

# Chapter 1

## Conceptualizing NCM

The focus on domestication carries novel implications, both theoretical and analytical, for the study of NCM. This emphasis is different from prior conceptualizations that rested on a dichotomous interpretation of either dominance or resistance. The concept of domestication is also different from recent discussions of the ‘integration’ of NCM. Furthermore, whereas the majority of researchers base their analysis either on questionnaires or interviews, this study offers an ethnography of NCM in the media, the colleges, and the clinics. Rather than concentrating on larger samples or a bird’s-eye discussion of the medico-legal system, it is essential, in my view, to understand what happens to NCM when it is taught, practiced, and consumed. It is within the negotiated order of such interactions that the domesticated nature of NCM reveals itself.

### Approaches in the History of NCM Research

The history of NCM research can be subsumed under four approaches: tradition versus modernity; limited dissatisfaction with conventional medicine; general dissatisfaction with science and technology; and medical pluralism. I present these approaches in the order of their development and then compare the most recent approach, medical pluralism, to the domestication approach offered in this study.

#### *Modernity versus Tradition*

The first and earliest approach in the study of NCM rested on a dichotomy between traditionalism and modernity. For example, studies

conducted in developing societies often labored under the belief in the dominance of Western biomedicine. In these studies, the relationship between indigenous forms of healing and Western biomedicine was viewed on a continuum of modernization on which indigenous, traditional medicine occupied the nonmodern pole, and Western biomedicine the modern pole. This approach predicted that a gradual process of modernization would eventually bring about the abandonment of traditional, nonscientific medical practices. The modern-traditional dichotomy can be traced back to classical sociological thought, first and foremost to the modernization perspective. The modernization thesis argued that non-Western “developing” countries are “modernized” by emulating the capitalist structure of Western democracy with its educational, technological, political, and medical systems (Parsons, 1966). This perspective rejected the viability of NCM and saw its retention by traditional groups as a temporary situation.

In this vein, for example, Finkler (1981) suggested that measures of an individual’s modernity such as level of education or type of employment could be used to predict the likelihood of resorting to biomedicine or traditional healers. Reciprocity between the two systems at the organizational level was not considered a viable proposition. Haram’s (1991) study of traditional Tswana medicine described how doctors at the government biomedical clinic expected traditional healers to refer patients to them, but would not, of course, consider returning the courtesy.

When the phenomenon of NCM was examined in the urban context of developed Western societies, the dichotomous principle persisted and the tendency was to transfer the modernization perspective, which had been employed in the study of traditional societies, to the modern milieu. The reason for this might be that homogeneous ethnic groups served as the targets of these studies. For example, Farge (1977) treated the use of traditional health systems by Mexicans as an indicator of low acculturation into the mainstream of modern American society, while Miller (1990) discussed the weakening of traditional health beliefs in non-Western medicine as a function of acculturation to the host society. Because a synthesis between tradition and modernity was ideologically rejected, dual system use, if and when it existed, was considered a transitional practice abandoned once acculturation had been achieved. This approach was aptly summarized by New (1977): “For the stereotyped, middle-class housewife, going

to a physician is perfectly respectable, but going to a *curandero* [traditional healer] would not be. If she took prescription drugs, this would be fine, but if certain herbal teas were found in the kitchen cabinet, she may have to explain and rationalize.”

In Israel, studies conducted on the health beliefs of homogeneous populations that had emigrated from North African or Middle Eastern countries and could be characterized by low socioeconomic status, extended families, and adherence to traditional beliefs, tended to adopt the view that these practices were transient. Nudelman (1993), for example, described the traditional healing methods of Ethiopian Jews, while Bilu, in a series of studies (1979; 1980; 1990), compared traditional healing among North African Jews and modern psychological treatment. Utilization of traditional healers was described in these cases as a pattern of behavior that had been prevalent in the country of origin and, as such, was carried over to modern Israel together with other customs that were labeled “traditional.” Although these studies are interesting, their specific demographic focus prevents the findings from being of relevance to the explanation of health-seeking practices of a more heterogeneous, less traditional population. The study of health practices of more heterogeneous groups brought about a change in the conceptualization described by the modernization approach that reviews the recourse to NCM as a transitional phase in a process of acculturation, the culmination of which will be ascription to one extreme of the modern-traditional sequence.

However, once studies conducted on heterogeneous population groups produced demographic data that indicated that consumers of NCM came from all sectors of society, dual use of different medical systems was no longer viewed as a transient element, nor as a measure of an individual’s modernity. The new approach explained recourse to NCM as a measure of an individual’s satisfaction with the outcome of treatment received in the framework of conventional medicine. Dissatisfaction with conventional medicine could be limited to a specific form of treatment or medical problem, or could be directed toward the entire system of modern biomedicine. While limited dissatisfaction with conventional medicine labored under the assumption of the hegemony of biomedicine, this tenet was not necessarily embraced by the general dissatisfaction approach. Both approaches, however, believed in a dichotomous divide between the various modalities of NCM and biomedicine.

*The “Second Resort” Approach—Limited Dissatisfaction*

The realization that explanatory models could not be transferred from low development societies or culturally homogeneous groups within high development societies to the more heterogeneous fabric of modern, Western society led to a different sort of conceptualization. I call this approach the “second resort” approach. Like the “modernization approach,” the second resort approach also assumed the hegemonic status of Western, scientific medicine. Departing from the confines of biomedicine was viewed as feasible only after a particular health problem had not been solved. The recourse to an “irrational” option such as NCM could then be constructed, in effect, as rational behavior.

A study conducted by Ronen (1988) in Israel showed that the use of NCM in Israel was not limited to a subgroup characterized by a specific ethnic background, low income, or low level of education. At the outset, Ronen indeed labored under the assumption that

In relation to people who utilize this type of treatment [NCM], general opinion is that, on the whole, they are ‘simple,’ uneducated, mostly from lower classes of society, not over-discerning, and prepared to adopt various beliefs without adequate scientific foundation making it easy to persuade them to try such kinds of treatment (1998: 17).

At the conclusion of his study, however, Ronen was forced to express “surprise” that consumers of NCM came from all levels of income and education. His conclusion was that recourse to NCM should be viewed as a “functional alternative” to conventional medicine—functional in the sense that it is limited to the attempt to solve a specific medical problem and does not reflect a comprehensive ideology, outlook, or lifestyle.

This position was also evident in studies in the same period by Kronenfeld and Wasner (1982), Gray (1985), and Goldstein (1988). These studies were conducted among patients suffering from chronic diseases such as rheumatoid arthritis or asthma and findings generally indicated that patients usually first sought help from an MD. However, when the problem was not solved by conventional medicine because the disease was chronic or recurrent, patients found it legitimate to turn to NCM. In an early work, Sharma (1992), too, did not view the increased resort to NCM as evidence of an important cultural shift in thinking

about health, the person, or the body. She claimed that users of NCM were impelled by a pragmatic concern to get relief from a disease.

*General Dissatisfaction—New Age Challenges to Biomedical Hegemony*

An additional group of studies conducted on the use of NCM in the modern context suggested that the growing popularity of NCM in healing, as well as health maintenance, reflected a more generalized dissatisfaction with conventional medicine. This general dissatisfaction or disenchantment has been labeled “postmodern” by some commentators (Lyotard, 1987). From this perspective, the clients of NCM could be characterized as not being in the process of modernization, but in the process of rejecting modernity. For example, in a study conducted by Cant and Calnan (1991), one nonconventional practitioner is quoted as saying that for 20% of her patients she served as a first resort for primary care since they had adopted a “natural lifestyle.” This approach can be seen to have replaced the “modern versus traditional” dichotomy with that of “West versus East” or “familiar versus exotic.” Furthermore, placing NCM as part of a more general, postmodern “counterculture” implied a process of demedicalization driven by a consumerist quest for alternative treatments and individual philosophies of health maintenance.

Whereas the limited dissatisfaction approach viewed NCM as “second resort,” the general dissatisfaction approach viewed NCM as “counterculture.” NCM use was equated with ideological concern for ecology (Bakx, 1991), preoccupation with the body (Glassner, 1989), and fascination with the cultural “other” and the supernatural. Once more a dichotomy is implied between established and dissident cultural forms. Lupton (1994), for example, saw NCM as offering a “solution to the growing domination of high technology with all its impersonality” because “most alternative therapies eschew the use of high technology and lab reports in diagnosing and treating illness and disease.”

Mary Douglas (1994) has proven a noteworthy proponent of the view that recourse to NCM should be seen as part of a countercultural movement. According to Douglas, NCM is “alternative in the full countercultural sense, ‘spiritual’ in contrast to ‘material,’ ” and provides a “cultural alternative to western philosophic traditions.” Douglas explained that

When the same population is divided in its adherence to one or the other world view, cultural conflict is present. As the people hear the themes of the conflict, competition between cultural principles spreads; soon no one will be able to stay neutral as to meat eating, or religion, or concern for the environment. Even medicine may be a ground for testing allegiance (1994: 25).

Douglas contends that “it is important to appreciate that a person cannot, for long, belong to two cultures at once” and assumes the existence of a coherent cultural type, arguing that “we would expect people who show a strong preference for holistic medicine to be negative to the kind of culture in which the other kind of medicine belongs. If they have made the choice for gentler, more spiritual medicine, they will be making the same choice in other contexts, dietary, ecological, as well as medical. The choice of holistic medicine will not be an isolated preference, uncoordinated with other values upheld by the patient” (p. 32). Douglas therefore extends the scope of dichotomies, suggesting that not only must behavior in the medical sphere entail choice, but that this choice will automatically lead to more inclusive and extensive dichotomies.

### *Medical Pluralism*

Many recent studies on recourse to NCM have shown that patients tend to adopt a pluralistic approach to health care and move with facility from conventional medicine to nonconventional medicine and also from one nonconventional modality to another, according to necessity. Seen in the framework of medical pluralism, health-seeking consumerist activity is no longer regarded as “dissatisfaction with conventional medicine” (second approach) or as “cultural rebellion” (third approach). According to the approach called medical pluralism, people seek nonconventional health treatments to maximize their prospects for quality of life. They are ‘smart consumers’ who make full use of the range of health therapies available in the market. This approach argues that the majority of health consumers use both conventional medicine and NCM concomitantly. Several studies conducted in different parts of the world such as Canada, Australia, the United States, and England have provided data that support this claim (Cant and Sharma, 1996;

Kelner and Wellman, 1997; McGregor and Peay, 1996; McGuire, 1988; Sirois and Gick, 2002).

Cant and Sharma's (1999) analysis of "medical pluralism" in the United Kingdom focuses on "pluralistic legitimation" and "therapeutic divergence"—a multiple coexistence of methods (e.g., homeopathy, Chinese medicine, chiropractic, and so on) side by side with biomedicine. In their conclusion, the authors contend that the recognition of certain therapies as 'legitimate' has meant that the state has been increasingly prepared to legislate accreditation; however, "recognition has only been granted where therapy groups have undergone a process of 'convergence' with biomedicine" (Cant and Sharma, 1999: 186). A parallel discussion of the status of a variety of heterodox medical systems in the United States is provided by Baer (2001) who offers an extensive list of the states in which each modality is licensed and suggests that licensing often entails compatibility with the biomedical model of organization (118).

In addition to the approach of medical pluralism, I would like to suggest another perspective to the study of NCM—that of domestication. In this process the philosophical tenets of treatment modalities that differ from the explanatory and diagnostic modes of biomedicine are modified and culturally translated. These modalities are rendered more culturally acceptable and less exotic, foreign, and ultimately challenging. The growing popularity of NCM modalities and the facility with which individuals move from biomedicine to nonconventional medicine, illustrated by the approach of "medical pluralism," can most probably be explained by the domestication of these modalities in the image of biomedicine. In this manner culturally foreign treatments seem feasible and make sense to patients from a cultural point of view. McGuire (1988), for example, has shown how modalities such as shiatsu, chiropractic, acupuncture, and reflexology have lost much of their ritualistic tenor, becoming more of a technique. McGuire argues that in this case the technique itself, and not the beliefs supporting it, seems to be the key attraction for most adherents. Barnes (1998) and Hare (1993) have also explored processes by which Chinese medicine delivered in the United States has been tailored to American needs and expectations.

Although the high incidence of nonconventional therapies and techniques could create the impression of medical pluralism, NCM has not gained equal status to biomedicine, in Israel and elsewhere, as the term "medical pluralism" would imply. Rather, its successful incorporation

into the therapeutic repertoire of developed countries has proved to depend, in principle, on biomedical approval and the imitation of biomedical symbols, terminology, and professional practice. The medical pluralism approach does not dwell much on the role of cultural commitment in the choice of health care, putting down these choices to pragmatic consumerism. My claim is that medicine must make sense to patients, and this feat requires cultural domestication. The counterculture approach, which does emphasize the cultural dimension of NCM, cannot explain the facility with which patients move between NCM and biomedicine as it presumes deep commitment to a specific worldview. On the other hand, the approach of medical pluralism ignores the issue of cultural acceptability. The question to be answered is how patients move among the various modalities, make sense of them at least in a perfunctory, superficial manner, and find them culturally acceptable?

#### Domestication: Making Sense of Medicine

In a discussion of the fit between cultural context and medical treatment, McQueen (1985) contends that the interest in Chinese systems of medicine waned in the United States after its popularity peaked in the 1970s. The reason for this decline in popularity was due, according to McQueen, to the ultimate unacceptability of the Chinese model in Western society. The author explained that culture, like a biological species, adapts to a particular niche in the ecology and is rarely, if ever, directly transplantable from one society or ecological environment to another. In the long run, however, McQueen's conclusions proved to be mistaken. In 1993, Eisenberg et al. published a widely quoted study in *The New England Journal of Medicine*, presenting figures that indicated that not only was the utilization of Chinese medicine widespread in the United States (among other forms of NCM), but that it was also a lucrative business.

The contemporary consumption of NCM points to a flaw in McQueen's discussion of NCM as an idea without context and therefore a misfit in American society. Something must have happened in the interim to explain the fallacy of McQueen's interpretation. If Chinese medicine continued to gain popularity, then ideas planted in unfamiliar niches could, in fact, flourish. This leads to two alternative explanations. First, the unfamiliarity of NCM could have become a source of attraction. This explanation continues the reasoning of "difference" that has been developed by the general dissatisfaction/counterculture



view. Second, NCM may have been contextualized and better adapted to its new niche. This explanation points toward acculturation and domestication, the focus of this study.

Discussing the consumption of a domesticated form of Chinese medicine in Western society, Unschuld (1987) explains the popularity of Chinese medicine in the West through the parameter of 'inauthenticity.' He claims that

Throughout the USA and Europe *so-called* Chinese medicine is practiced and finds a clientele of patients. Mostly, though, this 'Chinese medicine' is limited to acupuncture and to certain notions of health, illness and therapeutic intervention that often enough appear to mirror western ideas of what 'alternative' medicine should be like, rather than original Chinese thought.

Unschuld suggests that in the search for an Asian alternative, the basic values of Western civilization were applied to select from a heterogeneous bundle of concepts and practices those that appeared plausible to a Western audience. Unschuld discussed, for example, the culturally biased translation of a Chinese concept (*qi*) as "energy." According to him, the more exact term would be closer to the word "vapor," something like light tiny drops of matter, which has evaporated.

Unschuld's observations are supported by other studies. Barnes (1998), in a study of the indigenizing of Chinese healing practices in the American context, claims that the language of "energy blockages" used in American Chinese healing imitates popular American psychology that describes an individual as "blocked" or "stuck." This reflects domestication to American norms since it caters to the American need to externalize, discuss, and explain emotions, practices that would be considered deviant in a Chinese context. In order to find "authentic" Chinese treatments for psychological problems, American acupuncturists are going back to ancient Chinese texts and retrieving portions that had been deleted by the Chinese authorities in the "cultural revolution" because they were considered magic and religious and therefore "unscientific." According to Barnes (1998), this represents the cultural reinterpretation of "Chinese medicine" in American eyes. In her apt words, "What looks back at us remains Chinese medicine, but now wears a distinctly American face" (Barnes, 1998: 438).

Observing a consultation between a practitioner of traditional Chinese medicine and a Chinese patient in Taiwan, Kleinman (1980) describes an

encounter that lasted for less than two minutes. The practitioner registered the patient's chief complaint, took his pulse (a form of diagnosis in ancient Chinese medicine), and wrote a prescription. This technical transaction was a far cry from the holistic and philosophical style in which "traditional Chinese medicine" is represented in the West. It appears that, in its original location, traditional Chinese medicine can be overtly technical because there is no need to philosophize with patients about "energy." The philosophy is already taken for granted, and part of the common cultural heritage of physicians and patients. Kleinman's observations are especially pertinent when examined along with the following observation made by a Chinese practitioner working with an American clientele:

The whole relationship with patients is different. Here the patients seem to want to know more about what you are going to do, the components of the herbs and their side effects. In China people don't ask because they already know. It is part of their background even if it is the first time they are going to see a practitioner. Also Chinese people are not tending to ask questions. They don't ask why (Barnes, 1998: 420).

Studies such as these conducted by Unschuld, Barnes, and Kleinman show that Chinese medicine practiced in the West is selective and mirrors Western ideas of plausibility, and that the West constructs images of Oriental medicine. This brings to mind the work of Edward Said (1978) on Orientalism. We are standing at an important junction where positivistic claims regarding the "authentic" are replaced by postpositivist, interpretive arguments concerning mirroring and representation.

This fusion of the foreign and the familiar to produce a locally acceptable hybrid is a process that has also been observed when the center impinges on the periphery as in the case of Western, biomedicine becoming part of low development countries. For example, studies conducted in low development societies have shown how antibiotics have been used according to the color of the capsule in order to incorporate them into the categorization of diseases as hot or cold (Bledsoe and Goubaud, 1985). Another study involving African chemists in South Africa has shown how traditional herbs were packaged to resemble biomedical OTC pharmaceuticals but retained their culturally relevant African brand names and motifs (Cocks and Dold, 2000). This is the same process that occurs when nonscientific modalities, those called

alternative or complementary therapies, are introduced into high development, industrialized societies when the more esoteric parts of these modalities are played down in order to gain acceptance (Baer, 1998; 2001; Dew, 2000). According to Hare (1993: 38), “one of the most striking aspects of the incorporation of the Chinese medical systems into western health care is the degree to which there is a mixing of classical Chinese, other scholarly or professional east Asian, and modern Chinese medical thought, with a variety of folk paradigms from east Asia, and the many ethnic streams of the western locale in which the new ‘Oriental’ medicine is now being practiced.” All these examples entail a process of “making sense of medicine,” which is effected through the creation of local hybrid forms. This is the domestication that, I argue, serves as a prerequisite to practices of pluralistic consumption.

#### Acculturation and Assimilation

In order to understand the various stages and processes inherent in the interface between conventional biomedicine and nonconventional medicine, I will suggest a schematic model that organizes these processes on two dimensions: assimilation and acculturation.

This model was originally proposed by Hood and Koberg (1994) to describe the adaptation of nondominant minority groups to dominant majority groups in organizations. Indeed, contact between cultures has often been studied through the dimensions of acculturation and assimilation. McElroy and Townsend (1989: 297), for example, define acculturation as “continuous contact between two previously autonomous cultural traditions, usually leading to extensive changes in one or both systems.” Assimilation, on the other hand, occurs when the minority group becomes a normative component of the dominant society. Assimilation is not merely a consummation of acculturation, but an independent axis. The typology of assimilation and acculturation can thus provide a framework for organizing previous NCM research. Furthermore, the changes that NCM has undergone in the course of its integration can be conceived as a specific path of movement from one category to another within the matrix of the model. This complements my claim that domestication is a dynamic process.

NCM’s introduction into Western countries is comparable with the absorption of immigrants into a different society or country, a process variously described by anthropologists and sociologists in crosscultural research as adaptation, acculturation, or assimilation (Berry, 1990; Berry,

Kim, and Boski, 1988; McElroy and Townsend, 1989). In a similar manner, NCM is a “stranger” in the Western world of biomedicine, caught on the margin between two cultures—its original ideology and the host culture of biomedicine. Such marginality can be resolved through acculturation and assimilation.

The proposed model suggests a fourfold categorization of the statuses and roles of the “newcomer” minority group according to differing levels of acculturation and assimilation. Figure 1 illustrates the contact between the dominant (biomedical) culture and the adapting group (NCM). In studies of cultural contact it is customary to assess the difference between the two cultures by examining behaviors and belief systems in their traditional, pre-contact form, and then comparing them to the post-contact situation. The cultural features of the group, once adapted, may not be the same as those of the original group on first contact. With continued contact the groups and the individuals within them continue to change. In the case of NCM, we are interested not only in the post-contact form but also the original form. As a result of acculturation or assimilation, NCM can change its original form, becoming integrated, domesticated, or differentiated in the process.

Acculturation changes the nondominant group’s cultural patterns and behaviors to those of a dominant group or society; it requires the nondominant group to “take on” and learn the culture of the dominant group. Assimilation, by contrast, is the acceptance of a nondominant group (or individual members of it) by mainstream society. In the case of NCM, the major factor behind assimilation is public demand. Established biomedicine cannot, in principle, accept or assimilate NCM, which it regards as nonscientific and hence ex-paradigmatic. The ac-

|                     |             | <b>Acculturation</b>  |                 |
|---------------------|-------------|-----------------------|-----------------|
|                     |             | <i>High</i>           | <i>Low</i>      |
| <b>Assimilation</b> | <i>High</i> | Domestication         | Differentiation |
|                     | <i>Low</i>  | Selective integration | Rejection       |

**Figure 1.** Patterns of assimilation and acculturation.

ceptance of NCM practitioners into professional organizations, hospital clinics, medical school programs, and other institutions of mainstream society depends on the good will of biomedicine and usually occurs in response to public demand. Since NCM addresses the public independently through the media, forces of consumption may well generate a demand for NCM even under the gaze of biomedicine. I will deal with biomedical influence on the acculturation of NCM in the chapter on the complementary clinic, where NCM practitioners are partially and conditionally assimilated by working under the supervision of physicians. The public factor behind assimilation will be analyzed in the chapter on patients and their attitudes, as well as in the chapter on NCM in the media. My overall findings suggest that biomedical supervision and public demand have become entangled in NCM. For example, whereas NCM colleges and clinics might have been established in response to public demand, biomedicine retained its influence in these institutions.

In many cases, some degree of acculturation is necessary for assimilation to occur, although the opposite may also exist—for example, in the case of a counterculture, when a social group embraces an antiestablishment or alternative behavior. In such a case, the minority culture gains public popularity (assimilation) without altering its original form in order to be more like the host culture (acculturation). Some degree of assimilation can facilitate acculturation, since certain behaviors and values involving power and negotiation are often deliberately hidden from those outside the powerful group. As processes, acculturation and assimilation constitute an interactive system. In this capacity it is important to recognize the relative power of different sectors of the public and their potential influence on the medical establishment. For example, it might be relatively easy for the medical establishment to marginalize the practices of weaker, less influential groups in society, such as immigrants or migrant workers. However, the involvement of established, middle-class individuals in the practice and consumption of NCM and their demand for such services might be more difficult to ignore. It is also important to point out that the medical establishment should not be perceived as a heterogeneous group concerning its stand on NCM. While there are indeed MDs who practice NCM and GPs who refer patients to NCM practitioners (Perkin et al., 1994; White et al., 1997), many senior members of the medical profession who serve on political and professional committees often marginalize and reject NCM altogether.

Both acculturation and assimilation may be measured on continua, but for purposes of conceptual presentation, the two dimensions can be treated as falling into two categories—high and low. The result is a fourfold classification in which each cell represents a different pattern of adaptation: *domestication*, *selective integration*, *differentiation*, and *rejection* (see Fig. 1). These four patterns evidently represent ideal types. The course of development of NCM and the relevant approaches to its study can now be described in the following manner, using the concepts that appear in Figure 1.

The first encounter, more than thirty years ago, between biomedicine and NCM began in the lower right cell, where the low assimilation and low acculturation of NCM resulted in its *rejection*. This encounter took place when ethnic groups, usually immigrants, continued to practice their traditional medicine even though they were living in a modern, industrial context in which biomedicine was hegemonic. This situation represented the rejection of NCM (conceived as traditional) by biomedicine (conceived as modern). The first approach to the study of NCM, which regards the relationship between NCM and biomedicine within the dichotomy of tradition versus modernity, belongs to the category of rejection.

Public demand (responsible for growing assimilation) and biomedical hegemony (responsible for growing acculturation) were the major factors that drove NCM out of ‘rejection’ and into the nearby cells of ‘differentiation’ and ‘selective integration.’ The second approach to the study of NCM emphasized it as a ‘second resort’ owing to patients’ dissatisfaction with the results of conventional medical treatments. This approach leads to *selective integration*. According to this approach, NCM attracts pragmatic people who seek treatment for a specific condition that was not treated successfully by conventional medicine. From a diachronic point of view, the low assimilation of NCM in this approach can be explained by its adoption by specific and select segments of the population and the medical profession. This can be illustrated, for example, when an MD uses an NCM modality that has not gained public popularity. The option of domestication, which is characterized not only by high acculturation, as in the case of selective integration, but also by high assimilation, occurred much later when NCM became increasingly popular with large sectors of the public. In this capacity it was perceived as one more option on the health market as outlined in the fourth approach, that of pluralism.

The third approach regards NCM as a cultural alternative, and those who seek it as cultural rebels. This approach represents low acculturation, since NCM does not attempt to mold itself into biomedical patterns. A rising public demand for such NCM treatments represents high assimilation. This combination of low acculturation and high assimilation brings NCM into a state of *differentiation*. The differentiated NCM is not domesticated. On the contrary, its *raison d'être* is an emphasis on the essential and critical difference from conventional medicine. NCM methods such as crystals or Reiki can thus be popular and still maintain esoteric philosophical characteristics.

The fourth approach, medical pluralism, developed as both the acculturation and assimilation of NCM were on the rise. This approach regards NCM patients as smart consumers seeking to maximize their options in the health market. This approach is relevant to *domestication*. It is yet to be seen whether NCM will be taking any one prominent direction in the future, and which direction it will be.

#### Domestication and the Flow of Culture

I argue that the key to understanding the success of NCM can be found in the ways in which it has been domesticated or hybridized (Baer, 2001; Hannerz, 1992, 1996). In a parallel manner to Tobin's definition of domestication (1992: 4), the changes of NCM should be understood as "a process that is active (unlike westernization, modernization, or postmodernism), morally neutral (unlike imitation or parasitism), and demystifying (there is nothing inherently strange, exotic, or unique going on around here)."

A question often raised in regard to domestication is whether the process in which the exotic is rendered familiar actually results in the "other," forgoing its claim to uniqueness. Bauman (1992a) suggested that the extensive fragmentation of modern culture might indicate the absence of a fixed point of reference from which "self" and "other" can be defined. The nonexistence of a recognized mainstream would therefore preclude the existence of an alternative. Turner (1994) has pointed out that a new level of multiculturalism has emerged from globalization that posed a challenge to many of the traditional dominant cultures of nation-states. Said (1993: 15) illustrated the same point by asking: "Who in India or Algeria today can confidently separate out the British or

French component of the past from present actualities, and who in Britain or France can draw a clear circle around British London or French Paris that would exclude the impact of India or Algeria upon these two imperial cities?" The notion that "otherness has been domesticated" (Turner, 1994: 183) could in fact lead to a general sense of fitting in. However, the postmodern predicament of domestication seems to have propagated a sense of alienation and loneliness. The predominant sentiment is that of being a "stranger at home," rather than the sense of belonging to a community and developing communal bonds. In the absence of a center, the individual is forced into continual reflexivity and questioning of authenticity.

This sense of being a stranger at home has triggered a nostalgic quest for community and for "things as they used to be." I suggest that the growing popularity of NCM, in its domesticated forms, is part of this quest. NCM treatments are conceived by many as a personalized and intimate alternative in contrast to the alienating, technological anonymity of biomedical health care. Moreover, the body has become a primary locus of individual control and self-realization, providing a metaphoric dwelling for the "homeless mind" of the postmodern tourist. Much sociological discussion has recently explored the central place that trends such as body building, exercise, cosmetic surgery, and other practices of tending the body have come to occupy in our lives. We have indeed become "pilgrims of the body." Hannerz (1996: 27), for example, remarked that "If there is now a growing celebration in social and cultural theory of the body as a symbolic site of self and continuity, and of the senses, a greater concern with the body and the senses in their contexts might help us understand what 'place' is about." Similarly, Turner (1994: 190) argued that "in contemporary society the body has become a site of regulative beliefs and practices which help to constitute the body as a project." In Shilling's (1993) view, the unfinished project of the self has become converted into the (equally endless) project of the body. All this has meant good business for NCM treatments and practices, which are popularly represented as naturalistic and holistic. One of the goals of the following ethnography is to describe the practice of NCM as one more project of the body within postmodern consumer culture. In its public discourse, NCM portrays the body as a potential site of individual empowerment and purification, at the same time subjecting it to further regulation and control in a manner that reproduces and extends the medical gaze. The imagery and regulation of the body disseminated by NCM are therefore also pertinent to the study of its domestication.