assumed to be 'spiritual dirt'.

After dissecting the right eye he switched to the left. He then repeated the movements. Stella stood stoically at the foot of the couch during this time, the palms of her hands held up to the soles of Roy's feet. At one stage Charlie asked Roy to move his head to one side so that he could "check the valve and the pressure" that was building up. Roy obliged, and once this had been done Charlie held Roy's head for a moment and he came out of his trance.

I asked Charlie why he had asked Roy to turn his head. He said that the 'spirit doctor' knew that there is a valve at the back of the head which emits pressure, and if the pressure is great it will have an impact on the eyes and ears, which was also why the 'doctor' asked him if his ears were popping. The 'doctor' was just tightening things up.

I was then my turn to get onto the couch. As the weather was colder, I had been having trouble with my asthma, and so Charlie said I should lie on my front. I said it was a little easier on my back, but I agreed that if the 'doctors' are going to do the best healing with me on my front then so be it. Charlie got straight into the healing.

I sensed him moving around, his hands digging into my back at the base of the spine and around the chest area. At one stage he said, "You're going to feel a lot of heat on your back." He pressed his hands on my back and within about ten seconds my back felt as though it was being rested against a radiator. The heat sensation was pleasant. He finished not long after this, and told me that I could get up off the couch. He said this firstly as the 'Doctor', and then as Charlie. As I stood up I asked Charlie which doctor healed me and he said he didn't know. However, he explained that a Chinese man was doing Roy's eyes. Roy nodded nonchalantly and said he was excellent and clearly knew what he was doing.

Finally, it was Stella's turn. Charlie paid close attention to her chest area and at one point in the healing he appeared to be threading something through her right breast. It looked as though he was inserting some instrument through an imagined tube. Shortly after inserting the imagined instrument into the imagined tube he pulled it out again. This did not take long, and the healing finished soon after.

12. Stella and Stuart heal Cara.

In this, the final example Stella and I were upstairs in the pink room healing Cara, a woman in her mid-twenties. Stella asked Cara if she would like to have crystals or hands-on healing. "I don't mind really, whatever you like, whatever you think" Cara replied. Stella went over to the shelf by the window where I was sitting. There were a few crystals there, presumably left by somebody after a previous healing. She studied them briefly and decided to use them all on Cara's body. She placed the crystals at the feet, the crown, in the palms of the hands and a few on the chakra centres. At one stage though, as she swayed a crystal around, she explained that the crystal's energies might be incompatible. "Would you like to go at the feet?" Stella asked me. I nodded, and moved over to the end of the couch with my hands (palms up) facing Cara's feet.

Initially, Stella went to the top of Cara's head. She closed her eyes and held her hands very lightly on her head, just touching. She then held her left hand at the top of Cara's head, by the crown, and her right hand was guided towards her throat. Gradually, she then re-positioned her right hand towards the chest area. This was very gradual, gliding her hand just above the surface of the body, occasionally connecting with Cara's clothing, and she pressed lightly, sometimes with her fingertips only. She then moved her hands down to the hip area, and carefully placed her hands on either side of her hips and held them. Again, this position was held for a few minutes.

Stella then returned to her original position, at the top of Cara's head. This time she fixed her left hand at the shoulder, touching lightly, while her right hand glided gently down the contour of the arm. This stroking motion was executed carefully, as though straightening out creases in the sleeve. Her hand stopped short of the wrist, and then she removed both hands off to focus on the other side of Cara's body. Here she briefly checked the shoulder, arm and leg areas. Stella spent only a few minutes on the left side of Cara's body. She walked around to Cara's right shoulder and stood with her hands together for a moment, before finally looking over to me, smiling, and glancing towards the door. We then made our way out of the room while Cara rested.

Concluding discussion

Healing in local contexts: hands-on and crystal healing

Recent writing on spiritual healing in Western society (Benor 1984; Easthope 1986; Frohock 1992; Glik 1988; McGuire 1988; Skultans 1974) points clearly to the fact that hands-on healing, or what is also referred to as 'laying-on-of-hands', is an established and, indeed increasingly ubiquitous tradition in healing communities. Hands-on healing is synonymous with the healing activities of Christian groups (Glik 1988; McGuire 1988), metaphysical and psychic healers (Benor 1984; McGuire 1988; Glik 1988), mediumistic healers (Skultans 1974) and spiritual healers (Easthope 1986; Frohock 1992; Skultans 1974; Warkentin 2000; Wirth 1995). Crystal healing is used, predominantly by spiritual healers, both as an adjunct to hands-on healing, and as a healing practice in its own right. Both hands-on healing and crystal healing are 'symbolic healing systems' (Glik 1988), as such their effect and power relies on the ritualised, metaphorical, and mimetic nature of their actions. This chapter has described the use of such symbolic healing practices within the local context of the healing Centre.

What also comes through in these descriptions is the highly personalised nature of the practices, the manner in which healing is learned, and the ways in which healers innovate practices over time.

The nature of innovation and orthodoxy in healing practice

Each healer at the Centre generates innovation through the performative context - the enacting of the healing. I demonstrated in this chapter that innovation arises initially from the healers' apprenticeship, in which they are encouraged to on one hand, mimic and draw upon another healers' style and, on the other, bring into play more personalised practices. Furthermore, the media and method of learning give on to individual innovation. Neither written down nor passed on through intensive study, healing rituals are cursorily learnt from observation and then subjected to unfettered individual interpretation and modification.

However, through the innovatory forms arising in healing ritual performance, a kind of orthodoxy and consensus is reached about what works for individual healers. These are the 'standards', and these arise through the meeting of individual healing styles at the Centre. What I mean by this is that such a variety of healing innovations may give way to new forms of healing orthodoxy that have been fostered at the Centre. Consensus and contestation is thereby locally embedded.

So, each healer is bound by the approval of others. Each healer is a trend setter, and yet each is dependent on the other for acceptance and recognition. Each healer may try to influence others, but they are also influenced by the other. In such ways, their expression of their individuality is contingent upon their relationships with each other. For example, I explained how Charlie gradually integrates 'spirit guides' and 'doctors' into his healing canon, but the use of these guides is not effected until the practice is perceived as efficacious amongst other healers. Therefore, healers are used to modifying

their healing approach and receiving opinions from other ritual experts as to its appropriateness. In addition, consensus can be reached through more general trial and error, as we see with Margaret and my choice of crystals (case 8) and in the restricted nature of Stella's choice in the 'pink' room (case 12).

Healers learn to express a style of healing that is their own. This individuation reflects the healers' unique signature for the healing and it reinforces legitimacy in the healing performance. For example, Charlie uses his hands to heal; notably, he presses firmly in healing, relying on the heat of his hands to help the patient. In chapter three I noted how his hot hands represented his call to being a healer. Stella equally uses her hands, but in contrast to Charlie her actions are more gentle and based on light touch. Teresa uses, amongst other techniques, the 'resonance' method, a signal of her intent to be more systematised in the methods she teaches the trainees.

In addition, we see how individuation is codified and sanctioned within the healing centre as the normal orientation towards healing practice and knowledge. This can be seen in Teresa suggesting that 'You are the instrument' (case 7). By this Teresa means that the healer controls the event and generates the healing power. In this way, personalised expression gains power and credibility sui generis. It is 'internally' legitimated through the ideology of the Centre. All healers are initiated into the Centre's 'philosophy', and this is informally sanctioned through conversation around healing efficacy and interpretation. Again, Jack explains (case 9) that it is not important if the healers detect the 'sensations' at different times or even in the wrong order, because the sensations are 'subtle' and "we're all individuals."

Individuation and healing efficacy: the effect of individual healer performance

I have avoided the subject of efficacy for the following reasons. Having not been trained in anything approximating medical or health science, I do not feel sufficiently qualified

to pass judgement on the healing. Also, efficacy is one of many reasons why a patient would visit a spiritual healer, which is an issue that has been neglected in the writing on the usage of CAM, although Sharma (1990) concedes that efficacy is irrelevant for the majority of patients. Therefore, healing employs other levels of meaning, and it is these that I explore here.

I argue that the power and legitimacy of healing derives from two combined factors. First, legitimacy does not have to be decreed by expert sources, though it may have to be couched in 'professional' terminology or idioms. The utilisation of common metaphors and idioms in healing visualisations, such as 'light' and 'energy', reinforce this type of legitimacy, and also provide some consensus between healers. In this sense healing ideology in itself constitutes this type of legitimacy. For instance, many of the examples described in this chapter explain that the patient is just looking to relax and to be helped with everyday stresses. For example, note how Stella stresses the importance of the back in aiding the healing process (case 2). On this level touch-based therapies such as hands-on healing could be said to provide some 'subjective' relief.

Second, efficacy is based on "existential immediacy that constitutes healing as real" (Laderman and Roseman 1996b:9). This means that the perceived efficacy of the act relates to the immediacy of the performance. The healing performance must be in keeping with the healer's own personal style, which mediates between fixed forms. That is, healing generates innovation through the agency of the individual healer, so the healers' style is always being modified. Schieffelin (1996) makes a similar point in discussing the way audiences perceived authenticity in a séance performance, and that improvisation and creativity provides a crucial form of legitimacy in the act: "...however fixed the ritual script or structure may be, the participants must still work creatively to articulate these forms to the particular contingencies of the living situation if the rite is to be convincing and effective" (ibid:82). For example, I go on to show in

chapter seven that the identities of Charlie's spirit doctors change over time. Teresa's healing is another example. She explained how her healing styles – 'healing sleep' and 'resonance therapy' - were in the process of developing and that she had been trying the style out with other healers.

Innovation in healing practice: creative improvisation or the reflection of orthodox medical ideology?

The question I explore in this section is whether we interpret the nature of these varied healing rituals as inherently creative or merely reflecting orthodox medical ideology. Anthropologists such as Bloch (1986) argue that ritual stifles or leads to the negation of creativity, because the purpose of ritual is the "reproduction of legitimate authority" (ibid:192).⁵ For example, in his work on the circumcision ritual of the Merina of Madagascar, Bloch argues that ritual carries with it both ideology and history. The purpose of these rituals, which consist of very similar symbolic acts (ibid:48), is to perpetuate notions of power and domination. As he explains, "...for a society such as the Merina, ritual has the burden of carrying ideology" (ibid:176), which is "an ordered consciousness, a complete system of knowledge, which will directly organise the actions of individuals" (ibid:178). Creativity is therefore a by-product of those who are in positions of authority - in this case, the individual agents who commit violence in the ritual, as they are closer to the source of this authority.

In contrast, the view that ritual acts - the product of individual agents - function to generate and support creativity and innovation can be found in the work of Barth (1987). Writing about the mountain Ok community in an area of inner New Guinea, Barth has been interested in the considerable variations that are represented through ritual form. Barth recognises the process of creativity and sees this as one way to overcome the traditional anthropological reliance on an overly-determined individual, who is the

product of a historical set of circumstances that transcends the individual. His concern was to elucidate the nature of ritual creativity and innovation. As rituals were not written down in this 'society' (the mountain Ok maintain an oral tradition) each ritual expert would have ensured the continuity of ritual form and content in its enacting. However, in the process of this re-enacting, Barth argues that a process of creative improvisation would shape the performance. I include a passage from Barth to shed light on this issue:

...there is every reason to assume that each such transformation requires an active intellectual effort and thus stimulates –no, indeed requires – creativity on the part of the ritual expert: to re-create in the one modality materials articulated in the other. The results of such creativity cannot be expected to produce complete identity of content, but rather to entail potential for incremental modifications within each sub-tradition (Barth 1987:29).

Furthermore, modification would be the inevitable consequence of personalisation and subjectification, as ritual experts would need to engage personally with the symbols in the ritual and that these may be transformed at each separate ritual occasion:

...the 'storage' in the individual mind, without literary aids, of complex cultural materials over long time, followed by a demand for their manifestation in complex and vital performances of mystery cults, must be highly evocative of personal involvement by the ritual expert in the cultural symbols in his keeping, and could be expected to result in his marginally reshaping them in form and content, in harmony with his own visions, at every new performance (Barth 1987:30).

I noted that there are similarities between healing practices at the VEHC, such as the use of particular metaphors and particular techniques (a point made by Bloch in his analysis

of circumcision rituals), but it is the improvisation that provides a sense of authenticity and flair – ‘internal’ legitimacy amongst fellow healers, adherents and patients. In addition to this, the success or efficacy of a healing relies on things being in order, such as the room or the preparations in terms of the healing environment. For example, in a number of the case studies in this chapter I noted the use of gentle music in the healing sessions. Indeed, healers rarely carried out a healing session without it. For example, in case 12 Stella and I initially could not get the tape to work in the machine and this made Stella anxious.

Fluidity in healing role: healing in a postmodern era

Finally, in chapters one and two I explored the way in which the status of expert knowledge has shifted in our postmodern or ‘late-modern’ society. ‘Experts’ and ‘expert-based’ knowledge is still required, but the relationship between expert and non-expert (lay) is in some ways more changeable. The changeable and ‘fluid’ nature of expertise at the VEHC encapsulates this debate. Here, expert and non-expert are situational ‘roles’ that healers and patients play. We could argue that so-called experts must adapt their role, or must engage in other roles where they are not expert or where their status may be contested/challenged. In this sense, expertise should be reflexively managed and not taken-for-granted. We can identify these issues in this chapter.

In Frankenberg’s (1986) article on cultural performance in the illness situation, this kind of role swapping and doubling of roles is seen as crucial to the way the healing acts are interpreted. The fluidity and interdependence of roles and healing contexts can be identified in this chapter. For example, these case studies represent a variety of situations and contexts. We can pick out the healer and visiting patient (cases 3, 4 and 5); healer and healer (cases 5 and 6); the healer and trainee healer (cases 1, 2, 7 and 9);

the trainee and the trainee (cases 8 and 10); and multiple healers and healings (cases 10, 11 and 12).

¹ Teresa uses the word 'sensitive' to describe individuals who are perceived as embodying some special abilities, in which they experience more acutely the connection to the spirit world.

² A pendulum crystal is a single-terminated quartz that is usually attached to a piece of string or something similar so that it can be suspended over the body.

³ These are normally long and slender quartz crystals. They may be decorated with etchings or markings and do not look especially attractive.

⁴ 'Tumbled': a crystal that is rounded, with no rough or terminated edges.

⁵ See also Csordas (1997:250-262) for an in-depth discussion of Bloch's work on the nature of ritual communication.

The orchestration of healing II: exploring procedure and performance in the healing act.

Introduction

In the title of this and the previous chapter I refer to the descriptive term ‘orchestration’, as healing involves both structural and individual performance. In using the term orchestration I am also referring deliberately to the way that musical scores involve interplay between structure and improvisation, procedure and performance.¹ Here is an apt analogy for healing, an analogy that reflects the dialectical nature of the healing process.

The aim of this chapter is to explore the nature of this dialectic in relation to healing practice, including a focus on the use of intuition and the senses in diagnostic procedures. Also, performative elements of this process will be highlighted. I further consider the importance of the healers’ need to stamp their personal signature on the healing, whilst at the same time I describe the procedures (forms of systematisation) that may establish points of consensus between individual healers, and healer and patient.

In addition, by focusing on the dialectical nature of healing performance, key questions can be raised about its wider social and cultural significance. In particular, an issue I explore in the concluding discussion is the extent to which healing performance, in its ‘orchestration’, is ‘playful’ or representative of a ‘playful spirituality’ (Luhmann 1993). I highlight this issue in relation to theories of postmodernity. More specifically,

the case studies used to illustrate my argument come largely, though not exclusively from the preceding chapter (listed as cases 1 - 12).

Using crystals: ‘ordering’ spiritual space and bodies

The crystals’ differential usage reflects particular healers’ perceptions of the physical body. Crystals are usually ‘prepared’ and laid out on the body, an arrangement which largely depends on what kind of ailments the healer is treating. Teresa’s crystal layouts follow a similar pattern, based on what she believes is an accepted ‘tradition’ of crystal healing. Her knowledge of key healing texts provides additional legitimacy for these layouts. For instance, one day she demonstrated a typical crystal healing.

In this healing a single-terminated clear quartz crystal is placed at the feet end of the couch, the terminated point facing the body. A similar crystal is set at the head-end of the couch, its terminated point directed downwards towards the feet. Two more quartz crystals are positioned at either side of the body, usually rested in the palms of the hands. If we imagine ourselves above the body looking down, then one single terminated crystal is placed in the palm of the hand, on the left side of the body, with its termination pointing down, and another is placed in the palm of the hand, on the right side of the body, its termination pointing up. The left side crystal should appear transparent. It is regarded as the ‘male’ crystal. The right side crystal should appear ‘cloudy’. This is the ‘female’ crystal. The inclusion of both male and female crystals is seen as balancing the healing energies. They face in the specified directions so that the healing energy is directed in a circular motion around the patient.

The bounded concept of the spiritual self

In Teresa's healing the physical arrangement of the crystals enclose the body within a kind of imaginary protective shell. Crystal placement thereby creates an imaginary axis from which the body can be observed. This bounded or contained sense of self is a dominant image and its usage raises some important issues. For instance, in chapter two I described how modernity encourages bounded conceptualisations of self, and that the bounded concept of the self resonates with the biomedical model.

In exploring the relationship between ideas about containment and control in relation to Alzheimers, Oliver (1999) argues that what we see in the treatment of sufferers is the dominance of modernist strategies of bodily control. Therefore, the healers' ideas about the relationship between the physical and the spiritual body reflect a very modernist conceptualisation of the body. The ubiquity of this bounded image in the healers' cosmology is, perhaps inevitable, as the healers are operating with spatial metaphors which evoke the dualism inherent in Western thinking.

Crystal healing layouts: between procedural consensus and intuition

The formation described above was regularly employed in Teresa's healings, and its usage can be described as a routine and habitual practice. As such, its prevalence as a routine practice reflects the way in which certain kinds of healing practices become formalised and agreed upon collectively over time.

Charlie occasionally uses this basic layout. However, in Charlie's case, the crystals placed in the palms of his patients' hands were sometimes the wrong way around, or both would be 'transparent' quartz, rather than one being 'cloudy'. In contrast, Teresa and Sally prioritised their use, and came to develop more formalised practices. I asked Teresa how closely one should adhere to the 'procedures' specified by the 'experts' in

the crystal healing textbooks. Teresa exclaimed, “Some layouts are of a specific nature. However, you can do a healing either side of the body for instance, top to bottom or bottom to top, and so on, it doesn’t really matter.” In this way, healers practice ‘what works for them’, which involves varying degrees of improvisation. Nevertheless, there are ‘guidelines’, which are the result of how consensus about certain practices can be reached over time.

In cases 3 & 4 Teresa asked Peter questions about what he was feeling while she chose the crystals. Accordingly, crystals were placed at different parts of Peter’s body. I suggest that these can be seen as ‘static’ crystals, though this is not their distinction. Other crystals she used were the pendulum, various ‘wands’, and clear quartz crystals with terminated points. Let us assume these are the ‘mobile’ crystals. The placement and movement of the crystals in the healing process correspond with these distinctions and the healing with crystals may be judged on how these styles are managed.

Teresa explained some of the crystals’ uses. The ‘laser crystal’ is primarily used for spine work. Spine work is a delicate operation for Teresa, and the long, slender wand crystals are ideal for ‘surgical’ type work. I note the metaphorical association: laser crystals are like surgical scalpels.

Procedures: colour symbolism

I explained in chapter four how crystal healing textbooks (healer expert-systems) can inform crystal choice. Furthermore, these texts classify crystals in relation to points on the physical body, and places on the body correspond with particular colours. As such, crystal healing employs a certain amount of colour symbolism, a system of healing that is practiced in other healing groups (Helman 1994; McGuire 1988).

Alternatively, crystals are associated with healing certain kinds of ailments. For instance, malachite is said to be good for stomach problems, so it would be placed on

the corresponding chakra. It is up to the healer which method he/she utilises. Jenny demonstrated one method of achieving this on one of my visits to her in Broadville:

Place stones along the body, in order usually from the top, starting with the head. You place in colour routines- white for the crown chakra, purple for the brow, blue for the throat, pink or green for the heart, yellow for the solar plexus, orange for the spleen, red or a dark colour for the base chakra. The chakras are divided by colour although you can place a crystal from one area into another if it feels right. I start the healing from the head usually, then go down the body, finding blocked parts of the chakras. I finish at the root chakras, then maybe go back up the chakras again to check them. You can place as many crystals as you like on the chakra points, although I don't like to use too many.

In addition, expert-led procedures can be identified in the use of crystals for a protection method. In this example, the healer holds the crystal that is healing the patient in the right hand, and in the left hand they hold another quartz crystal with its terminated point facing away from themselves and into the room. Here, the negative energies being drawn out of the patient are then perceived as being directed harmlessly through from the right hand over the body of the healer, out of the crystal in the left hand, and into the healing room. This is a key crystal healing practice and was perceived as 'common knowledge'. This method was adopted by all of the healers at some point, and it can also be found in key healing texts:

...the person you are working with will more than likely be... discharging negative energies. As a healer it is important to protect yourself so that you don't take that energy into your aura and on into your personal life. One of the best ways to protect yourself is by holding your favourite meditation crystal...with the termination pointing out away from you while performing the therapeutics of the healing (Raphaell 1987:17).

A certain amount of consensus is established in relation to key healing procedures. Nevertheless, these forms of orthodoxy are locally derived, and are reached partly through the conventional means of training and studying-up that healers may go through. But, orthodoxy is also established through the informality in which healers agree upon practices over time. As such, the procedures are not 'officialised' in the way that other kinds of institutional knowledge can be.

Intuition and crystal placement

However, more often than not the healer is playful with the crystal choice and placement as the supporting ideology is that they are using their 'intuition'. The use of 'intuition' thereby helps to legitimate the use of highly personalised practices and the innovations this inevitably gives rise to.

For example, on one occasion Jenny intimated that she asks the patients what colours come into their head during a healing. The patient's response informs her decisions about crystal placement. This can also counter received wisdom about 'procedures'. For instance, Jenny said that pink coloured crystals are usually placed in the chest area - in the crystal healing texts the 'heart chakra' is associated with the colour pink. Yet, sometimes she feels like putting the pink crystal in the stomach area (the 'sacral chakra'). She doesn't rationalise this decision, it just "feels right". The intuitive aspect of the healing guides her decision, and the ideology of individuation further legitimates this process. On another occasion Teresa stated that during the healing the healer should subsume their rational thoughts, and hope for some spiritual intervention that will aid the intuitive process. As she explained, "When attempting to find the nature of the problem with the crystals, you just have to go with the flow, just go with upstairs and that's the best thing you can do really."

Diagnosis: the use and meaning of intuition

This section explores healers' methods of diagnosis, and what these methods signify about the role of intuition in healing practice. Sally explained that diagnosis refers to the process of locating what needs to be 'worked on', a concept which is familiar in other group-based therapeutic practices, such as dreamwork interpretation and analysis (Edgar 1994:106; 1995:11). In chapter eight I go on to explain how the root of disease or 'dis-ease', as some healers are fond of saying, is seen as located in the spiritual body, and not in the physical body. As the 'problem' (illness or disease) is embedded within the spiritual body, and as the healer has to draw on their intuitive powers in order to decipher it, the 'signs' to be read are always complex and multi-faceted. Therefore, illness and/or disease is observed and interpreted through a unique individual healer lens.

Locating the energy imbalance or 'blockage' that has created the 'dis-ease' requires the healer to apply their 'intuitive' skill to the spiritual body, and not their 'technical' skill to the physical body as in biomedicine. In this way, spiritual healing embraces an individuated approach to diagnosis and therefore each healer may approach this process in a personalised manner.

The 'aura scan' and 'psychic hovering'

A healing can be started by 'checking' and 'cleansing' the aura. This process is also referred to as an 'aura scan', which is one particular method of healing 'diagnoses'. In this method, the healer 'scans' the area of the aura in order to pick up any blockages. Again, there is some mimicry of medicine; such activity bears similarity to a brain scan or x-ray. The aura denotes the spiritual bodies that surround the physical body, and

which healers say people cannot automatically perceive. In cleansing the aura, healers can check the state of individual chakras. Furthermore, they also check the 'meridian lines' - areas of the body that have corresponding acupunctural points. Jenny explained this cleansing process to me, and I note her emphasis on the intuitive nature of this practice:

I cleanse the aura first. Cleansing the aura means going through all the levels - usually top to bottom - and there are various techniques to do this. The aura is all of the subtle bodies. This is just the way I do things. You don't have to... although there are chakras above the head and below the feet. I don't know about them so I don't concentrate on those. After the aura is cleansed then you can do the healing... Some can see the aura, but I can't. I have to be intuitive about it. They would look at your body and tell you what you needed; instead I have to do cleansing to find the problems.

A variety of techniques can be used in 'cleansing'. For example, a clear quartz crystal pendulum can be stroked up and down the body, at a distance of about three or four inches. As noted in McGuire's (1988) study of 'psychic healing', the pendulum acts as a diagnostic device. The pendulum is Teresa's preferred method for checking the aura (see cases 3 & 4 from chapter five), and she calls the cleansing 'psychic Hoovering'. The metaphor is a curious one as it suggests the integration of both diagnosis and cleansing. In this process Teresa moves the pendulum over the body, and up and down, to identify areas where she senses 'spiritual dirt'.

In cases 3 & 4 the pendulum's movements from Teresa indicate the flow and direction of any particular blockage. For example, Teresa explained (see case 7) that a sign of a blocked chakra is when the pendulum rotates in a wide arc. Conversely, the chakra is balanced when the pendulum comes to a rest. In summation, the spiritual

landscape of the aura is scanned in order to locate the chakras requiring healing energy. In his analysis of 'touch healing' (hands-on healing, essentially) Frohock (1992) sums up the principle behind this approach: "If the subject is sick, the sweep of his or her body will reveal areas of congestion, deficit, or imbalance in the energy field" (ibid:175).

The use of the senses in healing diagnosis

I note another technique in case 9. Here, Jack held a single terminated quartz crystal in his hand to carry out an 'aura scan'. He passed the crystal over the patient's 'energy field', and used his 'senses' to detect a blocked area. For example, s/he might experience a tingling sensation in the hands, or perhaps will feel suddenly hot or cold - these are taken as denoting a 'blockage'. This experience of a tingling sensation is also noted in Frohock's study (1992:175). In addition, Skultans (1974) raises the significance of these experiences, but in relation to the heightened awareness of spirit possession. Skultans' contention is that these bodily experiences and sensations of spiritual states are learned through membership of the group:

...sensations of heat or cold, tingling or throbbing may be interpreted as signs of the onset of possession. Thus possession does not require any prior peculiar state of mind but rather, membership of a social group in which detailed attention is given to bodily states and in which heightened awareness of such states allows them to be identified and defined in a special way (Skultans 1974:7).

The emphasis on the group perception of the tingling sensations in case 10 resonates with Skultans' point, in that the healers learn to read/interpret the individual nature of these 'signs'. To recap, for Jack each healer receives different, even contrary signals and

impressions. Jack explained that this does not matter, as the signs are different for each person. As he exclaimed, "We're all individuals." The healer has to be 'sensitive' to both the patient and the healing sensations. Teresa explained this position on 'sensitivity' in the following statement:

Awareness is listening with all of your inner body, go with the first thing that you get...It's all about listening and going with spirit, you instinctively go with what you get first, it goes with a flash, and it's like directions without words.

Spiritual healing prioritises use of the senses, particularly in the diagnostic process. As Laderman and Roseman (1996b) note, for a healing to be truly successful as a performance, "the senses must be engaged" (ibid:4). Also, this data has indicated that there is no objective diagnosis in spiritual healing, no repeatable and measurable outcome that can be tested for its reliability. Healing that utilises the senses is a counter to the expert-led and authoritarian models of biomedical knowledge and diagnosis, where each practitioner should receive the same results and make the same interpretation in the desire for reliability and objectivity.

Another good example of the use of the senses can be seen when Sally was once healing Stanley upstairs in the sanctuary. When the healing finished, Sally explained that during the healing she experienced a ringing sensation in her ear, which she felt for sure was a sign of Stanley's ear trouble. Therefore, each healer must train their awareness and sensitivity to signs that the spiritual body evokes. In addition, Teresa, Stella and Sally each argued that women are more 'sensitive' to these signs, and it could be argued that the use of senses in these therapies marks a turn to or an assertion of the 'feminine' in a traditionally patriarchal context, such as biomedicine (Synnott 1993). I mention this more in passing only, as issues surrounding gender and gender role did not

emerge as a very significant or contentious issue at the VEHC. Nevertheless, gender has featured significantly in writing on alternative medicine (Scott 1998) and feminist spirituality (Greenwood 1995).

Spirituality and role of intuitive knowledge

In healing, spirituality refers to the primacy of 'intuitive' knowledge. Moreover, the spirit is not observable and therefore it cannot be measured and objectified. The spirit is a subjective construct, although healers recognise that individuals have tried to systematise its character. I conclude with some points about the nature of that challenge.

Teresa argued that the healer should be 'sensitive' to the energies of the patient, and this raises concerns about the status and legitimacy of healing knowledge. This is because of the sanctioning of individuation at the Centre. Healers individually comprehend and interpret in order to diagnose, so how would they know whether that was the correct diagnosis? Examining the core concepts of healing knowledge helps us to unravel the nature of what people mean by spirituality and the spiritual body. There is as much a process of learning about what would be acceptable 'signs' in diagnosis, as what would be unacceptable. A diagnosis made on a spurious basis - a random guess as to the nature of the problem, may be noted by Teresa in particular. The legitimacy of the healer's diagnosis depends upon whether it approximates in some 'meaningful' way with the patient's experience.

However, if the diagnosis is made by reference to certain 'signs' or feelings/impressions that the healer received during the healing, then that invokes the diagnosis with more 'authenticity'. Why? Because then there is something inchoate and underdeveloped in the analysis that can be filled in at a later stage. In other words, the spiritual idioms and metaphors applied at a post-healing analysis and interpretation stage may work in order to bring clarity to the healing experience for the patient.

Spiritual healing diagnosis therefore works by a kind of 'auto-suggestion': the barely comprehensible sensations that the healer receives can be put to the patient for comment. The patient and healer, both 'experts' in this context, then mutually extrapolate meaning and construct a diagnosis/interpretation out of these sensations. Therefore, it doesn't matter if the signs are completely individual, or even nonsensical. For, as Jack neatly put it: "It differs with everyone you work on, everyone is different."

The healing performance: generating 'authenticity' and 'flair'

In this section I examine the performative aspects of healing practice. I examine how movement during the healing 'structures' the healer's performance. The use of bodily movement during healing is important, because it emphasises what constitutes authenticity. In this way, deliberate and careful movement is a sure sign that the healer is in control of the healing. When the movement is highly personalised (as in the case of Charlie's 'spirit doctor' approach) then some healers may raise an eyebrow to the appropriateness and legitimacy of that performance, and so healers are therefore bound by the approval of others who may vouch for its authenticity.

In Charlie's case particularly, the issue of improvisation is given added complexity. For example, Teresa told me that because Charlie heals with his hands a woman may receive the wrong 'signs' from the healing. Because the basis of Charlie's healing is that he 'channels' spirit doctors, the actual movements he enacts on the body may be differently understood by the patient. Therefore, it is difficult for outsiders to interpret his movements. Teresa explained, "We now know by his movements what's going off, so it's easier for us to understand where the impressions and sensations are coming from." That Teresa states "we now know" implies that not only patients but also healers

can be in the dark as to the reasons why a healer may innovate in a particular way. More importantly, her statement suggests that other healers at the Centre must first of all corroborate over the level of a performance's authenticity.

Authenticity in the healing performance

A key concern in this section is the issue of how healers perceive problematic performances. This is particularly the case when the authenticity of the healing is in question. For example, one day I asked Charlie why crystal healing texts suggest placing lots of crystals on the body, rather than a small selection, in order that the healer may give the patient a complete healing (see Raphaell 1987). Charlie's reply was that these books are illustrative of American healing, and he seemed quite dismissive of this approach:

The Americans do layouts with sometimes 250 stones on the body. You'd spend all your time laying them out. It's a bit over the top really, and they spend too long on the healing, up to two and a half hours! You'd get really bored wouldn't you? Also, they have to take all their clothes off in their layouts. It's not really appropriate here is it, I mean it's not legal. Could you imagine being a male healer and asking a woman to take her clothes off for the healing, or a female healer asking a man? You just can't do it, can you?

Charlie perceives the use of 250 stones as attributing the crystals with too much importance. As he states, it would be "over the top." For him, the crystal is an accessory, used in order to draw in healing energy that exists 'out there'. In addition, Charlie dismisses this kind of regimented healing in which some of the attention is taken away from the agency of the healer.

'Being good at being a healer'

Healing practices that are more performative, as opposed to essentially 'technical', rely on combining moments of activity and inactivity to imbue the healing with authenticity, and they also provide the healer and patient with a set of constitutive boundaries around the performative act. For instance, after a series of healings the patient may obtain a greater familiarity with the healer's personalised routines. In this way, a good performance also equates with an efficacious healing.

Through certain actions and innovations, the healer demonstrates that they are 'good at being a healer'. This is a concept that I have adapted from Herzfeld (1995). In a study of the performance of masculinity in a Cretian mountain village, Herzfeld argues that 'being good at being a man' is something that is achieved through 'performative excellence'. The key to this excellence is to enact 'man-ness' with not just technical skill, but with flair and style: "There must be an *acceleration* or *stylistic transfiguration* of action: the work must be done with flair" (ibid:16).

In addition, Herzfeld examined the way that improvisation is used in achieving a good performance, and that the display of masculinity involves a certain amount of self-reflexivity and awareness, so the audience is also aware of the improvisation and play with convention: "Improvisation is at a premium, and a good performer will make sure that his audience realises that he is indeed improvising" (ibid:47). By focusing on the enacting of masculinity in a variety of social situations, and by enabling creativity and improvisation to guide these ritual performances, Herzfeld argues that these individuals transcend the usual social conventions. This non-conformist behaviour has 'playfulness' at its centre, a theme I return to in the conclusion. In the following section I draw upon Herzfeld's idea in relation to personalised healing styles.

Healing with 'flair': 'clearing' the chakras and healing the blockage

Once the healer has established through the diagnosis that an affected area requires healing, he/she sets about enacting the healing process. The healer can adopt different methods to heal the affected area. Indeed, hands-on healers and crystal healers do this differently, and even within their respective styles key stylistic variations can be observed. More importantly, I go on to demonstrate the ways in which material actions and objects are subjugated to the spiritual domain through the healer's gestures. In essence, the spiritual domain acts as a 'parallel universe' through the appropriation of medical gestures.

This is illustrated particularly by Charlie's 'spirit doctor' approach, which closely mimics (and parodies) biomedical surgery through gesture and implied metaphoric association. For example, this mimicry is illustrated by his holding an imaginary hypodermic syringe (see case 6), and in his surgical digging into and scraping the spirit body (see case 11). Charlie's unique style of healing allows him to bring into play multiple healing styles, which are the property of independent spiritual entities. Also, in drawing attention to the metaphoric, Charlie can add stylistic aspects to the healing performance – the use of the 'syringe' and his 'nodding' to the 'spirit guides' in the corner of the room (see case 5 and 6). The linking-up of the spiritual and the medical metaphoric domains allows Charlie to enact the performance with 'flair', and demonstrate that he is 'good at being a healer'.

In case 1 Charlie uses the pressure of his hands to evoke a sense of the healing energy coming through him. His hands heat up through the activity itself and this provides the patient (myself) with a sense that healing energy is being transmitted. When healing the blocked area, Charlie, his eyes closed, places his hands there for some time. He visualises the healing energy entering my spiritual body. This can take a considerable

amount of time as the healer must focus on building up the intensity of the experience in order to generate enough energy.

In an article on a séance performance, Schiefflin (1996) describes this process as a kind of ‘interactional credibility’, or credibility with your audience. In order to achieve this credibility Charlie draws on external strategies of legitimacy, the spirit doctors who evoke more established and authoritative healing practices, such as biomedicine. Here, Charlie’s performance draws attention to the interplay between the material and spiritual, and it manifests as a creative engagement with the hegemonic discourse of biomedicine, an issue I elaborate on in a later section.

Once Charlie introduces spirit doctors into his healings he utilises what he considers to be their healing style. As there are a number of spirit doctors available, we can see that he can use an infinite number of different techniques for different healing situations. My point here is that Charlie invokes the spirit doctors in order to provide additional legitimacy and flair in his healing practice.

In case 2 Stella switches the intensity of the touch on my body as a way of marking the transition from ‘checking’ to ‘healing’. The movement of her hands from one area of my body to another is perceived as a smooth one. With touch-based, hands-on healing it is important that the touch is not heavy handed or clumsy. Again, such actions can be enacted with a degree of flair. Stella achieved this when scanning my aura, and with a heavy press of the palms of her hands to indicate that healing energy was being channelled. The use of touch is important as the patient may him/herself be a healer and aware of the complex cosmology that lies behind healing actions. In the following passage, Frohock (1992) succinctly defines the aim of the touch and its importance in creating healing authenticity:

...[touch aims to] restore the subject's energy field by rebalancing it, removing congestion, repairing breaks and rough edges by smoothing out the troubles areas, replenishing energy levels, and in general stroking and tuning the field until it is in a healthy integrated state, flowing easily and continuously (Frohock 1992:176).

Harnessing crystal energy: noting the 'dangers' of crystals

When using crystals in clearing the 'blockage', the idea is that the terminated crystals emit healing energy from the crystal point. This energy is drawn from the 'source' and cuts through and into the spiritual body.² Teresa argues that wand crystals are particularly effective in completing this stage of the healing, as their energies are invariably more intensive, although each healer establishes their own method of achieving this. For Teresa: "The laser penetrates the non-physical into the physical and it can leave holes so you need to seal the hurt, whereas Charlie sews it up when he's doing his healing."

However, Teresa also described the risk in using the laser/wand crystals in performing this act. Laser healing can leave 'holes' in the spiritual body. As a consequence, the physical body is left open and vulnerable to the threat of contamination. Teresa explains that you need to seal the hurt. Charlie 'sews' his holes up, which further confirms that Charlie is a healer who utilises physical imagery to generate legitimacy in the healing act. The act of crystal healing energy pouring into the spiritual body makes it seem more like the penetrative act of certain medical instruments – for example, the acupuncture needle or the surgeon's scalpel. The act is similar, metaphorically. Though, unlike the needle or the scalpel knife, the penetration is conceived as being on the spiritual level, so patients do not perceive it as being as intrusive and/or brutal. Yet it does involve the 'opening-up' of the spirit body, which is why when the healing energy enters the spiritual body a 'hole' will remain.

In chapter four I made some initial comments about the perceived ‘dangers’ of healing. Again, I note a direct parody of the ‘risks’ and dangers that may come with surgical healing, in that not only does the healing leave ‘holes’, but that the body can become ‘contaminated’ if spiritual hygiene procedures are not adhered to. To conclude, I argue that these practices and discourses highlight the cultural prevalence of biomedical practice, and that spiritual healers are enticed into drawing on its imagery when making these assertions.

Spirit doctoring: dissolution of the material and spiritual domains through performative improvisation

A notable aspect of the ‘performance’ can be seen in the way Charlie manages the change of role from himself as healer to being one of the ‘doctors’. Ritual performances are inherently risky and must create ‘performative authority’ or credibility (Schieffelin 1996:80). Charlie must convince the viewers of the transitions, which are brought about by “shifts in behavioural and linguistic features” (ibid:61). Brown (1997) explains that once in a state of trance, many channels adopt a distinctive speaking style and body language that is noticeably different from their own. For instance, in Schieffelin’s article there are two individuals who both go through a séance performance and impersonate spirits, but the audience sees only one of them as convincing. The other performer misjudges the mood of the audience, sustains little rapport, and for Schieffelin has “a mediocre ability to impersonate spirits” (1996:78).

Many of Charlie’s healing gestures are exaggerated, simulated and stylised (see cases 5 and 6). When healing Sally he used his fingers to manipulate the area around her eyes. Here, he must evoke the sense that he is working on the spiritual body, which itself

mirrors the physical body. So, he pulled and scraped at something that appeared to be blocking that part of the aura. In healing Teresa he used his hands to clear the blockage in her lump, only this time he altered his approach by introducing an imaginary instrument - the hypodermic syringe. By performing this in such an 'obvious' way, he lets the audience know what the object is and its symbolic value in the healing act.

In exploring non-Western contexts, other social anthropologists have drawn attention to the mimetic movements of healing rituals. For example, Lindquist's (2001) study explores the performances of a healer in Moscow who, like Charlie, practices hands-on healing. The healing acts are perceived by Lindquist as self-consciously similar to those carried out in a biomedical operation: "They are mimetic movements that iconically represent the operations he performs virtually" (2001:5). In addition, Roseman (2001) describes how the Temiars of Malaysia, through the use of Shamanistic mediation, incorporate and alter the symbols of commodification and modernity in their healing ceremonies. Roseman states that the process of mimesis both reflects and subverts modernity.

Charlie relies on the literal conclusion that the spiritual world is a mirror of the material world: it is a parallel universe. The healing instruments used are a reflection of those used in the biomedical arena. Filling, injecting, and emptying the syringe is a performative and metaphorical way of bridging the generally exclusive worlds of the material and the spiritual. It is performative in the sense that it relies on an orchestrated and stylised representation of a physical act.

The additional sense of 'parody' for example, can be noted in Charlie's self-conscious awareness of the 'audience' in his comment to Ruth about the number of spirit guides in the room (see case 5). Additionally, though Ruth giggles slightly at Charlie's verbal 'slip', she does not later question Charlie on the authenticity of his actions. Why is this? I argue that Ruth keeps quiet as it would not be a good idea to

question another healer's innovatory practice. To do so would threaten the legitimacy and cohesion of the group, and it would threaten the ideology upon which healer membership is based. This reluctance to question practice is another key explanation for why such individuated practice becomes institutionalised or 'formalised' at the Centre. Nevertheless, Charlie knows that he relies on the other healers for their approval. Thus, the limits to individuation are defined by the limits to the approval that may be offered by other key members at the Centre.

In his essay on the role of metaphoric assertions in human life, Fernandez (1986) contends that metaphor is not neutral; it brings to light significant forms of tension and contention in social life. This point is made by Lupton: "metaphors are commonly used in ideological struggles around a contested site of meaning" (1994:55). In addition, metaphoric assertions are embedded in human behaviour as well as discursive arguments. Further, "differing domains are brought together in unexpected and creative ways" (Fernandez 1986:viii). In this sense we can capture the way in which metaphoric assertions influence behaviour (ibid:6). In performing the trance (cases 5 and 6) Charlie enacts the changing status of immaterial to material objects; surgical medicine is thereby brought into the domain of spiritual healing.

In healing Roy (see case 11) Charlie takes this one stage further. There are similarities to the healing with Sally: in examining Roy's eyes he utilises the same movements and gestures in order to give the sense that 'auric gunge' is being drawn out of Roy's spiritual body. However, at one stage he asked Roy to adjust the positioning of his head so that he could examine the "valve and check the pressure" that was building up. Charlie explained why he did this citing the spirit doctor's reason. His point was that the 'pressure' was having an effect on Roy's eyes and so, manifesting the spiritual energy of one of the doctors, Charlie was just "tightening things up."

Here, the performative domain had changed from one borrowed from the medical and surgical arena to one that is taken from the engineering arena. Charlie sees the body as not only a biological and a spiritual site, but also one that is constructed in a mechanical sense, which bears an obviously similarity with the biomedical model. Also, the phrase evoked a similar visual impression to when someone is 'letting off steam'. Charlie is not only demonstrating his skills as a healer of the spirit but also as a healer of the emotions, as Ron is given a vent to his stored-in emotional heat. This shift in the figurative domain denotes a realisation on Charlie's part that the spirit doctors can combine their style and medical interpretation from any number of arenas.

Various interpretations can be made of Charlie's actions. They can be perceived as engagement with the hegemony of biomedical discourse and expertise, and this can draw our attention to the relationship between biomedicine and alternative medicine. Kleinman for example, suggests that this approbation is not surprising as many healing practices borrow symbols from biomedicine (e.g. white coats, stethoscopes) as "status enhancement" (1984:148).

Alternatively, we can interpret the playful appropriation of biomedical discourse as a form of subversion and resistance to medicine, and there is evidence of this in the 'metaphorisation' of biomedicine. Charlie uses the 'doctors' (here he plays the paternalistic role) and the surgical routine, which is in some ways a parody of the expert in the biomedical arena. We can see this in the way Charlie responds to Sally and the other doctor's 'opinion' during his healing as the 'spirit optician'. Charlie's responses seem more judgemental than we would expect if they represented mere mimicry.

Through embodied, expressive and routine ritual actions the healers make statements about the relationship between medicine and healing; materiality and spirituality. In Charlie's healings there is dissolution of the material-spiritual interface through the 'spirit doctor' approach. This dissolution is brought about in part by the discursive

dimension of healing, in that healers talk through their position by explaining the meaning of crystals, and it is achieved partly through the embodied healing performance. Both employ the use of metaphoric assertions in order to predicate a domain of experience onto another (Fernandez 1986).

Practising absent/distant healing

Absent healing refers to the process whereby healing energy is 'transmitted' across any conceivable distance to the recipient of the healing. Using physical imagery once more, healing energy is compared to the way radio or television frequencies are said to travel. The use of absent or distant healing has been noted in a number of texts on spiritual-based healing groups (Easthope 1986; McGuire 1988; Skultans 1974).

Teresa explained that very often a person requiring healing is unable to be present. Therefore, the healer should contact their (the patient's) 'overself' and send out a message to it. By 'overself' Teresa is referring to the idea that the person has a higher self that exists in a spiritual dimension. The message is said to feed into the subconscious mind of the person one wishes to heal. Furthermore, Teresa explained that absent healing can be conducted over any conceivable distance.

Each Wednesday evening this healing method is carried out upstairs in the sanctuary, and is attended by a mixture of local healers and novice adherents. The number of people attending the session would vary. Sometimes as many as twenty would be present, at other-times as few as four or five. This became known as group meditation and the philosophy behind it was that the collaborative nature of the meditation would provide a greatly enhanced healing effect. For example, on one occasion Teresa explained that we were there to send healing energy to a woman called Heather.

In addition, we sent out healing thoughts to the elderly people at the care centre where Sally works. With the tape playing gentle New Age music, Teresa spoke during the meditation for about fifteen minutes while the rest of us, with our eyes shut, listened intently. For Teresa, the most important part of the absent healing is the visualisation accompanying 'the guidance'. Each time Teresa utilised similar phrases to accompany the visualisation, which invariably began with the phrase, "Now take off your everyday garments, leaving your everyday problems behind, and wrap yourself in your rainbow coloured garments of light. Join your Brothers and Sisters of light", or "we welcome our Brothers and Sisters of light to bring down their healing rays...send out a thought of love to the Mother, send out a thought of love to the Father." Then, she would finish with the statement, "Heal the earth", which participants would also chant three times. This phrase is an interesting neo-pagan touch, which brings together some of the principles of both spiritualism and environmentalism. Luhrmann (1993) also highlights the use of such phrases in her work on neo-pagan spirituality.

McGuire (1988) makes similar observations about the use of visualisation in meditation. Like the members of the VEHC, the healers that McGuire discusses sat in a circle, holding a particular posture, and were led by similar meditations given by the leader of the group. Here, I quote a small section of one of these meditations in order to draw some parallels:

In your mind's eye, hold the colour green...Bathe yourself in that green. It envelops your body and the space around you. It lifts you up with new energy and new life. Breathe in the green, breathe in the energy...Now let that green move out from you to envelope the whole room, the whole building, all of the space you will go out into this week...Breathe in the fresh air of these new beginnings (McGuire 1988:26-27).

Group meditation: constructing and maintaining healer solidarity

Group meditation is a collective performance. It appears that the aim of the meditation seems less to do with the healing of the 'earth' or of those that are absent from the group, and more to do with establishing integration and solidarity of the group itself, and with crystallising a consensus of purpose – that they believe they are participating in the activities of the centre for similar reasons.

In discussing 'dreamwork' groups, Edgar (1994; 1995; 1997) makes some pertinent statements about the role of group interpretation, the process of narration and the metaphorical play with meaning. Edgar argues that the participants' discussion of the dreams altered over time in the desire for the dream to be translated from its 'raw' state to one that makes narrative sense. The process is one of transformation from dream image to one of social and personal meaning for the dreamer (1994:100). In chapter eight I go on to explore how this transformation works in relation to meditation analysis and interpretation.

It is significant that Teresa leads these group activities, and that she would not let me attend until she felt I could handle the meditation energies. Was this less to do with handling the energies and more to do with me being integrated into her philosophy for the Centre? Frankenberg (1986) considers this issue when discussing the significance of self-help groups. He explains that, "...each sufferer reaffirms his or her own social reintegration by repetitive ceremonies that centre around the arrival and acceptance of the newly afflicted" (ibid:621). Teresa's visualisation is very similar each time, perhaps with slight variations or twists. Its ending with the collective mantra of 'Heal the earth', therefore, serves to bind participants in affirmation of a common dictum, one which McGuire (1988) also notes the use of.

Conclusion: spiritual healing and the playfulness of performance

In this chapter I explored the ways in which healers engage in healing the spiritual body. As such, I drew attention to the enacting or performance of healing, and the relationship between material and spiritual domains. As in all health care systems, both the healer and the patient construct and agree upon the 'signs' that healing is taking place. This 'impression management' is essential to all social activities, but is particularly pronounced when individuals engage in activities devoid of fully prescribed (and written) rules and procedures. In this way, a number of questions have guided the chapter. For example, what can be defined as an acceptable healing; how do healers authenticate the primacy of a spiritual reality in both healing gesture and discussion; and what does the healer need to do in order to legitimate healing, or distinguish it from non-authentic healing practice?

The chapter has prised open some of these issues. Central to their discussion has been the notion of 'playfulness', or creativity in the healing act. Routine improvisation during the healing (when required) is fully sanctioned by the Centre and adds 'flair' and 'élan' to the individual healing performance. In addition, I have shown how the issue of managing competence and performance is very much at the fore from the beginning of the healers' training.

Luhrmann (1993) considers the significance of the increase in neo-pagan spiritual groups and the appeal of like kinds of religious belief. She argues that neo-pagan spiritual groups fulfil a need for a "playful spirituality" (ibid:222). Charlie and Stella satisfy this need in their ideas and healing practices. They experimentally explore the boundaries of their own healing style. The playfulness is integrated into the healing act and allows healers to individuate the healing experience, though, it should be noted, they may choose not to do this. Good examples of this are the visualisations that are

encouraged in the group meditations. In addition, I have shown how emphasising 'intuition' and use of the 'senses' suggest that ritual modification is collectively legitimated and sanctioned as good practice.

Most importantly, this emphasis on the personalised aspects of healing practice is illustrative of the 'playfulness' at work. Further, this playfulness is representative of a profound socio-cultural transformation towards postmodernity. As I explained in chapter two, people increasingly act as '*bricoleurs*' in that they build upon their own cosmology and/or world-view, and one that makes sense of their own life events and everyday concerns. Also, I explained that postmodernity allows for the privileging of the subjective, and healers' performative healing practices are key examples of this process. The use of intuition and the senses points to the centrality of subjectivity in the use of knowledge.

Furthermore, this individuation helps us to locate the relationship and boundaries between a marginal concern like spiritual healing and a large hegemonic institution like biomedicine. For example, I stated that postmodernity has broader implications for knowledge, in that no longer do scientific forms of knowledge have a privileged place. Thus, knowledge can be legitimated, not just through the systematised processes associated with 'modernity' (external legitimacy), but also through individual self-reflexivity (internal legitimacy).

At another level, Luhmann (1993) argues that another part of the appeal of this kind of religious belief is that individuals can partake in the intensity of the religious symbolism and ritual, but not have to deal with the issues of authority and control that are synonymous with conventional religion: "The experience of this intensity without the demand to adopt some authority's belief is an important part of what makes neo-paganism appealing to its modern enthusiasts" (ibid:222). Creating intensity in the healing act arises from the need to distinguish acceptable or legitimate healing from

unacceptable or illegitimate healing. Luhmann's point also hints at the eschewal of control in totalising belief systems.

My claim is not that spiritual healing is associated with neo-paganism, but that postmodern aspects of both new religious and healing modalities are tied up with the desire for 'playfulness' in relation to both identity and ritual symbolism. This point is reiterated by Laderman and Roseman when they speak of the power of the performative act as being the "heightened intensity of communication, and enhancement of experience" (1996b:2). Healing acts bring about intensity in the performance, but for healers such as Teresa, Charlie and Stella, this may be just about organising the ritual in a particular way, or reciting the correct invocation. I have also shown how healing is organised around a combination of movement and stillness, both in the use of crystals and with the healers own gestures. These are the external 'signs' that give the impression of a successful healing.

Therefore, healing efficacy has more to do with the success of the performance. Or (following Herzfeld 1995) that the healer demonstrates that they are 'good at being a healer'. The importance of ritual performance is emphasised by others, notably in Laderman and Roseman (1996a); Schieffelin (1996); Csordas (1996); and Taylor (1984) who claims that clinical efficacy is rarely an important issue for the general public, especially in terms of what they might find acceptable. This situation regarding the acceptability of the performance is particularly pronounced in interpreting Charlie's use of spirit doctors.

¹ For the analogy between music and social action, see Richards (1996) – 'Human worlds are culturally constructed: against the motion'. Levi-Strauss (1964) has also drawn our attention to this analogy

² I explore this issue of the source of healing and healing energy in chapter eight.

Healing bodies: bridging the material and the spiritual.

Introduction

As human beings we all have a body, though it is usually assumed that we have just the one which is material in nature. In contrast, spiritual healers (and, I would contend, many lay people) believe that spiritual bodies encapsulate the physical. More importantly, in social science the body is viewed as a referent for discussing both individual and wider socio-cultural concerns (Csordas 1994b). In particular, I show how individual concerns over the body are prevalent in a healing centre that seeks to redress the nature of people's bodies.

The aim of this chapter is to examine the ways in which healers at the VEHC define and classify the human body. Furthermore, I explore the ways in which a degree of consensus and orthodoxy is engendered amongst a diverse range of ideas and discourses. The focus on the body is important for two reasons. First, individual concepts surrounding the body are inextricably linked to notions about health, illness and the causation of disease (O'Connor 2000:39). Secondly, it is argued that CAM concepts of the body resonate particularly for a large section of the population, because they appeal to the 'lay' view (ibid:39).

This chapter begins by exploring the key differences between 'typical' biomedical and CAM/healing approaches to the body, and I recap on some issues raised in chapter one. I go on to discuss the relationship between medicine and healing as it applies to the body. Material and spiritual bodies are discussed, as well as spiritual body concepts such

as the ‘aura’ and the ‘chakras’. I go on to assess the role and meaning of ‘spirit doctors’ in relation to Charlie’s healing practice. I conclude with a summary of the material-spiritual interface and what we can infer from this in relation to the hegemonic position of biomedicine in the field of health and, the nature of the challenge from healing.

Biomedicine and CAM: approaches towards the body

Medical science is founded on pathology: a science of the material body discovered through studying the symptoms of disease. The biomedical model of disease traditionally “reduces illness to a biological abnormality inside the body” (Armstrong 1989:1). Although in recent years medicine has repositioned itself in recognising that the body exists in a ‘psychosocial’ context (Armstrong 1989; Hughes 2000:14), this has had little effect on medicine’s belief that the material reality of the body exists *a priori*. Also, this recent repositioning of medical ideology has been perceived as signifying a wider shift from the concept of ‘diseased’ to ‘healthy’ bodies (Hancock *et al* 2000). It is further argued that CAM, with its focus on ‘holistic’ approaches to the person, forms a notable challenge to medicine’s monopoly over the ‘truth’ about the body (Hughes 2000). Therefore, it is the nature of the challenge from healing practices at the Centre that I consider in this chapter.

Firstly, in chapter one I described biomedicine’s heavy and well-documented reliance on the idea of the body as a machine (Samson 1999). This metaphor of the body as machine has its origins in Descartes’ mind-body dualism, in which he postulated that the body is a thing in-itself and exists external to the place of self-identity and mind (Synnott 1992). Furthermore, Samson (1999) implies that modernity contributed in

secularising the Cartesian notion of mind and body and, thereby changing the way scientists conceptualise individuality and the body:

As science became increasingly secularized and scientists felt less obliged to refer to the existence of other-worldly and non-material phenomena, the mind or soul also came to be considered in mechanical terms, analogous to those for the body...By dispensing with the presence of a nebulous soul, the purely rational and materialist approach to the body has proceeded to the present (Samson 1999:10).

In contrast, it is argued that CAM fosters approaches to the body that maintain a lesser reliance on materiality. Indeed, CAM establishes “a range of conceptions of the body that differ significantly from the anatomical and physiological constructions of the conventional medical model” (O’Connor 2000:39). Typically, it is argued that CAM focuses on how the body is inherently healthy in its natural state (the body has the potential to be ‘self-regulatory’); that the body is interconnected with other aspects of the person (the mind, psyche, emotions); and that the practitioners emphasise the importance of ‘energy’ or ‘vitalism’ in the body (English-Lueck 1990:6; O’Connor 2000:50-51). More specifically, the ‘New Age’ healers’ focus on concepts such as ‘energy’ or ‘vital force’ represents a clear challenge to the scientific concept of the body as machine (Lewith 1985; O’Connor 1995; Synnott 1992).

Secondly, at the Centre spiritual healing encompasses a set of practices that reflect “the ‘privatisation’ of the body” (Bauman 1995:119). In other words, the body is a referent for discussing individual concerns. Turner has described how anthropological interest in the body stems from the notion that the body acts as a referential locus for classificatory systems (1991:9). In contrast, writers such as Foucault have brought attention to the idea that the body is not just an object, the biological body is itself

discursively constructed (Fox 1997). For Foucault, then, the body is a referent, not for reflecting individual concerns, but for the use and governing of power. Furthermore, Bauman argues that the body is a key domain with which to discuss socio-cultural differences between modernity and postmodernity, a theme that is central to the concerns of this thesis. Bauman's interest lies in understanding the body in postmodern times, in which the body is a consumer aiming at "sensations-gathering" (1995:118). For Bauman, individuals increasingly seek out new sensations and sense-related delights. Aspects of this pursuit can be seen in spiritual healing practices, in particular the importance of the senses in diagnosis procedures. For example, in chapter five I described how Jack said that healers will know when they reach a 'blocked' area of the body because they will experience certain bodily sensations – tingling, hot and cold, etc. Further, these sensations are individually perceived and interpreted, and all such interpretations are equally valid. In this way, healing emphasises the importance of personal interpretation and making sense of 'senses'. In such ways, we can see how the body is a site of contestation within social science.

'Blurring the boundaries': towards knowledge system heterogeneity

In addressing spirituality healers' practices contrast significantly from those that engage solely with the material body, although there are note-worthy overlaps which may preclude us from making an absolute differentiation between biomedicine and healing. In addition, CAM practices are not homogenous in their understanding, theories and treatment of the body. I suggest, therefore, that the boundary between medicine and healing should not be seen as exclusive or fixed.

In chapter one I highlighted the individualised character of lay knowledge of the body and that the healers and patients at the Centre retain concepts of health and illness that reflect lay perceptions of health (Astin 1998). This contrast with biomedicine has been

noted by a number of writers exploring the 'lay' appeal of folk and 'spiritual' healing (Engebretson 1996; McGuire 1988).

However, there are key similarities between lay and healer classifications of the body. Lay and medical/expert knowledge systems do not inhabit mutually exclusive worlds, we can observe a two-way relationship. For instance, in chapter four I demonstrated the ways in which biomedical practices are influenced by the lay model (Helman 1986). In contrast, lay knowledge has become increasingly reflexive and therefore makes use of the wider public availability of expert knowledge (Giddens 1991). The fixed boundaries that had existed between the medical specialists and the lay public have become increasingly permeable; therefore the boundary becomes more ephemeral and discontinuous as the flow and interplay of knowledge increases. This discontinuity and interplay, I argue, also leads towards greater knowledge system heterogeneity.

Materiality and surgery: the relationship between medicine and healing

A key feature of biomedicine is the materiality of its practices. In her article on healer-patient relationships, Douglas (1994) argues that the various 'crises' experienced by biomedicine are a consequence of its conflation with the physical and by implication, the violent. As she explains, "the idea of spirituality in [alternative] medical practice is contrasted in these conversations with materiality, physicality, violence" (ibid:25). Douglas implies that the materiality of biomedicine clashes in language with the 'softer' discourse of the alternative therapist, whose 'gentle' approach emphasises the holistic and spiritual:

Tension between material and spiritual values is always present. What I am calling the option for gentleness is a surfacing of a new trend, against the material, against vulgar, harsh, rough, hard, brutal, mechanical and impure, complementary to a preference for spirituality (Douglas 1994:26).

Sharma (1990) also notes this focus on the perceived radical and intrusive nature of biomedicine. Here, she recounts a story from a woman who was seeking an operation for the relief of back pain: “A major operation which did not have any certain outcome seemed too drastic a step to take” (ibid:132). In contrast, Coward (1989) argues that such widely held perceptions of biomedicine instructs much of the mythology surrounding CAM - that therapies can provide less invasive and intrusive methods of healing for the majority of patients (i.e. women). As Coward explains, “[women want] health practices that are gentler, safer, more in touch with people and their wants than the harsh, brutal methods of uncaring professional men” (ibid:153).

Early proponents of and writers on the subject of CAM referred to the term ‘natural’ therapies (Coward 1989; Inglis & West 1983; Stanway 1979 & 1994), and this is still popular as a descriptive term amongst practitioners. This is possibly due to the fact that other areas of social life were aided by techniques claimed by their proponents to be ‘natural’. However, I agree with Taylor’s contention: “There seems to be little that is “natural” or non-invasive about the acupuncturists technique of sticking needles into various parts of the anatomy” (1984:197).

The term ‘natural’ also has connotations in terms of providing a critique of modernity and the foundations of biomedicine. The negative implications of modernity are signified by its association with the appropriation, exploitation and destruction of the natural. As Porter (2001) explains, the Enlightenment period viewed ‘nature’ as that

which needed containing; the learned circles had little sympathy with the pantheistic ideas prevalent at the time. Furthermore, the term ‘natural’ encapsulates a certain mythology about women and their links to usage and practice of CAM. ‘Nature’ embodies powerful symbolic meaning, and links cleanliness, purity and virtue to the re-assertion of the feminine (Coward 1989).

Although biomedicine concerns itself with an application to the brutal, physical facts about being embodied, it is argued that allopathic practices are not the only ones engaged in this approach. It has been noted that increasingly influential ‘complementary’ therapies such as osteopathy promote this physical and ‘mechanistic’ view of the body (Lee-Treweek 2001). Surgical approaches to healing confirm Douglas’ statement, but biomedicine generally is criticised for its intrusive curative practices: “For disease such as cancer the cure seems more horrifying and disfiguring than the disease itself” (Taylor 1984:197). Biomedical intervention is not centred solely on the surgical approach, though as it happens to be perceived as the most technically advanced and specialised, it appears to be more firmly imprinted on the lay person’s psyche than other less intrusive practices.

Embedded within spiritual healing discourse is a substantial critique of biomedicine. Insofar as these therapies represent a critique of medicine they seem quite unlike other more mainstream CAM practices. I explained that healers at the VEHC invariably entered into healing because of their different, though equally problematic, experiences with biomedicine, and therefore the healers embrace the critique. Yet, I show in this chapter how this critique involves a degree of interplay and engagement with the language and science of biomedicine. For example, the appropriation of the surgical approach in terms of its status and imagery is fundamental to ‘spiritual surgery’ that is the cornerstone of Charlie’s practice.

The body in healing: the material and the spiritual

The healers at the Centre agree that the physical body is not the only body we have that makes us who we are. They argue that there are two sets of bodies: the material and the spiritual. The notion that humans are more than just material entities is prevalent across a range of healing groups (English-Lueck 1990:132). This focus on the 'immaterial' part of the body is perceived as a key aspect of the CAM/healing challenge to biomedicine, and is also viewed as one of the contributing factors for its popularity amongst the lay public (Braathen 1996:152; O'Connor 2000:52). Lay people do not accept a purely biological conception of their own body (Braathen 1996:152). As O'Connor explains: "This concordance of CAM theory and practices with popular ontology, or understandings of bodily reality, helps to account for public acceptance and popularity of complementary medicine" (2000:53).

The healers state that most people cannot see the spiritual body, though it exists and has a profound effect on the health of the physical body. 'Seeing' the spiritual body/ies is not something that can be learnt. People have the 'gift' to be able to do this. Nevertheless, what can be learnt are the strategies to be able to detect it and consider its state and development, just as the student of biomedicine learns that coming to terms with pathology requires learning a particular way of seeing the physical body. Thus, perspectives or views of the body are always 'trained ones' (Power 1996:105-6). In his astute anthropological analysis of biomedical science, Good (1994) explains this more clearly:

Within the lifeworld of medicine, the body is newly constituted as a medical body, quite distinct from the bodies with which we interact with in everyday life, and the intimacy with that body reflects a distinctive perspective, an organised set of perceptions and emotional

responses that emerge with the emergence of the body as a site of medical knowledge (Good 1994:72).

Therefore, healers learn to read the signs that tell them that not only does a spiritual body exist, but that it also maintains a causal relationship with the physical body, an idea that is popular in a range of syncretic beliefs. At this stage it is worth considering the kind of syncretism that spiritual healing generates, as knowledge that engages the dissolution of fixed cultural forms also creates added legitimacy, particularly where legitimacy is achieved through the power of alterity.

The healers' individually diverse concepts regarding the nature of the spiritual body stem from a global hotchpotch of sacred religious beliefs: early twentieth century theosophy, Tibetan and Indian mysticism, North and Central American Indians, the Minor Upanishads, Puranas and Tantric works, and 'New Age' mysticism. However, I must stress that the sources they read and allude to in order to give legitimacy to their views tend to emphasise the supposed 'universality' of such concepts. I go on to explore, for example, what this 'universality' indicates in terms of the concept of the 'chakra'.

This form of medical pluralism, where healing traditions are based on a plethora of culturally embedded practices is not unusual. New syncretisms are made possible by 'cultural flows' in the 'global ecumene' (Hannerz 1996).¹ For instance, in an article on the physicians of rural highland Bolivia, Crandon-Malamud (1997) argues that when discussing illness symptoms the people drew on multiple medical ideologies: "[ones that] drew upon nosological and etiological categories that derive from Indian, folk and cosmopolitan traditions" (ibid:34).

Explanations for the possible existence of spiritual bodies owe much to a selective interpretation of quantum physics, and the healers would admit this. For example, they

explain that the physical body is an illusion, because its physicality is merely the appearance of matter that occurs through energy. That is to say, fixity, stasis and solidity are constructed in a world of energy, movement and ephemerality. The view is borrowed from the Einsteinium argument concerning energy, matter and light, but it is obviously an extreme and metaphorical interpretation of those ideas. Therefore, healers such as Teresa argue that individuals are essentially composed of light, which is the impression of movement of that which makes up matter, the frozen particles of electrons. If energy is equivalent to matter, then the physical body is a total representation of light in movement.²

Furthermore, the physical body that biomedicine recognises is a manifestation of a particular kind of energy - a dense physical energy. The spiritual body is not empirically knowable; it is a part of the individual that is detected through subtle healing. Therefore, different healers will learn and interpret different signs from the patient's body. As such, there is no need for the healer to operate under a systematic set of principles regarding the nature of the non-physical body, because of the individual and personalised nature of the diagnosis.

However, there is a point at which biomedicine and healing converge. Whereas biomedicine is focused on the space inside the physical body, the healer prioritises the space surrounding the physical body, which they would argue reflects the inner nature of the individual. This also translates into what is an ambiguous and ambivalent relationship with biomedicine. For instance, biomedicine is established around certain fundamental ways of seeing the body, in terms of exteriors and interiors. The interior of the body is the site for discussing the inner state of the individual, in terms of disease and bodily functioning. Yet, the healer is also interested in revealing the hidden depths of the individual. At one level, both practices claim a legitimate interpretation of the inner space of the body. At another level, the issue of 'convergence' can also be seen as

a claim for control over intimacy: the inner body represents the intimate socio-cultural and ontological space of the embodied self. It is the site of the secretive, arcane and unknowable. Importantly though, both health ideologies deal with the same phenomenological concept of intimate space and this ambiguity and fluidity arises in the relationship.

In the following two sub-sections I explore the ways in which the interface between the material and the spiritual dominate healers' discussions surrounding the body.

a) The etheric body: the aura

The energy field encapsulating the physical body is referred to as the etheric body or the 'aura'. The word etheric derives from the term 'ethereal' - meaning light, delicate, and heavenly. As such, this energy field is a lighter and less dense form of matter than the physical body. The term 'aura' denotes something more generalisable and is used in everyday discourse to refer to a person's presence or emanation. For example, in early Christianity the idea of the emanation was referred to as the 'halo'.³

The etheric body is not empirically observable, and so recognition of its state relies on the individual healer utilisation of 'subtle' senses, such as intuition, clairvoyance or clairaudience. As it is not observable, it is difficult to determine the exact location of the etheric body. For example, Teresa argues that each individual's aura is unique in shape and size – it reflects the individual's character. Jenny explained that you should locate the aura 2-3 inches above the physical body, while another source argues that it is six to 18 inches (Walker 1988:31).

This uncertainty as to the aura's existence and nature became a source of contention and a legitimate practice in which to emphasise individual concerns. For example, on one occasion Teresa organised an experiment to establish its size as Helen had mentioned that she was worried about the size of hers and the risk of 'exposure'. To

illustrate its size Teresa asked us to use the pendulums that we were given and to ask the pendulum for an indication of the size of each person's aura. We asked the pendulum a question such as 'is the aura extended further than four inches' and the swing of the pendulum signified a yes or no answer. This continued until we all came up with a set of scores. Unsurprisingly some of the answers differed by several feet. For example, Bridget elicited much laughter after she gave me an aura of about 20 feet. Others had recorded between 8 inches and 2 feet. Teresa seemed quite amused about Bridget's calculation and exclaimed, "Yes, I think that would be in the Maitreya league, if someone had an aura like that".⁴ Naturally, we were all amused at the incongruity of my achieving such an elevated spiritual status. More soberly, Teresa explained: "The aura should not really extend beyond 3 feet for most ordinary people. The auric field of someone on drugs can extend beyond this but that is because their emotional field is way out."

That this practice elicited a different set of scores underlines the individual nature of this kind of diagnosis. Therefore, although the etheric bodies represent something about our inner nature, healers' differ in their ideas regarding the kinds of higher bodies existing. Nevertheless, the higher bodies can refer to a number of different interconnected subtle emanations, all of which maintain a causal relationship over the state of the material body.

b) Chakras: bridging the material and spiritual domains

The concept of the chakra further illustrates the complex interface between material and spiritual bodies. Chakras are a healing focal point for healers at the Centre, and are normally defined as the area where an element of 'vital' energy in the etheric body intersects with a corresponding area of the physical body. If we identify the original Sanskrit meaning of the term, the chakra as 'wheel' is meant to signify the cyclical

pattern of life (Ozaniec 1990:4). However, Ozaniec is a figure within the field of alternative spirituality, so care should be taken in drawing conclusions from this, as I have explained the characteristic of such sources is to stress the supposed ‘universality’ of such symbols.

The concept of the chakra is one that exists in many different cultural contexts and has a long history. It originated in the Hindu tradition and was adopted over time into Tibetan Buddhism (Ozaniec 1990), but its use can also be seen very broadly in the beliefs of North and Central American Indians, Eskimos and Egyptians. It was not until the early part of the twentieth century that these ideas entered theosophical thinking in Europe. Therefore, the chakra comes closer to the ‘global hotchpotch’ I alluded to earlier.

The symbol of the chakra is important to this chapter for two reasons. First, because it symbolically stands as the link between the material and spiritual domains; chakras are said to be the bridge between. Secondly, the chakras are the central focus for healing, as they mirror the healers’ perception of the individual in a microcosmic sense. Human beings are placed in an oscillatory position, caught between the spatial domains of the physical and the non-physical. Similarly, chakras are at the interface of these contrastive arenas and in this respect the coil imagery manifest in the symbol of the chakra serves as a rich and imaginative metaphor for the human condition as they seem to perceive it.

Amounting to hundreds of intersections, healers are normally only concerned with the seven or eight major chakra points that connect the spiritual to the physical bodies. These major chakra points can be identified on the body along the path of the spine, dimidiating the body and providing an imaginary axis. Each chakra point is symbolically associated with a particular colour and also relates to a major gland located in the physical body. Further, as Teresa explains: “Chakras are spinning vortexes of light that

move in a clockwise and anti-clockwise direction, simultaneously. They do not just have to look like one colour, such as red. They look like the whole spectrum of that colour.” This also explains why coloured stones are placed on certain parts of the body, as there is a corresponding colour symbolism.

The chakra as conduit for multiple metaphors

At the Centre healers’ refer to chakras being open, closed, blocked and so on. Chakras are like an empty container that can be filled with metaphors meaningful to the healers’ everyday concerns. Some of these metaphors imbue the chakra with a living presence, like an organism or a flower: “Just like a lotus, the chakra can be closed, in bud, opening, or blossoming, active or dormant” (Ozaniec 1990:5). Here, the metaphorical emphasis is on the chakra as a bridging mechanism that links together the body and nature.

I raise the issue of metaphors as their usage and prevalence is perceived by some anthropologists as a gateway to understanding people’s conceptual system, and their locating of personal experience to the wider world (Fernandez 1977; Fernandez 1986; Lakoff & Johnson 1980). Metaphors are devices for argumentation, in that they aid the individual in expressing their world-view (Fernandez 1986). For example, Lakoff and Johnson state, “the way we think, what we experience, and what we do everyday is very much a matter of metaphor” (1980:3). Furthermore, metaphorical utilisation sustains particular resonance in a ritual context. As Fernandez explains, “metaphors provide organizing images which ritual action puts into effect” (1977:101). Therefore, metaphors help people to articulate subjective feelings and move beyond the privacy of individual experience (Fernandez 1986).

I note another metaphorical association with the chakra. The idea that chakras are opened before a healing can begin, and that they have to be closed once the healing

energy has entered the patient's body is remarkably similar (metaphorically) to surgical healing. For example, the clinician opens up the patient's body, and once finished the body is closed and sewn up. Other commentators have noted the use of more mechanical and instrumental metaphors. As Graham (1990) explains:

[In these cases a chakra] is equivalent to a transmitter or transformer of energy, is therefore believed to vibrate at a characteristic frequency as it distributes this energy throughout the body, the energy pattern around each being predominantly of a certain colour and associated with a musical note and a symbolic form whose vibrations also correspond with its basic frequency (Graham 1990:188).

In chapter eight I go on to discuss the importance of the chakras in relation to the healers' concepts of health. It will suffice to say at this point that I interpret the chakra to be a type of spiritual 'organ'. The metaphorical expressions applied to the chakra oscillate between one of nature, beauty, harmony, and ones of more technical scientific precision, such as the notion of chakra as 'vortex' or 'vibration' (see chapter eight). More significantly, immaterial images are often constructed in relation to physical ones, which Lakoff and Johnson term 'grounding'. As they explain, "We typically conceptualise the nonphysical in terms of the physical" (1980:59).

Physical and spiritual anatomy

Despite the centrality of spiritual bodies, the very materiality of the physical body is still important for the healer. For example, a key component of the crystal healing diploma at the *Vital Energy Healing* Centre is elementary physiology. Nevertheless, healers perceive parts of the body to be imprinted with an individual's uniqueness. Organs,

limbs, and blood are peculiar to that person and embody their spiritual energies. Therefore, a conventional medical procedure such as organ replacement is deemed problematic, as this would be replacing the person's spiritual energies as well as a physical organ. In the following example, I show how Teresa links together the body and the individuality of the person in her response to issues about organ transplants. This translates into a critique of 'expert' approaches to the body that, I contend, eschew individuality in the person.

On this occasion, Teresa was explaining what happens to the energies of a particular organ when transplanted into the body of another. As she explained:

I am completely against these forms of organ transplant, because it means you are dividing up the spirit and I don't think people know what they are doing. To transplant a heart they need to keep the heart pumping when they transfer it over, so they keep the body of the person it is being transferred from artificially alive when it is moved over. The person who receives the heart is pumped full of steroids so that they will accept the heart, and few people will live beyond a few years anyway. The heart is the chalice for their spiritual energies, so when the heart is put in the body of another then the spiritual essence of that person is transferred with the heart... I am against transplants of the major organs. Also, after death it takes three days for the spirit to totally detach from the body; and look at what's happening now with animal to human and human to animal transplants, I think it's disgusting. So you can have human pigs and pig humans.

It is perhaps no coincidence that Teresa chose the heart to exemplify her point. The heart is, in Western cultures at least, constructed as the centre of one's emotions and hence one's spirit. If the heart is seen as acting as the conduit for the person's individuality then we can argue that spirit energy transfer is a risk solely in the transplanting of specific

body parts, rather than transplant generally. However, when a question is asked about blood transfusions Teresa is equally dismissive:

Well, I'm against that also. The blood is the life force and you cannot put that into another individual as it will take the life force of the individual into another and will mix up the spiritual energies. You cannot make happiness out of other people's suffering, and that is exactly what they're trying to do.

Good argues that blood transfusions are invariably seen as unclean, foreign or dirty, and that the blood of the individual is pure, the essence of life (1994:94-101). Here, the blood of the individual carries with it the spiritual essence of a person. Therefore, transfusion would cause the spiritual energies to be mixed-up, thereby complicating the individual's nature. In such ways, blood plays a mediating role between purity and impurity (ibid:99). The symbolic potency of blood, as a symbol of bodily and societal disorder has been noted by other commentators (Helman 1994; Lupton 1994).

However, the healers do not seem to mind the external influence of others' spiritual energies impeding on them if they are 'protected' or if an item is spiritually 'cleansed'. For example, to wear another's jewellery if it has been cleansed is acceptable. Yet to take something into the body is deemed wrong because it is impervious to cleansing and the body will reject the organ. As I explained, the inside of the body is bound up with intimate space: it represents something about the person's essential identity. As such, the inner body is more likely to be protected and kept pure.

As I explained in chapter six, these ideas put forward by the healers denote an extremely modernist conception of a 'contained' body (Oliver 1999). On another level, this unacceptability of organ transplantation represents Teresa's distaste at having something alien entering the internalised private space of the body. Part of the distaste

arises because the transfusion of organs or blood is carried out at a physical level. It does not pay attention to the immaterial nature of spiritual energies and how these can be mixed-up through these physical processes.

Spirit guides and doctors: non-physical entities

There are numerous discussions surrounding 'spirit guides' in sociology and social anthropology, particularly in the study of ritual healing.⁵ In the late nineteenth century such practices were referred to as 'mediumship' amongst spiritualists in England and the United States (Barrow 1986; Braude 1989; Brown 1997; Owen 1989). Spirit guides feature prominently in Brown's intriguing study of trance 'channellers' in Sante Fe, United States (1997), they are also noted by McGuire in her discussion of 'psychic healing' in Baltimore (1988)⁶ and in English-Lueck's analysis of Californian 'New Age' holistic practices (1990). In addition, spirit guides constitute a significant focus in Skultans' study in South Wales (1974), mainly in relation to understanding the nature of spirit possession, and in Easthope's (1986) sociological analysis of healers in Southern England. They are further discussed in relation to issues of healing performance and authenticity (Laderman and Roseman 1996a; Lindquist 2001; Schieffelin 1996; Skultans 1974), and in non-Western contexts (Koss 1980; Laderman and Roseman 1996a; Schieffelin 1996).

Teresa explained that spirit guides provide assistance in the material and spiritual worlds. Furthermore, spirit guides are invariably drawn from other nationalities, and from other periods of history. As she explained, "Often they appear to us as American Indians or Chinese and this is because of their healing talent and awareness, the ancient civilisations were wise and had esoteric learning." In McGuire's study, spirits were equally drawn from a variety of backgrounds: "Spirits of "Red Indians", Chinese sages,

or wise doctors were believed to aid the healing process and give diagnostic or therapeutic advice” (1988:132). Spirit guides with these identities represent something far removed from biomedicine. They represent the ‘traditional’ or indigenous healer who is largely absent in modern post-industrial societies. For example, Teresa emphasised what she saw as the spirit guides’ specialised healing abilities:

The ancient Chinese were very philosophical and are an indication of the teaching being brought to you and for others that will bring inner illumination, an opening of the inner eye to ancient wisdom. They were masters of etheric healing and many Chinese helpers come through on a very special healing link... A North American Indian brings a very definite healing talent because they were so close to the earth. They were of course the Toltec’s of ancient Atlantis and they kept their cosmic awareness with them when they settled in that land now known as the Americas...The Tibetans invariably bring occult awareness. The Egyptians also usually come forward in the guise of the initiate priest from the past.

Skultans makes a similar point and suggests the healers believe that those of a certain cultural identity are more likely to be able to exhibit potent healing powers: “Such guides are frequently, though not necessarily, thought to be the spirits of deceased doctors and preachers” (1974:38). A similar connection is made by Walter (2001) in addressing Western concepts of reincarnation. Walter argues that the notion of selecting different identities from which an individual has been reincarnated is a playful engagement with the self, and this is no more the case than in choosing ‘exotic’ identities:

A postmodern hypothesis might therefore suggest that the idea of reincarnation provides wonderful opportunities for people to play with entirely different identities – witness the

number of people who claim to have led highly exotic past lives, notably as Egyptian princesses (Walter 2001:25).

One of the notable characteristics of channelling is its improvisation and eclecticism (Brown 1997:18). One can certainly identify a degree of eclecticism in the use of spirit guides, although the adoption of certain spirit identities is no accident and I explore an example of this in the case of Charlie's healing. Improvisation is central to utilising spirits in healing, as it is the use of improvisation and creative innovation that offer greater insight into the mimetic nature of the acts.

The status and number of the 'doctors' involved in Charlie's practice altered during the course of my fieldwork. At first Charlie identified five different spirit doctors acting through him. At a later stage he could distinguish between each one, and each spirit doctor had an established area of expertise which was normally couched in biomedical terms. This is an important point to make as the identity of the spirits tells us something about the nature of Charlie's healing. In the following passage we see Charlie emphasising the medical expertise of each spirit presence.

One day, after a healing, I asked Charlie about the status of these helpers: "When you go into that particular state when you are healing, what exactly happens, are they spirits that you use or something?" I enquired. Charlie explained:

Yeah, they're the Doctors, the spirit guides. They use my body as a way of directing healing energy. There are five of them, Doctor Tai, Doctor Dai, Doctor Samuels, an eye specialist, and a throat specialist. One of them that has just introduced himself is a Japanese man. One of them is a tumours and cancer specialist and another is a bones specialist. They keep introducing themselves to me, but so far I only know five.

I continued, "Are they more effective healers than you, is that why you use them?" "They're specialists at what they do, they each have their expertise," Charlie explained. Ruth interjected: "I didn't realise you had a name for another one - Doctor Samuels?" Oh yeah, Doctor Samuels is a bone specialist. When I was doing a healing the other day, I was asked by one of the Doctors if I could use another Doctor's help, and so he introduced him as Doctor Samuels." Charlie responded.

Towards the end of my fieldwork this situation altered. After a healing that Charlie had conducted on Stella, Ron and I (see chapter five, case 11), Ron asked Charlie which of the doctors did the healing on his eyes. Charlie replied: "I just get 'em through all the time now when I'm 'ealin, do you know what I mean? Sometimes they come through so fast, and I'm not aware of any of this, I think they're all testing me out, you know." Stella pointed out, "Yes, well it used to be Doctor Tai, Doctor Dai and so on," and so Charlie explained more fully:

Yeah, I mean they're still there. It's the spirit world 'innit, so it could be anyone in a million, I never know which one will use me from one healing to the next, but they seem to do the job. Eventually, I think maybe ten years down the line, I'll settle down with a small team of them, but at the moment a lot of them are using me and are just trying me out really.

His increasing confidence in his own healing 'talent' (the ability to channel spirits) meant that his use of spirit guides became somewhat promiscuous. He was channelling a variety of spirit entities and identities. His idea that he would eventually 'settle down' with a few of them does add some credence to this viewpoint. Charlie even prided himself on 'poaching' other healers' spirit doctors as he increased in reputation, a concept that has some validity in non-Western contexts. For example, in a study of the

Shaman healers of the Iban of Sarawak, Harris describes how a shaman's status is closely tied to the numbers of spirits they can use: 'a *manang*'s (shaman) reputation is highly dependent upon the nature and number of *yang* (spirits) that he has" (2001:139).

Psychic surgery

What is of further significance is the relationship between what Charlie tries to do and the healers that Teresa refers to as the 'psychic surgeons' of the Philippines. One day I was discussing Charlie's progress with Teresa, and I asked her, "What Charlie does, I suppose that's shamanism in a way?" Teresa looked at me intently and shook her head slowly:

No, Charlie is trying, well, what he's aiming to do is to be a spiritual surgeon. It's like the Filipino psychic surgeons, except without the physical tools and so on. With the Filipino's, they actually do the healing with all the scalpels and there's blood and something comes out of the body and it goes into a bucket, and when you look into the bucket, there's nothing there. You have to be careful though, there's a certain amount of charlatanism there, but a lot of it is genuine.

Filipino psychic surgeons and psychic surgeons from other parts of the world have been documented elsewhere (Easthope 1986; Graham 1990; Wirth 1995), and the similarities with what Charlie is trying to achieve are evident. Though with psychic surgery the boundary between what is non-physical and what is physical is traversed by giving the appearance that blood is emitted from the body, and that actual physical instruments are used. Charlie applies his skill solely in the spiritual domain, as then the experience within this arena cannot be shared. Spiritual surgery and spiritual healing more generally

is a private and individual experience for the healer. Charlie explained the difference between his own style and that of a psychic surgeon in London:

When I look around the room, I don't see it the way you do. I see all these Doctors and people helping out, because I'm in it, I'm in the middle of it. This trance healer though, he uses real instruments, you see, whereas I use spirit instruments. It's just a different approach. But he's got all these knives and scalpels and things, and he uses them on his patients and afterwards they seem all right, after he's been moving things around.

Conclusion: exploring the material-spiritual interplay through concepts of the body

In this chapter I have moved beyond the assertion that biomedicine and spiritual healing are wholly contrastive healing practices and systems of knowledge. We can see that, on another level, healers retain concepts (of the body) and enact curative practices that throw into question the conventional medicine-healing interface. For example, we see this in Charlie's use of spirit doctors, essentially bearers of expert, specialised knowledge. In conclusion, I make some brief remarks about what we can interpret from these activities and what they tell us about the dualistic nature of systems of knowledge.

Firstly, certain healing appears to be a parody of biomedicine, as the healer is self-consciously and critically aware of those associations. The healers have grown up in a socio-cultural context where biomedicine is the dominant system of health care. Perhaps because of this they are susceptible of expressing its influence in both intended and unintended ways. In chapter six I demonstrated that parody is apparent in Charlie's self-reflexive and critical awareness of the use of spirit doctors – for example, in his use of

the invisible needle and in his correcting Ruth when referring to the numbers of people in the room.

We could argue that certain healers mimic biomedicine in order to make a statement about the cultural legitimacy or professionalism of the healing. This could be due to the culturally embedded place of biomedicine in Western society, such that, so the argument would go, they cannot escape its influence and cultural frame of reference. However, there is some concern that, by reflecting the language and imagery of biomedicine, healing acts further legitimate the biomedical model. As Baer explains, "...in seeking and achieving legitimation; alternative medical systems often undergo a subtle process of co-optation as they incorporate required aspects of the biomedical model and, thereby, inadvertently contribute to biomedicine's dominance" (2001:336).

Nevertheless, what emerges is a creative and playful engagement with the hegemonic discourse of biomedicine and I described how this creativity is reflected in the 'metaphorisation' of biomedicine. Healers thereby draw upon the metaphorical relationship between acts/discourse in the domain of biomedicine (specifically surgery) with those in the domain of spiritual healing. For example, we can see this in the image of the chakra. In describing the healers' ideas about the charka I argued that it stands as the link between physical and spiritual energy, and that whereas the doctor opens and closes (sews up) the body following surgery, the healer opens and closes the chakra.

Secondly, in chapter two I referred to the work of Lyotard (1984) and how he explains in his analysis of the postmodern condition that individuals are restricted in their actions; that is, "[the] inventiveness of the players in making their moves" (ibid:17). By this Lyotard was also, I contend, referring to the way in which certain institutional domains, such as medicine, are embedded in the socio-cultural fabric of Western society. Because of modernity's 'weight' of influence, when individuals generate new practices, such as healing, they are subtly influenced by this hegemonic

structure. So, in drawing attention to the mimicry inherent in healing acts perhaps we see something paradoxical at the heart of spiritual healing. Healing at the VEHC is largely critical of biomedicine and its hegemonic position, although in Charlie’s healing we can also see how it is deferential. For example, consider his use of ‘experts’ (medical specialists) in the spirit doctor identities. This playful and reflexive engagement with knowledge also informs us about the fluid and contested nature of knowledge systems in ‘late-modern’ society (Giddens 1990).

Thirdly, the material-spiritual interplay can be seen in relation to a set of dualisms, which emerge in our analytical understanding of crystal and spiritual healing cosmology. Edgar’s discussion (1994; 1995; 1997) of dreamwork groups is also essential to this debate as he flags-up the use of binary opposites in the participants’ recounting of their dreams. Edgar points to the reliance on epistemological dualism (e.g. material-spiritual; inner-outer) in Western thinking (1997:83). The following list is a recap of the dualisms noted in the diverse and contested healing practices at the VEHC:

Healing	Medicine
Spirituality	Materiality
Individuation	Systematisation
Personalisation	De-personalisation
Crystals	Drugs
Laser wand	Surgical scalpel
‘Subtle’	‘Brutal’
‘Sensitive’	‘Invasive’
Light	Dark

However, spiritual healers engage with the boundaries between contrasting healing ideologies. For example, I explained that the concept of aura embraces a contained conception of the body, a concept which essentially reflects a modernist ideology. Furthermore, the spirit guides provide an emphasis on individual identities, and the use of those identities in the context of healing appears to be a uniquely postmodern manifestation. And yet, each spirit doctor, as I explained, had an established area of expertise. These examples highlight the combination of healing ideologies in crystal and spiritual healing at the VEHC.

These illustrative examples addressed in this chapter point to another more interesting explanation: that these practices are evidence of the ways in which those involved in healing combine cultural discourses and ideology - between materiality and spirit; science and spiritualism; biomedicine and alternative medicine. This combination of healing ideology makes it seem more 'holistic', and such eclecticism may additionally explain its wide appeal to growing numbers of patients.

In chapter two I argued that the use and practice of spiritual-based CAM reflects a profound socio-cultural shift, conceptualised by social theorists as the move from modernity to postmodernity. Moreover, I argued (with reference to Thompson 1992 and Saks 1998) that postmodernity is perceived as being characterised by the need to combine multiple and sometimes (seemingly) conflicting cultural codes and discourses. New forms of social identity offer outlets to express these crossovers of codes and discourses. Therefore, new social groups seek to *combine* the institutional features of modernity alongside others such as spirituality, a form of reality which healers are attempting to solidify or 'ground', whether this is in relation to healing performances or metaphors that seek attachment to spiritual bodies.

¹ For a description of 'syncretic practices' in relation to charismatic healing in Russia, see Lindquist (2001).

² Ash and Hewitt (1990) is one such text that presents a spiritualised version of physics.

³ Additional reference and discussion of the use of the word and concept 'aura' can be found in English-Lueck (1990); McGuire (1988) and Skultans (1974).

⁴ 'Maitreya', sometimes called the 'world teacher', is an amalgam of significant and highly spiritual religious figures. Hence, the incredulity of that comparison despite claims regarding my 'past life' (see chapter three).

⁵ More commonly referred to in social anthropological literature as 'trance healing' or 'shamanism'.

⁶ McGuire's category of 'psychic healers' is very similar to the kinds of healers I encountered; indeed, she identifies psychic healing with broader forms of spiritualism.

Concepts of health and illness: contested healer views at the VEHC

Introduction

In the previous chapter I argued that focusing on the body is an imperative, as body concepts are linked to explanatory models about health and illness. Moreover, I stated that the perceived existence of the spiritual body enables healers to make individual assertions and interpretations about health, healing and illness. Therefore, in the midst of this uncertainty and ‘fuzziness’ amongst healers as to the nature of the spiritual, lie contested ideas about the nature of health and the healing process.

Healers, medical practitioners and ordinary people all establish and build upon concepts regarding what is health, and what causes people to become ill. Three key questions underpin this chapter. First, what is perceived as health for the healer, and is this a contested value amongst healers? Second, how do healers explain the process of healing? Third, how do healers engage with generally incomprehensible and highly subjective interpretive images, such as meditation imagery, and what role does individuation play in interpreting these images? Such questions bring to light the role of the individual and creative interpretation of practices within healing groups.

This chapter begins by contrasting scientific and ‘narrative’ forms of knowledge, and the changing nature of knowledge in postmodern society. I draw on the work of the postmodern theorist Jean-Francois Lyotard (1984), in exploring how his contrast between scientific and narrative knowledge can illuminate knowledge issues in the healing centre. Further healing issues are discussed such as the meanings behind crystal

usage and the function of the meditation and post-healing discussion. I conclude with a summary of the issues raised in the chapter.

‘Scientific’ and ‘narrative’ knowledge: systematisation and individuation

In *The Postmodern Condition* (1984) Lyotard addresses a number of issues in relation to knowledge, such as the legitimacy of knowledge, and its changing condition in a postmodern and post-industrial era. First, Lyotard clearly states that the nature of knowledge as it enters the post-industrial stage cannot remain unchanged. He points to the transformation of knowledge, a situation that has been underway since the end of the 1950s.

Secondly, he posits a distinction between ‘scientific’ (*savoir*) and ‘narrative’ (*connaissance*) knowledge. For Lyotard, knowledge refers to the knowledge system brought about by modernity and by recent technological advancements. In this context scientific knowledge relies on meta-narratives for its existence and legitimacy, narratives that exist outside of its own sphere of competence. For Lyotard then, science is a discourse of legitimation. Furthermore, as Lyotard states, “scientific knowledge does not represent the totality of knowledge; it has always existed in addition to, and in competition and conflict with, another kind of knowledge, which I will call narrative for the interests of simplicity” (ibid:7).

Thirdly, Lyotard states: “Knowledge is not the same as science” (ibid:18), so it is a contested value. Scientific knowledge has largely imposed the rules in Western society, and this can be witnessed in the place biomedicine holds in the field of health. Also, Lyotard argues that modernity denied narratives through the use of science, a form of

knowledge that requires 'external' forms of legitimation (see chapter one for the distinction I make between 'internal' and 'external' legitimacy). By external forms of legitimation Lyotard is referring to 'metadiscourses': the totalising stories of science, the idea of science as the liberator of humanity. Examples of this legitimacy include sciences' use of quantifiable measures such as verification and falsification.

Finally, Lyotard points to the contradictory nature of scientific knowledge. He states that scientific knowledge itself invariably resorts to narrative knowledge as it aids its legitimacy. This can be seen in the fact that the users of scientific knowledge are aware of the 'appropriate' socially-determined contexts in which to give voice to scientific knowledge. Also, science relies on the story format in order to explain its superiority over narrative discourses (see for example, Haraway 1991).

Scientific knowledge

As a scientific discourse biomedicine is a key model of systematised knowledge. First, despite its competing branches of knowledge, biomedicine or "biological technoscience" as Bauman has called it (1995:173), is founded on intense training. This type of training provides the medic with both a legal and moral right to distinguish herself as an 'expert' and an arbiter in public decisions regarding questions of health, illness and the body.

As I have explained in relation to Lyotard, science is medicine's principle claim to legitimate expert knowledge status. For example, Varcoe and Yearley (1990) explore dimensions of this in their edited volume on the influence of both science and technology as tools of legitimacy (see also Wynne 1982). In this way, biomedicine delegitimises the need for personal meaning in illness. In so doing, it sanctions the notion that illness is the same for all people and for all time. In that process of rationalisation,

biomedicine demotes subjectivism - the individual's perception and experience of their state of health.

Secondly, biomedicine centres firmly on the physical and objective causes of disease. Furthermore, its *raison d'être* lies in defending the nature of physicality and the material in their myriad forms. Biomedicine, as systematised knowledge, builds upon complex explanatory models that emphasise the objective principles of the effects of disease on the physical body. Disease is seen as a pathological condition, indicated by a range of signs and symptoms. In this sense health "is the absence of disease or death" (Stacey 1988:169).

Thirdly, an early standpoint in the sociology and anthropology of health and illness stated that biomedicine is based upon the concept of disease, whereas lay knowledge rests on the experience of illness (see Frankenberg 1980; Kleinman 1978; Kleinman 1988). Frankenberg highlights this particular distinction by contrasting interest in disease, "a biological or pathological state of the organism" (1995:199), with illness, "the patient's consciousness that there is something wrong" (ibid:199). Others have summed up the differences thus: medicine makes claims to expertise and authoritative knowledge; lay persons rely on and have more trust in their own observations and experience (O'Connor 2000:53).

Narrative knowledge

Lyotard explained that narrative knowledge is largely 'story-like', and so the set of 'knowledge' that it produces is not based on facts, but instead is the product of social relations. In addition, Lyotard perceives narrative knowledge as initially 'pre-modern'. However, he argues that it reasserts itself in a postmodern era in which science is experiencing crises of legitimacy. In our postmodern era then, Lyotard states that we can

note the break up of 'meta' or 'grand narratives' such as biomedicine. In its place new forms of knowledge are asserted into the public domain.

Knowledge that draws upon issues and ideas that are personally meaningful and given resonance through narrative form (that they provide stories), constitute individuated knowledge. In this way narrative knowledge gives meaning to story-telling as being a crucial part of the transmission of knowledge. 'Narrative-based' knowledge is the primary knowledge transmission in spiritual healing modalities and it is prized at the Centre, a place where healing concepts and practices are supported by recourse to personally meaningful stories. However, I differ to Lyotard's conclusions in that, although he recognises that science can be influenced by narrative, he does not explicitly recognise the process as two-way, that science can equally play a more central role in governing what is truth and knowledge in 'narrative' forms. In the following sections I explore the ways in which story-telling and individual narratives are crucial to the emergence and formation of healing concepts at the *Vital Energy Healing Centre*.

The individuation of health and illness

The lay person, with her necessarily subjective and emotional response to illness, may experience a degree of alienation from the technical and rational form of knowledge that biomedicine generates. Individuals attach meaning to an illness or disease, so that they can make sense of it in terms of their life experience. As Stacey explains, "...each individual has to make sense of her/his health and sickness experience for her/himself" (1988:144). Disease and illness is experienced as a chaotic life event. The rational explanations contained within biomedicine do not ease feelings of personal confusion and the desire to place illness in the 'narrative' context of the person's own life story.

For example, this process can be identified in Becker's (1997) account of the way in which individuals deal with events (e.g. medical) that disrupt their sense of 'normal' life. Becker explores how individuals go about re-establishing an ordinary life through their narrative reflections on the illness.

What is health?

At the VEHC, Teresa's view of health incorporates two key ideas. Firstly, health is perceived as the absence of 'blockages' that occur in the chakras or the etheric body. Here, the theory has parallels with medicine as it is dealing with a concept of health as a 'negative' one – the absence of blockages is like the 'absence' of disease. Second, these blockages are perceived by Teresa as being caused by negativity, which originates either in the thoughts, emotions or actions of that individual, or in the actions directed towards them from a third party. Therefore, health is seen as a fluctuating state of the spiritual body that requires constant monitoring.

In addition, to an extent spiritual healers emphasise the notion of individual 'blame' for illness. For example, Teresa explained: "You see, a lot of our illnesses are caused by personal, private problems, it's those emotions that block our chakras and cloud our auras." Emphasising the emotions as being the cause of ill-health is highlighted in Warkentin's (2000) study of a hands-on healer in Canada, and also in McGuire's study, in which she states, "Like physical pollutants, these negative emotions were viewed as toxins to the body, introducing illness or making the body vulnerable to external sources of illness" (1988:105). Similarly, as I shall demonstrate, the spiritual body is perceived by healers as acting as a magnet for attracting negativity. If the blockage caused by such negativity is left unchecked then this soon translates to the physical body where it manifests as a disease.

‘Negative’ mental and emotional states: personal responsibility for health

On one occasion Jenny outlined her approach to health and illness, and she revealed that disease arises, firstly, in the spiritual body: “Disease manifests in the etheric body first, before the physical body. If you treat it at the etheric level, then you are treating it early.” Here, Jenny is stating that disease is a spiritual process foremost, later it manifests as a physical disease. Primacy is thereby accorded to transformations on the non-material level, a central tenet of other healing groups including Christian Science (Jaye 2003:18). In addition, Jenny’s emphasis on treating the etheric level first seems to mimic the medical notion of ‘preventive’ medicine. She continued:

People enter this life knowing that they are going to have a certain disease, but the healing is not curing. Healing does not mean curing, it is helping the person to understand the illness. You cannot cure some diseases, I just try to get the person to understand why they have it, and to treat the illness and the person. The illness is part of the person. This I don’t say to a patient. I don’t say you have a disease like cancer, and it’s all your fault. They wouldn’t know what to do.

This statement raises a number of interconnecting issues. The onset of disease is closely associated with ideas regarding the individual emotions and subjectivity - disease is the physical/material manifestation of internalised trauma. Illness is considered to be a part of the person - that is, the individual has personal ownership of that illness. For example, Coward (1989) explains that these ideas regarding personal blame for illness are central to many alternative therapies.

On another occasion at the Centre I was talking to Stella about a patient she treated for eczema. She went on to explain:

...he had visited me a number of times over the past three years and every time the same problem occurs. He has quite a bad skin complaint - eczema - and he has said that he has spent thousands of pounds on different drugs and therapies and nothing has helped him and I know that's because he blames it on everyone else except himself, and now he wants the eczema, I think. It isn't going to go away because he seems to want it.

Perhaps unhelpfully, Charlie joined in the conversation, adding to Stella's remark:

"Yeah, you see, he wants the eczema now, it probably keeps him company. He doesn't seem to want to help himself or anything like that."

"I know," said Stella "but I so badly wanted to give him a proper healing but he just gets very uptight, saying he finds the healing relaxing and that's it. He won't help himself."

"Yeah, I'll give him a good healing, he needs a good slapping, that's all!" exclaimed Charlie, seemingly both amused and bemused.

Therefore, to 'want' or to 'choose' the illness is to claim it as one's own. That someone does not want to help themselves means that they are forced to live with it. For example, the individual says it is not asthma that I have in the objective, de-personalised sense of the term; it is *my asthma* and I have a certain personal control over its direction and meaning. This form of personalisation is a key example of the individuating process, in that people link illness to individual biography. This is also a good example of the way in which a personally meaningful story or narrative may be emphasised so as to make sense of an illness condition. This form of knowledge is fundamentally different to scientific knowledge. Whereas science eschews the individual from the meaning of illness, through a process of de-personalisation (see chapter one and two), healing brings it into sharper focus.

In addressing the issue of 'blame', McGuire explains that people are said to be responsible for bringing on the disease through 'negative' mental thoughts (1988:142-144). This relates to the idea that attitude of mind is important in determining the lay response to ill health, an idea that is seen as widespread (Pollock 1993). For example, in a case study exploring perceptions of health in Nottingham, Pollock argues that, "mental attitude was thought to influence both susceptibility to illness and its outcome" (ibid:50). This was certainly the case with people discussing general and mental health, rather than serious illness which "were beyond the reach of personal control or prevention" (ibid:67), and for which people tended to be more fatalistic.

In spiritual healing the focus is on serious illness as well, as we see in Jenny's earlier point about cancer. The idea of being responsible for health, an issue I addressed in chapter two, is not a new one, but it has certainly received new vigour in CAM and other health practices such as fitness (Goldstein 2000). Goldstein explains that some health-related statements by therapists or fitness trainers may be moderated, rarely would the trainer say that an individual's behaviour needs to be modified in order for them to be healthier. Other statements, however, may be more extreme, and Goldstein notes this position with 'New Age' practices that also stress the importance of people's mental states in causing illness. For example, Stella's earlier remark implied that the eczema sufferer did not have the right mental state to cope with their condition.

Furthermore, Brown (1997:66) also explores this relationship between illness and personal volition. He explains that the notion of individual responsibility for health/illness has less to do with 'victim blaming' (the conventional sociological interpretation – see Baer *et al* 1998b) and more to do with letting individuals wrestle control from the meaning of illness. As the person retains ownership over the illness, the illness becomes increasingly connected to subjective ideas about illness as the place of

personal identity. To get to the root of someone's illness the healer must try to understand the emotive and subjective experiences that the individual is going through.

In addition to the individual bringing illness upon him/herself, there is the possibility that the everyday feeling of being miserable or 'under the weather' can be a result of one absorbing other people's negative energies. Disease can be considered to be migratory in that it spreads through negative thoughts and feelings of inadequacy. As Stella explained (see chapter four), the healer should use protection methods so as to protect him/herself from externalised negative thoughts.

These 'narrative-based' explanations for health and illness bring to light Young's (1976) contrast between externalising and internalising medical belief systems. In examining the Amhara in Ethiopia, Young explains that explanations for sickness must be meaningful to people. Whereas internalising explanations tend to focus on the body, externalising explanations focus on the social events surrounding sickness. At the VEHC the model is slightly different. Similar to the biomedical or 'physiological' model, the focus for the healers is on the body, but their theories draw attention to the individual via the immaterial/spiritual body. However, a threat from external sources is also identified, which is the 'negativity' I have spoken of. In short, there is a fundamental difference between illnesses that are a result of a lack of protection from internalising others' illnesses (negativity), and those that are a result of you not coming to terms with and looking into the bases of your own illness (negative mental states). Whilst one outcome is an unfortunate result of internalising the external, the other is a regrettable consequence of not externalising the internal.

‘Good vibrations’: the nature of crystal and spiritual healing

How do healers explain the healing process? Teresa explained that although crystal healing was a relatively new addition to the burgeoning field of CAM, its usage represents a continuing trend with what is termed ‘energy medicine’. Here Teresa is drawing a distinction between ‘fringe’ and mainstream therapies. Nevertheless, ‘energy’ is often interpreted as a ‘shared’ concept amongst CAM therapists (Coward 1989; Frohock 1992; McGuire 1988; O’Connor 2000), although it is associated more with ‘New Age’ practices (English-Lueck 1990; Synnott 1992).

‘Vibrational healing’ refers to that which is beyond the material. The terminology suggests that the process is quite physical; the term ‘vibrational’ denotes physical changes. However, in healing the term refers to spiritual-level changes, although I stress that there is some overlap, as healing that takes place at the spiritual level impacts on the physical body at a later stage. In this respect there are some similarities between the concept of vibration in healing and that of ‘pulsation’ which is more commonly used in Buddhist and Hindu thought (Singh 1992). In addition, Teresa emphasised that vibration is a kind of ‘resonance’ which can operate on different levels. She explained that resonance can occur at the emotional level, or perhaps at the mental level, in terms of the thoughts that are directed towards someone.

*you can't
heal
a term!*

The senses in vibrational healing

On one occasion Teresa explained the concept of ‘resonance’ to the healing trainees in the sanctuary. She used the example of sound in order to explain vibration. Teresa had come into the room laden with an assortment of brass coloured bowls and wooden pestles. She explained that the bowls were a composite of seven metals - lead, mercury, copper, nickel, silver, gold and brass. Each was individually made and had different

markings. In addition, she showed us a chime type instrument that she struck with a crystal to give us some idea of the different sounds.

As Teresa chimed the instrument she asked the healing trainees to 'feel' where the sound resonated on the body. Adele and Helen closed their eyes to feel the sounds more clearly. Teresa then explained how the chiming bowls and other calming sounds can change the 'atmosphere' of a room, as sound alters the vibrations of an environment. She explained that sound can also alter the vibration of an individual, and it is used to bring 'clarity' to the chakras. As such, the bowls should be used before healing or personal meditation. As Teresa explained:

The sound can be used to balance and cleanse the chakras. You should hold them (the bowls) under the base with the palm of your hand, and press the wooden stick against the rim, moving it at a constant speed around the bowl. With the chime I also use crystals to tap the keys to make a sound, as I think that with the crystals you get a clearer sound.

On another occasion, Teresa asked us to explore the sense of smell, again, using the 'resonance' technique. Taking each of us in turn, she demonstrated the effect of channelling an 'essential oil' (aromatherapy oil) through the hands and asked us how we experienced the vibration of the oils. This was achieved by the healer rubbing the oil onto their hands and wafting the smell over the patient's aura. Teresa went on to explain that the vibration of a crystal, flower or oil can be channelled or resonate through anything because it doesn't matter what physical barriers exist. "With the energy of vibration you can get through anything, concrete, wood, glass, whatever" Teresa said.

Clearly, the senses play a key role in vibrational healing. Vibrational healing is perceived as operating at a level beyond the physical. Rendering physical barriers obsolete, vibrational healing operates on a different level - a subtle level of healing

energy. For a healer to ‘tune-in’ they must, it is claimed, raise the level of their senses, and become ‘sensitive’ to the healing process. In chapter six I identified the emphasis on the senses as a key feature of spiritual healing groups, and in this way their ubiquity is tied up with the spiritual domain. In particular, I have demonstrated the ways in which their emphasis on the senses is a counter to scientific knowledge and diagnosis.

In contrast to the biomedical model, healing can be viewed as a ‘feminised’ discourse of healing. Spiritual healing emphasises ideologically ‘feminised’ concepts - intuition, the senses, instinct, subjectivity, and so on. Here I reassert a point I made in chapter six in discussing the meaning of the senses, in which I stated that healers perceive the use of senses as a feminine characteristic. Synnott (1993) makes a similar point in his socio-historical analysis of the senses: “Some therapists see this as the emergence of the feminine in traditional patriarchal therapies: a shift from mind to body, thought to feeling, sight to touch” (ibid:129).

However, as I stated in chapter six, gender did not emerge as a contentious issue as the Centre, certainly not in the way that it has featured in, for example, feminist witchcraft practice (Greenwood 1995). The language of Teresa’s visualisation in the absent healing (chapter six) refers inclusively to the ‘Father-Mother’ and the ‘Brothers and Sisters of light’ – perhaps a less radical and contentious use of gender than that found in the ‘Goddess’ imagery of witchcraft healing practice (ibid).

The contested nature of healing ‘source’: the healer, the crystal, the ‘higher source’, and the spirit doctor

The VEHC is the focal point for competing ideas about the source of ‘healing energy’. Each healer has provided explanations, sometimes multiple, about where the healing

power comes from, and these ideas invariably make sense in terms of their individual biography. In this way, individuation, the process of imbuing personal relevance into meaning-making, plays an important part in determining the role of a particular healing source. Various sources of healing include the healer, the crystal, the notion of a 'higher' source, such as God, and the channelled spirits. The inclusion of multiple sources of healing has been noted in other writing on healing groups (see Benor 1984).

In addition, the discussion from healers surrounding the 'source' of healing inevitably focuses on a personal story or individual narrative that explains how and why the healer came to find their healing 'ability', or how the healer came to realise that the healing power comes from a 'higher source'. Again, as I explained in relation to Lyotard's (1984) theory, narrative knowledge places truth in the context of what are personally meaningful stories. Also, healers' views on the subject of the 'source' arise from their conversations with others; they do not necessarily emerge in isolation.

Healer ability

First of all, I was led to believe that healers would claim some right to heal, in that they were 'chosen' because they exhibited a special talent. It is true that some healers do make these claims, and I would argue that the biography of the healer is central in this respect. In other words, the 'story' that led the healer to the Centre is important because it legitimates their claim to healing, an idea that I addressed in chapter three. For example, I explained that Charlie's interest in healing came about through his belief that his hands were often hot for a reason that went beyond the physical. One of the reasons why healers are uncertain about the nature of ability in healing is because they also wish to be able to provide explanations for the 'special talent' that certain individuals in history have had, such as Jesus or Sai Baba.

The crystal

In taking into account the importance of healer ability, I asked Teresa how the crystal is supposed to heal. For instance, does the crystal encapsulate healing energy, or is it just a technical instrument which obtains the energy from another source? Teresa replied:

You direct the energy into the crystal to focus the energy. The crystal can do it on its own, I have seen it. The energy that you put into the crystal comes from another source, higher energy, consciousness, God, Allah, or whatever you want to call it. It is there if you want to draw on it and use it...Don't forget, you are the instrument, and you should fine tune the instrument for what you are doing, whatever the purpose of the healing is.

In essence, this statement suggests that the crystal's energy is harnessed in some way. That is, the healer draws healing energy from another source, but the crystal also imbues the energy with healing properties that are perceived as unique to a crystal type. For example, in chapter four I referred to the way different crystals are seen as embodying particular healing qualities. Hence, each stone is useful for healing certain ailments. As Jenny explains, the crystal is used alongside more potent healing energy:

...the crystals are a catalyst for your own healing energies. The crystals can heal but their effects are greater combined with the energies of the healer. I feel very attached to the crystals, it is this which increases the healing power of the healer. You are then working with pure energy.

This statement implies that crystals heal regardless of being used by a healer - to merely have them on the person may actually prove beneficial to health. This implies that crystal healing can be practised without any knowledge of how it works and, by implication, that anyone can become a healer. Ability is not important, as the energy that

the healer uses is drawn from a seemingly limitless reservoir of healing energy. Such a statement corroborates with the other healers' claims. For instance, Jenny remarked, "I hold the crystal in my left hand and direct the healing energy through my right hand. I am just a channel for the energy."

A 'higher source'

Equally, Stella addressed the issue of how the crystal provides healing energy. She explained that healing energy comes from a 'higher source' and is something you ask for. She added that you can ask for the same help from the crystals, but ultimately the higher energies must be utilised to create an effective healing. In her study of healers in the US, McGuire (1988) offers a very similar quote from two healers who describe themselves as an instrument for 'channelling' energy:

One woman explained, "I am the vehicle – I am not a 'healer' – but I am a channel who pulls the energy from the universe and focuses it." Another said, "I'm merely an instrument of universal energy. There is energy all around us, and all I am doing is directing it" (McGuire 1988:116).

A similar 'New Age' type statement is made by Brown (1997), an anthropologist who explored the world of spirit 'chandlers' in the US. He defined 'channelling' as the process whereby 'channellers' perceive themselves to be engaged in contact with the spirit world, a theme I explored in chapter seven. As Teresa explained, healers emphasise that healing energy often comes from the 'source', which is characterised as a universal type of energy. Again, this idea is reiterated by some of the healers in McGuire's study. For example, one female healer states: "'The source is essence, or 'prana', which is the yoga way of thinking which is spirit, all the same thing – life's

force. It's got a lot of different names, but it's something that is around us, in us and of us'" (1988:112). The 'source' is not seen as a personal God or part of individual consciousness, "Another person stated, 'The source is the source that runs through the universe. Some call it 'God'. Some people call it 'cosmic consciousness'. There's just an energy that connects all of life, that feeds and grows from life itself'" (ibid:150).

Channelled sources

Charlie too emphasised that he has no inner ability to heal. He said that he attracts the healing energy through a source, and that spirit doctors operate through him and act as intermediaries in order to bring healing energy. Charlie explained more fully:

I don't have any healing ability at all...we can't heal by ourselves; we have to ask our spirit guides which will help us. They provide the energies and they do the healing. When I'm healing, the spirit guides work on the body while I channel the energies through me, I don't try to interfere with them.

This opinion caused some dissension when he raised it with Emily, who opposes the idea that the spirit doctors act as an intermediary for the healing energy. In the following dialogue I note that Emily tried to get Charlie to be more responsible for the healing process. But the tension being played out raises other questions about the construction of consensus amongst healers. For example, Charlie explained:

"The guides are there to help channel the energy from the source, so that you don't get frazzled out, they act as an intermediary between you and the source."

"Yes" said Emily, "but sometimes you use healing energy direct from the source... "

Charlie shook his head in disagreement, “Well no, because you wouldn’t be able to handle it, that’s why the guides are there, to channel it for you.”

“I disagree Charlie,” Emily argued “because the energy you’d receive would always be such that it would not harm you, it would be able to be used through you so as to not cause you any harm.”

Charlie emphasises that the healing energies are harmful, which is a confusing message, as the energies are supposed to be helping. Again, when discussing the kind of healing energy which spiritual healers channel, he dismisses the idea that a healer can choose what healing energy they want.

The ‘source’: contested healer concept

In the following example, Charlie is talking about healing energy with Peter (the crane operator) and a female healer. The woman mentioned to Charlie that she knows a Reiki healer who argues that she uses ‘universal’ energy in her healing, whereas spiritual healers use ‘spiritual’ energy. She explained how the two forms of energy, ‘universal’ and ‘spiritual’, are not always seen as equal; indeed, her Reiki healer friends believe that theirs is a more powerful form of healing. Charlie laughed and added:

“Energy that you use in the healing is just energy from all things.”

“Well, God.” said Peter, looking concerned.

“Yes, there’s not a higher energy or whatever,” the woman added “maybe one is greater but I don’t think so.”

“It’s just the same energy and it comes from the same source.” said Charlie defiantly.

The concept of the healing source is contested amongst healers, which is a desirable and inevitable consequence of a healing Centre that sanctions and fosters individuated

approaches to health, illness and the body. It is also inevitable due to the fact that the healers cannot verify the 'truth' of other healers' 'inner-directed' thoughts and actions. As Rapport (2002) explains, in discussing the relationship between individual meaning and interpretation:

The meaning of other people to themselves, the meaning of their words to themselves, of their artefacts – these are all closed off because individuals can only and ever approach them via their own processes of interpretation, their own bodily engagement (2002:11).

Lyotard argues (1984) that in scientific knowledge any generally accepted statement can be challenged. This challenge to knowledge statements can be seen in healing but the challenge is not about a general statement of proof and validity. Healers do not resort to 'proof' in the way that scientists do. 'Proof' in healing is based on whether the healer, through the use of a personally meaningful narrative, can fully support their statements. That is, the 'personal' narrative is the story that led to the belief, and that validates the statements. In this respect, the argument between Charlie and Emily that we see being played out is irresolvable, but they pursue it in order to make clear their respective individual beliefs.

The contestation seems to be played out between the notion that the healer should be able to tap their own reservoir of healing energy and that the healer has little innate ability and, more importantly, little free will. The issue of free will is raised again when Emily discusses what she thinks I will be doing once my studies are finished. I explained that I hadn't made up my mind and added:

"It depends, I'm happy at the moment so I think that I'll wait and see what happens as these things tend to happen accidentally anyway."

Charlie shuffled awkwardly in his chair, looking quite animated, “What, are you going to be an ‘ealer then?”

“I don’t know. I’ll have to wait and see.” I explained.

“Oh, don’t worry, they’ve got plans for you mate.” said Charlie smiling.

“Yeah well, what you were saying about things just happening sometimes, it is true, I mean, you can’t always plan can you?” said Emily.

Charlie sat up, slightly agitated: “I disagree, I think it’s all planned, the lot.”

“Well no,” said Emily “because you can’t have everything planned out for you, otherwise you deny somebody else the meaning of their actions and their free will. Then you wouldn’t be able to choose your own path.”

At this point Stella surveyed the room and calmly suggested, “Yes, I think that’s true.”

“No,” Charlie retorted “I think you’re all wrong. Look at me, it was all planned, all mapped out for me that I came here, saw Stella, got into healing, so that I could get to the stage I’m at now.”

“Yes,” said Emily “well, I think that’s partially true Charlie, but some things have got to be accidental...”

“No, you’re all wrong.” continued Charlie, raising his voice as he sits back in his chair with his arms folded.

“Some things have got to be, otherwise you wouldn’t be able to choose a path or direction of your own free will. You (Emily looked over at Charlie) to a certain extent, chose to come here.” said Emily.

“No, I had to. I didn’t have any other choice, did I, other than end up in a nut house. It had to happen, they made it happen and it was given the appearance that I had a choice.” said Charlie now looking quite flustered.

Stella nodded and joined in again, “Yes, I think that I understand what Charlie is saying, but Emily has a point here, in that at certain times a path is being presented and you can choose to follow it. But with Charlie I think the path was really set out for him and in that sense he had no choice.”

On the one hand, Charlie wants to be viewed as someone singled-out for the task of healing. On the other, he does not want the responsibility of being in charge of the healing energy he transmits to his patients. But if the healer acts merely as an instrument for channelling ‘universal’ or ‘higher’ energy then surely anyone can be a healer. For the healer, only conflict and uncertainty is the inevitable consequence of such ideas, as they have no recourse to a form of scientific knowledge that allows for doubt. Thus, healers give precedence to individual knowledge.

Contested values: between autocratic and democratic forms of healing knowledge

Uncertainty about healer ‘ability’ comes about because of an innate distrust at being a holder of conventional expert knowledge. The idea of anyone becoming a healer is quite different to the systematised expert systems of knowledge where the belief is that someone has to be good enough to get through a period of training.

The democratising elements in spiritual healing imply that there is no hierarchy of healer ability. What we see here is a shift in forms of knowledge, between autocratic and democratic modes of knowledge and healing practice. As we can see, each healer still wants to be individual and imprint their sense of individuality and personal meaning on the healing, which is why their adherents still venerate the healers in history who they argue have had an unusual ability or are particularly charismatic (for example, Matthew Manning, Sai Baba).¹

Crystals (or rocks): at the material and spiritual interface

In this section I discuss the healing function of the crystal. Crystals heal at the spiritual level. It is argued that crystals amplify and direct healing energy, channelled by the

healer. Straddling these two domains, the material and the spiritual, the crystal also aids the healer in thinking about and making sense of complex issues to do with self identity and the relationship between nature and culture. Crystals (or rocks) are part of the earth, and yet are also complex 'agents of healing', ushering in a 'New Age'. As Hess pointed out, in occupying and 'bridging' the ground between the material and the spiritual, crystals are 'good to think with' and are "mirrors for the New Age self" (1993:46-48). Further, in drawing upon Levi-Strauss' (1963) work on 'totemism', Hess explains that the crystals are totemic in that they represent the healers' view of what constitutes a person.

Understanding the crystal as a tool for healing has been a consistent theme in each chapter. It is widely held amongst crystal healers that the crystal harnesses 'universal' energy, and acts a medium for its channelling into the patient. The crystal directs and amplifies this energy, as well as imbuing it with unique qualities, an issue I have explored in this chapter. Healers hold an ambiguous position regarding their own healing power, due to the plural and contested ideas at the VEHC about the nature of healing, and this is a reflection of wider issues of individuation. If healers believe that they influence the healing by their ability alone, then this leaves too much control in their hands and generates an over-bearing individual emphasis on the healing itself. The crystal stands as a metaphor for the healer's position.

Also, the crystal acts as a catalyst in helping healers make sense of their own self. For example, of all healers at the VEHC, Sally mostly emphasises the crystal's human like qualities, with regard to its potential agency. Sally explained that the crystal is aware of people, surroundings, and so on. In addition, she contends that the crystal can heal regardless of a healer being present and, even with a healer present, the crystal may act against their wishes. As Sally explained:

The crystals often do something different to what you wanted them to do. So you might be working on the physical level and they will be working on the emotional...the crystals will choose to do what they want to, often they will lose themselves and turn up where you had looked ten times previously.

On another occasion I asked Sally whether it matters that people have handled the crystals in the reception area, and will it affect them in the healing. She replied: “The crystals heal each other, so it doesn’t really matter if lots of people are touching them, even if they do put a lot of negative energies into them.” This is important as, it is commonly held, the crystals can be harmed by the amount of energy a patient needs. For example, Teresa said that you had to be careful when using rose quartz as it loses its colour after healing, particularly if the patient urgently needed its healing qualities. She recounted how she had seen rose quartz go white after being used. The quartz was just drained of its energy and consequently, its colour. “Stones will lose their colour if the person needs its energies very badly”, she explained.

In addition, crystal usage reflects the risks inherent in biomedicine. Despite the commonly held assertion of CAM therapists that their practices are natural and safe, healers at the VEHC seemed to engage with the idea that there is a risk component in crystal healing. For example, in chapter four I explained that risk can be identified in relation to ‘programming’ the crystal. In chapter six I argued that the laser crystal raises certain ‘risky’ situations in healing, such as leaving the body ‘open’ to contamination. Healers also enjoyed recalling ‘danger’ stories. As Sally explains:

You can receive too much crystal energy. There was a woman who before crystals became popular to use, meditated with a large amethyst cluster for three hours a day for

three months and she suffered a nervous breakdown. She had a complete nervous collapse, because she was trying to take in too much crystal energy.

On another occasion Teresa referred to risk, but only in relation to the pivotal role of the healer in harnessing the energies: “You should be careful of how much energy you put into the healing. Some of the early pioneers would over do it a little, they would just want to do the healing in one go, but you need to be more gentle than that, you don’t want to blast the patient.”

The use of crystals for the purposes of healing signifies something about the relationship between nature and culture. Crystals as ‘rocks’ are said to represent indigenous healing energies. For example, quartz is found widely in all parts of the world and the UK is no exception. Teresa stressed the importance in using crystals indigenous to your area. This was reflected in an occasion when Teresa handed round some ‘Blue John’ stone to do a group meditation with. As a stone indigenous to the Derbyshire area of the UK, Teresa felt that its use would intensify the meditation experience. After our meditation and group reflection Teresa added, “These are indigenous stones of course, they are hand gathered, and with this comes a purer experience in meditation.” As natural objects they are rooted in the healer’s idea about what constitutes a natural environment.

The process of individuation: healing and meditation analysis

A key domain in which individuation is a central process is that of the post-healing and post-meditation analysis. After a healing or meditation session the individual reflects on the impressions they received during the session, regardless of how bizarre they may seem. It is important to see how the healer and patient make sense of these impressions.

In his analysis of ‘dreamwork’ interpretations, Edgar (1994; 1995; 1997) draws together similar conclusions in that the personal and subjective nature of the images needs to be made more coherent to the group. Linking personal narratives to meditation interpretation was evident during a number of healings at the Centre. For example, after one particular healing I had with Stella, we discussed with Teresa how the healing went:

“I noticed something in your wrists, I got a feeling there.” said Stella tentatively.

“I’m okay there, I think”. I replied.

“Yes, and your feet as well.” added Stella.

“Ah yes, I have a sore foot”, I said.

“Both feet?” Stella asked.

“No, this one (I point to the left one), it’s bruised,” I explained.

Teresa interrupted, “Yes, how did that go? You went to see someone about that didn’t you?”

I elaborated. “Yes, he (the doctor) said it was just bruised, so he told me to get my soles sorted out and rest the foot for a while.”

“Do you suffer from foot pains?” asked Stella.

“I have wide fitting feet, that’s all.” I said.

“Are you Piscean?” Teresa enquired.

“No, I’m Aries.” I replied.

“Well,” said Stella “If he suffers from the feet, I would have suggested that as well”.

“Yes, Pisceans suffer from the feet.” added Teresa.

“He looks Piscean, doesn’t he?” said Stella.

Teresa agreed, “Yes, doesn’t he.”

“What about the head, what did you feel there?” asked Stella.

“It felt warm and very heavy.” I replied.

“Yes, that’s interesting, because there was a lot going on there as well.” confirmed Stella.

In considering why they see someone as a healer they draw diagnoses from knowledge of one's life. For example, in saying that there was a lot going on in my head, Stella's perception of me is obviously influenced by her knowledge that I am Stuart 'the university student and scholar'.

In addition, after a meditation even the most absurd images are discussed seriously. At one level, the analysis suggests some useful parallels between healing and psychotherapy, psychoanalysis and dream interpretation. For example, I have drawn some parallels between these interpretive practices and the 'dreamworkers', which Edgar argues is popular amongst those with 'New Age' pursuits (1994:105). In particular, Edgar explores the difficulty individuals have in presenting and making sense of individual and subjective experiences for the purpose of social group consumption. Yet, in doing so the dream image is transformed from inchoate private experience to one that gains wider personal and social meaning. At another level, this interpretive work reflects an obsession with locating and analysing bodily sensations, but in a way that imbues them with subjective meaning. For instance, after a healing I gave to Helen on one of the training course days, Helen tried to make sense of the sensations she received from my 'cold' energies:

"What about you Helen, what did you get?" Ken asked.

"I had an image of...I don't know why. It sounds strange, but of a camel in my mind, you know, the mouth of it is sort of soft, when suddenly I just had this feeling I had to spit at it...I don't know why," Helen explained.

"So Stuart was the camel?" Adele remarked, clearly amused.

"Well, no. I don't know why this was there. Also, I felt terribly cold in the healing and I kept on thinking, 'Oh, why are you making me cold with your energies', and each time he touched me with the crystal he was like injecting ice into my body. I hate being cold, I hate

it. I also had an image of an Arctic place I was in and I think this might have had something to do with it,” said Helen.

“Oh, you torturer you,” laughed Adele.

“Yes, sometimes it does bring up emotion,” Ken explained “or maybe it was in a past life, the feeling of being in this cold place.”

“Well yes, that’s what I’m wondering,” Helen said, “I shall have to watch out for it.” Helen looked over to me. “Has anybody else said anything about you having cold energies?”

I shook my head slowly. “Not really...well, a couple of times it’s been noticed.”

In these interpretations the healers stressed that the meditation crystals can bring up a range of different impressions, and each person meditating on them will pick up different and sometimes quite contradictory images. In many respects the narrative nature of this knowledge, and the fact that it is constructed in a group, helps to legitimate the diagnosis.

On one occasion Teresa had handed round a boracite crystal. We meditated on this as a group with each of us holding a piece in our hands while Teresa led the visualisation. Afterwards Teresa asked each of what kind of impression we had received. I admitted to receiving “nothing much” with this crystal. Helen said something about “cleansing...well it was obviously, wasn’t it?” Kate mentioned something about a “car wash.” Adele said that she received light and dark images and in particular images of the light of angels and water. She also said that it had affected her right side which had become very warm and her left side cold. “Peacocks”, Barbara said, “...and like Adele, it made my right side very warm.” Teresa was clearly very excited by the variety of responses and uncannily summed-up the paradoxical nature of meditation analysis with her statement, “The similarity is that everything is different.”

Conclusion: the primacy of narrative and biography in contested notions of health, healing and illness

In this, the final chapter, I have explored healers' varied and contested views of health, healing and illness. I have considered the ways in which the healers' views contrast with biomedical ones, which are primarily based on scientific and systematised knowledge. In spiritual healing, health and illness are seen as originating in the biographical circumstances of the sufferer, and are seen as reflecting or being the result of more personalised concerns. For example, I have shown how the person with eczema is seen as personally responsible for their situation, and that a story which is personally meaningful helps to legitimate the explanation. In this way, illness is woven more carefully into the biographical circumstances of the sufferer.

Taking Lyotard's (1984) idea, I have shown how healing is 'narrative' knowledge, but, as I have explained there are tensions in this type of knowledge because of the need for healers to act as experts in their field. Also, I have shown how 'narrative-based' knowledge is the primary form of knowledge transmission in spiritual healing modalities and it is supported by the Centre. I have explained that, while science eschews the individual from the meaning of illness, healing brings it to the fore, and I have offered examples of this in this chapter. For example, I explained that healers, in discussing the 'source' of healing energy, have recourse to 'stories' or personally meaningful narratives that validate their statements, and also help the healer to resolve the issue of whether they have the ability to heal. We saw this irresolvable tension in the discussion between Charlie and Emily. Here, Charlie explained that the 'spirit doctors'

provide the healing expertise and that he “has no ability”, while Emily pursues Charlie about the level of his responsibility for the healing.

Biomedicine has been described as embodying an ‘individual model’ of health – that is, by tweaking the independent disease entities in the physical body the person can be restored to health. This is in direct contrast to a social model of health that promotes understanding of social determinants and environmental approaches to health. Crystal and spiritual healing equally employ an individual approach to health – that is, by tweaking the ‘energy blockages’ in the spiritual body the person can be restored to health. Therefore, both biomedicine and spiritual healing employ the individual approach to health over the social one. In this way, there is a degree of interplay between contested forms of knowledge.

However, in explaining the nature of illness, healers also combine these respective healing ideologies. Indeed, the healers advocated multiple perspectives in explaining the nature of health and illness. We can identify this in the ideas healers propagate about the nature of healing, and in their concepts about where healing energy originates and who has the power to access it. This multiplicity is a consequence of a healing modality that is personalised, and one that does not value systematised, codified knowledge.

Thus, over time healers’ ideas may change and central tenets of crystal and spiritual healing orthodoxy may be modified through the meeting of multiple and individual perspectives. For example, in the dialogue between Charlie and Emily we see how central healing tenets are contested and that ‘scientific-type’ knowledge and proof is demoted in relation to the place of ‘narrative’, or what I have referred to as individuated knowledge, in which the construction and playing-out of healing ideas incorporates personally meaningful concerns.

¹ Matthew Manning is a well-known faith healer in Britain, and Sai Baba a ‘spiritual teacher’ from Puttaparthi in India.

Being individual, while being with others: postmodernity and alternative health practices in Northern England

In this thesis I have explored the local use and practice of crystal and spiritual healing and what these 'represent' in the context of a profound socio-cultural transformation, from modernity to postmodernity. In the Introduction I highlighted some of the key reasons for investigating this topic. First, I argued that crystal and spiritual healing practices, which are located on the extreme fringes of CAM, had been under-addressed in social science. Also, I noted that such marginalised therapies are particularly instructive in understanding the nature of the emergence of a varied field of CAM in the context of an ongoing biomedical hegemony. Secondly, I stated that there was a need for social science research to explore the usage and practice of these therapies in more local contexts: the context in which healing emerges and is practiced. In this, the conclusion, I revisit the aims of the research and highlight my key findings.

The individual and highly personalised nature of healing

A central theme in this thesis is that healing practice and ideas which emerge at the *Vital Energy Healing Centre* reflect individual concerns and, therefore healing practices themselves are often highly personalised. I have explained how this personal expression is sanctioned and actively encouraged by the unofficial institutional credo at the Centre, and therefore individuation functions as a kind of institutional 'ideology'. For example, individual expression is fully supported by the figure-head at the Centre – Teresa - such

as in her encouragement of healers using their own methods of protection (chapter four), and in the ‘guided imagery’ visualisations (chapter five).

In chapter three I explored the different approaches to healing adopted by Teresa, Charlie, Stella and Sally, and I explained that healers’ activities at the Centre reflect concerns that are biographically meaningful. In chapter four I highlighted the personalised nature of healing by focusing on key healing concepts and practices in preparatory ritualisation, such as the use of intuition, healing protection methods, and ‘visualisation’ techniques.

In chapter five I described Charlie’s hands-on healing and the use of spirit doctors, and I contrasted this with Stella’s hands-on approach to healing. I also described and reflected on Teresa’s ‘healing sleep’ method and her ‘resonance’ technique. In summation, I explained that the individual and personalised aspect of the healing generated the power, legitimacy and efficacy in the act.

In chapter six I focused on the ways in which individual creativity or innovation is legitimised through healing practices and concepts such as the use of intuitive knowledge and the ‘senses’ in healing diagnosis. In chapter seven I explored how the body was a site of reference for discussing individual concerns, and in chapter eight I explored the personalisation of health and illness, in which personally meaningful knowledge is given resonance through narrative form.

The collective ethos of individuality

On a more abstract and theoretical level, I explored in chapter two what this individual expression signifies in terms of the contemporary ‘resurgence’ of spiritual healing and the ongoing transformations to modernity. I explained that such individuation is a key feature of postmodernity, where we can see the privileging of the subjectification and personalisation of forms of social life.

At this stage, therefore, it is perhaps worth returning to the debates raised in chapter two and, in particular, the place of the individual in postmodern society. There have been a series of perspectives and theories written about individuality, individualism and about the rise of the individual in contrasting socio-cultural arrangements - modernity and postmodernity. Furthermore, these debates have focused on the changing relationship between the individual and the community or wider social group in 'modern' societies. I argue, therefore, that the key thematic concern of this thesis, regarding the tension between individual expression and the formalisation of group practice, is indicative of our times.

Theoretical debates surrounding the ubiquity of the individual in modern society have varied considerably. If we consider writers such as Sharma (1992), we can see that the person's potential for individuality is closely related to what they can consume – consumerism is perceived as the overriding ideology in this social arrangement. For Sharma, the rise of the individual is in some ways synonymous with the rise of consumer society. In such ways, by 'shopping around' (see chapter one and two) the person comes to be defined as an individual exercising choice.

On the other extreme, in *The Lonely Crowd* David Riesman (1961), writing about the issue of individuality and conformity in post-war US society, argues that certain personality types arise and change as specific socio-economic conditions themselves alter. Primarily, he points to the increasing decline in two personality types in modern industrialised societies. For example, he states how 'tradition-directed' individuals are the remnant of another period of society, which is mostly rule-bound, a concept not dissimilar to Giddens' (1994) 'traditional' society. In addition, Riesman also notes the decline of the 'inner-directed' individuals, those who live their lives by defined morals and codes which arose in early life: "*the source of direction for the individual is "inner" in the sense that it is implanted early in life by the elders and directed towards*

generalised but nonetheless inescapably destined goals” (Riesman 1961:15). For Riesman, the inner-directed person is confident and, on the whole, rarely needs the approval of others. This individual rarely changes their ideas about their identity throughout the life-course.

In modern societies, and specifically middle-class America, Riesman stated that we can observe the rise of ‘other-directed’ individuals. This person needs to have others around them to define who they are and for the person to feel happy. Their actions and their sense of self are therefore bound by the approval of others. Riesman stated that the ‘other-directed’ person does not want to control these other people (the group) but to ‘relate’ to them. More generally, due to the increased “flow of mass communication” (ibid:21), individuals experience greater ‘relations’ with the outside world, and so in the process of making sense of this, the other-directed individual habitually personalises or atomises these external events.

So, for Riesman, the sense of conformity to group action, or collectivity, is achieved through a sophisticated understanding of the actions and wishes of others. That is, we increasingly develop a fluid and flexible sense of identity as we move between diverse social groupings. Riesman argues that by being in social groups, the ‘other-directed’ individual seeks what he terms “antagonistic co-operation” (ibid:81), which means essentially that the relations between other people in the group becomes just as important, if not more important, than the ‘goal’ of the group itself.

Other theorists have focused less on the atomistic aspects of individuality and more on the processes of individualisation in modern society (see Beck 1992; Beck *et al* 1994; Giddens 1990). For instance, Beck (1994) argues that individualisation refers to the way that people “produce, stage and cobble together their biographies themselves” (ibid:13). The process of individualisation, therefore, represents a change from more traditional societies where there was little social mobility. This process is not perceived

as accidental or even voluntary, but as an inevitable response to changes in modernity. For Beck, individualisation means the seeking out of new forms of interdependence and belonging and, it is not therefore, a free decision on behalf of the individual. People are thus condemned to individualisation. In many respects, Beck's idea about being condemned to individualisation has much in common with Bauman, who said that belonging in a social group, however antagonistic or fleeting, leads to "the unloading of the burden of individuality" (1995:47).

However, despite their different underpinning theoretical assumptions, each of these theories point to the inexorable rise of the individual in 'modernity'. Taking into account the individual points above, I argue that in my study the healers' privileging of individuation and personalisation has much in common with Riesman's (1961) other-directed individual. What emerges from my study therefore, is the idea that the Centre fosters an ethos of the individual, but it is a collective ethos. In this respect, individuality is always collectively sanctioned.

Individuation: individuality as a construction of the relation between individuals

While highlighting the individual and personalised nature of healing, in chapter two I explained that individuation is the construction of the 'relation' between individuals, emphasising that through the engagement with other healers and the sociality of this exchange (both 'antagonistic' and 'cooperative'), healers are able to express their individuality and the concerns that are meaningful to them. Thus, the Centre caters for two essential needs. It allows for individuals to be different from other healers and for their healing to be unique to them, but it also allows for the individual to be protectively submerged in a 'group' which sanctions and legitimates this individuation, a philosophy which, I suggest, has parallels with Riesman's (1961) theory.

Healing at the VEHC can be creative in that the healers often seek to transform existing healing practices. Also, being creative is the VEHC's *modus operandi*, in that the institution supports and legitimates this creative action. In addition, it is creative action that has local resonance, in that their innovatory or improvisational performative action makes sense primarily in relation to others' acts and ideas. Healing is therefore creative in parts, but the creativity does not make sense in isolation. The Centre provides the legitimacy for this innovation and the promotion of individuality provides its means, but I demonstrated that healers differ in how they utilise its power.

Individuation Vs. orthodoxy

Thus, despite exploring how healers develop personalised styles, this thesis has also pointed to the ways in which they also generate a degree of orthodoxy and consensus. That is to say, from individuated practice, sedimentation of collective practice emerges. We can see how the healing centre necessitates a structural demand to formalise healing practices, and this occurs in varying ways at the Centre. I examined how this kind of consensus between healers or orthodoxy of healing practice arises through different processes. For example, in chapter four I explored how healers are instructed by Teresa to limit the ambiguous and subjective nature of healing objects and personal symbols. Furthermore, in describing the visualisation symbols used by healers in the protection methods, I stated that we can see how orthodoxy is established through the common nature of the symbols in both medicine and healing.

In chapter five I stated that this orthodoxy arises because, despite the personalised nature of the practices, healers are necessarily bound by the approval of others. Individual expression is not necessarily limitless, and its appropriateness is contingent upon the healers' relationship with others who act as judges over the act. For example, in Charlie's healing I explored the ways in which his practices came to be accepted over

time and through the process of peer observation, such as when Ruth chooses not to question Charlie over a 'problematic' performative aspect of his healing (chapter six).

However, it is also creative in that each individual performance must involve a certain amount of 'flair', an issue I reflected on in chapter six. Healers, then, must show that they are good at 'being' a healer, and that this performance will largely determine the efficacious quality of the healing. Also, I stated that this 'playfulness' is representative of the documented socio-cultural transformation from modernity to postmodernity and is a legitimate response to hegemonic forms of medicine and healing.

Orthodoxy can also arise through more general trial and error, which is one of the learning processes in healing. For example, in chapter five I pointed to the ways in which trainee healers agree upon largely subjective interpretive processes. Also, in chapter six and chapter eight I pointed to the shared nature of symbols and visualisation in group meditation, which aids this process of institutionalising practice.

Marginality: coping with and expressing marginal and stigmatised identities.

Insofar as crystal and spiritual healing can be described as marginal forms of CAM, I explained that it is also true that these practices have a propensity to attract individuals who may be experiencing crises, and may therefore be considered to be marginal (or stigmatised) in wider society. For example, I explained that we can identify such a theme in Charlie's body project – his combination of bodybuilding and spiritual healing. Charlie had been dependent on steroids for his bodybuilding, and therefore in some ways lays claim to the 'wounded healer' status. As someone who has come from a position of socially situated vulnerability he found the ability to heal. In the healing role

Charlie generates power, respect and status. I also argued in chapter three that we can see this marginality and vulnerability in Sally's sensitivity and poor health, which is reflected in her 'adoption' and anthropomorphizing of crystals.

In addition, in chapter three I explained that other marginal groups or 'cults' tend to work towards the eschewal of individuality. It is significant then, that in spite of being marginal, healing at the VEHC fosters the expression of individuality.

Dissatisfaction with biomedicine: responses to biomedical hegemony

Evidently, the usage and practice of CAM often reflects levels of dissatisfaction with biomedicine, and perhaps no more so than in the case of marginal healing practices. In this thesis I have demonstrated that healers at the VEHC raised a number of concerns about the intrusive nature of biomedicine, and discussed biomedicine as a problematic medical practice. Also, I have explored the ways in which the current ubiquity and variety of alternative health practices in the Western world is both a key contributor and a response to the ongoing biomedical hegemony.

The doctor/healer relationship

In chapter one I argued that the relationship between the patient and the practitioner can be instrumental in determining the level of criticism. Increasingly, patients want to share information and knowledge with their healer/doctor, and so therapies that have this separation of expertise as a central philosophy may be more appealing. I pointed to the declining authority of doctors – experts of 'the body'; though not individual bodies. In addition, in chapter three I demonstrated how the healers' involvement in the Centre was partly due to their experiences of doctors of biomedicine. For example, both Stella and Sally felt that they had been wrongly treated by doctors and that their initial

involvement in the VEHC was a reaction to this treatment. Both Stella and Sally had been seeking help for chronic conditions – those illnesses for which biomedical treatment is less than satisfactory.

Expert (systematised) Vs. lay (individual) concepts of health, illness and the body

In this thesis I have argued that an integral part of the socio-cultural transformation, from modernity to postmodernity, is the rise of lay knowledge and the equal problematisation of expert knowledge. For example, in chapter one I stated that CAM demonstrates a certain sensitivity to lay concepts, and that this contributes in part to its wide appeal. I explored aspects of this appeal in chapter eight when examining healers' concepts of health and illness.

The healers at the Centre wanted to relate their health experiences to their personal situation. Biomedicine is considered to be a de-personalised form of knowledge, and it is this that has had the effect of alienating the patient from their illness. In such ways, biomedicine too eschews individuality in the person. In this respect, healing brings the personal back into the management of illness conditions. The extreme personalisation, I argued, was a counter to the perceived de-personalisation in biomedicine. These are issues I explored in chapters one and two.

In addition, consider, for example, the over reliance on the expert basis of biomedical knowledge. I showed in chapters one and two how this knowledge was also perceived as de-personalised, as the expert knowledge of the doctor took precedence in the diagnosis and treatment of the illness condition. As such, modernity de-legitimises the use of individual narratives; this knowledge contrasts heavily with the subjective knowledge held by the patient. These concerns have set the tone for the critique from alternative medicine, and also contributed to the increasing disillusionment on the part of ordinary people. In a postmodern context the relationship between expert and lay

knowledge has been blurred, and this points to the way a greater range of knowledge(s) exist.

The boundaries between medicine and healing: materiality and spirituality

In chapter one I argued that crystal and spiritual healing ideas and practices are radically alternative to biomedicine's ideas and practices. In this way, alternative health practices generate a particular relation to orthodox medicine. This can be both intentional and unintentional, yet the important issue to note is that this raises questions about the boundaries between alternative and orthodox medicine.

Despite being critical of biomedicine, healing practices draw upon biomedical-type practices and ideas, actions which can be interpreted in different ways. Certainly, this appropriation can be seen as interesting from the point-of-view of understanding the nature of the boundary between healing and biomedicine. In this way, the thesis has pointed to the ways in which even esoteric therapies are influenced by the hegemonic discourse of biomedicine, and the utilisation of medical imagery in certain healing acts suggests that there are limits to individual creativity.

Modernity, in the guise of biomedicine, has undoubtedly influenced the development of CAM. For example, I showed in chapter three that these forms of professionalisation can be witnessed in Teresa's activities in the regulation of training standards of a healing organisation. Also, in chapter one I explained that the process of professionalisation can de-radicalise therapies, such as in the name changes which some therapies have effected over time ('mesmerism' to 'hypnosis'). Some of Teresa's activities at the Centre can be described as attempts towards professionalisation, and a few of the other healers, Charlie in particular, have raised their concern about the

appropriateness of these activities. Therefore, Teresa acceded to forms of systematisation in response to the needs of her business, and not necessarily because she agreed with it. We can see this in her regulatory work for the CCHI (Confederation of Crystal Healing Institutions). Nevertheless, as I demonstrate below, the continuing influence of biomedicine can be seen in less obvious ways.

The 'metaphorisation' of biomedicine

This appropriation of science and biomedicine can be witnessed in the healers' use of mimicry of medical practices and ideas. These ideas and practices constitute the multiple discourses I spoke of in chapter two. Thus, healing ideology and practice represents the 'combinations' and 'crossovers' representative of postmodern knowledge positions. I also spoke about how in the case of Charlie's healing these metaphorical linkages between healing and surgery spill over into parody, rather than just mimicry, and can be seen as a creative and empowering response to biomedical hegemony.

Through this 'metaphorisation' of biomedicine, healers can attain greater control over - and individual power for - their own material and spiritual bodies. Alternatively, I also argued that it could be perceived as reflecting and mirroring biomedicine's hegemonic position in health care. In this way creativity is incorporated into the 'metaphorisation' of biomedicine. For example, I explored dimensions of this in the 'risks' and dangers that healing is said to exhibit. That is, I have shown how healers draw upon the metaphorical relationship between acts/discourse in the domain of biomedicine (specifically surgery) and combine them with those in the domain of spiritual healing.

Postmodernity and knowledge

Most importantly, this thesis has not addressed exclusively the substantive issue of alternative medicine. Thus, I have explored the emergence of a varied field of CAM in the context of ongoing socio-cultural transformations, in particular the movement from modernity to postmodernity. Whatever its limitations, the term 'postmodernity' has drawn our attention to important social and cultural phenomena that is having a wide impact in Western societies. The features of postmodernity that I have been particularly interested in include, first, the 'subjectification' and 'personalisation' (individuation) of social life, and second, the uniquely postmodern features of a plural health care context.

I stated that a postmodern socio-cultural system encourages the use and privilege of different knowledge systems, which confer legitimacy to individual and personalised healing practices in various contexts. Individuation, where individuals increasingly have to personalise aspects of their life, is perhaps not a uniquely postmodern feature, but the increasing ethos of the individual exhibits new features in the postmodern context. In this way, I explained that healers are *bricoleurs*, in they individually construct healing ideologies and practices that make sense in relation their personal life situation, and these practices transcend local rules and barriers. In this respect the use and practice of spiritual healing has a significant relation to issues of identity rather than just consumption of alternative medicine.

Internal and external legitimacy

In chapter one I stated that some CAM therapists legitimate their practices through science and the processes of systematisation. For instance, I showed how some healers emphasise external legitimacy through appropriating modernist biomedical strategies. Sometimes this appropriation is used to establish credibility with significant others, and

at other times it is just indicative of a lay response. Alternatively, therapies can be legitimated through the individual response. 'Internal legitimacy' is normally emphasised through individuation in healing – e.g. healers utilise their own styles of healing, and health is related to individual biography.

There is also a 'narrative' quality to that form of legitimacy (Lyotard 1984). As such, in chapter eight I contextualised these healing practices as 'narrative'-based and, it is these practices and ideologies that form a substantial critique of the de-personalised knowledge found predominantly in biomedicine. Also, my point in chapter eight is that recourse to individual and personalised explanations is increasingly used as a legitimating function. Indeed, Lyotard saw that medicine increasingly resorts to legitimate itself in relation to 'stories' about science and not science itself.

To conclude: increasingly diverse health practices exist in a plural health context, although I explained that it is one that bears only a tentative resemblance to the health care pluralism found in the pre-Enlightenment period. The field of CAM is indeed heterogeneous, yet it is important not to over-emphasise the choices of the individual consumer in this schema. I have stated that individuals use and practice the extreme and esoteric therapies not because they are 'shopping around', but because the healing ideology at the Centre encourages, and is indicative of, this postmodern 'personalising' obsession, while recognising at the same time that such personalisation is more likely to occur as a response to the sociality that the *Vital Energy Healing Centre* fosters.

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