

The London School of Economics and Political Science

**Healing Ourselves: Ethical Subjectivity in the Stories of
Complementary Self-Help Users with Cancer**

By

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Declaration

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Abstract

This thesis explores conceptualisations of ethical subjectivity in the stories of people who have, or have had, cancer and who use complementary therapies and self-help (complementary self-health). In England the increasing emphasis on individual responsibility and choice in healthcare means that those with cancer are now in the position where they have to make many of their own decisions about their treatment. For the people with cancer in this research this included choosing complementary self-health.

The thesis explores the stories and experiences of people with cancer who used complementary self-health. The aim of the thesis is to document and make visible the many original ways people come to understand themselves as able to ‘heal’ their health, self and life. The thesis also reflects on the highly unusual position of the author, who was himself diagnosed with cancer mid-way through his fieldwork. The problems and challenges to the research are explored in the thesis, which became a story in itself.

The thesis finds the ‘price that is paid’ for the way that the interviewees came to think of their selves in their subjectivity. The interviewees told open and ongoing stories of ‘balanced living’ and how they found ways to listen to their ‘embodied guides’. They also described how understanding ‘cancer as an opportunity for change’ helped to transform and transcend their previous ways of living. In doing so they provided themselves with new narratives of the past and future, which were situated by ‘living in the now’. The thesis explores the ethico-political repercussions of these new formations of subjectivity. In doing so it argues that the ‘spiritual’ component of the stories remains unaccounted for and under conceptualised in contemporary sociological theory of health. It concludes with suggestions of how to move contemporary analysis beyond its present ethical concerns with the subject.

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Prologue

‘My Cancer’

“Stories we tell ourselves about what is happening to us are dangerous because they are powerful. Stories come to us from many sources; some we seek, many happen without our notice, others impose themselves on our lives. We have to choose carefully which stories to live with, which to use to answer the question of what is happening to us”.
(Frank [1991] 2002: 81)

A doctorate thesis, I was told at the start of my research, should aim to be ‘an original contribution to knowledge’. Well I hope that the reader finds that this is the case. But what the reader will certainly agree is that this research is unusual. When I started my research into people’s experiences of cancer I had a not unusual claim of a personal experience of the disease; during the 1990s I had watched my mother ‘battle’ and ‘survive’ cancer. Indeed, it was her experience that was brought to mind when I read Carlos Novas and Nikloas Rose’s (2000) paper on somatic individuality, which in turn started my initial ruminations that manifested into this research. That project, as PhD research projects do, morphed and changed. But in February 2009 I was faced with becoming my own research subject. My discovery of a lump, later confirmed as testicular cancer, substantially altered my position to my research in a way few ever get to experience. What are the chances? Well, of getting cancer, it is said to be around one in three in one’s lifetime. For it to be testicular cancer, a young man’s cancer, I believe it is the rather larger odds of one in 500. Whilst you are writing your PhD on patient’s experiences of cancer? Even longer still.

When I returned to my research, what became immediately apparent was the question of how I would account for this change in position within the research itself. With half the interviews conducted as a concerned ‘outsider’, I could not now re-write the voice of the thesis as though I had always been an ‘insider’. Furthermore, to do so would lose an interesting point of contrast for this research. I had a highly unusual opportunity to document in real time a patient’s experience of cancer, as a sociologist who already had a specific interest in the narratives of people who have, or have had, cancer and who use complementary medicines.

But the question remains as to how to account for ‘my account’? This question is one that is not just directed at making sure that I convey an ‘affective’ story of my

cancer, and not just the clinical facts, but to noting this unusual position. However, I was concerned not to let my story dominate those of the interviewees who had given their time to my research. Whilst I considered what to do, I re-read Arthur Frank's book *At the Will of the Body*. Those who know this book will see that it is an obvious choice for me; he too is a sociologist of health and illness who got testicular cancer. What followed in my reflections largely became a conversation with his story. But whilst Frank is right to note above that my narrative will be affected by all those stories and experiences I had become aware of during my research, it was important to not to let the *analysis* become purely an affirmation of my experiences, where the voices of those that I interviewed are indistinguishable from mine.

Therefore, with these two concerns in mind I first present to the reader my account of my cancer. This is put together via the thoughts and reflections that I had as I progressed through the various stages or "Acts", as I referred to them in one email. I recorded what was happening in a journal, but also in emails to friends and family. My account below draws heavily from these emails as much of the sense making happened in the writing of them. The writing of emails to people very close to me became my opportunity to edit and present what was happening to me, like an ongoing and open soap opera storyline.

When I looked at my emails it was possible to find that each email has a sense of a beginning and each has a feeling of its place. It is only now that it is possible to discern whether this is near the beginning, middle or end of my story. The chaos that Frank (1995) refers to in narratives is therefore managed somewhat. Although this is often with the use and referral to regurgitated medical language, which he might reason barely qualifies them as narratives. But, like a soap opera where the plot is unknown, there is a distinctive voice that is choosing what to regurgitate and, more importantly, how it is presented – the tone and affect conveyed allow the reader to know it is a story that they are being told. I can be sure of this as one or two emails in response commented on how well I was presenting my story of 'My Cancer'.

Whilst much of this first part, bar some editing, was written during my experience of cancer, my cancer journal continued afterwards and the reflection from that forms the second part of my story. At first writing these reflections were not something that I was particularly keen to do, I was happy that I had survived and, in the main,

done so in a way that had minimised cancer's effects upon my loved ones and myself. But the push to reflect came from the need to understand my cancer story in the face of all those stories that I knew before I was ill and would hear, as I progressed with my research.

I have chosen not to incorporate these retrospective thoughts as another layer within the first account as, apart from worrying that it would be seen as disingenuous, it provides those of us interested in narratives the opportunity to see how the telling and re-telling is important in the building of an account. What I have presented here are some of the main pieces of writing that I did in the months after I returned to work and to my PhD. Indeed, these reflections were written with this preface in mind. I wanted to consider and examine my experience in light of the germinating structure that I had placed down for my PhD, just before I had to stop work on it. I felt it was important for me to recognise the narratives and 'blind spots' in my own decision making narratives, before I continued to analyse those of my interviewees.

However, I avoided doing this in a thematic way. I did not want to use my provisional analysis of my interviewees as a framework for my own story. Yet at the same time it would be quite impossible not to be affected by the stories I had heard, the books I had read and the opinions I was developing, when I was writing my reflections. This methodological problem cannot be easily overcome. So instead of attempting to ignore or eliminate any 'bias', this Prologue, my story of My Cancer, is my way of owning that problem.

* * *

One weekend sometime around the start of February 2009 I was, as directed in the literature, checking myself for lumps after a hot shower. This was something I had done for many years and so was 'familiar with the shape and feel of my testes', again as directed by the literature. But this time, unlike any other time, there was something different. Something small, but distinct. A lump. But, as I was in the midst of a mild hangover, I hoped that it might be due to some sort of tactile hallucination. Or perhaps it was a cyst, something that will go away after a day or two. Besides, it was the weekend and it would be a hassle to go and see my General Practitioner (GP). But on Monday morning, with my hangover clearly a past event

and with a more conservative voice in my head, I telephoned the GP and booked an appointment for a couple of days later.

That appointment resulted in being referred for an ultrasound. “Not because it is anything to be worried about, but because all lumps worry the patient and therefore this helps to reassure you and me”, said my GP. Three weeks later I was sat back in the GP’s office with the radiographer’s post scan “not all lumps are cancer, but I think you should see a surgeon, just to be safe” speech, ringing in my head. The GP put me on the NHS’s urgent referral pathway, a Labour government policy that aimed for people with possible cancers to see an appropriate specialist within two weeks of cancer being suspected.

The appointment with the Surgical Urologist (Registrar) started as I expected, I explained how it was I was sat in her office and she considered the notes. She then turned to me. “Well I can not be sure at this stage”, she said, “but we are not happy with what we are seeing here so we want to remove it. I have a slot free tomorrow, can you come in for surgery then?” This set me aback. I hadn’t quite expected such a short timescale. I had imagined that I was there to arrange a biopsy or some similar further testing. The surgeon explained that she wasn’t going to take any chances with this sort of growth. After a moment to check my diary – a strategy to give me a second to catch up with myself more than anything – I nodded and agreed. Tomorrow it would be.

Once I left the clinic I telephoned my partner. Whilst I listened to her tears as I told her what was happening, I also found part of myself thinking about what an interesting research opportunity I was presented with. I must, I thought, ensure that I document as much as possible about what happens and how I feel.

I went and grabbed some lunch and sat in a square near the hospital. It was a strange moment choosing lunch, why bother with the veggie or healthy choice now? It hasn’t seemed to do me any good so far. But I decided to have the ‘vegan super healthy’ option anyway, it sounded tastier. So, it was clear that to me that to change my habits I’ll have to change what sounds tasty to me. Anyway, I sat in the square and enjoyed some sunshine and stillness. I knew it would be the most still and most sunshine I would experience for the next few days and so just wanted be sure I knew for myself how it felt.

The pre-op went by and that evening I emailed family, friends and the necessary work colleagues. I spent much of the evening responding to my family as the word got round. And all this on a *differential* diagnosis. I don't think most people heard that word, differential, just testicular *cancer*.

My partner and I arrived at the hospital early the next morning. The surgeon, who was again extremely professional but not unpersonable, then saw us. At this point we were given what we thought at the time was some good news. The blood test had not shown any cancer markers and the X-ray was also clear. This reduced the chance of there being secondaries and the need for chemo, if it did turn out to be cancer.

And it turned out it was cancer. A few weeks later I found out that, in fact, it was particularly aggressive type that would not appear on the blood screens. There was also a possibility that there were microscopic cancer cells in my system that they could not see on CT scans. It was explained to me that pretty much the only way to see where else the cancer may be would be to remove some abdominal lymph nodes and put them under a microscope. This wouldn't cure me if cancer was found, but it would help in knowing what to do next. That is, to chemo or not to chemo.

Whilst I waited for the days to pass to my keyhole surgery on my lymph nodes, I undertook to get myself as fit as possible, under the circumstances, both mentally and physically. Part of this entailed long walks around the area that I lived in, as well as to the University and back – about six miles round trip. I also visited a London Cancer Support Centre for a 'taster' session of Relaxation and Visualisation. My notes of the day record:

“Two things from that session: (1) 'to allow' myself to feel how I feel; (2) how I have found ways to get the space for silence. By not saying anything for long periods of time. Or by going on long walks. How, as the therapist put it, I can 'engage the lower brain waves'. And how the session felt very affirming of how I was handling my illness.”

I went on to compare this visit to the Support Centre with my engagement of the NHS and found that my interactions with biomedicine were much more stressful. There were the obvious reasons for this. The biomedical staff are charged with providing the news, whereas the Support Centre is a place to go and reflect upon that news. There is also a lot of responsibility upon the patient in the NHS to make the

most of your five to ten minutes with the clinicians, at meetings that are scheduled at times determined by others. This non-transparent and seemingly random schedule of interaction itself raises levels of anxiety. Then, when you do attend the appointment, the cancer is at the forefront of the interaction, as it should be. But this has the consequence of increasing distress and anxiety, as the person is lost behind the disease. However, seeing the complementary practitioner is a different experience. The focus is the person, the life the individual. Cancer may be what brings you there, but what is discussed is the general feelings and levels of stress or dis-stress. Moreover, this is usually an appointment you have booked to fit in with your timescale and where you get an hour; an hour you know you can repeat hours or days later if needs be.

During these weeks of recuperation, a close friend of mine, who was about to complete his training to become an acupuncturist, offered me a free course of treatment. My friend was someone who I had always shared my experiences with. But never before had he, after our discussion, produced an array of coloured needles, which he then inserted into various points of my body. I have never been sure if I'd like acupuncture, but I presumed that I would find it affirming, relaxing and perhaps even pleasurable. However, all I felt was apprehension, invasion and discomfort. Afterwards, I had to admit, I didn't feel 'better' in any sense and was not sure it was a therapy for me. But he reassured me this was normal and that the benefits took a few sessions to materialise. So I decided to make a decision at a later date. Sadly, as events transpired, I was not to get my follow-up sessions anytime soon.

Eight weeks after my first surgery, I again went down to theatre. What followed almost fits the surgical cliché: 'the operation was a success, but the patient died'. Indeed, after the operation on Monday we were told that it had gone excellently. But as the day and night progressed my post-op stats didn't do what was expected. My pulse rate increased, blood pressure dropped, blood counts were low, and people's nerves frayed.

During this time I was being dosed with morphine, so my memory of things is pretty hazy. But I'm told that I looked in a pretty bad way. A CT scan showed a haematoma (bleeding) in the right side of my abdomen. But the bleeding was slow and the hope was that it would soon stop and, after five units of blood, all would be

well. But by Wednesday morning that clearly was not the case and the decision was made to go back in, drain the bleed, find the source and stop it.

The operation was, again, successful. However, as I was coming round my right lung filled with fluid and partly collapsed. This was all a blur to me, and there's a lot where I remember being conscious but I have no memory of. But I do have a distinct memory of being in the operating theatre and having high pressure oxygen mask on, of being propped forward by two physiotherapists, who were working my back to get me to cough up some nasty looking fluid, and of staring intensely into the worried eyes of the anaesthetist on the other side of the room.

Once stabilised, I was then transferred to the High Dependency Unit (HDU) where I spent the next 24 hours. In a testament to the body's remarkable ability to recover I was, within days of my return to the ward, almost ready to go home. The day before I left, I experienced a remarkable feeling after the last tube had been removed from my body. Once on my own, I recall looking down at my body and enjoyed the marvel of how it had survived what had happened to it. There was evidence all over it of what had happened in the shape of the dressings over the wounds and the multi coloured bruising covering most of the right side of my torso. But my body was now free from the ties that had aided my recovery. And as I stroked my torso, like one would stroke an old dog, I felt to myself with a smile, "welcome back".

Just about a week after I was discharged, the Consultant Surgeon told me that there were cancer cells in the lymph nodes he removed. I had therefore officially moved to 'stage two'. I met with the oncologist a few days after that and we decided that it was time for the chemotherapy.

So within three weeks of my eventful trips to theatre, I was again sat on a hospital bed waiting for the "Act Three" of my treatment to begin. The cycle of three drugs, given intravenously, was an intense twelve day burst of treatment – a 40 hour session followed by eight days recovery at home followed by another 40 hours of chemo. It was debatable whether I had fully recovered from my first surgery before going into my second, but I was certainly not in the best physical or mental shape when the chemo started. As I wrote to a friend, "The fatigue has been one thing, the weird sort of chemo sleep you get another. And the general uncomfortableness from the nausea

is a form of slow torture. On its own, for a while, it is bearable. But hour after hour, non-stop, no relief. [Fill in your own expletives here!]"

But my energy reserves had not completed their trial. Two weeks after returning from what I still hope will be my last session of chemo, my partner and I had to pack up our flat and move out. Thankfully for us both, her father and brother, along with two good friends of mine, helped us with the lifting and carrying of boxes. I was gratefully sidelined into wrapping breakables in bubble wrap. Something that in retrospect, was a very symbolic job.

But the effort of the move was worth it. The country hamlet my partner's parents lived in provided us with the space and support we both needed to recover. The move marked an end to many things, a life shared in London, as well as a series of treatments and, I hoped, the existence of cancer in my body.

Two months later I saw the oncologist to get the results on my first post chemo CT scan. For the first time after visiting this clinic I left with good news. I didn't need any further treatment at this stage, as the scan was clear. I could continue my return from My Cancer, to my life. My partner and my mother were obviously very relieved. For them and everyone else I was now officially 'in remission', a label that has become synonymous with the 'end of cancer'. But to my mind, this did not bring 'closure' to my experience. The cancer I have has never been seen on a CT scan or blood test. The reality for me was indistinguishable from the 'we don't know if you still have cancer' status I had been carrying since my first surgery. There is no way to be sure at this time. I can only know that I will be more certain in the future.

* * *

"The responsibility of the ill, then, is not to get well but to express their illness well. And the two have nothing to do with each other... I believe that those who express their illness live their lives fully to the end of the illness. For me this is enough – it has to be enough" (Frank [1991] 2002: 127).

My ongoing wellness is not, then, the end of 'My Cancer' story. By this I mean two things: first, this may just be a hiatus for the disease. Secondly, I also have a serious period of illness to reflect upon. And one of the first things that I reflected upon was my experience of my body. In particular, I was always interested in the various ways

that cancer was perceived and experienced in its relation to the body in the stories I read. For me, I remember the general aching and the repeated stabbing pains in both testes in the weeks between first seeing my GP and my first surgery. At the time I could not say whether the pain was being caused by something or whether they were psychosomatic. I couldn't recall, and still can't, whether I had such pains before I felt the lump.

Arthur Frank, in *At the Will of the Body*, described his mother-in-law's experience of cancer as 'abstracted', as she was fortunate to be operated on before she felt the pain that cancer can cause. This, compared to the 'reality' of his crippling experience, might be seen to set the two ends of experiencing the thing that is cancer. But this spectrum seems misplaced for my experiences. In my journal I described my experience of cancer as 'surreal'. It was a definite experience, but often with a non-specific object that was allowed to morph and excite the body and mind in a variety of different ways.

For example, after the (very) small but deadly aggressive lump was removed, it was evident that we were chasing a phantom or, as I referred to it to my friends and family, a stealth cancer. It didn't show up on any blood tests or scans. But that did not mean it wasn't there. Of course, I could wait for it to come knocking in my body; await the lumps, bumps and pains to appear. Or we could get closer, beyond my blood and into the cells of my guts, to see if we could see it. The reality, though microscopic, was real. It did not have to cripple me in bodily pain for me to feel its presence. But this is not an account of cancer via the proxy of medical intervention, as for Frank's mother-in-law. Perhaps surreal is the wrong emphasis, this was *sous-reality*, available on a different spectrum, at a different scale that is made available through the technology of the microscope, but experienced through a different language of the body.

It is in this search for a language of the body that my account finds echoes with Frank's and those of my interviewees. Frank's account includes a sense of 'wonder' at the body. At different times I had a similar intense awareness of my body – such as when the last tubes came out after my third trip to theatre, which brought an amazed and pleasing feeling. As Frank notes, this is an experience that uses language that goes further than biomedicine's disease language will allow. But

where does that take us? ‘Wonder’ is one such attempt to forge a language of illness. It is something that, for me, seeks to identify something more than mind-body conceptualisations have access to. It also has echoes of the languages of the holistic body that are present in the complementary medicine field. This language of the (ill) body had been at the forefront of my work before I was ill and would continue to be after I returned.

Having spent so much time reading complementary literature, attending the centres, talks, open-days, and fairs, it would be strange if the narratives within it have not influenced my story. But, there are two areas that I find, when I reflect on my cancer, that I do not seem to share with my interviewees – at first glance anyway. First, ‘the place the cancer has in the person’s life’. Often this is referred to as a ‘turning point’, that is it is some form of springboard to changes taking place in their life. The second aspect refers to the ‘spiritual’ dimension, or the ‘deeper’ contemplations that people have about life.

Looking at my own thoughts in my emails and journal, I can see that my initial reaction has been to fail to spot any significant changes or transformations in my life. But this, I feel, is more because I have been contemplating what it is to have cancer, or be at a higher risk of cancer, for many years now. For a long time, since my later teenage years, I have considered myself to be at a high risk of bowel cancer, due to the family history on my mother’s side. For many years I had slowly adapted my lifestyle to reduce my risks, mainly though adapting my diet. However, in 2007, after being genetically tested, I was told that I did not have the gene. But instead of reverting to a less restricted diet I continued with it. It would seem that this was for two reasons: habit was certainly one; secondly the diet I had was generally considered to be a ‘health conscious’ one – no (land) meat, high in oily fish, plenty of fruit, vegetables, pulses and the like. Perhaps it went further than some might suggest, having soya rather than milk where possible, but this could hardly be considered radical. So there was no major turning point, more the gradual movement, all of which happened before my cancer. All that has happened afterwards, so far, seems to continue that gradual trajectory.

So what of the spiritual aspect? It is evident that along with the diet came changes in attitude to life. But that might be too quick an association to make. I remember well

back into my early teens, before cancer was any sort of consideration for me, of doing and feeling the sorts of things that Frank talks about in *At the Will of the Body*, and that many of my interviewees and the complementary self-help books refer to. The awareness of the singularity of life, the appreciation of the moment, the moments of empowered transcendence that they describe; all are familiar features in my life, although the language I would use would be different in many cases.

Nonetheless, my story certainly contains evidence of an appreciation of the ‘slowness’ of life. There were times in London where I noticed this. Immediately after my differential diagnosis – I took the time to enjoy the space I had and the sun on my face. At various times whilst waiting for my second surgery, whilst I was effectively ‘well’, I walked around the city, taking time to be within, but some how not a part of the hussle-and-bussle of city life. And of course, the times spent recuperating in the countryside. Where I relaxed in a garden lounge, in the warm shade. Or taking the dogs for walks; short at first, then longer as I explored the landscape around me. One such walk found me sitting on top of a hill that overlooks the vale below where, as I enjoyed the fields full of summer colours and volume, I felt a deep joy for life.

However, I had similar experiences before my cancer. There have been many moments in my life when I have been acutely aware of my surroundings. Moments when I looked down from an imagined above and to see that myself as a single person in a thronging city, then on an island, zooming back to reveal the planet, then imagining the planet’s place in the solar system and then the galaxy – borrowing images from the various sci-fi films or documentary special effects departments – all the time seeing my place against these different scales.

But in these times after my cancer there was something more also. I was aware of time passing, sometimes like a large grandfather clock in an empty Victorian room. At various points I had already been off work for longer than any point since I started a paper round at thirteen years old. This in itself was a strange experience. As Frank notes being ill ‘releases’ you from these ‘productive’ duties. However, I didn’t quite feel I’d been cast aside, as he describes. For me, perhaps naively, I experienced it as being given the space to recover. That said, there was a six-month deadline that weighed heavily on all my treatment decisions. That was, my (paid) job, generously,

provided six months full pay sick leave. But after that I would be on half pay. This would not be disastrous financially; our plans to move in with the in-laws for the summer would help soften the blow. But, there was the worry, there is the worry, that the cancer may come back and I will need a further six months off for a further intensive bout of chemo.

Nevertheless, along with these worries, this clock also provided a certain freedom. But I always felt that it was a freedom on loan. I knew I could not spend all the time I had like this, on top of a hill. I can only liken this paradoxical state to the feeling I often get towards the end of a two-week holiday, when you *just* start to feel relaxed and settled, but when you realise that you will be back at work in two days. At that moment of realisation, this freedom was like being gifted with a third week. But on other days, it was like living that realisation of the penultimate day over and over again.

So this leads me to another consideration: death. This is, ultimately, what the reflections on change and spirituality are concerned with. But again, whilst I have throughout my adult life contemplated my own death, I do not currently share the 'being ready for death' that Frank and others describe. Indeed, my distinct recollection, at the moment I was closest to death – in matter of fact the moment had probably just past – was when I became conscious in the operating theatre after my lung had partially collapsed. At that point, I had the most powerful instinct (feeling, need, drive or desire are all too weak sentiments to describe this) to be alive. At that moment of extreme vulnerability, I felt as though I could take on the world. Perhaps it was the drugs that they had (possibly?) used to revive me, or my own adrenaline. But I certainly did not feel 'ready'. And nor have I done since.

The idea that I am not 'ready for death' may not be surprising to many, but to those who have read or heard the descriptions of individual contemplation of life, death and spirituality I hope will recognise the disjuncture to which I am alluding. Having contemplated these things deeply and for some time the authors come to a realisation of their preparedness for death. This is not to be mistaken for 'giving up' or a psychodynamic 'desire for death'. Rather it is a *profound* acceptance that death is inevitable. I emphasise the profound as I, like most, am aware that death happens to us all. But for some people, this realisation takes on another 'deeper' meaning that

permits a change in their sentiments. It is this profundity of acceptance that I do not currently share.

That said, it is one I do believe I have experienced. As I grew up I was brought up in an environment that can loosely be described as having a developing understanding of liberation Catholicism. The political aspects of this form of Catholicism were, perhaps, out of place in the north Manchester suburbs. However, there was an affinity to the spiritual aspect of this movement and its juxtaposition with Vatican II, which was something that was felt in the household that I grew up in. The point being, deep reflection upon your place in life, your spirituality and your death were practices I was familiar with. And it was during these years that I last felt the feeling of 'being ready'. But over the years, as I became increasingly agnostic towards ideas of the afterlife, I have found it much harder to contemplate 'being ready' for what is the ultimate end.

This brings me back to my starting point; that little has changed, as I have already changed. But this is in itself an interesting point. That is, why do I feel that I 'ought to feel' the need for change, to have a (new) spirituality or to be ready for death? What is it that brings me to set these expectations for myself? Or is it just a matter of time. Perhaps these reflections are too soon. Maybe these are the opening thoughts to *the* changes I *need* to make in my life, to the developing of a *profound* spirituality and of *being ready* for death.

Introduction

The Reason of Reason's Enemies

“Today, while we indulge unproven healing magic, tried and tested scientific medicine is under attack ... health has become a battleground between reason and superstition” (Dawkins 2007).

Richard Dawkins' remarks reflect a familiar reaction to hearing about the use of Complementary and Alternative Medicines (CAM). What is needed, he argues, is not just a defence of reason, but an aggressive offence that shows CAMs, and those that propagate and use them, as the snake oil sales merchants and unfortunate dupes they are respectively. He goes on to assert that the causes of this failure of reason illustrate the ills of today's society. In concluding his polemic he finds: “Sceptical rational enquiry is always the best approach. We don't have to follow the herd and buy into trendy untested health fads. We don't have to be swayed this way and that by media driven health scares. Instead, we can think independently and be truly open-minded. That means asking questions, being open to real corroborated evidence. Reason has liberated us from superstition and given us centuries of progress. We abandon it at our peril” (Dawkins 2007).

There are a number of claims about the nature of society in Dawkins' arguments that sociologists might want to dispute, perhaps with an ironic nod to years of rigorously collated evidence (cf MacArtney and Wahlberg 2011). But the contribution that this thesis makes is to re-approach Dawkins' concerns about people's choices of treatment using the broader question, ‘how do people experience their healthcare?’ To address this question I have engaged a large body of evidence in the sociology of health and illness, which suggests that people are not as easily duped as Dawkins fears. On the one hand this is good news for Dawkins, as the evidence shows that people use their critical faculties when deciding upon their use of CAMs and orthodox healthcare. But on the other, this literature also shows that users of CAMs articulate a need to be responsible to more than just the scientific and biomedical evidence that is available. This evidence brings a different, less pejorative, emphasis to the question of why people use CAMs, as it locates the problem of CAM use within the embodied lives of the users. Indeed, as I will show in chapter one, what this evidence suggests is that the users of CAMs do not turn from science, but look to

‘go beyond’ what biomedicine can tell them about their self, health and life. CAM becomes less about alternative medicines and ideologies and more about integration and complementarity. Therefore, identifying the numerous factors involved in experiences of healthcare is only the first part, as the question remains: How do users of complementary health bring the potentially incommensurate worlds of biomedicine and non-biomedicine together? Or put another way I ask, what do users find to be complementary about complementary healthcare?

One place where these many problems intersect is that of complementary healthcare and ‘self-health’ (J Stacey 1997). I use Stacey’s ‘self-health’ to distinguish that part of the ‘self-help’ phenomenon that focuses on the health and wellbeing of the user. Self-health is part of a self-help culture that seeks to encourage people to take individual responsibility and become experts of themselves in all manner of ways, from their workplace to their relationships. As Stacey notes, self-health crosses the commercial and public fields of health and can be seen to have strong links to government initiatives to improve the health of its citizens. I have come to call that which has direct links and associations with complementary and alternative medicines and therapies ‘complementary self-health’, which also helps distinguish the particular part of this self-health culture that I am interested in.

I also wish to distinguish complementary self-health from CAM. However, this is somewhat problematic as definitions of what CAM is, and what is or is not a CAM, vary from study to study (Zollman and Vickers 1999; cited in Broom and Tovey 2008). With my concern about the *use* of CAMs this thesis cannot be restricted to definitions or discussions of CAM that start with a concern with efficacy (e.g. House of Lords Select Committee 2000). As Broom and Tovey (2008) note what largely characterises CAMs are, first, a lack of integration into the biomedical or ‘Western’ healthcare model; and, second, an approach that includes some degree of physical *and* metaphysical elements. For this research I would also note that CAMs – whether ‘whole system’ approaches like homeopathy or ‘less ideological’ practices like reiki (ibid) – do little of the epistemic or pragmatic work that would allow their users to form a “practical epistemology” (O’Connor 2000: 54) that is important to an understanding of their use in a self-health context. In contrast to this, complementary self-health is typified by meta-approaches that seek to provide

formalised programmes that allow the user to develop a ‘best of both worlds’ attitude to healthcare (see chapter three for examples).

Of particular interest to this research are the many complementary self-health approaches that are particularly concerned with people who have cancer. These approaches largely acknowledge the advances biomedicine has provided, but point to the sometimes severe iatrogenic and interpersonal costs that are also associated with biomedical oncology. In response to this *healthcare* deficit these approaches look to complement biomedicine’s ‘instrumentalised’ or ‘reductive’ approach with a ‘holistic’ or ‘person centred’ framework of *support*. Here the individual is not so much told what to do, as provided various techniques and practices through which they might come to know what is best for them. Treatment decisions are placed firmly within an understanding not only of the science of biomedicine, but also within an experience of who one is.

In order to examine what is happening within this field, this thesis considers how the person comes to understand herself as capable of thinking and acting in particular ways. This entails an understanding of not so much *the* subject, but of the formation of one’s self¹ as a subject of one’s subjectivity. In order to address this broad conceptual problem, I first needed to explore the array of factors that are experienced as influencing the formation of subjectivity in complementary self-health. To do so I re-phrased the question, ‘how do people experience their healthcare?’ to ask my first research question: (i) How do people who have, or have had, cancer and who use complementary self-health, experience their use? Rather than leap from the evidence that questions the efficacy of CAMs to the assertion that practitioners are ‘quacks’ and that users of complementary self-health are in some way cognitively or emotionally deficient, I have used the available evidence to ask a different sort of question. By answering this question I will be able to describe the ways in which complementary self-health interpellates the user. For example, do users feel they must adopt particular practices in regimented ways, such as changing their diet, towards the specific end of curing cancer? Or are they engaged in caring for their

¹ In places in the thesis I distinguish ‘herself’ ‘themselves’ and ‘oneself’ from ‘her self’, ‘their selves’ and ‘one’s self’ etc. This is to emphasise the differentiation necessary in the formation of the self, by the self, in complementary self-health.

self, health and life, which seeks to provide them with a particular sort of relationship with their self?

Dawkins' critique of CAM users judges people's decisions as either good or bad. Many analyses have also explored people's individual ethical considerations in order to comprehend what is happening. This may take place under the guise of more formal philosophical ethics: for example, discussing the extent that a particular decision can, or cannot, be regarded as properly deontological. However, this research draws on a different mode of ethical analysis, one that focuses on the formation of subjectivity in contemporary ways of experiencing what counts as ethical. Drawing on Foucault ([1982] 2005; 1986; 1988) this research considers the way that an individual's ethical subjectivity is problematised as such. In doing so it allowed me to consider what has to be, in order for the subject to think, feel or act about just these issues, in just these ways. Therefore the second research question was: (ii) How is the use of complementary self-health experienced as part of an ethical formation of subjectivity? By answering this question, this thesis explores the ways that subjectivity is formed so that the person is able to know and feel what is right about what they are doing.

Cancer services, and the users within them, are the focus of intensive economic and political resources. In the public arena contemporary policy discussions have informed the wider health picture leading to an increased emphasis on active preventative medicine (Wanless 2003) and a citizen-consumer model of the subject (e.g. Dixon, Le Grand, and Smith 2003). The sociological literature highlights a myriad of issues that inform this. These include the problematising of medical and scientific knowledge (e.g. Foucault 1973), the implementation of 'choice agenda' (e.g. Dixon et al. 2003), the new ways of evaluating risks (e.g. Beck 1992), the role of individualisation, responsibilisation and expert knowledges (e.g. Giddens 1991), the formation and resistance of biopower (Foucault [1979] 1998b), the conduct of 'biocitizens' (Rose and Novas 2005), and the politicalisation of the 'war on cancer' (Proctor 1995); to name a few. People who have cancer and who use complementary self-health are therefore in a position where the effects of the wider social forces within the health context in the UK can be seen to intersect. In turn, this literature will inform my reflections on the third research question: (iii) What are the

implications of the new formations of ethical subjectivity for sociological reflections on contemporary healthcare? By looking to answer this question the thesis will consider how, or in what ways, use of complementary self-health can be located in the new formations of healthcare generally.

In summary, this thesis looks to understand how people with cancer, who have used complementary self-health, have come to experience their self, health and life as they do. It looks to describe not only how they came to form themselves in their subjectivity, but to describe the recognisable cost of understanding themselves in that way. To receive a diagnosis of cancer can be a life transforming experience for many people. In the UK, the increasing emphasis on the autonomous, responsible individual who is free to choose their healthcare means that those with cancer are now at the focal point of intense socio-economic, political and ethical forces. This thesis describes some of the ways people found to form their ethical subjectivity when living with cancer and, more generally, illness in this western healthcare context. I have found how the practices and techniques of complementary self-health support the formation of the self as an ongoing, relational, embodied, situated and transformational achievement. This, in turn, illuminated numerous possible ways for understanding modes of subjectification for other sociological research on self, health, and living. As well as the political and ethical dimensions of forming subjectivity in contemporary healthcare, this thesis finds that there is a new formation of spirituality that needs to be explored. One that is found by the interviewees to be integral to the way they experienced their freedom and that challenges many assumptions about ideas of the autonomous free individual.

Structure of the Thesis

The next chapter of the thesis provides a systematic review of the literature that informs my analysis and discussion of ethical subjectivity. There are a large number of influences informing the experiences of the individual who has cancer and who uses complementary self-health, but it is possible to consider these under two broad headings. First, as Dawkins would assert, these experiences are to do with issues of knowledge and ignorance. However, as I have already touched upon, this is not a simple binary choice between what is true and false. I have therefore reviewed the sociological discussions that have sought to make sense of people's experiences of

illness and in particular what it is that sociologists can say about the role of ignorance in these experiences.

The second field of consideration draws on sociological work that has explored the question, ‘what do people say are the factors affecting how they think and act?’ This brings into focus the role that people create for their self in their subjectivity. What is known, or not known, is sometimes evaluated against a myriad of factors that are drawn together under the heading of ‘self’. However, things are not as simple as they first seem. The literature shows a field where ‘the self’ is problematised, disrupted or fragmented. Yet, what I find in both the problematised fields of knowledge and selfhood are a group of people with cancer who use complementary self-health and who narrate their experiences, despite the uncertainty that surrounds them. I go on to pose this problem by expanding Frank’s (2010) ‘companion stories’ to describe cancer as a ‘companion illness’, in order to explore how complementary self-health might allow people to find ways to continually be with their experiences of cancer.

In the final section of chapter one I question the conceptualisation of ‘subjectivity’ that comes out of the previous two sections. I posit that Rose’s (1999a; 2007) ethopolitics provides an acute diagnosis of the problem of subjectification for complementary self-health. Here attention is drawn to the ways in which the conduct of human beings is shaped through acting upon their ethics. Ethopolitics suggests that this analysis should be concerned with the techniques and practices that are used to make human beings better than they are. Here problems of choice, responsibility and freedom are contestations that are defined as they are formed in the fields in which they are found. But ethopolitics, by its very definition, does not describe what the outcome of any specific ethopolitical contestation will be. In order to consider this I will attend, in the following chapters, to the subjectification as described and experienced by the interviewees. Before I can do that, I will explore the relationship of the researcher to both the research and the interviewees.

In chapter two I return to the problem that my diagnosis and my story bring to this research. Whereas the prologue provided my story of My Cancer, in this chapter I will consider how this poses a particular analytical problem to a sociologist researching the stories and ethical subjectivities of people with cancer. The

analytical problem here, to borrow from Foucault's 'conduct of conduct', is one of 'the account of the account'. As a 'wounded ethnographer' I need to be honest about how my stories might fold into those of my research and the interviewees. But I found this is more than just acknowledging the 'double hermeneutic' of qualitative research. Rather this chapter explored the importance of situating and explicating the strategies of analysis deployed in the following chapters.

Chapter three provides an in-depth introduction to several complementary self-health approaches. I also explore both the empirical and conceptual tensions that complementary self-health presents to an analysis of ethical subjectivity in ethopolitics. In this chapter I pose a key conceptual distinction that I use to explore subjectification in the stories of the interviewees. This distinction is between the hermeneutics or systems of care and the practices and techniques that form what I call 'the *support* of the self'. Rather than a practitioner led 'care package', complementary self-health aims to support the user with a toolbox of useful techniques and practices from which they can draw as and when *they* choose. I suggest that this posits a different, perhaps more ethopolitical, relationship between complementary self-health and the user.

In chapters four, five, six and seven I turn to the stories of the interviewees to explore and situate the narratives and experiences involved in the formation of their subjectivity. In chapter four I explore how balance shifts from an objective category described as having 'a balanced life', to a subjectivised mode of experiencing 'balanced living'. What an exploration of balanced living considers is how the interviewees problematise the polarised ideas of right and wrong in their choices and look to go 'beyond' by recognising the embodied, situated and open nature of their experiences. In order to highlight the importance of this I consider the discourses of 'responsibilisation' and 'blame' in complementary self-health. Here I am able to show how the excessive feelings of responsibility, implied in complementary self-health's approach, do not necessarily lead to a blaming oneself if one fails to recover from cancer. Rather, through overidentifying with responsibilisation in an ongoing subjectivation of balanced living, the interviewees are able to show the limits of a rationality of responsibility by highlighting how little else they could do in order to get better.

In chapter five I turn to look at the embodied practices and techniques involved in complementary self-health. In particular I explore the ways that interviewees talk of following what I have called ‘embodied guides’, such as intuition, gut feelings, following the heart, or doing what ‘feels right’ etc. I describe how this ‘practical wisdom’ of the body is recognised as a truth that is to be felt and understood by the interviewees. The interest here is in how the interviewees’ stories are not only told through their wounded bodies, but in turn are understood to be able to affect their embodied selves. It is then possible to start to understand how the interviewees are able to say that they seek experiences that will allow them to heal themselves.

This leads me to consider in chapter six the transformative and transcendental aspects of complementary self-health. Here I explore the stories and experiences of cancer as an opportunity for change, which are so familiar to users of complementary self-health. I describe how the interviewees have found the anxiety and fear brought by cancer to be emancipatory, as it enables them to challenge their previous notions of self, health and life. However, I find that the changes that occur are not only in the stories that are told, but also in the way in which the interviewees experience themselves in the world. Following on from the discussion of the practices and techniques of situating one’s embodiment in the previous chapter, I find the development of a new mode of subjectification based on this embodied biochemical understanding of the self. This non-discursive relationality of the body – the capacity to affect and be affected – is found to transcend not only any account of the self, but also between experiencing bodies.

It is at this point that I consider how users of complementary self-health experience how they take themselves to be. In chapter seven I consider how techniques and practices of ‘living in the now’ are part of experiences of time, so that past and future ‘imagined trajectories’ can situate purpose in one’s embodied subjectivity. In particular, learning to live in the now has a specific impact on the subjectification of narratives and experiences of fate and hope. Through realising the situated position of their formation of subjectivity, the interviewees come to recognise that there are some things that they have little control or influence over. But rather than this loss of control bringing fear and anxiety, living in the now allows the interviewee to ‘accept’ their situation. Living in the now therefore involves techniques that both

accept and refuse the norm of autonomous subjectivity. However, this finding potentially challenges the perspective of ethopolitics that I opened and framed the thesis with. A problem I address in chapter eight.

In the final chapter I start by providing a summary of the main empirical findings of the research. Following from this I take the opportunity to explore the problem of becoming spiritual that is so much a part of complementary self-health. It is only at the latter stage of the thesis that I am able to explore how spirituality is such an integral part of the formation of the self in one's subjectivity in complementary self-health. Here it is possible to consider how the various techniques and practices of complementary self-health support a formation of an experience of self, health and life that looks to situate an embodied subjectivity in order to find a better way of living. However, this poses two problems: first, what does it mean to find that spirituality is found by users of complementary self-health to provide a means by which they understand themselves to be 'free'? Secondly, what implications does this have for an ethopolitical understanding of subjectivity? In addressing both of these questions in chapter eight I am able to re-situate the very basis of the thesis itself. I do so by developing Rose's ethopolitics to explore how complementary self-health might be an emerging pastorate of 'pneumapolitics'. Here I argue that the problem of spirituality cannot be subsumed or understood solely within discussions of ethics of the self. Rather, the analysis must account for how formations of freedom and refusal have become situated within an experience of spirituality. However, I will first start with an exploration of how I might understand the use of complementary healthcare and self-help by people with cancer.

Chapter One

Fateful Decisions in Uncertain Times

I. The Field of Agnotological Problems

In these times of Evidence Based Medicine one could consider the choice of Complementary and Alternative Medicine (CAM) or use of self-help by someone with cancer as somewhat strange, if not irrational. This is because it has become commonplace to say that the correct medical decision is the one that is based on sound evidence and is rationally reasoned. This section will explore what it means to describe such a decision as a ‘good’ or ‘bad’ decision based on ideas of knowledge and ignorance. I will explore how knowledge becomes infused with ethical considerations, as one either has the knowledge to prove an action correct, or the knowledge to show – as many would argue for most CAMs – the inefficacy of that course of action. However, as I will also explore in this section, things are not always as clear-cut as this: what is known and what is not known are related to each other, not as opposites, but as interrelated spheres. So what follows is not a condemnation of biomedicine or its methods, or a polemic advocating CAMs. Rather I have a more modest aim: first I will highlight how it is possible to legitimately doubt the authority of some medical claims by *engaging* in the evidence based medicine of cancer care. Secondly, I will consider how people negotiate uncertainty, how their ‘ignorance’ is not necessarily something to criticise, at least from a position of totalised knowledge. And how, in order to evaluate knowledge, people regularly rely on valuations that are dependent upon criteria from ‘outside’ the field of ‘rational’ knowledge. Thirdly, I will discuss how the individual is responsible to their ignorance, and what this means for ways of conceptualising the self in this research. I will start, then, with this question: what is there to doubt about biomedical care and treatment for cancer?

False dawns and mis-sold truths

Numerous controversies have come and gone in the field of cancer treatment and prevention. Robert Proctor’s *Cancer Wars* (1995) details many of these; Proctor describes the bias in the balance of funding that is towards treatment and away from prevention. In contrast to this he finds that the balance of knowledge about what is

known about what causes cancer is greater than what is known about curing it. This is an issue that gains greater clarity when one considers the continued rise in the incidence of cancer and the relatively modest gains in the effectiveness of current treatment. But the ways of preventing cancer are also hotly contested. They include debates on banning certain products, pre-emptive biomedical treatments, lifestyle change, and genetic and physical screening. In regard to biomedical treatments, the hype of the effectiveness of chemotherapy and radiotherapy, and the underplaying of the damage they do to the body – including their carcinogenic effects – has also served to undermine the legitimacy of scientific answers. It is also worth noting that the measurement of cancer morbidity and mortality is also greatly contested, with various models and approaches demonstrating different trends (Rosen, A Smith, and Harrison 2006; De Angelis et al. 2009). Given this, it becomes difficult for the individual to assess the impact of various factors in the environment or the influence of efforts to reduce cancer. Added to this are the various lobby and pressure groups including patient, environmental and business, each with their own interests and agendas.

For my purposes, Proctor's analysis is particularly striking when he deals with the controversies of both what is known and the spaces of not-knowing and ignorance that define the field. His political history shows how structural incommensurability is manufactured by the production of doubt and fact, how there are degrees of difference by various interest groups regarding the same facts, and how confusion and controversy are caused by this. He argues that the "persistence of controversy is often not a natural consequence of imperfect knowledge but a political consequence of conflicting interests and structural apathies" (1995: 8). From the perspective of the individual with cancer, the strength and depth of disagreement between the various bodies that all claim, to some degree, to have the best interests of the individual at heart, provides a perplexing context within which choices *must* be made. Proctor's work on 'agnotology,' or the study of the cultural production of ignorance, provides the context and some of the language that an analysis of ethical subjectivities will need.

I read Proctor's understanding of ignorance through Nietzsche's 'will to ignorance' (Nietzsche [1886] 1990), where Nietzsche sees knowledge as the refinement of

ignorance, rather than its opposite. This conclusion is derived from Nietzsche's assertion that what appears to be the antithesis, say truth and error, right and wrong, or good and evil, are in fact not opposed to each other; in fact, they derive their character and meaning from their interrelation (Nehamas 1987). As with good and evil, knowledge is not the antithesis of ignorance, rather they have productive interrelationship and the paradoxes they create should be seen to hold transformative potential. However, before I can explore this further I need to consider one contemporary trend that is pertinent to many people who have had cancer, their use of complementary medicines, which are seen by some as one of the greater acts of ignorance in healthcare.

An 'other' way of knowing?

In the mid-nineteenth century what I have so far unproblematically described as biomedicine and CAM operated on a more equal and competitive footing. However, in order to come to this point, the 'orthodox' medical profession, as it was then described, sought and gained a substantial and legally underwritten monopoly in the market place (e.g. 1858 Medical Registration Act). During this time, orthodox medicine also became more focused on the biomedical model (M Stacey 1988) and sought to win exclusive rights to the title of doctor (Saks 2000). Simultaneously, 'unorthodox' practitioners became marginalised and vilified by the orthodox professions, although they were still allowed to practice under Common Law (ibid). But during the 1960s there was growth of interest and use of what came to be known as CAMs in the UK and North America.

The use of CAMs has increased sharply since the 1960s, with conservative estimates indicating that a quarter of the general population now use CAMs and with one in seven visiting a CAM therapist every year (Sharma 1995). In one of the most comprehensive meta-analysis of cancer patient's use of CAMs, Cassileth and Ernst (1998) found the figure ranges between 7 percent and 64 percent, with an average of 34 percent. More recent single sample studies have found over 50 percent use (DiGianni et al. 2003; Cassileth and Vickers 2005). Although Corner et al. (2009) found that CAM use by cancer patients is not significantly different to the general population at 28.9 percent and 32.9 percent respectively. Nonetheless,

cancer patients remain both a key market demographic for CAM practitioners and for complementary self-health approaches, as well as some of their biggest advocates.

Saks (2000) suggests that there are many possible reasons for the growth of CAMs. The rise of consumerist healthcare in the politics of health is certainly part of the explanation. There is also the promise of CAM's safety and efficacy, particularly with chronic conditions (Saks 1994; cited in Saks 2000). More ideological shifts can also be seen to have had an effect, such as individual's desire for more holistic and organic (as opposed to mechanistic) perceptions of the body and well-being. This is also related to their desire for more weight being given to the subjective experience of illness as well as the desire to side step (or counter) the limitations of modern bioscience. And, of course, one should not ignore the political lobbying of CAM professional associations and the support that they have received from significant public figures, such as the Prince of Wales.

It could be argued that the current popularity of CAMs means that people find them effective. Indeed, people do report high levels of consumer satisfaction (Abbot and Ernst 1997; cited in Ernst 2000). However, this feedback does not match other claims about the efficacy of these therapies. Randomised Control Trials (RCTs) are, for many, one of the gold standards of scientific testing, as they control for both placebo effect and bias (through the double-blind technique). RCTs and meta-analysis have been conducted to look at the efficacy of CAMs with, at best, mixed results. Ernst notes that for three of the most prevalent CAM treatments, acupuncture, homoeopathy and spinal manipulation, "the trial evidence is often contradictory and overall, the effectiveness is not proven beyond a reasonable doubt" (2000: 166).

Ernst (2000) argues that the general failure to be definitive when evaluating a CAM's effectiveness is due to a number of reasons. First, there is insufficient evidence upon which to judge. Whereas biomedical treatments have pharmaceutical and biotech companies funding studies, there are no such equivalents for CAMs (although CAM is increasingly becoming 'big business'). This problem is compounded when one considers the range and type of CAMs that need to be tested. Secondly, there are particular difficulties associated with testing certain CAMs. For example, as Ernst questions, how can physical interventions such as massage and

acupuncture be ‘blinded’? Thirdly, there is resistance from both biomedical and CAM establishments, who see testing the claims as either a waste of time or antithetical respectively. None of these problems are insurmountable in the long term and indeed, since Ernst wrote that paper much research has been conducted into the efficacy of the three main CAM treatments.² But what I wish to highlight here is that evidence against efficacy does not seem to dissuade many people from using CAMs. Many biomedical and natural scientists argue this is due to failures in people’s understandings of science (Dawkins 2007; Goldacre 2008; Singh and Ernst 2009; Baum 2009). They argue that if only those who chose to use CAM would listen to science – or more accurately to knowledge produced about CAM using scientific methodologies – they would understand the futility of it all. However, as MacArtney and Wahlberg (2011) have argued, this is a leap of reasoning from knowing the efficacy of a treatment to assumptions about a CAM’s use and the user. The question remains: given the evidence against CAMs in general, why do people use them?

Of the reasons for the increase in using CAMs the three most pertinent theories for this research can be summarised as: 1) dissatisfaction with biomedicine; 2) desire for personal control; and 3) philosophical or value congruence. In seeking evidence to substantiate any of these theories Astin (2000) evaluated the evidence from numerous studies as well as his own research data. He found that the evidence is weak for the first two theories, but stronger for the third. The third theory argues that people who are drawn to CAMs are those who perceive them as being particularly in line with their own beliefs, values, spirit, worldview or general perceptions of health and illness. Some have reasoned that this reflects the more general desire for medicine to contain a more spiritual dimension, for it to be more holistic, and therefore provide some form of purpose in people’s lives (Charlton 1993; cited in Astin 2000). This link between the philosophy of some CAMs and individuals’ metaphysical beliefs often centres on the idea that there is a ‘universal life force’ or

² Homeopathy’s claims have been dismissed as baseless and without evidence (Goldacre 2008; Ernst 2010); the concerns about spinal manipulation have focused on its dangers and chiropractors’ failures to substantiate their numerous claims (Singh and Ernst 2008; Walker 2010); however acupuncture has been shown to have some limited and specific treatment use in the management of some pain and nausea (Ernst 2009).

healing energy centred in or around the human body. Furthermore, many CAM users see their health and physical well-being as part of a wider pattern of spiritual and psychological growth and as part of a counter to the over-rationalisation of the human body (McGuire 1988; cited in Astin 2000). Using his findings, Astin summarised the CAM user as more likely to be educated, have a philosophical orientation towards health that can be described as holistic, have had some form of transformational experience that changed their world view, identify with a subculture of ‘cultural creatives’ (a commitment to the environmentalism, feminism, esoteric spirituality, and/or personal growth), a liking of foreign and exotic things, and poorer health overall.

The philosophy and values of complementary practices

What Astin and others have shown is that much of what is attractive about CAM is the ‘philosophical’ orientation of the treatment or therapy. This is something I will discuss in more detail throughout the thesis, but here I note that self-help advocates have developed this attraction into what I have come to call ‘complementary self-health’. I distinguish complementary self-health as that which seeks to establish an overall philosophy of CAM (I will explore in detail specific examples of complementary self-health in chapter three). Complementary self-health draws on the observation that many users of CAMs do not use one in isolation, but look to combine numerous forms (e.g. Hok et al. 2007). This is something that is not only advocated in complementary self-health, but also an attitude that arguably many complementary self-health approaches were born out of. In turn, those who use complementary self-health approaches may also use more than one approach.

But are the values in CAM and complementary self-health truly alternative? Or is there scope for them to be complementary or even reinforce the norms and values from biomedicine? In short, the answer is ‘yes’ to all of these. Attempting to understand CAMs and complementary self-health on a general level is fraught with difficulties, caveats and exceptions. The scope for generalisations are limited as, on the one hand, they draw on some specific philosophies and understandings of the body – meaning that many concepts are not comparable in their contextualised state. And on the other, the intra-related and mutually generative nature of some the concepts makes them extremely difficult to separate out and define singularly.

However, Aakster (1986; cited in Furnham and Vincent 2000) found five general areas where the contrasts between biomedicine and complementary practices are most acute. The first is (1) health; whereas complementary practices look to balance disease in the context of life, biomedicine sees health as the absence of disease. Indeed, (2) the way that disease itself is conceptualised is a key difference, with biomedicine seeing disease as specific, locally defined deviation in organ or tissue structure, while complementary practices stress underlying causes, wider signs, disruptive forces and restorative processes. (3) In diagnosis biomedicine uses a morphological classification based on location and aetiology, whereas most CAMs consider problems of functionality. (4) The form of therapy also differs, with biomedicine looking to destroy, demolish or suppress, but complementary practices aim to strengthen vital and health promoting forces. Finally, (5) biomedicine historically perceives the patient as a passive recipient of external solutions, whereas complementary practices look to the patient as an active participant in regaining health.

While there is considerable debate about whether these contrasts are necessarily incommensurable, this review, with its concern starting from the perspective of the individual with cancer, needs to be more specific than these general considerations allow. For this reason, it is important to pay attention to lay non-biomedical conceptualisations of the body as, first, in these conceptualisations, the body is inextricably linked to definitions of disease, illness, care and treatment; and secondly, (as I have already shown) the conceptualisations of the body in CAM resonate for many with their own philosophical dispositions and experiences (O'Connor 2000). So, what I find is the user of complementary practices seeking to go beyond the materiality of the body, which is seen as too limited to encapsulate the many aspects of human existence and experiences. These immaterial considerations can include intelligence, the mind, the soul or spirit, a person's psyche (metaphysical rather than neurological), a vital force, and/or energy. Biomedicine's authoritative claims about the nature of illness and disease are therefore challenged. First, because it restricts valid knowledge to that which has been generated via certain controlled methods, by certain professional people. Second, biomedicine's validity does not always resonate with lay people's own experiences and observations, which are increasingly felt to be as the best sources for authoritative knowledge in contexts

where professional knowledge is neither available nor wanted. Whilst biomedicine resists or rejects such idiosyncratic claims, CAMs, and in particular complementary self-health, are more open to such lay empirical based knowledge. As O'Connor comments, based on her empirical research, "Personal experience as a source of knowledge *about* the body readily engages with acceptance of an inherent wisdom *of* the body" (author's italics; 2000: 54). This generates a 'practical epistemology' of the body, whereby one's own judgements are the basis of efficacy of a treatment or experience (ibid). Many complementary practices recognise and encourage this both explicitly and implicitly – via philosophical congruence between a CAM or complementary self-health approach and the individual's system of understanding.

However, there is evidence to suggest that the effect of the rise of many CAMs, and again complementary self-health in particular, is equivocal and not necessarily a challenge to biomedicine (Smithson et al. 2010). On the one hand, different CAM models and their rationales provide a direct contrast to that of biomedicine; on the other hand, the medical establishment has shown some capacity to incorporate a number of complementary practices, particularly when a CAM regulatory body has shown willingness to utilise RCTs to test their claims (Saks 2000). And this hybridisation is reflected in patient's attitudes towards, and use of, CAMs. For example, Thomas et al. (1991) UK found that the majority of patients (64 percent) had received biomedical care for the illness they took to the CAM practitioner. Just under a quarter of those continued to do so whilst seeing the CAM practitioner with the other 36 percent not receiving any treatment from their biomedical practitioner (usually their GP). Thomas et al. rejected the view that patients attending CAM therapists did not appreciate or understand the benefit of biomedicine or that the popularity of complementary medicine represents a 'flight from science'. In summary, they found that CAMs were a supplement rather than a substitute for biomedical care – a finding Furnham and Vincent (2000) have found replicated in a good number of other studies.

But it is not as simple as biomedicine just 'making room' for complementary practices. O'Connor argues that the attempts by biomedicine to 'welcome' CAMs via RCTs and the EBM agenda fails to understand that the integrative approach is based upon a flawed assumption: that as the project progresses, those CAMs that

work will be incorporated and those that do not will be shown to be ineffectual and therefore lose favour and popularity. O'Connor points out that the current use of non-biomedical treatments, in the face of the great advances of biomedicine, strongly suggests that this assumption is false. She goes on to argue that this is not because it is the material efficacy of CAMs that is so attractive, but the robustness of their "popular epistemologies and ontologies that diverge from the scientific worldview; their profound connections to personally and collectively convincing and meaningful experiences of the body, of health, of illness, and of healing; and the extent to which complementary medical systems incorporate and address these issues" (2000: 57). O'Connor concludes that it is of uppermost importance to remember that any understanding of CAMs has to take into account the issues and experiences of those using CAMs "*as they themselves define them*" (author's italics; *ibid*), including the phenomenology of the lived body, the self and its interconnected dimensions, and the ontological and epistemological authority of personal experience.

Responsibly ignorant

It could be said that a contemporary moral dilemma in healthcare is how to achieve individual wellness. An obligation predicated on individual choice and responsibility: one should choose responsibly to make oneself healthy. What I have found so far is that a person with cancer is faced with degrees of confusion and controversy in the biomedical arena. Biomedicine is also found to use a language of the body that is distanced from how patients experience their lives. However, more than this is the attraction that some people have to the philosophical framework that CAMs are found to provide. But this does not negate the problem that many CAMs are considered, at best, to be controversial or, at worst, not to be clinically effective. Therefore, before I can go on to consider how this value congruence between the lived experience and complementary self-health might work, the question I will consider in the remainder of this sub-section is: to what extent can the use of CAM and complementary self-health be considered a responsible choice when it is based on ignorance?

In 2002 Donald Rumsfeld, perhaps most famously, put the problem of how people can make responsible decisions in the face of the many things that they do not know

in his ‘known unknowns’ speech. If that was the most famous, then Camus has provided in *The Plague* a more eloquent exploration of this problem:

“The evil that there is in the world always come of ignorance, and good intentions may do as much harm as malevolence, if they lack understanding. On the whole men are more good than bad; that, however, isn’t the real point. But they are more or less ignorant, and it is this that we call vice or virtue; the most incorrigible vice being that of ignorance which fancies it knows everything and therefore claims for itself that right to kill. The soul of the murderer is blind; and there can be no true goodness nor true love without the utmost clear sightedness” (Camus *The Plague*, [1948] 1960: 127).

Camus urges the recognition of ignorance as something more than a simple definition of ‘not knowing’ suggests. Indeed Camus’ use of ignorance can be read to hold a dual distinction. As well as the simple ‘not knowing’, he expands it to degrees of ignorance that can include the more malevolent ‘choice to ignore’. This form of ignorance holds a more severe moral sanction: it is one thing to not know, but quite another to *choose* to ignore some form of knowledge once its implicit and self-evident ‘truth’ is shown³. But is this not still too restrictive an understanding of ignorance? On the one hand, morality is intimately tied to future knowledge – that one could consciously have foreseen such an outcome and has not acted appropriately, makes one guilty. On the other, the choice to ignore this truth is condemned on a mono-ethical dimension of one’s responsibility to knowledge. It is not the fact that Camus is not open to interpretation via other ethical dimensions, but that he chooses to restrict judgement of decisions to contingencies of conscious knowledge that is problematic. The rest of this section will explore the relationship of knowledge to ignorance and how, if ignorance is to be comprehended productively, a multi-ethical analysis is needed, which, I will argue as the thesis progresses, takes the discussion beyond ethics itself.

Luhmann’s (1998) essay, entitled ‘The Ecology of Ignorance’ describes the political and social functions of ignorance and how the cultivation of ignorance helps to

³ To return to Rumsfeld, Žižek (2004) retorts that the worst ignorance is the ‘unknown known’ or the Bush administration’s failure to recognise that which was known, the Abu Ghraib scandal.

facilitate the defence of non-liability for one's actions. Although Luhmann is considering particular systems in society, namely bureaucracies, I find here that, like Proctor, ignorance is conceived of as a productive force in society. And in doing so, it is possible to start to see a flaw in the modern conception of the ethics of responsibility (Rabinow 2004). That is, being responsible does not imply the need to find out about everything that is not known, either individually or as a systemic project to develop more comprehensive knowledge. "Rather, it means that there are inherently volatile, temporally unfolding spaces of ignorance that do not require filling in (as they were not always there and there will always be more of them)" (Rabinow 2004: 3). Therefore what is needed is recognition of this "partial and permanent" (ibid) ecology of ignorance. This recognition will help to deflate the authority of futuristic pronouncements and locate them within the paradox of unbounded responsibility with finite knowledge.

To explore this problem of ignorance a little further, I will borrow some reflections from Rabinow who discussed Luhmann's thoughts on this issue. When summarising this situation of the "expansive normativity of communication" along with the "imperative to make decisions in the face of a contingent but on-rushing future" (2004: 3), Rabinow concluded that it is not surprising that this is a time that is awash with the term "ethics". Ethics here is understood as a procedural basis for decision-making, which ensures that even when good reasons are not known for a decision there is a basis upon which they can be tested, via communication. However, this communication centres on, quoting Luhmann: "a normative understanding of values [that] serves to allow an ethics to formulate moral demands for the behavior of others, demands that can be maintained despite constant disappointments" (in Rabinow 2004: 3-4). To demonstrate this, Rabinow notes that the value of autonomy cannot be fixed by representing it through a specific example, as it is a regulative idea and it is the role of experts – or in this case, the individual citizen – to constantly reassert how it is important. Hence the value's (autonomy) empirical failure feeds into its constant renegotiation. But, as Rabinow notes, there is a further constraint to this procedural ethics as value positions can only explain themselves via values. That is, the failure to resolve problematisations of knowledge within an epistemological framework necessitates an engagement with these incommensurabilities via alternative means, namely individual ethical decisions.

In summary, it would seem to be key to contemporary ethics that the individual has responsibility for the future consequences of their actions. A position such as this, however, has a couple of significant limitations. First is the inability of the ‘ethical actor’ to know the total chain of consequences of his or her actions, whether s/he chooses to act or not (as this is itself an act). Secondly, it is possible to conceive of (and find empirical evidence of) examples whereby one can ‘responsibly act’ in the knowledge that one cannot know what random outcome those actions might lead to (Rabinow 2004). In addition, as Žižek notes, it is possible to know the fatal consequences of your actions, yet still chose to act in that way due to some “inexorable ethical injunction” (Žižek 2001: 14)⁴. Rabinow concludes by stating that “we find ourselves in the world of being conscious of accepting risk, and [formal] ethics, at least until now, has not been able to provide any criteria for this. Only procedures and values. Hence the cost of a responsibility-based ethics may be its impossibility. *If we were to be responsible to our ignorance then we would have to think differently.* If we did so, there would be problems translating such structural ignorance and a principled responsibility to it into the kind of technical rationality that our bureaucracies demand. But those problems would be worth struggling over” (my italic; 2004: 4). Before I can look at the individual’s attempts to ‘be responsible to their ignorance’ I consider what more formal discussions can inform this analysis.

“Making-up risky individuals”: Rational choice and risk management

One way to approach these questions is via the language of ‘risk’. Giddens (1991) and Beck (1992) have both sought to conceptualise how to account for risk. These accounts, in many ways, inform Luhmann’s distinction that risk is “self-produced by observer systems in the environment of other systems” (cited in Rabinow 2004: 5). Rabinow asserts that this position results in any discussion of risk-taking or risk-making involving a reflective arrangement and decisions about significance. He goes on to assert that the risk/security criteria used in risk analysis are not sufficient and proposes a “risk/danger” conceptualisation.

⁴ Žižek provides a couple of examples, such as the film *noir* hero following the call of the *femme fatale* that leads to his demise; or Abraham’s commitment to kill his own son. He states that “[t]his split is not only the split between the domain of the ‘pathological’ – of well-being, pleasure, profit ... and the ethical injunction: it can also be the split between the moral norms I usually follow and the unconditional injunction I feel obliged to obey” (2001: 14).

However, it is unclear to what extent the reconceptualisation of the responsibility-knowledge-ignorance paradox, via the language of risk, actually resolves the original problem. Common to these formulations is the emphasis on a particular form of active agent who evaluates the knowledge available to them. But by reflecting on Rose's (2007) discussion on the "making-up" of the biological citizen risk can be found to be one way of reshaping the ways that authorities categorically understand people. This making up entails the creation of a person who has a certain kind of dynamic relation to himself or herself. These strategies, Rose notes, tend to represent science itself as unproblematic, preferring instead to problematise the ways that citizens can misunderstand it. That is, they belong to the "family of ways" of measuring risk that amount to a variety of strategies that try to identify, treat, manage or administer the predicted future of "risky individuals", groups or localities where risk is perceived to be high by measures in the present. And while this has certain advantages for those that govern others, when it comes to governing the self this presents its own set of problems. For example, one way of understanding patient choices is to reason that the patient is someone to whom the doctor can impart the necessary knowledge and who will absorb and utilise the information as a rational actor. In this way, the evidence-based model for doctors is equated with a rational, decision making patient. Hence, if patients deviate from the scientific evidence they are labelled as irrational and it is the duty of the physician to protect them. But as Charles et al. argue, in this model "[p]aternalism comes a full circle. This model leaves no active role for the patient in interpreting the scientific information or in trying to make it personally meaningful" (Charles et al. 1998: 88).

What the evidence does show, however, is that when lay constructions of scientific information on treatment risks are considered they can be seen to take several different forms. For example, Charles et al. noted that although some women with breast cancer retained the language of probability in their consultations with oncologists, they also added their own interpretation to the information they were given in the clinic in order to portray the risk in a more positive light. They also found that some women transformed the probability information in order to make it more personally meaningful, to reduce uncertainty or to simplify it into definitive outcomes: death or survival. Finally, they found that some women compared their position with people with cancer they had already known. Therefore the patient's re-

framing necessitates an understanding of these categories and how they are self-operationalised (if at all).

Conclusion

Ignorance is, for some, the sole preserve of epistemology. However, within statements on others' ignorance authoritative assertions on knowledge can be found that are not always as coherent as they first appear and often contain assumptions of how the subject ought to behave. As I have shown above, this is a problematic stance that is as unhelpful as it is impractical. But by moving considerations from exclusively epistemological concerns it leaves further, more problematic, concerns not just with the ontology of the subject, but the interplay between ontology and epistemology.

In the next section I will therefore consider how the individuals themselves manage this apparent paradox of their existence. That is, I will discuss the evidence that some individuals have sought to formalise their own criteria through which to be 'responsible to their ignorance'. The literature that I review suggests that some people are already complying with the demand to evaluate potential gain and loss over a number of decisions. However, their concern for values is not constrained by sole reference to the evidence. Indeed, I will argue that they are going some way to fulfilling what Rabinow and others are asking for: a way of evaluating values that takes into effect the context and relations that are involved. They cannot do this within a singular ethical framework – knowledge comprehended by other knowledge or values comprehended by other values – but what the literature shows is that values are weighted and comprehended via a complex relationship with knowledge and, crucially, understood via stories and experiences of one's self, health and life.

II. The Polyphonic Subject: Embodied and Affective Selves

Giddens (1991: 112) has argued that the contemporary context finds the individual faced with "fateful moments" in their healthcare. In particular, changes in healthcare in the UK finds the individual increasingly having to make fateful decisions and this shifts the individual from a passive to an active patient. But there are degrees of difference as to how this is experienced. Charles et al. (1998), in their interviews with women with breast cancer, have found that some women decided to rule

themselves out of the decision making process, as they felt they lacked essential knowledge, leaving it to the oncologist to decide as ‘they are the expert’. Others preferred the clinician to provide a ‘recommendation’ or ‘advice’, but it was for the woman herself to make the final decision. Then there were those who described the decision as ‘shared’ or something that was ‘done together’. Recognising the degrees to which decisions are a shared process is only the first step however; there is still the question of the basis upon which decisions are understood to be the ‘right’ ones.

This is to ask: if there are occasions when the ‘responsible patient’ cannot rely on the veracity of the knowledge before them, but is faced with a situation that compels a decision, even if that is not to decide, then on what basis can they decide? What I have found so far in the literature is that, when charged with individual responsibility for their healthcare in uncertain contexts, people turn to ‘themselves’ for the authority upon which to proceed. But in doing so, sociologists have argued that they utilise a combination of contemporary knowledge and values that are pertinent to an idea of an ethical self as the basis of action. Therefore reflections upon the ‘self’ become a key moment, as the analysis considers not just forces from ‘above and below’, but also those that come from ‘within and without’.

However, this does not simplify or resolve previous dilemmas, as the very situation that compels the individual to make such decisions is one that is uncertain, and one that can have dramatic effects upon the individual’s ideas of their self. That is, ideas of one’s self and values are important, but they can also be ‘fractured’ biographically, demographically, socially etc. Yet somehow people with cancer often find a way to ‘muddle through’. This then leaves me with the question of how exactly these fluctuations, contradictions and paradoxes inform not only the decisions made by the individual, but also their understanding of their self.

Living your story

Given what I have already discussed, understanding contemporary selfhood necessitates a different framework of consideration than that available in the biomedical understanding of the body. Starting with the people with cancer and how they understand their lives Frank (1995) finds that people’s *stories* of their lives figure prominently, so much so that those who were previously subjects of stories, such as those from biomedicine, now fashion their own accounts. But what might

those stories contain? From what I have already explored, it is possible to understand how, on the one hand, it might seem that illness provokes narratives of discontinuity, fracture and disruption that are faced in the diagnosis and illness of cancer. Cancer has been seen to challenge both older self-narratives and motivates the search for newer ones that can incorporate the meaning of the illness. A person who finds his or herself diagnosed with cancer often reports a “loss of productive functioning, financial strain, family stress, personal distress, stigma, and threats to former self-images. Taken together, these events signal that one’s identity will forcibly undergo transformation” (Mathieson and Stam 1995: 287). In this way cancer is not too dissimilar to Bury’s (1982) description of ‘biographical disruption’ in describing how chronic illness brings about a profound disturbance of the taken-for-granted aspects of daily life, those parts that bridge cognitive and material modes of thought, as well as mobilising concerns about uncertainties, resources, lay and professional modes of thought.

On the other hand, there are considerations of continuity and stability that can be found in the individuals’ accounts. Cancer patients can turn to any number of ways to stabilise their experiences, including (re)asserting their sexuality and gendered roles in life (Chapple and Ziebland 2002), or drawing on past health behaviours to think through present and future ways of coping (Bell 2010). In both these and in other instances, it is noticeable that it is often the stories that are given that allow the person with cancer to imagine their lives. This ‘emplotment’ is the shaping of past, present and future events to fit a plot. It attributes certain things to an origin and has a particular end in mind. Frank (2010: 193) notes, “The presupposition of emplotment is that life has an interpretive plasticity: what happens can be understood in diverse ways, and anticipations of what will happen become self-fulfilling prophecies, affecting what does happen”.

What I am coming to here is the importance of self-narratives in the understanding and meaning-making of people who have, or have had, cancer. It is through an analysis of interviewees’ stories and experiences that I will analyse ethical subjectivity (see chapter two). But it will assist the analysis here to be aware of the difference between stories, which are living, local and specific, and narratives, which Harrington describes as templates (2008: 24-5). To put it simply, narratives provide

the tropes and plotlines that then import the specific stories that are heard, read or seen in action. For an example of this important difference, I return to the reformulation of medical and scientific categories that I discussed above and consider the consequent implications on the individual's identity. As Mathieson and Stam (1995) state "medical talk becomes part of an illness narrative to the extent that it fits the renegotiation of identity. Words such as 'cancer,' 'tumour,' 'chemotherapy' and the like have meaning only to the extent that they form part of the patient's ongoing identity work" (1995: 302). That is, a patient will first learn about their disease and the nature of medical discourse around it and then decide how they fit into that discourse. "It is at once a participation in the global cancer narrative and idiosyncratic because patients must learn a cancer vocabulary in order to articulate *their* concerns" (author's italics; Mathieson and Stam 1995: 298).

Critiques of CAM use would point out that CAM only serves to further muddy the waters, in particular around biomedicine's precise scientific terminology, much to the detriment of the patient (Dawkins 2007; Goldacre 2008; Baum 2009). However, as I have already shown, the evidence tells a different story. For example, Foote-Ardah found that the everyday lives of people with HIV were "improved to the extent that CAM meanings addressed self-regulation of treatment practices and strategies to cope with uncertainty" (2003: 481). Other narrative research has also found that CAM allows people with chronic illnesses to increase control of their illness and attempt to normalise their health status through providing individualised ways of managing symptoms, medications and emotions, through self-exploration and providing complementary and alternative frameworks of understanding and meaning (O'Connor 2000).

However, while much of the literature on CAM narratives primarily elucidates the conflicting explanatory frameworks involved in individualised healthcare, it focuses less on how people evaluate and judge what they know, and do not know, in order to come to a decision. But this is not an argument from or for the Public Understanding of Science 'deficit model' (cf Sturgis and Allum 2004). As I have argued in the previous section, in a complex and contested arena rational 'evidence based' choices are not always desired by the individual, even when feasible. The individual and subjective experience of illness, of one's understanding of life, its meanings of what

is important and why, can bring important variation to concepts of choice, control and the premise of individualised evidence-based healthcare itself – to the extent that the conceptual assumptions are themselves redefined or negated. My argument is not that there is no logic or reason to how people go about their health decisions, but that the values and judgements that are deployed, and how these judgements are arranged into a hierarchy, are contingent upon the multiple factors and circumstances in which people find themselves, rather than being a product of a singular discursive or narrative force (Rapp 1999). That is, the question remains: how exactly do people understand their capacity to affect themselves and others, given the complexity of people’s illnesses, treatments and biographical situations, along with the ambiguity or incommensurability of the information that they have about their situation?

Embodied self⁵

In order to address the above question it is important to recognise, as Frank argues, that when people tell stories about their illness they also tell that story *through* their “wounded body” (1995: 2). As Greco (1998) describes, the body and its symptoms have become a site for ‘truth’ about the self and a new opportunity for self-revelation. This is because for a long time the body was seen as a machine, whereby its internal functioning was mute and devoid of purposeful agency, leaving it inconspicuous from the socio- and psycho- pathological perspectives. From the eighteenth century, the visibility of anatomico-clinical medicine made invisible the various moral and normative dimensions. Disease was understood in its objectivity, which was beyond the threshold of subject and truth. But it is this that is now problematised, Greco argues, in many modern discourses, particularly those that draw on ‘psy’ perspectives. In this way mind-body relations became problematised as likely places to find a hidden desire and a site of truth (for example, as they were seen at the time of Freud).

More recently, the ontological status of the embodied self is made more complex by considerations of the body as a contested site of authority and knowledge.

⁵ A number of authors, working largely from the perspective of feminist cultural studies and feminist anthropology, have recently addressed some of these issues. Their work is helpfully introduced and analysed by Lisa Blackman (Blackman 2008), whose book helped to shape my discussion here and elsewhere in the thesis (see p157).

Foucault's articulation of sovereign power, disciplinary power (1977) and biopower (1979) have been developed by sociologists, such as Novas and Rose's discussions of 'somatic individuality' (2000) and the 'biocitizen' (2005), to conceptualise biopolitical strategies, from 'above' and 'below' that shape ill and healthy bodies. Yet the value neutrality of medical science's claims upon the diseased body have been challenged by patient groups and academic literature, particularly feminist writings, who point out the various dialectical relationships that shape ideas of who 'we' are, such as the relationship of nature to culture (Lock 2001). As distinctions between the biomedical and the social are reformulated, so ontological boundaries also become open to reformulation and transformation.

Therefore, rather than consider narrative as simply a practice or technique of discourse, my concern here is to consider both how stories come from the body as much as how they can be seen to affect the body. As Frank (2010: 44) argues, "Stories are material-semiotic in their double embodiment". He goes on to clarify, "In storytelling, the body embodies the story, which consummates the experience of the bodies participating in the storytelling". Therefore, on the one hand there is the storyteller telling the story using words, images and gestures. But Frank, citing Scharfstein (2009: 60), argues that the performance of storytelling materialises these semiotic forms in muscular and sensory processes through which the embodiment is consummated. In CAM the idea that things transform and move between bodies is not unusual. This includes various understandings of sentiments such as affect, emotions or feelings, as well as forms of energies such as chakra and ch'i (Qi), and different understandings of the spiritual.

Experiencing the spiritual

A distinct part of much CAM use is the experience of the 'spiritual' aspects of life that it provides to users. As Sointu (2006) describes, experiences of CAM on the body are often related by practitioners and users as having 'holistic' effects upon the embodied life of the user. These effects are noted to legitimise the emotional and spiritual experiences of CAM users, which do not readily get recognition in other aspects of their life. Sointu notes how in many CAMs transformation is therefore linked primarily through the body, but it also "transcends the physiological body" (ibid: 218) to affect the user's subjective sense of self. As she notes, "Alternative

and complementary medicines remedy the embodied identities of those turning to these practices. In other words, these forms of health care provide a means of accessing, changing and healing the person through the materiality of the body, yet also beyond the materiality of the body” (ibid).

Characteristic of this contemporary form of spirituality, or what Heelas (2008) describes as ‘inner-life spirituality’, is that it is found to be holistic and life-affirming. However, reflections on one’s inner-life are by no means solipsistic, Heelas finds that by experiencing the “‘meta-empirical’ depths of life in the here and now” it is possible that “experiential contact with inner-life spirituality enables it to ‘flow’ through other aspects of one’s being to integrate, ‘harmonize’ or ‘balance’ oneself” (ibid: 5).

Heelas contrasts the move to spirituality in context to the “positivistic rule of reason” (2008: 2), which constrains the expressive self and the possibility to live ‘out’ through experimentation – a disempowering of the “affect/ive” (ibid). Heelas argues, “*The expressive self is undergoing the suffocating squeeze*” (author’s italics; ibid) that seeks to “kill the spirit” (Flanagan, 2007: 1; cited in Heelas, 2008: 2). Heelas goes on to say that through exclusion of the values associated with spiritualities of life capitalism creates a market that increases their value. For Heelas, New Age Spiritualities (NAS) are found to be charged with the task of resisting the ‘iron cage’ of restrictions, regulations and impositions of external sources of authority. In doing this Heelas questions whether NAS can ‘counter-balance’ capitalism’s “*bounded self*” (Heelas, 2008: 3).

That is to say, these spiritual practices have the potential to disrupt ideas of the self becoming synonymous with understandings of oneself as an *individual* subject in one’s subjectivity. As connections are made with other aspects of their being the spiritual person’s attention is drawn to the multiplicity of relations that influence their life and questions of freedom become associated with the possibility of changing their relationship to their situation. This is not simply the internalisation of discourses or practices that form the self as an individual as an object of knowledge. Rather, the conflicts that arise between these discourses and practices are internalised in an experience of subjectivity that disrupts the telos of these discourses and practices by inserting the self as an interlocutor. As I will explore towards the end of

the thesis, users of complementary self-health see this disruption of the telos of discourse and practice as crucial to the formation of the self as ‘free’.

Conclusion

What I have outlined here is the importance of the body and affect in formations of the self, for people who have cancer and who use complementary self-health. What I find is that people bring together multiple ways of knowing and being in order to contemplate their situation and to make sense of what is happening. In particular, in illness, perhaps more than any other time in life, people become acutely aware of their embodied constraints. Yet through the stories they tell to themselves and others they are able to ‘emplot’ new pasts, presents and futures. People also become aware of their relations to others, drawing on their affective responses as a measure and predictor of their circumstances. In this situation the categories and discourses of biomedicine and CAM (amongst others) become resources upon which to draw in order to form and re-form oneself. What is unclear, and what this thesis will go on to explore, is how it is possible to understand this formation of the self as a subject and as a moment within subjectivity.

III. Reframing ‘Ethical Subjectivity’

Thus far I have explored the two main ways of understanding how healthcare decisions are made via understandings of knowledge and ignorance, and via the embodied and affective self. These approaches have been able to elucidate some important issues, such as the productive roles of ignorance and the importance of contemporary ways of embodied, affective, knowing and experiencing. What I have also been able to do is to describe the major forces that social scientists have been able to imbricate as part of making-up ‘ethical subjectivity’. In this section I will look more critically at the ‘subject’ under discussion here in order to explore some of the assumptions of the above analysis. Finally, I will articulate how a broadly defined ‘ethical analysis’ was the starting point for this research.

Ethopolitics: Situating the subject

What I have shown so far, to a greater or lesser extent, is a subject who, when faced with a fateful decision in an uncertain and agnotological field, seeks to manage the risks via subjectivised categories. It is assumed that the ‘responsible citizen’

achieves this through their autonomous and reflexive choices, while aiming at constant improvements in his or her health. But it is also clear in these accounts that the freedom of the individual is less than this straw-subject hopes it to be. There are contingencies and restrictions at every stage. So why pose the subject in this way in the first place? Scholars in allied fields, such as Judith Butler (1997) and Talal Asad, have highlighted the ways that ‘agency’ within the social sciences is used to attack structural pre-suppositions. These structures are said to be inbuilt within the paradigm of modernity and it is reasoned that they remove from the subject the ability to make history, the ability to make choices in the face of structural normativity. However in doing so there is a placement within agency of the “...assumptions of self empowerment, responsibility, and constructivism...” (Asad 2000: 29). That is, in such circumstances, the concept of agency is employed to avoid talking about the subject in an essentialist manner, but this relies on a normalisation of resistance as an innate facet of human behaviour.

This is an important consideration as the subject in this research currently stands in a paradoxical position. These subjects are, as I’ve noted, open to forces from above and below and within and without. But what does this mean for subjectivity? In order to address this question I will return to the work of Nikolas Rose (1999a; 2007), who reasons that the decisions faced by people in contemporary healthcare are framed by what he terms “ethopolitics”. By using the term ‘ethopolitics’ Rose seeks to direct our attention to “attempts to shape the conduct of human beings by acting upon their sentiments, beliefs, and values – in short by acting on ethics”. Ethopolitics is therefore concerned with the “ways in which the ethos of human existence – the sentiments, moral nature or guiding beliefs of persons, groups, or institutions – have come to provide the ‘medium’ within which the self-government of the autonomous individual can be connected up with the imperatives of good government” (2007: 27). Rose locates ethopolitics by stating that “[i]f ‘discipline’ individualises and normalises, and ‘biopolitics’ collectivises and socializes, ‘ethopolitics’ concerns itself with the self-techniques by which human beings should judge and act upon themselves to make themselves better than they are” (ibid). Biological ethopolitics is therefore concerned with the politics of how people are expected to conduct themselves appropriately in relation to themselves and their future, and is the milieu within which novel forms of authority are taking shape.

When describing this milieu, Rose's attention is drawn to the 'pastoral powers' that are emerging in the context of what Margaret Lock terms "premonitory" knowledge (Lock 2005; cited in Rose 2007). This pastoralism differs from the explicit direction of the slave by the master. Rose's conceptualisation of the new pastoral power relations describes a form of collectivising and individualising power. But this contemporary pastoral power is not organised or administered by 'the state' and nor is it concerned with the welfare of the 'flock' as a whole. Rather, it takes place in a plural and contested field that is traversed by professional codes, empirical findings, attitudes and criteria of third-party users, the advice of self-help organisations and the critical reflections of many groups. This form of pastoral power is therefore best characterised as "relational" as it "works through the relation between the affects and ethics of the guider ... and the affects and ethics of the guided..." (Rose 2007: 74). This pastoralism advocates the ethical principles of informed consent, autonomy, voluntary action, choice, responsibility, and non-direction, and therefore entails a dynamic interaction between the individual and the practitioner. However, Rose reasons that this necessitates "microtechnologies" to manage the flows of communication and information and that these are "inescapably normative and directional", blurring the boundaries between coercion and consent. It transforms the subjectivities of those who are subjected to them by providing new languages, criteria and ethics with which to understand and judge what has happened, is happening, and will happen. As well as providing new ways of making oneself and one's actions amenable to judgement, Rose points to the fact that these "bidirectional affective entanglements" (ibid) also reshapes the telos of such encounters, referring to the rise of the idea of the 'quality of life' that is defined and measured on a number of scales. Finally, this entangling of ethics whereby the present is managed in terms of an uncertain future in the face of new technologies, knowledge and pastoral expertise, has led to the development of a new pragmatic ethics of vitality and its management (Rose 2007), leading some to call those leading the way, "ethical pioneers" (Rapp 1999).

This is linked to what Rose has described as 'somatic ethics', which is an ethics not of moral principles but of "the values for the conduct of a life – that accords a central place to corporeal, bodily existence". But it also goes further than this by describing the desire to form novel ideas of what human beings are, what they can do and what

they can hope for. Rose's analysis considers: "not what human beings are, but what they think they are: the kinds of human beings they take themselves to be". It is his argument that people are increasingly relating to themselves as "somatic" individuals, which is to say "as beings whose individuality is, in part at least, grounded within our fleshly, corporeal existence, and who experience, articulate, judge, and act upon ourselves in part in the language of biomedicine" (Rose 2007: 26). By relating these changes to ideas of health, illness and life Rose argues that people are increasingly governed as biological citizens.

From this perspective, and in partial answer to Asad, instead of abstractly invoking where authority does or ought to lie, attention should be given to the individual's experiences with enquires to when and where it is that they feel 'empowered', 'constrained' or 'free'. That is, the analysis – like the subjects in question – is a situated moment of interpretation: "If to interpret means to seize, by violence or by deceit, a system of rules that does not have any essential signification in itself, and to impose upon it a [new] direction, to bend it to a new will, to insert it into a different game and to submit it to secondary rules, if so, then the destiny of humanity is a series of interpretations" (Foucault 1971; cited and translated in Harrer 2005: 81).

This brings me to the vexed question of how subjectivity might not only be understood in contemporary society, but also how I might go about analysing it. The latter part of this question will be picked up again in the next chapter; here I would like to make a few remarks about how to start this exploration of subjectivity. The starting point, like many in the thesis, is with Foucault and those inspired by him. From this opening juncture subjectivity is the "lived multiplicity of positionings. It is historically contingent and is produced through the plays of power/knowledge and is sometimes held together by desire" (Blackman et al. 2008: 6). However, for some, this is problematic as the subject becomes a bi-product determined by historical forces of power and knowledge, whereby the subject is emptied out of any difference it can make. In short "there has been a merger of the subject with a general ontology of discourse, power and historical events such that there is no longer anything self-defining or distinctive about this subject *itself*" (ibid: 8). One way of addressing this, it is argued, is to provide an analysis that can examine the 'somatic singularities'

(Foucault 2006; cited in Blackman et al. 2008: 9), the “forms of materiality out of which subjectivity is modulated and augmented” (ibid).

It is important to recognise that Foucault’s reflection on subjectification⁶ in the ethics of the care of the self sought to situate “an analytic that could make visible the vectors that shape our relation to ourselves. In the slight gap that opens when one moves from the question ‘what kinds of selves have we become?’ to ‘how do we relate to ourselves as selves of a certain kind’ – in this ‘epistemology of the relation’ – history inserts itself not in our psyche but in that silent thought that inhabits the most intimate aspects of our experience of ourselves” (Rabinow and Rose 2003: xxi). Following this, an analysis of complementary self-health users relations to themselves, as I discussed above, should consider the myriad of ways that the person with cancer who uses complementary self-health has come to ‘relate to herself’ in what Foucault ([1982] 2005: 10) called “games of truth”. In particular it should seek to understand the ‘price that is paid’ for living in a certain manner.

The following analysis of ethical subjectivity will therefore need to be centrally concerned with embodied experiences of complementary self-health in the user’s lives. In doing so, instead of theorising the subject as the foundation of practices and discourses, “[s]he remains on the level of how subjects appear to themselves as subjects of possible actions” (McGushin 2007: 11). That is to say my concern is with how users of complementary self-health have come to see their self as a subject within their subjectivity. In doing so, as I have already noted above, this opens possibilities of experiencing something beyond the materially embodied self. However, the challenge that this ‘spiritual’ experience might pose to the original conceptualisation of the field, as ethopolitical, will be discussed in detail in chapter eight. It will only be possible at that point, once I have explored the user’s experiences of the non-discursive aspects of their use of complementary self-health, to say whether ethopolitics is a sufficient conceptualisation for what is happening in complementary self-health.

⁶ A crucial distinction that helps to elucidate what is at stake here is that between subjugation and subjectivation. Harrer (2005: 79) points out that Foucault often used *assujettissement*, which translates to submitting to, subjection or subjugation, in contrast to subjectivation, through which individuals are guided in their own process of becoming capable of governing themselves and others (a distinction similarly made by McGushin 2007: 98).

Conclusion

This chapter was principally concerned with the two main ways in which people with cancer and who use complementary self-health experience their lives. The first sub-section showed how knowledge and then ignorance have become problematised, leaving the responsible individual in a position of uncertainty. The second sub-section demonstrated how the turn to one's self for a position from which to decide is similarly vexed, as the dilemmas of healthcare became embodied in people's lives and illnesses.

However, these analysis themselves were found to be problematic, as they can be critiqued either for preceding the assumption of agency with the conclusion of the active subject or for denigrating the self for knowledge, or vice versa. Rather, in the third sub-section, I showed how this thesis draws on work on 'ethical subjectivities' in ethopolitics in an attempt to draw a workable analytic; one that *situates* attention on to the self-techniques by which people judge and act upon themselves to make themselves better than they are. The following analysis will take into account the bidirectional pastoral relationship between the guider and the guided and the microtechnologies that provide the normative and directional ways of managing communication and knowledge. In summary, in order to comprehend the cartography of this ethical landscape I therefore need an analytical position that can articulate the acts and practices of the subject, but which avoids normalising either the subject or their relationship to particular practices.

As I will explore further in the next chapter, this research attempts to honour the subjectivity of the interviewees in two ways: following on from the discussion in the third sub-section of this chapter, it attempts to consider the direction of movement of thought *as first put by the interviewee*. This respects the integrity of the stories given by the interviewees. Second, the formation and use of these stories and experiences can be explored through four dimensions, which enable the ethical content to be recognised as such. Before I do this however, the next chapter starts with an exploration of the unusual position of the researcher himself.

Chapter Two

Cancer, My Unintended Companion: Analytical Strategies in the Movement of Thought

This chapter describes how I have come to present this thesis as I have. It allows the reader to understand the process of its production and the analytical strategies that have been employed. I also explore the problems encountered when doing this research. I start with the most significant problem that confronted me: unintentionally becoming a subject of my own research mid-way through it. Following this I will provide an account of the analytical practices that developed, explaining what I did and why. In the final section I will outline the analytical strategies that I use in the following chapters.

New stories for old

The question that came to mind soon after my differential diagnosis of testicular cancer was: what difference does this make to my research? Embarking upon an unintended ethnographic study appeared, in part, to be an exciting opportunity. Following Sontag's metaphor, cancer was a passport to a new world. One, granted, that no one – including myself – wishes to go to. But, as I had been bundled aboard and was disembarking, I could not help but 'find the positive' in that it might provide a new set of stories and greater access to possible interviewees.

But apart from the opportunity to engage a new research method, there was also the question of what 'difference' this made to me, as well as to my relations to those I interviewed in my research. Of course some things had changed, but even more had stayed the same. What troubled me from my diagnosis onwards was how I could respond to the qualitative researcher's need to 'account' for my 'unintended companion'. But when I reflected upon this I came to realise that it was the way the expectation of difference first presented itself to me as a methodological problem that was, itself, the problem that I now encountered as I wrote about it. What the unusual circumstances of this thesis permitted was not just the acute examination of the position of the researcher, but also the implicit and the, all too often silenced, embodied aspects of what goes into 'doing' qualitative research. Furthermore, the difference that My Cancer made to this thesis was that it brought into sharp relief

how stories are situated, so that ‘old’ stories can be situated in ‘new’ contexts and ‘new’ stories can be projected retrospectively to make sense of ‘old’ events. To help elucidate this I turned to Arthur Frank’s work on illness stories. I draw heavily on Frank’s work here and throughout the thesis, not only because he too is a sociologist who had and writes about his experience of testicular cancer, but because his attitude to the analysis of illness stories is one that resonated with me – even before my diagnosis.

Frank (2010), borrowing from Donna Haraway’s ‘companion species’, describes people’s relations to stories as ‘companion stories’ using two parallels: first, he notes how companions shape each other in their progressive coevolution; and second, how companions generally take good care of each other, “although ‘taking care’ always involves each shaping the other” (ibid: 43). In both instances, Frank notes, the companion enables the other to be. But what was particularly troublesome to me after I returned to my research, was the realisation that what had become my personal narrative companion – which can be summarised as ‘remission-as-normality’ i.e. being somewhere between ‘illness-as-normality’ (Frank 2010: 121) and being a member of the ‘remission society’ (Frank 1995: 8) – would be unacceptable as an analytical account to many researchers in the field.

Why is this? Frank notes that a ‘good story’, one which engages people’s imagination, holds them in suspense and calls for interpretation, is not always a ‘good story’ in terms of encouraging ‘goodness’. Social science tends to focus on the former of these two understandings of good story, Frank argues, and often serves to perpetuate those individuals or groups under analysis. By contrast, what Frank calls ‘socio-narratology’ should concern itself with the “normative questions of what makes life not just performatively competent but actually good – this question is what people’s lives truly depend on” (2010: 146). As I will explore in this chapter, my approach to Frank’s work is to take it as a form of productive description that not only highlights the possibilities in the way users of complementary self-health form their selves today, but also considers the costs of so doing. It is a ‘practice of critique’ (Rabinow and Rose 2003), insofar as it does not seek to argue from a standpoint of what *should* count as good, but rather highlights what the cost is for saying that something is good in the way that it is conceived or enacted. But this is

not a ‘revelatory’ practice; rather it is the situating of the analytical practice as a process that is continually producing the field it seeks to study – in this case, via this thesis.

Returning to my problem: for me, asserting the socio-linguistic competence of ‘remission-as-normality’ was sufficient to demonstrate that My Cancer was a good (well told) story that enabled me to ‘be’ in most spheres of life. However, in the production of research such assertions were problematic, as by asking ‘what is being silenced in my story?’ I found the assertions to be ethically loaded. By asking this question I found that My Cancer was a story that contained more possibilities than the single narrative conclusion of remission-as-normality. Indeed My Cancer story was somewhat an attempt to refuse cancer as a companion story at all. Through this refusal, I allowed space for, but did not give form to, the other narratives that formed and enabled me. Having cancer as a companion illness to my research required me to have polyphonic narratives that actually enabled my thinking to move away from being caught within that one, compelling, story of cancer. As Frank argues, the polyphony of narratives is part of what makes stories ethical; the beginning of thinking about stories is placing one with another or more. This is part of, Frank (2010: 149) argues, ‘living well with stories’.

For Frank, being caught up in, and thinking ‘with,’ a story allows the analyst to learn from it and come to understand how the story can engage people, which then enhances the interpretive possibilities of his or her analysis. But Frank notes that in order to avoid missing what the story excludes, one must eventually come to think analytically ‘about’ stories. But this is not a ridged dichotomy, as there is no ‘outside’ of stories. This ‘thinking about’ is itself never purified or abstracted. Nor is it seeking ‘to go back to’ a story, as each re-telling – even in the context of a research thesis – is another telling and the production of another story. But the process of telling and re-telling has other advantages. Frank argues that one must learn to think with other stories in order to better think about a given story. For Frank, having two stories or more makes an important ethical difference, as the dialogue they instigate is the start of learning to ‘think about.’ This leads Frank to argue that good storytellers ‘bring in more stories’. Indeed, what they need to do is allow stories to

bring in other stories themselves, as Frank argues this is what ‘good’ stories do anyway.

When I started my research, the story I brought with me was about a researcher who had a familial experience of cancer and complementary therapies in his life. As I explore in the prologue, my mother’s cancer had affected my life; of particular relevance for this ‘research story’ is that it had been the story I turned to in order to draw some contrasting questions when I read Novas and Rose’s (2000) paper on ‘Genetic Risk and the Birth of the Somatic Individual’. My story of my mother’s cancer had come together with Novas and Rose’s article to provide the genesis of the research story. However, around a third of the way through the recruitment process I gained a further significant story: My Cancer. The story of my mother’s cancer became my ‘old’ story and My Cancer my ‘new’ story, “Old stories *take their place* in a past that is still resonant but no longer has the power to set parameters of the future” (author’s italics; Frank 2010: 158). Frank reflects on memoirists, and on how they work through old and new stories to find which they want or need as companions at a given moment. Their ability to do this, to decipher and use stories to their situated ends is a ‘trickster’ quality that depends on an understanding of the moral ambiguity of their acts. In doing so, they show how to cultivate ‘smart luck’ – in other words, to listen and retell stories in order to be able to hear the different possibilities that might at first seem intolerable. It is not to seek to fit new stories with old ones, but to treat the new story as a lucky find, “a gift that will require working with but can bring riches” (ibid: 159). Indeed, as I explore in chapter six, some of my interviewees came to see cancer as just such a gift. But the question for me was how to handle this ‘gift’ to my research?

Becoming a wounded ethnographer

What makes Frank’s approach apposite for this research is that he differentiates how telling a story is “not just *about* illness. The story was told *through* a wounded body. The stories that ill people tell come out of their bodies. The body sets in motion the need for new stories when its disease disrupts the old stories” (author’s italics; 1995: 2). What appeared to make matters more problematic, however, was the fact that both the storyteller and the listener were similarly wounded bodies.

For myself, my new research story was that I had come to embody my analytical field – I had become a ‘wounded ethnographer’. My newly scarred and damaged body allowed me access to new places where stories of complementary self-health were told. It enabled me to take part and be caught-up in some of these stories, to struggle with their multiple ethical demands and to wrestle with how I came to think of myself as forming my subjectivity. But Frank (2010) warns those who, like himself, were previously familiar with illness due to their research background who then become ill should not look to take on the position of expert or authority on the matter. In this thesis, as in the fieldwork, my attitude to my previous experiences and knowledge were that they are only tools – or a toolbox of stories – via which I can put my experiences into words. Neither my past story nor my research story allowed me to substitute the stories of people I meet with my own. This was no different to the attitude I took to my research prior to My Cancer. Yet I suspected that this new story had changed my relationship with the field in a way that was different to being in another moment, as my body had changed.

Before I was a wounded ethnographer, I considered myself to be doing an embodied sociology, specifically embodied narrative ethics research. Embodied narrative ethics is based on body specificity. It is consistent with the discussion in the previous chapter of a move away from a conception of ethics as a set of true propositions leading to moral precepts. In narrative ethics the body is located as a site of one’s habitat or subjectivity, constituted through a dynamic relation to other bodies within a social context of power desire and knowledge (Diprose 1991; cited in Fraser and Greco 2005). Instead of posing the relationship between ethics and the body as a pre-constructed moral subject applying criteria to pre-constructed objects, narrative ethics is conceived as coming from “*processes of being and encountering*” (author’s italics; Fraser and Greco 2005: 32).

The researcher’s embodied position is therefore part of what constitutes the research field. For example, Valarie Walkerdine’s (2010) article exemplifies one experiment with the interviewing method and ‘speaking subject’. Here, Walkerdine “invites the interviewer to examine their visceral and affective response to the interview” (Blackman and Venn 2010: 18). This includes paying attention to the incongruous feelings that you might have when placed alongside those of the interviewee or that

direct you to what are seen as ‘gaps’ or things ‘left unsaid’ in the account provided, but that might be communicated in some other bodily knowing. As Blackman and Venn (2010: 18) note, for Walkerdine, “affective processes or dynamics are seen as ordinary (see Stewart 2007) and the researcher is placed not as a neutral observer but rather as somebody who interferes and helps to orient the interviewee to that which might usually remain unsaid”. However, Walkerdine’s approach draws on psychoanalytic traditions, which is not something that I seek to do (see below sections). Nonetheless, as Blackman and Venn argue, there is space for developing an embodied approach that draws on discourse and narrative. The approach I took prior to my illness was part of this creative experimentation by body-studies scholars. It was therefore with some trepidation that I re-entered the field after my illness, suspecting as I did that the whole dynamic of my relationship with my research had changed.

As I spent time in the various groups I became aware of the narrative of remission-as-normality that at that stage I had started to tentatively wear. It was, as Frank (1995: 32) might put it, developing into a narrative of ‘meta-control’ that allowed me to ‘pass’ (Goffman [1963] 1990). It covered for the anxiety (expressed towards the end of My Cancer story) that my reality was really a faux-remission as no non-invasive imagery or blood test had ever detected cancer. My concern upon entering the field was that the narrative of remission-as-normality would be challenged or even destroyed; what I found was a recognition that most of us in the groups carried some sort of dual cancer passport that allowed us to be both ‘ill’ and ‘well’ (Sontag [1979] 2009).

In the groups we spent some time exploring what it was to become bodily aware or develop what Frank (1995) calls ‘bodily relatedness’. But this was less of a challenge to my story as, after all, My Cancer started with an acute episode of bodily awareness; an alertness that was favourably remarked upon by my General Practitioner. In the groups such bodily awareness practices, worked on in visualisations and meditations (see chapter five), were related somewhat to what Frank (1995) calls ‘other-relatedness’. Here, the embodied dyadic relations to other persons were explored (see chapter six). Again, this group work did not contest previous stories that worked for me. I was not unfamiliar with experiences of

sharing the messy and intimate ‘otherness’ of people’s bodies, having worked for many years on mental health and neurological wards as a nursing and care assistant. However, a final concern of the groups was with the exercises that sought to re-animate the person, to reconnect them with their desires and drives after the flattening effects of cancer treatment upon a persons affect. This work looked to explore the purpose one found for one’s life through visualisations and small group discussions. This was a ‘compelling’ open-ended narrative that sought to invoke from within you a renewed or new purpose to life, which as I discuss in chapter six holds both transformational and transcendental possibilities.

That is to say, the fieldwork and the interviews were as much a bodily experience as they were about listening to and telling stories. The body was worked upon to both fully hear and express the stories it had to tell, and also to affect it through the stories that were told. Unlike Walkerdine what was being produced was not the imposition of a psychoanalytical body, but the opening of ethical possibilities for the body. To paraphrase Frank (1995: 40), a distinct tension was ever present between the expressions of being told how to have cancer, and being shown that you can have cancer in another way – often a way that sought to reaffirm the humanity within and between members of the group.

Tracking the Movement of Thought

Given the above, it is possible to question what it is, having witnessed someone’s story, to then tell others of it. To reflect on this, I start with Frank’s (2010) observation that sometimes the creation of a narrative silence is to remove someone’s story from the world altogether. The person or group remains unrecognised, and their unarticulated story is unable to affect them, never mind affect others. Frank provides the example of Michael Bérubé’s *Life as we know it* about his two sons, one of whom, Jamie, has Downs syndrome. In telling Jamie’s story, Michael seeks to provide a voice to a body that is ignored due to its ‘abnormal’ development. In doing so I ask, is Jamie’s story not really Jamie’s story? Is Jamie being placed into a discourse that he has no hope of owning, no possibility of staking his own place within? In short, does such an act of ‘subjugation’ mean that Jamie would actually be better off not having his story told by another? Or perhaps these are the costs of Jamie’s story being recognised at all. It is, in this framework, a secondary position to

that of telling one's story for oneself. But if stories allow people to become their lives, then this is the price Jamie pays for moving beyond being an injurious, unrecognised silence towards having the opportunity for his life to be enriched by his father's narration (Frank 2010: 75). Michael gives *witness* to Jamie's body and helps, as Frank might say, breathe life into it. Witnessing is therefore a precarious position and demands qualities of recognition (Frank 1995) and a capacity to listen (Back 2007).

But there is something more that is being done to tell Jamie's story. There have been processes of selection and editing; there have also been interpretations. Stories have been situated within other stories, and even located within a socio-political horizon. So, when it comes to my analysis, how will I account for such methods? Do the unusual circumstances of My Cancer make specific methodological demands? Should I carry on as before, or should I start again? Should there be a compare-and-contrast between the interviews before and those that followed?

The above suggests a different analytical tack that is not a methodology as such. Instead, I distinguish the analysis that follows as a form of "practice of criticism" (Rabinow and Rose 2003: xv). Reflecting on Foucault, Rabinow and Rose argue for an approach – not a methodology – that is characterised as a "movement of thought that invents, makes use of, and modifies conceptual tools as they are set into relation with specific practices and problems that they themselves help to form in new ways" (ibid). Therefore nor do I provide a method (and not simply because it would be disingenuous to argue that having the very illness you are researching mid-way through the fieldwork is a valid or reliable process for research). Here I again echo Frank (2010) in attesting to a particular *attitude* to the way I go about analysing stories and narratives and conducting this social research. But as I explore below, whereas I share with Frank's approach of 'socio-narratology' a similar inspiration from Rabinow and Rose's reflections on Foucault and method, I draw a slightly different emphasis on what this allows me to do. However, before I explore these strategies of analysis, I will first explain the key analytical practices through which I conducted this research.

The Analytical Practice

The thesis explores eight interviews with people who had cancer and who used complementary self-health. They were recruited from Cancer Support Centres, which are usually charitable healthcare organisations that provide information, guidance and services to cancer patients and carers. Many are associated with a particular self-help ‘approach’ (see chapter three) that is either developed by a founding figure or drawn from a similar role model centre. However, instead of eschewing mainstream medicine these approaches look to provide new understandings of healthcare via a ‘properly multidisciplinary’ approach, which will complement the treatments the person will receive in their biomedical care. There is some evidence to suggest that “[cancer support centres] are a key informative and pragmatic resource in the provision of CAM services to patients” (Chatwin and Tovey 2004: 210). Although Chatwin and Tovey also find that there is currently a paucity of research into the ways that they advocate, promote and supply CAMs and self-help.

The interviewees in this thesis were selected with two things in mind. The first and weaker consideration was because these interviewees satisfied a demographic picture. Demographically, as I explored in chapter one, the ‘typical’ user of CAMs and complementary self-health is a middle-aged, middle class, white, woman (Astin 2000). However, in contrast to this the second, stronger, concern was with their stories, not because they were ‘typical’ stories, but because they were ‘vivid’ (Frank 2010). The stories in this thesis connect life to times and uniqueness to representativeness (to paraphrase Williams, cited in Frank 2010: 116). The aim was to ensure that these stories could be seen as representative of the uniqueness they tell. The objective was to make the reader feel that they are in the presence of the interviewee. In doing so I recognise that while the analytical frame is important, what often remains with the reader is the story and the character’s presence. Therefore, each interviewee is not an example of what is being discussed in each chapter; rather they are the source from which the recognition of what is being discussed comes from.

For this reason, an interest in the age, gender, class or ethnicity of the complementary self-health user was not the principal focus of the research. If I take

gender as an example, as Sointu (2011) notes, although CAMs are not ‘inherently’ gendered, they have come to be associated with a feminised space through a number of strategies and associations. Therefore, although this thesis does not focus on problems of gender (age, class or ethnicity) explicitly, it contributes to that literature by examining the *forms* of subjectification that are found to characterise complementary self-health. It is hoped, as I discuss in appendix five, that this will contribute to further work on how these techniques and practices facilitate some gendered, aged, ethnic, or class formations of subjectivity over others.

I provide a detailed explanation of the ‘research practicalities’ in appendix one, where I describe how I located the research field as well as the specific interviewees. I also provide an explanation of the practicalities of how I collected and analysed the interviews. This analysis included the practices that allowed me to constantly question the boundary between being the participant of my own story and participating as a ‘researcher’. These practices of situated and embodied questioning took place throughout the fieldwork and continued to take place each time I revisited the stories.

The ethnographic fieldwork, primarily conducted at a South London Cancer Support Centre between April 2009 and October 2010, allowed me to become more familiar with the narratives that are used in the field of complementary self-health. The fieldwork was part of a process of collecting stories so that I could not only learn to ‘live well’ with My Cancer story, but it also prepared me to think about the stories in my interviews. My use of the complementary self-health techniques and practices folded into my experience of cancer. I sought to experience what it was like to think and feel as a user of complementary self-health, recording my experiences in a journal. This allowed me to understand the field in new ways, to experience some of what happens in Cancer Support Centres, and to develop those tacit understandings. In doing so I was able to witness not only my own efforts to situate the ‘lessons’ to be learnt, but also witness the struggles, over periods of weeks and months, of those in my self-help groups. This supplemented my attempts to think *with* the stories that were provided by complementary self-health, which later became the stories I needed to think *about* in the analysis of the interviews.

But I should also note a limitation of the ethnography; it was mostly conducted at one Cancer Support Centre. Only two of the interviewees whose stories are presented in this thesis attended this particular centre. Even more than this, a number of the interviewees had not done the sort of group work I had done around a particular complementary self-health approach. They had reflected on self-health approaches on their own or in one-to-one sessions at the Cancer Support Centres. But this reflects what I found in the field. As I will describe in detail in chapter three, complementary self-health is used as a resource for people who see themselves as largely on their own, but who need and who find ways to support themselves. Part of this is a naturalised attitude of recognising difference across fellow cancer patients who might share a space or even a similar biography. Yet crossing this divide, as I will explore in chapter six, is sharing the capacity to affect and be affected by others. The Cancer Support Centres were largely more of a portal; a place that the interviewees passed through, much as they did with the websites and books they read, to 'pick-up' supporters. This included seeing therapists as much as it did learning techniques and practices of complementary self-health.

When collecting and analysing my interviews I first sought to listen to the stories people had told me. Through activating my 'sociological imagination', by reflecting on the ambiguities and complexities involved, and by bringing the life of the interviewee to the fore (Back 2007) I was able to think with the story and not just a single narrative. Then, by drawing out narrative 'tropes' (Frank 2004) I have, in turn, self-consciously worked upon these stories myself. As I note above, this assembly work is premised on the research being different from, yet involved with, the field it came from. It was important to remember that the narrative interview was a situated event and not a privileged look inside a person's head. Moreover, this thesis is not a representation of what occurred; it is a reconstituting of the stories I heard into my research story, and I therefore accept that these form new renderings. I have not 'stripped away' things to 'reveal' what is 'actually there'. Rather, I believe that they *add* to that field (Latour 2004); they certainly do not stand neutrally separate from it.

When writing the chapters I divided each one into two parts, which can be understood simply as the first part 'shows', the second 'tells'. In doing so I hope to

be able to provide an ‘honest’ (Back 2007: 19) account of how the analysis was achieved. While this is my telling of the stories I was told, I work with the assumption that the interviewee is an expert in her own life and that the research interview provided one opportunity to demonstrate that. The analysis that I develop is therefore only one understanding, its contingencies open to further interpretation not only by the interviewee or myself, but also by the reader.

Strategies of Analysis

Sociology of ethical subjectivity

In recent years sociology has increasingly paid attention to ethics. However, there are different forms of ‘ethical analysis’ and it is worth distinguishing what this study can bring to discussions of ethical subjectivity. One thing that differentiates this research is that it is not concerned with formularising the procedural ethics of the bench or bedside. This is because my interest is in the less formalised criteria that are used by the users of complementary self-health but which are, nonetheless, involved in the formation of subjectivity that also involve ideas of right and wrong. This ethical discussion is not an abstract discussion; it is interested in, and comes from, the empirical context.

Haimes (2002) highlights how sociology provides useful epistemological and methodological contribution to the study of ethics. Its ethnographic, participant observation and in-depth interview methods are very powerful in revealing details of how people think and act ethically in everyday life. In particular, Haimes reasons that they provide access to the locations where ethical dilemmas arise; the actors involved; they provide a range of definitions and meanings; and they provide a broader socio-cultural framework that shapes and are shaped by ethical issues. In short, what makes sociological discussions distinctive is their ability to connect empirical data with theoretical explanations.

While it is inappropriate to make unified claims about such a diverse body of work it is possible to see how sociological discussions describe the ways that ethics shapes and is shaped by social forces. That is, sociology highlights social, cultural, economic, political, and historical factors in ethical discussions. Sociology shows how “social processes, meanings and institutions that frame and produce ‘ethics’ and

ethical problems” (Haimes 2002: 110). This allows for new ethical models and conceptualisations to emerge.

Attitudes to analysis

Much of what I have described as my analytical approach thus far has drawn on what Frank (2010) calls a ‘dialogical narrative analysis’. However I wish to distinguish one emphasis and one possible difference from this approach. First in what follows there will be an emphasis on how embodied, non-discursive affect is experienced. This involved discursive explorations of the feelings stories generate, but it also highlighted the impossibility that is found in a story’s ability to actually narrate that embodied affective moment. What I describe in chapters four and five, in particular, are the ways that stories are able to show, but not tell, of how users of complementary self-health feel. I therefore needed an attitude to analysis that allowed for the productive possibilities that this descriptive failure held.

As I sought to show in the first section of this chapter, the problem that My Cancer brings to the fore in this research – a problem that is present in most qualitative research, but rarely in such an acute way – is the researcher’s own investment in the stories they hear. What became apparent was my sociological desire to hear stories in a certain way, to hear them end in particular ways, or the wish to tell or be told a certain story. Being aware of the normative affectivity in my sociological imagination became a key attitude that I sought to develop. Coupled to this was the problem of recognising ‘good listening’, of knowing how to attend to the story that was being told and recognising how I was hearing the story. In practice, I attempted to do this through describing how I felt in my notes at the time of the interview or soon after. Then, again, as I transcribed the interview I made notes of my various reactions to the hearing the interview. And finally, I have sought to show and tell this in the accounts I provide of the interviews themselves in each chapter. This attitude to ‘embodied listening’ therefore involved repeated story telling of the same story to myself and recognising that each telling was a different ‘account’, yet each time trying to be with the story to hear both the narratives of the story and my sociological imagination unfold.

The second point I wish to make is to contrast the approach I take; I would not call what I have done ‘hermeneutics’, as Frank does for his work. There is a possible

reading of Frank's work that could emphasise the subject as a trans-historical actor. However, it is also possible that Frank seeks to show how he finds the subject to think of herself in the present ways of knowing and being – a possibility I will take a moment to explore here to help elucidate my own position.

Interpretation, Frank asserts, generally seeks to point towards some form of truth. He therefore looks to consider what sort of truth stories might be able to offer. In doing so, Frank seeks to be aware of the possibility that interpreting stories can reduce them, rather than 'let them breathe'. To counter this, he provides an account of hermeneutics, the objective of which "is not to display mastery over the story, but rather to expand the listener's openness to how much the story is saying" (2010: 88).

This is a dialogical interpretation that draws on Wilhelm Dilthey, Martin Heidegger, Hans-Georg Gadamer, and Paul Ricoeur and looks to engage the story in an ongoing dialogue. This dialogical hermeneutic interpretation does not stand 'outside' of a story and decode it with a master schema. Rather it begins with the recognition that the interpreter is caught up in his or her own stories. Interpretation may need substantial work to recognise the difference between one's own horizons and those of the storyteller. The hermeneutic commitment is therefore to not only ask what the story means within one's own horizons, but to consider how far one is able to understand it in the horizons of the storyteller and other listeners. It recognises the need for, and the dangers in, one's own prejudgements. "A hermeneutic interpretation presupposes the interpreter's personal transformation but then redefines the personal within the dialogical. Hermeneutics is clear that the issue is *someone else's* story, but knowledge of that story always proceeds within the horizons of an interpreter as knowing subject" (Frank 2010: 96).

Frank recognises the inherent danger in some interpreter's promises "to reveal truths not readily accessible to those who see only appearances" (ibid: 93). What is interesting about Frank's discussion here is that he finds that what was problematic was not the validity of these 'master' interpretations, but that "The problem was their politics of interpretive privilege" (ibid). Furthermore, he argues that such interpretative schemes "do yield genuine insights" pointing to Marx's false consciousness and Freud's psychic mechanism of repression as two that have "considerable validity as observations of the human condition" (ibid).

But recall Foucault's ([1979] 1998b) critique, where he traced the genealogy of the hermeneutical subject of desire to the confessional practices and spiritual exercises of Christian ethics. Prior to this, Foucault found there to be a whole range of possible experiences of ethical subjectivity in ancient texts that were not hermeneutical, but rather "aesthetic" or "etho-poetic" (Foucault [1982] 2005).

Rather than the desire to know oneself, he found that the fundamental task in such texts was the broader commitment 'take care of oneself'. It was in the exploration of these texts that Foucault started to consider techniques and attitudes of acting upon oneself that were other than forms of political discourse or which could be found to be hermeneutical (McGushin 2007). What distinguished this attitude was that "truth was spoken as a goal to be attained and as a technique for attaining that goal rather than as a pregiven nature, a static essence" (McGushin 2007: 13). This attitude was a productive mode of being; it did not renounce, but added something to the subject so that she might come to understand and know herself in her subjectivity.

Therefore Frank's position might be problematic as it is not wholly clear whether his acceptance of the validity of false consciousness or the Freudian unconscious is because such ideas now flow freely within contemporary stories of the self and are, for many, part of what constitutes their subjectivity. Or whether he is arguing that these ideas, if not the means of producing the insights, are valid as Marx and Freud themselves put them. Certainly, Frank has moved his hermeneutics a long way from the description Foucault based his critique upon – so much so it is possible to ask to what extent Frank's hermeneutics would still be recognisable to Foucault. For Frank there is no closed ending or singular truth. His approach is more open, ongoing, and not seeking to reason *for* a pregiven nature. He also rejects the authority of the interpreter or author. However there is still an unease that Frank is still somewhat concerned, if not with a participant *nee* subject, then with *the* Subject of the Human Condition. That is, it is questionable to the extent that this hermeneutics is still concerned with creating knowledge of oneself as *the* way to form oneself.

However, Frank has also argued that the development and use of heuristic frameworks aid in helping to listen to the stories that are told. But he cautions, "The [heuristic] frameworks are not the truth of the stories, which is how modernism often

presented typologies. The frameworks I present are only a means of heightening attention to stories that are their own truth” (ibid: 24).

In summary, while the label of ‘heuristic’ brings questions of a trans-historical actor, my reading of Frank’s use of this term is to find him more concerned with how the subject finds herself as able to think of herself in the present ways of knowing and being. That is, I certainly believe there is enough to suspect that Frank is moving towards, if he does not already argue for, the latter of these two possibilities. More would need to be said, in space that I do not have, to question the usefulness of calling such an analysis hermeneutics. However, the point of this little *sojourn* is to make clear the problems in describing this analysis as ‘hermeneutic’ and differentiate what it is that I seek to achieve in this approach.

This is because, as I described above, I take this thesis as an intervention in the field. As Latour eloquently describes, “The critic is not the one who debunks, but the one who assembles. The critic is not the one who lifts the rugs from under the feet of the naïve believers, but the one who offers the participants arenas in which to gather. The critic is not the one who alternates haphazardly between antifetishism and positivism like the drunk iconoclast drawn by Goya, but the one for whom, if something is constructed, then it means it is fragile and thus in great need of care and caution” (2004: 246). He goes on to say, “What would critique do if it could be associated with more, not with less, with multiplication, not subtraction” (ibid: 248). The critique offered here, then, is one that adds to the possible ways to approach users of complementary self-health in their subjectivity. Latour argues that the writer’s intervention is with the reader, through providing him or her with an opportunity to reflect by taking just these stories, from just these interviews, and telling this story in just this way.

Analysing contemporary ethopolitics

The concern here is with how I have come to analyse how the interviewees situated their selves within their subjectivity. To return to the problem described at the end of chapter one, ethopolitics is concerned with “the self-techniques by which human beings should judge and act upon themselves to make themselves better than they are” (Rose 2007: 27). Here, ethics is not just the adjudication of values, but a response to the question “how should one live?” This involves (i) ideas of practice

(‘how’); (ii) a notion of the subject of ethical reflection (‘one’); and (iii) questions of norms and values (‘should’) (Lakoff and Collier 2004).

In order to orientate the strategy of my analysis, I have used four dimensions of analytical categorisation, which come from reflections upon the empirical and theoretical literature. In particular they are influenced by Foucault’s work in the first volume of *The History of Sexuality* ([1979] 1998b). Foucault approached the production of subjectivity through the practices, understandings and aspects of existence that became evident as problems that needed some sort of work done upon them and/or transformation. In order to do this he marked out four key areas for exploration of subject-formation or subjectification. These ethical dimensions include: (i) “*the determination of the ethical substance*; that is, the way in which the individual has to constitute this or that part of himself as the prime material of his moral conduct” (Foucault [1979] 1998b: 26). This is the field that is to be examined and the agenda by which it is to be set against, which involves separating a part of the self so that it can be scrutinised. (ii) “*The mode of subjection (mode d’assujettissement)*; that is, the way in which the individual establishes his relation to the rule and recognises himself as obliged to put it into practice” (ibid: 27). (iii) “*the elaboration of ethical work (travail éthique)* that one performs on oneself, not only in order to bring one’s conduct into compliance with a given rule, but to attempt to transform oneself into the ethical subject of one’s behaviour” (ibid). Finally, (iv) “*The telos of the ethical subject*: an action is not only moral in itself, in its singularity; it is also moral in its circumstantial integration and by virtue of the place it occupies in a pattern of conduct” (ibid: 27-8). This is where the action falls in terms of the stage of life, its continuity to previous actions and the commitment that it implies not only to other actions always in conformity with values and rules, but to a certain mode of being, a mode of being characteristic of the ethical subject.

It is important to note that Foucault recognised that analysis of each of the four dimensions was not necessarily needed in every case or for every story. Rather they were indicators of what areas need exploring in order to address the question of subjectification. Indeed, as noted above, I take Foucault’s work as a starting point for my own analysis and have sought to take a loose understanding of the four dimensions. As Rose (2007) succinctly summarises, these dimensions can be

understood as a set of analytical strategies that (i) identified an aspect of the person to be worked upon, (ii) problematised it in certain ways, (iii) elaborated a set of techniques for managing it, and (iv) set certain objectives or forms of life that were to be aimed for.

A similar method was also used by Blackman (2001) to analyse the practices and techniques of members of the Hearing Voices Network. To summarise, she found that these disciplines somewhat assume that these kinds of discourses and the psychological and psychiatric concepts that underpin them do determine the ways in which people understand their own distress and suffering. Blackman noted that this is largely due to the fact that these analyses were conducted at the level of the text, and so construct selfhood in particular types of ways, which are linked to wider practices of governmental practices. In order to address this problem Blackman used the later work of Foucault, which was interested in how selfhood shifts and changes over time – he argued that there was no stable or constant self that can be offered as the basis of the means to be human. Moreover, rather than assuming that the individual meditates and reflects on their inner self, his later analysis directed concentration to the places where aspects of being were marked out for attention, as well as the ways that these aspects of existence were made intelligible and amenable to particular kinds of intervention.

For this thesis, the focus was upon the stories that were told and how, where and when each dimension was understood to be problematised by the interviewee herself. Table 1 provides a broad overview of how all this comes together. It is only at this stage, now that the attitude and strategies of the analysis have been made clear, that it is possible to provide an overview of the analytical structure.

	Mode of subjectivation (obligations)	Ethical work (practices and techniques)
Ethical substance (field, agenda)	Balanced living (4)	Embodied guides (5)
Telos (objectives, aims)	Cancer as a Gift (6)	Living in the now (7)

Table 1. The general analytical concerns of the substantive chapters (in ellipses).

It is important to note that this table *came out of the interviews*, and was only constructed late into the writing period of the thesis. There was no attempt to ‘fit’

the respective dimensions into each chapter. This will be evident to the reader as they progress through the chapters; as although the table suggests that each chapter focuses on two dimensions, others are both implicitly and explicitly explored.

Conclusion

The epistemology and analytical attitude outlined here aims to provide a situated account, rather than a privileged look inside a person's head. It takes seriously the possibility that interviewees can display their "moral adequacy" (Seale; cited in Frank 2006: 248), whilst also recognizing the impact of the context in framing their story. Therefore the following chapters do not map out instances of the four ethical dimensions. Rather each dimension can be found to be present to a greater or lesser extent in each of the chapters. Moreover, how and when they occur is dependent on the situation and the aim of the following analysis will be to show what is happening, what is the focus of the story and how this is experienced by the interviewee.

However, in order to listen with the interviewees in the following chapters it will first be necessary to introduce the field of complementary self-health that they have used. Specifically, in the next chapter, I will provide a summary of several key complementary self-health books that were used by the interviewees in this thesis. I will also provide an outline of the key spheres and themes that I identified within these texts and during my fieldwork. Following this I will introduce one of the key analytical distinctions that I argue problematises the field of complementary self-health: that between a hermeneutics of care and the 'support of the self'.

Chapter Three

Complementary Self Health: A New Pastorate

Attention to self-discovery, self-knowledge and self-expression has been part of defining contemporary culture since the 1960s. On the one hand, self-help has been viewed as a kind of self-governing prison. That is, self-help has been found to hold the potential for the extension and intensification of power-knowledge in governing the self. But on the other hand, self-help can also be argued to hold the potential to be a site of resistance or refusal, by bringing attention to the relationships users takes up with their selves. Following this, in this chapter I will explore both the conceptual and empirical tensions that complementary self-health presents. As I explained in chapter one, complementary self-health refers to that part of self-help that draws on complementary therapies with the aim of affecting a person's health. Through an examination of several self-health texts found in complementary cancer healthcare, I will highlight in this chapter some of the main spheres and themes of the field. While an analysis of these texts does not allow me to discuss how they are used by the users of complementary self-health, the first aim of this chapter is to appreciate some of the tensions and spaces that are a part of this field of enquiry by asking how the complementary self-health field is itself differentiated in sometimes implicit, sometimes explicit, ways. In doing so, I hope that the reader will develop an appreciation not only of the limitations that self-health poses, but also of the possibilities those same tensions hold for the self, health and life.

The second aim of this chapter is to explore the critique that self-health is a disciplining framework that inculcates the individual into a regime of health, or what can be described as governance through ethics. I argue that whilst under an ethopolitical analysis (Rose 2007), an analysis of strategies of governance might be necessary, it is not sufficient to examine the claim that those using self-health are being subjugated through ethics. I argue that self-health needs to be conceptualised within an ethopolitics that gives room to the 'double game in play' in Foucault. One way to do this is through complementing an analysis of the 'care of the self' (Foucault [1988] 1997; [1982] 2005) with an understanding of what I have come to call the 'support of the self'. By doing so I argue that it is possible to move beyond

an analysis of discourse, disciplining and governance, to explore the possibilities of subjectification and the formation of one's self as a subject in one's subjectivity.

A New Pastorate

Critiques of self-health come from many quarters; more still if one takes into account commentaries on self-help, which tend to view self-help as an exemplar of wider social, cultural and political forces. Rayner and Easthope (2001) explored how self-help might be seen as a symptom of postmodern society. Elsewhere, Giddens (1991) has argued that self-help is part of the individualization and responsibilisation of subjects in contemporary society. Whereas Bauman (2007) has argued that self-help is part of consumer culture's self-absorbing fashion, or what McGee (2005) described as the Protestant work ethic being augmented by a Romantic imperative – elsewhere identified as the 'entrepreneurial self' (Rose 1999b). Returning to cancer healthcare, based on her personal experiences of cancer and CAM in the early 1990s, Stacey argued that in 'self-health' (J Stacey 1997) narratives' masculine values are often seen to be under attack, yet finds their gendered appeal as part of their potential complicity with emergent and established forms of enterprise culture. A self-health culture that is linked to a complex apparatus of professional authority and financial interests (King 2008).

Whilst these critiques are important and must be considered in any discussion of self-health, I will do so tangentially and through a closer examination of another major critique of self-help and self-health, which has come from extensions of Foucault's work. One way this has been done previously is through an appropriation of his later work on the care of the self and the aestheticisation of life (Foucault [1988] 1997; [1986] 1998a). For example, Rimke finds that self-help is an extension of a psychologically orientated culture organised according to the 'psy complex' (Ingleby 1985; Rose 1990; 1996; cited in Rimke 2000). This is part of a deeply held belief, Rimke asserts, that psychology can help people become 'happy' or 'normal'. Self-help is therefore part of the discourses and technologies that contribute towards the invention, scripting and governing of selves. Self-regulation here holds a supposedly paradoxical relation with the liberation and self-realisation that comes from it.

For some this might sound like a disciplinary network from which subjectivity cannot escape. However, what I will argue is that such an anxiety is conceptually unwarranted and empirically unfounded. Whilst many, including Foucault, have criticised the self-help *dispositif* for locking the individual into a particular form of political rationality, I will explore how there are possible readings of self-health in ethopolitics that allow for other possibilities. In doing so I draw attention to the plural and contested field of a new form of pastoral power that is best characterised as “relational” as it “works through the relation between the affects and ethics of the guider ... and the affects and ethics of the guided...” (Rose 2007: 74). This pastoralism entails “bidirectional affective entanglements” (ibid) between the individual and the practitioner, which necessitates “microtechnologies”, that blur boundaries and transform subjectivities of those who are subjected to them by providing new languages, criteria, ethics and the telos of encounters with which to understand and judge what has, is and will happen. Hence I start with the premise that self-health holds one opportunity for new subjectivities to challenge, as well as fulfil, contemporary ideas of self, health and life.

Introducing Complementary Self-Health Approaches for Cancer

The following is not a comprehensive glossary of the cancer complementary self-health texts available, nor is it a genealogy⁷. The books covered below were selected because they were the texts recommended to me by my interviewees. Each book was referred to as being a significant resource that the interviewee had turned to in more than one interview. For this reason, I have not included Bernie Siegel’s significant and influential book *Love, Medicine and Miracles* ([1986] 1999) in which he finds through the power of unconditional love, many ‘exceptional’ patients can bring their own miracles to their illness. Similarly, neither have I provided detail comment here on Louise Hay’s ([1984] 2004) *You Can Heal Your Life*, a text that seems to have had more resonance in the USA than the UK. One interviewee (‘Angela’, chapter six) cited it in her interview, but as well as this being the only reference to it in my interviews, I have also chosen not to cover it here as Hay’s

⁷ Boris Traue (2010b) has provided the closest I have found to a genealogy of self-help. However, I am only familiar with it through a seminar he provided in October 2010, as this book is currently only available in German.

position that ‘positive thoughts can cure cancer’ (discussed below by Jane Plant) was seen to be too extreme for those that I discussed it with in my fieldwork. I have also only included books that are directly related to cancer and complementary self-health. Books such as Eckhart Tolle’s *The Power of Now* ([1999] 2005), or Rhonda Byrne’s *The Secret* (2006) have been greatly influential in the self-help field more generally and can be seen to resonate through the self-help texts covered here. For example, Tolle aims to transform the person’s inner consciousness by questioning Descartes’ assertion ‘I think therefore I am’. He seeks to do this through applying ideas of Eastern mysticism that draw a distinction between the self as thought and the self as that which can watch him or herself thinking. In *The Secret* there was the more diffuse message that focused positive thinking can bring great changes to the way the user lives their life and increases their good health, happiness and wealth. However, as both texts did not address the specific issues faced by the person with cancer, I felt it best that they remain in the background for this research and to be highlighted where necessary.

Therefore, for the purposes of this thesis I will focus on six specific texts that were highlighted by my interviewees as particularly important to their experience of cancer. The texts considered are: Lawrence LeShan’s ([1989] 1994) *Cancer as a Turning Point*; *The Bristol Approach* edited by Cooke ([2000] 2003); Rosy Daniel’s (2005) *The Cancer Directory*, part of her ‘Health Creation’ course; Jane Plant’s ([2000] 2007) *Your Life in Your Hands*; Chris Woollams’ ([2002] 2005) *Everything You Need to Know To Help You Beat Cancer*; and, Alistair J. Cunningham’s ([1992] 2000) *Healing Journey*.

Lawrence LeShan’s ‘Cancer as a Turning Point’

LeShan’s *Cancer as a Turning Point* ([1989] 1994) is one of the foundational texts for many self-help books. LeShan, a psychotherapist, considers how the psychological factors “play a part in how and when people become sick and how their immune systems function when they are sick” (ibid: xii). This is an idea that existed before LeShan, but it is his book that was most frequently referenced as the starting point for developing not only ideas on how the mind and body relate but how the person can affect this by working on his or her self in the complementary self-health context. It is a position that has been developed considerably since his book,

with the mind-body relation now more often framed as ‘psychoneuroimmunology’ (PNI) – see the Bristol Approach, Daniel’s Health Creation and Cunningham’s Healing Journey, below.

Nonetheless LeShan’s main contribution was to draw attention to the psychology of cancer. However, he cautions that, while psychological factors are certainly part of the process “no one ‘makes themselves sick’ by how they behave or feel” (LeShan 1994: xii). Noting the importance of hereditary and environmental factors, LeShan stresses, “*you are not responsible for becoming ill, and you are not responsible for your recovery*” (author’s italics; *ibid*). LeShan is quite clear on this point. He repeatedly stresses, “*Thoughts and feelings do not cause cancer and cannot cure cancer*” (author’s italics; *ibid*: xiv). However, what complicates matters is that he notes that they are an ‘important factor’ in the total ecology of the human being. Feelings, he notes, affect the body chemistry and this can affect the development of a tumour. Following William James, LeShan asserts there is “no clear dividing line between a person’s philosophy and physiology, between mind and body. All the different aspects of a person interact with, and influence, each other” (*ibid*: xiv).

LeShan goes on to discuss how, if there are two factors to cancer, the genetics that you cannot change, and the environment, which you can, then “To minimise the chances of a return of the illness we must change one of the two sets of factors” (*ibid*: 70). However, LeShan notes that the emotional work he does with his patients may only count for five percent of the factors involved, but he reasons that five percent may make a crucial difference for many people. Therefore, there are certain psychological steps that a person can take to increase their self-healing abilities and aid their medical programme. The exercises he provides in his book, LeShan notes, are there to help the person look at his or her self so that they can “see what changes are necessary to bring you to a fuller, richer life. And to find a possible and realistic path to move in this direction” (*ibid*: 220). But, again, LeShan is careful to note that in his approach he does not blame the ‘patient’ for their cancer – severely chastising those that do and asserting that they should be ignored as they increase the guilt, confusion, anxiety and anger that is felt.

As well as the contested relationship between psychological factors and cancer, LeShan is also famed for the maxim of seeking to help each individual person to

‘find her song to sing’. He found that, when they do find this song it was “socially positive, and improved his or her human relationships” (ibid: 53). His “method concerns people taking control over their own life – of searching for a life-style especially suited for them and, when found, actively working toward living this life” (ibid: 62). This can entail a “complete restructuring of their thinking about themselves”, away from thinking about what the user ‘should’ do towards what would they would enjoy doing, “what *style* of being, relating, creating would bring me to a life of zest?” (author’s italics; ibid: 63).

LeShan describes this as directing the user’s lives from the needs of their individual structures, rather than from what they are supposed to do. He argues that rather than worry about what the ‘world’ wants from the user, they should worry about what makes them come alive. LeShan argues that the important thing “is that we develop the attitude that we are worth caring for and worth taking care of. . . all [of the changes we make] are in the direction of our *becoming*, our learning to live more and more under our own name” (author’s italics; ibid: 247). To follow this is to become an ‘authentic’ individual; but this will not necessarily make people like the user, as people may react against the choices that have been made.

‘The Bristol Approach’

One of the oldest and certainly one of the most established ‘Cancer Support Centres’ in the UK is the Penny Brohn Cancer Care (PBCC)⁸ centre. *The Bristol Approach* (edited and updated by Cooke [2000] 2003) is the most formalised account of the form of support advocated at PBCC. It is not the product of any one person, although it owes its ‘spirit’ to Penny Brohn. Rather the approach, as well as the book, is the product of the input of many complementary and orthodox practitioners, as well as the PBCC’s users.

Cooke explains how PBCC was born out of Penny Brohn’s need to help her soul and emotions, as well as provide the physical treatment that she received for her body via orthodox and complementary treatments. It describes how Penny wanted somewhere where they could all be provided under one roof, “...where mind, body and spirit

⁸ PBCC was known up until 2007 as the Bristol Cancer Help Centre (BCHC), when it was renamed in honour of its founder, Penny Brohn.

could be thought about simultaneously - a place under strong medical guidance where all this fear could be contained and all levels of being could be cared for and involved in the process of self-healing” (Cooke 2003: 5).

The Bristol Approach describes how it is underpinned by the science of “psychoneuroimmunology” (PNI). In summary, this states that the mind is continually interconnected with the body through neurotransmitters called neuropeptides. Neuropeptide denotes a group of “chemical messengers - specific ones for each emotion - that are in intimate communication with every cell of your body.” The advice is therefore that “*the most immediate way you can influence your immune system is by activating the positive emotions*” (author’s italics; *ibid*). Cooke then notes the “profound realisation that the intelligence and memory of the human being are not confined to the brain” (*ibid*).

In *The Bristol Approach* this support for the self is summarised as having the following “essential ingredients”:

- “Think about *getting it right for yourself* in all situations. While this may be initially feel selfish and uncomfortable - like crossing your arms the wrong way - you will quickly find that if you learn to get things right for you it will be far better for everybody else around you.”
- “*Take time for yourself*. Allocate several days and evenings a month which are solely your time. Make this unstructured time that you can use as appropriate when it arrives. Use these times to be reflective, and to do only things that sooth, nurture and lift your spirit. In addition to this, make regular time for important therapeutic sessions or self-help classes.”
- “*Be gentle with yourself*. Do not make the holistic approach another stick with which to beat your back. There are absolutely no shoulds or oughts involved in any of the many aspects of the holistic approach. It is not about setting yourself gigantic tasks, feeling guilty if you fail, and in general assuming too great a responsibility for yourself and your health. Quite the reverse: it is about identifying the aspects of yourself that tend to push you too hard, and allowing yourself to find a new way of being - one that is gentle, spontaneous and feels very right to you. Remember, you are the only one that can judge that.”

- “*Prioritize* activities that excite and enthuse you, and allow you self-expression.”
- “*Let go* of your concerns about the opinions of others.”
- “Most important of all, *be yourself*” (author’s italics; Cooke 2003: 167).

In summary, the Bristol Approach is about recognising the “strong threat to our very being” (Beales 2003; in Cooke 2003: 58) that a diagnosis of cancer brings and the awareness this awakens of knowing that, in the end, everyone dies. “Our ability to cope and deal with the threat is likely to be helped considerably by awareness of the interacting influences that go to make up our own unique way of dealing with the threat brought about by the cancer diagnosis. We can then choose interventions, within a framework of support” (ibid: 58-59).

Rosy Daniel’s ‘Health Creation’

Daniel is a medically trained doctor who worked at BCHC (now PBCC) between 1985 and 1999, latterly as their Medical Director. After leaving BCHC she went on to develop her own programme called ‘Health Creation⁹’, which includes the ‘Cancer Lifeline Kit’ that the main text, *The Cancer Directory*, is part of. Daniel acknowledges that her work draws heavily on that done by many people who have worked at BCHC since it was founded in 1980.

Daniel describes her approach as being part of ‘integrated cancer medicine’ and whilst this follows much of the Bristol Approach, its methods and exercises differ somewhat. Like the Bristol Approach, Daniel notes that the causes of cancer are both direct, such as chemical toxins, and indirect, such as things that prevent the body from repairing damage or that fuel cancer once it is established. However, Daniel introduces her main tool for assessing your whole health, the ‘Picture of Health’ exercise. This involves answering ten questions on twelve ‘Health Creation Principles’, which are divided evenly between the body, mind, spirit and environment. Once you have a score for each of the twelve it is plotted on a twelve spoke wheel. The shaded area marks where you are strong and well, the unshaded denote where further work is to be done (see Figure. 1).

⁹ See: <http://www.healthcreation.co.uk/>

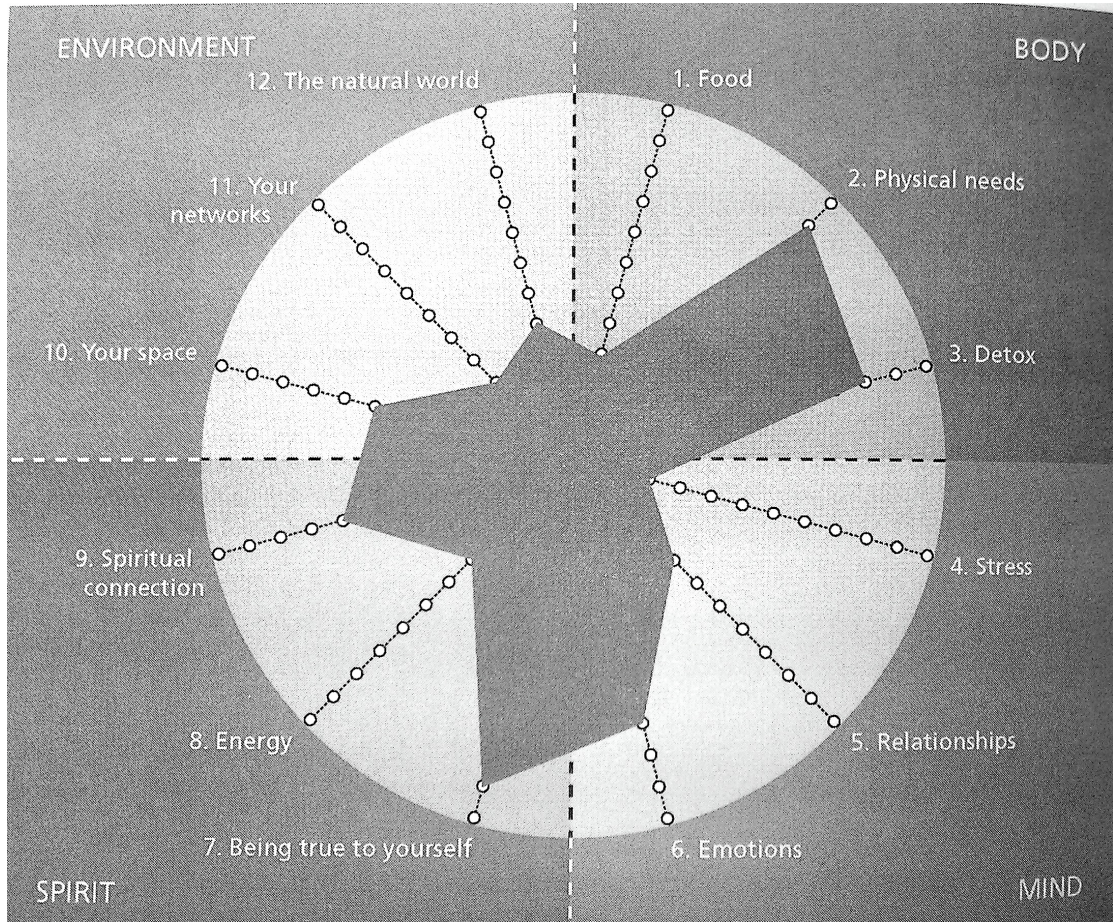


Figure 1: An example of a completed 'Picture of Health' (Daniel 2005: 176).

Once the user knows where their strengths and weaknesses lie in the Picture of Health they can then look to tailor the 'five vital steps' to improve the weaker areas of their life. These five steps are: first, they should 'improve your relationship with yourself', ensuring that they get rest and the nourishment that they need and through learning to value and nurture herself. This will help the user have a better sense of 'what you really need'. Second, they should 'care for your body' with a healthy diet, regular exercise and reduction of toxins in your life. Third, the user needs to 'improve the state of your mind' so that it is more balanced by reducing both external and internal stress, improving relationships, and offloading toxic emotions or 'letting go' of unhealthy goals she may have set her self. Daniel notes that stress is also strongly linked to feelings of powerlessness and that the internal and external causes of this need to be addressed to improve your health. She also finds that once these exercises have been done it will create room for the person to grow, but in time they will need to repeat these exercises as the new ways of living overgrow and become part of an unhealthy way of being. A significant part of the Health Creation

programme is the fourth aspect, which seeks to ‘revive and honour your spirit’ through regular spiritual healing or reiki. This helps the user to use cancer as a ‘wake-up call’ and bring their life to a “healthier, happier, more authentic footing than before” (2005: 180). Fifth, the user should ‘care for your environment’ by making sure that the places that they live and work make them feel good, through establishing good networks of friends and being environmentally responsible.

What also distinguishes Daniel’s book is that it also asks something of the reader. Once they have recovered their health, she requests that they “become active politically and environmentally to stop the cancer epidemic we are witnessing at this time” (ibid: 227). She goes on to say, “We must ensure that the next generation eats balanced healthy diets, has access to safe, nutritious food, and lives in a smoke- and pollution- free environment. Let us go together, step by step, determined to clean up our environment, and restore the health of all the people as well as this beautiful and extraordinary planet that we share” (ibid). She argues that with one in three people getting cancer there has never been a clearer need to act and “restore our health and balance in all aspects of life” (ibid).

Jane Plant’s ‘The Plant Programme’

Professor Jane Plant’s book *Your Life in Your Hands* ([2000] 2007) can, at first, be seen to contrast quite distinctly with LeShan’s approach and those influenced by him – emphasising, as she does, the role of diet and the user’s environment in causing cancer. Plant’s book reflects on her own diagnosis and experience of breast cancer, bringing to bear her ‘scientific training’ as a geologist on what can be done to help women. She argues that women should have the best available information available to them so that they can make ‘informed decisions for themselves’.

Plant starts by asserting that the ‘Plant Programme’ is not a diet. Rather it is ten food and lifestyle factors that can be used to overcome advanced breast cancer and keep you cancer free¹⁰. She says, “they should be seen as helping hands, not as severe dietary constraints” (Plant 2007: 115). Plant notes that many anti-cancer diets are

¹⁰ Plant’s original book in 2000 focused on seven food factors and five lifestyle factors, whereas the 2007 book has ten of each.

based on the principles set out by Dr Max Gerson who argued that cancer is a symptom of a diseased body in which the organs, in particular the liver, were out of balance. However, her Programme differs from the Bristol Approach (which she herself followed for a while) and Gerson diets as it is specifically targeted at breast, prostate and ovarian cancers. Furthermore, Plant argues that doctors should not object to it as the programme is based on good science.

Plant bases her diet on the Chinese diet following an epidemiological analysis of their incidence of cancer, in particular breast cancer. She found that in China there was a low incidence of breast cancer that could be attributed to the low amounts of dairy products of all kinds in their diet, coupled with the high use of soya products. A diet she notes that “evolved over thousands of years of observation and practical experience and has been thoroughly documented and referenced” (2007: 341). It is therefore, she says, not a ‘new’ fad diet or based on a single-issue bio-chemical theory but the product of “the most biologically successful people on Earth” (ibid: 342). Plant repeatedly attributes a great deal of their dietary success to the fact that in China a healthy diet is seen to contain over 30 different ingredients a day, whereas for the average American 40 percent of all they consume is dairy based.

Plant is clear about her attitude to mainstream medicine, as she recommends that people stay with the NHS and follow the recommendations of their doctors. She goes on to say, “**I emphasise that these would be my personal choices and that you must make your own decisions about treatment options based on the advice given to you by the physicians treating you**” (author’s bold¹¹; Plant 2007: 273).

Plant then reviews some of the available CAMs, focusing mainly on herbal remedies. She repeats that she would use ‘conventional medicine’ in combination with the Plant programme. Plant reasons that CAMs remain on the fringes not because of the failure of pharmaceutical companies to take them up or because these companies seek to suppress CAMs in defence of their profit, but because of the poor outcomes of trials. Nonetheless, Plant notes that she would use acupuncture and that other therapies such as reiki and reflexology are useful. This is because “the best

¹¹ If it were not already obvious, there is a lot of emphasis to the written word – through the use of italics, bold, underline and capital letters – used in these texts. I have chosen not to remove these stylisations, and thus make the page more aesthetically pleasing, as part of my aim is to provide the reader with an experience, albeit partial, of reading these books.

alternative and complementary therapists will give you that most precious thing, their time. Just talking . . . is, I am sure, healing” (Plant 2007: 277-8). This ambiguity of such ‘psychological factors’ in Plant’s approach is something I will return to below.

Chris Woollams’ ‘Beating Cancer’

Someone with much less ambiguity about his position is Woollams’ book *Everything You Need to Know To Help You Beat Cancer* ([2002] 2005). In it he tells how his daughter, Catherine, was diagnosed in 2001, days after her 18th birthday, with a brain tumour. This set him into action to find out all he could about his daughter’s disease. Woollams notes that his background includes four years at Oxford University reading biochemistry, with a year specialising in cancer research and viruses, but that instead of pursuing the offered PhD he went into advertising and marketing, ‘retiring’ aged 45. From his ‘homework’, after Catherine’s diagnosis, he drew five conclusions: first, that there is lots of information out there, if patients and doctors had the time and inclination to look. However, most doctors and scientists do not seem to be communicating well with each other “*let alone passing it on to GPs and patients*” (2005¹²: 2). Second, he finds there is no “***single source, no fount of knowledge***” (ibid) that the person with cancer can turn to. Third, therefore “***people are dying of ignorance***” as the relevant information is not getting through. Fourth, Woollams maxim is “*there is so much you can do to increase your odds of beating cancer*” . . . [But] “***Sadly, the onus for building this ‘total package’ of activities lies with you and no one else***” (ibid: 2-3). Fifth, people “***should do everything in your power not to get cancer in the first place***” through “*loving your immune system*” (ibid: 3).

By Woollams account, there are “generally four factors common to cancer sufferers:

- i. “Cancer sufferers are ‘toxic’ . . .”
- ii. “Cancer sufferers often have ‘acid’ cells . . .”
- iii. “Cancer sufferers often have a parasite (and/or heavy yeast infection) and about 20 per cent have some sort of virus . . .”
- iv. “Cancer sufferers can have a self-debilitating mental attitude . . .”

(Woollams 2005: 38).

¹² Woollams writes the whole of the introduction in italics, using bold to add further emphasis.

Nonetheless, Woollams believes that despite the problems with contemporary society and the environment that affect the person with cancer, “it is still possible for you to create your own highly successful micro-environment” (2005: xvii). In order to do this, Woollams argues that people with cancer need to break ‘bad habits’, quoting Samuel Johnson “*“The chains of habit are too weak to be felt until they are too strong to be broken”*” (cited in Woollams 2005: 5). Woollams goes on to assert that “*With the modern world dragging you into bad habits, only serious self-discipline will get you out of becoming more and more at risk*” (2005: 5-6). Underpinning Woollams’ recommendations, he says, is the axiom, ‘you are what you eat’, which “Stems from naturopathy and the belief that we are at one with our surroundings. The opposite of health is illness. There is only one state of health and all illness is one; it is just represented in a number of forms. If cancer is brought by poor nourishment, then good nourishment is the way to beat it” (2005: 134).

Moreover, Woollams argues that in order to prevent or beat cancer the user must work on their underlying health. The following is worth quoting at length:

“Cancer is the symptom of another illness; one which may have started even now to overtake your greater body and one you must address if you really want to beat it.”

He goes on to say:

“A healthy body starts with a happy attitude, a sense of purpose, and a total feeling of self worth and value. This feeling in itself directly stimulates the nervous and endocrine systems, making your immune system and your cellular biochemistry stronger. This will in turn make you happier and lead you to value yourself more, for example, in your approach to your life . . . This in turn further stimulates the immune system and builds your body energy. This is the way to beat cancer, and indeed all illness” (author’s bold; Woollams 2005: 170).

In summary, Woollams argues that each person can ‘beat the odds’ through evaluating and amending their diet and lifestyle, by taking a crash course of supplements, getting the right sort of support, through ‘concentrating on you’ by removing stressors, and through ‘being determined’ – “be absolutely clear. This is a fight to the death. The death of you or the death of cancer, and the odds already say

you should win” (2005: 188-9). Woollams concludes, “Make no mistake, you were no victim . . . By and large you contracted cancer because of our own personal habits” (2005: 189).

Alastair J. Cunningham’s ‘Healing Journey’

Cunningham originally trained in veterinary medicine, before completing a PhD in cell biology and doing twenty years of research in immunology. From 1980 he retrained and did a second doctorate in clinical psychology and developed a particular interest in the beneficial effects of counselling and coping-skills for cancer patients. He also had his own diagnosis of bowel cancer in the 1990s, which he responded to with an increase in his “own search for ‘connectedness’ with all aspects of my being” (2000: 15). He went on to write *The Healing Journey* ([1992] 2000) and associated workbooks¹³ and developed the ‘Healing Journey Programme’.

Cunningham believes that many people avoid taking the step to change their lives and slide back into that familiar loop of old habits; of “ordinary ‘automatic’ (unaware) living” (2004a: 38). For them he feels that it is easier to deny the seriousness of the situation, leave it for others to fix, or just hope that everything will turn out okay. However, “Others decide to use the threat as a stimulus to personal growth, and begin to ascend the first ‘leg’ of the journey” (ibid). The journey is divided into three stages, each with five parts. In the first stage is called and starts with ‘taking control’; this is followed by acknowledging the threat, expression of emotional reaction, learning self-control strategies, and practicing them. The second stage of the journey is aimed at ‘getting connected’ and looks to develop an understanding of how the mind works as well as “getting to know the old patterns, some of which hold you back” (ibid: 39). The parts to this stage include, a shift to an inward focus, an increasing awareness of authentic needs, and of coming to understand personal motives, drives, and obstacles. The third stage is called ‘finding meaning’, which “is about connecting with some order, purpose or dimension that is bigger than we are; it’s discovering how we fit in and what purpose our lives have. Through such spiritual work, we eventually find that the search for meaning in

¹³ Level One (Cunningham 2004a) and Two (Cunningham 2004b) Workbooks, adapted for the Healing Journey UK programme are referenced here. But all five generic workbooks are available for free at: <http://www.healingjourney.ca/resource.htm>

cancer is a quest for meaning in life itself” (ibid). The first part then, starts with a shift to a focus upon transpersonal goals, which is followed by a growing identification with ‘higher self’ or community. These are followed by parts called quiet, meaning and purpose, and peace.

The idea of the human being in the Healing Journey is one who is ‘connected’. In describing the person in this way Cunningham explores how cancer can affect the person in many different ways. To summarise this the Healing Journey uses five concentric circles (see Figure 2: Key: A (‘black blob’) = Traditional view of cancer’s location as a collection of cells in the body. B (‘party balloon’) = Cancer as “a distortion or imbalance of the whole person” (Cunningham 2004b)).

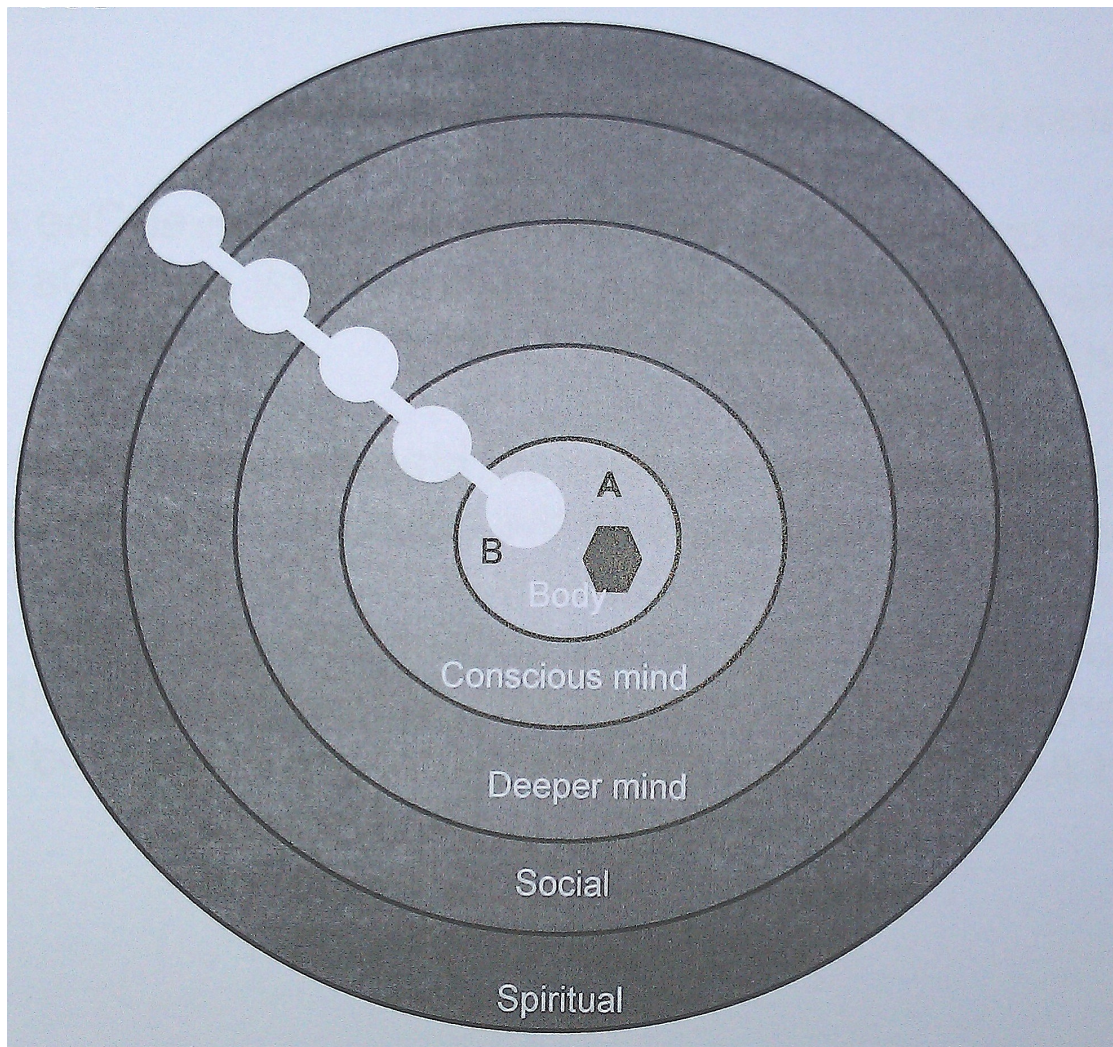


Figure 2: Cunningham’s diagram of ‘connectedness’ (Cunningham 2004b: 11).

Starting in the centre there is (1) the ‘body’; then (2) the ‘conscious mind’. Then there is (3) the ‘deeper mind’ that includes emotions and buried imagery, ideas and

fears. The next level is (4) the ‘social’; and finally there is (5) the ‘existential or spiritual’, which shows how “we are all a part of some higher non-material order, although we do not see it directly” (Cunningham 2004a: 22).

Spheres and Themes of Self, Health and Life in Complementary Self-Health

As Cunningham exemplifies, within complementary self-health approaches there are often several distinctions or ‘spheres’ of self, health and life. In this section I will provide an outline of some of the salient features of the complementary self-health understandings. In doing so I will preview some of the tensions within and across the spheres of life described as mind-body-spirit-(energy-environment-society), as well as within and across the themes or attitudes of holism, connectedness, listening and healing.

Mind-Body-Spirit-(Energy-Environment-Society)

Although the body is the most obvious site for healing, for many of the above approaches the first step for healing is to do with the ‘mind’. Like all of the spheres under discussion here the definitions are loose and sometimes contradictory, both internally and externally. But under the banner of mind there is talk of four general forms: emotional or psychological attitudes; rational-cognitive or what might also be called instrumental reasoning; brain-talk or neurochemical descriptions; and, orientations around the self. No one approach commits to only one of these forms, preferring to find different combinations.

Central to many of the approaches’ understanding of this sphere is the life history of patients and their susceptibility to cancer, or the ‘psychosomatic viewpoint’. LeShan finds that a person’s “emotional life history often does play an important part in determining an individual’s resistance to getting cancer and in how a cancer develops after it appears” (LeShan 1994: 11-12). That is, it was the context in which the cancer developed that was important. He found that in many of the cases he saw there had been “a loss of hope in ever achieving a way of life that would give real and deep satisfaction, that would provide a solid *raison d’être* . . . [A] lack of hope” (LeShan 1994: 13).

Woollams probably takes up this finding in its most aggressive form when he asks the question: “How important is my mental attitude?” Answering: “**Crucial**”

(author's bold; 2005: 165). He goes on to explain that as well as diet and physical lifestyle, cancer patients need to change their attitude to become more relaxed and content with themselves. The combination of LeShan along with Eckhart Tolle's (2005) 'living in the now' can be heard when Woollams urges people to "live neither in the past nor the future but here and now, don't apologise or feel guilty, be happy, have fun, love life, love yourself, think nice things, don't be habitually critical. Most importantly realise that you have strengths and skills, that you are a 'loved' person who deserves the best in life and has the ability deep inside you to be special" (2005: 165). In this Woollams argues that conventional biomedicine overlaps with naturopathy in the study of PNEI (Psycho-Neuro-Endocrino-Immunology). The findings of which are simply put as "our feelings, emotions and thoughts are fundamentally connected to the working of our bodies" (2005: 167).

The Bristol Approach, Daniel and Cunningham take a less aggressively worded stance, although there is still a strong directive current towards becoming attentive to what one thinks in order to affect the body. Developing this attentive attitude to oneself and one's environment is a significant part of the self-health approach. However, it would appear that there is no predetermined end point. Also, by urging the person to find their *own* intuition, their own way, it is left open to the person to decide how they will proceed. For example, focusing on the mind is designed to assist the person in becoming aware of what they are thinking, ". . . of our stream of self-talk . . . Without awareness, we do not have the option to change – we don't even know there could be such an option" (Cunningham 2004a: 44). In this practice, Cunningham notes, the person will see that some thoughts and images will come from a relatively 'superficial' place. By which he means that the person is controlling what they see with their will. However, "other images will 'well-up' by themselves, as they do in dreams" (2004a: 59). Cunningham goes on to say, "As you work on your imagery, you will begin to encounter images about which you have a strong inner feeling (really an intuition). Trust those intuitions, and shape your imagery accordingly" (ibid).

However, before I conclude that the mind is fetishised as the source of all health and all that is needed to avoid, cope or cure cancer is positive self-regard, I should emphasise that this level also holds an important tension. It is not always clear

whether, if at all, this is simply about the mind directly curing cancer or if it is about becoming aware of coping styles. For example, Plant rejects the idea that you can be cured of cancer purely by ‘thinking positively’. She quotes Louise Hay’s *You Can Heal Your Life* where she finds that cancer is caused by “deep hurt, long standing resentment, deep secret or grief eating away at the self” and recommends a new thought pattern along the lines of “lovingly forgiving and releasing all of the past, choosing instead to fill your world with joy” (Hay 1984; cited in Plant 2007: 203). To which Plant quips, “Fine, but I prefer a more rational approach which seeks to remove cancer-causing chemicals from my life!” (ibid). Plant also rejects LeShan’s assertion that there is a ‘cancer personality’ arguing that all the available evidence goes against this theory. Plant restates that the problem is “one of chemistry and is rooted in the Western diet” (ibid). Yet Plant also accepts there is a chemical basis to stress, which can affect the immune system and even goes as far as to provide examples where she “learned to turn an extremely negative situation into something positive” (2007: 206). Plant goes on to describe her use of psychotherapy and cognitive therapy as she notes it helped her general health and well-being. Nonetheless Plant reinforces her argument that positive thinking is an ill-founded way of curing cancer, citing a systematic review that found positive thinking was not key to fighting cancer (Petticrew et al. 2002; cited in Plant 2007: 381).

Therefore, although Plant has rejected Hay’s argument that it is repressed negative emotions that cause cancer, she did seek the help of a psychotherapist to reduce her ‘emotional baggage’ of her past life and to develop a ‘new perspective’. Similarly, Daniel sees tackling emotions as part of the ‘fighting spirit’ needed to deal with cancer as, for PNI (psychoneuroimmunology), she says outbursts of anger or tears are just as good for you as laughter. Daniel finds that it is repressed feelings and being depressed that flatten the immune system. The user is therefore encouraged to locate and express their true feelings and base their action plan on these.

All the approaches discussed – with the exception of LeShan who notes the importance, but gives little in the way of advice other than seeking specialised help – provide detailed advice on how the user should best approach their diet and exercise programmes. Nonetheless, the various approaches evaluate the weight of the

evidence differently, as well as how it might affect the user's susceptibility, treatment and prevention of cancer.

As I have shown, Plant takes a strict line on what can and cannot be eaten: essentially no dairy, high in fermented soya products, lots of whole foods. Woollams matches this, although is less strict on the no dairy, but asserts that supplements must be added to the person's diet, rejecting Plant's claim that whole foods do enough. The deontological tensions are less in both the Bristol Approach and Daniel's health Creation, providing what can be summarised as lists of 'best to avoid', 'in moderation' and 'many everyday'. However, Cunningham cautions that there is no one dietary programme that he would advocate, as he finds that none have been proven to be effective. Nonetheless, he would advocate changing the diet to reduce the amount of fat and protein in it, and that people should follow a 'good' diet. But again the consensus is not as clear as it may seem. This is because, for Cunningham, it is in bringing the user's attention to 'controlling one's diet', that gives people "a very powerful psychological message about our determination to do all we can to fight the disease" (Cunningham 2004a: 31). It is, he argues, "more relevant to say that 'You are what you think'" (ibid: 32).

Given the above discussion, it is already clear that the distinctions between mind and body are somewhat blurred. But such imprecision should not be dismissed as arbitrary or irrelevant. Much has been written about the extent to which the complementary approaches that form a large part of self-health offer alternatives to Cartesian dualism (e.g. Hanegraaff 1999; Lorentzen 2008; Papoulias and Callard 2010; Scott 1998). What is pertinent here is that these tensions and distinctions are left open to be formed and reformed through the stories and experiences of all those *using* self-health.

This unbinding of the categories of the self, health and life are often described as part of awakening or re-discovering the spiritual aspect of being. Sometimes this is framed as a beneficial by-product of some of the exercises or the experience of cancer, others as an explicit aim of the work that is undertaken. Cunningham defines the spiritual as "the idea that we are all part of a greater whole, that there is a deeper or higher dimension...", which he notes has been called many things by different traditions or religions. He goes on to say "*Others may see spirituality in terms of*

finding a meaning or purpose. Through our spiritual journey we find our relationship to this dimension” (author’s italics; Cunningham 2004b: 48). The purpose of looking at the spiritual in the *Healing Journey* is not to advocate a religious system, but to help the person work towards having their own spiritual experiences. This he notes, “*will allow your inner being, the highest or deepest level of yourself, to exert its balancing, healing effects on your body, mind and emotions*” (author’s italics; ibid).

For the Bristol Approach it is clear that to undertake the practices of complementary self-health is to develop a spiritual awareness and consciousness. This, in turn, causes reflection and changes in the whole of one’s life. Life’s focus changes to a ‘here and now’ attitude, which is combined with a knowledge of ‘unconditional love’ that allows one to face death. This is a profound altering to the way life is lived; the order, mode, forms and purposes are affected as they move to what is called a ‘healing way of life’.

Put another way, Daniel finds that when someone is dispirited or their “spirit is crushed or broken by life” (2005: 210) it is their will to live that has gone. It is possible to see this in the person she notes, as “We actually ‘embody’ the feelings we can’t let go of in our posture and breathing pattern” (ibid: 211). In summary, Daniel says that to ‘attend to the state of your spirit’ there are three phases: first, unburdening of yourself of toxic emotions and disabling attitudes that stop you from being yourself. Second, ‘discover who you really are by becoming true to yourself’ through ‘listening to your core values’ and ‘finding what gives you purpose in life’. Once this ‘false-self’ is identified and the user’s core values are recognised, they can then seek to “change the balance in your life step by step” (ibid: 219) so that their life reflects better who they are; citing LeShan, Daniel notes that this is about learning to ‘sing your own song’.

Third, Daniel (2005: 221) urges the user to attend to your “spiritual nourishment” through lifting their energy levels and consciousness through various practices or exercises. She notes that this process, of moving from “material to spiritual values”, is often described by those who are undertaking it as being “in transformation”.

These people report how they now “live in the present moment” and how in doing so life is truly happy (ibid). These are sentiments shared by Woollams, who finds that

“Spirituality is about strengthening our total being...”. As well as being about a connection with a greater energy, god, universe, death or the after life, it is about “the life in your days rather than the days in your life. It’s about the life inside you. And the life inside you that can protect and cure you from cancer” (2005: 182).

However, there is an apparent paradox at the heart of many of these spiritual understandings. In the Bristol Approach being spiritual often means both being fully individual and expressing one’s true nature, whilst also seeking to transcend this so that the user can ‘let go and let god’. Once again the user’s awareness is brought to a category of selfhood, but again it remains unclear what it is and the users are left to decide for her self how to resolve the tensions that she experiences.

As well as mind, body and spirit, there are numerous other spheres or levels that the user is urged to become aware of in the self-health literature. It is not possible to discuss them all, but I will briefly touch on three: energy, environment and society, which can include ideas of biochemistry and Eastern bodily forces; the chemical or organic environment; and family, friends and wider economic and cultural forces.

Somewhere between ideas of spirituality and the body are discussions about ‘energy’. Woollams attempts to explain what is meant by ‘energy’ by describing how there is an interaction between beings or things, such as between the healing power of love or prayer, or between the user’s own energetic being and the energy of the universe. This includes body ‘energies’ such as auras, chakras, chi, bodily-vibrations, or life-force (also, see Daniel 2005). In general, these are found to be connected to, but separate from, the person’s physical, emotional and spiritual being. As Woollams (2005: 163) says, “Illness is believed to start with your energy flow being weakened or disrupted. In other words your energy system becomes unbalanced and gets ill first”.

The idea of the environment can generally be said to be used to describe the material world outside the person. On the one hand there is a concern with the organic or natural environment, denoting that which is untouched by mankind and where, on the whole, good things come from. Then there is the chemical environment, which is seen as presenting a multitude of carcinogens; something discussed at length by Plant in her ‘Lifestyle Factors’ and to a lesser degree by Woollams and Daniel. The environment is also a way of importing tropes from evolution or ecology into the

approach. Finally, the environment is sometimes also used to describe familial or societal situations. As many of the approaches borrow from psychodynamic thought there are, unsurprisingly, some references to the quality of relationships, personal and professional, that the person may have in their life. Also included here are calls for group and political action, such as Daniel's explicit request to her readers to seek to improve the environment through political action and Plant's advocacy of boycotting particular products.

What I have shown thus far is that the key concepts that shape the idea of self in self-health are not always fixed, even within a single text or approach. Of course, this is no surprise to those acquainted to the 'textual turn' in sociology. But what is evident is that this ambiguity is written into the concepts of mind-body-spirit-(energy-environment-society) themselves. Moreover, urging the individual to 'find their own way' is not a solipsistic turn. As I will show below, it involves ways or processes of relating that seek to situate and embody the individual in the context s/he finds his or her self in.

Holism, Connectedness, Listening, Healing

A common association with complementary self-health is its utilisation of ideas of holism. The Bristol Approach "...is holistic in the sense that it recognises the unity and interdependence of body, mind and spirit within each individual". Woollams provides a view of holism drawn from biology that he sees is neglected by mainstream bioscience. He argues that cancer is a systemic problem that affects the whole body and therefore needs a whole body approach to tackle and beat it. "You, your body, your attitude and your 'total personal programme' have to 'make up the difference'" (2005: 158). What Woollams argues is that being healthy is more than ensuring the 'mechanical parts' are in working order, "Your health stems from your attitude to life, your body's energy systems, endocrine, blood, and lymph systems, well ahead of any problem in a localized area such as your breast or prostate" (2005: xiv). Therefore whilst one must pay attention to diet, exercise and supplements you also need to give time and effort to "your overall happiness, your sense of purpose, the laughter you share with friends and even your sex life. All these things can and do affect the immune system. A healthy life is about balance. Think of it as a health 'bank balance'" (ibid: xv). However, whilst it is not intended that the individual

takes on healing each sphere simultaneously, the goal is to create a balance in each sphere that will, in turn, aid the person to create balance in their other spheres. But whilst holism depicts a totalised system of being, the way it is depicted in the self-health texts leaves it to the individual to identify which spheres ‘exist’ and how they are in need of better integration.

A theme that is similar to, but distinct from, holism is that of ‘connectedness’. In short, connectedness draws attention to the relations between spheres, rather than constructing a whole system of things to be considered. For example, Cunningham outlines five main levels or spheres of being, but emphasises that it is how the user connects to these that is important, “we need to connect with all of these dimensions or levels of ourselves. To *connect* means to become aware of what is happening and what needs to happen at each level, then to supply that need. As this process gets stronger we come more and more to a state of balance and harmony” (author’s italics; Cunningham 2004a: 22).

Throughout complementary self-health, users are told that they need to ‘become attentive of...’, ‘increase our awareness of...’, or ‘listen to ...’ and are provided with practices and exercises that will aid them. For example, in the Bristol Approach advocates that users “listen to our own inner voices and the guidance and intuition we can offer ourselves. Our inner wisdom is often very underused in our normal busy way of being” (Cooke 2003: 63). Listening to these inner voices therefore allows the user to connect with and “identify what our soul and spirit are yearning for” (ibid: 64). Similarly, for LeShan, to ask how one feels about one’s life necessitates the user learns to “*listen* inside for an answer” (author’s italics; 1994: 67). This listening directs one’s attention to how one reacts or feels about things and why. It is an inward practice that is directed outward so that anything can be ‘listened’ to.

The aim of all this work is to heal the person with cancer. But this has a different meaning to more conventional understandings. It is evident that the above approaches are enough to show that healing needs to take place on a number of different levels or spheres and that healing in one of these spheres is felt to lead to beneficial affects in the others, or at least aid the way for progress by other means. Healing itself can also come from internal and external sources and be aimed at one

or more spheres. For example, feeling better spiritually has psychological benefits, which are believed to improve the body's internal environment, such as decreasing stress hormones and improving the immune system. If this does not itself promote actual healing, it is felt that it better helps the person to cope with whatever orthodox treatment they are being given. To be clear, healing in this sense is not solely, if at all, about physiological recovery from cancer. For Cunningham, "'Healing' means making whole, and it has been known for thousands of years that fostering harmony can have a profound healing effect on the body" (2004: 22-23).

Exploring Ethopolitics: Between Care of the Self and Support of the Self

The complementary self-health *dispositif* is part of what Rose calls 'ethopolitics'. As I discussed in chapter one, ethopolitics is concerned with the politics of how people are expected to conduct themselves appropriately in relation to their selves and their future, and is the milieu within which novel forms of authority are taking shape. But Rose (2007: 97) warns that, at least in the field of medicine and healthcare, "we have yet to diagnose the costs and benefits of this reconfiguration". What is evident within the commentary about complementary self-health is that there is a tension between those who see it as a crux of contemporary advanced liberal lifestyles and those who argue that it offers a new way of living. In this section I will explore these arguments through the problematic of the analytic of 'care'.

In Foucault's (2005) explorations of the care of the self in his 1982 lectures *The Hermeneutics of the Subject* he described how the importance of self-knowledge preceded modernity and can be found to be the goal of the Socratic quest of the examined life. He found there to be a whole range of possible experiences of ethical subjectivity in ancient texts that were not hermeneutical, but rather 'aesthetic' or 'etho-poetic'. Here, rather than the desire to know oneself, the fundamental task was the broader 'take care of oneself' (*epimēleia heautou*). 'Care' is therefore a practice or ensemble of practices, with the self being the ethical substance and the telos. However, Foucault argued that the ancient imperative to 'take care of oneself' has now been eclipsed by the need to 'know oneself'. It should be remembered that Foucault's distinction between knowing and caring for oneself where conceptual musings that were born out of reflections on ancient texts. I therefore ask: how is care deployed in contemporary times?

What I find is that care has been deployed in a number of ways as a counter to what are seen to be maleficent modes of contemporary life. Two striking examples come to mind; the first is Carol Gilligan's use of care to counter a formalised, staged and gendered system of moral and emotional development. Gilligan (1993: 74) argues the ethic of care "reflects a cumulative knowledge of human relationships, evolves around a central insight, that self and other are interdependent". Care was understood as the "psychological logic of relationships" (ibid: 73) and what it enabled Gilligan to do therefore was to show the lived empirical reality of many people, mainly women, that ran counter to a universalised formal moral and social point of view in psychological literature at that time. More recently, in the second influential example, AnneMarie Mol (2008) contrasted the 'logic of care' to the 'logic of choice' that is dominant in much health policy in the Western world. Again her empirical analysis shows much of the work that is done in constituting care in practice; she finds that it is diffuse, yet an important but all too often implicit presence in the management of health. In contrast to choice, which neatly divides into roles and responsibilities, 'good care' demands collaboration of knowledge and technologies bringing together the actors in continually new ways. However, what Mol's analysis allows appreciation of is that there very much is a '*logic of care*'.

The question I raise here is to what extent have such concerns moved away from the original analytical concern that Foucault had with care? McGushin posits that Foucault should be read as arguing that the care of the self is a response to a contemporary ethic of the self where the concern, formation and truth of the self are already permeated by relations and techniques of power. This is not to seek to provide an answer, understood as a solution, but to show that the work of thought is to problematise; to end with a question that might open new possibilities. Therefore the care of the self, McGushin notes, "is not a turn inward but rather a turn toward the world as that evolving web of relations, practices, and knowledges in and through which my self manifests itself" (McGushin 2007: xxi). It is also a concern for 'truth' or for truthfulness, as it is linked to *parrhēsia* understood as 'frankness' or 'free speech'. In particular, the purpose of ethical *parrhēsia* is to transform individuals, both speaker and listener as it challenges them to rethink their notions of truth. Therefore, if the "Formation of the self has been almost completely absorbed within the biopolitical project and its disciplinary techniques – then care of the self offers a

possible counter practice in the form of alternative techniques of self-fashioning” (ibid: xx) or as Andrew Cutrofello notes, to develop “disciplines of resistance” (cited in McGushin 2007: xx).

But herein lies the problem: on the one hand the contemporary empirical evidence would suggest that care has become its own discipline or its own hermeneutical practice contrary to its initial inception. It has ceased to be simply a practice or technique and has become a goal that formal systems – both conceptual and managerial – should be set up to attain. In this way care has succumbed to an analysis whereby discourses of care close down the capacity of the subject to affect itself beyond the systems of care that initiated one’s original concern with oneself. In response to this, on the other hand, it has become necessary to assert that such analysis of contemporary practices of care are a misreading of the care of the self. What is needed, it could be argued, is a reassertion of the initial difference between care of the self and knowledge of the self. For example, as Traue (2010a) posits, there is capacity in Foucault’s analysis to distinguish between self-care (‘true’ care) and ‘control care’; McGushin (2007) reasons that an interpretation of Foucault’s (2005: 237) ‘etho-poetics’ will return the analysis to a care of the self that provides the subject with an attitude to herself as a subject of possible actions.

However these conceptual readjustments or re-statements will not suffice for this thesis. As I have already shown the care of the self is, and is increasingly becoming, a technology through which people come to know the self as an object of particular systems of thought. Therefore, such conceptual clarifications do not emphasise enough the significant problem that is pointed to in this critique of care; namely that since the 1980s, when Foucault explored care in texts of ancient thinkers, care has now become a hermeneutic of its own – it is increasingly an object of practice, about which a significant body of knowledge exists and that is increasingly related to a government of the ethical self. The attempts to salvage the analytic in deeper and more nuanced readings of Foucault’s ‘later’ work reduce the empirical problem to one of the intellectual history in Foucault Studies. Therefore what I would like to do in closing this chapter is to pose an analytical distinction between care of the self and what I will go on to argue is a more apposite description of the contemporary

formation of the self – at least in complementary self-health – the ‘support of the self’.

That is, what I wish to posit is the possibility that complementary self-health plays a *supportive* role in the contemporary formations of subjectivity. In arguing this I wish to note the genealogy of the support of the self as, not only is it a response to new formalisations of the care of the self, it also holds many similarities with the ‘psy complex’ (Rose 1985). That is, with the body of psy techniques, discourses and material ways that are drawn upon to form the self. As Blackman et al. (2008: 10) neatly summarise, “these practices are not simply epistemological (knowing oneself through a particular regime of personhood, for example), but are also corporeal (the shaping of bodies) and intellectual (what Rose (1998, p. 31) terms the ‘implantation of certain capacities of reading, writing, and calculating’).”

Yet there is something different in complementary self-health that, in this analysis at least, marks it as distinct from being yet another formation of the psy complex. The psy complex was the response to ‘trauma’ in that it provided the means – the techniques, practices and microtechnologies – through which ‘desires’ are managed and has become part of what I now recognise as the care of the self. But complementary self-health is the response to a different type of problem, as Traue (2010a) has described, self-help is the response to ‘crisis’¹⁴. The individual – the autonomous, flexible, fluid, lonely, reflexive, uncertain, free, bounded and single individual – does not seek care, but support. They will make the decision, say to supplant the discipline of biomedicine with the hermeneutic of care, then it will be theirs to make. But to be able to make it they will require support – informatively, spatially, temporally, emotionally, and physically – to do so. The support of the self is the provision of, and an addition to, the toolbox from which the person can draw at moments of crisis in their life. Indeed, it is possible to argue that complementary self-health – and I would suppose a lot of self-help generally – provides a mechanism or medium through which to do this in the face of *continual* crisis. What I am arguing is that the rolling crisis of living, in particular of living with a companion

¹⁴ In the original Greek (*κρίσις*) *krisis* meant decision or discrimination; in pathology “The point in the progress of a disease when an important development or change takes place which is decisive of recovery or death; the turning-point...” OED, Second edition, 1989; online version March 2011 <http://www.oed.com/view/Entry/44539>

illness such as cancer, necessitates strategies, practices, and techniques of support. As I will demonstrate in the following chapters care is not enough as, in the ‘good’ usage, it is restricted to the *ethical* relations of the self to itself and others and, in the ‘control’ usage, it is but another formation of a hermeneutics of the self.

The assumption here is that the practices and techniques of support in complementary self-health are therefore an arms length pedagogical resource. It uses a language of facilitating, sign posting, and mapping, as well as practices that are open and non-directive. Support of the self does not always seek to tell you what to do, rather it wants to show you all that is available. It trains in practices and techniques, but it holds back from directing the uses to which you can put them. It is therefore subtly different to the new hermeneutics of care, which are now procedural and have been operationalised into acceptable forms and outcomes that come with guidelines and coding schema. Here it is now possible to know when someone is being ‘cared *for*’ because there is a formalised knowledge base to care, where the ends have been independently (of the patient) defined. But support is about opening a kind of space to allow the user to ‘sing her own song’. Nonetheless, this does not remove complementary self-health from the field of tensions explored in chapter one. Rather, as I will introduce below and explore in the interviews in the following chapters, support of the self brings the opportunity for the person with cancer, who uses complementary self-health, to posit her self as a subject in her own subjectivity.

Governing the Care of the Self or a New Opportunity for Subjectivity?

In what follows I will explore how complementary self-health provides support for the self through making available narrative resources for those that have cancer as a companion illness. That is, if cancer is to be a narrative in one’s life and if that entails all the fear, anxiety and uncertainty that it would seem to, then it is possible to understand complementary self-health as providing the complementary narratives that allow one to continually live with cancer. However, it should be evident from this and the preceding chapters that these complementary narrative resources are in themselves problematic. What I have argued above is that, in order to allow for the complexity and problems that complementary self-health entails, the approaches create a space for the user to decide for his or herself. Complementary self-health cannot decide for them, but it can support the user in making a decision and living

with any decision that they make. In this final section of the chapter I will therefore describe four of the key narrative tensions that the person with cancer is faced with resolving.

Doing what's best for me

In order to better understand what sort of support is being advocated and what relationship that has to knowing, attention needs to be given to the exercises, practices and techniques that are promoted and, more importantly, how these are found to inculcate the user. That is, how is the user supported in their incorporation of truth? Are these exercises themselves found to be the ends of the approach or are they a means to something else? That is, to what *use* are they put?

In general, the starting point for most complementary self-health books is to contrast themselves to mainstream medical model by arguing the importance of putting the person with cancer, and therefore not just the cancer, at the very centre of the recovery process. They claim to do this via various strategies. These include looking to understand the user's needs, values and insights into their illness; through attempting to support and empower the user so they get the best from their treatment; by preparing them psychologically and physically for their treatment; and through exploring the meaning of illness by using it to help "transform the crisis of illness into the opportunity for health creation" (Daniel 2005: 5). For most, they work not by ruling treatments, therapies and interventions of any sort *in*, but by not ruling them out. In this way they have legitimised access to all sorts of exercises that are available including: orthodox, alternative, and complementary; psychological, spiritual and self-help; and, more broadly still, all those that seek to provide a 'healthier' lifestyle orientation. These approaches are therefore about the user, first, becoming aware of and, second, undertaking exercises to contemplate their relationships with their self, with others and with life itself; often with an emphasis on seeking to achieve the right equilibrium, balance or sense of connectedness for that person.

However, it is possible to roughly summarise the style or method of attention that is advocated in reaching this balance and therefore construe the means and ends of the exercises they advocate. For some it is quite clear, Plant takes a broadly epidemiological approach; LeShan uses a form of psychotherapy. But others take a

more varied approach. For example, Woollams adapts a broadly naturopathic approach to which he subjects a form of bioscience (PNEI) that is, he says, interested in going further than conventional medicine in seeing ‘what works’. Elsewhere, Cunningham, who also shares a history with the scientific method with Woollams and Plant along with their concerns for clinical efficacy, finds that a psychologised account best incorporates the diversity of the field. And others, such as the Bristol Approach and Daniel’s Health Creation, triangulate their accounts between bioscience, psychology or psychotherapy, and naturopathy.

I therefore return to the tensions and conflicts between and within the complementary self-health approaches. In particular, it is not always self-evident where responsibility, and all too often the implicit blame, lies for first getting cancer and then doing something about it. For example, in the above approaches I have found that a positive attitude is important for the user to have. Although none of the approaches considered go as far as to explicitly suggest that the user ‘ignores the truth’ or ‘represses their anger’ it would seem, as Ehrenreich (2009) points out, that the imperative to do so is felt and imposed within the networks of cancer patients. Similarly the hyper-individualisation of choice and control (‘singing your own song’, ‘finding your own way’ etc), are set in the context of multiple factors that the approaches themselves find as foolhardy to not at least consider – the outcome statistics of mainstream medicine being the most obvious. How the user is to deal with these differs for each approach, but it would seem that the user is to reinterpret for themselves how this is to be done, through bringing their attention to their self, health and life. Consequently these different exercises include finding ways to ‘take time for yourself’, to ‘find out what it is that *you* need to prioritise’, and to find ways to breakdown ‘your journey’ into a step-by-step approach. There are also exercises that seek to go beyond the ‘superficial’ mind and ‘connect’ with the realities of life and living, as well as those that seek to help the user ‘listen’ to the messages they are getting from all parts of their life. So on the one hand the user is directed to a particular mode of subjectification, but on the other the form that takes is left to the user in the particular context she finds herself in.

Choosing how to decide

It can be said that the use of complementary therapies and self-health approaches brings added complexity to a healthcare field that already has numerous competing voices and forces acting on, or through, the individual. What I found in the exploration of the complementary self-health literature above were various ways of examining the situation that the user found her self in. In places I found what might be expected from ‘psy’ discourses (Rose 1999b), attempts to dig deeper to find and know the ‘true authentic self’. At other times it is possible to elaborate on a more comprehensive discussion of how users are to change and behave; the mind-body-spirit discussions here envelop broader concerns not only with diet and exercise, but also with notions of energy, environment and society.

It might be argued that in offering a new approach, self-health simply proffers another disciplinary system of truth that is either imposed or to be deciphered through following prescribed practices or techniques. However, a closer look shows that self-health styles have come some way since the ‘counter-culture’ approach of alternative approaches in the 1960s (Heelas 2008), which advocated a more structured and regimented – a more deontological ethic – than is currently the case. Therefore, whilst some specific approaches can appear stringent, the wider self-help setting makes a virtue out of individualised decisions. For example, consider Cunningham’s advice when choosing a dietary regime: “If you want to take a rational approach, I would say there are two decisions you need to make: First, will my eating patterns be guided by taste (i.e. the desire of enjoyment), or by the desire for health? Most of us try to combine both. It makes sense to lean towards the ‘eating for health’ end of the spectrum if you are aiming at better health. And second, if I’m going to adopt a strategy of eating for health, at least in part, will I try to find some authority figure to tell me what to eat, or will I be guided by common sense and the ‘messages’ I get back from my own body?” (Cunningham 2004a: 31-2). So, on the one hand, there is a direct compulsion for the user to attend to their diet. But on the other, it is possible to see that there is a ‘spectrum’ of possibility that the user is left to make their own way through. But rather than being left to flounder, they are provided with advice as to how to make their own way, by listening – in this case to their body. So again in the literature examined here I found a tension

between explicit direction and agenda setting, and an empowering message of ‘finding your own way’ and ‘making your own choices’.

But how is this any different to the disciplinary or hermeneutical techniques found in the psy discourses or in the new formations of the care of the self? I posit that the self in self-health is not always something to be found ‘deeper’ within the user. In places this self holds the potential to be relational. There is much talk of the user’s ‘needs’, which are opposed to ‘shoulds’. But how the user is to understand these needs can be differentiated across the self-health approaches. For some approaches they are directed towards the ‘uncovering of inner desires’ in order to become an ‘authentic individual’. But others take a more situated and embodied approach. The need is relational to the context users find themselves in. Sometimes these are layers or levels of self. But in others the user is urged to connect with multiple spheres of life and may hold a different potential for subjectivity. The challenge is to see whether within these texts there is the possibility of, first, supporting rather than caring for the self, health and life and second, whether this support allows for a refusal of contemporary notions of political rationality and if there are any ‘return effects’ on how the user might conceive self, health and life?

Transforming life

LeShan’s headline message, also used in one way or another by the complementary self-health approaches considered above, is that the ‘crisis’ of cancer and its treatment presents the person with the opportunity to ‘take a good look at their life’ and change it for the better. Hence one aim of self-health approaches is, having performed the correct work upon her self, that the user gains a new relationship to truth. This is valued so much that cancer is itself described as a ‘gift’, an opportunity for change or in some other transformational language.

But this is not the only possible experience of cancer. As Ehrenreich (2009) argues, her life did not ‘need’ cancer and she found that this ‘gift’ was no more than a delusion of positive thought. Even in the approaches of Woollams, Plant and to a much lesser degree, Cunningham, I found that they were more fixed on the idea that the transformed and healed life is one of beating cancer and ongoing physical wellness. Any new knowledge that is gained allows the person to make better choices in repairing their sick body. Indeed, when ‘spiritual’ concerns are broached

by Woollams, they are in service to the sick body and are about ‘strengthening our total being’. But again I found that such matters are not easily compartmentalised. Woollams’ use of the aphorism that life is about ‘the life in your days rather than the days in your life’ shows that a new concern for the quality of the user’s post- or with-cancer life is not wholly disregarded.

What is to be made, then, of the oft-valorised experience of the ‘post-traumatic subject’ within the self-health literature? In the Bristol Approach the transformation that healing brings comes through both a connectedness to love and through the exercises that the user performs upon herself. It is telling that the aim of healing for the Bristol Approach is not necessarily ‘beating cancer’, but gaining a new mode of being with oneself “even if death is quite imminent” (Cooke 2003: 90). But what is this transformation towards? Is it to a spiritual self that is either transcendental or ‘deeper’, an ontological shift, or is it ‘merely’ a narrative transformation, an adoption of a new affect? It is not possible to say by only reading the complementary self-health texts, which simply claim to seek to provide the tools to support the person with cancer. Therefore in order to answer this, it is necessary to ask how this ‘wisdom’ or new knowledge is, if at all, taken up by people with cancer who use these complementary self-health approaches.

Situating the examined life

As I have shown in the accounts above, the experience of cancer and complementary self-health therapies is not conceived as a single event. As Frank (1995) describes, part of the ‘postmodern’ nature of cancer is that it is increasingly seen as a chronic condition, whereby the ‘survivors’ enter into the ‘remission society’¹⁵ and cancer becomes what he now calls a ‘companion story’ (Frank 2010), or what I have termed a ‘companion illness’. In this context cancer brings with it a set of ongoing responsibilities that may entail repeating exercises and practices. Whether that is on a regular or *ad hoc* basis, it is the tension between developing new good habits over a long period of time and the need for daily vigilance and attention to the user’s self, health and life that is part of ‘living in the now’, which is important. For example,

¹⁵ There is double meaning in Frank’s remission society, (i) society as club and, (ii) society as culture. In this passage I very much infer the latter of these meanings.

the changes that are needed are not usually singular decisions, such as having a treatment; rather they entail ongoing support and may involve a step-by-step approach. Therefore, the use of self-health techniques or therapies can continue over months and years. This can mean that the reasons for engaging a particular practice or exercise can also develop, as what is found to be the right blend of narratives for one situation might not necessarily be the same for a later, similar, experience. In summary, what can be found in the approaches above is that there is a tension between one-off transformations and to repeatedly examine how the user is living.

The repeated examination and questioning of the user's motives – such as in the exercises to come aware of the 'shoulds' of one's thinking – will seem familiar to analysts of many psychological therapies. However, when these techniques are applied in the field of complementary self-health therapies, it is possible to see how they bring to bear their own questioning power upon the new styles and habits that they are looking to embed. Moreover, this and other maxims that seek to have ongoing effects on perspective, such as the Bristol Approach's 'living in the here and now', are often juxtaposed with other 'metaphysical' perspectives, such as the feeling of unconditional love or there being a 'higher power'. For the self-health approaches, this is a powerful combination that profoundly alters user's perspectives on life, towards what the Bristol Approach calls a 'healing way of life' or what Daniel describes as a move from material to spiritual values that living in the now brings.

The paradox of 'living in the now' and developing better long-term habits can be likened to the contrast between what Foucault ([1982] 2005: 282) described as *vue infinitésimale* and *vue plongeante*. Similarly, as the Bristol Approach describes, there is a contradiction between their advice on the one hand to be truly authentic and, on the other, knowing when to 'let go and let god'. However, they maintain this as it brings an experience of "being in the world, but not of it" (ibid: 222). That is, there is a tension between the self as a point in the world (*vue infinitésimale*) and the rational subject gazing down on that point from above (*vue plongeante*). The question that holding any of these dual aspects raises, Foucault argues, is whether they allow one to see both the true nature of things as well as the true value of things, as one is able to see oneself in one's truth as a point in space and a point in time.

Further, is the self to be ‘placed’ in its place in the whole, rather than deciphered? In which case, interiority is not the problem, rather “The only problem that is posed to this point is precisely both being there where it is and *accepting* the system of rationality that has inserted it at this point in the world” (my italic; *ibid*: 279). It is possible that self-health practices and relations of holism, connectedness, listening and healing seek to support the individual to do just this.

Conclusion

In this chapter I have sought to introduce the field of complementary self-health through describing six of the key self-health texts that were referenced by the interviewees. As part of this I outlined some of the key spheres of life and self that complementary self-health seeks to address, the mind, body, spirit as well as energy, environment, and society. I also considered some of the main understandings of how users are urged to relate to their health, self and lives by exploring what is meant by holism, connectedness, listening and healing.

In the second half of the chapter I considered what might be a useful starting point for an analysis of complementary self-health. In doing so I approached the field as one laden with tensions, rather than as one that either determines or sets one ‘free’. As well as introducing the reader to the language and ways of complementary self-health this chapter has allowed me to present the field as an empirical problem. Here the people with cancer, who use complementary self-health, are permitted the space in this analysis to show what the price is for the ways that they have come to understand themselves as subjects of possible actions. A key distinction that allows for this space is the support of the self which, to use the complementary self-health maxim, is where each is left to ‘find his or her own way’. The assumption here is that although complementary self-health provides the tools for the ‘journey’, it refuses to individualise where that journey is going or how you should get there.

Given the possibilities I argue that are present in complementary self-health I now turn to the interviews that I conducted with users of complementary self-health who had, or did have, cancer. In the next chapter I describe how two users of complementary self-health were able to respond to the demand to be responsible for their health, by seeking to ‘balance’ the multitude of factors they identified as affecting them.

Chapter Four

Balanced Living:

Responsibility and Blame in Complementary Self-Health

“TO RECOGNISE UNTRUTH AS A CONDITION OF LIFE; that is certainly to impugn the traditional ideas of value in a dangerous manner, and a philosophy which ventures to do so, has thereby alone placed itself beyond good and evil” (Nietzsche [1886] 1990: 13).

Life for someone with cancer can often be described as ‘hanging in the balance’. The problems they face and the balance to be struck does not just concern decisions about biomedical and/or complementary treatments; but the whole gamut of life – from family considerations to work, including all those ‘mundane’ features of life that affect who they are and what they do. This chapter explores the stories of two people with cancer, who used complementary self-health, in order to explore how they sought to balance the competing demands on their health and life that they faced. In this chapter I ask: what happens when balance moves from an objective category to a subjectivised mode of being? As Frank (2010: 41) notes “Stories have the capacity to balance multiple truths that have respective claims to expression”.

As I explored in chapter one, for the person with cancer it is not always clear what is the ‘right’ thing to do. In order to allow an analysis of thought and acts based on non-knowing I started with Proctor’s work on agnotology, the study of the cultural production of ignorance. I read Proctor’s understanding of ignorance through a consideration of Nietzsche’s ‘will to ignorance’ where he sees knowledge as the refinement of ignorance, rather than its opposite. As part of this analysis I will explore the problem that Rose’s (2007) analysis of ethopolitics brings for the formation of one’s self as a subject in their subjectivity. In order to do this I consider how the self incorporates discourses into their subjectivity to form herself as a subject. In short, I explore how subjectification occurs. In doing so I question the possibilities for going ‘beyond’ the self-governing or disciplined subject.

What this chapter finds is that an attitude towards oneself of ‘balanced living’ is one way of managing the multiple limitations and constraints, as well as the productive forces, passing through subjectivity. In order to further consider the possibilities

within this attitude I explore a significant discourse in ethopolitics of ‘responsibilisation’ and the concomitant problems of blame. Responsibility – understood through associated ideas of empowerment, choice and agency – instead of being an ‘empty signifier’ (Laclau 2000: 207; cited in Reuter 2007), is instead felt to be in ‘an excess’¹⁶ producing a subjectivisation of ‘overidentification’. By bringing balance to the fore, I am led to consider what it is that is balanced, and whether the content is affected in any way the structuring of that balance. That is, I found that what makes balance problematic is its slippage from a rhetorical and discursive device in ‘balanced life’ – used to navigate uncertain, ambiguous or contradictory contexts – into a mode of subjectivation in ‘balanced living’, in which the interviewees experienced a situated, embodied and ongoing relation with her self, health and life.

Fiona

‘Fiona’ had originally contacted me in February 2009 and we had arranged to meet at her place on the evening of 16 March 2009. However, that turned out to also be the day when I meet with the surgeon who gave me my differential diagnosis. One of the things I had to do that morning was to text Fiona and postpone the interview. I did not get back in contact until February 2010 when I sent a hopeful text to her enquiring if she was still interested in meeting.

I got a bus at the start of its route and got off at the end, where Fiona lived. I thought I had set off in plenty of time, but as I hit the evening’s rush hour traffic and a well-known bottleneck, I pondered whether I had. As someone who always likes to be 15 minutes early, I was surprised that on this occasion I was not finding that this delay to be so much of a stress for me, as it would have been in the past. I had

¹⁶ I am grateful to Blackman’s (2008; 2010) articles for bringing my attention to the discussions of ‘excess’ in the ‘affect literature’. I should stress here that my use of excess in the thesis mirrors the field of complementary self-health, rather than the distinctions Blackman draws out in her discussion. Blackman points to voice-hearing, telepathy, and suggestion as that which cannot be contained by – or is in excess of – a ‘flexible versus rigid’ understanding of bodies. Whereas I find that complementary self-health takes experiences of the ‘excesses’ of affect to move from, using Blackman’s terminology, a rigid, bounded, and singular body to a flexible, unbounded, and ongoing experience of living. A question Blackman’s work poses for complementary self-health, which I am not able to explore directly here, is whether complementary self-health is better understood through a ‘informational’ or ‘cybernetic’ model, or whether it is striving to (re)form subjectivity as an “artefact produced through the intra-action of specific im/material agencies, human and non-human” (2008: 188).

Fiona's number with me so could always text her and update her. I had a book to read to make the most of the time. Perhaps the meditations and relaxations I had been engaged in for the past six months were helping me – I certainly seemed to be entering such situations from a different point.

Fiona greeted me with a smile; I apologised for my freezing hand as we shook hands. As she welcomed me in she politely returned the apology, this time for the cold in her flat; although I could not detect it coming in off the street. In the living room she had a small fan heater running that quietly rattled away during our interview. The flat was filled with the smell of incense, which might have been sandalwood. There were items and trinkets that you would easily associate with 'alternative lifestyle' decorated about the flat.

As I got my things ready Fiona offered me a cup of tea, which I declined thinking only that I did not need the caffeine. But I immediately kicked myself; I had passed over an opportunity to use a request for soya milk in my tea as an identifier, as I had done on previous interviews. That is, I had come to use this ritual of offering a guest a drink to as an opportunity to 'show not tell' my sympathy for alternative and complementary lifestyles by enquiring if the interviewee had any soya milk. But given my unusual behaviour in setting-up this interview, I was sure that the opportunity to allay any suspicions that Fiona might have about me would come up if she enquired into that situation. So as we settled down I apologised for having to cancel the original interview saying 'I wasn't very well at all'. But Fiona did not ask me what happened and the opportunity for self disclosure quickly passed. But still I did not worry, as I was sure that at some point in the interview the opportunity would surely arise. However, it did not happen. I made various hints that I sympathised from a position of personal experience in the interview, but these were either too subtle to be noticed or passed over as Fiona was deep into telling her story, which was why I was there after all. But what these reflections point to was that at no point did I feel that I needed to disclose in order to move the interview on or encourage Fiona to tell me something she seemingly was holding back, like in Pat's interview (chapter five). These observations supplement the argument I made in chapter two, that what the problem of My Cancer does is to point to the situated nature of the

interview situation, and highlight the import of the researcher's expectations and imaginings of difference.

But at the time of the interview this realisation had not fully formed for me and I was still concerned with the matters of difference and the comparisons that My Cancer made to the interviews. So at the end of the interview, when the dictaphone was switched off, that I forced into the conversation my own experience. However, as we chatted after the interview about the horrors of chemotherapy – Fiona was due her sixth and final chemotherapy later that week – I did not sense that my telling affected what Fiona wanted to tell me about her experience. In all, she seemed assured in a quiet and confident manner about her decisions and experiences so far. There was no awkwardness as we sat together on the leather two-seater; indeed, Fiona seemed more relaxed with the whole process than I did. Perhaps this was because she was a psychotherapist and such one-to-one encounters were more familiar to her.

As I will explore below, Fiona's story is one of multiple experimentations as she sought alternative treatments to attain the goal of physical reduction of her tumour. Structuring her narrative in many ways was the idea of balance, which was played out in numerous forms. And despite the appearances of being radically alternative and the accounts infused with counter-biomedical suspicion, Fiona's narrative was 'grounded' (as she said) in detecting physical results and change. This bodily materialism balanced out her therapeutic and ideological experimentation and brought her, reluctantly but pragmatically, to have chemotherapy.

Fiona was diagnosed with breast cancer in her right breast in July 2008. She described how she had not perceived herself to be in a high-risk category, having not smoked or taken drugs and with no familial history of breast cancer. To this she added that since she was 21 she had an active interest in alternative lifestyles. Therefore one narrative for her use of alternative, then complementary, therapies was continuing this exploration. Another extended from witnessing a friend's bad experience of chemotherapy. A further narrative informing Fiona's decisions was her concern about losing her fertility due to the chemotherapy.

Therefore, after diagnosis Fiona had IVF as soon as she could. She then went to several alternative and complementary practitioners to see what they could offer.

Her exploration of these therapies included attending an ‘integrative clinic’ (not a Cancer Support Centre) and having mistletoe and hypothermia therapy, as well as partaking in art therapy and eurhythmy (a movement based therapy). Elsewhere, Fiona also tried homeopathy, herbal remedies, theta healing (using theta brain waves to heal), Chris Woollams’ Rainbow Diet (Woollams 2008), kinesiology, installing a home sauna, acupuncture, visualisations, and supplements – including reishi mushrooms. Fiona also looked into, but largely due to the cost did not take up, intravenous vitamin C, having a thermogram (a form of imaging), and blood route (a herbal chemotherapy). Fiona talked about the amount of time she initially spent on the internet researching treatments, but over time she utilised two centres for information and advice; ‘Cancer Options’¹⁷, where she came to trust one of their researchers, and ‘Cancer Active’¹⁸ and its ‘Icon’ magazine, which were set up by Chris Woollams.

However, Fiona’s exploration of alternatives proved disappointing.

F – I think that up until the end of that year [2008] I was not actually seeing much result in terms of the tumour shrinking. [0:07:35]

Despite her pursuit of an alternative to chemotherapy and surgery, Fiona had not completely withdrawn from the NHS and orthodox care. Fiona found the first consultant oncologist, who had diagnosed her, to be patronising and defensive in her attitude to Fiona’s choices. So after Fiona had returned from integrative clinic it was recommended by Cancer Options that she try another NHS hospital. This time she found the consultant to be neutral in his position on her use of complementary therapies, which Fiona found to be helpful. Moreover, this consultant offered Fiona a hormonal chemotherapy that would not affect her fertility in the long term; a treatment Fiona described she was still ‘resistant’ to, but took up. However:

F – After a couple of weeks of not quite being able to make a decision I did actually decide, well, you know, I really wanted to see some results [laughs]. I wanted to see something work, so I decided to go on to that, which was

¹⁷ <http://www.canceroptions.co.uk/>

¹⁸ <http://www.canceractive.com/>

okay. It did have side effects, which I did try and control with homeopathy . . .
 . [0:12:46]

Fiona's decision is one that could be seen under a framework of 'patient empowered choice', a discourse that is increasingly associated with mainstream healthcare (Andreassen and Trondsen 2010). But I should note that the impetus to choose appears to come from her complementary and alternative experiences. Fiona explained to me that with the first surgeon the option to have chemotherapy was not presented as a choice, but a matter of inevitable fact. So it was Fiona's awareness of the alternatives that came from her own experiences as a complementary therapy user that led her to assert her story as one of choice. In doing so she empowered herself and took responsibility for what was about to happen to her. Fiona made what many in the complementary self-health literature call an 'active' choice, instead of being passive and letting mainstream medicine dictate what will happen to her body¹⁹. Part of this active choice is working out what is important for you, so you then know what to choose. In doing this, the person is urged to examine each level or sphere of her life and consider how each is affected by cancer and, in response, consider how they might then change their relationship to that 'problem'.

Fiona's narrative explores the classic tension between the ideological attraction of complementary and alternative therapies and the questions of efficacy that they pose (Sharma 1994). For Fiona, this is not just an intellectual exercise. She seeks to experiment, using her body and cancer as a testing ground. But ultimately she has to balance these two parts. Fiona explained how she went about making the decision to have chemotherapy later on in her account.

F – . . . I then spoke to [researcher] . . . at Cancer Options . . . at that point I just said "what do you think I should do?" He said, "I think that your best option is to do chemotherapy". So again I was very resistant. I was referred to another person who does something that's called 'life alignment' but she's a body psychotherapist. . . . Again she works with the body to see what the body says. Again, she tested me to see if chemotherapy was now the next

¹⁹ I am aware that there is a sizeable commentary on 'active' patients in biomedical healthcare (Novas and Rose 2000; Bury and D Taylor 2008; Lorentzen 2008). However, I follow Fiona's lead in presenting her 'active choice' as coming through her complementary self-health use.

step. At that point the muscles she was testing said, ‘yes, chemotherapy is the next step and that all that I had done up to then was right’. It was preparation work and I had given myself a real health boost by using all these techniques. After that session I just thought ‘okay, that’s the decision. I’ll go forward and know that it was a decision that I’ve made’. It wasn’t made for me. I hadn’t been pushed into this. So I said to the hospital I’ll go for it. [0:22:24]

Fiona consulted both an orthodox medical researcher, who was ‘sympathetic’ to complementary therapies, as well as a complementary practitioner. The former provided the evidence-based rationale; the latter assisted Fiona in forming an embodied response that she needed in order to go on to, still reluctantly, chemotherapy. Working with your complementary therapist to listen to your self and body is an important aspect of using complementary therapies (Gale 2011). As I will show below, for Fiona this entailed being aware of her emotional needs and finding ways to balance these as she progressed through her treatment. But as well as this, the above passage shows how Fiona sought to listen to her body in deciding what to do.

F – For me, its been a journey of trying to keep a kind of balance of, well certainly trying to keep my feet on the ground; one foot in the hospital as well as exploring a lot of other things. [0:58:43]

Fiona described her attitude not as a rejection of orthodox medicine, but rather that she believed there is more to health than they can offer. Her use of complementary self-health is therefore seen to provide hope and be part of a ‘pioneering exploration’ (to paraphrase her) of new treatments and techniques, balancing the effects of orthodox care – from the impact of chemotherapy to the psychological and emotional effects of orthodox treatment. However, at first, the only the idea of balance structuring Fiona’s narrative is balance as an objectified goal. Fiona sought to find *the* treatment to cure cancer with minimal long-term effects on her body. That is, a ‘balanced life’ is concerned with taking a ‘wider’ perspective on things, bringing in factors into decision making and accountability that might otherwise be marginalised or undervalued (cf R Taylor 2002). In doing so it is therefore often concerned with

striking an ‘objective’ idea of balance; it often seeks to objectify a satisfactory compromise that will stand over time (e.g. Johansson et al. 2010).

But, Fiona failed to see any reduction in the size of her tumour during her use of alternatives and so she then went on to use chemotherapy, which did. At this point there is a change in the use of balance in her narrative. She notes that the use of alternatives was also part of preparing the body for the chemotherapy. This ‘paving the way’ changes the temporal and special dimensions of her evaluation and use of complementary therapies. So what follows is not a critique of a ‘balanced’ understanding. Rather, I pose the question: what happens when people seek to live a balanced life? That is, when balance moves from an objective category to a mode of subjectification.

‘Anything that works with the health of the body’

From here on my argument is that Fiona’s managing of polyphonic narratives should not just be considered in terms of a balanced life, but of balanced living. This is because Fiona’s balanced living comes through the ongoing shaping of subjectivation in her story. In effect, balanced living is part of what is needed if cancer is to be a companion illness. In order to explore this shift in modality, I will now explore two areas where this change can be witnessed most acutely, in Fiona’s treatment choices and her judgements of efficacy of complementary therapies, and in managing her ‘embodied emotionality’ (Robertson, Sheikh, and Moore 2010).

Lets return to Fiona’s reflections on her decision to have chemotherapy and how this affected her use of complementary therapies. Fiona’s story up until this point was about seeking an alternative to chemotherapy; but because her cancer failed to respond she returned to orthodox care. However, Fiona did not write this exploration off as wasted time. Instead “It was preparation work and [I] had given myself a real health boost by using all these techniques” [0:22:24]. Furthermore, the alternative treatments were now there to complement the orthodox, “[The chemotherapy] did have side effects, which I did try and control with homeopathy” [0:12:46]. So in the move from balance life to balanced living the decision taken to have chemotherapy is retrospectively offset against the ‘preparation’ credited to her body over the previous months. In turn, Fiona’s narrative shifted from a pursuit of *an* alternative to chemotherapy, to an *ongoing* need to complement and mitigate the effects of

chemotherapy and cancer in her life. This change in Fiona's experience of complementary self-health also has implications for the definition that Fiona is using for efficacy.

F – . . . I feel like I have had a huge sea of complementary therapies for the past year and a half. I have always been quite interested, but I feel like I have really explored quite a lot since the diagnosis. And I feel that it has probably worked well for me, because a lot of people say that I don't really look like, you know, so worst for wear as perhaps some people do. I don't know if that is to do with all these complementary therapies or luck of the draw or whatever. But I think, I feel in myself it's probably because I have kept a strong inspiration going. Complementary therapies are anything that works with the health of the body rather than kills off the immune system, is the way to go really. The way that healing should go. [0:32:12]

Although no alternative therapy provided Fiona with that elusive 'shrinking' of the tumour and so mainly disappointed her, she is still able to draw from them the idea that they have, actually, complemented orthodox treatments. The non-mainstream treatments she undertook go from ineffectual, as judged by the non-reduction of her tumour, to effective, in that they prepared her body for the chemotherapy as judged by the less severe side-effects she says she is experiencing. This is no better expressed than when she reflects on how she – in her body – has coped with the effects of the treatments, noting how friends tell her that she does not look like someone who is having chemotherapy.

In turn this retrospective balancing becomes a template for future actions as complementary therapies are now "anything that works with the health of the body rather than kills off the immune system". In this shift, from finding an alternative cure to complementing the health of the body, I again argue that there is an important shift the temporal and spatial forms in operation in Fiona's account of balance. Here, as balanced living, it incorporates retrospective considerations as well as imagined future trajectories of balancing, which are used *in situ* to form an ongoing account. That is, it is a modality that makes sense of past and forthcoming decisions from *her* situated and embodied position (something I will return to in chapter seven).

As I noted above, the use of complementary therapies and self-health are not restricted to its mitigating effects of chemotherapy on the body. They also seek to affect changes in the experience of having cancer. In this regard, Fiona identified a number of related concerns for herself. She described how it was important to deal with the emotional issues that diagnosis and treatment of cancer brought. She explained that in her pursuit of an alternative to chemotherapy that she used both a form of visualisation and, separately, theta healing. In both cases she told me that she undertook them with gusto, only to become disillusioned as the physical changes failed to materialise. But she also noted how they failed her emotionally. That she found them to be ‘flimsy’ and full of ‘wishful thinking’, which could have led her to become ‘deluded’. She described how people she knew who had used them had made things worse for themselves by ignoring the facts of their cancer. Instead, Fiona sought to fashion a ‘realism’ using the affirmative ethos of complementary self-health, but combined with staying grounded through “monitoring scientifically what is going on” [0:40:03]. Thus Fiona marked out how, on an emotional plane, one must take up an attitude to living that accepts the reality that cancer brings, facing one’s mortality and the pain of the disease and treatment, whilst at the same time not succumbing to purely denial, fatalistic or positive attitudes.

F – I think there needs to be a balance of allowing yourself to feel terrible about it all and just feel ‘life isn’t fair, why should I have this?’ Just to feel all the gritty, difficult feelings – I probably would be saying this because I am a psychotherapist . . . Just to accept it rather than rise above it, I feel is a much better approach. That’s why I was speaking about the flimsiness of just creating your own reality – all retraction etc etc. I feel it encourages people to rise above some of the more gritty feelings that are around. In that you get people cut off a part of themselves or feel bad about certain part of themselves where it is very human and very natural to feel terrible about a diagnosis that you would never want. I think that across treatments you have to feel the underbelly feelings of ‘this is tough, this is rotten, sometimes I am just not going to feel positive and upbeat about it, I am just going to feel a bit depressed and lie in my bed and just not want to get out of bed today’ kind of feelings, which everybody feels as part of human life but particularly when

you are dealing with something like this. I read a book actually '*Cancer as a Turning Point*'. [1:03:10]

Fiona's critique of some of the complementary self-health approaches and therapies she used seeks to qualify her comments as different to others in the complementary field. And her distancing allows an understanding of the emotional discourses that she sees much of the complementary field to be governed by. But at the same time, as she notes, an influence on her thinking is a complementary self-health book, LeShan's (1994) *Cancer as a Turning Point*. So, whilst on the one hand Fiona's account demonstrates the strong, although diffuse, influence of much of psychotherapeutic thought within both her story and the complementary self-health field generally, she also provides a recognition of the complex formation of narratives that are involved in her subjectification.

In the above quote Fiona's use of complementary therapies is now about finding ways to cope with the ongoing demands of chemotherapy. At this point in her story this sits somewhere between balanced life and balanced living. At times Fiona can be heard to say that the complementary therapies helped her cope in pragmatic and physical moments, but in others there is a sense that having a balanced way of living is an important part of how she coped. She listens to her body and hears an ongoing narrative of changing needs, part of what Robertson et al. (2010) have called 'embodied emotionality'. Fiona tells of how she has sought not to ignore or 'push under the carpet' 'darker' feelings about her cancer. She shares some of the suspicions that argue self-health can lead to denial, yet she draws on both her previous experiences as well as complementary self-health literature to find a way to 'accept' the feelings (see chapter seven). Whilst acceptance and 'being authentic' are also part of the complementary self-health techniques, Fiona's balanced living is an attempt at a pragmatic-realism. She hopes to avoid being caught in a particular ideology or rationality so much so that it 'blinds' her to the reality of her situation.

There are a number of techniques used in LeShan and other complementary self-health literatures that seek to move perspective and generate this form of authenticity or realism. Some borrow from psychotherapy and use the language of 'going deeper', others speak more of altering the space or time that you are feeling or are thinking from – letting the world flow through you as you situate yourself in the

present. The connection of psychotherapy to ideas of the subject that go ‘deeper’ and the critique of these is largely well documented (e.g. Foucault [1979] 1998b). However, it is also possible to argue that the movement across planes of time and space is a move away from psychotherapy and towards the self taking a critical or new mode of subjectivity. The question of whether the self’s mode of subjectification is truly transformational, as Foucault ([1982] 2005) might put it, is therefore not negated by psychotherapy’s presence in Fiona’s story.

Moreover, a potential difference is present in Fiona’s story. Fiona recognises that an open and movable perception of her self is necessary in order to hold a critical position, which is part of a balanced way of living. What I seek to describe here is a possible mode of subjectivation in ethopolitical subjectivity. I am not making claims to the veracity of the content that is presented or re-presented. Rather I am describing the way that Fiona creates and understands her criticality: of how the self might form herself, as a subject, in her ethopolitical subjectivity. What I will go on to argue is that, as well as the possibility for the subjectification of balance to be a way of self-governing in advanced liberalism there is, in undertaking balanced living, ways of refusing, of experiencing the self, health and life, which is other than.

Karen

‘Karen’ contacted me after seeing one of my posters at the West of England Cancer Support Centre; the same place that Emma (chapter five) had got my details from. I met Karen a few hours before I met her friend Pat (also chapter five). My car crept up around the corner as I drove into a ‘hidden driveway’, which opened up to greet you with a large oak tree, around which was organised a turning circle-cum-parking spaces. As Karen waved me to a parking spot a mid-sized ginger terrier dog came bouncing up to meet me. I got out and greeted Karen and the dog, and looked around. There was a large farmhouse with a number of converted out buildings set off to the right hand side, where Karen and her family lived. She later told me that they were currently renting the house. When I got inside Karen offered me a cup of tea, which I accepted with my usual enquiry about soya milk. The house had the feel of a busy family about it; a family that had not properly settled in and worked out where things should go, or if they ever would. As well as the child’s toys, there were

the objects of working life around the open plan room. In particular, a foldaway treatment table was propped in one corner of the room.

Karen had a headscarf on, tied in a way familiar to the stereotype portrayed on many a charity leaflet of the ‘cancer sufferer’. It is always hard to judge the age of someone when they are ill, more so when they lack a distinguishing feature such as hair, even if you are a good judge usually – which I am not. But I would guess from her circumstances – breast cancer’s epidemiology and that she had one pre-teen child – she would be in her late 40s (she was to later tell me that she was 50 that year).

As we chatted I noticed that Karen was very softly spoken and noted to myself to ensure the dictaphone would be well placed. She floated around the house delicately, rather than in the fragile way I did when I was in the midst of my illness. I got the impression that this was how she always moved; perhaps it was due to the years of experience she had gained as a practitioner of Alexander Technique. Once the teas were ready we went to the sitting room and sat on a large two seat sofa, joined by the dog (for a while).

Karen told me that she was diagnosed in February 2009 whilst on holiday in India with her husband and young son. She decided to finish her holiday as she was told that she did not have to rush back. But she also commented on how this enabled her to be distracted from what ‘it’ meant. However, when she returned to the UK “it became much more real and alarming” [0:04.15]; a fear that was not helped by a long-standing ‘phobia’ of hospitals. Nonetheless, Karen spoke of how she found the oncology teams to be “lovely, very dedicated, very heart centred” [0:05.02], unlike other mainstream health professionals she had encountered until that point. But her warm sentiments did not extend to the environment that they worked in, which she found to be “quite alien to healing and I felt very sterile hospital environment, very frightening looking machinery, metallic sort of environment” [0:05.24].

Unfortunately for Karen, her tumour was found to be quite large and she was advised that her best option was to have chemotherapy before surgery, in order to shrink the tumour and to help reduce the severity of the surgery she would later need. This came as quite a surprise to Karen who, as a close friend of Pat (see chapter five) – who did not have chemotherapy – was not expecting to have this treatment. Moreover, Karen explained that she was reluctant to have chemotherapy. “It was

one of the hardest decisions that I have ever had to make, because of my background, because I was already a body worker, because I already knew about some of these other complementary treatments” [0:07:34]. However, she explained that:

K – . . . because I have got an 11-year-old son, I felt that statistics of just going alternative were not great. I made the decision, all-be-it against every cell in my body, to agree to the chemotherapy. What helped me to make that decision was that my surgeon was extremely special man. [0:08:32]

As an established complementary therapy practitioner, Karen talked easily of being aware of where ‘every cell in her body’ wanted to take her. She later explored the hypothetical situation of whether she would have had the chemotherapy if she was not married and did not have her son. Even then she was not sure, as what was important to her was being provided with suitable levels of support, which she found came from her family and friends, her surgeon, and the complementary therapies she used.

Karen framed her decision as one of empowered choice, guided by every cell in her body. I should note again that not only was the language of choice framed by complementary self-health, but so too was the impetus to choose. Karen explained that her decision to have chemotherapy was not ‘presented in that way’ by her surgeon and her awareness of alternatives came from her own experiences as a complementary therapy user and practitioner. So it was Karen who asserted in her story her desire to frame the agenda as one of choice. In doing so she empowered herself and took responsibility for what was about to happen to her. As I showed in chapter three, part of this active choice is working out what is important or affected, so one then knows what to choose. In doing this, the person is urged to examine each level or sphere of their lives and consider how they are affected by cancer. This process and its consequences is something I will return to in the next chapter.

Returning to Karen’s decision to have chemotherapy, she was aware that the statistical outcomes of alternative therapies were not as good as chemotherapy. Later in her story she recounted several examples of people who did take an alternative route, but she drew out significant problems with each of these. In one case it was simply the poor statistical chances, and in another it was how the particular treatment

(Gerson diet) came to dominate every aspect of the user's life and the life of their family and friends, even more problematically than chemotherapy.

'I needed to get some support for myself through the chemo'

Fiona's story allowed me to introduce and artificially separate 'balanced life' and 'balanced living' as mostly disconnected modalities of subjectification. But in Karen's story I am further able to explore the folding in and emplotment of different narratives and experiences in her story to show how multiple forms of subjectification are given in any one moment in a story. Karen's story also allows me to reflect on the ethical substance being worked upon in the two stories. For Fiona it is largely the 'mind' that is in the foreground, whereas for Karen she looks to how her body feels. This is perhaps unsurprising given their respective therapeutic backgrounds (psychotherapy and Alexander technique respectively). However, what I find is that the mode of subjectification in question, balance, operates regardless of the substance being worked upon.

Karen's discomfort with doing the 'right' thing was more easily over-ridden by another concern. For Karen the question was about the best way to ensure she got the support she needed during her illness. Karen's story provides several examples of this; for example, the role of the surgeon is one key part of it. But this is not all of it. Karen told me that she was able to get support from the complementary practitioners that she saw:

K – . . . I felt that I needed to get some support for myself through the chemo cause it did really knock me for six. The things that did really help me were Shiatsu treatment [0:14:42] . . .

Karen went on to say how this support work on a number of levels:

K – . . . I would have chemo on Thursday and I would see her [shiatsu practitioner] the week after. And what it helped me to do was to put me back into my body. Because with the chemo I realised I was sort of, so didn't want to be there, I was spacing out. I felt very, very spaced out I suppose is the word. And having the hands on, having that gentle healing touch just put me back into my body and helped me to breath again and helped me to relax and let go of a lot of tension. I didn't realise how much tension I was holding

really. It helped me on other levels... The anti-sickness tablets made me very constipated and the Shiatsu, every time, just balanced me out. I was able to go to the loo after the treatment. So very tangible benefits just to help with all the drugs I was taking really. [0:16.02]

So, as in Fiona's account, the use of complementary therapies helped in balancing the effects of the orthodox treatment and thus supported Karen through the chemotherapy, helping her to 'cope'.

K – So it was really the therapies that helped me to cope with the treatment I was having. Without it I think I would have really felt very vulnerable, it just about put me back together again in time for the next dose of chemo. And it just made it easier for me to cope really. [0:28.05]

Here Karen's narrative of balanced living goes further than the physical effects of using complementary medicines to cope. She sees the emotional trauma of her illness needing the support from family, friends and the affect of practitioners – both biomedical and complementary. This along with the statistical support, combined with a strong motivating goal of being well for her son, was a powerful and decisive combination. Indeed, it moved Karen to go beyond what every cell in her body was telling her.

As I will show in chapter four, listening to your self and body is an important aspect of using complementary self-health. For Karen, this entailed being aware of her emotional needs and finding ongoing ways to balance these as she progressed through her treatment. As well as this, as I have already shown, Karen listened to her body. And whilst this message was heard but discounted in regard to choosing chemotherapy, this does not mean that it was always disregarded. I asked Karen to tell me more about the balance that she wanted to achieve through her use of shiatsu and reiki:

K – I think having the therapy work, with the shiatsu particularly was just made me feel human again. Having the chemo was a very dehumanising experience. [0:24:35]

She went on to say:

K – So to kind of have an antidote to that [chemotherapy ward], the therapy was like going from hell to heaven, because it was gentle, it was focused totally on me and my needs, it was a healing environment, I always came away feeling nurtured and more whole. Whereas, the hospital environment was very fragmenting, very scary, very alien really. [0:26:22]

Karen's use of complementary therapies then is about finding ways to cope with the ongoing demands of chemotherapy. As I found at points in Fiona's story, much of Karen's story sits somewhere between having a balanced life and balanced living. At times it is possible to hear Karen say that the complementary therapies helped her cope in pragmatic and physical moments, but in others there is a sense that having a balanced way of living is an important part of how she coped. Re-humanising herself through balancing out the physical and emotional effects of chemotherapy becomes an embodied practice, an embodied balanced living. She listens to her body and hears that it has been dehumanised.

For example:

K – I am a bit schizophrenic, I sort of try it and I think 'oh to hell with it – I fancy some cheese!' Because I was, I did go vegan for about five months and I really missed cheese a lot. So I would feel, I would have a little bit, and I would feel really guilty. The nutritionist at the [Support Centre] said to me, 'look just have the 80 to 20 sort of rule'. Which is 80 percent of the time eat healthily and 20 percent of the time, you know have some cheese, have some chocolate, have some alcohol. And don't feel guilty when you do it, because that isn't going to make you, isn't going to help. So I still feel guilty when I have dairy, I have to say, because of having read that Jane Plant book, I think, 'Am I ... Is this a death wish that I am eating this bit of yogurt' ... Which is crazy really. I think my decisions are based more on intui- not intuition, but just sort of gut feeling at the time. As you say, you can read one book and it says one thing and another bit of research says something else – you just go round and round. So I am not particularly consistent.

J – Sort of case-by-case?

K – Yeah sort of week-by-week really . . . [1:08.44]

The question I have to explore in Fiona's and Karen's stories is, what is their relationship with the mode of subjectification of balance. Karen describes a field here that is, to her, much less certain than the decision to have chemotherapy. Many might also argue that the stakes are also a lot lower. In contrast to choosing chemotherapy, a potentially life saving treatment, deciding whether to eat cheese or yogurt does not seem to hold the same sort of consequences. It might well be said that Karen too would agree that it is a less important decision. Nonetheless, it might be argued that it is a more 'vital' decision for Karen affecting, as it appears to do, questions of how she sees herself. Therefore, it is clearly one that provided some cause for reflection. Karen does not know what is the best thing to do, even when provided with a rule from the Support Centre's nutritionist. Karen told me that she had read conflicting accounts of whether dairy caused breast cancer or not (see chapter three). She also spoke of her concern not to do anything to aggravate her health, but it was also clear that she did not want to go to an extreme. (She later told me [1:19.36] of a friend's story, about a friend, who undertook a strict regimen of juicing and coffee enemas, which quickly overtook her life.) But whilst hoping to avoid the excesses of an alternative lifestyle Karen also seeks the benefits that altering her diet might bring. In seeking to decide what to do Karen follows a 'gut feeling'. In doing so she told me of how listening to her body, the embodied affectivity she has developed through using complementary self-health, has not only brought her to an awareness of her needs, but to an awareness of how they need to be acted upon and to the use that this awareness needs to be put. This is something I will explore in much greater detail in the following chapter, but it is suffice to say here that this ethical work of an 'embodied guide', as I call it, is infused in her subjectivity here with the mode of subjectivation of balanced living.

The Challenge of Balanced Living

Steven Shapin (2011)²⁰ argues that whereas balance used to mean that you could do no better for your (god given) body than be balanced; now it is understood to mean

²⁰ I first came across Shapin's discussion of the question of balance in his lecture 'The Long History of Dietetics: Thinking sociologically about food, knowledge and the self' (2011) at LSE (see: <http://www.youtube.com/watch?v=GTRbdEFjhOk>). However, further discussion of the commercial discourse of balance can be found in his book review essay (2002) 'Barbecue of the Vanities'; also for

that we can make our bodies better through balance. In particular he notes that the language of balance comes less through medical discourses and more through commercial ‘big-food’ enterprises, like fast food chains. Within this contemporary understanding of balance is an idea that the outcome of balance – being ‘better’ – might somehow be measurable. For example, Shapin points to commercial food manufacturers’ focus on the number of recommended calories, saturated fats etc as one way in which the customer may monitor and balance their consumption ‘as part of a healthy lifestyle’. Here a technology has formed to shape people’s relations to their bodies and health through which interested others, as much as the individual, can monitor the balance that is being maintained. Whereas, in Shapin’s historical examples, it was the experience – the feeling of the body – that was the guiding modality through which balance was sustained. Shapin (2002: 23) concludes, “in the 16th century, civic culture had a way of talking back to the experts who advised on how to live long and healthily, a counter which is almost inaudible in late modern culture. Montaigne, for example, doubted that there was genuine expertise to be had, other than that you obtained from your own experience”. Shapin finds that what is missing from contemporary experiences of dietetics – and what the public lack in the face of ‘expert’ discussions of health and wellbeing generally – are ways in which the subject can again rely on herself, so that an adherence to an expert’s rule does not make her life not worth living. What I will explore in the remainder of this chapter is how complementary self-health might be seeking to re-establish an experiential component to this encounter via what I call balanced living, from that more objectifiable discourse of balance that Shapin describes in contemporary society, or what I call balanced life.

It has become commonplace to understand problems in healthcare through frameworks of biopower (Foucault [1979] 1998b) and biopolitics (Foucault [1978] 2008; Turner 2008). As I explored in previous chapters, Rose (2007) argues that when people are understood to be self-governing through their emotions and affect, they are no longer subject to biopolitics, but ethopolitics. In turn this changes what is at stake in the self’s relation to their subjectivity. Ethopolitics is therefore

more on his exploration of dietetics in the 16th and 17th century see (2003) ‘Trusting George Cheyne’.

concerned with the politics of how people are expected to conduct themselves appropriately in relation to themselves and their future, and is the milieu within which novel forms of authority are taking shape.

In order to better understand the relationships of care and support that are being advocated in complementary self-health and what relationship each has to a field of agnotological problems, I turned my attention to the obligations that are promoted and, more importantly, how these are seen to inculcate the individual. Part of this is the recognition of the continuum that one is subjecting oneself within and then the attempts to move beyond it, which echoes with Foucault's work in *The Use of Pleasure* (Foucault [1986] 1998a) and *The Care of the Self* (Foucault [1988] 1997). For example, Foucault considered the ancient Greeks' attempts to avoid the excesses of pleasure, which included sexuality, to avoid becoming 'enslaved' to them. With the above distinctions in mind it is possible to say that the practices of self-mastery were, then, attempts to gain freedom via a life of moderation, a way of balanced living. But it is important to note that Foucault differentiates this experience of the subject from that of modernity, where the relationship between the subject and knowledge is objectivity. This is the difference between taking an objectified balanced life position and that of balanced living whereby one seeks an ongoing placing of one's self as a subject of possible acts in one's subjectivity. Balanced living therefore has an ontological dimension related to producing the subject as a certain kind of relationship between the individual and her self. Therefore, I ask, just how are Fiona and Karen directed to incorporate knowledge? Are the exercises undertaken in complementary self-health to be the ends of the approach or are they a means to something else? That is, to what *use* are they put?

In order to address these issues I distinguish between the discursive equipment that Fiona and Karen use and the mode of subjectification through which these are made sense of. There is therefore a process of transformation as the stories, narratives, discourses etc move from an authority of the reasoned word into a truth that is to be lived. What is important is to distinguish between those moments where the knowledge is 'stored' as memory, habit or in a discursive form (e.g. rhetoric) and where it is active in Fiona's and Karen's corporeality, a thinking-body, and not just a

biological process. In this way narratives add something to the self, which transforms the individual into a subject. The equipment that complementary self-health provides, the companion stories that can be used to protect the individual from the dangers they may confront in life, are discursive in nature. However, Fiona and Karen have described that, as well as discursive changes in their lives, complementary self-health has helped them change how life feels. It is therefore the mode of subjectification that is potentially unique and to which I now turn.

Therefore, whilst it is evident that the discursive equipment that complementary therapies and self-health provide are potentially technologies of self-governance, I have argued that in the ethopolitical context that this is not necessarily so (see chapter three). So on the one hand, balanced living could be argued to be a hermeneutic of care involving techniques that seek to uncover or interpret from the available evidence the best way to be, the ways that users *should* care for themselves. But on the other, balanced living could be the way that the user supports her self in order to situate herself in the place she finds herself, while recognising and accepting the system of rationality used to posit one's self as a subject in that particular point in the world. To develop the latter of these possibilities it will be necessary to consider the subjectification of temporality and teleology from complementary self-health (see chapter seven). Here the aim is to consider whether balanced living constitutes a form of (unthinking) strategic 'practice', an adherence to a political or ethical discourse. Or whether there is the possibility to challenge these and 'go beyond' through incorporating discourse as a process of subjectivation. The way I will do this is to explore a key discourse in the relationship to ourselves in the ethopolitics of healthcare, that of responsibility and blame.

An excess of responsibility

Problems of individual and practitioner responsibility have been widely discussed in the literature on complementary self-health (e.g. Sharma 1994; McClean 2005). However, the problem of 'responsibilisation' has not. Here, the individual comes to accept responsibility for their health and in so doing employs various operations on their body, thoughts and conduct in order to transform themselves (Foucault et al. 1988; cited in Reuter 2007). In particular, responsibility becomes an individual's right, which calls into question "the notion of agency in ... decision-making and

revealing that choice in this context is in fact the unfreedom to choose” (Reuter 2007: 236). Moreover, Reuter notes, to truly make an informed choice one must have complete knowledge of all the options available. She finds that in biopolitics this is found to be an impossible task and therefore choice and the agency it implies become ‘empty signifiers’ (Laclau 2000: 207; cited in Reuter 2007).

The question I ask here is whether this is also the case for complementary self-health in ethopolitics, particularly if one takes an agnotological perspective? What I have found is despite the limitations of knowledge, individuals still wholeheartedly take up agency, choice and responsibility. In Fiona’s and Karen’s stories choice, empowerment and agency are not empty, but are associated with an ‘excess’ of feelings of an earnest obligation to ‘do the right thing for me (and my family)’. By using these feelings to situate what is at stake in their stories, I argue there is an ‘overidentification’ with the ethical political strategy of responsabilisation.

Overidentification was originally used as a political strategy of resistance by alternative activist groups in 1980s and 1990s Yugoslavia²¹. For the activists, overidentification meant refusal of any distance through taking up of symbolic forms at face value. Through repeated and reflexive use it sought to take the state’s demands to breaking point and was seen as a way through the stranglehold of the apologists and loyalists to the regime (Parker 2004). Whilst the domain of ethopolitics is some distance from the politics of Tito’s Communism, the concept of overidentification is now again useful as, much like the activists, it is a way through a stranglehold of forces that seek to govern the subject. But, unlike the activists, it is not a strategic political act; rather it has become an embodied and productive mode of subjectification in the support of the self.

An understanding of subjectivity in ethopolitics is one that centres our analytical attention on the ways in which the conduct of human beings are shaped through acting upon their ethics. Within this we find that one of the most pervasive discourses is the individual’s responsibility to her self (and others). But this presents

²¹ Overidentification was theorised at the time by Slavoj Žižek (Richardson 2000). However, he argued that overidentification was merely a tactic that allowed one to refuse the covertly state sanctioned position of ‘dissidence’, in order to gain time for a later, more dramatic refusal of power at the level ‘act’, which would not take place in the domain of collective political action.

the user of complementary self-health with a problem: part of complementary self-health is to become more aware of the number of ‘spheres’ (as I described them in chapter three) that affect the individual. This increases the things to which the user feels responsible to and which she feels obliged to take into account in her decisions. At this point complementary self-health appears to have made matters more complicated for the user, perhaps even adding to the dis-stress that she might feel (Ehrenreich 2009). But Fiona’s and Karen’s story points me to one way that they have found to manage this – through an ‘overidentification’ with being responsible for themselves. But rather than the Yugoslavic strategic adoption of over identifying with dominant rules, Fiona and Karen undertake a sincere and earnest embrace of being responsible for their self, health and lives. I find that this affective response, in contrast to the Yugoslavic strategy of political (over) rationalisation, is somewhat more in keeping with the ethopolitical context they find themselves in. Moreover, by seeking to be responsible to all the spheres they identify as affecting them, they recognise they must situate these demands and come to a balance that best suits that moment. Each new situation will demand a reassessment of what spheres need to be accounted for and therefore what ‘balance’ is appropriate. Balance is then less a premade objectifiable framework that can be applied to any situation (balanced life) and more an open and ongoing mode of subjectification (balanced *living*).

This analysis also allows us to understand how it is possible to pose the user of complementary self-health as both partaking in marginal or non-mainstream practices, while at the same time understand them to be an exemplar of advanced liberal norms and values. This is because when we consider something to be balanced we might suppose that it exists away from the peripheries. But also, by seeking to be responsible for more than most would say is reasonable (which includes their ignorance), users of complementary self-health expose their self and their decisions to critiques of being *too* subjective. However, I argue that it is at this very point that the limit of the notion of the political rationality that advocates the responsabilisation of the subject as applicable in most, if not all, circumstances can be found. Further, it is now possible to understand how complementary self-health, thus far understood to be the ethopolitical product of advanced liberal rationality, has maintained a claim to be ‘outside’ of the contemporary rationality governing the self and be a place of potential refusal. That is to say to understand complementary

medicine as ‘complementary’ is to already have an idea of what is a reasonable act for a person to take, when being responsible to their health, and to know that engaging in complementary self-health pushes, transgresses or is even ‘outside’ of this reasonableness. Fiona’s and Karen’s stories are therefore recognisably part of contemporary healthcare, yet distinct from it.

But I still need to answer the question whether balanced living could be a modality of refusing self-governance, which seeks to produce the subject with a certain kind of relationship between the individual and her self. I argue that this certainly seems possible. Balanced living as a form of responsabilisation is a modality through which the individual incorporates the truth of being responsible. In doing so the subject overidentifies with responsibility, they go beyond what might be expected to be taken into account. That is, Fiona’s and Karen’s acts make visible the maxim ‘to be responsible’, as understood as a *particular* way of being responsible. But it is evident that in being responsible as they are, by incorporating the rationale of responsibility in her mode of subjectification, she is going ‘beyond’ and acting ‘other than’. Fiona’s and Karen’s subjectivation not only overidentifies with the discourse of responsibility that informs ethopolitics, but I argue that it posits a self that unbinds her self from being solely to blame.

Unbinding blame

Fiona’s move from seeking an alternative to biomedicine, to complementary therapies that prepared and sustained her body through chemotherapy, is followed by a move from balance as an object in life, to balanced living as a mode of subjectivation. Underwriting the latter of these is overidentification with the politics and ethics of responsabilisation to one’s health and life. In balance living balance moves from end to a means of living. Moreover, Fiona’s overidentification with responsabilisation is a form of realism that seeks to allow the self to go beyond the constraints of ethopolitical milieu, in particular the move to blame the individual for either getting cancer or not getting better ‘in the right way’.

Sharma (1994) finds that part of the ‘moralistic victim blaming’ that can occur in complementary therapies and self-health is somewhat related to holism. By which she means “The personal *right* to take responsibility for one’s own health is all too easily elided with the civic *duty* to take this responsibility (with the certainty of

censure and the possibility of penalties for those who fail in this respect)” (author’s italics; Sharma 1994: 90). Similarly Sered and Agigan (2008) found that CAM practitioners’ used broad and complex etiological frameworks based on an understanding of ‘holistic sickening’ that could suggest to cancer patients, they argue, that they might be responsible not only for healing themselves, but causing their cancer.

Sharma argues that in order to overcome such problems what needs to be addressed is whether these therapeutics empower or disempower. Or to use the terms of this thesis, the balance between short-term care, direction and intervention of the practitioner must be balanced with the longer-term possibility of providing the user with the tools to support their selves. In this way the balance of control is seen to shift over time with the patient becoming more self-reliant, which in turn changes the analysis from one of a zero-sum game of power to one where empowerment of the user is not seen to detract from that of the practitioner, biomedical or complementary. In conclusion, Sharma also notes “Most complementary practice does not (at present) participate in the panoptical surveillance of citizens envisaged by Foucault” (Sharma 1994: 102). The optical image she prefers is that of a ‘mirror’, which reflects back an image of the patient’s life so that they can see aspects of themselves and lives that were not clearly perceived before. In this way, it is the patient that heals him or herself, with the practitioner merely providing favourable conditions.

Sharma’s initial description of complementary self-health is now recognisable as part of the ethopolitical milieu of balanced life. Here, the focus on the responsabilisation of the subject has only served to intensify the problem of blame, as any failure to get better or utilise the ‘proper’ (orthodox) means leads to moral if not physical sanctions upon the individual. However overidentification with responsabilisation through balanced living holds the possibility to go beyond the limiting positions initially found within subjectivity, through the user’s ‘excessive’ feelings of agency and empowerment. However, the question here is whether the support of the self in complementary self-health reinforces conceptualisations of blame that are bound to the singular individual subject within the ethopolitical milieu, or if it holds the potential to go beyond it. My argument here is that overidentification provides one

possible way for Fiona and Karen to take responsibility for their lives through an ongoing balancing of relations with objects, events and their bodies. Part of this is the collapsing of the distinction between blame and action, through overidentifying with responsibility and doing all that they could do in order to get well.

For Fiona and Karen being responsible meant ensuring that they got adequate support, both physically and emotionally. Balanced living thus became a form of subjectivation. In doing so they recognised and took on the need to be individually responsible, whilst at the same time recognising and managing the demands of other discourses and desires. This was an ongoing process, where the (objective) balance lay at any one time would shift; nonetheless, the means of balanced living was open to any end that the circumstances provided.

In many respects this might not be surprising. As Hughes (2003) notes, the relationship between the practitioner and patient in complementary therapies and self-health is seen as one that is part of an ongoing process and is thus predicated on the assumption that both are in a constant state of change (see also McClean 2005). As I noted above, it is not life that becomes balanced, but *living*. Hughes also finds that the therapeutic intervention is sometimes less seen to be about curing the user and more about guiding the person through change. Thus change that comes through this healing process, she notes, is both means and ends and not just a means to an end. Therefore, although complementary therapy practitioners sought to overcome the perceived artificial separation of person from the body as well as emotions from physical state, it was also inappropriate and inaccurate to blame the individual for being ill. Hughes notes that key to complementary therapy's philosophy is positing that the user is responsible for maintaining their health and seeking appropriate healthcare. But it also holds significant tensions between the relationship between the macro socio-historical factors and micro responsibilities to take action. Specifically, this tension is manifested in attempts to avoid responsibility slipping into blame, which Hughes finds is under constant negotiation as the boundaries between discourses of causation and social location become confused and conflated. When this negotiation is pushed towards the patient end of the spectrum, I argue that Fiona and Karen found that overidentification with responsibility through a subjectivation of balanced living, allowed them to manage the associated blame by

highlighting their extensive efforts to become well. Any ongoing illness could then be said not to be ‘their fault’ as they had responsibly done all they could to get better.

Conclusion

Balanced living is a mode of subjectivation that allowed the interviewees to situate themselves, on an ongoing basis, in their formation of themselves as subjects in their subjectivity. Fiona and Karen spoke of how they continually sought to ground themselves in their embodied realities as a way of experiencing each of the rationalities or discourses that are found to be acting through them. By doing so I found that any understanding of the subject became slippery, as this allowed the interviewees to maintain their criticality. Instead, the analytical focus was on how balance formed part of their subjectivity and how it was interpellated. What I found is that balanced living is one way of living with cancer as a companion illness.

In order to demonstrate that balanced living is not always a reducible to technologies of self-governance, I explored its position within a dominant political rationality of responsabilisation. What I found in Fiona’s and Karen’s stories was an excess of feelings associated with this core ethic of healthcare, which was felt as an obligation by Fiona and Karen to take ‘total’ responsibility for their health and cancer. This led to acts recognisable as an overidentification with responsibility for their self, health and ways of living. Through refusing to distance themselves from responsibility and taking on all they could through a subjectivation of balanced living, they sought to absolve themselves from any concomitant blame. In sum, they were able to ask, ‘what else could we have done in order to get better?’

As part of their balanced living Karen and Fiona spoke of ways they listened to their bodies as part of deciding what to do. What the following chapter will explore are the practices and techniques, the ethical work, which is undertaken on the body, the ethical substance. In doing so I will be able to elucidate further how the support of the self in complementary self-health seeks to situate an unbounded body in its affectivity.

Chapter Five

Feeling Your Way:

Embodied Guides and Doing the ‘Right’ Thing

“I was misdiagnosed initially. So my message to all of you and everyone at home is: because someone is in a white coat and using big, you know, medical instruments, doesn’t necessarily mean they are right. And the amount of stories that I have heard of women going for a diagnosis and being told, ‘Don’t you worry about a thing, its fine’ . . . I don’t want to say that to frighten people, but that is just a fact . . . I guess you follow your intuition and if, if you have any doubt, go back again”

Kylie Minogue on “Ellen” DeGeneres’ chat show, 8 April 2008 (my transcription²²).

Kylie was diagnosed with breast cancer in May 2005 and underwent surgery the same month, followed by chemotherapy. Although she did not use any complementary medicines²³ she describes how, by using her own “intuition” as a basis for doing the ‘right’ thing, she felt she went beyond what many within a biomedical model of healthcare would describe as appropriate form of decision making²⁴. In doing so Kylie provides one example of how an empowered ‘citizen-consumer’ has found a way to circumvent the authority of the biomedical doctor.

In the interview with Ellen, Kylie’s speech and mannerisms would suggest that she is not comfortable with what she is saying. Perhaps this is because of the basis of her decision, or that she went against medical advice, or simply that she is not comfortable talking about having had breast cancer. Which makes it all the more interesting when she summarises her reasoning as “I guess you follow your intuition”. Although such a basis is felt to be problematic it is seen by Kylie and

²² For the full interview see: <http://www.youtube.com/watch?v=zI6KwaedeKk>

²³ On 7 October 2005 *The Sun* broke the story that Kylie was seeing Nish Josh, author of ‘Holistic Detox’ <http://www.thesun.co.uk/sol/homepage/news/article97966.ece> However, by 21 October 2005, Kylie had denied use of CAMs: <http://news.bbc.co.uk/1/hi/entertainment/music/4365390.stm>

²⁴ On 9 April 2008, in a statement released the next day Kylie stated, “I have a great respect for the medical profession and the numerous, in fact, countless, people who helped me on my road back to health. I am in the very best of hands now, but it is a fact that my initial diagnosis was that I was, ‘Alright, and had nothing to worry about’. A few weeks later this was clearly not the case. Early diagnosis and prompt treatment is the key for any woman diagnosed with breast cancer.” Quoted in the Daily Telegraph, last updated 14 April 2008, <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2008/04/08/nkylie108.xml>

recognised by Ellen, who responded with a similar revelation, as a legitimate basis upon which to act. In sum, the tensions in Kylie's statements, between the need to succumb to biomedical authority for her survival and the vital drive for an empowered and responsible individual involved in one's care, are negotiated by the foregrounding of her intuition.

As I explained in chapter one, the sociology of embodiment has located multifarious influences that work through, on, with or from one's ethical subjectivity. In particular, there has been a turn to feelings, emotions and affect for considerations as to how the embodied self might differentiate between these. However, this has not been without problems, as Lisa Blackman (Blackman 2008; 2010; Blackman and Venn 2010) argues such approaches have suffered, either from a favouring of discourse and narrative as a representation of affect, or have imported biological, neuro, or psychological concepts into bodily-studies without giving thought to the potential for co-productivity that studies of affect can provide. As part of addressing this problem I have argued (in chapter two) that I needed to recognise my position as an embodied sociologist. But I did so in a way that accepted a more far-reaching interpretation of Frank's 'thinking with stories', so that the situated character of the embodied co-production of stories was better recognised. In doing so, instead of theorising the subject as the foundation of practices and discourses, "[s/]he remains on the level of how subjects appear to themselves *as* subjects of possible actions" (author's italics; McGushin 2007: 11).

Moreover, I identified in chapters one and three that an embodied sociology in the field of complementary self-health needs to account not only for the factors described by the sociology of embodiment, such as mind and body, but consideration should also be made for the place and affect of other factors that are seen to influence users of the complementary self-health literature, such as spirit, society, environment and energy. Bringing all this together, I argue in this chapter that in order to differentiate between these influences, a number of my interviewees, like Kylie, used what I have termed is an 'embodied guide'.

What does describing 'intuition' as an embodied guide 'add' to the field? First, the description of the embodied guide is not a categorical description. It involves, in part, a technique of discernment that can be recognised in descriptions of gut

feelings, following your heart, resonating with what is right, or going with your instincts etc. But what is also recognisable in each of these techniques is that they refer to something that the term itself does not quite encapsulate. Those listening to Kylie would know what she meant by following her intuition, even if they recognise that their intuition would have directed them otherwise or even if they were sceptical that this ‘actually’ took place, perhaps preferring a cognitive model of understanding Kylie’s questioning, for example. So by describing the ethical work in such descriptions as an embodied guide it is possible to distinguish a form of simultaneous knowing and acting that previously might have been called *phronesis*, which is conventionally understood as ‘practical wisdom’. For Aristotle, *phronesis*, contrasts to *episteme*, the concern with universal laws that are context invariant, and *techne* that involves making or craftwork. However, Frank (2004) finds that neither *episteme* nor *techne* are able to help the person decide what ‘ought’ to be done, which is why *phronesis* is needed. *Phronesis* is the product of experience, “is the opposite of acting on the basis of scripts and protocols; those are for beginners, and continuing reliance on them can doom actors to remain beginners” (2004: 221). Frank goes on to adapt this understanding so that *phronesis* can be considered “as being of the heart, in the sense of that which **exceeds reason**. *Phronesis* is the type of knowledge for which we lack any contemporary English term, which may be a bigger part of our problem than we realize: contemporary society has lost the understanding that *phronesis* is necessary to becoming a complete human” (my bold; 2004: 221). I will explore in this chapter how a sense that exceeds reason, an embodied guide, is part of how the subject comes to know herself as a subject within her subjectivity.

I will do this by describing the ethical work (the situated, relational practices and techniques) that are used on what is identified as the ethical substance (the affective, relational and embodied self) to explore how complementary self-health seeks to provide its users with a form of ‘practical wisdom’ that together exceeds reason. Although the description of embodied guide is not (yet) found in the field, I aim to demonstrate how I believe it to have fidelity with the sense I seek to explore and it is, perhaps, something this analysis can return to the field (Latour 2004).

Pat

I had been put in contact with ‘Pat’ through ‘Karen’, who I discussed in the previous chapter and who I had interviewed earlier the same day. Pat was Karen’s friend and shiatsu therapist. After I had finished interviewing Karen, she gave me directions to the complementary therapy centre²⁵ where Pat worked. It was early evening in late October 2009 and it had already gone dark when I knocked on the door of the complementary therapy centre. I made my way up the stairs to be greeted by Pat, who told me that she would be with me in five minutes as she was just finishing with a client. She gave me a glass of water and I sat in the small waiting room, which was a square landing at the top of the stairs, with a reception desk. Off the waiting area were about four treatment rooms, each with the name of the practitioner and the complementary therapy practiced upon them. The client left and Pat told me that we could not use the treatment room for the interview, as she hired it for a set number of hours and the landlord would charge her if he found out that she was there after a certain time. As she got her things ready in the treatment room I looked at a rack of leaflets, advertising the various treatments and therapies available.

On the rack I found two that had Pat’s name on them. I briefly scanned over them as we chatted about where we could go. I read that Pat had been practicing shiatsu for around 20 years. As well as this she was also trained in Naturopathy and Nutrition. The leaflet went on to say:

“I find the body biologically and energetically fascinating and I believe shiatsu is a wonderful tool for healing. My approach is holistic. I deal with physical, mental and nutritional issues and I encourage my clients to understand their body through a self help approach”.

We left the centre and walked for five minutes to a pub Pat assured me would be quiet enough for me to record our interview. As we walked I explained my research to Pat and what I was interested in. Pat’s questions made me distinctly aware that she was assessing not just my research but me personally: I suspected that she was asking herself if she trusted me. It was clear that she was wary of me as she spoke.

²⁵ The centre was not a Cancer Support Centre, but a general centre where complementary practitioners hired space to treat clients with, or without, an illness.

She glossed over certain things and approached some questions defensively. Perhaps this was a false impression. It could just be that she wanted to skip the pleasantries and get on with the interview. She had already told me she only had an hour to meet with me, as she had to go on to a social engagement later that night. She had hurried around when at the centre and we walked briskly to the pub.

Once in the pub it was clear that Pat was, if not a local, known by people in there. We ordered our drinks – half a Guinness for Pat and a lime soda for me. I took the opportunity to literally ‘buy some favour’ by getting the round in. Pat smiled and I explained it was the least I could do for her agreeing to speak with me. We then found a quieter spot in the pub and settled down.

Pat was probably in her early 50s. She told me that she was married and had one child, but said little else about her ‘home life’. As we chatted I was aware that I was struggling to get Pat to feel at ease. I hoped that it was because she was just winding down after a hard day at work. But I was also aware that she could well suspect that I was out to expose complementary therapies, a scepticism of newcomers I felt sure she had developed over years of working in the field. My usual opportunity to show my badge of sympathy, the soya milk request, was not possible in the circumstances. And I had not yet been provided the occasion to introduce my own experience of cancer and complementary therapies, if this was indeed the problem.

I later found that speaking of my own experiences appeared to help. As the interview progressed it seemed that Pat grew in her confidence about me. In particular, when initially telling me her story she glossed over a particularly important incident in her life; a transformational experience. She said she was able to tell me that it changed her, but not what happened, as it was too personal. But later, right at the very end of the interview and after I had spoken of my own cancer, she let me hear about her most personal experience: how her late father helped her through the radiotherapy.

Pat was diagnosed with breast cancer in the early 1990s. She told me of her shock and surprise at being diagnosed. Having been a shiatsu therapist and generally ‘health conscious’ for twenty plus years she felt she had taken good enough care of herself to avoid serious diseases. However, her determination remained undimmed, saying “so I thought, well, I have got breast cancer I am going to give myself

everything I can give” [0:15.19]. For Pat, like many I interviewed, being diagnosed with cancer meant continuing to take control of one’s life and choices. She was going to be responsible for what happened to her. She quickly made the decision to have surgery and a week after she saw the surgeon she had a lumpectomy. She went on to tell me:

P - . . . Then I had to decide what I was going to do next. I didn’t need to have chemo because I had caught it so early on according to my lymph, they took a central lymph node out and it was clear, thank god. But then they wanted me to have radiotherapy. And I spent a long time looking into that and searching my own heart, meditating with it. Because I had a real, a lot of anguish and resentment and bad feeling about radiotherapy, because my father had it when he had cancer and he died two or three days later.

[0:19.02]

Pat explained how she considered her treatment options. Like many of my interviewees she took the time to consider her options, she did not just follow the ‘treadmill’ of the mainstream treatment pathway. Each of her decisions had to be weighed up carefully. Taking time to consider your options is not necessarily because of an ‘ideological aversion’ to mainstream medicine, as it is considered good practice (whenever possible) within mainstream medicine itself. Indeed, Pat had explained to me that she would have waited a month to have her surgery, so that it happened when she had the right level of progesterone in her body, which would be at a particular moment in her menstrual cycle. Pat noted that this was something her surgeon was aware of in terms of improving outcomes²⁶.

But in contrast to the surgery, Pat needed the time to contemplate having radiotherapy because of what are often described as ‘personal reasons’ and the biographical uncertainty this caused. In doing so, Pat used meditation to ‘search her own heart’ to decide what to do. But this was not all she did:

P - . . . So I had to sort of really intellectually look at what radiotherapy had to offer me and what the side effects would be and face that full-on. I also

²⁶ There would appear to be some biomedical evidence for this around the time of Pat’s surgery (Badwe et al. 1991).

had to look into my heart and my emotional side to deal with, you know to try to make a level ground, to not be frightened or resentful because of my father's experience, but to find a place where I could make a sensible decision, for me. [0:20.29]

Pat continues her story of her decision, having explained how awful and distressing she found it to watch her father, an "English gentleman", lose his dignity, because of the radiotherapy that he experienced. Nonetheless, she shows that she separated out the work she needed to do in order to make the decision. There was the 'intellectual' work, which explained the risks attached to radiotherapy and what the outcome statistics were. Then there was the emotional background that she had with this form of treatment, as she had already explained. She notes how she tried to not let that negative experience colour her decision either way. That she sought to provide an emotional level area. This language echoes that of 'visualisation therapy' (a guided form of meditation), where helping the individual find an 'emotionally secure area' is sometimes used to describe a mental image of a 'safe' place that one can go to in, say, times of distress during treatment.

So what I have shown, so far, in Pat's story is someone dividing up the spheres of work needed in order to come to a decision and in one of those parts she uses meditation and inner reflection. Rather than being some esoteric mumbo-jumbo that many people who are anti-complementary therapies might have others believe, it seems to be a reasonable process of evaluation. Here there are two parts of what is often called 'mind', the intellectual and the emotional, as well as the physiological metaphor, if not literal, of searching her heart for how it *feels* about the radiotherapy. The outcome, Pat goes on to explain, is that she was sure that radiotherapy was the right thing for her to do.

P - . . . The radiotherapy ended up being a really good experience for me; it wasn't awful, it wasn't traumatic. Because I had become emotionally and, I know it sounds a bit odd, spiritually come to terms with it. [0:31.54]

In this comment Pat brings in a further level or sphere of her decision making, her spirituality. She goes on to explain:

P - . . . When I was facing the radiotherapy I went to a Quaker meeting because I go to the meetings. I was visualising being in a radiotherapy room,

having it, because I was very frightened of the thought of having it, having seen my father come out of it and suddenly, I know this sounds very weird, suddenly someone took my hand and it was father who's been dead 15 years. I know this sounds weird . . . I'm also very down to earth too. But it was *so* clear he took my hand. He said, 'I can be with you now, I'll be there for you'. Every time that alarm went for the radiotherapy and they all went out, there was his hand. It was really physical. So actually it turned out to be a wonderful gift because I had this connection with my father every time I was having radiotherapy. So most people would think I was completely wacky, but it was a gift and I was tears in the last session because the last time the ding went I said, 'We can't go on meeting like this because I'm not having radiotherapy anymore dad!' I said, 'I just want to keep in contact with you'. But I was actually upset that I was having my last one. [Laughs] It's ridiculous! It was because it was such an extraordinary experience that I just got this support from my father. [1:13.29]

Pat explains that it was whilst preparing for her radiotherapy, by doing the visualisation exercise I mentioned above, she becomes aware of her father's support that would help her through it. It is this 'spiritual' dimension that helps empower her so that she can face going through something that clearly frightened her. But she goes further than this, having this spiritual experience is described as a 'gift', to the extent Pat is sorry to have the last radiotherapy session as she is aware it will be the last time she will see her father. I had previously spoken to her about the use of the phrase 'cancer as a gift', which Pat had said she was familiar with. In this understanding, cancer and the mainstream treatment that comes with it provide the individual with the opportunity to experience something special, something transformational, that they otherwise probably would not have had the chance to experience. This 'positive' is drawn out of the experience of cancer and, as Pat intimated at the beginning, is held very close to the person's new sense of self.

There is, in this one story, much of what I will explore in this thesis. The description of the experience of cancer as a 'gift' and the transformative potential it apparently holds will be explored in chapter six. The serious contemplation of how to not only make the 'right' decision, but to place it within the user's overall life, will be the

focus of chapter seven. And the use of complementary therapies to supplement the mainstream treatment and to balance out the experience of cancer, both in terms of its physiological trauma and wider disruptions, were considered in chapter four. In this chapter it is Pat's 'looking into her heart' for a sign of what to do that is of interest. What Pat's story helpfully illustrates is the place this seemingly 'inward turn' has within the diorama of influences, events and questions that she faced. As I progress through this discussion it should be remembered how her embodied guide was *part* of her decision making. In order for Pat to have radiotherapy she needed to evaluate its worth, but this was not just an 'intellectual' question. It was also a question for her heart. Moreover I have shown that, in part, her answer to this question involved her spirituality and, just as importantly, that her answer or 'truth' was accepted; therefore enabling Pat to go ahead with the treatment.

An alternative way of doing the 'right' thing

There are a number of embodied experiences in Pat's story. One place to start is with her noting that she meditated on the problem of radiotherapy. It was problematic, she told me, in terms of its clinical efficacy and risks. But this was something that she was able to reassure herself about through researching the 'statistics'. However, it also brought quite understandable emotional issues, given the upsetting experience Pat witnessed her father having. So by first using meditation and later visualisation, Pat explained how she came to find a way through.

Pat explained how radiotherapy was a problem that needed considerable work at an emotional level. She described how she searched her heart through meditation. By listening with Pat's story it is possible to hear that, rather than being self-centred, solipsistic or denying reality, she seeks to relate the needs of her body, which are seen to be largely addressed by mainstream medicine, to the emotional desire to not undertake this treatment due to her memories of the trauma that her father suffered. From this embodied, connected, reflection she becomes aware of a guide that takes her hand and helps her through a very difficult part of her life. Through the practices of complementary self-health Pat is able to hear, visualise and feel what is the right thing to do. Her affective response is a move beyond the discursive to an embodied

relationality. Indeed, it might be argued, as I will discuss in the final chapter, that this is also a move from an ethical to a spiritual relation to oneself and others.

Pat's experience of her father's presence guiding her through her radiotherapy is a story of how she was able to take responsibility for her care and treatment. By overcoming her fears she could wholly accept the decision to give her body the radiotherapy that she felt it needed. From an 'objective viewpoint', Pat does the 'right' thing. She takes the best that biomedicine had to offer. But, in these times of individual responsibility and choice, that decision was not inevitable. Pat, ever serious about her health, had to work hard and found a surprising way to empower herself. Let's not forget that she implores me to understand that she is not "weird", "wacky" or "ridiculous": she is also "very down to earth too".

Pat's story introduces one way that a person's story uses an embodied guide to overcome the agnotological questions and the emotional uncertainty that cancer posed to her. For Pat, the treatment she was offered and the risks it posed were not things that caused her concern outside of ensuring that the statistics were in her favour. However, this is not the case in the following interview. Here a combination of concerns, about the quality of interaction with the doctors and the perceived imbalance between outcome and risk, are understood and resolved through 'doing what feels right'.

Emma

'Emma' had contacted me after seeing one of my posters at a West of England Cancer Support Centre. I arrived at her home on a grey Sunday afternoon in October. Emma welcomed me in with a smile and offered me a cup of tea (with soya milk). As she was making it she asked me about my research. While I explained what it was about, I found myself telling her that she was the first interview that I had done after my own experience of cancer. I found her manner was warm and approachable, but as the interview progressed I could not help but sense a vulnerability about Emma that I found saddened me. There was certainly an emotional poignancy in the air as the interview took place.

Emma was somewhere in her mid 50s, and told me that she was a primary school teacher. She did not say whether she had any children and at several points in the

interview she noted how she was ‘all on her own’. She mentioned that both her father and mother, who she alluded she was close to, had passed away in the last ten years. And although she mentioned a couple of friends that went with her to her medical appointments, they do not seem to play a close part in her experiences. This narrative of a newly found loneliness seemed to be something Emma was still developing. Indeed, I could reflect that much of Emma’s cancer story was still unfolding, or in ‘chaos’ as Frank (1995) might put it. At one point she reflected, “I’ve never actually sat and just told someone the whole story just like that” [0:28.10] and towards the end of the interview she remarked, “I haven’t quite got there yet” [1:39.40], about her journey.

Emma sat huddled in an armchair, with her feet on a large square foot stool. On the stool was a pile of newspapers and a number of complementary self-health books. I placed the dictaphone on this pile and started the interview. Emma told me that following a mammogram she was recalled for further scans in November 2008. At the time she said she thought, ‘it will be a cyst’ as she had had a number of those before. However, three mammograms, an ultrasound and a core biopsy later it was evident to her that this was not the case. Emma told me how it was Christmas Eve when she found out there was a 16 millimetre mass they needed to remove, but it was not until mid-January that the surgery took place; a wait that Emma described as “horrendous”.

However, when she went back for her results they told her that they had removed a lump that was 47 millimetres and, because of this, they wanted her to have chemotherapy. Emma described this as the hardest appointment of all, simply due to the complete shock she experienced. Emma’s voice wavered as she recalled:

E - And the surgeon just sat there. I mean I was in *pieces* and she just *sat* there. And the breast care nurse just sat there. And in the end I said, ‘I’m sorry, I don’t know what else to say’. We were just sitting there in silence with me sort of snivelling a bit, but I said ‘I don’t know what else to say’. You know, they didn’t say, you know, ‘go and have a couple of hours and come back’ or ‘come back tomorrow’ or next week or... [0:09:45]

This non-recognition (Frank [1991] 2002) and depersonalisation (Broom and Tovey 2007) by the mainstream medical practitioners continued at the oncologist’s

appointment some weeks later. Emma recalls, “All she [the oncologist] was interested in was my left breast” [0:11.01]. However, in the intervening period between appointments, Emma said she had started to do lots of research into her options. When she was told of the chemotherapy combination that was proposed she questioned its suitability; as she was aware it could affect her heart. This was a problem for Emma as she had surgery to close a hole in her heart in the 1990s. Similarly, Emma had found that Tamoxifen posed a significant risk for her as one of the recognised side-effects is thrombosis, which she had suffered from six years previously after breaking her leg. In both cases, she said, the oncologist proposed ways to help mitigate the risks.

The oncologist then provided Emma with a printout of some relevant statistics, saying, “This is your risk of death”. Emma described how she was taken aback by this, wondering if the oncologist could not have presented this with a little more thought as ‘chances of survival’. As it was, Emma saw that the chemotherapy would only increase her chances by seven percent, given her age and complicating factors. After leaving the appointment, Emma said:

E – From that point I just suddenly thought, actually I’ve got a choice here. And I started reading voraciously [sic]. I mean I have never read as much or retained it ever in my life I don’t think. Because I just felt that this girl [oncologist] had no empathy with what I was going through or what I was feeling . . . I asked to see another oncologist, which . . . actually gave me three weeks breathing space. So the long and the short of it is that I haven’t had the chemo and I haven’t had any further [biomedical] treatment. I have changed my diet pretty radically. I’ve been to see a doctor who practices complex homeopathy and Chinese herbalism to rid myself of the toxins and the viruses and parasites. [0:16:50]

So a few weeks later, Emma told her new oncologist this. He asked her why she was making that choice.

E – And I said, ‘I just can’t reconcile myself with being pumped full of poison and you know that’s the end to it really’. And I told him about the Tamoxifen and I also said that the radiotherapy could damage my heart and lungs and, you know, I’d take my chances. So he said, ‘was I happy to come

in and have check-ups?’ I said, ‘yes I am, but I don’t want any more mammograms, unless they are for diagnosis’. [I went back for an appointment] with the Professor, who obviously thought I was a complete nut case. And I just switched off, and he said come back in six months . . . [0:19.13]

Having ‘switched off’ from the mainstream treatment Emma described how she at first felt bewildered about what to do. However, it was not long before she sought out a number of complementary practitioners and had come across the West of England Cancer Support Centre. She telephoned them and spoke with their breast cancer support nurse, who she found to be “wonderful”. Nevertheless, Emma realised that, even though she had radically changed her diet and undertaken other practices to improve her health, she was not feeling as good as she expected. She explained “I was feeling very tired and I just thought, ‘there’s got to be more to it than this’” [0:23.02]. Emma explained that she explored how her physical environment might be affecting her, telling me about her concerns with the toxins in her environment, such as the paint she was using to decorate her porch. Emma also told me she was looking to move home so that she could find somewhere that she felt more comfortable with. However, this was more of a long-term goal. In the meantime Emma decided to have shiatsu and acupuncture, but found that the shiatsu only helped to a certain extent. However, after her second acupuncture session at the Centre Emma felt “completely different” and had “got my energy back” [0:24:31]. Emma went on to say that it had been very difficult for her to make these changes to start with, as she was on her own. But as someone she met in the doctor’s waiting room said to her:

E – She said ‘I think it is easier because you are not making decisions based on other people, you making the decisions completely for you’. And it suddenly made me think, ‘Yes actually that’s right’. I’m not being forced into chemo because somebody else wants me to have it. And, you know, I still, I’m pleased with that decision because I think my body is in a much better place now to cope. And I just think, I couldn’t have done it, I just couldn’t. . . I think I was frightened of how I would feel coming home afterwards as well. I kept saying, ‘well you know, well what, how am I going

to cope if I am suddenly taken ill in the middle of the night?'. I said, 'I've got no one that I can phone and say, can you come round, or can you take me to the hospital. I just thought, I'd never cope. I mean I suppose that was by-the-by really, it was just the thought of being pumped full of these poisons, I just couldn't reconcile myself to it. [Sighs] So whether it's the right decision or not, it remains to be seen. But I feel I've got as much chance as anybody else really. [0:26:44]

'Sitting right' with doing the 'wrong' thing

Emma's story was not one I felt comfortable listening to. As she notes in the above quote, she was on her own and this was an important factor in her decision making. Chemotherapy seemed to present her, someone on her own, with an insurmountable problem. I could not help at the time but feel very sorry for her, even though I expect such sentiments might well be seen as patronising. Emma was clear in telling me that the reasons for not having the chemotherapy were because she could not reconcile herself to, first, a pay-off of seven percent that was not significant enough to expose herself to the high risks it imposed on her, and secondly, because she did not wish to be 'pumped full of poisons'.

Nonetheless, I wondered if her experiences with the mainstream doctors had been better, would she have gone through with the chemotherapy? It's impossible to know, but it is clear that the failure to show recognition, when she cried in front of the surgeon and breast care nurse, was significant. This combined with the perception of the oncologist's interest only being with Emma's left breast and ill-considered presentation of her survival statistics would not have helped an unpleasant experience pass more smoothly. Sadly, it would seem that narratives such as these are not uncommon enough in people's experiences of mainstream treatment (Davidson and Mills 2005; Cox et al. 2006). Whilst some might argue she should have sought treatment elsewhere or just found a way to 'grin-and-bear-it', Emma's story highlights another possibility.

E – . . . Because I think in all these things, you've got to find someone that you can empathise with and make some sort of connection with. Because I don't think any of this would feel right if I was . . . Hummm what am I trying to say here? Well just as I couldn't have had the chemo, because I would

have been thinking, ‘no, no, no I don’t want this’. Similarly, I don’t think I would feel the benefit from the acupuncture if I didn’t completely believe in it. [0:52:54]

There are two things here that Emma identifies. Having a connection with the individual practitioner and the presence of ongoing problematic feelings about a choice that she made or, as she rephrases it, not ‘completely believing’ in it. And somehow, these issues seem to be interconnected. Emma’s later comments help explain how:

E - . . . I think, like anything you are trying to make up your mind about, once you’ve made that decision, you feel better. Whether that’s the right decision [laughs] remains to be seen. But I think if you *feel* if it’s not the right decision you’ll probably still question it. [1:19.23]

Within this narrative is the idea that there is a ‘right’ position that one inherently knows is true and the problem is to work out what this is for you. In places in the complementary self-health literature there is talk of getting to know your ‘authentic self’. In particular Emma had read LeShan (1994; see chapter three) who talks of being ‘authentic’, and Woollams (2005a; also chapter three) who urges you to be ‘true’ to yourself. The idea is that, having undertaken various exercises or practices, you come to learn what your ‘true’ values are and how it *feels* to live a life in accordance with those values. Experiences, as Emma explains, then become tested against how they feel. And these experiences can pertain to any object, whether that is a course of treatment, or how you judge a practitioner. But I should be clear here that first, there is the reaction to the object and second, comes an awareness of how this reaction makes you feel. What complementary self-health seeks to do is to provide techniques to bring the person’s attention to this process. In doing so it provides a third moment whereby the person reflects upon the attitude she takes to herself. This is one form of embodied relationality, a way of feeling the truth in order to affect oneself.

Therefore, becoming aware of such feelings is not always an instant process. Emma told me what advice she would give to someone recently diagnosed with breast cancer. She started by explaining that it was important to ‘diagnose’ what your problems are. By this, she did not just mean what biomedical treatment issues you

face with a disease like cancer, but also how other levels or spheres have been affected by this physiological problem. In her case, she explained that she went for ‘Vega’ testing; a ‘bioenergetic testing device’ that uses acupuncture points to tell you what stress factors are affecting you in your environment²⁷. Such diagnoses are, to say the least, part of the more controversial group of complementary therapies. However, this is not the place to evaluate its efficacy, but rather to note the use to which the results were put. Emma talks of becoming aware of her holistic needs as a consequence. Having identified these needs, she has to decide what to do.

E - . . . I think the other things you’ve got to spuddle [sic] around until you find what sits right with you. And I think, as you become less toxic, you become more aware of the things that upset you . . . [1:29.44]

Recognising the You that Moves You

As I explored in chapter one, the body and its symptoms have become a site for truth about the self and a new opportunity for self-revelation. Harrington (2008) finds there is a contemporary narrative whereby the person ‘listens’ to a ‘talking body’, what she calls “the body that speaks” (2008: 68). This narrative can be seen to draw upon a number of conflicting and contradictory antecedents, each of which has great differences in the conceptualisations and practices of such ‘mind-body’ relations. What they have provided, Harrington finds, at various times and in multiple ways, are generalised narrative resources from which ‘patients’ can draw when seeking to make sense of their experiences. Therefore in order to better understand the embodied guide, I will locate it within a language of what can loosely be termed ‘mind-body problems’. However, this is not the usual ontological concern, but an epistemological one. As Despret (2004) argues there are more interesting questions to be asked when one turns one’s attention to the ways of knowing, the beliefs about mind and body, and how they allow the existence of new experiences of subjectivity. Here the concern is with how Pat and Emma understand their stories to come through, and return to affect, their (mind-body) selves. As Frank (2010: 44)

²⁷ Vega testing, also known as electrodermal testing, is an ‘unproven’ diagnostic technique. Most independent tests have not found it to be reliable or valid for diagnosing diseases, see Which? <http://www.which.co.uk/advice/the-truth-about-allergy-tests/vega-testing/index.jsp> (accessed 25 February 2010)

describes, “Stories are material-semiotic in their double embodiment”. He goes on to clarify, “In storytelling, the body embodies the story, which consummates the experience of the bodies participating in the storytelling”. Therefore, on the one hand there is the storyteller telling the story using words, images and gestures. But Frank, citing Scharfstein (2009: 60; *ibid*), argues the performance of storytelling materialises these semiotic forms in the senses, muscular and sensory processes through which the embodiment is consummated.

As I will explore, the problem of the embodied guide – of listening to the heart, of doing what feels right – is a problem that involves relating oneself to the world through the ethical acts of being *with* the truth one knows. Here the mind-body is not a problem to be resolved, but the product of practices and techniques situated within an embodied subjectivity. Ontologically this cannot be made sense of, as the Cartesian dualism is simultaneously affirmed, in the use of mind-body terminology, and refused, in the mind-body’s becoming. Moreover, and moving away from concerns solely with the mind-body to encompass those other spheres of complementary self-health (spirit, energy, environment and society etc), the ‘failure’ of fit between the ontological and the lived being-with is experienced as an ethical limitation, providing the opportunity to become the subject of one’s subjectivity. Put another way, in order to explore the embodied guide it will require a move beyond a discursive analysis so that a better reflection on feelings, emotions and affect and their place in embodied subjectification can be described. What I find is that the subjectivity of the embodied guide is not a singularly bound thing, but that it relates to other spheres (as well as biomedical knowledge there is the environment and toxins (Emma), and the spiritual (Pat)). Indeed, in order to set-up a question that I will address through the next three chapters, I will consider whether it is possible to move from an ethical relation to the self to an embodied spiritual relation to oneself. Of course, what I am seeking to describe in the embodied guide is not something that has no conceptual history²⁸. There are those who have sought to destabilise the epistemology of the body, such as those who have questioned the boundaries between human-animal bodies, including the previously mentioned Despret (2004).

²⁸ I am grateful to Lisa Blackman’s (2008) book *The Body (The Key Concepts)* for bringing my attention to the work of many of the authors cited in this section.

Game's (2001) use of attunement and entraining described how the rehabilitation of her horse also lead to her co-rehabilitating her bodily awareness. Brennan's (2004) book, *The Transmission of Affect* similarly starts by arguing that there is considerable evidence to suggest a model of affective transmission between bodies. Brennan then goes on to argue that individuals should be encouraged to think in more relational ways about their own bodies. This is not the split of the mind and body found in cognitive reflection, but through the development of practices that work with "the intelligence of the flesh" (ibid: 140). Here the body is found to think and feel, rather than be seen as an inert mass. Therefore there is a coupling of the breaking down of boundaries between things along with the formation of the unbounded body-self.

Such problematisations, as Tamborinino (2002) explains, go even further back in philosophical thought. For example, Tamborinino shows how Nietzsche's central position was that knowledge is always perspectival and embodied. Tambornino goes on to find in Nietzsche the argument that to focus on rationality alone in thought is to 'devitalise the intellect'. Such rational engagement can be uncritical and is often ineffective, as "that which one adopts *without* reasons – affect, mood, disposition – often cannot be challenged *with* reason" (2002: 89). Therefore these embodied habits, tastes, dispositions etc need to be subjected to consideration and criticism in ways that will engage them. This involves particular work on the self, bringing attention to the political and cultural operations of the body and the activities of daily living so that one "does not merely perpetuate one's inherited morality and culture but rather attempts to modify or depart from them" (Tambornino 2002: 90).

Transformation, as I shall explain in the following chapter, needs to be concerned with changing affects, moods, desires and dispositions. However, in what follows I will consider the practices and techniques through which Pat and Emma come to situate part of their embodied subjectivity, so that they are better able to make the 'critical' decisions that face them.

Coming to your senses

Brennan (2004) defines the general contemporary distinction between 'affect', which involves discernment, judgment and formation of attitudes, and 'feelings' which are the physiological phenomena. She also cautions against mistaking 'bloodless emotions', such as envy, as having no basis in physiology. Nonetheless, for Brennan

(2004: 7), the distinctions between affect and feelings are useful when focusing on the ‘transmission of affect’, which “undermines the dichotomy between the individual and the environment and the related opposition between the biological and the social”, although she contends that this never goes as far as to remove such distinctions entirely. What Brennan argues is that people need to bring their attention to the various ways in which the distinctions between affect and feelings are embodied, deployed and maintained. In doing so, they become aware of the disjuncture between language and emotions, which allows for new couplings and associations to form individually and socially.

Pat and Emma both describe the work they had to do on their ‘emotions’ in order to be comfortable with the decision that they made. As I have described, they both recognised they had a more immediate feeling towards the treatments proposed and then spent time working on why they reacted in such a way, in order to ensure that the actions they took ‘felt right’. Their emotions are recognised by them in different ways, such as biochemical reactions, as general bodily dispositions or as cognitive-behavioural reasoning. Yet they sometimes used the same words to describe each of these. Emma used conjugations of ‘to feel’ to describe most of the various formations of her emotions. Pat used a lot of psychological or ‘affective’ terminology, speaking of her “anguish and resentment”, but she also spoke about her more generalised “bad feelings”. But this is not just a linguistic account or analysis, both Pat and Emma sought to tell how the decisions they made involved coming to terms with what they felt – the mental and physical unease – about what they faced.

Brennan’s original distinction between affect and feelings is therefore useful, but Pat’s and Emma’s stories remind me to take such distinctions as – at best – a starting point for this exploration. I do so, whilst remaining mindful of Greco and Stenner’s (2008) strong rejection of such *a priori* distinctions (for the analyst), finding they obscure more than they assist at a conceptual level. This is because they find that such distinctions are overly value laden and perpetuate the idea that such differences can operate unproblematically, avoiding the need to think carefully about the conceptual issues at stake in the stories. Similarly, Despret (2004: 125) argues that a more productive analysis will follow if the language that is used is made available to the “‘affecting’ that both creates events and is created by them”. Thus

any dividing-up is situated in the being-with and is able to “resist” any authority that seeks to articulate on behalf of the individual.

How then can I understand Pat’s story of accepting radiotherapy? Pat explained how facing radiotherapy meant returning to “bad feelings” about the treatment and a great deal of anguish and resentment about what had happened to her father. Pat’s reaction to this is to first establish the scientific and statistical basis for the treatment. But, whilst necessary, this in itself was not sufficient for Pat to undertake the radiotherapy. For this she needed to create an emotional “level ground”, “to find a place where I could make a sensible decision, for me”. Pat did this by looking into her heart and her emotional side, which brought Pat to tell me of the spiritual encounter with her father that was also “really physical”; recalling the touch of his hand, as much as how the meetings made her feel. Pat’s following her heart is therefore not a reactionary judgement; it entailed locating the initial bad feelings, a generalised physiological reaction, within an account of past psychological trauma described in language of anguish and resentment. Pat then returns to work on levelling these physiological feelings, which brought her to visualise her father’s physical presence in the treatment room. Radiotherapy then becomes “a really good experience for me” as the consequences of being-with her emotional reaction leads to a physical and spiritual connection with her father.

One of the techniques in Pat’s story is the meditation she undertook to explore her feelings. During my fieldwork with one of the support groups I asked what it meant to meditate on a problem. At that point I had done several meditations ‘on the breath’ and with a mantra. Here you try to focus the mind on either the breath or a chant and, if your mind should wander, you are told to gently bring it back to the breath or chant. I was told that meditating on a problem meant that you tried to hold an issue at the forefront of your mind. The idea being that you could then let other thoughts, feelings, or images ‘well-up from the subconscious’ like dreams. As these sensations come into your awareness, you would acknowledge them and gently return your focus to the problem. In this way meditation is a way of bringing to one’s attention the psychological, emotional, physical and social associations one has with a problem. Becoming aware of one’s own position, status or feelings towards each of these spheres or levels is part of an embodied holistic practice. Thus, what is

seen to be looking inwards is actually considered to be part of looking outwards. How Pat differentiates what to do in response, when she looked into her heart, is when she listened to her embodied guide.

Pat's story of an embodied guide tells of how she listened to her heart and experienced her father's support in order to be able to make the right treatment decisions. However, her story is told from a position of remission some years after the events she tells of. Therefore, in case the embodied guide is mistaken as some form of retrospective mythologizing, I also consider Emma, whose story spoke of decisions she had made and continued to make. And, in turning to Emma's story, I find there is a stronger depiction of the unbinding of the individualised body that I found in Pat's story. Pat explained how, for each radiotherapy treatment, the experience of her father's body helped her cope with the treatment that she was having. For Emma, someone 'on her own', the positions that different health practitioners took *vis-à-vis* their attitude to her cancer and its relations to her body feature strongly in her story. Again, as in Pat's story, a strong narrative for Emma was the search for and maintenance of the support that she felt she needed. But unlike Pat, she did not receive this from either her biomedical teams or a spiritual encounter.

The work that Emma undertook was focused on generating knowledge and information – seeking support of the self – about what she was experiencing. Emma's story is one that is full of feeling, but at first these are feelings and emotions are largely unnamed and not understood. Emma commences vega testing, web based research, reads books and attends lectures and discussions with orthodox and complementary practitioners to diagnose her needs. At the same time this she seeks to experiment with several different CAMs. All this is orientated around changing how she feels. Emma tells me how initially none of it made her feel any different, any better; Emma's embodied guide is this yardstick of feelings and emotions. This might be described, to paraphrase Frank (2010), as just a search of the health library for sources through which to tell better stories. But this would be to mistake stories as 'purely' abstracted. As Frank finds, stories are embodied and so I can understand Emma's story, in part, as one that is seeking the right story to *affect* her; to change not only how she 'sees' her experience, but how it makes her feel. But I want to be

careful here; I do not wish to imply that complementary self-health is to be solely understood through as a psychologised ‘coping’ strategy, as some biomedical and scientific commentators have (e.g. Baum 2009). Instead of providing evidence of how complementary self-health ‘actually’ works, what I wish to explore in the next section is how, by following the embodied guide, Emma seeks to heal herself by recognising that changes at one level of her being, bring changes at another.

Embodying new techniques of discernment

It is at this point it will help the analysis if I reflect a little on the complementary self-health approaches in Emma’s story. She told me that she had read a couple of Woollams’ books and recently attended one of his lectures. Woollams, as I described in chapter three, uses the science of psychoneuroendocrinology (PNEI) to explain how improvement in one’s emotional state can improve one’s health. (Other complementary self-health approaches use a similar model of psychoneuroimmunology (PNI).) This is because these complementary self-health approaches understand emotions as fundamentally biochemical. Therefore, to change one’s emotions is to change one’s internal chemical environment. A less toxic life – the eradication of ‘bad’ chemicals – therefore involves not just changing one’s diet or environment, but one’s feelings to ensure that the immune system is working optimally.

PNEI and PNI provide models for the interaction between psychological processes, the nervous system, and the immune systems of the body (Vedhara and Irwin 2005). For complementary self-health this includes all spheres of life that you choose to identify, from one’s body and environment, to one’s mind and spirit (see chapter three). It is held in complementary self-health that the more complete this picture – the better understanding the user has of all that affects them – the better the chance they have of becoming well again. A key aspect for complementary self-health then is how the person ‘feels’ about any aspect of their experience. Previously, CAM practices prioritised rules drawing on particular alternative models of health as the basis to act, such as naturopathy’s ‘letting nature heal’. Whereas, in complementary self-health, feelings and affects have now come to be understood, through PNI, as crucial regulators of the internal biochemical environment. The person with cancer is encouraged to believe that if it feels like it is doing them good, it probably is ‘at

some level'. This is an important shift in the ethical basis of considering how one should live.

In Wilson's (2004) work on psychosomatics and neurology she argues that the digestive, nervous and other 'discrete' systems of the body can be shown to be psychologically 'attuned'. By which she shows that these systems communicate in such a way so that the body is understood to be networked and exhibits 'relational complexity' (Wilson 2004: 20). Wilson concludes, "The nervous system extends well beyond the skull, and as it so travels through the body it takes the psyche with it" (ibid: 47). Moreover, as Brennan (2004) notes, the extension of the psyche is not just to the whole of the body, but is connected or networked to other humans, non-humans and objects.

Continuing with Emma's story, I have described how Emma's very personal reaction to her diagnosis and treatment options were also located within discussions of her loneliness and her relations to her physical and chemical environment. This is juxtaposed with her experiences of – in particular her relations with – the various health practitioners: her oncologists, breast care nurses and complementary practitioners. For Emma the need to "empathise with and make some sort of connection with" seems to help things to 'feel right'. She also talks of not being able to feel the benefit of the biomedical and CAM treatments if she does not "completely believe in it". Despret's (2004) thoughts on the types of authority that allow and those that make docile come to mind; in particular, Despret describes belief as that which makes events 'available'. The closed biomedical impositions are refused by Emma; whereas the authority of the complementary practitioners, which allowed Emma to shape her experience, are engaged as they allowed 'belief in' their treatments. Furthermore, the toxicity Emma spoke about was understood both in the cognitive-behavioural sense ("things that upset you") as well as the biochemical and physiological sense. As Sara Ahmed (2004) explains, emotions are powerfully performative as signs and become 'sticky with affect': "in reading the other as being disgusting, for example, the subject is filled up with disgust, as a sign of the truth of the reading". In Emma's story she describes how the doctor's depersonalisation of her cancer and body resulted in further upset. This, when combined with the proposal for chemotherapy, results in Emma being unable to believe in such

distanced people or reconcile how what they are proposing – to introduce toxins to her sick body – might be able to help her.

Instead Emma goes on to research and seek out other possibilities and contacts a number of complementary and alternative practitioners. Searching for ‘what feels right for you’ at first looks like a very individualised act, but Emma seeks guidance from a multiplicity of sources that come to support her. At first this does not seem to help Emma, after changing her diet and undertaking various treatments she does not feel any different. However, after the second acupuncture treatment Emma’s ‘energy’ comes back. As I noted in chapter three, energy is not an easy thing to understand in the CAM literature, as many branches of CAM use it in different ways. Here Emma relates it to ‘feeling’ “completely different” in a way that she was able to get on with (normal) life again. As Brennan (2004) describes, ‘affects’ have an energetic dimension that can either deplete or enhance a person. Moreover, this is a process that occurs between people. Emma’s search for support can therefore be considered as one that looks to move her from a person on her own, to one that is related and networked to other bodies that can enhance her feelings and health.

Living your body’s truth

It is recognised in the field of CAM generally that there is a process of subjectification occurring (Heelas 2008; Broom and Tovey 2008b). But such a general description remains unsatisfactory here, regardless of whether such a process is seen to be emancipatory or disciplining. That is, it remains for the empirical detail to consider Pat’s and Emma’s accounts to highlight the ‘truths’ that were seen to move them. In doing so, I find that attention is drawn away from considerations related to learning and repeating lessons or rules, and moved towards the affective and embodied work that is undertaken on one’s life, or rather, in creating and living a new way of being-with one’s subjectivity. What I also find is that such ethical work is concerned with situating a self-critique; the target of which is an ignorance, neglect or forgetfulness of living. This is not to argue that the complementary self-help literature does not direct the individual. But to note how the user puts these directions into use; that she is given techniques to become aware of what matters to her, so that she may take into account in her thoughts and actions all the necessary parts or spheres of life. Moreover, in doing so she is urged to undertake this

critically, to see how these spheres could be moving her in ways previously unrecognised by herself. Finally, she should question if this is what she wants and, if not, to explore how she might come to change things.

The embodied guide is therefore not just a technique or a craft, but a way of being-with; a way of relating to oneself so that one becomes oneself as a subject in one's subjectivity. It would appear that it holds the possibility for subjectivity that is not necessarily founded upon a subject, but which precedes and then structures the subject. Through an ensemble of conditions and forms it provides the acts through which the subject can exist as an act of truth to herself. The embodied guide is a way of forming in the listener the listener's own truth, the listener's ethos, "by speaking in such a way that the listener is thrown back upon [her]self" (McGushin 2007: 10). She has not told herself who she objectively is, but the embodied guide has brought the listener into a new relationship with her self. What is evident in both Pat's and Emma's accounts is that complementary self-health is not equivalent to a singular external disciplining or governing authority. Indeed, to some extent, that there is no one authority is itself the problem. I have described how, in complementary self-health, there is a dispersion of roles and accountabilities, so much so that the individual is now called to listen to her own teachings, her 'practical wisdom'.

Conclusion

I have described how Emma drew on a multiplicity of sources and sought to feel her way through the problems they posed. Pat drew a more figurative explanation of the single figure of her father that 'comes from her heart'. In considering their stories I again draw on Blackman's work, which explores a number of neglected concepts that provide a non-logocentric feminised space of 'relationality'. This relationality 'makes available' (Despret 2004) a way of thinking about social influence that does not utilise an idea of the bounded individual, who needs to exert her will or exercise her rationality as the way to set herself apart from others (Blackman 2008: 31). While both of Pat's and Emma's stories are located in their very particular contexts, they draw attention to the embodied techniques of discernment that work with one's perceptions and are part of affective transfer, so that the user's focus is on the "relationship between bodies, affect and *trauma*" (Blackman 2010: 165). In doing so this analysis is drawn away from the idea of the bounded, singular and "distinctly

human body” towards an analytic that is capable of dealing with intergenerational, intercorporeal transmission of trauma – something particularly evident in Pat’s visualisation of her father and in Emma’s feelings of loneliness and feelings towards her practitioners. That is, the embodied guide brings attention to what Blackman describes as the status of non-knowing (or non-conscious), those forms of knowing that are felt but not easily articulated and that “direct our attention to the realm of the intercorporeal and trans-subjective in our ‘sense-making’” (2010: 188). The embodied guide is not to be posited as a practice of purely discriminating subjects, but as an artefact produced through the intra-action of specific im/material agencies, human and non-human.

As I described in chapter three, complementary self-health can be understood as a response to the ongoing crisis that is brought by living with cancer as a companion illness. Rather than seeking to manage desires in the face of trauma, part of what distinguishes the support of the self, I argue, is the ongoing and repeated relationship of forming one’s self as a subject in one’s subjectivity. In the embodied guide – listening to your heart or feeling what is right – I find that Pat and Emma described their immediate feelings towards what they faced. They then explained that they considered this response, questioning what formed their emotional reactions. Both biomedicine and complementary self-health provided the techniques to do this via statistics, diagnosis, meditation and visualisation. The problem faced – to have radiotherapy or chemotherapy – is then situated within their life, including all their emotional history and prejudices. Instead of seeking to escape this, as I similarly argued in the previous chapter, I have explained how Pat and Emma now looked to become responsible for and be-with their prejudices. In doing so they told of the new formation of an attitude that allowed them to make the decision that was right for them, at that time. As Emma demonstrated, once the user of complementary self-health is aware of their embodied guide, they are able to engage it for each new limit experience.

The embodied guide is part of what it is to recognise the effect one has on one’s self; it changes how it is possible to view one’s self as a subject in one’s subjectivity. It is a move from a discursive understanding of one’s self to an embodied affectivity, which can be related to different objects, but that is always situationally defined.

Located in complementary self-health the embodied guide approaches, juxtaposes or folds in numerous other concepts and mechanisms drawn from a history of mind-body approaches (Harrington 2008). In particular, the complementary self-health literature encourages the activation of the embodied guide through particular practices that seek to increase awareness of an unconscious ‘voice’ or ‘feeling’. The embodied guide is also a subjectification that draws on embodied narratives. As Frank (1995) argues, illness stories are not only about bodies, but are told by bodies that testify to values through their being and very presence. Yet such ‘testimony’ is an impossibility of detachment or abstraction and implicates and transforms not only others, but oneself in what one witnesses. The individual cannot escape the illness in their story and so, for the listener to recognise their story, they will be called to stay with their embodied teller and offer an embodied presence to commune with the pain and experience.

As I explored above, through an embodied guide, Pat and Emma provided some way down this shared, plural and circuitous model through drawing on, yet making their own, narratives and affective conventions in complementary self-health and the wider healthcare culture. This brings the question of whether the embodied guide and balanced living are part of a more general process of ethical-political governance. However, in the following two chapters, I will explore how the re-engagement of an affective embodied subjectivity is also found to allude to another, spiritual, form of experience. In addressing this in chapter seven I will consider the purpose to which this subjectivity is put. But before that, I will explore in the next chapter the transformational aspects within complementary self-health.

Chapter Six

Cancer As An Opportunity for Change: Experiencing Transformation and Transcendence

*God, grant me the serenity
To accept the things I cannot change;
The courage to change the things that I can;
And the wisdom to know the difference.*
([Serenity Prayer](#), Reinhold Niebuhr, 1892-1971)

Phrases like ‘cancer was an opportunity to change my life’, ‘cancer was what my life needed’, and ‘cancer is a gift’ circulate widely in accounts and reflections of those who experience cancer. In this chapter I will explore how two interviewees have come to experience cancer as opportunity for ongoing change in their self, health and life. I will describe how, in this mode of subjectification, narratives of transformation articulate not only changes to the stories people tell, but also in how cancer is felt to be embodied. I go on to explain how the difference that cancer makes to their lives also provides a new way of relating to others in the world, which is both physical and transcendental. As I explained in the previous chapter, the techniques and practices of complementary self-health are central to a change in the embodied experience of cancer and the place of cancer in the interviewees’ lives. What this and the next chapter illustrate respectively is, first, how that situated experience becomes an ongoing way of living and, second, how this locates an overall purpose for life.

The following two interviews are with people who have been ‘in remission’ for some years. While it is possible to find discussions of the changes cancer brings to the self, health and life in the stories of those undergoing cancer treatment, I have chosen these two interviewees as their stories allow me to explore how change came about for them and was then solidified, as the existential threat of cancer is seen, at least by ‘outsiders’, to recede. What I find is that in the narrative demand to tell and retell – that is so much a part of cancer as a companion illness – there is the opportunity for the experience of cancer to be relived and so the self, as a subject of her subjectivity, is reanimated and renewed. As I will show, this practice brings experiences of depth and wisdom into the accounts of the interviewees. Also, by drawing on these

interviewee's retrospective stories I can consider how the narrative demand to tell and retell is experienced by the interviewees. Here a productive tension exists between the situated narratives of transformation and the feeling of an experience that transcends the situated story telling.

In the interviewees' stories I find that one of the problems of knowing that 'cancer was what my life needed' is recognising the difference it made to the self, health and life. The 'Serenity Prayer' in the epigraph, taught to me at the Catholic high school I attended, frequently came to mind when I was in the midst of my fieldwork and I was listening to the groups talk about how they managed the changes that cancer brought about in their lives. Often, as I will show, the stories are infused with a greater sense of knowing and wisdom about life, where 'living' is about 'knowing the difference'. But for the interviewees, telling their stories is never enough as it fails to grasp the intensity or 'wisdom' that has been experienced. Therefore, in this chapter I argue that an analysis of the experience that transcends the situated account is needed. One that continues to draw on the non-discursive and affective responses to cancer, but that also recognises the new ontological formations in biochemistry found in complementary self-health's use of psychoneuroimmunology (PNI). This is to say that traversing both narratives and experiences of transformation and transcendence is a problematisation of the embodied encounter, which situates cancer as the 'semiotic-material' basis of an individualising and collectivising experience.

What is it that complementary self-health and cancer bring to long established discussions of transformation and transcendence? In the interviews that follow I will explore how the interviewees challenge their past, current and future possible ways of living. How complementary self-health provides the means to use the fear and anxiety that cancer brings in order to change themselves from their past 'false' life. Finally, in this chapter I will describe how the person with cancer who uses complementary self-health describes a subjectivity of affect that they consider to be rooted in the biochemistry of the body – as they describe the ways that the power of the mind can affect the body and how the body can speak to affect the mind.

What I will argue in this chapter is that, first there is the formation of depth to the self brought through the telling and *retelling* of stories about the *ongoing* experience

of cancer. Here, if cancer is to be a companion illness, I again find that it is complementary self-health that provides many of the means for it to be so. However, secondly, I also find that there is an ontological flattening of the self through a biochemical understanding of affect. This is because it is a biochemical understanding of affecting the self that is understood as something that is common to all subjectivities. This then allows for assertions to be made about how the capacity for subjectivity transcends the embodied and situated self. Narratives of transformation and experiences of transcendence become entwined together so that they allow the formation of a mode of subjectification that provides a profound basis upon which to seek continuous changes in the interviewees' lives.

Mary

I have known Mary all of my life and she knows me and my family well. Between 1990 and 1996 Mary had two episodes of cancer. However at the time of the interview Mary had been in remission for over ten years. Mary was in her early 60s, a retired nurse who was very active in her Roman Catholic Church community. She told me that she was currently studying for a degree in theology. In the mid-1990s Mary had been to the then Bristol Cancer Help Centre, three months after her last surgery, but had not had any direct contact with the Centre since.

It was October and I was visiting my family in the North West of England when I interviewed Mary at her home. A couple of roads down from a rundown paper mill, she lived on a quiet street of compact semidetached redbricks. The end of her street merged into a dirt track that took you down to a reservoir, a place I would frequently visit as a child. The street itself was quiet, with more children playing on the road and horses being led back to a local farm, than there was traffic.

Mary's children had all married and had children of their own. Her husband had died in the mid-1990s, around 18 months after they separated. Although Mary lived alone, she told me that she always had her family and friends to turn to when she needed support. However, with her cancer, separation and death of her husband, it is evident that the mid-1990s were a tumultuous time for Mary and brought her to reflect seriously about her life.

At this point in her interview Mary had been comparing her reaction to her two experiences of cancer, when she reflected upon her experiences as a nurse.

M - ... so the psychosomatic thing runs through and I can see it in patients, observing others, you know, why do some people get over their heart attack and they did what I did and they go back as if its never happened to them. And others take on board certain lifestyle changes ... they acknowledge they've to change. And they change within themselves and that's the key thing. Yeah. That's key I think, change your attitude to yourself. Cause your illness is telling you something, always. [(2)0:22:02]

Mary's account is a reflection upon her own reaction to illness, as well as those of her husband and the patients she cared for over the years. She was diagnosed with bowel cancer in 1989 and underwent surgery to remove a section of her bowel. Four months later she was diagnosed with cancer of the uterus, which was also surgically removed. She went back to work, but five years later she was again diagnosed with bowel cancer. Her account of the changes she made in her life are set against her husband's response to his heart attacks and her first response to her diagnosis of cancer – to put it behind them and “get back to normal”. She reflects upon this first diagnosis and treatment and her focus upon getting well *enough* to go back to work and look after the two teenage children she had at the time. After her second episode of cancer, Mary said that she realised that something had to change so that the cycle of cancer diagnoses would stop. This lead her to the thoughts above where she reflected on the two sorts of patients that she had seen on the wards: those who had taken their illness seriously as an instigator of change in their lives and those who, once well enough, continued as though nothing had happened. This, along with her personal experience of the latter – her own recurrence of her cancer and her husband's repeated heart attacks – moved her to seek a way to change her attitude towards her life and health. What is in the foreground of this account is the idea that “your illness is telling you something” and that with this knowledge you can improve your chances of survival. Therefore, the key to this attitude change is to listen to what this voice or feeling, this embodied guide, is telling you.

Mary told me that she had been on numerous religious retreats over the years and was familiar with many practises and techniques of listening to one's self.

Nonetheless, complementary self-health brought something different into her experience.

M - ... complementary medicine took me from being a victim into giving me some part to play, however illusory, in so called controlling my illness or being in charge of my cancer, rather than it being in charge of me. [0:05:48]

Mary recognised the potential for her “to be made a fool of or exploited ... by charlatans” [0:28:16]. But she went on to try a number of complementary therapies and made many changes to aspects of her life including her diet. Even then she questioned, “whether [they are] doing me any good or not? But I always felt better for it ... in me spirit, in me self ...” [0:29:46]. But Mary also noted that:

M – ... I’ve not, I haven’t been sick since, not with cancer - I’ve had coughs and colds ... my life is enriched. They told me to make a friend of my enemy and psychologically that was a good thing to tell me and I look back now and they said, ‘one day you might be thankful for this illness’. And I thought, ‘your crackers!’ But I now think, I learnt so much through it ... [00:07.02]

I can be sure that Mary directly contributes this change in her attitudes to complementary self-health as she told me:

M – I think that a lot of it is down to changes in my attitudes... I also think I could not have got it again had I not gone to Bristol, but I don’t think I would have managed so well and have my life so enriched and doors opened through this illness rather than shutting, you know ... So, I let go of a lot of things as well... [0:10:01]

Mary distinguishes between complementary self-health’s capacity to prevent cancer and the difference that the experience of complementary self-health, in contrast to her religious practices, had for her. Complementary self-health may or may not have been the difference in preventing cancer’s reoccurrence, but it certainly was the difference in providing a degree of control to her life, however ‘illusory’. Indeed complementary self-health is attributed to instigating the ‘opening doors’, ‘enriching life’ and ‘letting things go’. It was, in short, part of the transformation in Mary’s life. And such is the significance of this transformation, she has come to be ‘thankful’ for her cancer.

But unlike in chapter five, where it sufficed to listen to your body in order to take the ‘correct’ action for you, Mary folds this into an experience whereby this action is linked to better health and life. Mary also found there to be a large ‘psychosomatic’ component to illness, which was linked to her ability to recover and prevent relapse. But in order to achieve this recovery, a considerable amount of reflection upon one’s life was needed. As I will explore below, Mary’s use of a psychosomatic language draws upon a narrative framework that, as Monica Greco (1998) has described, first needs to assert there was a ‘previous’ separation of mind from body, before secondly, describing how a transformation took place in order to bring them back together.

‘One day you might be thankful for this illness’

Mary spent a lot of the interview telling me about her life, from childhood through the years until her decision to separate from her husband. Although I had known Mary and her husband well, it became evident as the interview progressed that he was a man she cared for deeply, but she had come to understand that the way they were living together was making them both ill. Mary told me how she struggled with what to do in the face of her problems with her marriage, her cancer and the fact that, at the time, she had two teenage children who were facing exam years. In doing so she described a way of living that she had developed since childhood; a way of living for others, of making sure that everyone else was happy, before attending to herself, which inevitably meant there was no time spare to attend to herself. In many ways Mary’s narrative reflects that of ‘second wave feminism²⁹’, whereby she came to a realisation of the roles demanded of her as a woman, whilst she also developed a sense of her own worth for herself in her life. A narrative that perhaps is not at all surprising as she had been an activist in feminist theology for many years. Mary described to me what the change in her subjectivity meant to her.

M - ... when it’s all out and happening unconsciously, you know, the chemistry is going bananas and on the surface you’re doing all the right things. You know, ‘Mrs I’m for everybody’, you know, and you’re fulfilling

²⁹ I acknowledge this is a crude characterisation of a significant body of work; nonetheless I find that the characterisation enables a productive analogy here.

your own prophecy about yourself, but it's a fakey one, it's not really you at all. And yet there was so much of me in it. I wasn't a totally... you know, another person, I'm still the same person. But, so there's a lot of the real me mixed up in it you know. So that I didn't just turn into somebody else ... and then when the marriage was over I turned into somebody else again, I mean you wouldn't notice the difference. I do. But, because there was a lot of me in the marriage, in the way I did things in – I was fulfilling a lot of my own potential in many ways, but right down at the bottom, under all these layers was sitting this unmentionable I couldn't look at, you know. So it made me ill. I think that's why, I know I've got the gene, so I was predisposed, you know to, but I would get sick ... [(2)0:13:20]

Mary went on to recount several stories from her childhood. In one, a strict authoritarian teacher would punish Mary when she did too well in class, forcing Mary to monitor her achievements so that she did not score too highly and come to the teacher's attention. During that year, Mary told of how she was uncharacteristically off school several times due to sickness. Similarly, in Mary's other stories, she sought to tell about how she was forced to keep her 'true' self hidden in order to conform to the demands of the authoritative Other she found herself facing. Therefore, Mary's early stories are layered with constructions of various determinants in her life. But as Mary's story develops she comes to find a retrospective lesson in the ways these Others affected her.

M - You know, and so all those things come back to you; you realise then, 'why am I getting sick all the time?' you know. It's avoidance. And it, you know other people would have had a nervous breakdown or they'd have gone off schizophrenia or some... you know, it will out won't it, that kind of prolonged dis-stress. It will out. And in me it's physical sickness.
[(2)0:15:57]

So on the one hand, Mary's account looks to draw on the role of autonomous-individual that people have when faced with a genetic predisposition, as noted by Novas and Rose (2000). But on the other, Mary seeks to fold in narratives about how one reacts to what I've described as 'authoritative Others' that need to be accounted for in Mary's life. Gilligan's (1993) work regarding the 'ethic of justice'

and the ‘ethic of care’ is particularly apposite here. Gilligan might argue that Mary can be seen to be drawing a distinction between an ‘old’ self, which sought to find an equitable solution that was fair and was a way of negotiating through the demands that are being ‘dropped’ on her; and a ‘new’ self, which has an understanding that brings other considerations not contained within the negotiation of the task or work in hand. This ethic of care allows her to justify to the Other - where permitted - but certainly to herself, alternative sorts of actions, namely caring for her mind, body and spirit. That is:

M – ... I made decisions that ... subsequently hurt other people, but, again one has to learn to survive, it, you know, and ultimately, you were trying to live your truth, rather than live a lie. Living a lie is exhausting and it makes people poorly, [getting softer and quieter] it wasn’t just making me poorly it was making others poorly as well - you know what I mean.” [0:18:24]

Mary is referring to her husband, whom she recognised was also suffering from the problems in their marriage. What I show in contrasting the ethic of care with the ethic of justice in Mary’s story is that they are two ways of understanding how she had become ill and what she should do about it. Similarly, as Sointu (2011) has argued, narratives of wellbeing in complementary therapies transform women’s experiences of care from ‘caring for the other’ towards ‘caring for the self’. For Mary, the recognition of the emotional distress caused by living for the other was a contributory factor, not just in the way she handled her illness and wellness, but also in the familiar restructuring of her life. For Mary, the transformation in her story is the breaking down of the affective boundaries between her mind and body, her self and her husband, so that she becomes aware of the connections between them and how they affect her health. The transformation to the ethic of care in Mary’s story is not just about how she *will* live her life, but it allows her to know the difference and tell of how she *had* lived.

However, there is one further narrative that I must acknowledge in Mary’s account, that of the place of fear and anxiety that is experienced in cancer and its treatment. Mary told me about the lack of support she, a qualified nurse, experienced within the mainstream framework. She told me of being ‘left on the streets’ after her surgery in 1990, with little advice on how to react, cope or prevent further recurrence. This

experience was little bettered the second time around and pushed Mary to explore other forms of support, namely her religion, which was ever present in her life, and complementary self-health. Mary explained how she then found a way to make fear and anxiety emancipatory.

M – . . . and cancer did that for me; it frightened me into seek – you know, I was more afraid of that than perhaps than I was of ... of public failure.

Whereas before, nothing had been greater than the idea of public failure. So ... i-it frightened me into a more honest assessment and I thought I can't do this any more, you know. [00:24.08]

The fear and anxiety cancer brought into Mary's life provided her with the impetus to make a more 'honest' assessment of her life, and change from her old unhealthy ways of living. Complementary self-health along with her religious retreats provided the techniques and practices needed for the introspection to see what needed to be changed. But it would seem that complementary self-health was central in providing the mechanism through which the relation between emotions and subjective wellness could be related to the physical wellness of the body. This is part of complementary self-health's attempts to recombine mind and the spirit with the body. Indeed it is this 'holism' that is so attractive to so many complementary self-health users, such as Mary. And being 'honest' to your self at every level is the lesson Mary retrospectively draws from her reflections, one that she recognises she was untrue to in her life before cancer.

As with the interviewees in the previous chapters, complementary self-health encouraged Mary to become aware of all aspects of her experiences of cancer. It helped her open up her psychosomatic dualism into a more multi-sphere understanding that encapsulated the effects of diet, job, family and spirituality. Her story shows that the changes that are made are slow and ongoing. Mary tells me of the many opportunities for reflection that a lifetime of religious practices brought. Yet it was not until the second experience of cancer and the narratives of transformation, drawn from complementary self-health, which supported her own observations of 'psychosomatics' over the years as a nurse, as a wife, and as a mother, which initiated the changes. Cancer was therefore the opportunity that produced a new way of living, for which Mary was thankful.

Angela

‘Angela’ contacted me via my website. A friend of hers, who I had interviewed a few weeks earlier, had directed her there. Angela worked at a Cancer Support Centre where she was one of the ‘mentors’ to people starting the approach. I had not met Angela before, but we had a series of friendly email exchanges prior to meeting. In one email, she informed me that she had “depended heavily on CAM for my recovery and continued wellness” and would sign off her emails ‘LL&L’, or ‘Love, Light and Laughter’, later telling me “...laughter is a huge thing and always has been in my life...” [00:20.00]. At one point Angela had invited me to go with her to a workshop that she was attending, unfortunately I was not free when it was on. Eventually we found a date we could both make and Angela agreed to meet me at the nearest train station to where she lived. We chatted briefly in the car journey to her houseboat – she lived on a large barge on a major river – and had a coffee and further chat in the barge, before starting the interview. Angela told me that she was divorced and remarried, with a son from the first marriage now in his first year at university. She had lived in both the UK and the USA, with much of her early story taking place in the States.

Angela was told in 1992 that she had non-Hodgkin’s lymphoma – a treatable but incurable cancer. At the time of diagnosis it was indolent (very slow-growing), however it would at some point become aggressive. She underwent several series of chemotherapy and a bone marrow transplant. But as the cancer kept returning this only bought time. Then in 1998 a new experimental treatment became available (rituximab), a contraction of monoclonal antibody therapy, which has put the cancer into remission. During these years Angela described the cancer as a license to go try out all the things she had heard of.

Angela described the development of an attitude that came from early experiences with mainstream medicine. Having experienced epilepsy from a young age she described how she had been tested and then labelled as ‘stupid’. But over the years she had realised that she was ‘different’ and had found that her experiences and attitude of ‘not getting it’ were valid and useful in life. Another attitude she

developed was to ‘tell one’s own truth’³⁰ when confusion surrounded her, she likened herself to the small child in ‘the emperor’s new clothes’. Therefore her starting point became her own understanding, which allowed her to get a handle on what else is going on.

Angela had not always had such a perspective on life. Her story contained a narrative of realisation about the mind and body’s relation and the problems that occur when the mind’s stresses are not adequately dealt with. As an example, Angela explained that sometime in the 1970s, many years before she was diagnosed with cancer, she got an eye allergy causing her eye to go red, puffy and weepy. She recalled visiting her family doctor in the States who said to her, “you know that there’s a school of thought that says your eyes get red and weepy erm and make you look like you’ve been crying because you’ve feel like crying and you’re suppressing it. So is there something going on that you want to talk about?” [0:07:14]. Angela told me she was taken aback by this suggestion, questioning “what was with him?” and just demanded the relevant prescription so that she could get out of there. But it was an experience that “stood out like a pillar on a plane” [0:08:02] for her over the years.

This was just one experience of many over the years where Angela visited the doctor with various ailments. In the years before her cancer diagnosis, Angela recalled that she visited several doctors as she was not feeling well, but none could provide her with a diagnosis. Around this time one thing she was being treated for were gallstones. This time the doctor provided the relevant pills, but it was Angela who considered that there might be more to it in her life and that she might want to address this too. She vowed to not take the pills and find an alternative cure to her problems and told me “I guess this was the moment I really committed to alternative medicine”. But as she then recalled, “But, of course, I didn’t do anything! [Laughs] So I then got seriously ill and had to have the surgery.” It was during the pre-surgery tests that they found that Angela had the Epstein-Barr Virus, which is thought to

³⁰ ‘To tell one’s own truth’ is, as parts of complementary self-health have also called it, ‘being honest with yourself’. The truth here has a dual meaning. It is a situated subjectivity that the interviewee has developed as a means to negotiating uncertain situations or problems. But as well as this, there is the objective or a shared truth around which all further interactions can be orientated. This distinction is much like the one I made about balance in chapter four.

cause autoimmune problems as well as various cancers. And it was whilst they were investigating this that they found out that Angela had cancer. Looking back, for Angela this now all makes sense.

A - ... But of course, I mean, knowing what I know now the cancer manifested because my body was trying, and trying, and trying to get my attention and ... I was in a state of real *dis-ease*, I was in an extremely toxic situation in my marriage and all that, and what happens is that unless you, unless you pay attention to the signals that your body is giving you erm and change the state of dis-ease it goes on getting bigger. [0:10:55]

This time Angela took the message cancer was giving her seriously. In the next few years she changed her lifestyle, divorced from her husband, and tried multiple complementary therapies. She concluded:

A –... And I’m in better health now than I was in my thirties so, you know, having had *massive* amounts of chemotherapy and all kinds of other rubbish. So, I’m a complete believer in our, in the importance of us taking real responsibility for our health and being cognisant of, you know, body, mind and spirit ... aspect, you know, the body, in holistic medicine we say, ‘what the mind suppresses the body expresses’ and I just think that’s just so neat, perfect, true. [00:14:09]

‘...it was not a punishment it was a gift...’

As I described in the previous chapter, recognising the body’s messages is one part of what is needed in complementary self-health. As Mary noted above, it then takes considerable reflection to recognise what it is that needs to be changed and how that should be done. Angela told me that her diagnosis of cancer, which at the time had very poor rates of survival, gave her the licence to experiment with all sorts of complementary therapies. On one occasion, a few weeks after she had finished chemotherapy, Angela visited Christopher Hansard, a physician of Tibetan Bön medicine. She told him:

A – ... ‘I want a miracle I am not prepared to die, this was not going to work.’
... And I went in and I said, ‘Christopher, I’ve decided I want a miracle.’ And

he went, ‘You can have one.’ I said, ‘No did you hear me? *I want a miracle*, I am not going to die.’ He said, ‘Yeah you can have one’ [laughs].

He went on to tell Angela:

A – ... ‘everybody is entitled to trust, safety and security.’ And the fact that that seemed like such a distant mirage to me was, looking back, was really a wake-up call that my life was in a pretty shitty place, you know, despite the fact that I was driving a BMW or a Bentley and living in a certain place and practically glamorous lifestyle. The idea of ‘trust, safety and security’ was so poignant to me that I cried. ... And I wrote it down and kept looking at it, [whispers] ‘wow! Can you really have that?!’ ... So you see, when you know that, one’s not surprised that the body manifests dis-ease because the life place I was in was in such a state of dis-ease. [00:33.13]

‘Trust, safety and security’ are recognised by Angela as key words and mark a difference in perception between the life she had and the life that she now has. She notes how she used to have a ‘glamorous’ lifestyle, but that ultimately she was not happy. This unhappiness she links to a number of illnesses that she had throughout her pre-cancer life (or Before Cancer: BC; as she called it) that were the psychosomatic manifestation of her dis-ease.

Leaving a life (and husband) that was associated with material wealth for one based on these principles sounds a little like a contemporary fairy tale – the ‘self-health Cinderella’. But it should not be compartmentalised so easily. That the realisation that she was missing these three things in her life was such a shock to Angela, and that she had a desire to give up a lot of what she had in order satisfy them, marks an important moment and holds sociologically important questions. For Angela the lack of ‘trust, safety and security’ in her life were things that were lacking since her childhood. She went on to describe how she felt that babies ‘adore’ themselves, but over time they are ‘trained’ to internalise someone else’s world view and in the process ‘shut down’ parts of themselves. Something she found to be part of the education system, where she was told ‘oh you’ll never amount to anything’, which for a long time became her way of living. But Angela described to me that no matter what her problems or the state of her health, she had come to realise that, “your

number one fundamental problem is your inability to love yourself” [01:09.05]. She went on to explain:

A – And the fundamental thing is that people don’t love themselves enough and that is what helped me pull off a miracle because I was reading that every single day ‘love yourself, love yourself, love yourself.’ That’s why people stick with health programmes is because, ‘I am important enough to make that effort for’ ... [01:14.54]

Recall that Angela’s sign-off on her emails was ‘love, light and laughter’. These three things are all associated with healing in complementary self-health. Finding a way to love her self was clearly an important moment for Angela, it was part of what she described as a ‘miracle’ in her life. Loving one’s self gave Angela the reason to keep on making the effort to get well. Light is synonymous with ‘good’ things generally and is regularly used in complementary self-health. As Frank (2004) describes, narratives of light play an important part in illness stories, banishing ‘Grendel’ (the monster from *Beowulf*) forces that might destroy the person. For example, every group meeting during my fieldwork would finish with the group members standing in a circle, holding hands, with our eyes closed, as the group leader would describe a ‘healing light’ that started ‘within each of us’, but would ‘pour out and into a pool that we each could take from’. This was a light that would be visualised as cleansing at a molecular level. Many in the group would describe this as their favourite part of the meeting; such was the strength of the feelings it generated. Angela did not tell me what the ‘light’ in her sign-off referred to, so I can only suppose it is related to similar experiences. But she did tell me where the sign-off itself came from.

A – basically because I was told by the same mysterious source that told me, three days after the diagnosis that I wasn’t coping with the diagnosis of cancer at all well, that it was not a punishment it was a gift and an opportunity, and that same voice after lots of work on lots of spiritual retreats and things to do two things really, one was, one was to let go of the resentment that I was carrying, and I knew perfectly well what that was. And the other thing was to find out what my purpose on the planet was because it seemed to me that if I had already fulfilled whatever my purpose had been to

be here then it was a bit like trying to overstay your welcome, you know, at a party, if it was time for me to move on. So, that, while I was having the high dose of chemotherapy and the stem cell transplant I was told that my purpose on the planet was to increase the sum total of love and laughter and I thought ‘crikey!’ ... [01:08.14]

In summary, in narratives of love, light and laughter the intention is to generate ‘good feelings’ and develop a ‘healing way of life’. It involves techniques to both become aware of these things within oneself and from others. As I described in chapter three this is a goal in itself in that it helps the person with cancer cope with the shock and depressed feelings that come with a diagnosis. But all three are also thought to do more than provide a psychological coping mechanism. As Angela explains about laughter:

A – When, once you start laughing, your body actually changes on a cellular chemical level. And it just sweeps through the entire body, it relaxes the body to such an extent that people fall of their chairs laughing, or can’t stand up laughing. Its cause they are laughing so much that their bodies have become that relaxed. It drops the level of cortisol in the blood by up to 87% and cortisol is one of the stress hormones that does us a huge amount of damage... [01:16.01]

Angela went on to describe the evolutionary perspective of ‘fight or flight’ for stress hormones whereby modern life generates the stress, but does not allow it to dissipate in various actions, therefore causing the body damage. However, through laughter, “it sorts out the whole chemical thing” [01:17.14]. In describing this Angela is drawing on PNI, a model of healthcare that I described in chapter three that underpins many of the complementary self-health approaches including *Health Creation*, which Angela had used.

So the transformation in Angela’s life is from an individual, autonomous, singular way of life to someone who becomes aware of the ‘dis-ease’ in her life. She comes to relate to life through ‘love, light and laughter’, which are shared, expressive affects. Angela’s experiences of these are situated in each retelling of her story; the possibility to be ‘other than’ is now part of an ongoing reflexive process for her. At the same time, Angela describes the mechanism that makes sense of how these

changes to living produced her ‘miracle’. The transmission of affect is related to biochemical changes in the body that bring a better internal environment, which at worst provides Angela with a better mode of experiencing with which to face, as Angela did, an extensive range of mainstream treatments and at best, might also suppress the cancer itself.

Transforming and Transcending Anxiety and Fear

It is evident that for Mary and Angela, the experience of cancer and its treatment, along with the use of complementary self-health, is a conduit for bringing something into their lives that they otherwise might not have experienced. In what follows I will consider how cancer has become understood to be an opportunity for transformation by reflecting on the changes it brings to the interviewees’ lives. I will consider how post-cancer life somehow is better than life ‘BC’, before cancer, by exploring what it was about the life before cancer that was recognised as being so poor.

Reflecting on life BC (Before Cancer)

In Mary’s and Angela’s stories they come to recognise that that their life before cancer was somehow less satisfactory, less properly meaningful, than the life after cancer. What they also described was that they had not previously been able to name this lack in themselves. What became problematised was that, in contrast with a life with cancer or forms of remission where cancer is a companion illness, life before cancer was found to be lacking in the capacity to *properly* differentiate. This is because in stories of life before cancer, life was described as being determined by external events largely beyond the will of the interviewee. Here, the mode of subjectification under consideration starts with the assumption that within each individual there is a ‘hidden self’ or ‘rich inner life’. This is a narrative that, although it has a longer genealogy, has propagated exponentially since the time of Freud, to the extent that Greco (1998) has argued that it holds the position of an anthropological generalisation.

For example, Angela’s life before cancer was found to have an overreliance on others and ‘material consumption’, which might be seen to stem from an inability to distinguish between self and other, subject and object. Here, social forces and norms

are seen as the main sources of boundaries for the self. In retrospect she finds the coincidence between these and her ‘normal’ qualities of identity demonstrates an inability to be otherwise and hence her life before cancer comes to be seen as a form of pathology. From here it is evident that life before cancer is to find society to be a system of determinisms, living for the other, rather than constraints. This is because life before cancer is found to be missing the possibility of a subjectivity that is able to negotiate with a domineering society. To borrow from Greco, that there is no possibility for negotiation “means that no response-ability is possible...” (1998: 142). All that is left to describe about the body and illness is an autonomous nervous system, a biochemical reaction, or a disease pathology. Recall Angela’s reaction to her family doctor’s attempts to explore the psychosomatic aspects of her infections and Angela’s rejection of this in favour of a pharmaceutical solution. In sum, life before cancer is seen to be without ‘distance’ in respect of bio-social reality; in other words, the interviewees see themselves as lacking an embodied subjectivity that accounted for their selves.

Finding the wisdom of difference

Mary and Angela spoke of how, by using complementary self-health, they were provided with techniques and practices that allowed them to see cancer and their lives in a new way. Here, I wish to argue that complementary self-health facilitates and encourages an engagement in a mode of subjectification that involves not just the telling, but the *retelling* of one’s story. Implicit, or sometimes explicit, within an account – an occasion of telling one’s story – is the acknowledgement that these stories have been told before and will be told again. In each account the self is continuously created and recreated precisely through returning to it. This retelling of a story is always enacted within the situation of the telling, the self that is returned to being elsewhere and otherwise. As has been noted elsewhere, this distancing allows the person to split their experience into both being and appearing, enabling the subject to “re-signify the self in relation to the real, and the real in relation to the self, without allowing the two to become perfectly coextensive or identical” (Greco 1998: 143). The experience of cancer therefore comes to stand at a significant juncture in the way the self is formed as a subject in the interviewees’ subjectivity. Cancer, or the experience of cancer, becomes a pivot or fulcrum around which the quality of the

interviewees' encounter with reality is mediated, and so affects the different ways that the subject can see her self to be ill.

In Mary's and Angela's stories the experience of cancer was used to differentiate what were considered better or worse ways to live. This involved medical and existential concerns, which overlap, as the idea that healthy development of one's subjectivity is tied in with the very possibilities of physical wellbeing. Through telling stories of life before cancer, experiences of illness are retrospectively correlated with the narration of the self. At crucial moments of wellness and illness, behaviours, feelings and the social context generally are recalled and examined. Associations between poor (or better) subjective experiences and ill health then provide a series of lessons that come together to provide a general picture of what was 'wrong' with their lives. Both Mary and Angela described how in this process they became aware of the demands of others and how they were living according to these obligations, neglecting their selves. For both interviewees, this was related to repeated experiences of illness. Being able to be 'true' to one's self – removing extraneous obligations – was therefore part of assisting the body in its wellness.

Returning to the question of the inner life and the role it plays in constituting the self as a subject: an inner life in this mode of subjectification is part of what is considered to be a necessary feature of the 'true' subject. This inner life is not necessarily a 'truth' that is 'contained' within the subject – something I explored in the previous chapter and will return to below – but it certainly is a way of differentiating between, say, subject and object, self and other. The inner life is not a mere chronology, but an imaginative construction of how different elements of self, health and life relate to one another. As Monica Greco put it in relation to psychosomatics, the inner life “. . . provides a constant principle of doubt and the possibility for a constant re-signification of experience: the present in terms of the past, the past in terms of the present” (1998: 143). Therefore, as I explained in the previous chapter on embodied guides, questions of how people with cancer who use complementary self-health feel and relate to their bodies are related to judgements about what is best for their health, self and living. What I found is that this turn 'inwards' is relational, as it immediately brings the person to an awareness of multiple spheres of their life and how they affect them as well as how they are affected by them (for example, through

meditations or visualisations). This differentiation of perspective touches every level of the self and living, reorienting the person to their past, present and future. As I shall describe in the following chapter, this necessitates an imagining of who one is or, rather, who it is that the interviewees see themselves as becoming and what sort of person they take themselves to be.

However, what I have so far explored is an understanding of change that is largely descriptively achieved in the stories that are told. But as I have found in Mary's and Angela's stories, the change that is experienced in cancer is felt to be more profound than just changing the stories they use to 'cope' with cancer. In order to further explore this I now need to consider how narrating cancer as an opportunity for change is found to transform self, health and life.

Transforming the cancer narrative

Cancer often brings fear and anxiety through not knowing either what 'it' is or what will happen. What I will explore in this sub-section is how, through the techniques of complementary self-health, the emotional responses of anxiety and fear become an opportunity for transformation. In this mode of subjectification cancer is experienced as an ongoing presence in the formation of the self, which is reactivated in each telling and retelling. However, when retelling one's story of cancer, the fear and anxiety that cancer brings is also reactivated, which could lead to the reflections from that experience being closed down. But in Mary's and Angela's stories, complementary self-health provided various means – the narratives, techniques and practices – to use that fear and anxiety so that it repeatedly opens possibilities to transform how they form their selves as possible subjects in their past, present and future.

The transformation that occurs does not just affect the formation of the self, it also transforms the narratives, practices and techniques provided by complementary self-health. For example, consider the technical discourses of instruction for how the mind can affect the body, used by Mary and Angela respectively, in both the Bristol Approach and Rosy Daniel's description of the process of overcoming cancer. Premised on the bioscience of PNI, both describe how the mind is in every cell in the body. It is therefore explained that if users change how they think, it will also

change how they will feel, which might change the user's internal chemical environment and prevent or affect cancer.

However, the effect of the mode of subjectification on these technical discourses is the fragmentation of what was at first seen as a coherent set of practices for the self, health and life. The rules that users find in complementary self-health become adapted, even fractured, so that they better suit the situated conditions the user finds her self in. It is a fragmentation that occurs in two forms: one into an ineffectual descriptive technique of the narratives, practices and techniques; and two, it provides a mixed form of subjectivity that seemingly runs away with the subject – a subject that had previously appeared coherent and grounded. The user comes to stop seeing her self as already formed and to be deciphered, and increasingly approaches her self as an ongoing formation. She is now an endless becoming who will need new tools – adapted practices and techniques from complementary self-health and elsewhere – to approach and recognise her self, and to form her self afresh each time. In this mode of subjectification, differentiation and change permeate the practices, techniques and narratives under consideration so that they transform the self along with the practices, techniques and narratives.

To explore this further consider one of the presently associated 'symptoms' of this mode of subjectification, the requirement that the self love itself before it can go on to properly love others. Recall that Angela repeated to herself everyday 'love yourself'. In Mary's story I heard how, for a long time, she existed only to 'love the other' ("Mrs I'm for everybody") and forgot that an essential prerequisite of this was to 'love herself'. In the transformation of both Mary's and Angela's stories they noted how complementary self-health brought them to face loving their self. In turn this brought new ways in how they were able to 'love others', which also transformed their relations with their families. What is interesting is that this transformation occurred in both the (past) changes and the (ongoing) description of the transformation's effects in Mary's and Angela's stories. As a consequence of this, the end point of this mode of subjectification is continuously deferred in each telling. Clearly this perpetual transformation presents difficulties for the self who wishes to establish the precise limits of her self as a subject, as the possibility of transformation is able to permeate anything and everything that might pass through

one's subjectivity. However, it is important to stress that this is a consequence of a properly transformational discourse – one where the conclusions transform the assumptions.

If the transformational experience of complementary self-health permeates all discourses, techniques and practices, the argument that complementary self-health is a discourse of self-governance becomes harder to sustain. As I suggested in chapter three, the advocates and practitioners of complementary self-health recognise the capacity for the techniques and practices of complementary self-health to open up ongoing possibilities for the user. It is possible that once engaged, this mode of subjectification can be applied to all discourses seeking to interpellate the user, including those of biomedicine, hermeneutic systems of care and those of advanced liberalism generally. By using the techniques and practices of complementary self-health, the user finds she is able to support the self by opening-up such discourses so that they become amenable to being situated by her self, as she forms herself as a subject in her subjectivity.

However a significant problem with this analysis so far, both for this analysis and for the interviewees, is that this mode of subjectification becomes limited by an understanding of it as a *narrative* of transformation. That is, through the stories that are told the subject is situated in the moment of the account. This permits the distancing that is necessary for reflection and allows for a narrative depth to be alluded to, if not explained by the telling and retelling. But the accounts never fully articulate in the eyes of the interviewee the profundity of their experience. They were able to tell me of the changes, but there is a difficulty in explaining in words, in the narrative, what is felt to be both different, but the same – recall when Mary insists that *she* can tell the difference in herself, even if *I* cannot. Moreover, it is in this that the wisdom that is felt – the difference that cancer brings – something that is seen to 'transcend' beyond each telling both discursively and somatically.

Becoming transcendental

Mary's and Angela's stories, of coming to be thankful for a better life having had cancer, contain accounts of experiencing a 'transcending' of their situated stories. This transcending is found in the way that Mary and Angela narrate *and* experience the continuity of their subjectivity. Consider Mary's reflections on how she has

changed: while her experience of her self has changed in its relation to who she is as a subject, it remains as a relationship within her subjectivity (she is not ‘objectively’ different). As well as transcending the situated narration, the interviewees also experienced a particular change in their relationship between the embodied subject and her biochemical subjectivity. After the initial transformation the embodied subject is situated in her individuality, so that each user experiences her self as having her own unique way of being affected by life. As Mary said, the way her body was affected was through cancer, rather than the heart problems that her husband had. But Mary also came to recognise that both of them were affecting and being affected by their relationship in a very physical and biochemical way. It was this biochemical capacity to affect and be affected that transcended their individual experiences and related them to each other.

In particular, it is the *feeling* of transcending that ties both the narration of transcending and the experience of transcending in Mary’s and Angela’s stories. What is more, part of this feeling is a difference that cannot be fully narrated. As I have already noted for Mary she is able to tell me that it is the difference that I cannot see, but she can feel. As I described in the previous chapter, complementary self-health provides various techniques and practices to support the user in recognising what her feelings are saying and to hear her inner wisdom. For Angela, while she can tell me of the outcome of this process, it remains something that only she can feel if it is right or not. But unlike in the previous chapter Angela tells me of the significance of this ‘practical wisdom’ in her life for which she is so grateful. It is the profound realisation that she is able to affect change not only in the way she thinks about her self, health and life, but also that this will change how she feels about the world and it might even affect the cancer’s remission. In the previous chapter I described how listening to this embodied guide can help decide what the body needs. What I find here is that the ethical work on the body brings new relationships to Mary’s and Angela’s self, health and life; a new mode of subjectification that transforms relationships through the realisation of the transcendental nature of biochemical subjectivity.

In order to understand this consider again the narrative of an ‘inner life’ in both Mary’s and Angela’s stories. For Mary and Angela, in their life before cancer,

illness was felt in the body as a meaningless physical event. But what the experience of cancer in complementary self-health demonstrated to them was that the boundaries of that body are open to influence from their ‘minds’ and from ‘outside’. The ‘meaningless event’ of cancer was thus transformed into an experience of relatedness and connection, through the narration and feelings of biochemistry.

What is important to note is that this PNI based understanding of embodiment provides a mechanism that connects people, as Mary said: “Living a lie is exhausting and it makes people poorly, [getting softer and quieter] it wasn’t just making me poorly it was making others poorly as well...” Mary recognised that the ways she was living were not only making herself ill, but was forming a network of illness. As Mary contemplated her life in response to her fears and anxieties about cancer, she formed a new understanding of what it was to be able to affect and be affected by the world. Similarly, Angela’s spiritual reflections led her to let go of the ‘resentment’ she was carrying and moved her to contemplate her relation and purpose in the world, “to increase the sum total of love and laughter”.

Complementary self-health draws on PNI as part of its description of being human. The mechanism of PNI is reasoned to be not only within each person, but a way through which people can relate to each other. This is not biological reductionism, as the way this is used by the interviewees is relational, emphasising processes of becoming. That is, what is interesting is that it *is* the biological that is used to describe much of the transformation of the self – it is found by the interviewees to ‘hang together’ what is happening in their embodied lives. But in doing so PNI is used in ways that go beyond the (original) molecular conceptualisations or functions. Through exploring the meta-empirical depths of their embodied stories, the narrative wisdom that comes from telling and retelling, Mary and Angela felt that they were able to learn the lessons necessary to improve their somatic reality. Their recognition that the transformation of their biochemistry – their capacity to affect themselves – becomes recognised as that which transcends any situated and embodied telling. And once the mechanism to transcend the situated and embodied self is felt, it is recognised that it also transcends subjectivity. Through an ontological flattening, this biochemistry of affect experienced as being shared in the subjectivity of all.

Turning to Rose's (2007) conceptualisation of the molecular view of the body, it is evident that complementary self-health's use of PNI has similarly molecularised conceptions of affect in a new conception of life. Mary and Angela relate to their selves in this new language of biomedicine and see personhood as open to modification and alteration at the molecular level. It is also clear that this mode of 'auto-biologisation' (Clinch 2009) is part of the socialisation of biology whereby stories provide meaning through conceptualisations of normative personhood found in the narratives. When these biomedical molecular languages are used outside of biomedicine it, of course, entails their modification. For example, it is clear that Angela's reference to 'cortisone' is understood in quite a different way to, say, how an endocrinologist might understand the same events. But instead of viewing this appropriation as a 'failing' by Angela, I find that it allowed her to relate to her body in new ways. The visceral pleasure of laughter is felt to change Angela's internal biochemical environment, preventing further experiences of cancer. But what Angela recognised is that this is something that can, and should, be shared – it is her purpose to increase the sum total of love, light and laughter in the world, which will create a healthier humanity. Again, this is possible because in complementary self-health it is the very way that people relate to each other that is said to be what they have in common.

Complementary self-health therefore draws attention to how the interviewees consider the transcendental aspects of subjectivity. That is, whereas once it was applications of Kant's disinterested and universal conceptualisations of judgement about the molar body that were found to be transcendental, it is now the capacity to affect and be affected comprehended at a molecular level. And whereas the Kantian notion stands apart from the world, this transcendence is embodied in it. In this mode of subjectification the interviewee's experiences – their narratives and feelings – constantly run into limit experiences within life that demand a retelling of their cancer story. This is based on an understanding of one's self that is open to affect and being affected through one's biochemistry. But this is not just the forming of a subject based on an unproblematic use of biomedical terms. As I have shown, the transformation of the self as a subject in one's subjectivity involves situating the embodied narrative of transformation, while relating to one's self and others through transcendental understandings of a biochemical experience of affect.

Complementary self-health provides part of this mechanism through an understanding of the body in PNI. In this mode of subjectification the interviewees find a way of experiencing subjectivity – their humanity – through a ‘transcendental biochemistry’. That is to say, a molecular biochemistry that is not just understood to be shared by all, but which is necessary to understand the way humanity relates to each other in its perpetual becoming.

Conclusion: Better Living Through Transcendental Biochemistry

In Mary’s story I found a tension between the narrative accounts of transformation and the ontological continuity she felt with being true to a younger self. Through a discourse of psychosomatics Mary described how she came to the realisation that those who survived were those who undertook broad lifestyle changes and listened to their illness. When she turned to complementary self-health Mary found a way to turn this psychosomatic discourse into a way of living so that she could exert control and implement changes to her lifestyle. Complementary self-health and cancer brought Mary to reflect on her emotional experiences. She reflected on her past life and ways of coping, how she had reacted and done what is best for the Other out of a misplaced attempts to fulfil the dictum ‘love thy neighbour’. Mary explained how this was related to her “chemistry” “going bananas” and how this mechanism of “distress” was a crucial factor in both her cancer and her husband’s heart attacks. Therefore, part of coming to a more ‘honest’ way of living, was to transform her relations to her self and others. The changes were profound, yet Mary acknowledges that I might not be able to see them. The tension between her ‘old’ self and her ‘new’ self is the tension that is made possible through the transformation in the formation of her self as a subject and her experiences of her transcendental subjectivity.

Turning to Angela, whose “miracle” of finding that she was important enough to have “trust, safety and security” in her life, which woke her to the realisation that she had been living an empty life, a place of “dis-ease”. Again a language adopted from a psychosomatic understanding, which she first heard from a family doctor, helped Angela make sense of how she could come to affect her cancer. But it was via her use of complementary self-health that the cancer became a message to change her life, bringing Angela to the realisation that her “purpose on the planet was to increase

the sum total of love and laughter”. Angela described the mechanism through which she might heal her self and others as one that affected the hormones in the body through sharing love, light and laughter. Here I described a molecularisation of living and, most importantly, of how Angela could affect herself and be affected by others. It was something that she said we all shared, no matter how different, something that transcended our situated and embodied selves.

Both Mary and Angela talked of how cancer had affected them at every level of their being – from the chemical and cellular to the psychological and spiritual. This is not just a case of the body multiple (Mol 2002), but ‘becoming multiple’; as the ways that the interviewees relate to their bodies multiplies, this has concomitant effects on the ways that they perceive their relations with others. The fracturing of the ontology of individual experience and the recognition of the relational mechanisms of living also has repercussions for any metaphysical conceptualisations operating in subjectivity. That is, if it was not evident in previous chapters, the role of the spiritual is a prominent concern in the lives of those that use complementary self-health. The difference that cancer brings in complementary self-health is an awareness of the spiritual being, the intangible wisdom to know the difference. Before I explore this in more detail in chapter eight, in the next chapter I will explore the attempts to form or imagine a new purpose to life that is grounded in experiencing the ‘now’, but recognises when it is not possible to affect one’s life as one wants.

Chapter Seven

Living in the Now: Accepting Fate-full Living

[Dr Snaut] *When a man is happy, the meaning of life and all the other themes of eternity rarely interest him. These questions should be asked at the end of one's life.*

[Kris Kelvin] *Who knows when your life will end? Nobody is sure, yet we race as if we were.*

[Dr Snaut] *Don't be in such a hurry then, the happiest people are those, who never bother asking those cursed questions.*

[Kris] *We question life to seek out some meaning, yet all the simple and human truths have their own mystery they are the essence of life, the mystery of happiness, death, love...*

[Dr Snaut] *You may be right. But try not to think about it.*

[Kris] *To think about it is the same as to know the day of one's death. Not knowing that date makes us practically immortal.*

(*Solaris*, 1972, Directed by Andrei Tarkovsky)

*Life ebbs as I speak:
so seize each day, and grant the next no credit.³¹*
(Horace, *Odes*)

Kris and Dr Snaut's dialogue expresses two parts of a familiar reflection upon death. Dr Snaut expresses what I have described as a 'before cancer' view of living – one where mortality is a question to be put off for tomorrow and where the aim is for blissful unreflective, happiness. But Kris provides a retort that will be the focus of this chapter: if life could end at any time then each day should be contemplated as the last, as to not do so is to live as an immortal. And, as Dr Snaut recognises, the last day is the day when one should reflect on the 'themes of eternity'. But Kris finds that, in any case, the simple and human truths in life are only to be known in their mystery. What, then, are those who reflect on the purpose of life and death to do? Horace, perhaps, suggests one response, '*carpe diem*', seize the day, or following the self-help guru Eckhart Tolle, 'live in the now'.

³¹ Horace *Odes*, I, 11, 7: "Dum loquimur, fugerit invida / aetas: carpe diem, quam minimum credula postero" (cited in Hadot 1995: 116 fn 74).

Andrei Tarkovsky's *Solaris* taps into problems and issues that have long provided social scientists, philosophers, novelists, as well as filmmakers and their audiences with a wealth of material. Peter Brooks, reflecting on Walter Benjamin's *The Storyteller*, argues, "that what we seek in narrative fiction is that knowledge of death which is denied to us in our own lives; that death writes *finis* to life and therefore confers on it its meaning" (1984: 22-23; cited in Del Vecchio Good et al. 1994). How and when thought turns to death can say a lot about the purpose that is to be drawn from life.

In the ethnographic part of my research, many of the meditations I took part in sought to situate me in the 'here and now'. The group leader would bring me to an awareness of each of my senses, of my body, of all that surrounded me in the room, and of my notions of what was outside of the room and beyond. As I explored in chapter four, part of the embodied response to this is to become aware of the thoughts and feelings one has. What I will explore here are the practices and techniques used when one relates to oneself and others in attempts to accept one's place in the here and now.

In the previous chapter I described how the tension between transformation and transcendence brought about a particular mode of subjectification in complementary self-health. This obliged the self to be in an ongoing process of change with her relation to herself as a subject. In this chapter I will consider the ethical work that is done to ensure that the self, in such a mode of becoming, is not lost in 'postmodernism,' or in a haze of relativism. In particular, I will describe how a realisation of one's situational constraints are 'accepted'. As part of this, it is evident that the interviewee moves closer to answering the question of 'what' or 'whom' she seeks to transform or transcend.

This chapter considers the experience of 'living in the now'. Like Horace in the second epigraph, the refusal to be directed by narratives from yesterday and tomorrow is seen as a positive affirmation for today. But this does not mean that all consideration of temporality, past or future, has been forgotten. Rather, the "immediacy of the present" (Bourdieu and Wacquant 1992: 138; cited in Binkley 2009: 98) reorients the *imagining* of various trajectories. What I find is that these considerations are distinctly teleological in mode – they are attempts to form or

imagine purpose. As I have already described in the previous chapters, this involves an ongoing examination of self and body in the face of the narrative demand to tell and re-tell. As Stacey (J Stacey 1997: 5) describes, cancer brings a jolt to people's temporal imaginings: "The usual temporal sequencing is both disrupted and reimposed in the search for order, reason and predictability. The past must now be reimagined and rescripted. Life, it has turned out, was not what it seemed. The Present is not the imagined future it once was. And as for the future, it is suddenly compressed into the most frightening of time scales, previously unimaginable. In the light of the diagnosis, the recent past must be reexamined for clues of this newly revealed deception. The body becomes the site of a narrative teleology that demands a retelling".

Unlike in mainstream biomedicine, where the aim is to cure the disease or, as in more therapeutic narratives, simply care (Mol 2008), the aim, the object, the telos, of complementary self-health is 'support'. But like much of complementary self-health's practices, this telos is ongoing, never to be attained and without a stabilised object. That is, the practices and techniques of living in the now facilitate a subjectivity that is to continuously examine the subject, so that she is better able to understand herself in her life, and to accept the challenges that Others bring to her subjectivity. Therefore, as well as the other ethical work undertaken as part of the embodied guide, described in chapter four, what will be emphasised in this chapter is how living in the now is a practice that situates the user of complementary self-health and helps show the contingency of ideas, concepts and practices. Moreover, living in the now involves the technique of 'acceptance', through which the user can come to understand the place of things at a given moment and therefore contemplate how they got there and what they are to do. In doing so, living in the now reorientates the purpose of life – when the future is uncertain and clouded by thoughts of death, the 'now' becomes the basis upon which decisions are made.

Living in the now can be described as a practice of 'situational living', which brings a particular ethic of support for the self. By recognising the situated position of each decision, the person comes to realise that, whilst there are some things that they can do to help themselves, there is also much that they have little control over. Therefore the person learns to 'let go and let god', or to accept a (secular) 'higher power', or to

recognise the ‘fate’ or ‘destiny’, or even ‘social constraints’ in their life. But instead of a loss of order and predictability bringing ‘biographical disruption’ (Bury 1982), the aim of complementary self-health is to support the user (and their family) through bringing a greater degree of acceptance of the situation that they find themselves in. That is, in an apparent contradiction to fulfilling the fiction of the autonomous self, users of complementary self-health talk of ‘letting go’ of their capacity to determine their futures. Living in the now and accepting one’s fate-full position is therefore experienced as a ‘refusal’ of the norm of a wholly autonomous subjectivity.

Rachel

‘Rachel’ contacted me after picking up my leaflet at a South London Cancer Support centre. It was a lovely, warming spring morning in 2009 on the day I went to meet her. As it turned out, Rachel was the last person I interviewed before my own diagnosis. I interviewed her in the kitchen of her spacious south London flat-share. The time between her welcoming me in, to me switching on the dictaphone was just a few minutes – as long as it took to make a cup of tea. In that time we briefly discussed the use of soya milk in tea as Rachel busied herself around the open plan kitchen. Rachel described herself as a “pretty happy, bubbly, upbeat, positive, person” [0:22:49] and, as we settled at the sturdy wooden kitchen table, I could tell that I was not going to have to worry too much about awkward silences in this interview. Indeed, it became apparent that Rachel was happy to tell her story. Towards the end of the interview Rachel said that she had recently been interviewed by a women’s magazine and that she also had a blog documenting her experiences of cancer³².

Rachel told me that she had been diagnosed with chronic myeloid leukaemia (CML) in January 2007. It is a form of leukaemia that is more commonly found in ‘old men’, as she described it, and so it was a rare condition for her to have been diagnosed with. Rachel was diagnosed while still at University in Scotland. She had since completed her degree and moved to London to look for a job, even though she

³² Although I have reviewed both of these sources, I have not directly used them in this analysis in order to preserve Rachel’s anonymity.

was still receiving treatment from the hospital in Scotland. Rachel told me that after her diagnosis she aimed to ‘carry on as normal’ but found that “within the space of a week [of starting chemotherapy] I went from pretty able, to couldn’t do anything. Making a cup of tea was completely beyond me” [0:23:07]. Rachel returned home to her parent’s in the south of England, but found that she was having a serious reaction to the drugs she was taking, causing her relentless, agonising pain. But when she told her consultant in Scotland, she was just told to take more painkillers. Rachel had been told that the treatment she was on was a ‘wonder-drug’ that would have her ‘back to normal in minutes’, but instead she found that she was in so much pain that when she moved in her sleep she would wake in agony. Eventually, another doctor told her to stop taking the drugs and over the next week or so the pain eased. Rachel understandably described this period of her treatment as “horrifically awful” and much of her account would return to it in deriving contrasts with her life before and after diagnosis.

Rachel’s use of complementary self-health was orientated to supporting her through her mainstream treatment. Rachel told me that she came from “quite an open-minded, alternative family” [0:00:44]. Her mother and father both practised forms of CAM: her father was a Reiki Master and her mother was trained in Emotional Freedom Technique (EFT), which is similar to acupuncture but were the therapist taps, rather than uses needles. As a child Rachel recalled that when she was ill she would be taken to both the mainstream doctor and a homeopath. This integrative approach was something she continued during her chemotherapy. Rachel asked her consultants whether they minded her using complementary treatments, saying how she would always ensure she took the prescribed drugs and “would never do anything that would interfere with that”. Their response was “‘As long as it didn’t interfere with what they were doing, as long as I carried on taking the drugs as they wanted me to...’ then pretty much I could do what I wanted” [0:01:57]. While her consultants were, at best, ambivalent about her use of complementary self-health, Rachel recognised that not everyone would agree with her use of it. She told me of the many discussions she had with one of her housemates:

R - ... he’s like ‘phah, healing-schmealing. Its rubbish.’ He’s a physicist.
But I walked in [from a ‘healing’ treatment] and I was like, ‘I feel really

good, I'm helping my body fight everything that it's got to deal with'. I think that even at the end of the day if they turn around and say, 'we didn't help you at all. Its all been a complete placebo.' I'll be like, well, I felt better and when you feel better it has a knock on effect on everything. Obviously I would be slightly irritated if I was told it was a placebo after convincing everyone that it is real and true and it does help. But I think that having an hour of chill out time, and walking away and saying, 'I feel really good'. That's definitely helping me. [0:12:35]

As I have found in previous accounts, complementary self-health is not necessarily viewed as an alternative to mainstream treatment. Rather it is seen as part of a support system for the various spheres of the self that are going through mainstream treatment. As with many of the previous accounts, this understanding of oneself forms the basis for the formation of one's self as a subject, in one's subjectivity. And, as before, Rachel recognises that this relationship, this support for the self, holds a twofold significance. On the one hand it is just about finding time to relax and feel better about her self. But on the other it also "has a knock on effect on everything". Rachel's years of CAM use and, as she went on to tell me, her participation in the 'Healing Journey' self-health approach, have provided her with a way of articulating this support. As I described in chapter three, the Healing Journey, in particular, talks of connectivity as a key way of thinking about the body. For example, Rachel explained how she managed many of the restrictions in her diet. She told me of the struggle she had to only eat healthy foods and that she would sometimes think 'sod it' and indulge in some cake, crisps or other such 'bad' food and drink. Rachel explained:

R – You know you only live once, so if being diagnosed with, well it's not terminal but if you say 'cancer' people freak-out, if that doesn't teach you to live and enjoy your life then what is? You get one go you might as well as have a good as time as possible [0:48:19] . . . So, it's just a case of, 'how am I feeling?' 'How good have I been recently?' 'How much do I *really* want it?' 'Is my mother around?' That's another one [laughs]... [0:48:36]

This quote is an example of the 'messiness' of narrative analysis, both in Rachel's struggle to articulate what she is saying and in its content. Rachel describes her

desire to grab life and live it to the full in the time she has available, but she quickly recognises her lived contradiction, as she takes all sorts of precautions to ensure her wellness. The way that she seeks to manage this is by orientating the decision to the moment it is being made. She looks to how she is feeling (her embodied guide, chapter five), her recent behaviour (balanced living, chapter four), as well as questioning her motivations and more practical matters, such as her mother's approval. This is all part of Rachel situating her account, of generating a narrative trajectory from her past, through her present predicament, while imagining the various consequences for the future.

Rachel spent some time exploring how, if at all, her experience of cancer had changed her. She started off noting, "I suppose I feel like I have a bit more purpose," [0:40.55] and described the charity and volunteer work she has done with people in their late teens and early twenties who have cancer. She also told me about how sharing her experience in an interview for a glossy women's magazine, in her blog and on Facebook had helped others, which felt significant to her. For example:

R – So I am glad that I can help and make a difference as well to people through my experience, which obviously if I had not been diagnosed then – god knows what I would be doing, hopefully working, you know just bumbling around. Not that I wouldn't have purpose, because that's unfair to be like, 'oh you've never been seriously ill so clearly you have no purpose to your life'. But there is that added thing that I really know I can help people if they need it because I know where they are coming from. And I've learnt and proven that through – obviously listening to the doctors and doing what they say – but that there is this whole other part to being ill. [0:42.18]

Rachel talks here of how her life post cancer does have a sense of 'added purpose'. Although she is careful to note that this is not to say that others, who have not had cancer, cannot have purpose. Rather, what Rachel has found is that cancer has provided an additional part to her purpose for life. Moreover, Rachel then links this to holistic experiences of being ill – as well as doing what the doctors say, "there is this whole other part to being ill". And it is her experiences and reflections upon this other area that have led to an added sense of purpose. As I will describe below, this

“other part to being ill” relates to her mind, body and spirit, which in turn affects how Rachel thinks about her purpose in life.

It's happened for a reason, whatever that reason is

It probably is not surprising that problems of purpose are so central to Rachel's account. As well as her awful experience of chemotherapy and cancer generally, Rachel was unemployed, having recently completed her degree. As Sanders (2010) has explored, the existential problems faced by graduates moving into the job market are enough to invite serious reflection on who one is and 'where' one is going. But as I described above, through her experience of cancer, Rachel finds a way through such uncertainty:

R – I would probably say, that is definitely say, that is a positive that has come out of it [having cancer], so I don't think I would change anything, actually. And also I believe that everything is meant to be, so it's happened for a reason, whatever that reason is. [0:43:00]

Much of Rachel's account was about the ways that she sought to support herself though her illness. Rachel also described how she advised her friends and those she met at the charities to eat well and look after their health. So with the sentiment that 'everything is meant to be' Rachel at first appears to be contradicting herself. That is, 'everything is meant to be' displays a form of fatalism, or at least some form of powerlessness in the face of her life and illness. But, Rachel qualifies this by noting that things 'happen for a reason', which does not necessarily mean that she is fatalistic. This is because in recognising that there is something other than her will involved, Rachel allows space for other things to ascribe meaning to her experiences which fills them with meaning and purpose. Life comes to be seen as full of fate: fate-full, rather than *fatalistic*.

Much of discussion in the previous chapters can also be considered as an exploration of how the interviewees situate and embody their will or autonomous subjectivity. What follows in Rachel's account is an attempt to account for those things that are beyond this will. There are many forms that such an Other might take and they are not to be taken as mutually exclusive; from those following the various Abrahamic religions, to a more nebulous 'spirituality', a Higher Power, or social determinants. And of course there are those narratives of fate, destiny, fortune and luck that are

seen to come from beyond the will to affect life. Whether any of these exist ‘in reality’ is a philosophically moot point. But it is evident that there is a sociological entity, that these Others have ‘real’ effects on the lives of the interviewees, which is folded into the accounts of the interviewees and which serves to provide a sense of meaning for the self.

Rachel’s Others involved both ideas of life being fate-full and a form of spirituality. She told me that, “the idea of something spiritual has never been an alien concept” to her:

R – So yeah I suppose it is just naturally just a part of me. And I use it to my advantage; being able to do reiki and things like that. And just being slightly aware – whether you believe in ghosts or not – but for me knowing that I have people around me all the time not knowing or sort of knowing that they are there but obviously you can’t see them; just sort of helping me and aiding me. I suppose to other people that is god isn’t it? It is nice and it is comforting to know that there is help there – I mean it might not be someone in a white coat sitting behind a desk with a stethoscope round their neck but I think it helps. [0:55.21]

Rachel might just be seen to be fishing around for a psychological crutch that helps her to make sense of all that is happening to her and that, ultimately, there is a point to it all. Rachel told me that she was a lapsed Catholic and this, along with her experiences of various CAMs, had provided her with a familiarity with matters pertaining to the spiritual. But Rachel tries here to convey how a spiritual awareness helps her. The awareness (or imagining) of spiritual beings are afforded a similar status of comforter and supporter as a doctor – and it is interesting that the flow of comparison goes the way of gods-like-doctors, rather than doctors-like-gods³³. Rachel’s awareness and engagement is also distanced from a ‘curative’ framework. Rather it is part of Rachel’s seeking to find things that might support her recovery and wellness. This is more the language of ‘healing’ than ‘curing’. She later goes on

³³ I refer here, of course, to the old joke: ‘What is the difference between God and a doctor? God doesn’t think he is a doctor’. A joke told in my presence several times during my fieldwork.

to say, “but it is just nice knowing that there is more help than there is physical[ly]” [0:59.53].

So what is to be made of Rachel’s experiences and polyphonic narratives? Rachel’s account is an attempt to manage the juxtaposition of her capacity to affect herself and the capacity of Others to affect her. At different moments one or the other is in the foreground, but it is evident that when I listen with her story neither is given a general priority. It is the tension that they provide that allows her to manage the situations she finds herself in. In light of the previous chapters I can now appreciate how Rachel took into account the multiple factors that could affect her health, self and life. This was done from a position in the now, so she was able to decide what was the right thing to do at that time. And now I can start to appreciate the ethical work that Rachel does, her balanced living, to not only take into account her previous behaviour, but also account for what she might do in the future. Therefore, in all of this, Rachel looks to account for not only how she can affect herself, but also how her family and her spirituality support her through her experiences of cancer. Complementary self-health has helped Rachel develop the practices and techniques so that each account of her story, situated in the now, relates to the sense of added purpose that cancer brings.

The story that Rachel told me was set in the context of her ongoing treatment. As I described in the previous chapter, cancer provides a particular opportunity for reflection upon how life was, is and will be lived. Listening to Rachel’s story and those in the previous chapters, I can hear that lessons learnt from vivid experiences at the boundaries of the self, health and life bring transformation to the stories that are told. In the following chapter I hear how these new formations of self, health and life are both formed and maintained.

Diana

I first met ‘Diana’ at a self-help peer support group based at the South London Cancer Support Centre, where I did most of my fieldwork. She was one of the two leaders of the group, along with ‘Brenda’, whom I also interviewed (but who does not feature in this thesis). I had hoped to interview Diana from the first time we met, when she mentioned how she tried to ‘live in the now’. Diana had also spoken about how her experience of cancer had brought significant changes to her life. Indeed,

Diana came across as someone who had taken the time to seriously contemplate her life and had accepted the answers she had found. But as with all those I met at the centre instead of asking her if I could interview her, I decided to see if she would offer. As it was, it was Brenda who insisted that I interview them both. This initially made me uneasy, as although Diana had consented to the interview, I was not sure she matched Brenda's enthusiasm.

I interviewed Diana just after what we had been told was going to be the last ever meeting of the peer support group she and Brenda ran. Whenever I had gone to the group it had not been especially well attended, with around five people present, including the two group leaders and myself. At this last group meeting Diana, as before, provided the structure to the proceedings as well as the air of therapeutic acceptance. Although neither of the group leaders were trained therapists or counsellors, they had attended a basic 'group leader' course. In the group Diana would take a more non-directive therapeutic approach, whilst Brenda would be happy to ask any question that came to mind, which would provide some revealing, if sometimes uncomfortable, moments in the group.

The interview took place in the same room as the group meeting. It was a warm spring day and the sun poured into the room. The windows of the third floor room were ajar, letting the noise of the busy London junction filter in. Diana had an easygoing manner about her, and any unease I felt about her being forced into the interview dissipated as the interview progressed.

Diana was diagnosed with breast cancer in February 2001 when she was 34 years old. But her experience of cancer started well before that. In the year or so prior to her diagnosis both her mother and her aunt on her father's side had been treated for cancer of the bowel and breast respectively. The week before Diana's diagnosis her mother finished her chemotherapy treatment and in celebration she went on holiday with her husband for ten days. Unfortunately Diana's aunt died on the day that her parents came home from holiday and Diana found herself having to tell them the news about her aunt, as well as that she was starting chemotherapy that Friday.

In July, after the chemotherapy, Diana had a bi-lateral mastectomy where both of her breasts were removed and reconstructed at the same time. When Diana got the results of the surgery her mother, who had at that point a large inoperable secondary

tumour, was with her. Diana asked the doctor if he had removed all of the cancer, to which he replied ‘yes’. But he then said that 14 out of the 16 removed lymph nodes had cancer. Diana recalled that at first she did not understand what he was saying – in comparing herself to her mother, Diana initially thought that as they had removed the cancerous lymph nodes, then the cancer had gone. She said it took about 24 hours of contemplation to realise what a high proportion of cancerous lymph nodes she had and that things might not be as good as she hoped.

Diana was discharged after her surgery but was soon readmitted as she became progressively more unwell. Her condition worsened and she was rushed into intensive care with what they thought was an infection in her heart. It was thought Diana would not survive. Diana herself could recall little of what happened. But somehow, two weeks later, she returned to the ward. Unfortunately, Diana was greeted with further bad news when she was told that they had also found cancer cells in her lungs. Even more problematically, because of the problems with her heart, Diana was not able to have more chemotherapy or radiotherapy. The doctors told Diana at this point that should she survive heart failure, she only had two years to live. But Diana recalled how this did not really register. Looking back on being told that she had incurable cancer, she recalled that for the two weeks previous she had been in intensive care and no one thought she was going to survive. So relative to that, Diana felt that her situation had improved, as she was at least alive.

In the next three months Diana slowly regained some of her strength. Part of her treatment programme was occupational therapy and physiotherapy. Although at the beginning there was not much that Diana could do with the occupational therapists, she recalled a relaxation and visualisation she did where she went for a walk on the beach. Diana also used another form of visualisation. She had a friend go and get her travel magazines and, in the side room she was in, she put up pictures of the beach. She told her friend “Yeah, that’s what I am aiming for. This is it” [0:27:53].

Diana was referred to the hospice that her mother had been visiting as an outpatient. Diana said, “I could see how it had really helped her to come to terms with what was happening. But also she started to focus more on what she could do, rather than what she had lost” [0:30:34]. This point in Diana’s story is pertinent as it is a reminder that the fear and anxiety explored in the previous chapter stems from the knowledge

that cancer does kill people. As I have described, this was something that Diana was very familiar with. As well as being told that she had incurable cancer, Diana had been with her aunt in the days up to her death from cancer and she also told me of her mother's decline.

However, Diana did not deteriorate as many people expected she would. Yet, in contrast to her own recovering health, Diana watched as her mother got weaker and approached what turned out to be her final couple of months. Diana recalled how she detached herself from the situation – she went to see her mother, but she found she could not spend long periods of time with her. Although Diana was aware that she was getting stronger herself, she felt that she had to be “quite single minded” about it. She recognised that this was tough for her father as he had told Diana that she was a great emotional support to him, which was one of the reasons she had to distance herself as she felt she could not do that and “be there for herself” [0:34:02].

Diana's mother died in July 2002. Diana continued to receive support from the hospice and, at that time, started to see an art therapist on a one-to-one basis. But Diana realised that she was getting stronger and that she did not need to go to the hospice any longer. Diana told me that this was an expression of her being in control and it was for her to decide. This was also around the time she turned to the Cancer Support Centre, as she knew that she would also need support.

'If it is meant to happen, it will'

Diana's story provides an interesting contrast into the perceived roles of hospices and cancer support centres and how the aims of the respective organisations affect the practices and techniques learnt. Diana told me that when her mum died she was very conscious of the ‘time limit’ that had been put on her life. She said that there was a part of her that thought, “I've got no time for grieving or to be sad or unhappy” [0:37:12]. But later she realised that there were things that she had pushed to the background that she needed to look at. Diana said:

D – Also looking at the fact that I was alive – I think that sometimes that the hospice is quite guilty of this as well – they are very good at preparing you for the fact that you might die; you know they have a whole wealth of expertise at that. But what I hadn't been offered was the possibility that I might live – and what was I going to do? [laughs] And I am still answering

that question six years on really. Realising that what the medics say doesn't always happen. And it is kind of like this, 'oh, yeah, what *am* I going to do?' [laughs]. I think that for me the relaxation and the meditation that I have done is kind of addressing that. But also it is very much the sense that a lot of people have of this being kind to yourself. You know, not being hard on yourself. Which I think for me is the biggest lesson to have learnt to think, well okay this is where you are now and that is fine. And if it takes me five years to figure out what my big plan is, well that is fine. That is okay.

[0:39:10]

Diana neatly explains how experiences of and reflections upon death led her to an appreciation and acceptance of 'where you are now'. This did not exclude plans for the future, but the realisation and acceptance that the plan for the future is today's plan. Diana's story therefore runs counter to the narrative that Armstrong-Coster (2004) and Bauman (1992) have described that – away from the hospice – death is no longer seen as part of life. Rather they find that fighting death has moved to become the meaning of life. But, for Diana, the move from the hospice to the Cancer Support Centre was a move from learning the techniques for dying, to those she needed to support life.

Del Vecchio Good et al. (1994) noted how, in the oncology clinic setting when treatments were seen to fail and the patient was facing death, the oncologist's and patient's narratives shifted from therapeutic narratives to a hospice narrative. Armstrong-Coster (2004) has described this as the 'destination' narrative whereby, within the hospice, plots and narratives are found to effect as 'good a death as is possible' (cf Seale 1998). But in Diana's story neither the biomedical clinical therapeutic narrative nor the hospice narratives were suitable for what she was experiencing. That is, she, like the other interviewees, was looking for narratives to 'support' living. These narratives of supporting the self, health and life are distinct from the hospice narrative, as the hospice narrative itself is distinct from therapeutic narratives.

For example, Diana explained that she was not looking to fight death, but to accept life. She goes on to say:

D – But I have learnt to be kinder to myself in thinking ‘well no. It’s fine. Yes that is going on and you maybe need to pay some attention to it’, but ... you know, so long as you are having fun and enjoying things actually isn’t that the point? [Laughs] [0:40:10]

Diana is not talking about fighting death to live, but about finding a better way of living with death; one that is orientated towards some meaningful purpose that she has established for herself. The constant presence of death therefore informs Diana’s attitude to life. Another example of this attitude can be found in her story about the review of her diagnosis that was undertaken sometime after she was discharged. Diana never really found out what caused her heart failure. Similarly, given Diana’s improvement, the doctors wanted to look again at the slides of the fluid removed from her lungs. Diana told me that the doctors now questioned whether it was cancer cells that had been seen; as it could have been that they were severely infected cells, as they can look similar in some conditions. But unfortunately they could not find the slides; so it is a question that will remain unanswered. Diana reflected on whether this mattered – if the quest was to ‘fight death’ it surely would.

In September 2001 Diana had been told she was incurable, but she told me that if someone said that she was now ‘cured’, she would not be sure whether that would make any difference to her, “because it is just words” [0:44:17].

D – The fact that I have lived has actually proved that probably that it is not incurable, so do I believe that? And should I be any more unlikely to believe a doctor if they said ‘oh now we think you are cured’ [laughs]. Is it because you want to believe it more? I guess the attitude I take is that things are what they are and, you know, only time will tell. What any one doctor says is not necessarily going to – it doesn’t change what is. Which is why this thing about having scans and having things is, I always tell myself ‘it’s not having The Scan that’s going to...’ That’s not the difference. What is, is the scan is, well in some cases, reveal what is. So there is no reason – no *logical* reason – people, I still get anxious about them, but there is no logical reason to be, really, because it doesn’t actually change anything except the knowledge, which probably changes everything actually. [Laughs] [0:45:43]

The struggle Diana has with articulating what she wants to say here mirrors somewhat the struggles with uncertainty that come not only with a cancer diagnosis, but also with trusting the accuracy of medical science. She notes how a diagnosis is not what gives you cancer or what removes it from your life; cancer and all it brings is a presence she knows she will always feel. Tests and diagnosis or ‘knowledge’ can only serve to heighten or diminish that experience. When Diana told me “things are what they are” she is looking to situate herself, her experience, and the knowledge available to her in the here and now. But she also acknowledges the contingency of this position saying, “only time will tell”. In doing so Diana is capable of imagining the various possible trajectories that her future holds. It is the tension that this distinction brings that needs to be managed, as Diana went on to say, “I think also it is realising that ‘this too will pass’. Just because you feel this way today, tomorrow will probably feel totally different about it, you know?” [0:46:05].

This tension, between embodied situated living in the now and the imagining of possible pasts and futures, permeated much of Diana’s account. She went on to describe how she might have been a typical ‘when I retire I will do this’ thirty-something where everything one wants to do in life is delayed. Whereas, as soon as she was well enough in 2003, she ensured that she “got to her beach” [0:59:15]. Diana told me a story that might seem somewhat typical of a person who has had such a significant traumatic experience like Diana’s. In 2004 Diana did something that she said she always wanted to do – she went to the Galapagos Islands. While there she noticed that almost everyone in her group was over 60. In drawing this comparison Diana was aware that she was living her life in a different way to her thirty-something friends. However, even within Diana’s account there is an interesting contrast to this more typical post-cancer experience:

D – I was very conscious that I was not going to live my life as though I had a short period of time. I was going to do things as though I had all the time in the world. I wasn’t going to dash off... I did do those things, but not immediately. Immediately, the things that I wanted were to be able to go and meet my friends for lunch. Or go into town for a quiet night out and it was things like that. I didn’t want the other big things that people like, if you find out you are going to die then you ... I was thinking, ‘no that doesn’t feel

right'. I was quite conscious of thinking that I wasn't going to rush things and gobble things up because if they are meant to happen they will happen. There will be enough time for them. And that was the attitude that I took."
[1:01:34]

There is therefore something more to be taken into account than just recognising the narrative that people who have had cancer might want to experience more from life or 'fight death'. Diana's account points to the need to distinguish the quality of time that is under consideration. In both her travelling and her time with her friends she focuses on the immediate quality of that time. As she says, her change in attitude is about "accepting that some questions are never answered" [1:04:19]. It is not about satisfying desires or needs, but accepting one's situation at *that* time; it is an *in situ* practice. There is a recognition that the way that one imagines the past and future, will affect how one sees one's place in the world in the present. In doing so the contradictions and possibilities of one's life are 'hung together' in a single moment: 'this is how it is and I accept that'. So on the one hand there is a recognition of one's will to be 'other than' and, on the other hand, a recognition of the constraints and forces that not only brought the user of complementary self-health here but will prevent future hopes being realised; uppermost amongst these considerations are cancer and death.

Imagined Trajectories And Accepting The Choice Of Unfreedom

Teleological understandings are often to be found in the temporal aspects of illness narratives and, as Kleinman (1989) argues, doctrines of meaning and final causes should not and cannot come from biomedicine alone. Davies (1997; cited in Ezzy 2000) describes three forms of temporal orientation in narratives. First, 'living in the future' and the refusal to acknowledge death; second, 'living in the empty present' where people believe they will die soon and mourn the loss of the future; and, third 'living with a philosophy of the present' where the person uses the experience of illness as an opportunity to discover new meanings and values that are orientated to enjoying the present. It is the resources, techniques and practices that this third form of narrative gives access to that I explore here. For both Rachel and Diana, and for my other interviewees, it is evident that they have come to live a new 'philosophy' and that this draws from a situated way of living.

What I will explore below are three practices or techniques of living that are part of the ethical work that Rachel and Diana undertake. The first practice is to situate one's experiences in the 'here and now'. In particular, I consider the narratives of fate and hope, as these appear to be particularly pertinent when considering one's purpose in life. But this is not to mistake the practice, 'situational living', with the content it is applied to, narratives of fate and hope. Rather, what is particularly interesting is the way that complementary self-health helps Rachel and Diana to bring these together to form a new way of living. The consideration of narratives situated in the here and now brings me to the second technique and to ask how the past and future might be, if at all, understood by Rachel and Diana. The movement between situated and transcendental positions (discussed in chapter six) brings an awareness of the various forces acting on the self in one's life. Here I find that a particular technique of 'imagined trajectories' is employed. The self is not necessarily to be contemplated 'within', rather it is orientated in the world and so its trajectory can be mapped as it is imagined to move from time-to-time and place-to-place. What is interesting about the third technique in Rachel's and Diana's experiences is that, as well as recognising these demands or contingencies they do not necessarily 'resist' them, but rather through situational living and imagined trajectories they find ways to 'accept' their position at that time. Indeed, I argue that this is itself a more profound refusal of the contemporary ontological status of the subject as an autonomous and free entity.

All of which brings me to contemplate the aim of complementary self-health, which is to *support* the person through their experience of cancer and in their life. In contrast to 'recovery' groups complementary self-health does not impose a narrative, but proposes an 'open' emplotment that allows the co-construction of the user's story (cf Frank's discussion of Irvine 1999 (2010: 136); and, Linde 2009 (2010: 183, fn30)). To enable Rachel and Diana to live with cancer as a companion illness, complementary self-health provides the narratives, techniques and practices – in short, the open and ongoing support – that are needed to transform their experiences, so that an experience of cancer can be continuously present.

Situating narratives of fate and hope

Narratives and experiences of living in the now are usually first encountered in biomedical clinics, rather than in complementary self-health.

Del Vecchio Good et al. (1994) considered how oncologists craft therapeutic time and how they deal with the problem of endings. They found that oncologists are given a ‘cultural mandate’ to instil hope through the therapeutic narratives that they create with their patients. Moreover, Del Vecchio Good et al. also note that clinicians express a time without horizons or very foreshortened horizons. This is because “they seek to create an experience of immediacy rather than of trivial chronology – of one meaningless treatment after another” (ibid: 856). Here endings are unspecified, even though they are present – deferred, instead, for the task of providing hope. Del Vecchio Good et al. also found that many of the metaphors used in the oncology clinic depend upon the mobilisation of ‘the will’ in the patient. But, they argue, these findings are not to be taken as a clinician-imposed discourse.

When ‘immediacy’ is emphasised in therapeutic narratives the horizon of the future becomes deliberately blurred, even if the patient seeks to live in the future. In the clinic, “The experience of immediacy is also contrasted with fear of ‘time running out’” (ibid: 858). The disruption by this clinical or therapeutic future therefore disrupts, as I have explained in chapter one (cf ‘biographical disruption’, Bury, 1982), the idea of self. However, as I have also previously discussed, complementary self-health appears to provide ways of managing the uncertainty and disruption that is brought about by a cancer diagnosis. Indeed, by placing disease within illness, and illness within living, it is possible to enable an attitude that celebrates the freedom that is brought by experiences of cancer through the immediacy of the present or living in the now.

In the biomedical setting, what is meant by immediacy and ‘for the moment’ is the careful calibration of stages in the course of treatment, where each step involves disclosure of information of prognosis (Del Vecchio Good et al. 1994). But as I shall show this is different to complementary self-health and the description of ‘living in the now’ which is – on the one hand – an attempt to move away from such talk of (clinical) ‘staging’ and – on the other – an attempt to provide a lived sense of experience through which to orientate one’s life. As in the clinic, this is done

through narratives of hope; but also through the ‘acceptance’ of narratives of fate. What these narratives have in common is that they are premised on a subjectivity that is situated in the now. Yet hope suggests trajectories that extend beyond or, in the case of fate, pass through, the subjectivity of the subject.

In Rachel’s and Diana’s accounts it is possible to find two forms or narratives of hope: ‘concrete hope’ and ‘transcendent hope’ (Marcel 1962; cited in Ezzy 2000). Concrete hope is focused on specific concrete outcomes, such as test results. But what I find in both Rachel’s and Diana’s accounts is the importance of transcendent hope, which is not orientated towards achieving a goal but which embraces uncertainty and finitude and celebrates surprise, play, novelty and mystery. It is experienced as an openness to novelty, change and shifting time horizons and with a focus ‘on the here and now’ independent of any sense of the future (Barnard 1995; cited in Ezzy 2000). As Diana struggled to tell me, the hope she got from believing in tests results that told her that she was ‘cured’ was set against doubt and uncertainty, born from previous mis-declarations, of the capacity of biomedicine to be certain. However, this doubt and uncertainty are used to open-up possibilities for her self, health and life. The struggle that Diana has in her account is when this doubt and uncertainty threatened to frame her whole life. In response Diana draws hope from past failures and situates her feelings in the now.

A similar emphasis towards living in the now can be found in Rachel’s narrative of fate-full living. Rachel describes how things ‘happen for a reason’. As with hope, this involves an engagement with the concrete problems that are faced, along with a transcendental meaning. Rachel’s story describes how by focusing on the now she recognises that there are things that she cannot change, such as having cancer. But there is also a sense that this fits into a larger purpose in her life or, as she says, it provides ‘added purpose’. As Ezzy (2000) notes, in polyphonic narratives fate is not simply the acceptance of the inevitability of death, but the rejection of the certainty of a long life that is implicit in linear narratives. It is clear that this is different to ‘fatalism,’ as polyphonic narratives assume that the future is formed by numerous factors beyond one’s manipulation. Illness and an awareness of death, which may have precipitated this realisation, are nonetheless seen to be only two of these

factors. As Ezzy (2000: 615) finds, “Polyphonic narratives accept and embrace this uncertainty”.

Imagined trajectories

In Rachel’s and Diana’s stories I found that as part of becoming aware of their embodied and situated positions, they sought to move attention ‘away’ from the concerns of others and knowledge of biomedicine and ‘towards’ themselves and forms of knowledge that enabled them to support the self. This is not to say that the turn to oneself can be wholly understood by attending to the interior life of the individual, understood as the movement of thoughts, desires, imagination etc. Nor do the interviewees necessarily seek to find final meanings for their experiences. What occurs is a move from what can be described as a curiosity in the failings of others (such as the problems with biomedicine or even failures to get well) towards that of temporality and embodiment.

Concerned as they are with purpose and the aims of living, Rachel’s and Diana’s narratives and experiences might be described as teleological. However, I would rather describe them as a practice of ‘anti-teleology’. In Rachel’s and Diana’s stories, the self is not always something that is found within. Rather the self also appears as a goal and a ‘trajectory’ that is open to being affected by life. (A trajectory refers to the distance between the current self and the goal of one’s self as a full and complete subject.) The self is not only experienced in its present form, but also in the goal to be attained, as well as in the distance between the two. The anti-teleological practices that complementary self-health provides seek to bring attention to the formation of the self as a teleological subject, and then situate it. Therefore locating the contingency of the teleological force in the narrative or experience and allowing Rachel and Diana to act upon it.

Again I must be cautious not to overstate the case here. What I seek to highlight is the possibility of an alternative analysis, rather than a prescription or generalisable account of all complementary self-health. What I am exploring is this possibility of subjectivity, for these interviewees, using these narratives. As I found in the previous chapter, the move of user’s attention is not so much about the ‘objects’ but the conversion of the ‘modality’ of their attention, so that the user changes the way that they see the world. In doing so, temporality becomes the site of tension between

the user's situated self as transformational material and as transcendental subjectivity. Yet this tension, the distance of oneself from oneself, is experienced in such a way as to contribute to the freedom of the will, to will itself and exit from the stasis of life before cancer. For example, consider again Diana's struggles with the possibilities of retrospective clinical tests. Diana is initially concerned with the objective knowledge these tests will provide; the results of which would set her on a particular linear path of more treatment or wellness. But the loss of this knowledge, while problematic, was moved to the background by orientating its usefulness to her life in the here and now. "Only time will tell" whether she was cured at that moment – she will only know her future in retrospect. This situated imagining of possible future trajectories, both well and ill, is set against the awareness of her well body, which Diana experiences at that time. The tension is in both experiencing this wellness and knowing that it may be otherwise at any moment.

In order to expand upon this point, recall that in chapter four I described how it was necessary for the user of complementary self-health to change the ways that they know their embodied world. That is, the same objects in the outside world are gazed upon, but what changes for the interviewee is the manner of knowing, or now experiencing, these things. As Diana explained, she was less concerned with the 'causes' or 'results' of knowledge. This is not to say that concern with the causes of things is not engaged with, but that she found it a distraction for someone striving to achieve a different goal, one that can be described as a form of freedom.

Accepting fate-full living

The user of complementary self-health faced with situational and transcendental objectives may perceive fulfilling them as one of choice. But 'choosing' itself may be one of those demands or values. Therefore it is possible for the user of complementary self-health to experience such imposed choices as devalued and ethically void. Certainly, there is evidence to suggest that when perceived this way by some biomedical patients, where choice is found to result in a loss of 'real' agency (Franklin 1998). But this is not necessarily a problem for users of complementary self-health. As I described in chapters four and five, the interviewees consider their position as one in which they are doing all they can in order to get well. After this, they find, all that is left is to accept one's fate.

Acceptance therefore ‘protects and shields’ individuals from the conflicts and dilemmas of existence, as the social standards of behaviours close down space for doubt and reflection. In turn this ‘delegation of responsibility’ to the social standards is also a delegation of response-ability (cf Greco 1998), or the capacity for agency. In the technique of acceptance, in complementary self-health, the amount of agency that is appropriated and defined by acceptance is the amount renounced by the self as she practices her liberty as if she were not free. So when Rachel and Diana recognise that they are unable to affect their lives and accept the forces that constrain them, it should be noted that it is Rachel and Diana who have experienced and narrated the degree to which they distinguish their selves as unfree. To this extent, I can be sure that complementary self-health invokes the self as an ethical self – in that Rachel and Diana are concerned with their freedom, responsibility, and agency of both their selves and others.

There is therefore a strong strategic dimension implied in the technique of acceptance. Put simply, the technique of acceptance asserts that the user can be modified, but only with their active or ‘willing’ participation. Moreover, once this being-in-the-world is recognised in Rachel’s and Diana’s experiences, it is only the amount of their enthusiasm that will hinder the degree of self-transformation and account for the persistence of these transformational characteristics. Thus, as I discussed in chapter six, the problem of complementary self-health does not have the same status before as it does after it is encountered. Posing the technique of acceptance in this way allows for its consideration as a strategic technique in healthcare, as the work done by the users of complementary self-health (visualisation, meditation, spiritual healing etc.) presupposes a willingness and ability to relinquish a prior balance. Moreover, this allows the pertinent question: who is responsible when complementary self-health fails? That is, when solutions proposed by complementary self-health fail the question returns, as I found in chapter four, to that which is beyond the user’s capacity to effect.

Both Rachel and Diana spoke of accepting the situation they now found their selves to be in. They understood themselves to be able to affect certain parts of their lives, even to the extent that they might prevent cancer or its spread. Yet through Rachel’s and Diana’s use of complementary self-health they also recognised how, at any given

moment, there were greater forces of biochemistry, family, society or spirituality etc. working from or through them. Complementary self-health can therefore be regarded as providing strategies that support Rachel's and Diana's experiences. It provides another way to experience cancer, by *accepting* and not fighting it, and in doing so it supports *their* constitution and transformation of their selves as subjects. That is, the problem of complementary self-health is a problem that starts with problems of intentionality and practices of the user's liberty. It involves Rachel and Diana taking a position not just on the aetiology of their cancer, but in respect to their relationships to their selves and others.

Rachel and Diana both recognised that their use of complementary self-health was still largely 'beyond' the norms of biomedical narratives and subjectivity. It is for this reason that it can be substantively seen by them to be an act of choice and freedom. Because of this, it is then possible for Rachel and Diana to refuse their initial starting position as an autonomous subject – necessary for ethopolitical subjectivity – and to freely accept their capacity not to be able to affect their lives or those of others. As such, the choice to accept their fate-full life is the choice of choosing their unfreedom. As unpalatable as this may be to biomedicine and the values of advanced liberalism it is, I reason, a necessary cost for the way users of complementary self-health experience their self, health and life.

Conclusion

In the previous chapters I have identified three characteristics of complementary self-health, which can now be folded into the analysis of this chapter. First, 'relational knowledge' is prioritised. Rather than knowing the causes, the user of complementary self-health is concerned with balancing the relationship between their embodied self and the temporality they find their self to be situated within. For example, Diana's account showed how the cause of her illnesses was less important than the relationship between her mortality and the realisation of the truth of her formation of her self as a subject, in any given moment. Second, the principles of the embodied self are essentially prescriptive. That is, the knowledge of their embodied experience of the world, their place within it and relationship to their self, health and life become the basis of their principles for living. Third, there is a 'return effect' of the truth on the self. That is, for the user of complementary self-health to

know the truth about their situated and embodied self is to complete their self. So by clearly seeing their goal of supporting their self the user avoids distractions and diversions from gaining that support.

To this I can now add a fourth characteristic of complementary self-health: what I have described in this chapter are Rachel's and Diana's stories of their experiences of adjusting and readjusting time, so that it corresponds with the ideal that they wished to achieve. Living in the now is consequently a necessary practice and part of forming a relationship with oneself in complementary self-health. The readjustment is not to a moment in the future, but to a practice of the *in situ* transformation of the self. The purpose of balanced living, the embodied guide, cancer as an opportunity to change, and living in the now are to support oneself. Through the practices and techniques that complementary self-health supplies, the interviewees were able to find ways to remain aware of the ongoing, relational, situated and embodied challenges to their formation of their selves as a subject in their subjectivity.

In this thesis I have found that by taking into account not just the discursive stories, but also the embodied experiences, it is possible to identify in the interviews a new formation of the self as a subject in her subjectivity. I therefore argue that complementary self-health presents the user with a distinct possibility. If the user is able to grasp the present moment in its pure presence, then she is able to grasp the truth and free herself from the false power of flux. Complementary self-health provides the techniques and practices so that the user experiences an embodied awareness of attachments to the past or the future. She can then see how such attachments give the present its power over her self, making objects appear as they are not. But through living in the now what 'truly is', is found to be devoid of attractiveness, or meaning. It is pure presence, now discontinuous and dispersed in the moment. Foucault ([1982] 2005) argued that such work might be considered a spiritual technique, not a theoretical metaphysics, as it is a practice aimed at mastering the flow of representations by which the object in its objectivity and the subject in its subjectivity are constituted. This is something to which I will return in the concluding chapter.

In chapter eight, I will explore that what the problem of complementary self-health shows is how, as soon as there is a search for the truth of illness beyond the static object-ness of the body, the analysis comes to a problem that fluctuates between ethics and politics, between the individual and the collective exercise of freedom. Moreover, if embodied subjectivity of complementary self-health does play an active role in the pathogenesis of disease, as PNI would suggest, then it is possible to argue that the user of complementary self-health who has cancer literally reactivates history. Here the description of a way of falling ill is also the way in which one actually becomes ill. This is not simply 'labelling'. Rather, this is a literal and paradigmatic space 'between words and things', which abstains from a static realism or a fleeting nominalism (cf Greco 1998).

This is to say: "The history which 'we must presume to be "alive" and present within each of us', is alive and present in us both as *subjects* and *objects* of knowledge" (Greco 1998: 70). For this reason, it is not possible to reduce, assimilate or confuse the problem of complementary self-health with the problem of the physiology of emotions. Rather, the problem of complementary self-health is one of self-reflexive, circular movements that reallocate subjectivity, repeatedly, *in situ*. Users of complementary self-health then reiterate that which biomedicine fails to see; that its object not only knows what it can see but that it can, and will behave accordingly. In turn, the problematisation of experience and support for the self brings medical thought into the work of illness. This is not a radical discontinuity with respect to the epistemological foundations of biomedicine; rather, in complementary self-health, there is a renaissance of the subjective via an embodied yet transcendental biochemistry.

Chapter Eight

The Spirit of Subjectivity in Ethopolitics:

The Problem of Complementary Self-Health

“We’ve got to avoid the sacralization of the social as the sole instance of the real, and stop treating thought - this essential thing in human life and human relations - lightly. Thought exists, well beyond and well within systems and edifices of discourse. It is something which often hides itself, but it always animates everyday behavior. There is always a little bit of thought even in the silliest institutions, always some thought even in mute habits.”

(Foucault 1982: 33).

This thesis has explored conceptualisations of subjectivity in the experiences of people who have, or have had, cancer and who use complementary self-health. In addition to an analysis of several complementary self-health texts, I have also shown how the experience of cancer and use of complementary self-health affected the lives of eight interviewees in England. I have described how they sought to manage the increasing emphasis in healthcare on individual responsibility, choice and care of the self. In doing so I explored the embodied experiences and the polyphonic narratives that are involved in the interviewees’ stories, in order to document and make visible the many new and original ways that the interviewees have found to manage their lives when living with cancer and, more generally, illness in a contemporary western healthcare context. More broadly, what I have also described is what subjectivity might be in Rose’s ‘ethopolitics’. As a result I have established what can be called the ‘price that is paid’ by users of complementary self-health for the ways that they have come to think of their freedom in “our current regimes of government through freedom” (Rose 2007: 273).

The research questions I posed at the start of the thesis were: First, ‘How do people, who have, or have had, cancer and who use complementary self-health, experience their use?’ That is, given the seemingly incommensurable possibilities that are present in the field of complementary self-health, how do these people find ways, if at all, of resolving or living with such apparent contradictions? Second, ‘How is the use of complementary self-health experienced as part of an ethical formation of subjectivity?’ And third, ‘What are the implications of these new formations of

ethical subjectivity for sociological reflections about experiences of contemporary healthcare?’

In the first half of this chapter I will summarise the research findings and, in doing so, look to draw some conclusions for the first two research questions. However, before it is possible to properly address the third question, it will be necessary to reflect on the findings from the first two. This is because the answer I draw from the stories of the interviewees impacts upon how I pose the third question.

Summary of findings

In chapter three I explored both the conceptual and empirical tensions that complementary self-health presents. Through an examination of six self-health texts found in complementary cancer healthcare, I highlighted the tensions and spaces that are a part of this field of enquiry by asking how the complementary self-health field is itself differentiated by sometimes implicit, sometimes explicit, ideas – such as mind, body, spirit, energy, environment and society – and also via key themes like healing, holism, connectedness, and listening. The second aim of this chapter was to develop a critique of the new systems or hermeneutics of care and posit that the ‘support of the self’ might be a more productive analytical construct. I argued that care was increasingly to be found to be an object in the ways of knowing the self. However, I found that the support of the self practiced in complementary self-health was a response to the continual ‘crisis’ of living with cancer as a companion illness. Here users were supported by complementary self-health as they sought to find new ways of experiencing the formation of their self as a subject, in their subjectivity. Complementary self-health was therefore understood as an empirical problem; a problem where the users of complementary self-health experienced themselves as ‘free’ to ‘find their own way’.

This understanding of the field allowed me to explore, in chapter four, how the interviewees sought to balance the competing demands on their self, health and life. In this chapter I asked: what happens when balance moves from an objective category to a mode of subjectivity? I described how a ‘balanced life’ is concerned with taking a ‘wider’ perspective on things, bringing factors into experiences and accountability that might otherwise have been marginalised or undervalued (cf R Taylor 2002). In doing so the ‘balanced life’ is therefore concerned with

striking an ‘objective’ idea of balance; it seeks to objectify a satisfactory compromise that will stand over time. Contrasted to this, complementary self-health emphasises a mode of subjectivation I called ‘balanced living’, which comes through the ongoing shaping of subjectivity in one’s story. In effect, balanced living is part of what is needed if cancer is to be a companion illness. Balanced living is a mode of subjectivation that makes sense of past and forthcoming decisions from a situated and embodied position. It incorporates a retrospective and an imagined future trajectory of balancing that is part of forming a more day-to-day or situated balanced living.

In this subjectivation of balanced living, rather than finding ‘empty signifiers’ in choice, freedom and responsibility as Reuter (2007) does in another field of biomedicine, I found an ‘excess’ of affect, in particular towards these values of choice, freedom and responsibility. Moreover, there was an ‘overidentification’, as I term it, with the political and ethical rationalities that takes responsibility ‘beyond’ what many may consider to be responsible in the first place, thus showing the limits of a political rationality of responsabilisation. And in doing so, it also unbinds blame from the individual. This is because the individual has sought to take into account and balance all possible factors in the way she lives. So it is now possible to understand how she can ask in all sincerity, ‘what else could I have done to get well?’ In doing so there is a refusal of blame for any ongoing illness being laid solely with the individual.

In chapter five I described the different ways that the two interviewees sought to relate to themselves as embodied. I used the term ‘embodied guides’ to describe the ‘ethical work’ (situated, relational, and ongoing practices and techniques) that was done on the ethical substance (the embodied self). This allowed me to explore the ethopolitical tensions present in the different problems of embodied knowing, or ‘feeling as a way of knowing’. For example, the interviewees would often speak about the various ways that they sought to ‘listen’ to their intuition or gut feelings. Others also described how they were ‘being led by the heart’, or were ‘resonating with what is right’.

What I found is that what I referred to as an ‘embodied guide’ actually entailed practices that involved hearing the truth that one’s self was speaking in order for it to

affect oneself. A ‘practical wisdom’ that denoted a simultaneous knowing and acting. This therefore involved practices and techniques that moved discourse into an embodied subjectivity. In exploring this I found that subjectivity in complementary self-health was unbounded from ideas of a singular, autonomous being. The interviewees practiced ways of relating to themselves that involved an understanding of the self premised on a relationship with others. The embodied guide involved techniques to situate the self and become aware of the various forces or factors that were affecting not only one’s judgement, but also one’s health and life. In this way the interviewee sought to fashion her own way of living, her ethos, and develop a new way of relating to her self. The interviewees’ discovery of these techniques and practices was found to have a profound effect on them, one they said they might not have experienced had they not had cancer.

In chapter six I explored how cancer in complementary self-health provided a significant opportunity for change in the lives of the interviewees. In this mode of subjectification it became clear that what the interviewees were seeking to express in such narratives was the capacity that they had discovered to know differently, in a profound sense, that cancer or the experience associated with cancer brought to them. In the interviews the problems of fear and anxiety, which diagnosis and treatment of cancer can bring, were described as part of an emancipation from ‘old’ ways of living. This change was found to be both transformational and transcendental. The transformational elements described the changes to the stories of self, health and life of the person. The new ways of living and knowing, the awareness of one’s embodied guide, the practices of situating, the capacity to be responsible for oneself in new ways. Yet these descriptions were not found to adequately describe the significance of these changes. Moreover, their non-discursive and affective experiences provided a way for the interviewees, through their cancer and their understandings of the body, to transcend their individuality. One of the new experiences was an understanding of what humanity shared, not a particular idea of the subject, but the capacity to affect and be affected by others: a new mode of subjectification.

It is at this point the particular importance of psychoneuroimmunology (PNI) to complementary self-health became apparent. I argued that it provided a mechanism

through which the interviewees sought to understand how transformations in their ways of thinking could affect their body and their health. Indeed, it might be better put that what PNI is able to achieve for the users of complementary self-health is the transformation of the metaphorical into the biological. As the thesis progressed it was possible to increasingly appreciate how the interviewees sought to provide new ways of acting upon themselves, which did not necessarily conform to an analysis that suggested that they were wholly self-governing through ethics or being subjected to new hermeneutic practices of care. But in order to better appreciate how it was possible to make this argument, I needed to return, once again, to the techniques and practices that the interviewees used – in particular, how they sought to situate themselves in the now, and how they used this to orientate themselves in respect of their imagined past and futures.

Narratives of fate and hope are familiar to those who hear the accounts of people with illness. These narratives are often explored in the ‘here and now’, such as in the immediacy of the oncology clinic, so that the clinician can avoid drawing out a ‘trivial chronology’. This, along with endings that are deliberately deferred or blurred, can leave many patients uncertain, anxious and fearful. In response, complementary self-health provided the interviewees with practices and techniques to emplot temporalities. Like the narratives of the oncology clinic, these narratives were also situated. But in complementary self-health I found that hope and fate became ‘imagined trajectories’. This is to say that an awareness of one’s situated emplotment allowed recognition that one would emplot otherwise at other times and in other circumstances. I also found that the capacity to manipulate one’s past and future, which shared with the subject in the clinic the mobilisation of their will, was contrasted with another practice of ‘acceptance’. In recognition of the limitations found both in their imagination’s and their body’s capacity to overcome cancer, users of complementary self-health utilised a narrative resource from psychotherapeutics. The interviewees told me how they sought to recognise all the significant factors in their life, how they had come to that moment, and how they could imagine possible futures. This brought hope through embracing uncertainty and finitude and avoided fatalism through rejecting the linear, Kantian, or masculine values of life. That is, the capacity to manipulate time became a situated practice that supported the interviewees in their experience of cancer and its treatments.

The interviewees did not, however, think of themselves in terms of the ‘fiction of the autonomous individual’ (Rose 1998). Acceptance therefore posed a problem of how to account for when the interviewee choose not to be autonomous; when they decided to let the flows of affects from others, of their fate – genetic, social and otherwise – pass through them. Alternatively it might be said that complementary self-health therefore delegated the capacity for ‘response-ability’ (Greco 1998). This is the recognition of the limits of narratives of empowerment and of articulating one’s capacity to respond when the person finds herself in particular situations. It is not that she decides that she cannot act, but recognises through consideration of her situated and embodied affectivity that she is unable to affect certain aspects of life.

It is at this point that I argue that complementary self-health poses a problem that is implicit within Rose’s description of ethopolitics: What is it to ‘choose to refuse’ the pastoral relations premised on the autonomous individual within ethopolitics? This is to ask: how is it possible to form an alternative analysis to ethopolitics, without ‘slipping back’ into an analytic of disciplinary forces or merely extending the hermeneutics or regulatory systems of care?

‘Philosophy as a Way of Life’

Throughout the thesis and in most of the interviews there has been the presence of the idea of ‘spirituality’. But it is only now, once I have fully explored the interviewees’ stories, that it is possible to consider what this is in the experiences of users of complementary-self health. This is no easy task: problems concerning spirituality address some of the oldest philosophical questions. Moreover, in today’s material-physical world, to consider such a problem from a secular position without the supposed necessary levels of scepticism, is seen to be a problem in itself. So I wish to be clear here, I am addressing ‘spirituality’ as an ethical, political and transcendental problem as it is faced, expressed and used by the interviewees. This is not, in the first instance, to seek to address the problem of the ‘spirit’ of an age or to define the force through which a society is thought to be governed (cf Weber; Simmel; Hegel etc). Whilst this might be something that is drawn from the following reflections, the concern here is with the ‘transformation of souls’ (Hadot 1995).

The sub-title, ‘Philosophy as a way of life’, borrows from Pierre Hadot’s (1995) book of the same title. Here Hadot draws on reflections of the Hellenist and Roman thinkers to argue what philosophy should be concerned with and what a philosopher is. He finds that these ancient thinkers were not professors or writers, but people who had a certain style of life that had been willingly chosen and not dependent on having been taught or becoming a writer. Thus, as well as the ‘philosophical figures’, anyone from statesmen to women who did not write could be considered philosophers by their classical contemporaries. These ‘true philosophers’ lived in society with their fellow citizens, but in a different way to other people. They were distinguishable by their moral conduct, by ‘speaking their mind’, by the way in which they nourished or dressed themselves, by their attitude to wealth or conventional values. The philosopher was therefore a philosopher because of his or her existential attitude. This attitude required that the person undergo a conversion, in the strongest sense of the word, which radically changed the way in which he or she lived his or her life. Therefore, what began with a fundamental choice of a style of life, which consisted of certain practices, activities and conduct – what Hadot calls the “spiritual exercises” – is given a concrete form either through an inner discourse or through actions and daily behaviour. Hadot argued that the goal of such work was wisdom. The texts, practices and techniques would therefore aim to produce a particular philosophical subject. It was through the maxims and formulae for thinking about oneself that one would be able to live a certain philosophical life.

Hadot’s work on Hellenist and Roman thought assists me by articulating a series of useful contrasts for my reflections on complementary self-health, which will also help in answering my third research question. However, this should not be mistaken as an attempt to fulfil Hadot’s programme to articulate how the wisdom of Antiquity can be reanimated within contemporary thought. Neither is it my aim to show how people who use complementary self-health are ‘actually’ living lives according to the rules of the Stoics, Epicureans or Plato etc. Rather, what I want to elucidate is how complementary self-health provides a programme of exercises, practices and techniques – a way of living – that seeks to form thought in a particular relationship to itself. As Foucault showed in his *History of Sexuality* and in many of his lectures at the Collège de France, reflections on these ancient texts provide a useful contrast to contemporary ways of living, as they can illuminate ways in which it was possible

to derive other relations between the self and knowledge. Using Hadot's and Foucault's discussions therefore provides a useful contrast, but it is still for me to explore such possibilities for complementary self-health.

Becoming your spiritual self

Foucault defined spirituality as: "the search, practice, and experience through which the subject carries out the necessary transformations on himself in order to have access to the truth. We will call 'spirituality' then the set of these researches, practices, and experiences, which may be purifications, ascetic exercises, renunciations, conversions of looking, modifications of existence etc., which are, not for knowledge but for the subject, for the subject's very being, the price to be paid for access to the truth" (Foucault [1982] 2005: 15). Spirituality is therefore a particular way of experiencing the relation between the subject and the truth; access to the truth is equated to having "access to being itself" (ibid: 191). To be clear, this is a non-religious formation of spirituality that has, as I shall show, a particular relation to secular ethics: it is a secular spirituality. But as Rabinow (1999) notes, the attempt to re-form the social and biological worlds with spirituality is not a 'remagification' of the world in Weber's sense of spirit. Rather the concerns here are with witnessing engagements and contestations of "how technologies of (social and bodily) recombination are to be aligned with technologies of signification" (ibid: 12). In particular Rabinow suggests that it is not values and beliefs that should be analysed, but the forms that are emerging, the embodied practices and the space that ethics takes that should be of analytical concern.

In complementary self-health I find that the process of becoming spiritual involves learning to form one's subjectivity in a new way. As I have shown in the interviews, this involves becoming aware of what affects you and what does not, as well as understanding what it is that you can and cannot affect. This needed a new non-discursive way of communicating with oneself and others; an embodied relationality that was used as the basis for narrating the molecular understanding of the body to the psychic, social and familial problems faced in life. New habits were formed, but often with the proviso that they were open to change, adaptation and to be balanced according to the situations of the moment. By learning to live in the present moment the interviewees sought to free themselves from past and future causations, as they

sought to de-couple their dependency on these past and future understandings. In this and other practices, they found ways to encourage their imagination and affectivity so that they could situate the problems they faced in the present and be better able to experience their contingency. Practices such as meditation and visualisation helped to bring inner discourses to light and make them coherent and subject them to analysis. Treatments from homeopathy and crystal healing to acupuncture and forms of massage engaged an idea of the placebo that looked to ‘help’ and ‘support’ not only the body, but also the psyche and spiritual self. And in doing so it should be remembered that this was not about curing cancer, but healing the person or, perhaps more accurately, healing their spirit.

In becoming spiritual the interviewees described how they had been on a journey. Indeed, it is part of complementary self-health’s emplotment to see oneself still on that journey. Each opportunity to reflect, to tell and retell one’s story to oneself or others, underlined that each solution that was found was the solution for that understanding of their problem. So, what was important was not so much the problems that were faced, but the attitude with which one faced them. In doing so the quality of the answer that was found – any objective measure or critical judgement – diminished as the emphasis was placed on the capacity to effectively practice the new formation of this spiritual subjectivity.

This trope of being on a journey combined with the outlook of healing one’s life brought a new attitude to death. Death was no longer something to be fought, but to be accepted and prepared for. In Hadot’s description of Hellenist and Roman philosophy the preparation for death included philosophical separation of the soul from the body. This allowed for the goal of liberating the soul from partial, passionate (affective) points of view clouded by the corporeal senses so that a normative, universal viewpoint of thought could be achieved. The death was to one’s individuality and passions so that one could come alive in the perspective of universality and objectivity. This death, Hadot finds, is to free oneself from servitude and to choose ‘lucidity’ over diversion.

But I find quite a different arrangement in the interviews of people using complementary self-health. The interviewees sought to become more attuned to their embodied position, attempting to situate their subjectivity within the multiple

demands they faced. As I found, part of this was coming to an awareness of the various spheres of life that were affected by cancer and its treatment, realising which they could and could not affect and then accepting that situation for what it was. They did not seek to fix an idea of the whole of life from all viewpoints, but to locate their self in the multiplicity of their situation. This is not an attempt to ‘elevate’ thought or escape the passions, but to fully embody thought and to recognise how subjectivity forms itself. Unlike Hadot’s reflections, the aim is not to fully identify with the Good, but – recalling Nietzsche once more – to find a *better* way of living. In sum, complementary self-health entails a new form of embodied attention to oneself, a form of vigilance, which seeks to find ways to better support the self through the experience of cancer and its treatments. And to repeat, these practices, techniques or exercises hold the capacity to be spiritual as they seek to affect the relation between the subject and herself – not in terms of an object and objectivity, but as the subject in her subjectivity.

Spiritual exercises as support for the self

The aim of complementary self-health is to support the formation of the embodied self, rather than inform it. Using complementary self-health can therefore be understood as the living of animated discourses whose main principle is not to transmit information, but to produce a certain embodied affect in the reader or listener. In this way complementary self-health seeks to form people and transform their souls. For this reason it becomes apparent that a passive reading of complementary self-health texts alone is unlikely to bring any transformation; the user must engage the texts in a particular ‘active’ way, as well as listen to recordings, complete exercises, visit centres, use the internet and meet others in groups. Moreover, I have found in the interviews that to prioritise the written or spoken word in any analysis of complementary self-health is to become too abstracted and to fail to engage the embodied reactions that are generated. Therefore to use complementary self-health, to fully experience its effects, is to learn how to become an embodied self who is able to find different ways to relate (e.g. holistic, connectedness, listening and healing) to multiple spheres of life (e.g. mind, body, spirit, energy, environment, and society).

Before I go any further, it is necessary to reaffirm why these exercises are ‘spiritual’ and not just exercises of thought, ethics or politics. A case may be made for all of these interpretations, and more, but I argue that each is too limited for my needs here. The exercises in complementary self-health are better characterised as spiritual because they draw attention not just to the work on thought, but to the embodied and cosmological self. Indeed, in this way it is possible to contemplate the place of the transcendental aspects of complementary self-health and to appreciate the ambition of the perspective that it seeks to provide.

Therefore, using Hadot, it is possible to consider how complementary self-health can be framed as a form of spiritual exercise, which stimulates the user to give attention to herself, to take care of herself, to know herself. Hadot noted that the Socratic maxim “know thyself” required a relation of the self to itself that “constitutes the foundation of every spiritual exercise” (1995: 90) and that “every spiritual exercise is a dialogue³⁴, insofar as it is an exercise of authentic presence, to oneself and others” (ibid: 91). Hadot also notes that it is the relationship or journey that counts, not the end or solution to a particular problem (ibid: 91-92). But recall that Foucault ([1982] 2005) documented how the self in ‘know thyself’ had increasingly become an object to be understood and how this maxim had become distanced from its Socratic relation to ‘take care of oneself’. In complementary self-health I have found that, first, knowing oneself can be understood as forming a subjectivity that seeks to understand its own conditions of formation. As one cannot know oneself by pure acts of introspection, complementary self-health provides a significant cultural resource – the means of intelligibility, such as the languages, methods, explanations etc – that are to hand in one’s cultural and specific practice or situation. Secondly, I have argued that this knowing oneself has become related to the dictum to support oneself.

This is because, bearing Hadot’s understanding of spirituality and spiritual exercises in mind, it is possible to see how complementary self-health fulfils the role as a distinct form of interlocutor – or, to use the language of complementary self-health, a

³⁴ While Hadot’s use of ‘dialogue’ is central to his argument, his understanding is not one I wish to invoke; it is too restricted to the ‘logos’ in communication and dependent upon a dialectical structure. Rather, as I have described in chapter three, I take the productive relations between particular things to be tensions, which has more in common with Foucault’s problematisations.

supporter – and how it is an essential and significant part of the process of embodiment and becoming transcendental. Contrary to the analysis of complementary self-health as a form of discourse that seeks self-governance, or that seeks to regulate the individual as a particular form of subject, complementary self-health contains something within it that prevents some dialogues becoming theoretical and dogmatic exercises: it works to ensure that it is an ongoing, relational, embodied, and situated transformation. This is the spiritual aspect of complementary self-health; as Hadot described, “For the point [of spiritual exercises] is not to set forth a doctrine, but rather to guide the interlocutor towards a determinate mental attitude. It is combat, amicable but real. The point is worth stressing, for the same thing happens in every spiritual exercise: we must *let* ourselves be changed, in our point of view, attitudes, and convictions” (author’s italics; 1995: 91).

Complementary self-health therefore involves exercises that seek to form a certain attitude and life-style. But as an embodied practice it is not solely concerned with the cognitive, but with the self’s formation as a subject, in her subjectivity. It does not seek a stasis, but requires that users become more than or move beyond; it involves an ongoing transformation of one’s ways of living. It talks of moving the user from an inauthentic life to a more healing, authentic way of living where they can attain an awareness of their self in the world.

However, I must draw up two reflections at this point: first, Foucault’s criticism and sceptical consideration of disciplinary and governmental forces within the interlocutor. Secondly, in regard to the wider concern of this thesis, I also question the effect this has on how I can conceive subjectivity in ethopolitics – that is, it would seem that the problem of ‘guidance’ or “bidirectional affective entanglements” (Rose 2007: 74) in ethopolitics leaves space for a spiritual capacity in subjectivity. Yet, as I will argue, if this spirituality were to be found, it would render the perspective or analysis of ethopolitics somewhat incomplete. I will address these problems below.

The Embodied Spirit of Refusal in Ethopolitics

I opened the thesis with the supposition that Rose’s concept of ethopolitics best encapsulated the position of complementary self-health in healthcare today. It is

now possible to explore this presumption and qualify how the concept of ethopolitics helps to understand what is happening in complementary self-health.

As I explained in chapter one, by using the term ‘ethopolitics’ Rose (2007: 27) seeks to direct attention to “attempts to shape the conduct of human beings by acting upon their sentiments, beliefs, and values – in short by acting on ethics”. Ethopolitics is therefore concerned with the ways in which “the ethos of human existence – the sentiments, moral nature or guiding beliefs of persons, groups, or institutions – have come to provide the ‘medium’ within which the self-government of the autonomous individual can be connected up with the imperatives of good government”. Rose places ethopolitics in the analytical spectrum by stating that “[i]f ‘discipline’ individualises and normalises, and ‘biopolitics’ collectivises and socializes, ‘ethopolitics’ concerns itself with the self-techniques by which human beings should judge and act upon themselves to make themselves better than they are”.

It is now possible to see how complementary self-health is, on the one hand, an excellent case example of ethopolitics. Complementary self-health occurs in a field where the people using it perceive few, if any, objective guarantees – I argued in chapter one that the problems of knowledge in complementary self-health are best understood through Proctor’s (1995) agnotological framing. Here the ‘social and cultural production of ignorance’ produces a space in which the individual finds herself under the obligation to choose, but at the same time finds that the possibility of a clear choice is either unknown or layered in the complexity of technical biomedical language. From here the ethical substance that is contested in the field of complementary self-health is the ‘ethos’ of the *embodied* self. Complementary self-health brings the affect of oneself and others into question. It seeks to ask the individual to (re)form herself in light of her experiences, to elucidate and choose on the basis of her character and beliefs. In doing so complementary self-health provides techniques and practices that enable each person to contemplate and act upon herself so that she may make herself better than she was.

But, on the other hand, I have also noted in my analysis particular problems that suggest that complementary self-health does not completely fulfil the ethopolitical mandate. This includes the epistemological field within which the use of complementary self-health occurs. One could also reason that, if the use of

complementary self-health is found by those who use it to challenge and refuse contemporary medical and political rationalities, it might do so on the basis that is beyond the mainstream governance of healthcare. For example, I described in chapter four that ethopolitics in complementary self-health is not experienced as ‘forced choices’ (Franklin 1998) or an emptying of responsibility (Reuter 2007), as had been found in examples of choice and responsibility in other fields of healthcare. It is therefore possible to start to question what it is that complementary self-health provides and whether that takes the interviewees beyond an ethopolitical analysis.

I have also sought to explore some distinct possibilities for producing other analytics within the accounts of the interviewees who use complementary self-health. This included how the interviewees used complementary self-health to situate and embody practices and techniques that produced the recognition of an excess of affect. In turn I argued that this led to an overidentification with ethical values and political rationalities such as choice, freedom and responsibility, which led to a refusal of blame and, ultimately, of being identified within the ‘fiction of the rational autonomous individual’. I also described how the non-discursive and affective elements of experience were emphasised in the accounts so as to allow the person to transcend her individuality and, through the idea of what humanity shares, her capacity to affect and be affected. Finally, I described how the practice of acceptance was drawn from complementary self-health to allow the person with cancer to delegate their capacity for ‘response-ability’ (Greco 1998).

What is happening in complementary self-health that is not found in ethopolitics? What I have found in the accounts of those who have cancer and use complementary self-health is a capacity to ‘go beyond’ – understood as the ‘spiritual’ aspect of complementary self-health – the original ethopolitical framing. What I will argue below is that the language and use of spirituality is unaccounted for in either the ethics or politics of ethopolitics. Moreover, I argue that this cannot and should not be subsumed within a discussion of ‘ethics’. This is because spirituality is self-defining and self-renewing and arguably beyond the ethical values or political rationality that set them into motion.

Therefore, one of the analytical problems of ethopolitics is its capacity to suggest how users might be ‘governed through ethics’, whilst at the same time holding the

capacity for them to refuse this possibility. That is, in this final section of the thesis I will address whether complementary self-health can be understood as a "... 'medium' within which the self-government of the autonomous individual can be connected up with the imperatives of good government". As I have shown so far, complementary self-health poses exactly this problem.

Or put another way, ethopolitics describes the contemporary political perspective that the acceptable subject is one who frames herself freely and autonomously as an ethical subject. Two questions arise from this: First, is a question of how to understand the ethopolitical subject in complementary self-health. The second is concerned with the particular problems that complementary self-health poses to ethopolitics. For example, how is ethopolitics to be understood when the subject chooses to be unfree, or refuses her autonomy, such as by 'accepting her fate'? Can this be understood within ethopolitics? Is it reasonable to argue that there remains a conceptualisation of the autonomous individual within this: she freely, individually and knowingly *chose* to be unfree. In juxtaposing these two problems within ethopolitics it becomes possible to contemplate how, if I am to conceive of users of complementary self-health as ethopolitical, I must recognise that there is the potential for the users to transform their selves and so transcend the conditions that provided that possibility of transcendence. Moreover, I will argue that this possibility of transformation is necessarily a condition of ethopolitics itself. That is, in order to fully understand ethopolitics in complementary self-health, it is necessary to recognise the possible 'spiritual' element implicit within it, that ethopolitics permits a subjectivity that holds within it its own refusal and a capacity to 'go beyond' being governed through ethics. Spirituality is therefore a possibility of a truly transformational embodied ethopolitical subjectivity. In these terms, this is not so much a critique of ethopolitics but a fulfilment of the possibility it holds for subjectivity in complementary self-health.

Going beyond ethopolitics

Foucault's original interest in the care of the self and spirituality was to destabilise the hermeneutics of the subject in terms of desire. In order to do this, rather than discuss hermeneutic practices, Foucault explored the forms of spiritual direction that were undertaken, which he argued did not interpret the self, but sought to fashion the

self. That is, Foucault's original aim of seeking to critique the hermeneutics of desire brought him to locate past non-hermeneutic practices of the self. Here, rather than the desire to know oneself, the fundamental task was the broader 'take care of oneself'. It is in the exploration of these texts that Foucault starts to consider ethical and spiritual *parrhēsia*³⁵. Ethical *parrhēsia* was found not to be hermeneutical, as what distinguished this attitude was that "truth was spoken as a goal to be attained and as a technique for attaining that goal rather than as a pre-given nature, a static essence" (McGushin 2007: 13).

However, spiritual exercises should not, Hadot argues, be limited to the realm of ethical exercises. This is because spiritual exercises involve all aspects of one's existence and do not seek to ensure behaviour in accordance with a code of good conduct. Hadot argued that spiritual exercises had a moral value and an existential value. Spiritual exercises were not simply part of the ethical philosophy, as theoretical discourses are not purely located in logic and physics. Conceptualising philosophy and spiritual exercises in this broad way led Hadot (1995) to criticise Foucault. Hadot's main concern with Foucault's work was that he gave too narrow a reading of ancient ethics, as well as limiting the care of the self to ethics alone. There was no room for the "cosmic consciousness" of physics as a spiritual exercise, which was also important to the way in which the ancient philosopher viewed his relation to the world. By failing to locate the care of the self within the cosmic dimension Foucault was not, Hadot reasoned, able to appreciate the full scope of the spiritual exercises that physics and logic, as well as ethics, aimed to facilitate in self-transformation.

It is not possible to provide a full overview of the discussion between Foucault and Hadot (or the various commentators thereafter) on this matter. I only highlight it to draw out a salient point for the matter under consideration here. In sum, in approaching complementary self-health I, on the one hand, accept Foucault's

³⁵ McGushin (2007) traces Foucault's discussion of the ancient problematisation of democracy and how *parrhēsia* is displaced from a political, where it is used as part of governing others, to an ethical dimension, where it is part of the spiritual direction necessary for the proper ethical and moral government of oneself. That is, although Socrates and Plato manage to detach ethical *parrhēsia* from the political field, it is in the Hellenistic and Roman texts that Foucault finds ethical *parrhēsia* and care of the self developed more rigorously.

criticism (as discussed above) of Hadot – that he was too uncritical of the possibilities that the subject’s ‘philosophy as a way of life’ could be the philosophy of self-government, or a philosophical mode through which the conduct of subjects could be governed – indeed Rose’s ethopolitics suggests this very problem for complementary self-health. But on the other hand I also accept Hadot’s criticism of Foucault, that his analysis was too narrow and failed to account for thought beyond ethics. It is notable that Hadot’s criticisms are based on Foucault’s *History of Sexuality* books. McGushin (2007) suggests that Foucault himself implicitly accepted this critique in his 1982 lectures. Furthermore, in his notes to these lectures, Gros (see Foucault 2005: 23, fn 46) suggests that Foucault did so through an under referenced – but apparently serious reflection on Søren Kierkegaard.

What is the significance of this for the present problem? Reflecting on Kierkegaard³⁶, it is possible that Foucault sought to separate out the spiritual as a sphere of thought in its own right distinct from aesthetics and ethics. That is, spirituality held the potential to become a different mode of thought. In doing so, as Hadot and possibly Kierkegaard have argued, spirituality contains within it parts of the other modalities, such as ethics and aesthetics. Indeed it is possible to read Foucault as seeking to show the ethical formation of the self as necessary, but not sufficient, to explain spiritual modes of thought. For example, Foucault’s discussions of the forms of rhetorical and ethical *parrhēsia* or his reflections on Marcus Aurelius and ‘nature’ brought him to conclude that spirituality was not just a necessary component of the subjectivity’s formation of itself, but was a modality of (philosophical) thought in its own right.

Similarly, the ethics in ethopolitics, no matter how empty, assumes a subject capable of freely acting upon herself. What I have shown in the stories of people who have cancer and who use complementary self-health is that attempts at ethical self-

³⁶ Kierkegaard described three parts to life: aesthetic, ethical and religious. Given Kierkegaard’s rejection of providing a singular understanding to his works there has been much debate about what he meant by each of these terms and how he saw them as related (Pattison 1999). They have been read as modes of communicating as opposed to descriptions of the psyche or thought. They have been seen to follow sequentially either in whole (one ‘leaves’ the aesthetic to go on to the ethical) or as a synthesis (that is the religious contains parts of the aesthetic and ethical), which need to be experienced linearly (the aesthetic as the ‘lowest’ and religious as the ‘highest’ forms) or situationally (as is appropriate to the situation).

formation sometimes results in what I can now call the spiritual formation of the self. That is, in order for relations to be *bidirectional* affective entanglements there must be a capacity for refusal. In ethopolitics this is largely, if solely, conceptualised as the ethical resistance of an autonomous subject through the use of alternative (affective) discourses, reason or rhetoric. However, for people with cancer who use complementary self-health I have found that if the self is to be able to conceive of how she can affect herself and others, she must actively engage at each moment her subjectivity as an embodied and relational being. In doing so I find that an analysis that draws on problematisations of the spiritual better encapsulates how the interviewees understand their position. While it is possible to see how a particular ethico-political rationality set them into action, the interviewees describe how they are transformed and transcend their original positions. This should not be ignored or subsumed within the opening analysis; indeed, as I have noted in previous chapters, the analysis itself should undergo a transformation.

The politics of the spirit

I ask at this point whether, if some of what I am seeing in complementary self-health requires an analysis that goes beyond ethopolitics, there is some way in which I might describe it? In order to answer this, it is useful to return to Paul Heelas's (2008) work on spirituality in contemporary Britain.

Heelas finds that contemporary forms of spirituality emphasise mind-body-spirit as an integrated personal whole³⁷. This contemporary 'inner-life spirituality', discussed in chapter one, contains what Heelas refers to as the 'golden triangle' of life, equality and freedom – an ethic that he argues is dominant in Western cultures. Heelas finds that this ethic is the combination of the ethic of expressivism, inspired by Romanticism, and the 'ethic of humanity', inspired by the Enlightenment. These contemporary 'wellbeing spiritualities', Heelas states, have a very basic theme, which is that "contact with, and specifically experience of, the inner-realm enables

³⁷ This is in contrast to the 1960s where Heelas finds alternative forms of spirituality to those of contemporary 'spiritualities of life'. Heelas finds that in the 1960s there was an emphasis on the liberation of the 'subjective life' from the "*imposition* or internalization of conformist regimes" (author's italics; Heelas 2008: 49). This resulted in a counter-cultural spirituality taking a dualistic form, which stressed the shortcomings or 'fallen' parts of the self and that had been acquired or determined by the mainstream.

spirituality to infuse life – transforming the quality of those aspects of one’s being which have previously been divorced from inner-life” (ibid: 53). These wellbeing spiritualities are therefore all about the whole person. And emphasis is given to the ‘potential’ for spirituality to flow through the person. This allows the person to be holistic, to be balanced or be in harmony, to heal and bring wisdom to their life. Their potential is fulfilled when activities make it possible for the spiritual flow to overcome ‘blocks’ within subjective life and the body. This is a ‘practical spirituality’ that is concerned with “wellbeing for the self *and* for and with others” (ibid). In these forms of spirituality of life, the dualism of previous forms has faded³⁸.

What this brief reflection on Heelas’ work permits is a consideration of the forms of spirituality that might be found in the narratives, practices and techniques of the interviewees. A spirituality, Heelas suggests, that addresses inner-life, is concerned with wellbeing and draws heavily on Romanticist and Humanist discourses. This is an important counter to what might mistakenly be seen as the thrust of my argument – that spirituality is an ‘escape’ from wider social or cultural forces. Rather, as I described above, I find that the self’s formation of herself as a subject in her subjectivity is under a particular form of contestation. I again must account for the forms of subjection and subjectivation that unfold in the support of the self. This time it is not just politics and ethics that I must look to account for, but also spirituality.

In doing so I call this ‘pneumapolitics’, after the Greek word *pnein* meaning breath or spirit, from which the philosophical term *pneuma* [pronounced ‘nu-ma’] is derived, which denotes a person’s vital spirit or creative energy. In doing so I invoke a double meaning of *pneuma* by keeping in mind Frank’s (2010) desire to ‘let stories breathe’. Therefore, following Rose, “[i]f ‘discipline’ individualises and normalises, and ‘biopolitics’ collectivises and socializes, ‘ethopolitics’ concerns itself with the

³⁸ Whilst spirituality may not always be an end in and of itself, it is possible to see spiritual well-being as part of people’s concerns though consideration of “a *spiritual* sense of purpose, meaning-in-life, ‘depth’ of relationships, experiences of creativity” (Heelas 2008: 172). In arguing this Heelas posits that it would be better if spirituality and a concomitant sacralisation of life were the ends to which these subjective life practices were put. However, this is quite a different aspect to Heelas’s work that I wish to sidestep; rather what is evident is that in the accounts that I have considered is that a secular spirituality is a significant part of the support for the self in complementary self-health.

self-techniques by which human beings should judge and act upon themselves to make themselves better than they are”; I argue that pneumapolitics is concerned with the practices of support that transform an embodied self so that she might recognise her subjectivity as a form of refusal or acceptance of her situated position.

Pneumapolitics is therefore concerned with the ways that the spirit, creative or vital energy of persons, groups or institutions have become the mode within which the subject comes to form her subjectivity and is situated within problems of self-government.

Conclusion

At first complementary self-health looked like excellent example of the ethopolitical milieu. But unlike other examples in biomedicine, the subject here did not take herself as emptied out. What I found was that complementary self-health provided ways for the interviewees to describe how they (re)subjectivised their accounts. Here use of complementary self-health challenged and refused contemporary medical and political rationalities – first, through an embodied and situated overidentification with the values, ideas and concepts within those rationalities, thus providing a tangential view on the limitations of those same norms (see chapters four and five); second, by transforming and transcending the situational constraints, via which the individual was able to refuse the pastoral relations premised on autonomous personhood and accept the position she found herself constrained by (see chapters six and seven).

While some analytical traction was gained through the various ethical formations intimated in Rose’s ethopolitical analysis, it was also evident that parts of this subjectification could not be contained by the description provided by ethopolitics. That is, by fully and seriously engaging in the practices and techniques afforded by complementary self-health the interviewees found themselves going beyond the ethico-political constraints they originally encountered and into a new relationship, with a new set of costs and with a different price that was to be paid for one’s freedom. I have called this pneumapolitics.

Therefore, if there is something called a complementary self-health discourse, which is to be argued to be part of the framing of contemporary subject’s who have cancer, then I need to take into account how people with cancer inculcate those discourses.

This is because, as Heelas also found for alternative spiritualities, those discourses also contain within them the possibility to refuse and be other than. In particular, in the use (mode) and content (form) of a spiritual subjectivity proves problematic for contemporary discussions of the autonomous individual in healthcare. Those engaged in this pneumapolitics are seen as non-materialistic, non-rational, non-individual, non-responsible, and non-empowered. This is the price they pay in order to conceive of themselves as they do. Previous critiques of such modes of subjectification have conflated their ethical content, which as Rose and others have shown is a productive force in contemporary ethopolitics, with the forms of transcendental or spiritual being. Whereas this pneumapolitics is self-defining and self-renewing and has provided these interviewees – in their accounts, in this thesis – with the possibility to repeatedly go beyond their physical, political and ethical constraints and become other than they were.

*

At first cancer was an ‘event’, which the interviewees did not see coming, an impossible possibility (Derrida 2007). However, in this thesis I have described how complementary self-health transforms the event of cancer so that it is experienced as an ongoing crisis, a repeated moment of critical distinction, in the lives of the interviewees. By using the techniques and practices in complementary self-health to tell and retell the event of cancer the interviewees found ways to reflect and work upon their self in their formations of freedom. Traditionally, philosophers have argued that the greater the role or power of freewill, the greater the freedom allocated to the subject, the greater responsibility the subject has for their life. But I found that, in order to understand this for the interviewees in this thesis, I needed to recognise that the interviewees were able to form their selves as subjects in their subjectivity.

The experiences in the interviewees’ stories showed one way in which I can recognise the limitation of freedom to be wholly responsible for one’s self. In each story it was possible to say that there was nothing more that she could have done. Or rather, the interviewees highlighted the extent that factors ‘other than’ their capacity to affect the world played in their stories. But instead of the diminishing possibility to affect the world posing a threat to the interviewee, I have argued that she posited

herself in her formation of freedom: what else could she do? This says a lot about how the interviewees have come to understand their selves as a certain type of subject. The cost of posing themselves within the myth of the autonomous rational subjectivity is that they found the need for a companion myth of ‘fate-full living’.

But this is not quite as Giddens (1991) described fateful moments, as it is an open and ongoing narrative. But nor is it fatalism or *fortuna* (events beyond control) that “allows a person to ‘ride along with’ a decision” (ibid: 141). Those whom I interviewed, who experienced the event of cancer, accepted that they could not know *at that time* the unknowns (whether known or unknown) in each telling and retelling of their story. The hubris of the enlightenment narrative to know and be individually responsible was met with humility born of the limitations of interpersonal and shared self, health and life. The ongoing crisis of cancer and the use of complementary self-health provided techniques and practices that allowed for a refusal, to use Giddens’ terms, not only of the ‘colonisation of the future’ (ibid: 111), but of the present and the past.

Rabinow (2004) asked: what is this new ethic of responsibility that is being formed in these contemporary configurations of subjectivity? The response of this thesis is twofold: at first I found in the stories how subjectivity ‘before cancer’ was felt to be existentially emptied of the capacity to affect itself, but which was also recalled to be full of individual responsibility. But after the event of cancer and the use of complementary self-health, the interviewees’ stories showed that the new *spirit* of responsibility gently returned the existential problem of responsibility to the door of the Other, while simultaneously claiming the freedom to do so. If the interviewees live in a time where they have never been more capable of being responsible for themselves, of knowing what they can do to be a responsible individual, the consequence of their stories is to find the impossibility of individually containing that responsibility. Others may consider them as having never been freer to know and choose, but the interviewees find this makes them more dependent, more interconnected and more in need of support than ever before.

Epilogue

It had always been my intention to write an epilogue to the thesis. It felt fitting to provide some sort of ‘ending’ or ‘closure’ to my research story. I considered this an opportunity to register my good health, to the extent that anyone who has had cancer can ever close the episode, and provide a few reflections on the experience of writing about a topic that one would expect would have so much resonance with my experiences.

What is of interest is that once I had written *My Cancer* I did not write any more personal reflections about my experiences in my journal. At first I was not sure why this was: perhaps with my attention so focused on drafting the chapters, and the critical analytical work that I did for chapter two in particular, I had no space or energy for further ruminations. As I discuss in chapter two, I had somewhat become comfortable with my remission-as-normality story. When asked, “how *are* you?” in that specifically-referring-to-cancer-enquiry, rather than the general polite greeting, I would shrug and briskly announce, “good, fine, I feel great” and, if pushed, refer to the latest neutral blood test or CT scan.

The question that kept preventing me from writing was: What would be sociologically interesting about my further reflections? What was it that I wanted to say in closing the thesis? The conclusion is sufficient as an ending of the analytical process, but as the thesis opened with a personal account, it felt symmetrical to close with some ‘final thoughts’. But perhaps this is just no more than a PhD student’s failure to ‘let go’ or to put the thesis down and walk away. However, if this was the case, then please be reassured that you would not be reading an epilogue.

Upon re-reading *My Cancer* for chapter two, I realised how over the previous eighteen months I had moved from an apprehensive ‘we don’t know if you still have cancer’ status, to ‘remission-as-normality’. To play on Clinch’s (2010) ‘normal abnormality’, I had become ‘certain of my uncertainty’. But as I proofed and edited the thesis and reflected on the problem of ‘having nothing more to say’ I became aware of how certain ways of ‘thinking about’ had become my ways of ‘thinking with’.

In the prologue the problem had been about how could I ‘think about’ the ways I had come to ‘think with’: how could I manufacture differentiation that would aid an analysis? For the sociologist it is perhaps too easy to mistake the formation of analytical thinking that results from this process as something other than it is: a *sense* of distance, or even objectivity, to my experiences that had become a lived way of being-with-myself, without the recognition that such an experience is itself now how I have come to live with My Cancer. This is not to argue that ‘underneath’ my sociology cancer story, as it may be called, there is an emotional turmoil being repressed. Rather, what I noted is that my sociology cancer story – my sociological mode of subjectification – was now largely recognisable as an acceptable account to myself of my experience of cancer. Yet, as a sociologist interested in stories’ relationship to formations of subjectivity, the recognition that my self had been colonised, if you will, by a habitual account of reflexive differentiation, by my sociological imagination, provides the open and ongoing ending that I feel is a more fitting close to the thesis.

Appendix One

The Research Practicalities

Locating the field

The main sites for this research were the people with cancer who used complementary self-health. In order to better acquaint myself with the language of the field, I started by reading the autobiographies and memoirs of ‘cancer survivors’. This included books such as *The Cancer Monologue Project* (Bull, T Taylor, and Thompson 2002); *Women Confront Cancer* (Wooddell and Hess 1998); and *Cancer Tales* (Dunn 2002), to name a few. It was on reflecting on these stories that the themes for analysis first germinated. However, while they provided an initial proving ground for my thoughts, I was wary of Thomas-MacLean’s (2004) comments about the silences in the completeness of such ‘quest narratives’ (Frank 1995). Moreover, there were few stories available of people with cancer from England who had used complementary self-health.

What this initial period made clear was that most of the work that people with cancer who used complementary self-health did was in the privacy of their own home. They would view websites (Ziebland et al. 2004) – but not necessarily rely on them (Broom and Tovey 2008a) – and buy self-help books to read and reflect upon. They would visit some of the thousands of independent sole-trading complementary and alternative practitioners throughout the country for treatments and advice (Tovey and Chatwin 2004).

I therefore set up a website (<http://personal.lse.ac.uk/MACARTNE/default.htm>) as part of a pilot stage of the research, which needed to include certain information. On the home page there was a brief introduction to the research. It listed the short criteria that I defined to select interviewees (see below) and asked the visitor to take five minutes to read a little more. A second page provided more detailed information about the research and my perspective as a researcher. It also provided the potential interviewee with information about me, along with a picture to aid recognition should I go to meet them. A third page was titled ‘The interview, permissions and feedback’. Here I explain how this was exploratory research and that, if the visitor felt that I had made any unreasonable assumptions, they should contact me and tell

me why this was so. On this page I hyperlinked to a document called ‘The interview procedure and permissions’ (see appendix two). This document provided the interviewee with practical information that aimed to further reassure them about what would happen and about their rights as an interviewee. Finally this web page contained, as did the ‘procedure and permissions,’ relevant contact information. As well as my details, which were also provided on every web page, there were the contact details of my supervisor, should the visitor or interviewee have any concerns about the research. The fourth page of the website is a Q&A page, where I shared answers to anonymised questions that prospective interviewees asked me.

For the pilot stage of the research I emailed a short summary of my research, along with a hyperlink to the webpage, to friends, family, other PhD students and the LSE Sociology department. The calculation was that, given the prevalence of cancer, those who received the email would either be someone, know someone or know-someone-who-knows-someone that had cancer and that used a CAM. From the first level (those on my email lists) responses I received, this appeared to be the case and they were, on the whole, happy to forward the email on. From this first level response I was able to arrange and conduct one interview. The second level (those from whom the email was forwarded) produced three other interviews. The third level provided one more.

Whilst the pilot study was a useful and interesting exercise, it was clear such an approach could not produce a reasonable number of interviewees. But what it did make clear to me was that almost all the interviewees from the pilot stage had used a Cancer Support Centre (described in chapter two).

I therefore compiled an extensive list of Cancer Support Centres in the country from the internet. I wrote a letter to each requesting if it would be possible to place a poster on their main notice boards and distribute some flyers explaining the research. As part of this I explained that I had passed the ethical process at the University and would be happy to meet with them regarding any procedural or ethical questions they might have. I also asked if I could write a piece or advertise the research in their newsletters or on their websites, where appropriate. The below three organisations responded.

I met with the Lead Therapist and Chief Executive of a South London Cancer Support Centre to discuss my request to recruit their service users. They interviewed me about the research and enthusiastically agreed to place my poster and flyers prominently in their centre. This was a medium sized centre, which was open five days a week. They offered a range of services from an advice line and library and information centre to various one-to-one and group complementary therapies. Many services were provided free or with a minimal ‘donation’ or subsidised fee. Of particular note is that they were a UK centre for the Healing Journey approach (discussed in chapter three).

The next centre to contact me was a Breast Cancer Support Centre, with three centres around the country. They wrote to me saying they would be happy to display my poster. This organisation again provided access to information and resources, focusing specifically on breast cancer. They also provided free access to complementary therapies as well as to breast cancer care nurses. This organisation was not associated with a particular ‘approach’, other than their general ethos of the centre i.e. they are quite unlike, for example, Penny Brohn Cancer Care centre that developed their own ‘Bristol Approach’ (see chapter three).

The third centre was based in the North West of England. This centre was the smallest of the three, running for only two half days a week from a church community centre. It provided subsidised and free drop-in services and access to complementary practitioners for people with all sorts of cancers. Again a few emails helped secure a prominent place for my poster and flyers. The Centre did not have its own ‘approach’, but had adapted the principles of the Bristol Approach and signposted its users to other forms of complementary self-health.

Interviewees

I interviewed 16 people in total, two of whom were male. Appendix three provides a summary of the interviewees and appendix four lists the range of CAMs referenced in the interviews. I interviewed six people before my own diagnosis, three of whom I ended up using in the following chapters. Six interviewees were receiving ongoing treatment at the time of the interview, of whom four are analysed in the following chapters. That means the other four interviewees were in remission at the time of the interview. Of those featured in the thesis, three were CAM practitioners, one was a

lay ‘mentor’ to a complementary self-health programme and another a lay support group leader – neither had any certification or formal membership to any CAM, as far as I was aware.

What is also of note is that, excluding those in chapter six (this chapter takes a longitudinal look over people’s reflections of how cancer transformed their lives), the interviewees were all diagnosed within the last ten years, i.e. since the enactment of the NHS Cancer Plan (Department of Health 2000). The one exception is interview nine, ‘Pat’, whose diagnosis and treatment occurred in the early 1990s. The possible contrasts her story provides are discussed in chapter five.

The interviewees were all self-selecting and provided consent. The only restrictions to recruitment were that they had or previously had been diagnosed with cancer and had used both orthodox and complementary treatments. The definition of complementary and orthodox medicine and indeed the terms used to define those fields were left up to the interviewee. My posters and flyers used the words ‘complementary therapy’ but it was open to the interviewee to apply such terms to themselves. This is not without problems however. On the one hand I could say that my target interviewees are those who use forms of complementary self-health, understood as people who use it in conjunction with orthodox medicines. This perception would therefore pretty much rule out people who use alternative medicines, understood as being used exclusively and instead of orthodox medicines. However, it is not quite that simple. Among many other problems, there is a difference between an alternative medicine and the alternative *use* of a medicine, such as off-label use. What was relevant to this research is not who is right and wrong in their or others attempts to define complementary and alternative medicine, but *how* those debates affected the ways that people with cancer use complementary, alternative, and orthodox medicines. Therefore, the best way to address this issue was to say that I was looking to interview people who recognised themselves as using either complementary and/or alternative and orthodox treatments in their healthcare, however *they* (not I) chose define them.

No effort has been made to ‘match-pairs’ of case studies, such as remission with an ongoing treatment. Nor have I sought to compare-and-contrast pre My Cancer

interviews with those following. As I explained in chapter two, my interest in each interviewee was in their vivid story of their experience.

Collecting stories

I used a narrative interview technique for the interviews. This meant I engaged the interviewee in a form of unstructured, in-depth interview that looked to go “beyond the question-answer schema” (Jovchelovitch, Bauer, and Gaskell 2000: 61).

Overcash (2003) notes that there is a degree of ambiguity in definitions of narrative methods. But Mattingly and Garro’s (1994) description of what narrative research allows the researcher to do is instructive here. Discussing narrative as a mode of thinking, they contrast it with abstract, propositional and scientific modes of thought. They note that narrative logic works differently than such ‘categorical’ thinking. Rather than ‘transcending the abstract’ it is grounded in the particulars of human action. It is through narrative that attempts are made to make sense of how things present as they are and how one’s own actions and the actions of others have contributed to our history. As Mattingly and Garro state, “we try to understand who we are becoming by reference to where we have been” (ibid).

Narrative research is particularly suited to exploring issues about subjectivity, as it allows the individual participant to determine the information that is relevant to the discussion. As a form of ‘collaborative research’ narrative research it has a more equal power distribution between the researcher and those who are being researched, at least as far as *creating* the narrative is concerned. The person telling their story becomes part of the research decision-making process, with more freedom to decide how the story is told, what is included and the length of the interview (Overcash 2003). Therefore I did not approach the interview with a set list of questions, rather I asked the interviewee to ‘tell me their story’ of their cancer and complementary self-health use. Once the interviewee started their account I did not interrupt, but looked to provide an encouraging listening context that enabled them to feel free to explore their story at length. During this part of the interview I made notes of anything I wished to return to in the next part, where I asked questions and looked to explore and clarify what had been said. When posing these questions, I did not take a confrontational attitude and did not argue with, or contradict, the interviewee. During the interview I was guided by the interviewee him or her self, although I did

have with me a 'prompt-sheet' of topics or issues that I hoped to address, where possible. The last part of the interview process is the informal 'concluding talk' (Jovchelovitch et al. 2000), where the recording equipment had been switched off and the interview process was wrapped-up. In this period it has been noted that further useful information may come to light and so I ensured that I made notes of this either at the time or as soon after as possible.

However, as I describe in chapter two, after my own diagnosis the research moved from being solely interview based, to being more ethnographic. The mainstay of the fieldwork was conducted at the South London Cancer Support Centre. Here I attended various groups including a peer support group, a self-help support group (where discussions led to the introduction and practicing of possible self-help techniques), and a meditation group. As well as this I attended the 'Healing Journey' self-help programme (discussed in chapter three). Of the six levels available I completed the first three. Finally, I also attended an introductory day course at Penny Brohn Cancer Care centre.

Field ethics

The fluctuating and often antagonistic reactions in the media and in biomedical circles to complementary healthcare meant that those who use complementary self-health can be highly sceptical of the motivations of those with a research agenda, even when they become recognised as an 'insider' (as I did). While many of the Cancer Support Centres work with biomedical practitioners, it was important that I made it clear to those gatekeepers in the complementary self-health field that my research was not concerned with criticising or validating their approach's efficacy or legitimacy. In most conversations such concerns were easily mitigated, by explaining that I was interested in people's experiences and stories of complementary self-health use.

Throughout the research I followed the research guidelines for professional conduct as laid out by the British Sociological Association. For the interviews, I sought individual informed consent and informed all interviewees that they could terminate the interview and withdraw their consent at any time. They were also made aware that they could request a copy of the transcript or a copy of the recording. Again,

please see appendix two for a copy of the ‘Permissions and Procedures’ that I handed to each interviewee.

This study also presented particular interpersonal ethical issues. As I interviewed people who had undergone a life threatening illness and who had undertaken a serious reflection upon their life and health, I needed to be aware of the personal and emotional concerns that could be present. Overcash (2003) documents how the telling of stories about traumatic events and illness can have therapeutic effects, but as welcome as this may have been for the interviewee, it was not an aim of the research. Although I informed the interviewees in the ‘Procedure and Permissions’ notes that I am not a trained councillor, the interviewee was open to interpret and use the interview context as they liked. And for all its potential for collaboration, the narrative interview is an unusual situation to be in. Providing someone with an opportunity to talk, at length, about one of the most traumatic and possibly significant moments in their life can have unintended effects, including those associated with therapy. While, on the one hand, some interviewees provided an emotive and lengthy account, others remained very matter-of-fact. In such cases however, this was largely a case of finding the right place to start their story. Too often, my simple opening question was heard to couple the start of their story with the start of their illness and/or use of complementary self-health. Whereas, of course, this is not always the case.

Process of analysis

In practice analysing the interviews meant that during transcription of the interviews I would set up a parallel document where I would place potentially relevant or interesting quotes. With each quote I would also provide a reflection of my thoughts at that time as well as indicate any necessary contextual information. By working in this way I was preparing a course of analysis that would eschew computer based programmes, which have been used in similar studies such as Kendall and Murray (2005), but which are not particularly “capable of perceiving a link between theory and data or defining an appropriate structure for the analysis” (Pope, Ziebland, and Mays 2000: 115). Therefore, as the research sought to find examples of *new* ethical subjectivities in the contemporary ethopolitical context, it entailed my reading and

re-reading significant sections of text so that new forms of connections, relations and phrasing could be highlighted.

Therefore, once the transcription and parallel documents were completed for an interview, I reviewed and solidified examples of tropes, what the key words and moments were, and how they might be seen as part of forming subjectivity. I was also able to return to the complementary self-health texts that the interviewee's had referenced and other materials they had discussed in their interviews, such as websites, magazines, and survivor memoirs. This was useful as it allowed me to explore how the interviewees folded-in and re-situated the practices and guidance that such materials gave. The analytical strategies used in the latter part of the analysis are described in chapter two. However, it quickly became apparent that a responsible analysis in these circumstances would 'build-up', or as Latour would put it 'study-up' (cited in Frank 2010), the analysis in a stepwise fashion. In particular, it was at this point that the tacit attitudes and collection of stories from the field that I had accumulated were particularly useful.

Appendix Two

The Interview Procedure and Permissions

As this research is fairly novel, some of the questions I may ask in the interview make assumptions about what you might have thought and/or done. But if these assumptions do not make sense to your situation, *please* say and tell me why this isn't relevant to you. Please see the questions as starting points. What I am interested in is understanding *your* experience, from *your* point of view.

Of course, when asking for your help I am aware that I am approaching what are, for many people, sensitive and personal issues. Therefore I would like to stress that foremost in my considerations whilst conducting my research are the important issues of discretion, anonymity and the need to provide a safe space in which to discuss these matters. So I have put together the following in order to help reassure people about what will happen and what your rights are.

Therefore, before I interview you, you may want to read the below:

The interview procedure:

- ✓ It is important that we meet in a place that is comfortable for both of us and which allows me to tape record the interview. I am happy to travel to meet you in your home, but please feel free to suggest an alternative place if you would prefer e.g. a quiet coffee bar.
- ✓ It is important to remember that I am not a trained counsellor, therapist or social worker, but a social researcher.
- ✓ Once the interview gets underway I will start a tape recorder and ask you to tell me your story of your illness and use of complementary medicines.
- ✓ As you do this, I will not interrupt with questions. I want you to feel free to talk uninterrupted for as long as you need.
- ✓ As you talk I will probably make some notes, but please don't worry about this. They are just reminders for me as in the second part of the interview I will ask you questions about what you have told me.
- ✓ Don't worry, these questions will not be a cross-examination or an attempt to pick holes in what you have said! I will just be asking you for more information and details about what you have told me already.

- ✓ Once this part is done I will stop the tape. However, in the past I have sometimes found that the conversation continues. If this is the case I may make some notes and use the information - if you are happy with this - to further inform my research.
- ✓ Of course, if you wish for something to be “off the record” please feel free to say so!

Permissions:

- ✓ I would like to record the interview so that I can then transcribe it.
- ✓ Some parts of the transcript may be used on this site, in the final thesis or in published texts.
- ✓ Please be reassured that every effort will be made to make sure that your identity cannot be discerned from the excerpts. For example, one of the ways that I will do this is to use a pseudonym. However, it may be the case that you are happy for your identity to be known. Please say if this is the case, as I will assume you would want to remain anonymous otherwise. Of course, you can change your mind at any time, until the thesis is finalised and submitted.
- ✓ Once the final thesis is submitted the recorded materials will either be returned to you - should you want the tape - or be destroyed.
- ✓ You can stop the interview and/or withdraw any consent that you have previously given at any time.

Feedback:

Finally, should you have any comments or complaints about my research please feel free to discuss them with me in the first instance (via my [email](#) or the [discussion page](#)); or if you would prefer you can contact my supervisor, [Professor Nikolas Rose](#), at the LSE.

Thank you again for taking the time to assist me with my research. Your help is invaluable to me as, quite literally, this research couldn't happen without you!

Appendix Three
Table of Interviewees

No.	Gender	Age at interview	Primary cancer (Year diagnosed)	Remission / Ongoing	CSH*	Chapter
1.	M	26-35	Brain (1995)	Remission		
2.	F	46-55	Breast (1980)	Remission	HC	
3.	F	56-65	Bowel (1991)	Remission	BA	6
4.	F	46-55	Non-Hodgkin lymphoma (1992)	Remission	HC	6
5.	F	56-65	Breast (1994)	Remission	JP	
6.	F	20-26	Chronic myeloid leukaemia (2007)	Ongoing	HJ	7
7.	F	46-55	Breast (2008)	Ongoing	CA	5
8.	F	46-55	Breast (2009)	Ongoing	HC	4
9.	F	46-55	Breast (early 1990s)	Remission	(JP)**	5
10.	M	46-55	Non-Hodgkin lymphoma (2009)	Ongoing	HJ	
11.	F	56-65	Womb / ovarian (2002)	Remission	HC	
12.	F	36-45	Breast (2008)	Ongoing	CA	4
13.	F	46-55	Nose (late 1990s)	Remission	HJ	
14.	F	36-45	Breast (2001)	Remission	HJ	7
15.	F	46-55	Breast (2008)	Remission	NWBA	
16.	F	36-45	Breast (2008)	Ongoing	NWBA	

*CSH (Complementary Self-Health) Approach:

** Ellipses indicate later / post remission use.

BA: Bristol Approach

CA: Cancer Active

HC: Health Creation

HJ: Healing Journey

JP: Jane Plant

NWBA: North West approach, a Bristol Approach spin-off.

NB:

Dash line: Interviews 1 to 4 were included in the pilot study.

Bold line: Interviews 7 to 16 took place after my diagnosis and treatment.

Appendix Four

List of Complementary Practices Used

The following is a list of the complementary medicines, treatments and therapies that my interviewees told me they had tried. I have not provided a frequency table, as I did not request a list of all CAMs used. It is therefore it is plausible that other CAMs were used, but were not disclosed to me in the interview.

Acupuncture	Healing, Theta
Alexander Technique	Herbal, General
Art Therapy	Herbal, Mistletoe therapy
Bach Flower Remedies	Herbal, Tamoxifen (Di-indolyl-methane (DIM))
Colonic Irrigation	Homeopathy, Chinese
Counselling	Homeopathy, General
Crystal Healing	Hypnotherapy
Diet, Budwig protocol	Journaling
Diet, Health Conscious (general)	Kinesiology
Diet, Non-dairy (Jane Plant)	Massage (various)
Diet, Juicing	Meditation (various)
Diet, Macrobiotic	Mind Watching
Diet, Rainbow (Woollams)	Osteopathy, Cranial
Diet, Raw	Osteopathy, General
Diet, Vegan	Prayer (Religious / Spiritual)
Diet, Vegetarian	Psychoanalysis / Psychotherapy
Emotional Freedom Technique (EFT)	Qigong (Chi Gong)
Essential Oils	Reflexology
Eurythmy (dance therapy)	Relaxation
Exercise, Martial Art	Shiatsu
Exercise, Swimming	Supplements, all
Exercise, Walking	Visualisation
Healing, Chrystal	Yoga (various)
Healing, Reiki	
Healing, Spiritual	

Appendix Five

Limitations of the thesis and suggestions for future work

By following what makes the interviews so vivid, there is a danger that I have overemphasized in my descriptions the ease with which complementary self-health provided the interviewee with a way of experiencing her subjectivity than was readily the case. So it is worth remembering here that complementary self-health, being as it places itself at the coming together of disparate knowledges, brings both the dangers and the benefits from each of these spheres. Nonetheless the description that I provide of complementary self-health, particularly through the interviews, could be seen to neglect many of the dangers of CAM. Within the CAM field there are plenty of stories of CAM that have left the user upset, scared, angry or even physically harmed. For example Stacey (J Stacey 1997: 37) provides a particularly striking account of a worrying encounter with a Reiki healer. I did hear similar stories in some of my interviews, however these related to single CAM practitioners, not advocates or experiences within complementary self-health. Further research would show the extent that this is an anomaly of this research or, as I suspect, whether it suggests something about complementary self-health as the formation of a new technology of support in the field of CAM and cancer.

A particular research site that would allow for such an exploration would be the Complementary Cancer Support Centres that I recruited my interviewees from. At these Centres the client is assessed by a multidisciplinary team comprising of mainstream and complementary practitioners and, with the client, a programme of treatments and therapies is devised. In the complementary self-health texts, websites and talks I found there was a greater emphasis, brought by the author or advocate, of the practitioner being responsible, of self-regulating, and of practicing the importance of 'do no harm'. By entering the Centres and sitting-in the various clinic consultations it would be possible to examine the degree to which complementarity or integration has brought formal and informal regulation. Similarly it would be possible to examine the ethical normativity of consultations, perhaps using follow-up interviews with the clients some months afterwards to explore the extent of the Centre's effects upon the lives of the clients.

Research such as this will also allow for a more fruitful exploration, than I have been able to afford here, of how the techniques and practices of complementary self-health reaffirm, challenge or reform ideas of self and subjectivity in terms of age, class, race and gender. Taking gender as an example, such research could ask: To what extent is complementary self-health generally, and the ‘support for the self’ in particular, gendered?

Stacey (J Stacey 1997) finds that self-health is infused with a masculine teleology within a discourse of masculine achievement. Sointu finds that CAMs contain a “caring femininity [that] perpetuates self-surveillance” (Sointu 2011: 362), as well as subordinating many women in a relationship of ‘caring for others’ at the expense of themselves. However, Sointu also points to discourses of wellbeing that are used to locate a different, although still gendered, space away from that of care.

Nonetheless, she finds that this is a strategic move, one that – sometimes literally – ‘buys time’ for women to spend away from their established gendered roles. The contrast this provides, Sointu argues, can motivate some women to reassess their lives and make changes to how they live and can be associated with wider social trends of detraditionalisation. There is therefore reason to believe that whilst CAMs may reaffirm many old and new gendered discourses and roles, they also appear to provide the users with the possibility of taking up new relations to one’s subjectivity that allow, in turn, for new strategic positionings. Whether this is the case for complementary self-health and how this might be gone about, will need further research and analysis.

While the above points to the further empirical work that might be undertaken to explore some of the questions this thesis raises, there is also further work needed on how I have conceptualised the field of complementary self-health. In particular, I would like to take the time to explore the thread that connects psychoneuroimmunology to the spiritual in complementary self-health. Whereas the thesis focused on what might be called the *bios*, the way of the ‘good life’ life in complementary self-health, there is something to suggest in the complementary self-health texts that the body should no longer be considered in the pejorative term ‘mere’ of ‘mere life’ (*zoē*). Rather, the simple fact of being alive is found in complementary self-health to be what I suggest might be called ‘munificent life’.

This form of *zoē* differs from ideas of the ‘good life’, which is located in the reasoned thought of particular groups, through its universality.

Yet this brief formulation is problematic. As Rabinow (1999) describes, Aristotle held that the care of mere life was restricted to the (feminine) household, which differed sharply to that of the political life of men in the *polis*. However Brennan (2004), Despret (2004) and Wilson (2004), amongst others, have described how the affective self-containment of the civilised body is no longer sustainable in biomedical terms. Given the argument in the thesis, further consideration is needed to explore whether or how the mode of subjectification undertaken by complementary self-health accepts this unbinding of animality, displacing *zoē* from the subject to subjectification. In turn the experience of this shift is felt by the user, as a spiritual connection. Put another way, the consequences of the existential becoming the ‘existentielle’ is one possible consequence that needs further unpacking.

This leads me to question the relationship of pneumapolitics to explorations of vitalism, which have followed in light of Canguilhem’s (1994) work. In particular Greco (2005) provides an invitation to consider the normative dimensions that are, once again, to be found in understandings and experiences of biology. The place of PNI is again instructive here, as to what might be the sort of questions and the types of answers that become recognisable as acceptable, when the user of complementary self-health examines his or her life. While the techniques and practices of complementary self-health suggest possibilities of an anti-teleological attitude to one’s self, health and life, it would be interesting to enquire further into what normative possibilities this attitude holds.

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