Marketing

THE POWER OF THE FART: MEDICALIZATION, NORMATIVITY, AND CONSUMING BODY-SUBJECTS

Jack S. Tillotson

Aalto University

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Abstract

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Abstract

The purpose of this study is to understand the embodied experience of lactose intolerance. More specifically, how consumers cope with the abnormal functioning of the body, intermittent and involuntary episodes of bodily discharges (farts, belches, loose stools) and associated distress, along with the subsequent discourses of health it implies. Most extant research focusing on why health-conscious consumers turn to self-care is of limited value to understanding embodied experience because it isolates the body as the object from its subject, the mind, the 'conscious' consumer. Somewhat more relevant to my bodily-level focus are studies on consumer health that address the power dynamics of medical intervention. These accounts render consumer bodies as objects of discursive inscription, taking little account of the body as a physical subject, a medium that is oriented to the world outside itself in constant engagement so as to maintain order and normativity in life.

I argue that impaired bodily experiences reach intelligibility through discursive activity that I refer to as *normalization work*, that is, self-disciplinary talk mediated by the body-subject. Normalization work offers an alternative approach and analysis of consumer talk that is oriented by embodied concerns and responsive to situated normativity. I understand talk as discursive activity that shows language in use, an embodied action, that is reflective of how the authoring body-subject finds herself in the world. My approach builds towards a *theorization of embodied consumer talk* conceptualized as an experience-near realm of possibilities and constraints on discursive action mediated by the orienting forces of bodily experience. The significance of such an approach sits in recognizing bodily subjectivity, the fundamental ground of human experience, from the outset and avoids distancing the body from abstract discursive (or cultural) systems.

I find that coping with an illness does not unfold only at the bodily level (i.e., the object level). Though at first glance, it is the body that is disrupted by lactose intolerance, it gains its fullest meaning when related to broader contexts of significance whether that be social situations, healthcare settings, marketplace interactions, or even self-understandings. That is to say, it is not so much the bouts of bloating, diarrhea, flatulence, and discomfort that become the object which consumers cope with but rather the immediate practical and material situation to which the impaired body belongs.

Keywords Embodiment, Medicalization, Normalization, Food Consumption, Functional Foods

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It was four years into my doctoral work, and my second child, Sylvia, had just been born. My wife, Heidi, and I had just purchased an apartment in Helsinki. A week later, I landed a job over the Baltic and the North Sea as a lecturer of marketing at Liverpool John Moores University in the United Kingdom. It was then that I decided to abandon my original dissertation topic to pursue my research interest fully.

Throughout the many challenges faced in writing of this manuscript, I have received a great deal of support and assistance from many people. None more so than from my supervisor, Dr. Sammy Toyoki, who commented tirelessly on early as well as advanced drafts and whose expertise was invaluable. I can not imagine having a better advisor and mentor.

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Helsinki, 8 May 2019
Jack Sheldon Tillotson

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This work is dedicated to my wife who always reminds me to follow the feeling in my gut.

1. INTRODUCTION

With growing intensity, people are compelled to worry about the food they consume. In many ways, food no longer connotes sustenance and pleasure nor lubricates social bonding and good conversation. Instead, food often signifies fear and aversion as ideological concerns over health accumulate on our dining tables alongside food-related allergies and dietary challenges. People talk of food in medically loaded terms. It makes them sick, ill, fat, at-risk, in-danger, allergic, skinny, or conversely strong and healthy.

In this doctoral dissertation, I explore the medicalization of food. Funded by Valio, the largest dairy producer in Finland, and inspired by their leadership in functional foods, that is, technologically innovative food that offers health benefits in relation to specific disease prevention, I focus on consumers' health conditions related to diet. Drawing on over 50 interviews with consumers of functional foods targeting lactose intolerance, I develop an understanding of how consumers cope with food-related illness.

As the direct result of dairy consumption, participants describe suffering bouts of "bloating," "diarrhea," "flatulence," and associated discomfort. These insistent and aversive episodes occur unexpectedly and often compromise social interactions. Unfortunately, the treatment of lactose intolerance is contested. A woman in this study highlights that doctors consider lactose intolerance a minor problem, something that does not warrant significant attention because it is not dangerous or life-threatening. Struggling to avoid consuming milk products in a national culinary setting that frames Finland as the cornucopia of dairy, consumers find themselves feeling personally vulnerable and socially estranged.

Against the backdrop of an erupting body, awkward social situations, the struggle for medical and nutritional advice, and entrenched socio-cultural dairy consumption practices, how do consumers cope? One way is to ascribe normativity to food-related illness as revealed in participants talk about lactose intolerance as the national disease of Finland. Questioning entrenched dietary practices becomes acceptable in a Nordic cultural context that espouses equality, communal responsibility, and health as civic right and responsibility. To that end, lactose intolerance and associated self-regulatory practices become normal.

To introduce this study over the coming chapter, I will first outline what this research concerns. Next, I will acquaint the reader with how I have come to pursue this topic of study. Following a summarization of how I have gone about exploring the topic, I will outline the key components of what I found.

1.1 What is this Research About?

Bouts of bloating, diarrhea, flatulence, and discomfort are the direct result of food consumption for lactose intolerant consumers. In medico-biological terms, lactose intolerance is a disease that manifests from a missing enzyme (lactase) in the small intestine that helps break down milk sugar into glucose that the body can digest. In this research, I investigate the embodied experience of lactose intolerance as an illness, the qualitative dimension of disease (Carel 2016). This study explores the extent of consumer subjection to medical language and knowledge in continuing efforts to infuse continuity to their dysfunctional bodies and the broader contexts of significance to which they belong. I suggest that consuming body-subjects cope with the abnormal functioning of the body, intermittent and involuntary episodes of bodily discharges (farts, belches, loose stools) and associated distress, by taking-up, negotiating, and transforming discourses of medicalization—that is, the use of medical language and knowledge to alleviate bodily impairment (Conrad 2007). The body-subject refers to a person as a physical subject that actively orients and re-orients itself in the negotiation of worldly influences, a body that gives meaning to the world and the stories people tell about it (Merleau-Ponty 1962; Widdershoven 1993; Wyllie 2005). Consumers absorbed in practices of medicalization in the marketplace engage in a form of identity work (Sveningsson and Alvesson 2003; Thompson 2004; Watson 2008); that is, activities that involve people maneuvering within pockets of freedom that emerge inside available discourses to reflexively formulate, repair, and revise identities in continuing efforts to maintain coherence and stability in their lives. I argue that bodily experiences reach intelligibility through a discursive activity that I refer to as normalization work, that is, self-disciplinary talk mediated by the body-subject. Other examples of normalization work in medicalization might include various forms talk about plastic surgery where medical intervention allows people to reposition their bodies as 'normal' bodies within society; normalization work could also appear in various forms of pharmaceutical consumption such as Viagra, which attempts to restore sexual performance with their partners to a 'normal' level. The potential

relevance of normalization work, I propose, is in offering an alternative phenomenological description and analysis of consumer talk that is oriented by embodied concerns and responsive to situated normativity.

The question guiding this research is: *how does consuming body-subjects cope with lactose intolerance through talk?* In this study, I understand talk as a discursive activity that shows language in use, an embodied action, that is reflective of how the authoring body-subject finds herself in the world (Foucault 1977; Ratcliffe 2008). The participants of this study talk of themselves as normatively situated and experiencing bodies (Csordas 1990; Foucault 1977; Leder 1990), affected by and attuned to the circumstances and possibilities they perceive their illness implies (Dreyfus 1991; Heidegger 1970). To the extent that bodily experience of illness produces a disequilibrium with normative expectations, consumers become receptive to what matters and make sense to do and say given the circumstance. For instance, consumers may experience bodily dysfunction like excessive flatulence as scary in formal social environments (where rule-breaking is dangerous) or comical in casual social environments (for example, amongst friends). Bodily experience affects the authoring body-subject by mediating one's sense of lived directedness and resonance with broader social contexts (Dreyfus 1991; Fuchs 2005; Merleau-Ponty 1962). In turn, this embodied situatedness is at once a readiness to act, an attunement to possibilities for meaningful action (Dreyfus and Dreyfus 2000; Merlau-Ponty 1962; Rietveld and Kiverstein 2014). By attending to the inextricable body-world relation of affectedness and attunement (Heidegger 1927, 1970), I propose to discern how lactose intolerant consumer bodies are subject to 'normative pull' (Rietveld 2008) by their situated affordances, as they seek 'maximum grip' over conditions of bodily dysfunction. As an account of skillful response, maximum grip refers to the tendency in practices (discursive or otherwise) to reduce a sense of disequilibrium, and conversely to produce and maintain flexible order and normativity in one's life (Merleau-Ponty 1962).

This study intends to understand how the experiencing body-subject, in their draw towards normativity (Merleau-Ponty 1962), makes possible and perpetuates medicalization. We know that medicalization is a type of discourse about health that is suffused with relations of power (Foucault 2006). Most extant research that sheds light on why health-conscious consumers turn to self-care (Fischer, Otnes, and Tuncay 2007; Giesler and Veresiu 2014; Kristensen, Boye, and Askegaard 2011; Moisio and Beruchashvili 2009; Thompson 2004, 2005; Thompson and Troester 2002) is of limited value to understanding the experiencing body-subject because it isolates the body as the object from its subject, the mind, the 'conscious' consumer (see also Gould 1991). Somewhat more relevant to my body-level focus are certain studies on medicalization that address clinical intervention in the marketplace (Askegaard, Gertsen, and Langer 2002; Cronin, McCarthy, and Delaney 2015; Schouten 1991; Giesler 2012; Tian et al. 2014). Such accounts have been used to investigate the objective body, in its materiality, to explain how consumer bodies are culturally constituted by

disciplinary regimes (see also Thompson and Hirschman 1995). Consumers' concern over health is triggered by somatically oriented anxieties (Cronin and Hopkinson 2018). The body becomes the definitive object of consumers lives, an "Archimedean point" (Cederström and Spicer 2015, p. 6), from which the surrounding world is perceived as either a threat or a remedy. The body becomes inscribed by discursive representations of what it means to be healthy and imbued with socially constructed meanings. In this way, menstruation, a routine experience for women, becomes medicalized and is deemed to require intervention in the form of hormone therapy or even surgery (Howson 2013). Media representations of the pregnant body shape women's experiences of pregnancy and produce conformity to ideal pregnant body types (O'Malley 2006), health risks of childbirth are culturally constructed through expert systems (Thompson 2005), and the points of contact between medical institutions and consumer culture can be disciplining (O' Malley and Patterson 2013) as well as liberating (Thompson 2004). These accounts, however, cannot explain the affective allure that plays an essential role in the way consuming body-subjects are responsive to norms. Nor do they shed light on the ways consuming body-subjects are attuned to normative possibilities of action within their familiar practices. Moreover, these accounts rest upon identifying the social and cultural variability of the body and the power dynamics involved in subjecting the body to such discursive forces. The consumer body is rendered a passive recipient of discursive inscription from without, taking little account of the lived, body-subject as a mode of being-in-the-world, a medium that is oriented to the world outside itself in constant engagement. This is noteworthy in part because researchers cast considerably less attention to the tendency of power to regulate familiar ways of being-in-the-world than to deviations from this order, struggles over control, or resistance to conformity. To add a new texture to this stream of work, I suggest that consumer research needs knowledge of how affective bodies solicit responses to overcome immediate impediments, where embodied know-how and skill in language use are attuned to a normalizing movement of familiarity and maximum grip.

I have conducted my fieldwork in the societal setting of Finland. First and foremost in the choice of context, Finns consume more dairy per person than anywhere else in the world (Astley 2014), making instances of lactose intolerance more pronounced and symptoms more prevalent. This unique societal setting illustrates greater nuance and variation within the phenomenon under question than might be found in a population with a low-level of dairy consumption and lactose intolerance (Arnould, Price, and Moisio 2006). Second but no less crucial, the Finnish welfare state, among other things, promotes egalitarian worldviews, equal citizenship, and universal health care (Byrkjeflot 2003; Østergaard et al. 2014). The underlying processes of consensus making, acceptance of difference, and shared social understandings constitute "a context of conformity" where power is "systematically legitimized" to produce and maintain order and normativity (Courpasson 2000, p. 157). Sampling consumers who use functional foods linked to lactose intolerance further refines the

research boundaries. Functional foods are scientifically modified to produce health benefits often based on medical claims associated with food-related disease (Östberg 2003) and, as such, are a concrete materialization of medicalization.

This study foregrounds the authoring of normative order through the consuming body-subject's talk. The authoring body-subject is compelled to purposively make sense of her impaired body when the intersubjective situation requires it. The bodily experience of illness and bodily impairment like lactose intolerance is a natural and cultural phenomenon that is largely not of one's own making, suffused in relations of power, the fuller meaning of which can be grasped through the embodied subject's talk. While much consumer research prioritizes the consumer subject's actions to grasp meanings of bodily experiences (Epp and Price 2009; Canniford and Shankar 2012; Thomas, Price, and Schau 2013; Epp, Schau and Price 2014; Maciel and Wallendorf 2016; Martin and Schouten 2013; Weijo, Martin, and Arnould 2018), they have not fully considered the extent such practices link to power relations (Arnould and Thompson 2015). Consumer research needs, I propose, knowledge of consumer talk as an embodied action (Csordas 1990; Thompson 1998), and I apply a discursive approach to practices because it offers the conceptual tools necessary to understand the dialectic relations of power that occur between structure and agency and our doings and sayings (Foucault 1980). Instead of assuming an external, one-to-one relationship between reality and language, my research adopts the phenomenological premise that embodied experience and the stories we tell share an internal, reciprocal relation (Ricoeur 1980; Widdershoven 1993). Talk is constitutive of experience but also founded upon it. Language, as Heidegger (1962) puts it, is the house of being. Bodily being-in-the-world reaches its fullest meaning in and through language, manifesting purposively through the performance of talk, constituting experience as a text, and disclosing its embodied immediacy (Csordas 1999). Consequently, I focus on long semi-structured interviews with people to evoke the ways that the consuming body-subject copes with lactose intolerance. The study's participants included consumers of all kinds including dairy farmers, nutritionists, businesspeople, shopkeepers, students, insurance agents, nutritionists, and nurses among others that offer the triangulation of viewpoints across the phenomenon of medicalization (Holt 1991). By paying heed to Heidegger's adage that language *discloses* experience, my approach builds towards an embodied theory of consumer talk that moves beyond the "consumer-as-text metaphor" beholden to interpretations of 'the body' as *representations* of experience (Thompson 1998, p. 149; Barnhart and Peñaloza 2013; Giesler 2012; Gould 1991, 1995; Patterson and Schroeder 2010; Thompson and Hirschman 1995; Thompson and Üstuner 2015; Schroeder and Zwick 2004). The relevance of such an approach, I suggest, sits in recognizing bodily subjectivity, the fundamental ground of human experience (Merleau-Ponty 1962), from the outset and avoids the treatment of people and actors within an abstract discursive (or cultural) system as incidental.

In addressing my guiding research question, I propose consuming body-subjects cope with lactose intolerance through what I conceptualize as normalization work. Normalization work refers to that dimension of talk that is affected by how the authoring body-subject finds herself in the world normatively, and in this affectedness, is attuned to talk that purposively makes sense of any disequilibrium with socially constituted norms and assuages perceived conflicts therein. In my findings, I demonstrate how consuming body-subject's talk is affected by a reification of bodily awareness that occurs in the experience of illness. Bodily dysfunction, linked to lactose intolerance, disrupts consumers' familiarity in the world, a disruption that resonates disjointedness with normative order. Here, the mismatch between bodily experience and situated normativity shapes consumers' felt sense of direction and potential for action. The consumer becomes attuned to talk that purposively disciplines discursive practices to get the best grip on the world in which the body-subject is thrown.

My concept of normalization work is a useful means for exploring body-subjects who are, in their thrownness (Thompson, Locander, and Pollio 1989), always already given to situations for which consumer needs are normatively imposed. Needs are imposed through the consuming body-subject's dissonance with intersubjective order, turmoil and conflicted meanings with public health care institutions, and disequilibrium with normative expectations of dairy. Yet, consumers in this study are not passive subjects of marketing activity and institutional control. Marketplace culture is mutually constituting interaction of structures, embodied dispositions and actions (Allen 2002; Giesler 2012; Holt 1998; McAlexander et al. 2014; Scaraboto and Fischer 2013; Thompson 1996). Reciprocal interaction between consumer needs, bodily dysfunction (e.g., symptoms of lactose intolerance), and discursive activity by the consuming body-subject shape the market. Embodied 'know how' (e.g., skills) of social structures produce enduring orientations to action which in turn, are constitutive of normative order that discloses in practical and material terms the market. Markets are the result of participants "practical mastery" of situated normativity (Bourdieu 1984, p. 466). My study elaborates practical mastery in participants attunement to intercorporeal norms, appropriation of medical diagnosis, and harmony with market offerings that serve the disciplinary function of normalizing medicalization. The mechanism (or apparatus) for this situated normativity, as well as practical mastery, is consumer needs. Consumer needs are more than merely a modus operandi of marketing activity (Allen 2002; Belk, Ger, and Askegaard 2003; Baudrillard 1981; Campbell 1987; Sahlins 1996), they are cultural constructions realized through embodied action.

1.2 How Have I Come to Pursue this Topic?

Valio Oy, Finland's largest dairy producer, was an integral component of my project and motivation for my chosen topic for several reasons. First, Valio underwrote my doctoral studies through a generous external business grant. And second, they guided me down the path to analyze consumption of Valio's

functional foods in the Finnish dairy market. I had consistent contact with the company throughout my project, and quarterly presentations on my research findings occurred over four years.

When I began fieldwork, I initially sought data for an empirical investigation of the ways marketplace mythology structures dairy consumption in Finland and shapes consumer relationships with products and brands. Mythology is often understood as a story that allows consumers to overcome oppositions (Holt 2004), and functional foods were useful for this purpose because they harmonize the opposition between food for healthy individuals and food for those who are ill. However, myth is a taken-for-granted phenomenon, and I found existing theory focused too much on the conflict and resolution between opposing cultural forces and ideologies. As such, myth did not explain what was happening with functional food consumption in Finland. During my research, I discovered phenomena about medicalization. I read this literature in constant dialogue with the data. My research topic of medicalization in the marketplace developed out of this dialogue between theory and data (Thompson 1997).

The medicalization of the food industry is not unique to Finland, and functional foods represent a much larger category of phenomena about which we know little. Functional foods are scientifically modified products that provide health benefits beyond their traditional nutrients (Heasman and Mellentin 2001). The major competitors in the functional food market are made up of an interesting mix of both food and pharmaceutical companies. Some of the major players in the global functional foods market include Abbott Laboratories, The Coca-Cola Company, Dean Foods, General Mills Inc., GlaxoSmithKline Company, and Valio Oy. The market for functional foods is huge and growing. Data offered by the Finnish dairy company Valio, suggest that the global functional food market is estimated at between $40 and $50 billion. The market saw a near 30% increase from 2009 to 2013. Coincidentally, 2013 was the year that I started this project. More recently, Nestlé hired a new CEO from the medical and health care industry and invested 500 million dollars in a venture called Nestlé Health Science. This company is designed to produce the government-required scientific data for the functional food marketplace (Geller and Hirschler 2016; Melnick 2010). Food is being called the new Pharma, and Nestlé seems to be repositioning away from the sugary candy bars that consumers know them for in favor of developing medical foods that treat diseases (Heasman and Mellentin 2001; Melnick 2010). Heasman and Mellentin (2001, p. 16) highlight that the "functional foods revolution is truly a global, scientifically grounded, high-technology, but marketing-led vision of future manufactured food supply."

With functional foods, companies have brought a new type of health driven consumer into the market. More consumers are becoming interested in preventative self-medication rather than institutional health strategies (Giesler and Veresiu 2014). These consumers are empowered and nutritionally aware while seeking personal control over their own health and well-being (Cronin,

McCarthy, and Delaney 2015). Kapsak, Rahavi, Childs, and White (2011) produced a study on consumer attitudes towards functional foods in the United States. They find that a majority of consumers believe food and nutrition to be their most important tools for improving or maintaining their health. Heasman and Mellentin (2001, p. 17) argue that "functional foods could be targeted at virtually all diet-related disease and ill health and the diets of healthy individuals." Consumer researchers such as Jacob Östberg (2003, p. 129) document that medical premises dictate the health claims made by functional foods, and consumers see the healthiness of functional foods as inherent in the product rather than an experience grounded in the body.

The body is an element of consumer experience that has not been given much attention. Existing research addresses the body in relation to consumer's extraordinary experience (Arnould and Price 1993; Woermann and Rokka 2015; Scott, Cayla, and Cova 2017). Here, the body is looked at as an object that gets inscribed by the macro-structures of culture and society (Belk 1988; Belk and Costa 1998; Arnould and Price 1993; Celsi, Rose, and Leigh 1993) and others focus on bodily representations or bodily practices (Canniford and Shankar 2012; Woermann and Rokka 2015). In my research, I am not looking to explain the body in relation to culture but rather as the subject of culture (Csordas 2002; Dion, Sitz, and Rémy 2011). Foregrounding the body as a subject of culture, Scott, Cayla, and Cova (2017, p. 1) show how consumers use their bodies to bring the experience of life into "sharp focus" and escape the boredom of contemporary work life or the mundane responsibilities of urban existence. Embodiment operates unconsciously and roots our interactions with the world (Joy and Sherry 2003). While these conversations are occurring in the literature on consumers extraordinary experiences, there are few attempts to convey the way the body grounds more ordinary experiences, like diet and health, in consumer research.

To summarize, the motivation for researching medicalization through the consumption of functional foods evolved over the course of my doctoral studies. As a broader category of a phenomenon for which we know little, medicalization seemed to be the most appropriate abstract phenomenon that described functional food consumption. Valio Oy directed the original topic and context of study as the primary funders of the dissertation project. However, I did not let these orienting ideas limit my data collection or distract me from understanding the phenomena. The marketing and business efforts directed at functional foods are occurring on a broad scale. Concerns about health and disease become the basis for functional food development and commercialization, and creates a fundamentally different consumer experience from of traditional foodstuffs. The body is a central element in my study, and it lays at the intersection of food and health, which implies broad implications for this study and provides another layer of motivation for the research topic.

1.3 How Have I Gone About Exploring This Topic?

Chapter 2, "Medicalization," lays down some grounding principles of medicalization while also examining some of the ongoing debates involving its definition and application. Accordingly, I will discuss in this chapter (a) the beginnings of medicalization as a concept; (b) the application of medicalization to the marketplace; (c) medicalizations relationship with preventative health management and self-care; (d) the application of medicalization in consumer research on health through studies on clinical intervention and consumer resistance and (e) how they lead to the notion of consumers' pursuit of health.

In Chapter 3, "Normalization Work," I introduce theory on normalization and how it has been applied in consumer research. I account for (a) my conceptualization of normalization work in-depth; (b) a contextualization of medicalization as the experience of illness; (c) how literature treats normalization, care, and talk in consumer research; and (d) how disciplinary power serves as a shared condition of possibility for meaningful action in the experience of illness.

Chapter 4, "Why Use Discourse to Study Consumers Experience of Illness?," addresses my methodological choices, the setting of the study, and research methods. The purpose of this chapter is to define the philosophical and methodological framework guiding my research. This chapter will discuss the (a) state of discourse in consumer research; (b) a phenomenological approach to discourse; and (c) implications for my analysis.

In Chapter 5, "Methods," I first justify studying normalization work related to medicalization by exploring (a) health, nutrition, and Nordic governance; and, (b) lactose intolerance in Finland. Next, I discuss (a) the issue of researcher reflexivity and researcher as an instrument; (b) applied data collection techniques, (c) the process of analyzing the data; and lastly, (d) I offer a brief conclusion to the first half of the monograph.

1.4 What Have I Found?

The second half of this manuscript offers an empirical analysis of how consumers cope with lactose intolerance through their talk and a discussion of the implications of these findings. Chapter 6 provides an analysis of the body-subject as the existential ground through which consumers with lactose intolerance experience the world. More specifically, the purpose of this chapter is to orient and anchor normalization work in the body-subject. I center my analysis on Drew Leder's (1990) ideas related to embodied breakdown and categorize my findings into three dimensions—the dysfunctional body, the dysappearing body, and social dys-appearance. Accordingly, I find that when the lactose intolerant body erupts and the dysfunctional body emerges, consumers' talk establishes differing existential meanings: the body is perceived as an oppositional force, disengaged from self, or even as a malevolent entity. Participants reveal an ever-

present distance or deviance from the tacit bodily capacity to eat and drink normally. Lactose intolerance forces a decoupling of the body-environment structure that makes up the field of potential affordance-relations that characterizes the social world for the individual. Under the dys-appearing body, marked by the disassociation of the self from the dysfunctional body, the destabilization of the body leads consumers to acquire new skills to cope with deviance from normality. Social dys-appearance, the re-appearance of the body as a result of social interaction, solidifies lactose intolerant consumers deviation from bodily norms as they negotiate the power dynamics inherent in the objectifying gaze of the Other.

Chapter 7 builds from the previous chapter and examines more in-depth how bodily illness affects consumers experiences at individual and intersubjective levels. Bodily dysfunction positions consumers in a subordinate position to prevailing normative expectations of body function. This deviation, in its affectiveness, attunes consumers to cope with social life. Particularly in regards to how they attempt to construct and enact what is normal and abnormal behavior. Normalization is a social practice, through which particular actions are seen as a normal part of everyday life. One way that consumers cope with lactose intolerance is to ascribe normativity to food-related illness through intercorporeality, that is the relating of the individual's body to the bodies of others (Merleau-Ponty 1962). As beings always already affected by their given social situations, consumers with lactose intolerance talk in ways that seek to negotiate intercorporeal normative expectations, thus, creating social spaces of possibility for stable ways of being-in-the-world with bodily dysfunction.

Chapter 8 turns to look at how normalization work takes place within the institutional context of the public health care system. Regulative influence positions the institution of health care as a social practice in Finland—that is, society shapes people's understanding of health. The public system establishes a cultural ideal that "health care is working" in Finland. However, consumers' experiences of illness establish deviations from cultural ideals of health care, contesting institutional meanings. In their affectedness, consumers become attuned to ways of talk that judge, contest, and even potentially reshape institutional norms. The welfare discourse that underlies the cultural ideal of health care becomes dominated by a market discourse. Health care services are treated as goods that appeal to consumers rather than patients or fellow citizens. Further, those who depend on the public health care system are, in this case, perceivable as morally inferior and lack the ability to "exercise of free personal choice in the private sphere of everyday life" (Slater 1997, p. 8). Such talk converges with changes in broader social practice toward the marketization of discourse whereby market discourses come to colonize the discursive practices of public institutions (Fairclough 1992, 1998).

In Chapter 9, I focus my analysis on the marketplace. The central argument this chapter offers is that consumers situate the dairy market as a site of

conflict as it makes their illness visible (i.e., it establishes their lactose intolerance), while providing some degree of invisibility through the provision of functional foods. The bodily experience of lactose intolerance contrasts with the perception of dairy as a health food and a rich cultural resource in Finland, thus making their illness evermore pronounced. Such sense of disequilibrium with the normative expectations of dairy consumption compel the participants of this research to be responsive in a self-disciplinary manner. These consumers regulate themselves per their situated affordance-relations, ultimately providing them with opportunities to render their illness invisible. Thus, talk about functional foods has the potential to transform medicalization from a disruptive force to instinctively normative action in coping with lactose intolerance.

Lastly, Chapter 10 discusses the implications of my findings, comparing them with prior research, while pointing towards areas for future studies. This chapter first address how I have answered my central research question through the conceptualization of normalization work. Second, I focus on positioning normalization work within existing conversations of medicalization as they entangle with consumer research and medical sociology. Third, I work towards a theory of embodied consumer talk and discuss its relevance in regards of themes of embodiment, power, and subjectivity. Lastly, I propose a contribution to the developing theorization on consumer needs before drawing my concluding remarks.

2. MEDICALIZATION

In this chapter, I will review the literature on medicalization as it relates to this research. First, this will entail a brief examination of the beginnings of medicalization theory as it is known in Western social sciences. Then, I will describe how theories on medicalization have intersected with the marketplace. Notably, this stream of literature on medicalization tends to neglect the "ways that hegemonic medical discourses and practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximize their health status and avoid physical distress and pain" (Lupton 1997, p. 94-95). The dissertation at hand attempts to tackle this neglect by focusing on the level of the consuming body-subject and her struggles with medicalization linked to food-related illness rather than medico-scientific discourses circulating the institutional level of analysis. By focusing on the ways consumers engage in preventative health management and self-care, another form of medicalization emerges. Health and medicine intrude on private lifestyles and individuals' everyday activities surrounding diet, fitness, sleep patterns, stress levels, and relationships with others. That said, I will then explore theory on medicalization through consumer research on health. While it is rare that consumer research directly tackles medicalization, empirical studies have substantiated phenomenon that directly relates. For example, consumer studies have focused on analytic cases where clinical interventions like cosmetic surgery or fertility treatments take place in the market. My research is different from this work because functional food consumption reveals a new consumer relationship with health that offers a different perspective on medicalization. Consumers of functional foods focus more on preventative health management and self-care and "behave empowered and nutritionally aware and are seeking control over their own health and well-being" (Heasman and Mellentin 2001, p. 18). I will establish

that consumer research addressing preventative health management and self-care primarily do so through acts of consumer resistance to Western medicine. Then, I will position this study on medicalization through consumer pursuits of health where the focus is on coping with illness rather than resisting institutionalized Western medicine.

2.1 The Beginnings of Medicalization

Building on the ideas of Micheal Foucault (1961) and Ivan Illich (1975), social scientists began writing about medicalization in the 1960s and early 1970s. The literature on medicalization developed into a critique of the expansion of medical authority into social life. Medical authority was thought of as a force of social control that should be rejected in the name of liberation (Lupton 1997). Authors such as Eliot Freidson (1970), Irving Zola (1972), Peter Conrad (2007), Moynihan and Cassels (2005) and Thomas Szasz (2007) have documented the spread and effects of such processes of medicalization, especially as medical businesses have made fortunes from selling sickness. For example, Moynihan and Cassels (2005) call out the pharmaceutical industry for especially grievous and profitable cases of exploitation and contend that major drug companies target the well and sick alike by inventing diseases for which they conveniently provide the cures. This critical stance encourages individuals to pursue self-management of health to avoid medicalization. In doing so, it encourages another form of medicalization, that of preventative health management and self-care. Preventative health management and self-care refer to an epistemic shift in how society understands and treats the body resulting in the transformation of people into patients (Foucault 2006).

The publication of Ivan Illich's seminal book *Limits to Medicine: Medical Nemesis* (1975) has been described as one of the earliest critical works of modern medicine that used the term medicalization. This book started a stream of literature that has been termed "the medicalization critique" (Lupton 1997, p. 94). Built from sociological theory grounded in Marxist perspectives and the "liberal humanism that underlay the emergence of social movements in the 1960s and 1970s," the medicalization critique evolved into a social theory that explains the ways that social life and its problems have become more and more medicalized (Lupton 1997, p. 95). Illich's book was inspired by claims made by Western science of improved health; yet, he highlights that in actuality Western science undermines it by limiting the autonomy of people to deal with their own health care. The central issue is that "medicine, as it is practiced in Western societies, despite its alleged lack of effectiveness in treating a wide range of conditions and its iatrogenic [illness caused by medical examination or treatment] side-effects, has increasingly amassed power and influence" (Lupton 1997, p. 95). The notion that the authoritarian power of Western medicine constrains people is an important aspect to early medicalization critiques. Analyzing the Western pursuit of medical utopia, Illich was struck by the fact that illness and disease seemed to increase rather than decrease as medical intervention

becomes more prominent. The question is raised: If contemporary clinical care is not beneficial to health, why is modern medicine so popular? His answer promoted new thinking: scientific medicine reduces people's autonomy to deal with their own health care while simultaneously undermining their health instead of improving it as a consequence of the unwanted side-effects of medical treatment. Lupton (1997) highlights the central issue of Illich's perspective and the medicalization critique, saying that "individuals should not have their autonomy constrained by more powerful others" (p. 97).

Debates about individual autonomy is a classic problem in social science grounded in humanist ideals of personal freedom, human rights, and social change that characterize the time period of medicalizations emergence (Lupton 1997). According to Illich (1975), doctors and other members of the medical profession possessed the exclusive right to define, treat, and cure diseases. Due to the lay population's lack of scientific medical knowledge, lay understandings about health were subordinate to medical professionals. Patients are left in a vulnerable position as they seek the attention of doctors with little to no ability to challenge their decisions. Authors such as Howard Waitzkin (1984, p. 339) analyzed this information asymmetry from the perspective of the working class and noted, "The medical encounter is one arena where the dominant ideologies of a society are reinforced and where individuals' acquiescence is sought." He found that socially and economically disadvantaged groups of society lacked power in their interactions with doctors who enforced existing conditions with scientific medical knowledge. For example, pregnancy and childbirth became a site of medicalization where the medical profession took control from lay practitioners like midwives (Ehrenreich and English 1979). Doctors used scientific medical language to reinforce and maintain power and authority over the patients in the name of preventing ill health and death due to childbirth (Illich 1975; Lupton 1995).

The medicalization critique, that is, the view that Western medicine is degenerating rather than improving people's health, is the dominant perspective on health and illness in social theory. Starting with Illich, this point of view emphasizes resistance to Western medicine and individual autonomy to deal with their health care. Further, doctors and medical professionals are viewed as power-hungry authoritarians that crush the agency of helpless and disempowered patients (Illich 1975). One shortcoming of the medicalization critique is its black-and-white portrayal of the doctor and patient in Western medicine where "the asymmetry of the relationship is exaggerated to the point that the lay client becomes not the beneficiary but the victim of the consultation" (Atkinson 1995, p. 33). Lupton (1997, p. 98) argues "rather there being a struggle for power between the dominant party (doctors) and the less powerful party (patients), there is collusion between the two to reproduce medical dominance." The judgments about the normality of health conditions are a collaboration where patients willingly participate in a relationship with Western medicine and the medical profession (Swan 1990; Schouten 1991; Lupton 1997; Giesler 2012). In the

following section, I will discuss the way medicalization encroaches on the market enabling patients to more freely engage with Western medicine through the logic of consumer choice.

2.2 Medicalization and The Marketplace

> *The dining table is no longer the altar of succulent delights, a place for sharing a meal and conversation, but a pharmacy counter where we keep an eye on our fats and calories and conscientiously eat food reduced to a form of medication (Bruckner 2000).*

This quote by Bruckner (2000) illustrates the phenomenon of medicalization as it occurs in the marketplace. Medicalization in the marketplace, like functional foods, spreads medicine outside its traditional field and leaves its authority taken-for-granted through the logic of consumer choice (Foucault 2006). In the example above, cultural and social practices related to eating and food take on new meaning, as pursuits of healthy lifestyles become the consumer's main objective. As medicalization spreads into the various aspects of social life, problems of the body become sites for medical treatment whether they are behavioral, physical, emotional, or psychological (Foucault 1973). For example, functional foods are promoted as providing health benefits like increasing immunity, improving digestion health, or combating lactose intolerance. These health benefits ease bodily issues often associated with food-related diseases (Heasmen and Mellentin 2001).

The increasing demand and consumption of functional foods contributes to the consumer quest for health through a medical market. Medical markets, Conrad (2007) argues, develop when consumers are urged to improve their health, well-being, or appearance by using medical products, services, or treatments. Medicalization of social and cultural practices like eating has become a regular part of the consumer and market culture (Conrad 2007). The emphasis on medical markets in the literature on medicalization is supported by marketing studies that address the way the logic of consumer choice affects traditionally non-market institutions like religion (McAlexander et al. 2014). Marketing is an influential force that shapes society, and it is quickly becoming the most important source for health-related information (Brennan, Eagle, and Rice 2010). Medical goods and services have become commodified due to advertising, the growing consumer culture for health products and services, and the standardization of medical services.

To illustrate the commodification of Western medicine, I would like to point to the legislation by the US Food and Drug Administration (FDA) from 1997 that, in effect, allows pharmaceutical companies to engage in direct-to-consumer advertisements (Conrad 2007). These relaxed restrictions opened opportunities for the pharmaceutical industry to reify ordinary, taken-for-granted social discomforts and challenges as medical problems. For instance, Conrad describes that GlaxoSmithKline, a British pharmaceutical company, was

approved in 1999 to use the drug Paxil for Social Anxiety Disorder (SAD), and then in 2001 for Generalized Anxiety Disorder (GAD). Conrad goes on to explain how they spent millions on marketing campaigns to raise awareness of SAD and GAD using the tag line "Imagine being allergic to people…" They turned shyness into a medical condition for two diseases with intent to market the diagnosis and sell their solutions in the marketplace.

Drawing from the example above, GlaxoSmithKline successfully marketed shyness as the disease of social anxiety disorder and commoditized it for consumers as the drug Paxil. The medicalization of consumer culture is well on its course, turning common human feelings or emotions, as well as traits and behaviors into treatable medical disorders (Conrad 2007). For example, what once was regarded as normal consequences of aging—such as baldness, sagging skin, periodic impotence, menopause, and loss of bone density—now fall under the horizon of pharmaceutical treatment. By emphasizing medicalization as an increasingly international phenomenon, Conrad appears to support the views of consumer culture theory (Arnould and Thompson 2005, p. 869) where medicalization is "distributed over a multiplicity of overlapping cultural groupings that exist within the broader socio-historic frame of globalization and market capitalism." Authors such as Schulz (2004) and Conrad (2007, p. 144) point out that pharmaceutical companies introduced "mild depression" as a disease in Japan and its marketing resulted "in a dramatic rise in SSRI treatment since 1999." McKinlay and Marceau (2002) argue that "Transnational corporations involved in the globalization of medicine (pharmaceuticals, services, medical insurance, and biotechnology) generate local demand for services" (p. 399). Medicalization has spread with globalization establishing the local and global nature of medical categories and treatments through the formation of medical markets.

Medical markets enable people to self-manage their health by transforming consumers into unwitting patients, who become increasingly responsible for their own health care knowledge, treatments, and outcomes (Conrad and Schneider 2010; Tomes 2016). Primarily as a result of medical markets, medicalized terminology is pervasive in common parlance, and medical metaphors are taken so literally that consumers find it difficult to think critically about medicalization and its possible effects or alternatives (Szasz 2007). For example, in the United States, it is common for people to say "I'm depressed" when they are merely sad, but that pronouncement may be enough to merit a prescription for antidepressants.

Corporatized medicine has fundamentally altered the organization of health care and contributed to "the growing consumer culture for health-related products and services" (Conrad 2007, p. 16). Lupton (1995, p. 61) argues that the public health and welfare discourse is "founded on the notion of the neutral and beneficial state acting in the best interests of the majority and standing above vested interests." Consistent with the medicalization critique, medical markets take on a need for ethical approval as they balance between interests of

business and public welfare "because corporations are ultimately more responsible to their shareholders than to patients (and) shareholder desires are often at odds with patients' needs" (Wilkes, Bell, and Kravitz 2000). The literature supports a strong emphasis on profitability (Conrad 2007; Szasz 2007; Van Zee 2009; Poitras 2012). The medical industry is expansive and includes practicing doctors, associations, medical technology companies, and their sales reps, insurance companies, pharmaceutical corporations, and everything involved within the academic institutions branching off from every element (Poitras 2012). The privatization of medicine has made the whole medical industry more dependent on the global financial markets (Conrad 2007). Market-driven growth and profitability become the test of viability for health care services and the assessment for increased financial investment (Conrad and Leiter 2004).

Conrad and Schneider (2010) argue that medicalization offers social benefits when business interests align with public welfare and well-being. The marketplace builds and engages a large number of social relationships. Once a disease enters marketplace discourse, a seemingly individual problem can be seen as a common ailment. Individual problems can transform and disseminate into societal level issues as social interaction occurs through market activity. The power of social normalcy can reduce the feeling of responsibility, blame, and stigma that comes along with health ailments and disease (Payton and Thoits 2011). For example, the characterization of obesity or alcoholism as a disease relieves individuals of feeling personally responsible for their condition, and instead, we turn blame towards genetics, physiological conditions, and even social structures.

Medicalization has led to remarkable economic prosperity for the medical profession but sometimes disrupts public welfare. Conrad and Walsh (1992, p. 107) argue:

> *Promoting health is unassailable; few would think to oppose it. On a deeper level, though, health can be viewed as a moral discourse that reflects particular, deeply ingrained values and consequently can be used as a legitimating vocabulary for instituting changes that might otherwise be resisted.*

In keeping with the ideas expressed by Conrad and Walsh, Poitras (2012) describes how economic incentive in the marketing of OxyContin by Purdue Pharma represents a glaring case of medicalization. Purdue Pharma introduced a controlled-release version of oxycodone, a schedule II controlled substance (i.e., high potential for abuse) in the United States, called Oxycontin in 1995. After an aggressive marketing campaign for the management of chronic pain, sales increased from $44 million and 316,000 prescriptions in 1996 to a combined total of nearly $3 billion and 14 million prescriptions in 2001 and 2002 (Van Zee 2009; Poitras 2012). The loosening of law over controlled drugs leading to direct-to-consumer marketing campaigns by Purdue Pharma seems to support the argument that medicalization can reflect the potential for conflict

with the moral discourse of health. Art Van Zee (2009, p. 221) emphasizes "controlled drugs, with their potential for abuse and diversion, can pose public health risks that are different from—and more problematic than—those of uncontrolled drugs when they are over promoted and highly prescribed." Since the public policy disasters created by drugs such as elixir sulfanilamide in 1937 and thalidomide in the early 1960s that created health problems (death, birth defects, etc.) for thousands of people, the conflict of interest between for-profit firms acting in private interest and the motives of the government, acting in the public interest, exposed the need for oversight and regulation (Van Zee 2009). The profit motives and aggressive marketing strategy by Purdue Pharma for Oxycontin took the form of a public awareness campaign called "Partners Against Pain" (see parntersagainstpain.com) and embraced actress Jennifer Grey as its spokesperson (American actress in Ferris Bueller's Day Off and Dirty Dancing). This campaign led to exorbitant profits and simultaneously might have got millions of Americans addicted to opiates (Van Zee 2009; Poitras 2012). More recent headlines suggest that opiate addiction in the United States has reached epidemic levels, largely a result of the abuse of prescription opioids (Mukherjee 2018). Opiate addiction treatment was up over 1000% between the period of 1996 and 2011, and it has been reported that 4 out of 5 people being treated for heroin addiction started with the abuse of opiate pain pills, which emphasizes the potential disruption of public interest medicalization can carry (Berman 2014).

Moynihan and Cassels (2005) emphasize medicalization as the phenomenon of selling sickness, arguing that large pharmaceutical companies now aggressively target the healthy and well in their marketing activities. Normal parts of everyday life are transformed into frightening conditions and disorders, making ordinary, healthy people worry about their health. They identify several strategies whereby pharmaceutical companies create markets for their products. For example, an unfamiliar condition is given new attention, an old disease might be renamed, or a brand-new disorder may be invented. Moynihan and Cassels support the notion of the medicalization critique and note ways that medical markets limit rather than enable individual autonomy over health. A key strategy is to change the way people think about their common everyday problems. Inconveniences that people might previously have accepted as a nuisance, for example, wrinkles or baldness, should now be treated with medical attention. A common factor underlying these strategies is the marketing of fear for specific outcomes like a heart attack or a perceived loss of virility.

Thus far, the literature on medicalization outlines obvious conflicts with moral discourses of health. To understand the way consumers take up, negotiate, legitimate, and transform medicalization from the bottom-up in everyday life, I will lay the groundwork that supports the ways that medicalization becomes institutionally unbound. I will focus on the role individuals rather than pharmaceutical companies, medical professionals, or health care institutions play in contributing to the spread of medicalization. In doing so, I will first

address the role of preventative health management in medicalization. Then, I will move on to outline self-care and its implications for medicalization and the body.

2.3 Preventative Health Management

Preventative health management consists of measures taken for disease prevention, as opposed to disease treatment. Preventative medicine "demands constant vigilance on the part of the individual" that has assumed "increasing self-responsibility for their health, body" and appearance. Also, preventative health management "offers the incentives of longevity and lowered risk of disease" and refers to the self-management of health in everyday life and is an important aspect of medicalization (Featherstone 1991, p. 183; Lupton 1997). Szasz (2007) takes medicalization closer to the consumer by discussing the different issues of the medicalization of everyday life. He notes that medical idioms are such an integral part of our contemporary culture that medical terms, even though commonly used for their metaphorical value, are understood literally without question. According to Szasz, failing to see the difference between disease as an objective physical condition versus the social status of being a patient, facilitates medicalization and the confusion between discovering diseases and creating diagnoses. He states that a disease is something that happens naturally, whereas diagnoses are human-made artifacts or constructs. The author argues that by creating diagnoses, the phenomenon of medicalization plays a role in educating people that non-diseases, such as depression or alcoholism, actually are diseases. Where Szasz's critique falls short, which I will briefly address later, is that medicalization and the various diagnoses therein can provide a sense of liberation for individuals, a sense of coherence in their lives, and a shift of responsibility for illness from the self to the body.

Medicalization has emerged even in the mundane activities of everyday life, such as eating and drinking, as a form of preventative health management. Kapsak et al. (2011, p. 804) describe functional foods saying they are "believed to improve overall health and well-being, reduce the risk of specific diseases, or minimize the effects of other health concerns." According to the authors (in the field of nutrition), these can include the healthful components in fruits and vegetables; whole grains and fiber in grain products, calcium in milk; fortified foods and beverages such as vitamin-fortified milk; and even dietary supplements. The authors argue that consumer interest in functional foods is thriving as they allow consumers to take charge of their own well-being by making improvements to their diets. They state that many multinational food and beverage companies are developing products that promote health to answer the expanding consumer demographics that demand functional foods. Kapsak and colleagues appear to emphasize that the consumers are taking responsibility for their own health as preventative measures against illness and disease. They argue understanding consumer attitudes, perceptions, and behaviors help "food and health

communicators tailor information that resonates with and motivates consumers to achieve optimal health through diet and lifestyle" (Kapsak et al. 2011, p. 806).

Heasman and Mellentin (2001) call this increase in functional food a revolution, stating that the future of food will be about how it affects health and well-being. The authors also make an important distinction between two types of functional foods; those that are aimed for people with specific medical conditions such as elevated levels of cholesterol, and those that are aimed at preventing diseases and enhancing the health status of already healthy individuals such as improving the environment of the human gut. Heasman and Mellentin (2001) support the notion of preventative health management in medicalization and note its influence on interest in functional foods. They identify several factors driving the functional food revolution including a truly ambitious health vision for the developed and developing world driven by self-care and preventative health management. Further, they point out that food companies are buying into the market potential of a new type of consumer of health. Food is medicalized and marketized for profit. Marketing claims about a products health benefits can be exaggerated and misleading. The actual impact of particular foods and food products on individual health, used through preventative health management, might not always be as straightforward as food and beverage companies would have us believe (Heasman and Mellentin 2001).

Medicalization promotes both the assumption of medicine's moral neutrality and the greater social control by those with medical authority. In the case of functional foods, this authority falls with food and beverage companies (Brennen, Eagle, and Rice 2010; Conrad and Schneider 2010; Payton and Thoits 2011). Östberg (2003, p. 129) describes that functional foods are "mimicking an abstract idea of healthiness" and in doing so promote "the notion that every problem in our consumer society is a consumption problem, or rather, a problem that can be solved with increased consumption" (p. 133). Östberg further argues the peculiarity inherent in functional foods saying, "the logic of functional foods only works as long as they are consumed in a highly controlled manner as the promises they are making only exist in a sterile world of controlled eating behavior. But that is not the context in which food consumption takes place and therefore the promises of the functionality of the products are even more peculiar" (2003, p. 133). For example, the healthiness of functional foods as preventative medicine is not a causal nexus when they are mixed with the short-term gratification of the fast food industry. This interesting idea touches on issues of consumer choice. Even though consumers know that hamburgers can nullify the benefits of functional foods (to some extent), they do not mind and will eat it anyway because 'they can.' In keeping with the ideas expressed about functional foods, people desire to manage themselves and their lives and in the context of health, choices about food, about smoking and drinking, and about the way in which leisure time is spent, are often thought to be most relevant (Cederström and Spicer 2015).

A critical idea behind this thesis is that preventative health management, together with self-care, brings medical and health concerns to bear on all aspects of life. In the preventative health management discourse, "the self that is being constructed is that of an enterprising and entrepreneurial self, and individual who is interested in and willing to take action to improve his or her way of living and acting" (Homlqvist and Maravelias 2011, p. 141). Authors such as Lupton (1995, p. 61) point out that this discourse assumes a "free subject" that has the freedom in various "choices of action." This plays out to suggest that all people have potential to act in the name of good health and that preventative health management "encourages or facilitates the realization of this potential" (Holmqvist and Maravelias 2011, p. 141-142). Thus, preventative health management suggests that health is an individual behavioral issue. As I have noted earlier, these authors argue that definitions of health are not fixed and enacted in a controlled environment. Instead, peoples' actions are conditioned by material and practical contexts that orient particular behaviors as normal or meaningful and others as not.

Preventative health management maintains that good health is the responsibility of the individual (Giesler and Veresiu 2014). The ideology of individual responsibility extends to all aspects of life, including fundamental identity issues and societal conditions (McAlexander et al. 2014). The marketplace treats these responsibilities as consumer needs and offers people choices and solutions to satisfy their obligations. Health and ill-health are removed from the broader social context as they become individualized, ignoring more systemic structural problems; and by individualizing health, the state is arguably freed from the responsibilities to protect the individual from illness and accident (Rose 2001; Holmqvist and Maravelias 2011; Giesler and Veresiu 2014). Preventative health management becomes not only a choice but also an obligation while embracing consumption as the primary means of delivery (Holmqvist and Maravelias 2011; Giesler and Veresiu 2014).

Preventative health management discourse frames health problems as behavioral or lifestyle issues and solutions are seen to lie within the realm of individual choice (Crawford 1980). Authors like Holmqvist and Maravelias's (2011) support the notion that consumers' pursuit of good health has shifted to lifestyles as the primary determinant. Authors like Crawford (1980) and Conrad and Schneider (2010) argue that individual responsibility depoliticizes disease and illness and overlooks social constraints, like the economic power to buy healthy food that may inhibit the ability to pursue opportunities for good health. As such, illness and disease become morally laden where people who are ill or diseased deserve it because of their unhealthy lifestyles despite the social constraints that may constrain them towards particular behavior (Crawford 1980; Conrad and Schneider 2010; Holmqvist and Maravelias 2011; see also Arnould and Thompson 2005).

Society has changed its views on what it means to be sick. In the past the 'the sick role' was reserved for those who were diagnosed ill by the authoritarian power of a medical doctor. Parsons (1951) argued that by giving over to the authority of the medical profession, an individual is released of responsibility of self-care as long as they adhere to treatments to get well. Medical practitioners are empowered to sanction the ill with temporary absence from the workforce and family duties, as well as absolve them from blame. That the classic 'sick role' has been replaced by personal culpability has been brought front-stage through individual responsibilization of health. Crawford (1980, p. 379) argues that individuals now take on the "potential-sick role through which the obligation to stay healthy is more strongly asserted." The author goes on to say, "in the potential-sick role, societal expectations are imposed on behalf of prevention. As potentially sick, individuals are experiencing more intense social pressures to act in ways to minimize that potential" (Crawford 1980, p. 379).

To repeat, the ideology of individual responsibility promotes the concept of healthy lifestyles. "Contrary to claims and first impressions, the new health consciousness (in its healthiest manifestations) entails a further medicalization of our culture, and, in particular, a medicalization of how the problem of health is understood" (Crawford 1980, p. 369). Here, abnormal and deviant behavior is understood in terms of illness and disease, and normal behavior in terms of health (Holmqvist and Maravelias 2011). Authors like Crawford (1980), Lupton (1997), and Holmqvist and Maravelias (2011) demonstrate that preventative health management has built additional meaning onto the concept of medicalization. The first meaning describes how the linking of social phenomenon with Western medicine and medical intervention is expanding into new spheres of social life. The second meaning emphasizes the way the terms of health and illness are mediating social phenomena. Moving forward, I will next sketch some ways medicalization has developed knowledge and practices of self-care and the body, and then, I will move onto proposing an understanding of medicalization through consumer research on health.

2.4 Medicalization, Self-Care, And the Myth of the Manageable Consumer Body

> *A major obstacle to coming to terms with the full reality of bodily life is the widespread myth that the body can be controlled. […] The essence of the myth of control is the belief that it is possible, by means of human actions, to have the bodies we want and to prevent illness, disability, and death. Like many myths, the myth of control contains a significant element of truth; we do have some control over the conditions of our bodies, for example through the physical risks we take or avoid and our care for our health. What makes it a myth is that people continue to cling to it even where there is overwhelming evidence against it, and that most versions of it are formulated in such a way that they are invulnerable to evidence against them (Wendell 1996, p. 93).*

Alftberg and Hansson (2012) describe how Western society stresses care for our bodies, the onus of which becomes individual. This paradigm encourages personal responsibility for health. You only get one body in this life, so you need to take care of it. The authors go on to describe how this is not limited to health optimization, but we also take care of ourselves when we are sick. As I explained in the previous section, this axiom centers on living a healthy lifestyle through exercise and diet. Authors such as Featherstone (1991) and Turner (1982, 2007) describe this paradigm through the term hedonistic body. Featherstone (1991) argues that the hedonistic body is built on a dialogue of personal freedom and choice that emphasizes bodily experiences of pleasure and expressions of aesthetic aspects in a person's lifestyle. For some, this dialogue of personal freedom can be menacing. For instance, Bryan S. Turner (2007) considers how new medical perspectives on the body challenge personal freedom. He writes about the subjugating nature of medical discourse as "a language of genetic causation that is very different from celebration of the hedonistic body that characterized the post-war period" (Turner 2007, p. 30). Genetic tests can render irrevocable knowledge of illness or disease that severely limits personal freedom to the extent of powerlessness. In this regard, in a culture saturated with medical dialogue and preventative health management, it is easy to read Susan Wendell's remarks above on the ‘myth of control’ as significant.

Stuart Murray (2007) expands on the paradigm of the hedonistic body by taking Plato's popular saying, "The unexamined life is not worth living" as an adage. Quoting T.S. Elliot, the author builds his argument that the life that matters is the one that submits to examination "Like a patient etherised upon a table." Michel Foucault (1977, p. 175) further expands on the idea of examination in a more relevant sense:

> *The examination combines the techniques of an observing hierarchy and those of a normalizing judgement. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify, and to punish. It establishes over individuals a visibility through which one differentiates and judges them.*

Murray (2007), as well as Foucault (1977), argue that to examine one's physiological or biological life is to submit to medical knowledge and its "techniques" and its "normalizing judgments." We give ourselves over to the opinions of the alleged experts, and the evaluation becomes a ritual of power and ceremony or even a celebration of visibility. As such, the medical and health discourse informs how the self is constituted.

According to Foucault (1984, 1988), the care of the self (i.e., self-care) was first given meaning in classical and late antiquity. The social consequences of this concept have gained momentum recently. The care of the self has been related to medicine's attempt to gain control over the sick and disabled (Wendell 1996). The care of self has become a part of the neoliberal paradigm that

suggests people take care of their bodies and their health as good employees and consumers (Cedeström and Spicer 2015; Giesler and Veresiu 2014). The science of medicine does not, however, take on the full responsibility to cure, as consumers have the responsibility to follow recommendations and guidelines for a healthy lifestyle.

A significant issue in my research focuses on medical technologies and interventions in the marketplace (e.g., functional foods) and their facilitation through discourses and practices of preventative health management and self-care. The responsibility placed upon individuals for their life and their health is exercised through a specific type of power used as a form of social control. Power is a central concept in Foucault's work, and he traces a historical transformation from sovereign power to more modern forms of power, one of which he terms biopower (1980). Sovereign power functions through rights and laws, whereas biopower functions through norms. He writes, "The right of sovereignty was the right to take life or let live" (Foucault 2003, p. 240-41). This suggests that sovereign power has historically determined *who* lives but not *how* one lives. Foucault's term of biopower fills this 'how' gap. Foucault writes of "a very profound transformation of these mechanisms of power…working to incite, reinforce, control, monitor, optimize, and organize the forces under it: a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them" (1977, p. 136). Biopower is thus a positive, creative form of power, guiding how to live our lives in a normatively orderly and efficient manner.

As described by Foucault, power bears directly upon the ways people develop models of selfhood termed self-care. Self-care is popularly understood as an action one takes to care for their physical, mental and emotional states (Foucault 1988). Hirschman and Thompson (1995, p. 150) write, "To be thinner, more toned, less gray, and less wrinkled, and to hide a variety of imperfections are acts of self-care that serve to discipline the body that has, without conscious consent, deviated from valued cultural norms of appearance." Stated simply, acts of self-care and body image are discursive modes of self-relation, a sort of, and I emphasize, non-conscious reflexivity that has become the foundation of the modern subject position (Murray 2007).

The vantage point from which an individual observes and speaks to the world is defined as a *subject position* (Peñaloza and Barnhart 2011). Subject positions are configured by discursive formations (Karababa and Ger 2010). A discursive formation is a system for the dispersion of statements that forms regularity of a practice: "A person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines, and concepts which are made relevant within the particular discursive practice in which they are positioned" (Davies and Harré 1990, p. 46). *Subjection* is a term that signifies the space of possibility where an individual passively receives and appropriates her vantage point on the world. We submit to our position or

role without conscious opposition or acknowledgment. *Subjectification* happens when individuals or collectives are not only formed as subjects but also wish to be the subject (Andersen 2003). Subjectification indicates that an individual actively engages their role or subject position, s/he recognizes the subject position and purposefully conforms.

The distinction between subjection and subjectification outlines two different ways a person is individualized. What makes up the individual is vital since this research is addressing aspects of individual responsibility of health through medicalization. Subjection refers to the space of possibility where you receive yourself; it exists outside of you and is given to you by external outside forces (i.e., discursive forces). Subjectification refers to your purposeful ownership of a subject position; one gives oneself to oneself in an appropriation of the subject position (Andersen 2003). The distinction between these two forms is important. There are different discursive demands at play. The conscious acceptance of a subject position by an individual, also called subjectification, describes how an individual does not only submit to a subject position but actively cares for oneself independently. You take charge of your own identity and sense of self (Giddens 1991). Who one is, matters to that individual and they actively engage in self-creation. This is what Foucault (1988) defines as *care of the self*, often referred to as self-care.

Self-care "...is a matter of acts and pleasures, not of desire. It is a matter of the formation of the self through techniques of living, not of repression through prohibition and law" (Foucault 1994, p. 89). Thus, self-care is an attempt to move past humanmade limitations such as laws and regulations and to form a unique individuality by way of one's own experience and ethical code. Care of the self implies a self-transformation from social order to the natural order. Foucault (1970, p. xx) describes:

> *Order is at one and the same time, that which is given in things as their inner law, the hidden network that determines the way they confront one another, and also that which has no existence except in the grid created by a glance, an examination, a language; and it is only in the blank spaces of this grid that order manifests itself in depth as though already there, waiting in silence for the moment of its expression.*

In simple terms, *social order* is the relationship between things and what they are called that is so deeply embedded that it is taken as natural, as taken-for-granted, or as the natural order of things. Foucault introduces the term *technology* as a mediating tool to understand this transformation. Foucault (1988) outlines four significant types of technologies: 1) *Technologies of production* allow us to produce and transform things; 2) *Technologies of power* determine social normalization, the conduct of people, and their submission to certain forms of domination; 3) *Technologies of sign systems* permit the use of signs, meanings, symbols or signification; 4) *Technologies of self* are procedures for how the

individual is to define, maintain and develop their identity while maintaining self-control and self-awareness. The self-disciplining discursive practice serves as a form of identity regulation shaped through processes of normalization, surveillance, and technologies of self (Brown and Toyoki 2013; Huber and Brown 2017). The concept technologies of self are important to the current research, as it underlines the role of individual responsibility of health outlined by Giesler and Veresiu (2014). The stigmatization of otherness helps explain why individuals attempt to be normal and healthy opposed to deviant and unhealthy. Andersen (2003, 26 [italics added]) writes, "self-technologies are defined as technologies through which the individual can transform itself from a state of *having* responsibilities into *taking on* responsibilities, which means that the individual puts her/his own development on the agenda and accepts responsibility for it." Giesler and Veresiu (2014) suggest that consumers *have the responsibility* for their own health, thus legitimizing the health-conscious consumer subject. My research aligns more with notions of *taking on responsibility* through technologies of self to flesh out the extent to which the socialization of medicalization as a consumption practice takes place. Consumers appropriate a sense of health under the guise of self-control and awareness afforded through embodied actions (Giddens 1991; Foucault 1994; Giesler and Veresiu 2014). The discourse of personal freedom and responsibility over health lives external to people; it assails consumers. Medicine is imposed on the consumer, ill or not, with a sense of authority and ultimately inscribed on the body through various techniques (Foucault 1988; Lupton 1997; Thompson 2004; Murray 2007; Johansson, Tienari, and Valtonen 2017).

In the current study, preventative health management may be conceptualized as techniques or practices of self (i.e., self-care) that specifically relate to how individuals learn to be healthy consumers through their body. "Medical models, ideas and the medical profession, have coercive elements by shaping human behaviors in certain ways" but medicine can also be self-empowering (Holmqvist and Maravelias 2011). Lupton (1995, p. 15) supports this argument by saying, "Where this attempt to control becomes invisible is in the justification used. In the interest of health, one is largely self-policed and no force is necessary." Similarly, Foucault (1988) suggests in his discussion of Roman medicine: "medicine was not conceived simply as a technique of intervention, relying, in cases of illness, on remedies and operations. It was also supposed to define, in the form of a corpus of knowledge and rules, a way of living, a reflective mode of relation to oneself, to one's body, to food, to wakefulness and sleep, to the various activities, and to the environment." These compelling descriptions of medicine, subjectivity, and even food frame medicine as freeing the self and are consistent with the discourse on health and medicine today (Murray 2007). The discourse on preventative health management supports this notion of medicine as self-empowering. Self-care moves the discussion one step further by outlining that medicine is the principle technology that the self ought to relate to itself as it occurs through the body.

2.5 Positioning Medicalization in Consumer Research on Health

My research builds an interpretive account of medicalization where normalized notions of medical disorders explain the increasing consumer demand for functional foods with health-promoting or wellness maintaining properties. The dialectic relationship between social norms and medicalization runs in both directions (Conrad 2007). For example, changing norms about breast augmentation is one cause of medicalization (Schouten 1991). Yet, medicalization leads to shifts in the social norms surrounding breast enhancements. Conrad (2007) suggests but does not address, how advertisements for Viagra de-stigmatized male erectile dysfunction, while a normalized notion of erectile dysfunction increased the consumer demand for Viagra. Likewise, market offerings can increase consumer awareness of functional foods and de-stigmatize food-related diseases, while a normalized notion of food-related diseases increases the demand for functional foods. Medicalization gives people the tools to take care of their health. People use medicalization to manage flaws related to a disease (Conrad and Schneider 2010). In doing so, they chase the social norms of health.

In carrying out this work, I attempt to unify a set of findings in consumer research on health as it relates closely to medicalization but does not entirely explain it. The term medicalization binds a heterogeneous assortment of phenomenon that surround the consumption of health like aging consumers, compulsive consumption, healthy lifestyles, therapeutic communities, natural health marketplaces, aesthetic cosmetic surgery as well as chronic disease (Schouten 1991; Hirschman 1992; Thompson and Hirschman 1995; Thompson and Troester 2002; Thompson 2004; Moisio and Beruchashvili 2009; Kristensen, Boye, and Askegaard 2011; Barnhart and Peñaloza 2013; Giesler 2012; Tian et al. 2014). Some of the key terms like the health-conscious consumer subject, self-management, consumer discipline, governmentality techniques, and health regimes employed by consumer research on health prove useful in understanding the phenomenon of medicalization (Fischer, Otnes, and Tuncay 2007; Askegaard et al 2014; Giesler and Veresiu 2014; Cronin, McCarthy, and Delaney 2015). I compliment work done by Schouten (1991), Giesler (2012) Tian and colleagues (2014), and Fischer, Otnes, and Tuncay (2007) that substantiates clinical and medical intervention is occurring in the marketplace. In my study, functional foods are comparable to medical intervention in the market but correspond more closely with research on preventative medicine and self-care. Importantly, while consumer research that addresses preventative health management and self-care tends to focus on resistance to medical intervention (Thompson 2004, 2005; Moisio and Beruchashvili 2009; Kristensen, Boye, and Askegaard 2011; Giesler and Veresiu 2014), my study focuses on the way consumer's consent to medicalization. This reveals a different perspective. As I have already argued, health is central to the construction of consumer subjectivities; health is an individual responsibility. As such, health no longer sits on the

shoulders of society but must be endured by the individual who is blameworthy if they get sick. According to his line of argumentation, people want to be healthy and pursue this endeavor without coercive intervention. I strive to develop a more dynamic account by considering how medicalization fosters an understanding of what it means to be a healthy or unhealthy consumer where "the ideology of individual responsibility poses an alternate social control formulation. It replaces reliance on therapeutic intervention with a behavioral model which only requires good living" (Crawford 1998, p. 88). In doing so, I will first address the ways consumer research has addressed *medical intervention in the marketplace*. Then, I will show how literature foregrounds issues of *consumer resistance to medicalization*, before outlining the dynamics of consumers' pursuit of health in the next section.

2.5.1 Medical Intervention in the Marketplace

Consumer research has empirically demonstrated that clinical intervention is occurring in the marketplace. Schouten's (1991) work brought a meaningful contribution to our understanding of identity through the context of cosmetic surgery, and I build on this understanding of medicalization by focusing on how the social practice of medicalization becomes conventional and commonplace. Consumers engage in cosmetic surgery as a means of appropriating positive or avoiding negative possible selves. Here, possible selves are defined as "hypothetical self-schemas, either positive or negative, that act as objects of aspiration, hope, fantasy, or fear that motivate approach or avoidance behaviors" (Schouten 1991, p. 413; see also Markus and Nurius 1987). Schouten seems to support issues related to the notion of self-care in consumer culture and outlines the influence of self-transformation on bodily identity. Women in this study felt they had an abnormal appearance, regarding their breast size, based on normative expectations around sex and femininity. Breast enhancement surgery gave these women a sense of control and efficacy as they repositioned their bodies to be 'normal.' While cosmetic surgery and alterations to the body were "Once perceived as vain indulgence of the wealthy," they have become "more widely available and accepted to the American middle class as a potential means for self-improvement" (Schouten 1991, p. 412).

Tian and colleagues (2014) foreground benefits of medical driven technologies for facilitating social collaboration in therapeutic communities. My study extends their insights by showing how consumers collaborate outside therapeutic communities through talk and normalize medical disorders. The privatization of medicine makes health "an acquired marketplace good." In analyzing people with chronic illness, they find that consumers utilize medical interventions in the form of "technology-enhanced narratives to build collaborative therapeutic communities" (Tian et al. 2014, p. 237). The occurrence of medicalization through therapeutic communities can provide medical support for marginalized populations like those living and self-managing chronic illness. Tian and colleagues (2014, p. 255-256) note that "participants envisioned a new form of access to therapeutic communities, inclusive of health care providers,

which ultimately allows the service client to more actively contribute information and resources that can improve the diagnosis, treatment, and delivery of health care services." In keeping with the ideas expressed by Tian and colleagues (2014), consumers of functional foods operate in a technological future that may revolutionize health care and, likely in doing so, also the food industry (Conrad 2007; Fukuyama 2002; Heasman and Mellentin 2001).

Taking a longitudinal approach to investigate the construction of cosmetic surgery as consumable health care, Giesler (2012) analyzes Botox and its transformation into a market by way of branding technological innovation. The study examines clinical intervention in the marketplace. It does so by "emphasizing marketers as the main agents," and its focus on macro-level influences offers a limited viewpoint on the role of consumers the health marketplace (Dolbec and Fischer 2015, p. 1447). Botox is branded for the "modern-day patient benefiting from the newest medical knowledge and scientific progress (Giesler 2012, p. 5). The role of the modern-day patient is recast as a consumer who is shaped by cultural ideals of appearance and subsequently raises the standards of normal body image through cosmetic surgery. Botox creates tension between nature (natural body) and technology (technological enhancement of the body) whereby modern American culture valorizes "narratives that portray an image of harmony between the two forces" (Giesler 2012, p. 3). As tensions between nature and technology arise, various stakeholders in the Botox market like Hollywood starlets, the media, activists, the Allergan pharmaceutical company, and its competitors produce cultural narratives that establish new meanings and relationships between the brand and its consumers. Despite differences, consumers of functional foods are consistent with Giesler's findings in that, at times, they align with prevailing social norms and ideals associated with health.

Medical technologies and their interventions in the marketplace are a reoccurring theme that gets foregrounded in consumer research literature on health. Fischer, Otnes, and Tuncay (2007) examine the way consumers pursue parenthood through Assisted Reproductive Technologies (ART) and valorize medical technology to infertility. The body remains absent in this study. The article does not explore or describe the way embodiment shapes infertility, a natural and cultural phenomenon that seems to escape the control of many participants in the study. Instead, they analyzed the way that cultural discourses inform cognitive aspects of consumer persistence as "those who ultimately conceived via ART typically did so after multiple trials of one technology or after escalating to progressively more intensive procedures" (Fischer, Otnes and Tuncay 2007, p. 427). A significant finding of this study is that consumers appropriate self-management discourse that "encourages people to view themselves as entitled and perhaps obligated to adopt a proactive, even entrepreneurial, approach to managing both the work and non-work elements of their lives" (Fischer, Otnes, and Tuncay 2007, p. 433). By being a well-informed patient, consumers felt they were more likely to succeed in conceiving than anyone else using ART techniques. The findings in this study seem to fully endorse care of

the self, emphasize consumer responsibilization, and contribute to medicalization. Because parenthood is socially and culturally normal, consumers cling onto cognitive goals of parenthood by controlling the conditions of their bodies with medical intervention despite the overwhelming odds working against them (Fischer, Otnes, and Tuncay 2007).

2.5.2 Consumer Resistance to Medicalization

A key argument of my dissertation is that functional foods are not only a form of medical intervention in the marketplace, but they also allow consumers to engage in preventative health management and self-care. Research by Thompson and Troester (2002), Thompson (2004), Thompson (2005), Moisio and Beruchashvili (2010), and Kristensen, Boye, and Askegaard (2011) describe consumers' "technophobic" aversion to medical science (Best and Kellner 2001, p. 25). Consumers in these studies are represented in their health pursuits as having sharp suspicions toward medical technology and Western science while attempting to resist the authority of Western medicine through preventative health management and self-care. My argument carries with it the implication that these consumers who try to resist Western medicine based on health are experiencing an extension of medicalization where good patients are educated and well informed and make consumption choices based on their health consequences.

Thompson's (2004) analysis of the natural health marketplace examines how consumer resistance to conventional medicine occurs in multiple forms through complex relationships within the marketplace. Luedicke and colleagues (2010) note limitations to Thompson's perspective suggesting it obscures the distinction between cultural narratives and "ideological meanings and effects" (p. 1028), which could be interpreted as the need to understand better how "scientific issues like medicine are culturally appropriated" (Robinson 2015, p. 34). I propose that the Nordic cultural context that promotes equality, offers publicly subsidized universal health care, and provides a legacy of universal equality, may provide new insight into the normalization of medical disorders by way of the cultural reproduction that occurs in discourse (Byrkjeflot 2003; Østergaard et al. 2014; Peñaloza and Barnhart 2011). The marketplace establishes "meanings and metaphors that serve" differing "ideological agendas" and frames for cultural ideals of health (Thompson 2004, p. 162). Consumers, who are seeking alternatives to conventional medicine for the purpose of escaping the market, find resolve through discourses in the marketplace based on health.

Kristensen, Boye, and Askegaard (2011) suggest that consumers establish a new market logic through resistance to health ideologies. I would argue that this resistance is a reproduction of the reflexive, well-informed patient who is oriented to the background of medicalization (Tomes 2016). The authors address the emancipation of Danish consumers from the ideological forces and beliefs around health and wellness imposed by "alliances among science,

corporate interests, and governmental agencies." Going against the national discourse on dairy based diets, consumers valorize dietary recommendations that exclude cow's milk and any derived products. Consumers in this study embrace self-care and change patterns of consumption based on a self-help book, *Kernesund Familie*. While maintaining resistance to mythologies surrounding milk as nature's most perfect food, this book allies with "medical doctors for increased authority" on issues of health and well-being (Kristensen, Boye, and Askegaard 2011, p. 196). A significant contribution of this study, that supports the argument of my dissertation, is that "the power of new radical health ideologies" establish "new types of knowledge and subjective experiences help the consumer when navigating between trust and mistrust, right and wrong and sickness and health" (Kristensen, Boye, and Askegaard 2011, p. 212). The authors describe health as a moral system; the system establishes what right and wrong activities to pursue are; and the system defines what it means to be virtuous or reprehensible concerning health and well-being.

Thompson (2005) addresses how cognitive based choices are contingent on cultural discourses. These frame differing degrees of reflexive doubt across divergent contexts like home versus medicalized childbirth. I extend these insights by focusing on the relationship between culture and the body rather than cognition. Introducing the concept of reflexive doubt, Thompson (2005) argues that activists and countercultural groups promote discourses intended to question normative guidelines extended by institutionally sanctioned experts like medical professionals. Loosely organized communities of reflexive doubt thus aim to contest medicalization and hegemonic medical practices associated with things like pregnancy, labor, and childbirth. Consumers are confronted with a plethora of potential dangers and threats, especially related to health, which gets classified as public concerns and dealt with through expert systems designed for risk reduction. "Pressing public concerns often reflect underlying cultural anxieties," that are assuaged through risk reduction practices like medicalized childbirth (Thompson 2005, p. 246). Communities of reflexive doubt "dramatically invert the orthodox cultural view that a hospital is the safest place to labor" by embracing alternative viewpoints where science, medicine, and regulatory agencies are no longer untouchable institutions. Consumers should deal with health risk anxieties not by trusting expert systems but rather by avoiding them, and in the case of pregnancy, one should choose natural home births. (Thompson 2005, p. 236). Implications that emerge from this study orient around the cognitive consumer research on risk avoidance where culture and cognition are functionally distinct but interactive domains.

In their examination of preventative health management practices associated with overconsumption, Moisio and Beruchasvili (2009) examine the way marketplace arrangements such as support groups uphold identity norms associated with health and establish sharp normative expectations that facilitate attachment to the therapeutic community. Unlike Moisio and Beruchasvili (2009), consumers of functional foods have less immediate control over

sustaining the norm because it is a question of the individuals' condition and bodily limits, not their will. That said, the authors identify several ways that members of weight watchers, a support group for overconsumption, strengthen their discipline through spiritual and therapeutic encouragement: consumers may engage in periodic therapeutic confession; consumers may embrace a system of therapeutic oversight of consumption; and from time to time, consumers may benefit from the auto-therapeutic testimonial. In the past, the medical profession had first call on defining maladies related to the body or psyche as disease or illness. But, "the shifting engines of medicalization" and support groups like Weight Watchers or Alcoholics Anonymous have medicalized various conditions like obesity or alcoholism based on social and communal engagement (Conrad 2007, p. 133). Like for alcoholism, medical doctors are not the primary source of treatment for obesity and overconsumption; yet, it is still considered a disease which shows that "actual medical treatments are not a requisite for medicalization" (Conrad 2007, p. 6). Moisio and Beruchashvili (2009) study seem to support notions of preventative self-management and self-care as support groups like Weight Watchers establish a therapeutic way of living and a reflective mode of relation to one's self and body that foregrounds issues of health to mediate social practices.

To summarize, consumers have become obsessed with their bodies; grooming them, clothing them, beautifying them, and even modifying them in various ways (Thompson and Hirschman 1995). These developments have occurred at the same time that science, technology, and medicine have achieved unprecedented levels of control over the body: there are now few parts of the body which cannot be remolded, enhanced or transplanted in one way or another (Askegaard, Gertsen, and Langer 2002; Schouten 1991; Tian et al. 2014). Here, conceptual themes of body modification closely linked with issues medical intervention emerge as consumers pursue alignment with social norms of body image and health. Scholars have devoted attention to the representations of bodies and branding and advertising as a way of showing how medical discourse culturally inscribes bodies in particular ways. The desire for parenthood or body beautiful becomes dictated by the cultural and social system and its entanglement with medical discourse. That is not to say that consumers are merely cultural dupes or puppets ubiquitously controlled by society and culture. Indeed, as medicine enacts its power on the site of the body, consumers resist by forming alternative discourse about health, nutrition, body image, and even childbirth. The dialectic relationship between social norms and the powers of medicalization become avenues for disciplining bodies and resistance to social and cultural forces in the name of liberation and freedom. While this is informative, functional food consumption can be viewed more accurately as a form of preventative health management and self-care. In keeping with the ideas expressed by the medicalization critique, consumer research addresses preventative health management and self-care through acts of consumer resistance to western medicine. What seems to be missing from existing research on health are studies that look at the ways the physical, symbolic, and sociological are mediated by a

felt and lived body. That is to say, the embodied experience of medicalization is a confluence of physical and cultural elements in which consumers are embedded as they are drawn to a situated sense of normativity in respect to health issues. Moving forward, I will outline my approach to addressing this knowledge through theory and literature on normalization. However, before we move on, I will describe the ways that clinical intervention, preventative health management, and self-care have led to the consumer pursuit of health.

2.6 Consumers' Pursuit of Health

The topic of health is becoming increasingly popular within consumer culture and its related research. Thompson and Hirschman (1995) concentrate on consumers' body image and its effect on people's consumption choices, often concerning wellness, through a model of the socialized body (see also Schouten 1991). Venturing into the domain of consumer culture, critical management theorists Cederström and Spicer (2015) go so far as to pronounce the health and wellness movement a syndrome that turns life into an exercise of wellness optimization and exacts a heavy toll on those that will not or can not conform. Thompson and Troester (2002) examine health and wellness in their study of consumer value systems within the natural health context, wherein medicalization occurs but resists allopathic (science-based medicine) norms. Thompson (2004) views marketplace mythology and discourses of power within the natural health marketplace. Giesler and Veresiu (2014) discuss the neoliberal responsibilization of the consumer, which further emphasizes the role of markets and marketing as the source of wellness.

In a study of consumer identity work, Schouten (1991) concludes that particular medicalized consumption acts, such as cosmetic surgery and the use of weight loss programs, "provide some direct control over the physical appearance and, through it, may provide greater power or confidence in social, occupational or intimate relationships" (p. 423). The body in such cases is a locus of control for wellbeing in other aspects of life. Following Schouten (1991) in a study of body image, Thompson and Hirschman (1995) define a model of the socialized body based on 1) an ideology of self-control, 2) social processes of normalization and problematization, and 3) the operation of the disciplinary gaze. The model emphasizes the dualistic conception of an immaterial self, or mind, housed in a material body. The mind observes and critiques the body and strives to transform it into a more desired state, dictated by the pervasive images of idealized bodies present in advertisements and media. The model of the socialized body moves from this dualistic conception of the self to an ethic, or ideology, of self-control, where consumers control not only the form of their body, but also the foods, substances, and environment that their bodies encounter. They also note that deviating from this moral code may lead to acts of atonement to ease feelings of guilt. Medical science and mass media promote a normatively adequate conception of the body, and deviation from that ideal problematizes the body, even to the point of stigma. Obesity, for example, is stigmatized and

associated with a deficit in moral character. Enforcing the ideology of wellness and the disciplinary gaze, individuals self-monitor and become his or her own judge of moral worth.

Introducing the concept of the wellness syndrome, Cederström and Spicer (2015) argue that, in today's consumer culture, wellness has become a moral demand, turning life into an exercise in wellness optimization. Consumers thus aim to maximize their wellbeing, even when engaging in the most mundane activities such as cleaning or baking. Failure to adhere to the wellness ideology leads consumers to feel stigmatized as lazy, unproductive, feeble, or weak-willed for not being able to look after their bodies. Cederström and Spicer note that this normalization and problematization of the body represents the concept of biomorality, which they define as the moral demand to be happy and healthy. Biomorality promotes the following axiom: "a person who feels good (and is happy) is a good person; a person who feels bad is a bad person" (Zupančič 2008, p. 5). Lapses in biomorality may result in feelings of anxiety, self-blame, and guilt, and that, according to Cederström and Spicer constitutes the wellness syndrome. As the authors put it, "when wellness goes from being a general idea of feeling good to something that we ought to do to live truthfully and righteously, it takes on a new meaning. It becomes an impossible demand that reconfigures the way we live our lives" (Cederström and Spicer 2015, p. 6). Part of the wellness syndrome is an obsession with the body, and what we put in it. Cederström and Spicer (2015) note that eating has become a paranoid activity, and being able to eat correctly demonstrates one's superior life-skills. As I quoted earlier in the chapter, the dining table is "a pharmacy counter where we keep an eye on our fats and calories and conscientiously eat food reduced to a form of medication" (Bruckner 2000, p. 53). Concepts wellness may stretch to include pleasure and a sense of authenticity. Therefore, unhealthy eating or drinking might be regarded as acceptable, as long as it can be included in one's wellness plan.

Conrad (2007, p. 4) argues that medicalization has transformed into "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders." He goes on to argue that the number of life issues that are defined as medical, and the impact of medicine and medical concepts, have increased enormously in the past fifty years. Clarke and colleagues (2003, p. 161) suggest that the increase in the medical jurisdiction is "one of the most potent transformations of the last half of the twentieth century in the West." Even the most natural process of human life, aging, has been medicalized and treated as a focus for medical intervention. Excessive medicalization transforms aspects of everyday life into pathologies and narrows the range of what is considered normal and acceptable. Responsibilization places the burden of medicalization on the individual consumer and markets exist to help consumers treat their health, reinforcing the wellness syndrome (Giesler and Veresiu 2014).

To conclude this chapter, health and medicine have been brought to bear on all aspects of life. Initially, the literature on medicalization addressed the spread of western medicine in a critical form. The emergence of preventative health management and self-care facilitated individual responsibility for health through everyday lifestyle choice. Consumers take on the "potential-sick role through which the obligation to stay healthy is more strongly asserted. In the potential sick role, societal expectations are imposed on behalf of prevention" (Crawford 1980, p. 379). Consumers are always "potential patients" and pursue being healthy to maintain social norms associated with being productive citizens (Tannenbaum and Branden 1935, p. ix). "As potentially sick, individuals are experiencing more intense social pressures to act in ways that minimize that potential," and thus health and wellness become an all-consuming ideology (Crawford 1980, p. 379; Cederström and Spicer 2015). Even consumer activists, that attempt to resist the western medical paradigm through communities of reflexive doubt (Thompson 2004), become intimately linked with notions of expert patients who participate in therapeutic regimes to keep them alive or healthy and only lead to an extension of medicalization as they fight against illness through consumption (Sontag 1978; Thompson 2004, 2005; Moisio and Beruchashvili 2009; Tian et al. 2014). In the next chapter, I will describe the logical consequences of the designation of healthy as normal and unhealthy as abnormal by outlining my conceptualization of normalization work.

3. NORMALIZATION WORK

At this stage, this dissertation has built a tentative understanding of medicalization through the last two chapters and alluded to the idea that medicalization is subjected to powers of normalization. More than that, I emphasized that medicalization is a type of discourse about health that is suffused with relations of power (Foucault 2006). Medicalization can refer to the power of medicine to shape a person's understanding of his or her own experiences (Starr 2008). Medicalization can refer to a process by which social and cultural practices become defined and treated as medical issues (Lupton 1997). Medicalization can also refer to the ways physical ailments become defined in medical terms, explained with medical language, interpreted through a medical framework, or attended to with medical intervention (Conrad 2007). In the investigation of medicalization as a phenomenon, this thesis began with the question: *How do consuming body-subjects cope with lactose intolerance through their talk?* Medical discourse obtains cultural authority that dictates the ways people discursively frame issues like lactose intolerance that are related to our bodies and behaviors (Conrad 2007; see also Cronin and Hopkinson 2018; Thompson 2004; O' Malley 2006). Talk about health "is constitutive of a disciplinary regime where normalization—which insists on 'we' rather than 'you'"— require individuals who experience illness to construct themselves as equal members of society (i.e., healthy) (Huber and Brown 2017, p. 1108). This thesis responds to the proposal for more research on the ways consumer "behaviour may be influenced by social norms and ideas of what is normal" by examining medicalization (Rettie, Burchell, and Barnham 2014, p. 11). Medicalization can be interpreted as a social theory that explains why people discursively organize around medical norms and in what situations people take purposeful, planned action over medicalization's structural constraints (Lupton 1997). This thesis advances this discussion by asking not why but rather how medicalization, as a discourse on health, is experienced and under what practical contexts does the lived body

dwell in (or inhabit) the experience of illness and take purposive action that is normalizing. That is to say, I do not presuppose intention or purposeful goal orientation but instead choose to look at intent as immanent in every adaptive action (Chia and Holt 2006).

In this chapter, I develop a phenomenology of the normalizing pressures of medicalization experienced by consumers that are enforced by society and played out in the marketplace. In particular, I focus on how consumers experience illness as feeling body-subjects. The feeling body-subject is a bodily awareness that establishes a sense of belonging to the world (Ratcliffe 2010), where the body-subject does not interpret the world passively, but rather actively orients and reorients itself in the practical and material context of worldly influences (Wyllie 2005). When people are healthy, they have a tacit certainty about their bodies that renders the feeling body unrecognized; a phenomenon described as the "forgotten body" (Scott, Cayla, and Cova 2017, p. 16: Merleau Ponty 1962; Leder 1990; Carel 2016). Consumers are unaware of certain aspects of their embodied experiences. This is a point that is fundamental to the phenomenological approach in this study, and my intent is to bring these un-reflexive aspects of experience to light. More specifically, I aim to develop a conceptualization of social norms that are mediated by the body-subject and will sensitize us as scholars to understanding medicalization.

This thesis explores how consumers' experience of illness casts them out of the immersion in health norms and into a state of suspension that is accompanied by a form of existential anxiety. The experience of bodily breakdown like the pain of a stubbed toe can be frustrating and disquieting, but one remains immersed in task and in the world. Anxiety in this sense is not a concrete emotion depicted in psychological renditions of the concept. Rather, anxiety is a way of finding oneself in the world affectively that reflects a sense of up-rootedness from the familiar material and social world (Heidegger 1962; Ratcliffe 2008). What makes consumers' experience of illness different from other types of anxiety is that they are embodied experiences of bodily capacities which are normally taken-for-granted. I am specifically addressing the taken-for-granted capacity to be healthy. I highlight the mutual relationship between the body-subject and the way consumers make sense of the experience of illness through talk. As such, bodily awareness becomes a way of finding oneself in the world; that is how the acting consumer body-subject is oriented to the world as she seeks maximum grip over her immediate situation. Talk about illness is co-constitutive of the feeling body and consumers' experience of illness is rendered visible and made sense of through what I conceptualize as *normalization work*.

Normalization work acts an interpretive framework for understanding a dimension of consumers' talk that is suffused with power relations occurring between the authoring body-subject and the discursively perceived practical and material environs in which they are embedded. This interpretive framework also serves to position my work about relevant consumer research. In the

coming sections, I will first outline an in-depth theorization of normalization work. Next, I will explore the embodied nature of normalization work in conjunction with phenomenology of embodiment. In sketching out the dynamics of the experiencing body-subject, the relational significance between the explicit felt body and the tacit lived body emerge in the contexts of ongoing directed activity. Building from an argument that medicalization is an experience of illness (Carel 2016), I will pay special attention to the embodied nature of disciplinary power and the way it resonates in consumer talk. Here, I will frame illness as both a bodily feeling and a discursively expressed experience of worldly possibility for action (Ratcliffe 2012). I will wrap up with a brief discussion on the implications of normalization work for consumer research.

3.1 Theorizing Normalization Work

I propose normalization work to be that dimension of talk that is affected by how the authoring body-subject finds herself in the world normatively, and in its affectedness, is attuned to talk that purposively makes sense of such situations seeking to assuage any perceived conflicts therein. In the current research, talk is affected by a reification of bodily awareness. That is an objectification of the body that occurs through one's deviation from health norms in their experience of illness. In this affectedness, the authoring body-subject attunes to talk that purposively self-disciplines to get the best grip on the world in which she is thrown. Figure 1 summarizes these relationships. To be affected by and attuned to the practical world is to perceive it for its affordance relations (Rietveld 2008, 2010). An affordance relation is one between the material realm and the abilities of the body-subject (Rietveld and Kiverstein 2014). In applying such terms where the material environment and its affordances are seen to 'invite' or 'solicit' certain actions (e.g., discursive activity), the model of intentionality that affordance theorization exhibits differ from theories based on a mind-body relation. Instead of depicting an intentional mind wielding reflexive powers over the object world, affordance relations are governed by 'normative pull' (Kiverstein 2008). The body-subjects responsiveness to affordance solicitations is normative because it is based on situated cultural and practical understandings. Expressly, I am referring to the types and levels of skill and aptitude possessed by the body-subject and subsequent space-for-maneuver perceived for meaningful doings and sayings (Dreyfus 1991; Schatzki 1996). Thus, affordance relations show up when the body-world relation is open to 'lived possibilities' for meaningful action (Gibson 1986; Merleau-Ponty 1962).

What is also of interest to this research is when once fluid affordance relations break down due to mismatch, de-coupling, or 'misalignment' between material possibilities and action (e.g., Seregina and Weijo 2016; Woermann and Rokka 2015). In situations of unimpeded action, the flowing alignment of affordance relations provide us with sense of stability and even ontological security through habituated modes of routinization as described by Phipps and Ozanne's (2017). When such relations are hampered or disrupted, say in

situations of disability and illness, the once implicit medium and background of experience that is the lived body (Merleau-Ponty 1962) becomes the explicitly felt body (Ratcliffe 2008), with the body-subject turning its gaze unto itself (Leder 1990; Scott, Cayla, and Cova 2017; Wainwright and Turner 2003), In such instances, not only is the body objectified but also the affordance relations as a whole become reified, no longer ready-at-hand, as Dreyfus (1991) would put it, but as explicit things in need of reckoning and overcoming. It is largely such situations of breakdown that I attend to in my analyses.

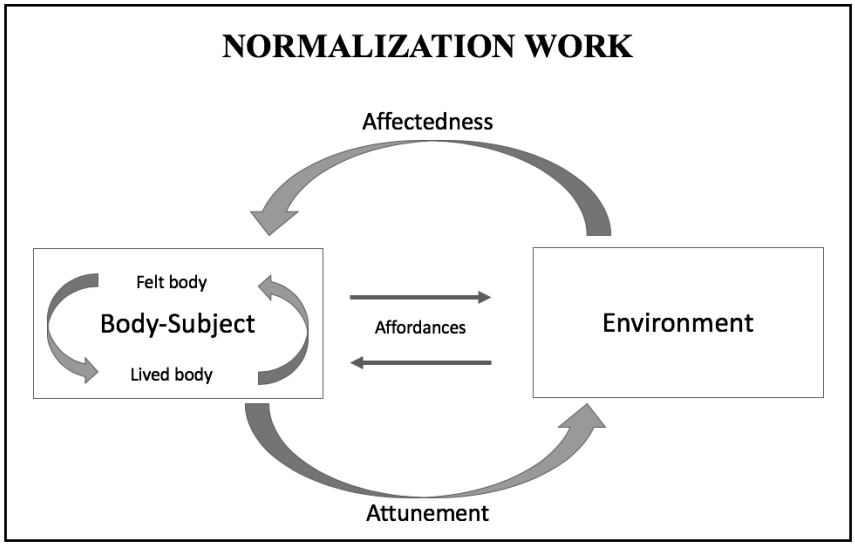

Figure 1: Normalization work

I further propose this affective and attuning body-world relation gains its fullest meaning through talk (Ricoeur 1981). Talk is constitutive of experience but also founded upon it. Language, as Heidegger (1962) puts it, is the house of being. In other words, as Ricoeur (1981) argues, the temporal structure of being (as a verb) and that of narrative share an internal, reciprocal relation. However, to render open this reciprocal relation to analyses of more arcane meanings of embodiment, I propose bracketing the temporal thematic. Understanding it simply as the co-constitutive relation between the affective and attuning situations people find themselves in and their talk thereof (Widdershoven 1993; Thompson 1997). I propose affected talk represents that dimension of normalization work that takes as its key external referent the material and the practical world as experienced through the self-authoring body-subject. Attuned normalization talk is expressive of the "tightness" of this narrativized body-world relation (Dreyfus and Dreyfus 1999). It is the potentiated readiness (Rietveld 2008) the authoring body-subject demonstrates in its attempts at gaining best possible leverage over perceived affordances, also known as 'maximal grip' (Merleau-Ponty 1962; Rietveld 2008).

Before pressing any further, let me pause and address the end to which body-subjects' relations with health norms are affective. Moreover, I will identify what these relations between the body-subject and health norms attune to. In respect to the affectiveness of health norms, people's deviations from normative expectations of bodily function primarily affecting the body-subject or prereflective embodied sense of self in the public unfolding of life. Relations between the body-subject and health norms attune to the experience of the felt body, the reification of bodily awareness by way of illness that must be reckoned with. It is an experience of the body that must be dealt with in such a way that we can appease the socially normative expectations of health. In the subsequent sections, I will demonstrate how health norms, as affective phenomena, serve as a backdrop that guides consumers' normalization work in their experience of illness. Here, the authoring body-subject perceives possibilities in the form of purposive, disciplinary action that may be said to 'tune' body, self, and environment (be that material, social or even institutional) to a common chord.

3.2 Phenomenology of Embodiment

In this thesis, I use 'affectedness' and 'attunement' to denote the embodied sensibilities of being corporeally and practically situated in the world as social beings. My account assumes that affect is not a discrete prior mental state that is then projected onto otherwise indifferent sums of material objects or social relations. Instead, this duality of affective-attunement designates modes of being-(as a verb) in-the-world that disclose how body-subjects find themselves in their idiosyncratic habitats. Sensitizing them to the doings, sayings, people, and objects that matter to and for them. Here, my treatment of affective phenomena is distinctly different from the psychological approach prevalent in consumer research. Therefore, I will first address this issue to establish clarity. Next, I will discuss in more depth the phenomenological role of affectedness. That is, how people are always already immersed in and touched by their material and social environs, and how the 'invitational structure' (Rietveld 2008; Rietveld and Kiverstein 2014) of these realms implies normatively constituted solicitations for meaningful action. Then I will further elaborate on the invitational makeup of the social and material world as a web of significance through which affordance-relations become perceptible in their 'relevance' to the action-solicited body-subject. This section will close with a discussion on the role of the body-subject, as it mediates people's' experience of the social and material environs in which they are immersed.

The predominant psychological approaches to affect designate the phenomena as feelings, emotions, and moods (e.g., Gardner 1985) and interjects them into cognitive models where an inner psyche is separated from the body and the world (Solomon 1973). Affects are generally conceived as a private mental phenomenon that arises in the subject's mind through cognitive evaluation of external stimuli (Gardner et al. 2014) Whereas the objective world (that includes the body) is essentially bare of any affective qualities or meanings (Prinz

2004). From a phenomenological standpoint, this depiction of affect is a remnant of a Cartesian dualism that is characterized by the separation of the mind and physical matter (Blattner 2006; Dreyfus 1991; Fuchs 2005; Heidegger 1962). It is a given fact that people do not solely live in a physical world. The world(s) people, or consumers, more importantly, inhabit comprise of nexuses of private and public spheres of everyday life as mediated in and through the socially and culturally defined marketplace (Arnould and Thompson 2005).

Furthermore, these life-world nexuses in which consuming body-subjects find themselves are charged with affective qualities (Lefebvre 1991; Yahklef 2015). People may sense an interpersonal "atmosphere" (Blattner 2006), for example, a welcoming (Arnould and Price 1993), solemn (Bonsu and Belk 2003), carnivalesque (Hietanen et al. 2016) or even a threatening social climate (Kates 2002). Feelings befall us, and they arise from situations (Goulding et al. 2008), consumers (Thompson 1996), brands (Fournier 1998), and objects (Bettany and Kerrane 2016) which have their expressive feature and which attract or repel us (Rietveld 2008). This affectedness is essentially felt through the medium of the body which bursts, swells, shrinks, weakens, or trembles in concert with affective relationships with environments that people experience.

I propose that we need to know more about how feelings, as affective phenomena, are attunements and dispositions that reflect how people are of always already sensitized to the practical and social situations in which they find themselves (Reckwitz 2017). Referred to as Being-in-the-world, people are immersed in social and material arrangements that solicit meaningful action. Again, 'world' refers to the public situations and specific social and material contexts that consumers are embedded in, affected by, and attuned to which make their actions socially intelligible and constitute a sense of belongingness and familiarity (Dreyfus 1991). To be attuned to the world is to be responsive to its relevant affordances. Affordances are relations of practical significance between man and world that when instantiated, create lived possibilities for action (Rietveld and Kiverstein 2014).

Moreover, affordances designate how "finding oneself in the world is thus a matter of being practically immersed in it rather than looking out upon it" (Ratcliffe 2008, p. 2). For example, consider the experience of eating at a restaurant. As I sit at my dining table, the fork does not appear to me as a conspicuous object of experience. Instead, it is withdrawn and seamlessly integrated into my activity, and my appreciation of its utility is inseparable from what I am doing. Plenty of other things also appear to be practically significant but to do not draw me in or solicit activities the way the fork does. For instance, the salt sitting on the table next to the napkins appears functional but does not currently summon me to do anything. Likewise, the bread on the table matters to me differently from the fork and salt. The bread could present itself as an impediment to my current project if I had celiac disease. Practical significance can show up as mattering in many different ways such as significant, enticing,

unappealing, threatening, safe, urgent, pressing, and others (Ratcliffe 2010). If I am sitting across from someone at the dining table, he or she may matter to me in different ways. The particular features, both social and material, of an immediate situation, weave a web of significance where the significance of one thing always relates to the significance of something else (Heidegger 1962). These relations reflect the various meaningful possibilities that one might be pursuing.

A key notion here is that this web of significance, the practical and material environment, is mediated by body-subjects "that in turn manifest (disclose) goings-on" in that environment (Schmitz, Müllan, and Slaby 2011, p. 245). In this world-creating process, the body is the "fabric into which all objects are woven, and it is, at least in relation to the perceived world, the general instrument of comprehension" (Merleau-Ponty 1962, p. 235), which relates to the significance of, but is distinctly different from, the body as an object, i.e., the material body (Fuchs 2005). Bodily feelings are modes of affectedness where something that is felt and at the same time amounts to a sense of reality and situatedness that constitutes how consumers find themselves in the world (Ratcliffe 2008). Further, bodily feelings are feelings of being: "bodily feelings are not just feelings of internal bodily states; they can also contribute to experiences of things outside the body," and certain feelings "are ways of finding ourselves in the world, existential backgrounds that shape all our experiences" (Ratcliffe 2008, p. 47).

Two broad categories make up the conceptualization of the body-subject. Both of which are implicated in the ways consumers affected by health norms in their experience of illness and attuned to meaningful actions. These categories are significant because they reveal the structure of embodiment (Leder 1990). First, the object body is the body as felt, requiring explicit attention (Fuchs and Schlimme 2009), a mode of existence where emotions or moods become manifest in people through specific kinds of corporeal feeling (Schmitz, Müllan, and Slaby 2011). These corporeal or bodily feelings are distinctly different from psychological renditions of bodily sensations. Here, the felt body-subject is revealed in fleshy feelings like vitality, vigor, and listlessness, "in one's being corporeally gripped by emotions and room-filling atmospheres" like shame or grief for example, and in one's bodily orientation in the world in contexts of perception and action (Schmitz, Müllan, and Slaby 2011, p. 244). In noticing one's' own body, it becomes conspicuous and disruptive of immersed experience (Ratcliffe 2008). The second category, the body-subject is lived, a tacit medium through which peoples' activity is directed outwards towards the world. Here, the body withdraws into the background even to the extent that it becomes 'absent' in experience (Ratcliffe 2015; Leder 1990; Fuchs 2005; Colombetti and Ratcliffe 2012). It can be argued that our body "is essentially characterized by absence" and "is rarely the thematic object of experience" (Leder 1990, p. 1). To illustrate the relational significance of the felt body: it is argued that the physiological organ that I eat my food with is rarely the focus my activity, neither are

my lungs when I breathe nor my eyes when I am seeing (Leder 1990). This point is emphasized by the notion of not being able to see yourself seeing. In other words; "to be situated within a certain point of view necessarily involves not seeing that point of view itself" (Merleau-Ponty 1963, p. 217). "The body, as a ground of experience, tends to recede from direct experience," and thus become absent or withdrawn (Leder 1990, p. 3).

The dynamics of the body-subject, the relational significance between the explicit, felt body and the tacit, lived body emerge in the contexts of ongoing activity and "are in flux throughout the course of everyday life" (Ratcliffe 2015, p. 86). In distinct contrast with extant consumption studies, my use of body-subject is to describe the balance and oscillation between felt and lived body rather than seeing them as distinctly different experiences. Within consumer research, the distinction between the felt body and lived body are described as qualitatively different experiences (Joy and Sherry 2003; Woermann and Rokka 2015; Scott, Cayla, and Cova 2017). When the body becomes conspicuous, it takes on the form of an intentional object to be dealt with and disrupts the state of flow in one's practices. Like a pianist who "shifts his attention from the piece he is playing to the observation of what he is doing with his fingers while playing it, he gets confused and may have to stop" (Polanyi 1958, p. 56). This bodily conspicuousness has been used to theorize temporal experiences of rush and drag in fast-action consumption practices (Woermann and Rokka 2015), as well as the escape from self-awareness through pain (Scott, Cayla, and Cova 2017).

To demonstrate the relational aspect of the body-subject embraced by my thesis, I draw on Merleau-Ponty's (1962) example of two hands touching. When you actively touch one hand with the other, only the touched hand is experienced as the object of perception. When you try to bring the other hand into focus, there is a gestalt switch where the perceiving hand becomes the perceived. The body-subject describes a practical context where one "is harmoniously entwined with its surroundings" establishing a style of experience responsive to the web of practical significance and the overall balance between the felt body and lived body. To illustrate the existential dimension of body-subjects we could draw on the experiences of "the first breaths outside in fresh air after having been locked inside a cramped and stuffy room, or the pleasant relaxing of the felt body when gently gliding into a hot bathtub" after a long day outside in the cold (Schmitz, Müllan, and Slaby 2011, p. 245). The feeling after a long run, a foot massage, warm showers on a cold day, or swimming in a lake on a summer night are situations where the perceptions of the body are heightened and the realm of significant possibilities that entice us to act become existentially inspiring.

Let us take a closer look at the example of an absorbed pianists from above, but this time in a way that highlights the dynamic flux between the felt and lived body. Colombetti (2014, p. 129) observes that while absorbed in playing the piano "my posture, my facial expressions, the way my fingers touch the

keys often come to the foreground of my experience without ever being attended. The body "dimly" or "obscurely" in the background, as that through which I experience the music as having some certain dynamic and affective qualities." Colombetti gives the further example, "sometimes I may explicitly attend to certain parts of the body— the way my right hand jumps over several keys in more acrobatic passages…these bodily feelings do not cease to occur when I play a piece I know well" rather they are "smoothly integrated into other forms of bodily self-awareness" (Colombetti 2014, p.129). The felt body in its conspicuousness, where the body has intentionality or in the foreground of experience through things like physical discomfort from pain or the warm embrace of a hot shower, is not disruptive of experience but on the contrary, enhance the experience by adding texture to it through certain dynamic and affective qualities.

Being absorbed dictates that body-subjects are in a "constant outward movement, directed to the environment from a hidden center, and participating in the world" (Fuchs 2003, p. 225). To bring clarity to this statement, I will return to the piano example one last time. Sudnow (1978) offers a first-person account of learning to improvise jazz on the piano. Like many who learn a new instrument or physical skill, he describes being highly reflective and observational about his technique and hand placements at the beginning of his training. He practiced deliberate movements and worked at looking for hand location and keys. As his skills improved, Sudnow (1978) illustrates that his playing was more improvisational—i.e., a non-reflective knowing how—that is guided by touch and embodiment: "Looking workload progressively lightens. … As I reached for chords … I was gaining a sense of their location by going to them, experiencing a rate of movement and distance required at varying tempos, and developing, thereby, an embodied way of accomplishing distances" (p. 12).

In this thesis, I argue that the consumer's experience of illness involves a type of bodily continuity anchored in body-subjects and embodied dispositions for disciplined action that bring to light the everyday negotiation of medicalization by consumers. This account of absorbed piano playing describes an expansion and integration of bodily awareness that is not absent of bodily presence but instead evokes a state of immersion in the practical and material context at hand (pun intended). This description indicates that people, with practice, learn to "submit" (i.e., become disciplined) to the increasing skills of their bodily habits—i.e., they are disciplined by bodily skill acquisition— and becomes an exemplar of the intentional arc (Merleau-Ponty 1962; Colombetti 2014). The intentional arc can be defined as the embodied disposition to "respond to the solicitations of situations in the world" where people are always already immersed in practical social and material arrangements that show up as soliciting their skillful response (Merleau-Ponty 1962). Skillful response (i.e., disciplined action) is much what Merleau-Ponty describes as a motor habit, that is, where the body becomes withdrawn and dimly present in the background, that does

not come without challenges during the activity but reflects one's ability to cope with those challenges through skillful, absorbed activity.

3.3 Medicalization as the Experience of Illness

I propose that extant medicalization research tends to focus on the system of health as a scientific medical discourse in its pragmatics rather than on the phenomena of how people may experience it. I argue that the experience of illness varies from the reality of things as medicalization. Medicalization is taken-for-granted as consumers' attention is focused on the explicit experience of illness and the emergence of the felt body. In this section, I will first make a distinction between disease and illness. Second, I will address medicalization as an invisible power relation that floods light on those who experience illness. Third, I will describe the dispersed relations of power in the market. Also, this section will address the body as the site through which power is performed.

Illness is the dimension of disease as it is experienced and made meaningful by the ill person (Carel 2016). This includes the experience of consumers' symptoms and physical changes, but also the experience of receiving health care and experiencing social attitudes towards illness, pain and negotiating one's mortality. For example, Carel (2016) points out that a person can be diagnosed with breast cancer but not have any direct symptoms and knowledge of cancer. As they have no direct experience of illness, that person is diseased but not yet ill. Conversely, if one is depressed and cannot pursue everyday activities but has no corresponding brain lesion, then that person is ill and not diseased because there is no physiological or scientific disease process.

Medicalization as a cultural authority on health is very much a power relation that is invisible and anonymous, and it is those who are subjected to it that are visible (Foucault 1977). As outlined in the previous chapter, illness, as well as disease, are described as a form of deviance because health is generally necessary for a functional society (Foucault 2006). Traditionally, being sick was temporary, and people would periodically be thrust into a binary sick role (Parsons 1951). Upon submission to medical care, a person would be temporarily exempt from their usual obligations, and after a stay at home or in the hospital, they would be become healthy contributing members of society once again (Parsons 1951). Illness is no longer a binary role (affording certain rights as well as obligations), it can, and is often, continually experienced where people must endure their work and social lives as normal. Medical professions have identified how unhealthy behaviors linked to diet, exercise, smoking or drinking are implicated in particular diseases (Cronin, McCarthy, and Delaney 2015). In contrast to subservient medical subjects who yearn to get better, people become more concerned with avoiding the sick role altogether by managing health risks in their everyday lives and occupy a continuous role of being a patient-in-waiting (Clarke et al. 2003).

The medicalization literature tells us that medical markets enable consumers to self-manage their health and avoid risks in a way that ultimately transforms them into patients-in-waiting (Conrad and Schneider 2010). Once the scientific discourse on disease forms a market, a seemingly individual problem can be seen as a common ailment as its knowledge disseminates through talk and social interaction connected to market activity. The medicalization critique tells us that normal parts of everyday life are transformed into fear-provoking conditions and disorders by the medical industry making ordinary, healthy people worry about their health (Moynihan and Cassels 2005). An important part of medicalization is its promotion of preventative health management. Preventative health management demands constant alertness to one's body and how it feels in order to lower the risk of disease (Holmqvits and Maravelias 2011). The onus of responsibility for one's health is on the individual who gets little help from health care institutions (Giesler and Veresiu 2014). Problems with one's health are framed as issues tied to lifestyle choice rather than scientific medicine (Cederström and Spicer 2015). Knowledge of medical dangers or one's genetic history and physiological dysfunction, like pain or discomfort, brings consumers into contact with disease through their experience of it.

Earlier in this thesis, I referred to preventative health management as techniques of self, also described as self-care, which details how consumers learn to be healthy through their body. The body has a dual role both as a physical, felt body, something that can be weighed, measured, diagnosed, examined, and described but also as a lived body source of practical knowledge, perceptions, and sensations (Merleau-Ponty 1962). The body is thus a subject-object that can be experienced from both points of view. "Diseases have bodily sites," and scientific medical discourse treats both disease and the body as a physical thing whereas consumers, as unknowing patients, experience these phenomena as the seat of subjectivity, as a body-subject (Murphy 2006, p. 107). The body is "much more than an instrument or a means; it is our expression in the world, the visible form of our intentions" (Merleau-Ponty 1962, p. 5). As such, in consumers' experience of illness, the body is not a passive material structure waiting for mental commands. Preferably the body is the core of consumer existence, the basis for interaction with the world; it is our general medium for having a world (Merleau-Ponty 1962, p. 147).

The social experience of illness forces the body to 'turn towards' itself, becoming aware of themselves as emotive body-subjects (Merleau-Ponty 1962; Fuchs 2005). The body is both active and acted upon; i.e., it is simultaneously a point of action and a mark of power (Crossley 1996, p. 104). Embodied identity is never self-reflected. Instead, it is produced through our continuous interactions with other human and non-human bodies (Weiss 1999). Disability and illness interfere with claims to competence, foregrounding the vulnerability of the body (Wainwright and Turner 2003). Such interference can become a critical

experience where people discover their absent-present embodied self. As Kirchner and Ainlay (1991, p. 21-22) write,

> *A person's ties to her/his body are perhaps made most clear when something about the body goes awry. Most people are aware then – whether they view their bodies as enabling or limiting – of both being and having a body.*

In a phenomenological sense, illness is an experience that re-configures an individual's everyday life, and relatedly the meanings and experiences flowing from it. To study an impaired or ill body would thus be fruitful to foreground the "critical cultural and moral frameworks which link the body, self and society" (Bury 1997, p. 112).

This thesis is about consumers' experience of illness and not the facts of disease. Disease falls within the domain of the hard sciences whereas illness has traditionally been understood through disciplines like psychology, sociology, anthropology, and philosophy. I suggest that illness can and should be studied by consumer research as well. Ample evidence points to the marketization of medicine and health care as well as to the invention of a health-conscious consumer subject (Thompson 2004; Cronin, McCarthy, and Delaney 2015; Cronin and Hopkinson 2018; Fischer, Otnes, and Tuncay 2007; Giesler and Veresiu 2014; Thompson 2004, 2005). "Illness is a fundamental experience in almost everyone's life," and by appreciating the impact of illness on consumers' lives, the ways illness deviates from normative order, I can contribute to a more complete account of consumption and the consumers' way of being (Carel 2016, p. 18).

3.4 Revising Normalization in Consumer Research

> *If the jurists of the seventeenth and eighteenth centuries are considered to have invented a social system that had to be governed by a system of codified laws, it might be argued that in the twentieth century doctors are in the process of inventing a society, not of law, but of the norm (Foucault 2006, p. 11).*

One of the ways society is governed is through medical norms. The medical profession aims to correct deviant behavior through prescriptive means. The effect labels what is not normal as deviant, and the stigma resulting from a deviant label encourages members of that group to adopt dominant social norms (Foucault 1961; Goffman 1963). Consumer researchers have studied many contexts in which consumption activities contribute to normalization, and these cases can serve as building material for my interpretive framework to understand medicalization. Embedded in these studies lays the assumption that such consumption acts can provide consumers an experience of the socially normative dimensions of the world. These studies take up a variety of analytic cases that range between bodily, socio-historic, and existential levels of analysis. For example, consumers submit themselves to the bodily inscriptions of gender,

athleticism, and self-image because it enables them to manage and train the actions of their bodies (Schroeder and Zwick 2004; Askegaard, Gertsen, and Langer 2002; Johanssen, Tienari, and Valtonen 2017). At the socio-historic level, reflexive activities like managing socially normal credit/debt levels establish opportunities to participate in normative consumption practices (Peñaloza and Barnhart 2011). Ethical consumers experience the stereotyping of their behavior as abnormal by the social majority who attempts to maintain the status quo, and they cope with the disparaging of sustainable values and ideologies in order to establish a sense of existential stability (Barnhart and Mish 2017).

These investigations can help explain how functional food consumers can cope with the experience of illness associated with food-related disease. Consumers value bodily practices such as the use of diet charts and exercise regimes as they afford opportunities for absorption in the world that does away with bodily limitations tied to illness (Featherstone 1991; Thompson and Hirschman 1995). The purchase of private insurance or the pursuits of alternative health perspectives are activities that give consumers self-sufficiency to govern their health in socially intelligible ways (Giesler and Veresiu 2014). Others utilize the social welfare state and public health care system, and they are subjected to being sick and providing visibility for their illness to get the appropriate treatment of their health issues (Warde 1990). Drawing on Heidegger's (1962) concept of Care, I am able to organize how the bodily, social, and existential modes of normalization into a single perspective. There is a distinction between self-care and the concept of Care that needs to be made clear. Self-care refers to the techniques of normalization and care as an autonomous self-project. In contrast, the concept of Care that this thesis embraces is one which deals with the ways people relate to the world, what happens in the everyday swing of life, and practical dealings with projects and people that are beached in engagement, connection, and concern. The concept of Care is the focus of the next section.

In the sections that follow, I will provide a theoretical overview of the concept of Care as it grounds my reconfiguration of consumer research on normalization into a single perspective. Next, I will address how this alternate view of normalization (the shift from a post-structural to a phenomenological lens) requires a parallel shift in how we view practices of talk. Discourses define "who and what is 'normal,' standard and acceptable" (Merilänen, Tienari, Thomas, and Davies 2004, p. 544), as well as acceptable and unacceptable ways to talk and act (Hall 2001). Thus, practices of talk are central to processes of normalization as we study them in consumer research and other social science disciplines. After a discussion on issues of power related to my framework for normalization work, I will identify the advantages of a revised view on normalization and what novel insights it will allow.

3.4.1 The Concept of Care

The term Care has two conflicting meanings: it describes both *devotion*, for instance, through the act of providing welfare to another and *the burden of concern* associated with that Care (Dreyfus 1991). "The double sense of cura refers to care for something as concern, absorption in the world, but also care in the sense of devotion," and to illustrate the struggle between the opposing meanings of Care—Care as burden and Care as devotion—I will draw on the Greco-Roman myth of Cura (e.g., Care) in more detail (Heidegger 1975, p. 303; Hyginus 1976). The story of Care starts in a river crossing. Care gathered clay and engrossed in thought began to mold it into the shape of a human being. Jupiter, the god of the sky, came along. Care asked him to give the figure spiritus, the breath of life. Jupiter granted the figure life. Care wanted to name the human after herself, but Jupiter insisted that his name should be given to the figure for offering it spiritus. While Care and Jupiter were arguing about to whom the figure belonged, Terra, also known as Earth, arose and said that the human being should be named after her, since she had given it form with her body. Saturn, son of Terra, who was known for his devotion to fairness and equality, rendered judgment over the dispute. Saturn decided that Jupiter, who gave life to the figure, would receive it in death. Since Terra had offered her body to the figure, she should receive it back after death. Since Care was the creator, she would hold on to it as long as it lives. The last resolution was that homo, human being, would be the name because it was made from humus earth.

Care as devotion is shown in the human being's "absorption in the world" and refers to the bodily element in the story that pulls you towards death but also holds the human together in wholeness (Heidegger 1975, p. 303). The concept of Care refers to a general attitude towards life where the most basic way of being a human subject is to be a self-interpreting subject (Dasein) that is absorbed one's own existence (Heidegger 1962):

> *A lifestyle that corresponds very well to the classic metaphor of sailing, which contributes a series of factors that affect the control and steering of an existence that endlessly floats on an ocean of desire and temptation. Life never stops being a journey; that is, a genuine movement from one point to another. This movement, in turn, implies having a clear idea of the port of arrival and, therefore, requires a set of knowledge and skills associated with steering that can be easily obtained for the destination of our own existence (Escudero 2013, p. 305).*

In this sense, life is very much a journey. When illness or disease plagues our life odyssey, medicine becomes the steering mechanism that leads us safely to harbor. "The perfectio of human being—becoming what one can be in being free for one's own most possibilities (project) —is accomplishment of care" and, from this perspective, self-care and subjectification seem to align with the structure of Care (Heidegger 1962, p. 199). Subjectification, which is the idea that consumers can maneuver inside pockets of freedom that emerge within the

structures of their practices, mirrors the self-interpreting subject's existence in a shared world as it concerns itself with what it means to be human and live out a human life.

Care as burden is shown through mortality in the myth of Cura and suggests the importance of the body and time. The experience of action and mortality is an important dimension to the structure of Care. The Care structure lies at the center of consumers understanding of everyday life and the meaning of being. 'Care' is a condition of human life. Our lives matter to us - we 'care' about it (Blattner 2006). From the lighthearted person to those whose lives are dedicated to others, Care is a condition that spans a variety of forms. In so far as we are presently concerned over our life, it matters to us; things are always coming forth, moving forward into the future and projected ahead to bring itself into consideration. Mortality is being-towards-death where the possibility of death is not an event that terminates life but rather reveals the indefiniteness and finitude of existence. Thus, an important dimension of Care is to use time (minutes, hours, days, weeks, and so on) in ways that matter to us and are urgent. The lifelong Care of the human that is undertaken in the myth of Cura entails a bodily element that grounds human experience. Death, as an indefinite possibility, gives us directedness as self-concerned beings that juxtaposes people's sense of agency within the social and material environment. In fact, it is through this very social and material environment that consumers learn of their mortality. Consumers attune and resonate with the shared world because they have a body. The knowledge of mortality and the realization of being-towards-death transform how things matter for consumers as they come to understand the burden of death as a uniquely individual experience.

> *We find ourselves delivered into a situation that must be dealt with somehow (past). Yet we are not mere slaves to this situation since we go to work on our current situation by glimpsing possibilities in it that we can try to actualize (future). Finally, every moment of factical life is a profound tension between what is given to us and how we confront it (present). Life is a kind of unrest, forever torn between poles of reality. Life is a movement, or "motility" (Harman 2007, p. 29).*

Consumers are always in a state of movement or a situation of having to act (Gadamer 1960). The primary orientation of Care is towards the future. Time begins with us always thrown ahead of ourselves into the future. The future and the possibilities it presents come first. People are always pressing ahead. This is in direct contrast to chronological time, described as the flow of a river, where the past comes first, and the future lies ahead (e.g., Cotte et al. 2004). "Through care, we are always already "ahead of" ourselves," and this anticipation of what consumers pursue to 'be' forms from the futures of past that make up prior experiences (Ricoeur 1980, p. 177).

Experience, as in "Being (as a verb)," is always-already directed toward the future in an involved and purposeful manner: "Being-ahead-of itself-being-already-in-the-world-as-amidst" (Heidegger 1962, p. 192; Blattner 2006). Being-in-the-world is a fundamental characteristic of Care that implies consumers' thrown-ness among things (Ricoeur 1980). To be 'thrown' into existence implies that there is always already a material and social world into which we are born and socialized, enabling and conditioning the ways we act, behave, and think (Thompson et al. 1989). Thus, people do not control thrown-ness, but rather receive their social situation from thrown-ness. A persons' social environment already dictates everything that a person could do, past, present, and future. Under thrown-ness, there is nothing unique about any particular human being, and nobody is an autonomous individual free to choose his/her way of existing. Instead, people reckon with being amidst their environment. Being-amidst (or more colloquially, 'being there,' i.e., being always has a 'there') is the bodily grounding that allows consumers to attune and resonate intercorporeally through absorbed engagement with the world (Merelau-Ponty 1962). In these ways, the Care structure synthesizes the bodily, social, and existential dimensions of normative experience into a co-constitutive whole. Together, Care and normalization work revise extant views on normalization in consumer culture theory by harmonizing different levels of analysis, and, as a unified whole, provide us insight into 'invitational' (Rietveld and Kiverstein 2014) relations that consuming body-subjects share with broader contexts of significance in which they are embedded.

3.4.2 Issues Related to Consumer Talk

Another dimension of experience that consumer researchers have not examined in depth is the relation between normalization and talk. Building on the Care structure, discourse is a fundamental way that things become seen (Dreyfus 1991). Discourse is a means of organizing background practices and gathering together what shows up to people as meaningful and how it does so (Heidegger 1962). Discourse becomes experienced as narrative and made concrete in talk (Dreyfus 1991). Talk is the way people find meaning in their lives through the stories they tell (Ricoeur 1980). Conversely, the meanings of the stories that people tell cannot be resolved without any reference to the lives that they live (Widdershoven 1993). "Language is the house of being" and is the primal mode that people experience, think, and develop meaning in the world (Heidegger 1962, p. 488). As people reckon with and respond to Being-in-the-world with others "language is the primal dimension" in which the responsive corresponding takes place (Heidegger 1977, p. 41).

The consumer research that addresses the relationship between normalization and talk does so through a post-structural approach where consumers are conditioned to act by dominant discourses of what is accepted and what is not. That is, they shape peoples' behavior according to norms (Foucault 2006). Consumers' ability to position themselves as subjects standing over and against an object (Hirschman and Thompson 1995; Cronin, McCarthy, and Delaney

2015; Barnhart and Mish 2017) through the imposition of moral regimes of governance (Sandikci and Ger 2010; Askegaard et al. 2014; Giesler and Veresiu 2014) and reflexive navigation among various discourses (Karababa and Ger 2010; Peñaloza and Barnhart 2011) is characteristic of such an approach. According to the post-structural approach, consumers conform to norms by taking the body as an object to manage it, order it, and work on it through discipline. The significance of such normalization implies situating "micro-level cognitive process within a broader socio-cultural, historical, and institutional setting in order to identify some of the structuring relations that arise among ideological, cultural, and psychological structures" (Humphreys and Thompson 2014, p. 882; Askegaard and Linnet 2011; Thompson, Arnould, and Giesler 2013; Humphreys 2010a; Giesler and Veresiu 2014). The phenomenological approach to discourse taken in my thesis contrasts, in certain respects, to the post-structural approach common in consumer research. For example, Blattner (2006, p. 76) argues that "We do not normally experience ourselves as subjects standing over against an object, but rather as at home in a world we already understand. We act in a world in which we are immersed. We are not just absorbed in the world, but our sense of identity, of who we are, cannot be disentangled from the world around us." Following Blattner, I will come to argue that lactose intolerant consumers' disciplinary talk attunes and directs their absorbed engagement with the world towards health. I will also establish how "language, with its storehouse of meanings," guides consumers' coping in purposive, pre-reflective, pre-theoretical, and mostly precognitive ways allowing them to overcome immediate impediments to their actions (Ricoeur 1980, p. 169). Talk and language establish and maintain our absorption in Care and concern over our lives. As I ground my analysis in the body, establishing the body as the common foundation in consumer experience rather than cognitive processes, it is important to consider the co-constitutive whole of bodily, social, and existential modalities that normative experience form together. Without an appreciation of Being-towards-death, such a perspective would miss the embodied nature of synthesis and the affectedness of talk. As a consequence, we would also miss the way that *being-in* bodily states conditions consumers' freedom and openness to the world. Our discursive practices are always made concrete in practical circumstances and material arrangements that reveal what matters and makes sense to do and say (Dreyfus 1991). By neglecting an explicit emphasis on mortality and the sense of ending it provides in the face of an open-ended existence, the bodily-directed nature of being-in-the-world and our talk about it go missing from theory. Affectedness implies thrown-ness into particular situations that show themselves in consumer's talk. Talk that organizes experience into a coherent, developmental whole and enforces anticipation of "something that has already happened stretched out between a beginning and an end" (Ricoeur 1980; Polkinghorne 2010, p. 133).

To recap, the experience of Being-in-the-world implies an experience of the world as one of familiarity and practical embeddedness. Consumers go about everyday life in a manner free from rules and pre-thought plans, and this

leads me to theorize that for consumers with lactose intolerance illness is a mode of existence that affects one's entire way of being (Smythe et al. 2008). Consumers do not experience the world by stripping practices down to their essential elements. For example, consumers do not problematize turning a door handle or opening a window. They just do it. Walking through the door is habituated in people, and they are familiar with it. Only when there is a breakdown with a particular tool do these habituated, tacit practices become explicit (Heidegger 1962). The breakdown of tacit practices invites the analogy to illness. The absorbed engagement of tacit practices can be described as Being-able-to-be, and illness creates a loss in one's way of Being that produces a breakdown, or the inability-to-be (Carel 2016). This breakdown situation can be likened to how Being-towards-death affects us because freedom and openness to the world are closed down. I propose that consumers of functional foods experience of illness establish a breakdown in the ability-to-be. The habitual, everyday experience of the world changes and affords a new set of meanings to consumers' practical engagement with the world as a way of working towards acceptable discursive conclusions for these breakdowns (Carel 2016). These discursive conclusions are specific to their situation and offer continued opportunity to press ahead into new possibilities.

To conclude this section, the fundamental way we exist in everyday life is "to get lost in things, to get caught in the whirlwind of daily tasks, and to be influenced by public opinion" (Escudero 2013, p. 304). In consumers' immersion and entanglement with the world, they engage in the process of normalization throughout everyday life. This state produces anxiety when consumers find themselves at the boundary of normal with disease or illness. Consumers' practices always have a concrete *there*, a situation or set of circumstances that discloses what matters and makes sense to do, which means that consumers are doing something that makes sense to do given the public situation. The world is always shared with others and offers possibilities for each individual to press ahead. When a particular practice breaks down, meaning that it does not make sense to do it given the public situation, then anxiety emerges as certain possibilities close down and others emerge. Again, anxiety describes how a person finds herself in the world affectively rather than as a concrete emotion illustrated by psychological approaches to the concept (Ratcliffe 2008). Consumers naturally and "repeatedly fall prey to the clutches of public opinion" by their fundamental familiarity and absorption in the world (Escudero 2013, p. 303). This normalization is not a narcissistic motivation for the promotion of self-aesthetics that researchers popularly describe in consumer culture (Featherstone 1991; Thompson and Hirschman 1995; Schroeder and Zwick 2004). In contrast, during the occurrence of a breakdown for which consumers appropriate in "a convenient getting-done of things themselves" (Heidegger 1977, p. 241), the self-concern that structures normalization in this phenomenological sense registers as the closing down of opportunities while offering others in their place. For example, the inability-to-be founded by illness establishes anxiety as one's experience deviates from the norm and consumers are subjected to continual

pressing ahead into new worldly possibilities in order to maintain a state of absorbed engagement. What counts as absorbed engagement is relative to the broader cultural background of significance and as such can be thought of as a norm; yet the norm is never given as a determinate property (Kelly 2000). There is no situation or condition of an inability-to-be that consumers find themselves in where they return to normal unchanged; thus, normalization work is co-constitutive of worldly possibilities, exercised through peoples' regulation of themselves and their talk about health norms.

3.5 Issues of Power in Normalization Work

I propose to investigate the relationship between the feeling body-subject and the phenomenon of medicalization through the way consumers make sense of the experience of illness, specifically, lactose intolerance. Appropriate to my cultural subject matter, I organize my analysis of consumer talk about lactose intolerance in a way that is grounded in a particular interpretive framework. Although my analysis is decidedly data-oriented, it does not emerge in a theory-free manner. An explicit theoretically informed interpretive framework guides my analysis of consumers' discursive practices (Thompson 2004). This framework foregrounds what lactose intolerant consumers' talk is about, how it informs their conditions of possibility for the experience of illness for these individual's (Foucault 1977) and opens up their talk to meaningful interpretation (Moisander and Valtonen 2006). In the following section, I outline part of this a priori structure; namely, disciplinary power (Foucault 1977) and the way it tempers consumer talk in the experience of illness. My approach focuses on the analytic appropriation of disciplinary power by body-subject as it is infused in the emotive and embodied orientation of everyday practices (Fuchs and Schlimme 2009; Merleau-Ponty 1962; Ratcliffe 2008; Dreyfus 2008). It is attunement to disciplinary power through the feeling body-subject that forms the conditions of possibility for meaningful action in the experience illness. Disciplinary power tunes the ill body-subject and the practical socio-cultural environment into a common chord that opens the kinds of possibilities and projects that make sense to do and say given the bodily impairment of lactose intolerance. My conceptualization of normalization work extends research on normalization and related past ideas that outline how institutional processes of surveillance encourages conformity (e.g., post-structural approach) by focusing on the way disciplinary power establishes consonance between the feeling body-subject, affective intersubjective environments, and belonging to the world. Consumer talk reproduces health norms regulating food consumption in ways to fabricate conformist selves.

Since my approach differs somewhat from the post-structural perspective on disciplinary power and the consumer research that mobilizes it (e.g., Cronin, McCarthy, and Delaney 2015; Thompson and Hirschman 1995; Thompson 2004), I will begin with a review of the literature. The broad objective of this thesis is to contribute to a more complete account of the lived experience of

illness by synthesizing the bodily, social, and existential levels of analysis that occur in the normalization of medicalization as Care. As a type of discourse of health, medicalization is infused with power relations. In the previous chapter, I noted that Foucault is a central figure in theorizing medicalization. What sets Foucault's discussion on medicalization apart from others is his theory of power (Lupton 1997). For example, Foucault's work emphasizes "the positive and productive rather than the repressive nature of power" that the medicalization critique embraces, as Lupton (1997, p. 98) also notes:

> *What makes power hold well, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse, it needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression.*

In the previous chapter, I outlined the term biopower through a discussion on technologies of power. Biopower is productive, and it informs how one lives (or should live) through "an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" (Foucault 1976, p. 140). In this sense, biopower operates at the macro-level, at the level of collective populations or species, and is about control of the population (Lynch 2014). One form of power that operates at the micro-level is disciplinary power. Like biopower, disciplinary power is directed at bodies; but, rather than groups of bodies or a population at whole, disciplinary power focuses on individuals (Hirschman and Thompson 1995). Both disciplinary power and biopower are connected and necessary for this research.

To describe this connection between these two types of power I evoke a discussion on the architectural structure of the panopticon (Foucault 1977). The panopticon was a building designed for prisons in such a way that guards could observe prisoners without being seen themselves. As such, prisoners assume that they are always being watched and alter their behavior accordingly through self-disciplining tactics. Prisoners inability to tell if they are being watched makes discipline a passive rather than active action and "He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection" (Foucault 1977, p. 202-203). The conceptualization of the panopticon, as a symbol of the disciplinary society of surveillance, cannot only be seen in total institutions such as prisons, hospitals, mental asylums, monasteries, or the military (Goffman 1962; Foucault 1977) but also in many other more mainstream and 'weak' institutions like factories, school houses, workplaces, organizations of all kinds, and most recently through the myriads of digitalized social media platforms. Techniques of discipline and surveillance manifest in moderate or implicit forms through daily social situations (Goffman 1969). Human roles are constituted in face-to-face interactions and

an individual's actions, as they appear before others, influence patterns of normality and deviance:

> *If the inmates are convicts, there is no danger of a plot, an attempt at collective escape, the planning of new crimes for the future, bad reciprocal influences; if they are patients, there is no danger of contagion; if they are madmen there is no risk of their committing violence upon one another; if they are schoolchildren, there is no copying, no noise, no chatter, no waste of time; if they are workers, there are no disorders, no theft, no coalitions, none of those distractions that slow down the rate of work, make it less perfect or cause accidents (Foucault 1977, p. 200-201).*

As a metaphor representing visibility and control, the panopticon gets spread and generalized into society as hidden surveillance. One can be seen and observed without another person being directly visible. Foucault (1977, p. 304) writes:

> *The judges of normality are present everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the' social worker'-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behavior, his aptitudes, his achievements. The carceral networks, in its compact or disseminated forms, with its systems of insertion, distribution, surveillance, observation, has been the greatest support, in modern society, of the normalizing power.*

"Discipline" and "surveillance" become the normalizing power that is pervasive within society. However, in its operation, the social function becomes concealed as discipline and surveillance become mobilized by "each individual, wherever he may find himself." By changing the conditions for which we see ourselves, the larger, communal governing body becomes absent and unseen as we self-govern.

Normalization refers to technologies of power that govern normality, the role of normative expectations, and the disciplining of the body as an object of control (Hirschman and Thompson 1995; Cronin, McCarthy, and Delaney 2015). The post-structural approach to power argues that consumers create and pursue "knowledge itself, which, by creating norms and standards, helps form a disciplined subject" (Shankar, Cherrier and Canniford 2006, p. 1017). These knowledge systems are characterized as totalizing and individualizing techniques (Foucault 1977). These knowledge systems are totalizing in that they are used in practical day-to-day human practices like health maintenance inscribed by medicalization. This type of power delivers "all thoughts, beliefs, actions, morals, and desires of individuals towards a norm that is acceptable" (Shankar et al. 2006). As such they are forced to act in accordance with a dominant discourse of what is accepted and what is not.

These knowledge systems are also individualizing in the sense that the idea of normality, and also "abnormality, become increasingly clear and more rigorously defined. As power is inscribed in all social practices, the notion of normality in terms of the body, behavior, attitude, or disposition become more apparent and easier to identify" (Shankar et al. 2006). Individuals at the boundary of normal, those who are not perceived as, among other things, rational, responsible, socially untainted, healthy, and regulated become the target for more control and discipline. Thus, in molding a particular kind of subject, the exercise of power creates an opposition between 'us and them' that legitimates actions undertaken in the name of good and marginalizes those performed by the "others" as bad (Shankar et al. 2006). This system of normalization sculpts identities that render useful the self-absorbed actions of those subjects and produces docile bodies that "may be subjected, used, transformed and improved" (Foucault 1977, p. 136). As such, discipline does not simply act upon subjects but materializes through the physical, object body as it creates a *capacity* to be normal (Foucault 1980).

In this thesis, normalization work is a dimension of discursive activity that is *affected by* and *attuned to* the circumstances and possibilities they perceive their illness implies (Dreyfus 1991; Heidegger 1970). I underscore two principles of power that are particularly pertinent to the affective-attunement duality. The first holds that socio-cultural conditions affect the body-subject via distinct practices of power (Foucault 1977; Thompson and Hirschman 1995). For example, society's images of masculinity shapes how stay-at-home dads portray themselves and regulate or normalizes the types activities in which they engage (Coskuner-Balli and Thompson 2012; Moisio, Arnould, and Gentry 2013). The second premise is such that body-subjects' active relationships to their environments attune the body-subject to context-relevant practical responses that constitute the world as 'ready-to-hand' to use Heidegger's (1962) expression. Here, power relates to the body's ability to act within a particular context such that peoples' concern dwells not with their body but with the at hand. For example, bodily skill acquisition and diffusion of embodied competencies allow consumers to immerse themselves in the experience of high-speed motorcycling (Murphy, Patterson, and O'Malley 2018).

To date, consumer researchers have touched upon the first principle, that is the affective link between power and normalization as it is associated with socio-historic patterns of consumption, normative expectations, and bodily norms (e.g., Thompson and Hirschman 1995; Schouten 1991; Schroeder and Zwick 2004). At the socio-historic level, consumer studies that view power as contingent to socially and culturally ingrained forms of knowledge and behavior consistently focus on either ideological or macro institutional structures and how consumers conform to them (Thompson 2004; Giesler and Veresiu 2014; Karababa and Ger 2010; Humphreys 2010b). Here, dominant discourse can provide legitimacy for the normal through defining the abnormal, but they often

conflict with practical activity and the meanings consumers make as they interact within its social field (Barnhart and Mish 2017). For instance, dominant discourses of western medicine tend to conflict with consumers seeking alternatives to their medical identities through the natural health marketplace (Thompson 2004). In regards to normative expectations, consumption theories that emphasize normative pressures and implicate power in self-reflection show how consumers recognize their identity and assign meaning and value to their lives (Peñaloza and Barnhart 2011; Sandikci and Ger 2010; Arsel and Bean 2013). For example, moral regimes become embedded in the normative system of food and health. Moral regimes refer to the discursive practices that: 1) accept a moral status and make it function; 2) accept the mechanism and instances that enable to distinguish good practices from bad; and, 3) accept the techniques and procedures that shape the way eating becomes an individual responsibility where unhealthy individuals are solely responsible for their own deteriorating health (Askegaard et al. 2014; Yngfalk 2016). At the bodily level, consumer researchers tie technologies of power to mind-body distinctions viewing the body as an object to be enhanced, modified, studied, and inscribed (Celsi, Rose, and Thomas 1993; Thompson and Hirschman 1995; Patterson and Schroeder 2010; Goulding, Saren, and Lindridge 2013; Schouten 1991; Valtonen 2013). When the object-body is discussed, it is most often referring to a range of regimes and technologies used to construct a positive external body image (Askegaard, Gertsen, and Langer 2002; Schroeder and Zwick 2004). Taken together, each of these different levels of analysis, tend to prioritize the way social norms get inscribed on consumers who, through purposeful self-control and discipline, work to obtain status and social acceptability. While I am interested in the link between power and normalization, what is missing is an understanding of the body as an affected medium that organizes experience (Fuchs 2003, 2005), and attunes consumers to what is meaningful to say and do.

Of particular interest to this thesis is to understand the ways consumer cope with the medical gaze and its constitutive power relations through their everyday purposive discursive actions and practices. The medical gaze describes the domination of medical norms on society as a system of knowledge that turns "sickness to spectacle" under the moral guise of doing what is right for the larger population (Foucault 1973, p. 85). Disease is viewed as a threat to public safety, and the ill are reorganized in order to be observed and the examination of the body "replaced the former holistic medical process that considered the person and their life" resulting in the patient's body becoming separate from their identity (Tian et al. 2014, p. 239). Taking this perspective, "power as it operates in the medical encounter is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies" (Lupton 1997, p. 99). The patient transforms from an obedient, non-thinking blind-believer to an active, thinking and social being who must detect behavioral deviances that get framed as existing health problems (Holmqvist and Maravelias 2011). In this setting, the central strategies of disciplinary power "are observation, examination, measurement and the comparison of individuals against an

established norm, bringing them into a field of visibility" (Lupton 1997, p. 99). This proposition supports the notion that power is a relational strategy that gets transmitted through social groups (Foucault 1980); "The power that doctors have in relation to patients, therefore, might be thought of as a facilitating capacity or resource, a means of bringing into being the 'doctor' and 'patient' subjects and the phenomenon of the patient's 'illness'" (Lupton 1997, p. 99). My study is inspired to locate power relations as institutionally unbound (Bartky 1990). It is not exclusively the medical institution that needs to be in focus, but a more bottom-up perspective that analyses the individual's everyday life and its entanglement in consumer culture (Hacking 2004; Thompson 2004).

I suggest that disciplinary forms of action can matter to consumers in a particular way as they occur through the medium of the feeling body. The priorities and possibilities that resonate with the affected body-subject sustains the ability-to-be and maintains the directedness of Being-in-the-world (Heidegger 1962). I propose, grounded in the phenomenology of embodiment, that disciplinary power infuses affective phenomenon like "feeling," "mood," and “emotion.” We know that the body is an object of experience, a site of the human mind, a discursively controllable entity, and an instrument to be molded in accordance with social standards of acceptability (Crossley 1996; Trethewey 1999; Styhre 2004). This "mentalization" of the body occurs in sites of symbolic interaction or discursive apparatuses through which disciplinary regimes or power/knowledge nexuses manifest, providing consumer theorists with explanations of how the body is seen as an object, vessel for the mind, and market resource (Strati 2007, p. 65; Schouten 1991; Celsi, Rose, and Thomas 1993; Thompson and Hirschman 1995; Askegaard, Gertsen, and Langer 2002; Giesler 2012). To add a new texture to this stream of research, I propose a need for a fuller understanding of the body-world nexus in regards to peoples' situated normativity (Merleau-Ponty 1962; Joy and Sherry 2003; Ratcliffe 2015). There is a distinction to be made between the feeling body-subject, a medium through which we experience other things, and the body as an object of experience (Ratcliffe 2015; Fuchs 2003). However, the two experiences are often inseparable and "most, if not all, bodily feelings are relational. They are seldom, if ever, experiences of just the body" (Ratcliffe 2015, p.82). Consumers' experience of illness is "both a bodily feeling and, at the same time, an experience of worldly possibilities" (Ratcliffe 2012, p. 23). The fact that things can matter in a particular way is always "grounded in one's attunement" (Heidegger 1962, p. 176). Disciplinary power becomes a relationship between the body and 'the world' people find themselves in, where things and options already matter "like an atmosphere in which we first immerse ourselves in each case and which then attunes us through and through" (Blattner 2006, p. 77). In contrast to the psychological approach to affect that is prevalent in consumer research, the phenomenology of embodiment regards affect as an encompassing phenomenon that connects body, self and world (Fuchs 2005).

3.6 Implications of Normalization Work for Consumer Research

In this thesis, I focus on the body-subject as a medium through which power affects and organizes consumers' experience of illness, while also disclosing how to act, talk, and think accordingly. Normalization work is a form of talk that is disciplinary in that it is affected by deviation from social norms, while attuning in our bodily feelings, to possibilities for purposeful action. Power is infused throughout the process of normalization work. It is a type of relationship between the body-subject with the social and material world in which people are immersed that sets the tone of life. The body makes up part of a tacit sense of belonging to the world that is normally unnoticed (Ratcliffe 2008). I propose that this conceptualization of normalization work enables us as scholars, to explore a dimension of consumer experience that is taken for granted—that of medicalization in the marketplace.

I draw attention to the three analytic levels of normalization that I adapt to Heidegger's threefold structure of Care. A point made earlier in the chapter addressing the bodily, socio-historical, and existential approaches to normative consumer experience (Humphreys 2010a; Karababa and Ger 2010; Peñaloza and Barnhart 2011; Giesler and Veresiu 2014; Barnhart and Mish 2017; Johansonn, Tienari, and Valtonen 2017). Power, structured by Care, is both a burden and devotion to the world in which consumers experience of illness is immersed. Care is the threefold structure characterized by bodily, social, and existential dimensions of experience. The social dimension describes our thrown-ness or affectedness by the social environment, our human setting, our physical, ideological, and moral situation that are the aspects of what it means to be in a world at all. Our familiarity with social environments, our' knowing our way about,' only comes from experiencing submission to established conditions in the 'here and now' mediated by our bodily feelings. In reference to the bodily dimension, body-subjects are culturally conditioned by the web of practical significance that projects worldly possibilities for purposive action in our immersed involvement in the world. An important note here is that the threefold structure of Care "are not pieces belonging to something composite, one of which might sometimes be missing." Instead, these characteristics are "woven together" in practical social and material environments (Heidegger 1962, p. 191). The threefold structure of Care reveals consumers' embeddedness in particular contexts that govern the dynamics of body-subjects (Dreyfus 1991). I suggest that the dynamics of the felt and lived body-subject offer a meaningful horizon of action in which things and projects can appear as they are engaged in a world with others. The threefold structure of Care not only sets the tone of life but through the body, "tunes us into the different imports of things, persons and events around us" (Blattner 2006, p. 78). Different degrees of bodily feelings are integral to consumers' experience of illness in so much as they impact one's concerns and the structure of Care (Ratcliffe 2012).

Within consumer research, the physical discomfort of pain has been argued to disrupt our participation in the world. The world ceases to appear as a

realm of significant possibilities that entices us to act and instead becomes something before which we are passive (Scott, Cayla, and Cova 2017). What is missing from this description of physical discomfort is an appreciation of the phenomenological dimensions of body-subjects. It has been argued that it is plausible to maintain that some pain may contribute rather than destroy our sense of belonging to the world (Ratcliffe 2010). For example, pain "opposes the expansive tendency of our personal impetus; we can no longer turn ourselves outward, nor do we try to leave our personal stamp on the external world. Instead, we let the world, in all its impetuousness, come to us, making us suffer. Thus, pain is also an attitude toward the environment" (Minkowski 1958, p. 134). By further exploring body-subjects in the absorbed, practical day to day coping of being-in-the-world, these theoretical limitations can be overcome by recognizing the ways that the felt body assail us, establishing dispositions and orientations towards the world. Here, bodily feelings are not regarded as synchronic episodes or one-off events (Scott, Cayla, and Cova 2017). Instead, bodily feelings develop in the context of peoples' ongoing activity such as wandering through an art museum in which feelings of anticipation may not meet with fulfillment, amounting to feelings of unfamiliarity that might shape our further actions (Joy and Sherry 2003).

One way to rescue the felt body and physical discomfort from the reactionary associations described above through the example of pain is to think more clearly about illness becoming embodied as suffering. On the one hand, suffering has implications for the marginalization of particular consumer groups in an oppressive form that politicizes medicalization (Hughes and Paterson 1997). This has individual repercussions where for example, consumers feel marginalized because of their inability to participate in fashion markets (Scaraboto and Fischer 2013). The reverse is also present, where the idea of suffering (and thus illness) is social. The narrativization of illness becomes social as it enters the world of discursive circulation and intersubjectivity (Hughes and Paterson 1997; Cederström and Spicer 2015; Fischer, Otnes, and Tuncay 2007). The discursivization of suffering takes illness out of the felt body and places it in what Merleau-Ponty (1962) refers to as intercorporeality—the relation of one's body to that of another. Bodies become social bodies because they share the same space or field of perception. It is illness, "the body as material entity appropriated as language and symbol," that structures intercorporeal encounters (Hughes and Paterson 1997, p. 336). In much consumer literature that addresses issues of social suffering, the body—reduced to illness—is afforded only its objective status as an object-body (Hirschman and Thompson 1998; Tian et al. 2014; Cronin, McCarthy, and Delaney 2015). In doing so, it reproduces the empirical body of medical intervention (Crawford 1998) and eliminates the dynamics of the lived and felt body-subject as the feeling of being. The consequence is that researchers are left with little to say about the bodily point of view of consumers, the embodied experience of suffering, oppression, or marginalization. If detachment is the affective position that impaired bodies take on as part of a process of resistance to social expectations of parenthood (Fischer,

Otnes, and Tuncay 2007), then, consumer research, by way of its cartesian worldview, is unable to explain this corrective. Detachment is not just an attitude determined by the experience of social and normative forces; "it is a carnal style; a way of being in the world that embodies resistance" to social expectations of parenthood when one can't participate and that disciplines our consumer needs and wants (Hughes and Paterson 1997, p. 337).

In a consumer society, individuals supposedly have the freedom to make choices towards the satisfaction of their needs and wants. They experience this perceived freedom as foundational to constructing their individuality and identity (Applbaum 2006). Sahlins (1996) argues that the belief in unlimited wants is distinctive of the West, and develops from the Christian idea of "fallen man" as sufferer. This culminates in a notion of the person "as an imperfect creature of need and desire, whose whole earthly existence can be reduced to the pursuit of bodily pleasure and avoidance of pain" (Sahlins 1996, p. 412). I argue that normalization work comes about when consumers cannot bear the constraint on their freedom and openness to the world that the experiences of illness and physical suffering impose. Poststructuralist studies, on one hand, argue that instead of dealing with anxiety associated with the experience of illness, consumers refuse to recognize the situation at hand and immerse themselves back into consumer society and conform to the world that lifestyle marketing offers that has now extended to the health-conscious consumer subject (Giesler and Veresiu 2014). A plethora of experiential consumer studies analyze the ways that individual consumers harness the market-derived resources to craft personal meanings and discipline themselves (Askegaard and Linnet 2011). Being highly attentive to consumer experience, I argue consumers are affected by power relations between the body-subject and the social as well as material context to which they belong, while simultaneously establishing a type of worldly possibility for normalcy in the face of experiencing illness. The restoration of normalcy directed through the body-subject turns normalization inwards and allows consumers with illness to extrapolate bodily distress as a normal experience of things.

I begin my investigation with the research question, "How do body-subjects cope with lactose intolerance through their talk?" To answer this question, I analyze medicalization from the consumers' perspective. Moving forward, I make a case for a discursive approach that focuses on consumer talk to grasp the recursive relationship between cultural norms that exist in the social environment, and the embodied experience through which consumers respond to these normative pressures, and in turn shape them. Bodies inhabit discourses of medicalization, and they provide local force and significance for macro cultural pressures of normativity. Building on extant literature, I offer an analysis of medicalization through consumers who cope with lactose intolerance and show how normalization work functions to both affect and attune their associated consumption experiences. Later, I will discuss the implications of my findings.

4. WHY USE DISCOURSE TO STUDY CONSUMERS' EXPERIENCE OF ILLNESS?

Building from the conceptual framework of normalization work that I outlined in the previous chapter, I will open up a discussion on methodological issues that the proposed research entails. This chapter is structured as follows. After the introduction, I will develop the methodological frame over three main sections that put forth a detailed exposition of discourse. My treatment of discourse is, in some ways, different from the conventional approach prevalent in consumer research. The first section will review these and relevant literature to establish clarity. The second section maps out the phenomenological approach to discourse central to this dissertation. Finally, I outline implications for this approach to discourse, followed by a brief conclusion.

This chapter suggests that discourse is apt for the study of consumers' embodied experience of illness. In the subsequent sections, I set out to further pursue the way normalization work allows consumers to negotiate the experience of illness through disciplinary talk. It is worth reminding the reader that the term normalization work is used as an interpretive conceptual framework. Normalization work denotes a form of talk that is disciplinary in that it is affected by the body-subject's deviations from social norms, thus revealing power relations between the felt body and the social environment, that attune to possibilities for purposive action. These discursive practices are directed at overcoming immediate impediments associated with the experience of illness. Body-subjects are a particular aspect of the interpretive framework that acts as one but not the sole determinant of normalization work. Equally important is

discourse and practical understanding (Ratcliffe 2010). These, mediated by bodily feelings, comprise the structure of normalization work.

In this study, I take a phenomenological approach to discourse where language can disclose the experience of familiarity in the world, and I take discourse to mean 'letting be seen.' This definition contrasts the conventional use of discourse as representations that constitute knowledge through the production and consumption of texts (Foucault 1972; Fitchett and Caruana 2015; Schroeder and Zwick 2004). In this study, I understand discourse as a way that the background practices organize, and gather together, what shows up for us and how it shows up for us. In this way, "discourse is the articulation of what understanding is," (Heidegger 1962, p. 203) and it becomes methodologically necessary to situate discourse in the structures of being-in-the-world (see Borgerson and Schroeder 2002; Dobscha and Ozzane 2001; Fairclough 1992; Humphreys 2010a; Roper et al. 2013). Heidegger (1962, p. 204) notes that "Discourse is the "meaningful" articulation of the understandable structure of being-in-the-world." Further, discourse is experienced as articulation and made concrete in talk (Heidegger 1962; Ricoeur 1991; Thompson 1997). While consumer researchers have made considerable advances in mobilizing discourse as a way of addressing the problems of consumer subjectivity, situating being-in-the-world within discourse (Karababa and Ger 2010; Peñaloza and Barnhart 2011; Giesler and Veresiu 2014), we know less about the affective-attunement of consumer talk that takes as its key referent the material and social affordance relations that the world is perceived to offer the feeling, self-authoring body-subject. The potential relevance, I propose, is to move discussions beyond hyper-individualizing examinations of consumer subject-formation that effectively situate 'being' into the secrete individual mind (Askegaard and Linnet 2011; Thompson, Arnould, and Giesler 2013) through an alternative phenomenological level of analysis. That said, I look to shift the focus from subjectivity to that of the world and take discourse as the explication of the being-in-the-world displayed by talk (Ricoeur 1981). In the phenomenological approach taken in this study, the ontological priority sits with Dasein (*there* being) where the self, one's subjectivity, is always already situated in the practical and material world in which one is immersed (Heidegger 1962); thus, the self and world are two sides of the same coin. Recognizing that "Language is the house of being" (Heidegger 1962, p. 488), my attention focused on consumers' discursive practice, how they co-constructed versions of their selves "relationally through direct engagement with the world they inhabit" (Chia and Holt 2006, p. 637), and how the world comes into being as an extension of their own body (Tsoukas 2005).

In this chapter, I argue that the full appreciation of consumers' experience of illness as an embodied aspect of belonging to the world (or being-in-the-world) can be revealed through the affective-attunement of discourse. I propose the affective-attunement of discourse captures how we as beings are directed or inclined towards maximal grip. Maximal grip refers to the struggle to get a "grip" on the world in which we are immersed (Merleau-Ponty 1962). The affective-

attunement of discourse refers to the ways people are concerned by their deviations from social order, misalignment with the social environment that disrupts and disjoint the public unfolding of life, and as such are directed and inclined to refine responses to bring the current situation closer to normalcy. Illness is an embodied form of suffering that sets limits to the world, enclosing the conditions of possibility for consumers' experience (Carel 2016). Such narrowing down of perceived possibilities for meaningful actions, experiences affectively shape how we find ourselves in the world and talk about it like, for instance, through a sense of frustration, dejection, or anxiety. Consumers' relationship with the everyday world is one of unquestioned habit to which we are thrown. In our thrownness, the meanings in our lives emerge "within already institutionalized orders, primarily the grammars, standards, and skills associated with everyday and shared use of language" (Holt and Cornelissen 2014, p. 526). Discourses are thus sets of statements which impose limits on what is meaningful in being-in-the-world (Foucault 1972), manifesting affectively in and through the feeling body-subject, ultimately infusing "the mobilization of discourses" (Cederström and Spicer 2014, p. 182).

Jørgensen and Phillips (2002) observe that discourse is often understood as the fixation of meaning within a particular domain. They give the example of a medical discourse in which the body, disease, and treatment are represented in particular ways that divide the body, disease, and treatment into parts. Further, they describe the relations between these parts in clear and unmistakable ways, noting "the body is typically seen as split into parts that are to be treated separately" and the causes of disease are often seen as local, like an infection regarded as being "caused by a local attack of micro-organisms that should be eliminated by medicine" (Jørgensen and Phillips 2002, p. 26). In this way, medical discourse stretches out a net of interrelated meanings over a domain about the body and disease that fixates meaning. In that sense, consuming body-subjects' talk about the experience of illness as the qualitative dimension of disease is affected by deviations from such meanings and associated social health norms. In and through engagement with discourse, consumers tend towards maximum grip, a bodily disposition to "respond to the solicitations of situations in the world" in a way that leverages whatever practical and discursive wiggle-room available therein, with the ultimate end of attaining optimal embodied equilibrium with social health norms (Dreyfus and Dreyfus 1999, p. 103).

Against the backdrop of health norms, it is through consumers' talk that affectedness and attunement to disciplinary action become ultimately intelligible. However, importantly, it is the feeling body-world nexus that initially mediates such affective-attunement. In consumers' deviation from social health norms, they are affected as emotive body-subjects (Wyllie 2005), giving rise to doings and sayings that are attuned to ends of attaining maximum grip (Merleau-Ponty 1962). Take the common experience of the sudden urge to use the restroom minutes before arriving at your home. The body becomes the driving force behind all your actions. The world around you closes down. The erudite

conversation you have with your travel companion is disrupted. You are suddenly directed with the sole purpose of obtaining relief from the bodily pressures that reside within. This urgency reaches intelligibility through a combination of facial expressions, bodily mannerisms – but ultimately through personal mumblings about having to get home quickly. In the winter months, for instance, your hat and gloves are removed before even reaching the front door. Moving through the threshold of the home, your jacket is off, and your actions are circumspective, absorbed, and purposive. You are attuned to every turn of a hallway, every passageway, and every potential impediment as you maneuver, without thought, for that moment of relief as you are directed towards embodied equilibrium: "whoaah, that was a close one!"

Illness, as a context, is an extreme example of this theoretical insight that can help give "veracity and texture" that foregrounds how bodily feelings attune our actions and talk (Arnould, Price, and Moisio 2006, p. 107). To extend theory on the affective dimensions of talk, as it is mediated by bodily feeling in consumers' normalization work, I chose a context that is likely to be fruitful in this case, consumers experience of illness within the functional food marketplace. I decided on an illness that directly related to the Finnish dairy market: lactose intolerance. Lactose-free dairy and probiotics are functional foods, characterized by their health benefits obtained through scientific medical intervention (Östberg 2003). Lactose intolerance, as an illness, was especially suitable for studying how talk is affected and attuned to disciplinary action for several reasons. First, when I initially encountered lactose intolerance in Finland, it was widely accepted as common and normal ailment such that participants knew the related functional foods history and development. Second, participants had a personal history of the illness and the bodily awareness to describe bodily feelings associated with lactose intolerance. Third, many of the participants were not stigmatized by the illness such that they were comfortable in navigating social situations with the lactose intolerant identity. Fourth, the functional food marketplace developed with the support of the publicly subsidized universal health care system and mainstream food industry that contributed to the institutionalization of its legitimacy. As I explain later in the findings, illness is made conventional and commonplace through talk that happens among consumers, and the cultural reproduction of the Nordic welfare regime and its legacy of universal equality informs the normalization of medicalization (Giesler and Veresiu 2014; Peñaloza and Barnhart 2011).

Among the challenges of studying medicalization and bodily impairments related to illness is the need to be sensitive to both theory and context. Hughes and Paterson (1997, p. 337) explain that medicalization reproduces the empirical body of medical intervention that "eliminates the 'lived body' (Leib) and as a consequence has nothing to say about the bodily point of view" of those who experience bodily impairment. To this end, I benefited from a phenomenological approach to bodily feeling to understand participants' experience of illness as lived, body-subjects. As I noted in the earlier chapter on medicalization,

Lupton (1997, p. 94-95) recognizes the limitations of institutional level data and calls for work that analyses how individuals take up, negotiate, and transform discourses "in their quest to maximize their health status and avoid physical distress and pain." To this end, I chose as a point of departure to focus primarily on consumer interviews to capture individuals' understanding of their being (as a verb) and the being of other entities encountered through concernful, ordinary everyday interactions of being-in-the-world (Heidegger 1962; Dreyfus 1991). Finally, as Askegaard and Linnet (2011) observe, a complete understanding of analytic abstractions, like for instance, medicalization, requires attention to experience and talk as it is affected and attuned to practical contexts. The interpretive approach to discourse that this thesis adheres to is primarily grounded in the phenomenology of Heidegger (1962), Dreyfus's (1991) commentaries on Heidegger's work, and to a lesser extent to the phenomenology of narrative, as outlined by Ricoeur (1981, 1984). In this tradition, it is highlighted that people do not exist in the world as spectators of objects, but rather, are always already absorbed and engaged with entities in the world that affect and attune their understanding and narration of worldly activity. In the following section, I will pause and review the current appropriation of discourse in consumer research and relevant literatures.

4.1 The State of Discourse in Consumer Research

The previous chapter on normalization work discussed the role of the post-structural approach in consumer research for studying normalization and power whereby consumers are forced to act by the dominant discourse of what is accepted and what is not (Foucault 1972). Here, consumers are guided by social norms, standing in as predefined goals and structural constraints, that direct, purposeful, planned action towards desired outcomes. In this way, normalization is the social process where ideas and actions become taken-for-granted (Foucault 2006). The habits of language and action in everyday life go unnoticed. One way to examine this process is to study related discourses. Discourses define "who and what is 'normal,' standard and acceptable" (Merilänen, Tienari, Thomas, and Davies 2004, p. 544). Discourse is a system of vocabulary, ideas, and beliefs that set limits upon and produce what a person can think and say about a given subject (Foucault 1972). As a result, discourses bring about power/knowledge relations that emerge through talk and are embedded in social practice (Heracleous and Barrett 2001). Discourses "'hook' into normative ideas and common-sense notions" and construct "ideas which convey messages, for example, of 'good' and 'bad,' morality and immorality, and acceptable and inappropriate behaviors" as a form of disciplinary power (Carabine 2001, p. 269). Discourse "creates bodies of knowledge that normalize certain ways of believing, speaking, and behaving" (Maguire and Hardy 2009, p. 151).

One substantial limitation of this post-structural approach is that consumers tend to be seen as "puppet(s) dangling from the strings" of dominant discursive systems (Alvesson 2003, p. 24). Discourses are said to constitute and

position consumer subjects in ways where the individual has no sense of choice in the matter (Moisander, Valtonen, and Hirsto 2009). This is what is meant by discourses of power where peoples' position in the marketplace is an outcome of the particular discourse(s) being present that constitutes the consumer subject (Thompson 2004). Consumer researchers have studied many contexts in which discourses are viewed to constitute consumer subject positions. These discursive investigations tend to collapse meaning and practices into a deterministic relationship between the consumer subject and the macro-systemic contexts in which they are embedded (Alvesson and Kärreman 2011). For example, news media shape public discourse and consumer subjectivities by "presenting culturally legitimated frameworks" for consumers to understand events such that social tensions are worked out into collective agreements through discursive media systems (Humphreys and Thompson 2014, p. 883; Humphreys 2010a; see also McCracken 1986). Likewise, ethically-minded consumers who are aware of the impact their consumption has on the environment, consumer health, and society are formed and actively managed by macro discursive systems that determine their behavior (Giesler and Veresiu 2014). While the presence of powerful discursive systems may stabilize subjectivity, as might be the case with the above ethical consumer subject, the plurality of discourses available to consumers nonetheless invite varied and fluctuating subjectivities (Thompson and Haytko 1997). Here, consumers find a sense of freedom in their reflexive maneuvering amidst a plurality marketplace discourses that impose meanings and influence their behavior (Murray 2002; Shankar, Cherrier, and Canniford 2006).

This post-structural approach to discourse in consumer research limits our ability to understand the relationship between embodiment and consumer talk. To back up this claim, let us first look at the post-structural lens. The body becomes molded and inscribed to the image of the culturally constituted world, under which meaning is collapsed and constrained. Market discourse becomes a "cultural resource" that constitutes the consumer subject, his or her talk, and the body as an object of representation (Holt 2002b, p.87; Belk 1988; Dittmar 2007; Elliot and Wattanasuwan 1998; McCracken 1986; Östberg 2010; Patterson et al. 2009; Thompson 1998; Woodruffe-Burton and Ireland 2012). In contrast, the approach taken in this thesis is consistent with research that takes embodiment as "the starting point for analyzing human participation in a cultural world" (Csordas 1993, p. 135). Embodied activity, the very way of being-in-the-world, underlie, and make possible the ways the culturally constituted world is accepted, experienced, and perpetuated (Merleau-Ponty 1962; Connell 1995; Watson 2000). Key to the approach taken in this thesis is that embodied experience organizes itself through perceived affordance-relations for lived possibilities for meaningful action, and perhaps more importantly, for salient, situated ways of talking (Merleau-Ponty 1962; Riceour 1981; Rietveld and Kiverstein 2014). For current purposes, the approach used in this work – that is a situating of discourse in and through being-in-the-world – is 'phenomenological.' Consumer research tends to prioritize understanding how "people reflexively

maneuver amidst a plurality of discourses through identity talk, thus ensuing the common moniker of 'identities in flux' (Thomas and Linstead 2002, p. 75; Thompson and Haytko 1997; Murray 2002; Thompson 2004; Ahuvia 2005). Here, the tendency is to limit the body to a material entity that can be shaped and molded according to a given identity project and the doings and sayings that comprise and maintain it. An approach where phenomenology of embodiment, being-in-the-world, and discourse are enmeshed, finds significance by orienting analyses of discursive and cultural systems in and through the consuming body-subject, the dimension of subjectivity that is the fundamental ground of human experience (Csordas 1990; Merleau-Ponty 1962).

The handful of consumer research that does address the reciprocal relations between the body and consumer talk mainly addresses how "the body is one shaped by discourses and used towards identity-expressive ends" (Woermann 2017, p. 9; Bjerrisgaard et al., 2013; Thompson and Hirschman, 1995). This stream of research conceptualizes the body as a potentiality, to be sculpted and worked upon, either from outside-in, as a site for disciplinary regimes to materialize, or from inside-out, as reflexive resistance or consent (Thompson and Üstüner 2015). Bodies are prone to "social conditions and institutions in order to 'be'" (Butler 2009, p. 33). This literature often takes recourse to the analytic construct of 'self' or identity to position the body as a discursively controllable entity, an instrument of (identity) work (Trethewey 1999). Contemporary sociological and organizational theorizing on the body often posits a close relationship between the body and (incomplete) self-identity, "a tendency for the body to be…in the process of becoming; a project which should be worked at and accomplished as part of an individual's self-identity" (Shilling 1993, p. 4-5). My phenomenological approach conceptualizes the body as an affective and attuning medium through which we experience our surroundings and make sense of our lives through the function of "embodied narrative sensemaking" (Cunliffe and Coupland 2012, p. 64). Post-structural approaches, on the other hand, focus on the body outside lived experience and abstracted as a container for the mind to be shaped, molded, and transformed based on the discursive imposition of various marketplace meanings (Schouten 1991; Askegaard, Gertsen, and Langer 2002). Even if I took the excess body and its leaking, farting, limping, and smelling, as the key to my analysis, it would retain essential limitations. Embodied intercorporeal experiences are permeable, like a membrane engulfing us, such that we partially make sense of our lives and experience in shared moments of bodily interaction with others (Cunliffe and Coupland 2012). The body interferes with the intersubjective world, and experience becomes a matter of condition, not of will (Merleau-Ponty 1962). I argue that bodies inhabit discourse, social practice, and meaning-making processes, all of which tend to be obscured within consumer research (Humphreys 2010a; Karababa and Ger 2010; Giesler and Veresiu 2014).

To the streams of discursive studies that exist in consumer research, I would now wish to add the affective-attuning dimension of discourse. Noting

the importance of embodied nature of understanding, and how consumers' discursive interpretations are underscored by how they find themselves in the world as directed, acting beings, there is a pressing need for more research on how our situated bodies conditions talk. Talk is always already an embodied capacity; it is a "bodily secretion" and an embodied skill (Csordas 2008, p. 119). Conversely, discourse is typically characterized by "language, genres, tropes, styles, signs, symbols, and semiotized entities, ideas, beliefs, meanings, understandings, explanations, opinions, concepts, representations, models, theories, and so on" (Fleetwood 2005, p. 200). Recent studies have aimed to separate discursive and non-discursive elements of consumer reality including material aspects like water and earth, or artifacts such a surfboard, or even social aspects such as western forms of capitalism that conditions and structures consumption (Canniford and Shankar 2012; Varman and Belk 2012). Similar to critical discourse analysis (Fairclough 2005), these studies argue that the earth or any other material object for that matter are not created by discourse, and separates discourse as a phenomenon from material entities, artifacts, and social structures. However, it should also be noted that consumer practices always have a concrete there, anchored and situated in normatively defined material and social realms. Though such practices are fundamentally embodied ways of being and perceiving, they are, in their meanings and meaningfulness always already given over to us discursively (Dreyfus 1991; Lakoff and Johnson 1985; Schatzki 1996). In some resemblance to isomorphic forces in institutional theory (e.g., DiMaggio and Powell 1983), *being-there*, that is, always already in given practical and bodily situation, people configure their talk by grasping events that occur in their lives into coherent wholes that work purposively toward ends specific to those situations (Ricoeur 1981). In this study, I highlight that the authoring body-subject sets discursive limits that fixate meanings in practical and material conditions. In the experience of illness, the body's dysfunction provides a sense of immediacy and need for discursive conclusions that being-in-the-world cultivates.

4.2 The Phenomenological Approach to Discourse

I now turn to phenomenology (Dreyfus 1991; Heidegger 1962; Merleau-Ponty 1962) to confront the shortcomings related to embodiment within existing approaches to discourse in consumer research. Critics of phenomenology, as it has been applied in consumer research, suggest that it has left a legacy of overemphasizing individualistic, agentic, and subjectivist approaches to consumer research (Askegaard and Linnet 2011; Moisander et al. 2009). It would seem, therefore, that further research is needed that "...connects the structuring of macro-social explanatory frameworks with the phenomenology of lived experiences, thereby inscribing the micro-social context accounted for by the consumer in a larger socio-historical context" (Askegaard and Linnet 2011, p. 381).

While noting that existential phenomenology in consumer research (Thompson et al. 1989), a rather eclectic blend of existential psychology (Valle

and King 1978), Husserlian (1960) and Heideggerian phenomenology (1962) has come under criticisms (Askegaard and Linnet 2011; Moisander and Personen 2002), I draw more narrowly on the tradition of Heideggerian phenomenology of being-in-the-world (Csordas 1990; Dreyfus 1991; Fuchs 2005; Heidegger 1962; Ratcliffe 2008; Rietveld and Kiverstein 2014; Ricoeur 1981; Wyllie 2005), and its premises to highlight how micro-level activity creates social order and has macro-level discursive outcomes; thus, making clear the macro-limitations of conventional views on medicalization (Brennan, Eagle, and Rice 2010). This section aims to build towards a more specific discursive oriented theory of consumer experience. To do this, I suggest the need to shift the emphasis of discourse from subjectivity to that of the world, that is, the context through which actions and talk are made intelligible (Schutz and Luckmann 1967). The analytic focus must balance between consumers' existence in their worlds as an individual and within their social context. From this standpoint, both the world and being are considered inseparable. In divergence from discursive approaches that collapse meaning into macro-systemic contexts (Alvesson and Kärreman 2011), my phenomenological approach views meaning as co-constituted through practices of talk about "being with others in the world, in shared humanness, and in shared interactions in the world (Horrigan-Kelley, Millar, and Dowling 2016, p. 7).

The purpose of this section is not to give an all-encompassing picture of phenomenology, but to explain some of its key themes and how they can inform our understanding of the affective dimension of discourse and its application to consumer research. For this purpose, the interpretive approach to discourse that this thesis adheres to is primarily grounded in the phenomenology of Heidegger (1962) and his followers. In this tradition, phenomenology is the study of lived experience (Carel 2016), and lived experience occurs through the activity of inhabiting the world. To inhabit a world implies always already being-there, that is, being situated in a meaningful setting, amidst particular circumstances, practices, and other actors. Lived experience is this way a medium and background of change, lacking content other than itself where understanding is achieved through attuned know-how—that is, embodied and habituated fluid affordance relations. To remind the reader, an affordance relation is a normative one between opportunities present in the social and material realms and the abilities of the body-subject (Rietveld and Kiverstein 2014). What makes affordance relations normative is that such lived possibilities for action (i.e., affordance relations) become perceptible to the body-subject when worldly opportunities and the skills and aptitude of the actor 'match' (Rietveld 2008). The analytic foci I want to emphasize is that of the consuming body-subject via their absorbed coping with entities (objects, tools, equipment, other people, etc.) in the world. It is worth reminding the reader here that entities exist in a web of practical significance and are not merely trivial things. For an entity to be useful and, thus, meaningful and significant, it would first have to be understood or familiar in and through embodied know-how. Consumers have prior knowledge of entities through their practical familiarity with them, that is to say, "a pre-

reflective, directed bodily self-awareness that constitutes the unnoticed background of all intentional feeling, perceiving, [talking], or acting (Fuchs 2015, p. 2 [brackets added]). Body-subjects are guided and solicited by the web of practical significance that their familiarity with the world affords. Discourse is the articulation of that bodily form of intelligibility.

Several attempts have been previously made to introduce phenomenology to the study of consumption. The most notable example is found in the work of Craig Thompson (Thompson, Pollio, and Locander 1989; Thompson 1997; Thompson 2004; Thompson and Troester 2002; Thompson and Coskuner-Balli 2007; Thompson and Tian 2008; Arsel and Thompson 2010). Drawing considerably from existential psychology (Valle and King 1979), but also Edmund Husserl and Martin Heidegger's work on individuals' everyday experience of the world, Thompson et al. (1989) emphasizes describing consumers' first-hand lived experience as it emerges in the cultural context in which it is embedded. Thompson et al. suggest' that meaning or experience should be studied through the hermeneutic framework of figure/ground (1989). Here, consumer experience (as figure) is never independent of a contextual back (ground) and the two co-constitute one another. Elements of the background "exert influences on the awareness of the consumer and may suddenly impress themselves as text" in ways that attune consumer psychological concerns and attention towards their context (Askegaard and Linnet 2011, p. 391).

Building from the figure/ground metaphor, Thompson (1996) transitioned to a more comprehensive hermeneutic phenomenology, developing a mode of interpretation that transcends psychological concerns of the consumer by focusing on broader socio-historical and cultural contextual elements. Within the hermeneutic endeavor, Thompson, along with others (Askegaard and Linnet 2011, p.394; Arnold and Fischer 1994), argues to retain detailed description of consumer experience while in reference to "extra-experiential contexts on theoretical and methodological grounds." Thus, the figure/ground metaphor is expanded to a grander dialectic of part-and-whole that encompasses the larger context of experience (Thompson 1996; Askegaard and Linnet 2011). While applauding the introduction of phenomenology to understanding consumption and consumers' narratives thereof, Thompson parts ways with the affective-attunement of discourse as to how this might be achieved. Instead of starting with the immediate material and social conditions of possibility for affectedness of experience and discursivity (as Heideggerian phenomenology proposes), he prioritizes the larger socio-historical backgrounds of significance in his analyses of micro-phenomena. In and through such a framework, Thompson comes to argue, for instance about the symbolic significance of emotional relationships to others. He argues that "interpersonal relationships are emotionally charged with symbolic significance…that animate social relationships" including those within the marketplace and its system of symbolic meanings (Thompson 1998, p. 7). For him, it is through the macro-systemic meanings of the marketplace that our affectedness is reproduced. This emotional space is also where

dominant discourses can be called into question and negotiated (Thompson and Haytko 1997). He suggests that these emotional, interpersonal relationships with the marketplace provide a gap for researchers to examine the politics of consumption and the various discursive clashes within (Thompson and Coskuner-Balli 2007). Finally, he suggests that the work of Merleau-Ponty may provide a way of thinking about how the lived body may establish different ways for thinking about discourse such that talk is the "means by which our bodies 'sing the world'" (Thompson 1998, p. 7).

Phenomenology has been widely applied to the study of consumer behavior (Askegaard and Linnet 2011). Consumer researchers have explored these ideas in the context of fashion discourse (Thompson and Haytko 1997), glocalization (Thompson and Arsel 2004), brand relationships (Fournier 1998; Thompson Rindfleisch and Arsel 2006), social movements (Thompson and Coskuner-Balli 2007), and institutionalized marketplace mythologies (Thompson 2004; Thompson and Tian 2008). What they have not done is draw out the implications for this line of study to the affective-attunement of discourse. I suggest that a phenomenological approach to discourse addresses three dimensions that primarily ignored by other approaches. First, I highlight how discourses are based on being-with-one-another such that we are always comparing ourselves with others and trying to orient ourselves in this way. Second, I focus on how distantiality—that is, the affectedness in ones talk that arises through the deviation that exists between the experience of the individual and their situated social normativity—mobilizes an attunement to public interpretations. Finally, I posit the affective-attunement of discourse is directed towards getting maximal grip on the world (Merleau-Ponty 1962). As a reminder, maximal grip refers to the body-subjects attempt to get the best 'grasp' on the material and social affordances the world is perceived to offer. The affective-attunement of discourse is expressive of the 'tightness' of this narrativized body-world relation (Dreyfus and Dreyfus 1999). By 'tightness,' I refer to the potentiated readiness the authoring body-subject demonstrates in its attempts at gaining maximal grip over perceived affordances, as she tries to cope with her lot (Merleau-Ponty 1962; Rietveld 2008). I will now develop each of these points in greater detail.

4.2.1 The Order of Discourse: Being-With-One-Another

An important assumption from discourse analysis that this research builds on is that discourse is the relationship between various social elements that produce meaning rather than the elements themselves as the bearer of meaning (Cederström and Spicer 2014). However, I diverge from more popular versions of discourse analysis in that I aim to understand not just textual elements but also embodied immediacy (i.e., affective-attunement) revealed through language (Csordas 1990; Holt and Cornelissen 2014). Thus, discourse helps render the intersubjective and intercorporeal nature of the bodily and material world in meaningful ways.

Discourses often refer to the fixation of meaning in a particular domain (Jørgensen and Phillips 2002). Thus, it is important to conceptualize the different discourses that compete in the same domain such that it defines the context of discourse. The context of discourse can be thought of as a complex configuration of meaning built from practical social and material circumstances that condition the possibilities for peoples talk (Foucault 1972). From a phenomenological perspective, discourse is seen to disclose or reveal the relational configuration of meaningful entities—also described in the previous chapter as the web of significance. The web of practical significance emerges through the individual's directedness and engagement with the world. Such practical significance is always already embedded in the intersubjective realm to which we discursively relate (Fuchs 2005; Merleau-Ponty 1962). Heidegger (1962, p. 154) draws on the example of a coming across a boat which is seemingly foreign and unknown:

> *The boat anchored at the shore is assigned in its Being-in-itself to an acquaintance who undertakes voyages with it; but even if it is a 'boat which is strange to us,' it still is indicative of Others. The Others who are thus 'encountered' in a ready-to-hand, environmental context of equipment, are not somehow added on in thought to some Thing which is proximally just present-at-hand; such 'Things' are encountered from out of a world in which they are ready-to-hand for Others—a world which is always mine too in advance.*

Looked at in this way, discourse does not merely encompass speech or written text, but also bodily and material aspects. This example suggests that we learn about things and entities through our relationships with Others. By Others, Heidegger does "not mean everyone else but me-those over against whom the 'I' stands out. They are instead those from whom, for the most part, one does not distinguish oneself—those among whom one is too… By reason of this with-like Being-in-the-world, the world is always the one that I share with Others" (Heidegger 1962, p. 154-5). Simply put, we are thrown into cultural worlds for which we are socialized to have pre-understanding of particular entities within that world, a pre-understanding that is reliant on the world as we share it with others. As such, Being-with-one-another is an a priori condition for how we discover the meaning behind entities in the world. Thus, when material entities like a boat become the focus of our attention, they have meaning in so far as they are rendered intelligible through their relation with discourse (Fleetwood 2005).

Foucault (1980) provides parallel examples through his metaphor of a book. A book is not made up of individual words on a page where each has its meaning; instead, a book "is caught up in a system of references to other books, other texts, other sentences" (Foucault 1972, p 23). The meaning of that book is the object of this discourse and connects to a more extensive web of knowledge and ideas. What (the object), how (the practice) and who (the subject) talk about things is what controls the discourse. Foucault (1972) "describes discourses as

practices specified in the element of the archive" (Foucault 1972, p. 131), the archive being "the general system of the formation and transformation of statements" (Foucault 1972, p. 130). I take Foucault's discussion on "the who" as the subject and extend it through phenomenology to Being-with-one-another where "the who" represents social normativity in a particular domain. Social normativity that is anchored to practical and material entities like the body, objects, tools, equipment, and immediate social situations.

To illustrate this idea of being-with-one-another, I will draw on an example from Dreyfus (1991), where he describes how every society has its sense of what counts as an appropriate distance to stand while communicating. This distance can vary depending on whether the person is a family member, a business colleague, a neighbor, a stranger, or a friend. Further, this can change depending on the context the verbal exchange is taking place, such as on a noisy train car versus a quiet room. The standing distance between your communicative partner involves social norms of what is acceptable and what is not, these norms being culturally specific. The Others—the group from which one does not stand out from—is ontologically equivalent to the culture. In simple terms, what a person does or says is absorbed in various ways from their culture, that is to say, absorbed through other people with which the public unfolding of life is immersed. Thus, our discursive interpretations are the ability to follow norms.

Discursive interpretation is closely intertwined with understanding. Discourse is the "universal medium through which understanding occurs" and is shaped by cultural and social life (Gadamer 1960, p. 389). Implicitly, the nature of human beings is to always be in a state of understanding where "[understanding is not] an isolated activity of human beings but a basic experience of life. We are always taking something as something. That is the primordial givenness of our world orientation, and we cannot reduce it to anything simpler or more immediate" (Gadamer 1960, p. 58). Discursive interpretation makes "explicit that which was already implicitly present in understanding" (Cerbone 2009, p. 62). There are two key structures linked with the activity of the interpretation of understanding: the "as structure" and the "forestructure" (Heidegger 1962). The "as structure" refers to the interpretation of an entity "as" something for something. "The 'as' makes up the structure of the explicitness of something that is understood, it constitutes the interpretation" (Heidegger 1962, p. 188). For example, we interpret a car as a car and bird as a bird. These are worldly interpretations and once we understand them, they do not require learning each time. They are performed so long as one's surroundings maintain themselves in a certain intelligibility that results in familiarity. Consumers' discursive interpretation is projected toward entities that are useful, revealing their purpose or function within the web of practical significance associated with this entity (Horrigan-Kelley, Millar, and Dowling 2016, p. 3). As I discussed in the previous chapter, practical significance refers to the possibilities for action provided by the social and material contexts relevant to the unquestioned habits which we are thrown. To illustrate, people find themselves thrown into a world at a given time

and place where definite alternatives are open to them: "I am in certain possibilities: my job, my occupation" (Heidegger 1962, p. 186). These possibilities are not uniform throughout history and space. For instance, watching television on our computers is a concrete possibility in one age and not in another, and, as such, determine possibilities that are social, economic, political, cultural, or technological that bring with them the language with which we make sense of the world. Our actions are not without presuppositions but rather guided by the familiarity of everyday interactions in a social world (Horrigan-Kelley, Millar, and Dowling 2016). Thus, we have prior and pre-existing knowledge about entities in the world—a pre-understanding—that is characterized as the "forestructure" and colored by our Being-with-one-another.

4.2.2 Delimiting Discourse: Distantiality

An important question facing discursive theorists is how to delimit a discourse. Delimiting a discourse typically refers to the practices that set limits on what is meaningful (Foucault 1972). Jørgenson and Phillips (2002) suggest that delimitation of discourse is determined strategically based on research aims. My dissertation is driven by axiological assumptions that connect the overriding purpose of the research with the questions being asked (Hudson and Ozanne 1988; Bono and McNamara 2011). In light of my research question— How do consuming body-subjects cope with lactose intolerance through their talk? —the axiology of this thesis is to illuminate the ". . . ordinary, taken for granted living as something more layered, more nuanced, more unexpected and as potentially transformative when something is revealed of the extra-ordinary" (Friesen et al. 2012, p. 33). What is more, exposing consumers' average everydayness in their lived experience of illness provides the researcher an opportunity to inductively reveal discursive meaning from the emic perspective through talk as they cope with the burden of diverging from social norms of health—a burden invoked by distantiality. This section will discuss the role of distantiality as a delimiting structure to social normativity.

I define distantiality as the ever-present deviation that exists between the experience of the individual and social norms. Distantiality refers to a person's relationship with 'the Others'. Building from Blattner (2006), I interpret the Others, i.e., Being-with-one-another, to be the phenomenon of social normativity. Distantiality is closely linked with Being-with-one-another that refers to the average everydayness of human existence. In line with previous statements, consumers practical way of being-in-the-world is non-cognitive and bodily, and the public nature of being-in-the world emphasizes the taken-for-granted and distorted nature of existence. Therefore, the jumping off point for analyzing consumers' being-in-the-world "is primarily and usually—in its average everydayness" where their daily lives and activities require them to put on a public persona (Heidegger 1962, p. 16). That is to say, average everydayness is anything but a consistent state, and is instead a type of commitment to and catching up with the Being of Others. Heidegger (1962, p. 126) captures this sentiment by saying:

> *In one's concern with what one has taken a hold of, whether with, for, or against, the Others, there is constant care as to the way one differs from them, whether that difference is merely one that is to be evened out, whether one's own Dasein has lagged behind the Others and wants to catch up in relation to them, or whether one's Dasein already has some priority over them and sets out to keep them suppressed. The care about this distance between them is disturbing to Being-with-one-another, though this disturbance is one that is hidden from it.*

This passage depicts the twofold nature of Care—that is, care to be both a burden and a devotion—as it is intertwined with social normativity. On the one hand, people always compare themselves to social norms in concern and attempt to orient themselves according to normative patterns of behavior. On the other side, social norms are never clear in our average everyday existence of being-in-the-world and instead always something that seems to be distanced from the self. This distance between the social norms expected by others and the being of the self is an ever-present distantiality that burdens our existence.

To repeat an old point, care as devotion is shown through our absorption in the world and refers to the bodily element of our existence that limits our lives and pulls us towards death, while simultaneously, care is a burden that mediates our lives and holding us together in wholeness. I will build on care as devotion in the next section, as I address embodiment and maximal grip. Care also burdens us in a way that is historically and culturally conditioned. Building on Dreyfus's (1991) example on the norms of standing-distance, the specific ways we communicate is what one does to be a good family member, a good friend, or a good colleague in this particular historically embedded culture. Social normativity "articulates the referential context of significance" (Heidegger 1962, p. 167), such that the web of practical significance is then culturally and historically conditioned, and this has several implications. First, the very essence of our average everyday world—that is our practical familiarity with the world described as Being-in-the-world—is a shared world. Second, Being-with-one-another and Being-in-the-world are deeply entangled. Last, distantiality implicates the Care structure such that in our talk, we are always burdened to get ahead of ourselves as we are already in practical contexts amidst social norms that direct our behavior.

4.2.3 The Content of Discourse: Maximum Grip

We have now explored how distantiality delimits discourses such that it creates a space for which discourses are structured around Being-with-one-another and the constant distance of self from social normativity. While together, these concepts give discourse its form, they do not tell us much about the force of maximal grip that mobilizes a discourse to be used and sustained (Cederström and Spicer 2015). Maximal grip refers to the body-subjects attempt to get the best' grasp' on the situation in which it is thrown (Merleau-Ponty 1962). Fairclough (1998)

argues that discourses work together with non-discursive dynamics, that is elements of the world that exist outside of discourse like material entities such as the body, in establishing the content of discursive practices. Under the guise of critical discourse analysis (Fairclough 1992, 1998, 2005), the body is implicated as a non-discursive space. Others suggest that modes of governance ensure that the content of practices is both material and discursive. Here, non-discursive entities, while they may exist, are made meaningful through our talk (Dreyfus and Rabinow 1983). Simply put, the practical and material contexts that make up the non-discursive world and talk thereof share a reciprocal relation (Ricoeur 1981). While the general notion of reciprocity between material, social, and linguistic realms is agreeable and very much applied in the current research, the idea that the body supposedly registers as wholly non-discursive in this nexus is not. In accordance with my phenomenological approach, bodies, practices, and discursive activities always have its there (Heidegger 1962). The situated body serves as a medium and background of immediate experience (Fuchs and Schlimme 2009), including experiences that have a discursive element to them. In its affectedness, this situated and discursively sensitive body is attuned to the kinds of talk that matters and makes sense in a given context (Dreyfus 1991). I put forth that talk is a practical form of understanding, sharing an internal reciprocal relation with a certain embodied know-how and skill (Dreyfus and Dreyfus 2000), and that bodies inhabit discourse. To inhabit discourse, I mean to be situated in a certain relationship with the world that is characterized by nurturing, enabling the world to be as it is (Heidegger 1962)

People's everyday habitual actions are often performed without recognition of their bodies as bodies (Leder 1990). Building on Dreyfus and Dreyfus (2000), people know how to do an infinite number of things like driving a car or talking on a telephone and this 'know how' cannot be reduced to a set of rules or formulations. Our bodies acquire skills that are purposive in a sense that they allow us to cope with immediate impediments in our everyday actions. These skills are not warehoused in the mind as a set of rules but rather as embodied dispositions that cope with and respond to the solicitations of worldly situations (Dreyfus and Dreyfus 2000). Truck driver syndrome is a good illustration of this type of skillful activity: the oft-told experience of driving a long distance in a withdrawn state such that upon arrival at your destination you cannot recall the turns you took, the stops you made, or the speed for which you drove. Many of our actions are not goal oriented; instead, they are skillful activities that allow us to get maximum grip on the situation.

In contrast to dominant streams of theorizing bodies (Schouten 1991; Thompson and Hirschman 1998; Schroeder and Zwick 2004), I argue that the felt, object body is inseparable from the lived body-subject (Fuchs 2005; Ratcliffe 2010). As people are already immersed in the material and practical world, the world solicits skillful responses to get the maximum grip on our situation without necessarily producing reflective contemplation (Merleau-Ponty 1962). Practices or attempts at maximum grip enables coping with the out-of-

joint feeling we may experience when something breaks down, becomes conspicuous, stands out, or is objectified in order to recover equipmental balance and equilibrium. For example, when reading this manuscript, readers would find themselves absorbed in a world of ideas, and not explicitly reflecting on the way their torso is aligned with respect to the computer screen or piece of paper on which they are reading the text. Neither would readers reflexively figure out the right distance between the screen and their eyes to achieve maximal efficiency and the right focal distance. But they will do all of these things nonetheless, but the question remains 'how'? I argue that it is a case of the object body being a dim background, always there but not explicitly in the foreground as people engage in focused actions directed outwards towards the world. Studies in consumer research have analyzed how people navigate museums to get maximum grip of perception on a piece of art (Joy and Sherry 2003). Similarly, when grasping something, we tend to grab it in such a way to get the best grip on it we can. In Merleau-Pontian phenomenology, people are fundamentally in an embodied relationship with the world, i.e., I experience the world through my body, and I experience my body through the world. The body is "no longer conceived as an object in the world, but as our means of communication with it" (Merleau-Ponty 1962, p. 106).

What happens when the body becomes unstable, either through illness or through other embodied constraints that deviate experience from social norms? The relationship between talk and body is more complicated than the inscription of cultural text upon the surface of the body (Schroeder and Zwick 2004). In Merleau-Ponty's (1962) phenomenology, the habitual body is also the seat of intentionality, subtended by the intentional arc. The intentional arc refers to purposive actions—that is actions that are not guided by predefined goals—that increase skill acquisition and refine embodied dispositions to discriminate solicitations of immediate situations (Merleau-Ponty 1962). Bodies are never just objects but part of a process of negotiating and re-negotiating a sense of coherence as it is embedded in worldly situations (Davis 1995). The body-subject derives worldly stability from its historical habits, and in turn, the habitual body forms the infrastructure on which our doings and sayings are built. However, it is also important to notice, the stability that Merleau-Ponty (1962) refers to is not long-term biographical stability, but rather a temporally situated, hour-by-hour, minute-by-minute stability. This contingent stability thus produces an identity-in-flux (Thompson and Haytko 1997; Murray 2002) always open to embodied change that is reflected in our talk.

To summarize, discourse always takes place in a context that I describe as the arrangement of meaning built from practical and material circumstances of being-with-one-another that condition the possibilities for consumer talk. Further, discourse is fundamentally an affected endeavor marked by distantiality, the ever-present distance that exists between the experience of an individual and social normativity. Lastly, the affective-attunement of discourse is directed by the authoring body-subjects attempts towards getting maximal grip on the

world (Merleau-Ponty 1962). Moving forward, I will discuss the implications of the affective-attunement of discourse and each of its dimensions on the analysis of consumer talk.

4.3 Implications for Analysis

In the previous section, I introduced some basic concepts derived from a phenomenological approach to discourse analysis that shapes their affective-attunement. To repeat, the affective-attunement of discourse refers to how people are affected by deviations from normalcy that disrupt established frames of reference and disjoint the public unfolding of life from their interests. Simultaneously, people are directed or attuned towards maximum grip—the struggle to get a "grip" on the world in which we are immersed and create stability and equilibrium in their lives. Next, I shall draw out implications for this approach to the study of consumer research. To do so, I will develop a framework that I call the phenomenological approach to discourse analysis, that can be used to examine the affectedness in consumer discourses. This analytical framework consists of three dimensions: tracing Being-with-one-another, identifying distantiality, and attending to maximal grip. In what follows, I shall describe each of these different dimensions and demonstrate how they can be mobilized in the empirical study of the affective mode of consumer discourses (for a summary, see Table 1).

4.3.1 Tracing Being-With-One-Another

The first dimension of a phenomenological analysis of the affective-attunement of discourse is the identification of the public disclosedness of Being-with-one-another. As I have already argued, Being-with-one-another represents the context of discourse that is made up of the complex configuration of practical and social circumstances that condition the possibilities for peoples talk. Undertaking empirical studies of this component would require the researcher to ask three sets of inter-related questions.

The first question would be: what are the acceptable social norms within this discourse? The aim is to trace the boundaries of discursive possibility in a given domain (Foucault 1972). In an attempt to understand these boundaries, it is important to understand the relationship between the sayable and the visible that make up the domain you are studying (Kendall and Wickham 1999). For example, in a study of medicalization, I might search for sets of statements and arrangements that make up the health care system-instructions of doctors, nutritionists, and nurses. Statements about what it means to be healthy, instructions from medical professionals to patients, suggested treatments for a condition of interest, and so on. Being-with-one-another, i.e., social normativity, is made up of the sayable and visible, or talk and things. The practical web of significance is an entanglement of people and objects. In our example of medicalization, I need to attend to both what is said about health (theories of learning, theories of discipline, etc.) and related visible objects (buildings, medicines, and

instruments of treatment, etc.). The critical point here is that I am focusing attention on the mutually conditioning relationship between our talk and the world in which we are immersed that is made of social and material elements (Heidegger 1962). For instance, in the social process of creating gambling markets, discursive frames such as crime, business and regulation are used by multiple stakeholders—regulators, public policy activists, and financial investors—to structure normative conceptions about the practice of casino gambling (Humphreys 2010b).

Table 1. Dimensions of the affective mode of discourse

Dimension	Core questions	Focus	Example
Being-with-one-another	What are acceptable social norms within this discourse?	Institutionally linked statements; statements that open up visibilities (things that make up the phenomenon)	Discursive frames of casino gambling stakeholders (Humphreys 2010a)
	What concepts are used in statements that link together different discourses?	Keywords and concepts, the vocabulary that renders a phenomenon accessible to us	Categories of credit/debt (Peñaloza and Barnhart 2011)
	What are the rules for repeatability of statements or the use of narratives?	Frequently referred to words and the words added for detail	Rules of public discourse during crisis (Humphreys and Thompson 2014); Discursive patterns of parenthood pursuit (Fischer, Otnes, and Tuncay 2007)
Distantiality	What sort of deviation exists between the experience of the individual and the social norms?	Narrative structures; totalizing statements; myths; subject and group formations that establish social boundaries; morally charged statements that evoke emotional attachment to a discourse	Hipster myth (Arsel and Thompson 2010); Commercial myths of the south (Thompson and Tian 2008); Neoliberal mythology (Giesler and Veresiu 2014); Morally charged myths (Luedicke, Thompson, and Giesler 2010)
Maximal grip	What are the rules or structures that thematize the body?	Body specific language; a foregrounding of the body in statements	Body in focus (Scott, Cayla, and Cova 2017); Skin and borderlines (Patterson and Schroeder 2010)
	What are the rules or structures that background the body?	Bodily habits and skill acquisition	Bodily habits (Woermann and Rokka 2015)
		Metaphors and other linguistic representations anchored in bodily experience	Personal myth and metaphor (Velliquette, Murray, and Evers 2006); Movement metaphors (Joy and Sherry 2003)

The second set of questions pertains to the order of discursive statements (Jørgensen and Phillips 2002). Here the question is: what concepts are used in statements that link together different discourses? The primary interest is on the ordering of statements such that talk by consumers in the marketplace and by medical professionals relate to one another. This investigation focuses on how social norms work linking the relation of one statement and other statements (Foucault 1972). For example, in the normalization of credit/debt in the United States, people order and categorize credit and debt to establish

normative principles in the constitution of themselves as consumers (Penaloza and Barnhart 2011).

The third question pertains to the repeatability of what people talk about. Social norms conventional in a particular cultural context are formulated through recurrent patterns of talk and behavior of 'The Others' (Dreyfus 1991). Here the question is: what are the rules for the repeatability of statements or the use of narratives? What is of concern here is "the ways in which certain statements (for example, concerning discipline) can come to be repeated" (Kendall and Wickham 1999, p. 27). To answer this question, I suggest focusing on how particular statements come to be repeated (Kendall and Wickham 1999). For example, the health care system may use specific procedures to deploy statements—say, statements concerning self-care or personal management of health—rather than others that may be just as feasible, such as booking an appointment to see doctor, nurse or nutritionist. Similarly, Fischer, Otnes, and Tuncay (2007) find that consumers pursuing parenthood tended to pattern their talk to three culturally pervasive discourses: scientific rationalism, self-management, and fatalism. Another example could be found in the way public discourse follows specific rules or repeatability to re-establish trust after global events that create systemic risk and crisis (Humphreys and Thompson 2014).

4.3.2 Identifying Distantiality

A second novel aspect of a phenomenological approach to discourse, I propose, is that it allows us to understand how consumer discourses attain a degree of deviation from social normativity through distantiality. Distantiality refers to the ever-present distance between an individual's experience and the social norms in which those experiences are embedded. In this manner, distantiality sets the boundaries of social normality in an alienating and affective manner. In its delimiting of social normativity, distantiality fixates discourses and puts a limit on the horizon of actions possible for us. In this taking away, we can think of distantiality as a form of suffering that is alienating. For example, Cronin, McCarthy, and Delaney (2015) find that the diagnosis of diabetes separated participants in their study from an old way of life that left them with an uncertain sense of self and feelings of futureless-ness in their potential shortened lifespans. Researching this component of discourse would involve asking: "What sort of deviation exists between the experience of the individual and the public unfolding of life perceived through social norms?" To answer this question, a researcher would need to identify consumer anxieties related to social normativity. As I mentioned in the previous chapter, anxiety in this thesis is a way of finding oneself in the world affectively that reflects a sense of up-rootedness from the familiar world (Ratcliffe 2008). Since the world is entangled with Being-with-one-another the ever-present deviation from social normativity that consumers face is an ongoing source of anxiety.

The fundamental way we exist in everyday life is "to get lost in things, to get caught in the whirlwind of daily tasks, and to be influenced by public

opinion" (Escudero 2013, p. 304). In our immersion and entanglement with the world, we engage in the process of normalization throughout our everyday lives. This state produces anxiety that burdens us when we find ourselves at the periphery of normal. We naturally and "repeatedly fall prey to the clutches of public opinion" due to our familiarity and absorption in the world (Escudero 2013, p. 303). Heidegger's primary objective is to understand the ways we stand against this tendency through the opposing meaning of Care: devotion to the cultivation of self. As a reminder to the reader, I previously outlined two opposing meanings of Care—as burden and devotion. The task of identifying distantiality, i.e., the burden of having a deviation from social normality, can be addressed through narrative structures of discourse. Narrative structures have two dimensions. The first establishes ordered relationships between story elements (sequence of events) and creates "the presence and critical role of goals and defined relationships between story elements (causality)" (Escales and Bettman 2005, p. 240). Narratives draw together the mess of human life, a heterogeneity of motives, characters, goals, actions, and circumstances, into the harmonious unity of a plot that has sequential order. What is meant by the ordered relationship between story elements is that any given narrative has a sequential structure: there is a beginning, middle, and an end (Riessman 1993). Ricoeur (1981) argues that it is due to this sense of sequence that we may experience narratives as lived, such that they reflect the lives we lead. Thus, to change the sequential order of an individual's narrative would also change the experience of the life that person lives. Causality, on the other hand, refers to the consequentiality of sequencing (Galloway Young 1987). Narratives are provided color, textuality, and sentience through the construction of gripping, believable (not necessarily factual), and lifelike stories of intention, action, and consequence. Drama is produced when an imbalance is invoked in the ration between various story elements (i.e., intention, action, and consequence) (Burke 1945). Drama aims to build towards a storyline that has enthralling sequences and contingencies, keeping the audience in anticipation until the end is revealed. As such, narratives inherently reveal distantiality through the burden of coloring them with drama.

The second dimension is referred to as narrative configuration (Ricoeur 1981). The organizing principle in narrative configuration is what is known as the 'plot' or 'emplotment' (Ricouer 1981). Here, the plot constructs meaningful wholes out of scattered events, 'grasping' them 'together,' thus eliciting a comprehendible pattern from a succession (Ricoeur 1981). Emplotment gives the guise that these contingencies are necessary and likely because they are followable and believable (Thompson 1997). The notion of 'grasping' the whole, in turn, refers to the abductive logic pertaining to the narrative mode of thought. Rather than trying to relate events to universal laws or established patterns and categories, as is the case within the paradigmatic mode of thought (Bruner 1986), abductive reasoning refers to the process of explaining phenomena through a process of 'filling in the blanks' (Polkinghorne 2010). The logic behind narrative emplotment is about anticipation, it is our purposeful configuration of

the story through linking of actions and events that we may arrive at an 'acceptable ending.'

The phenomenological relation of being towards death is the delimitation of discourse in our daily life that makes us press ahead but it can also be a form of understanding. Here researchers must identify how consumers are "governed by the recognition of the singularity of existence in the face of death" (Polkinghorne 2010, p. 133). Existential concern over life as mortals reflects "the primacy of the future over the past and the present in the unitary constituting of time; and the closure of the future by being-toward-death in its untransferable individuality" (Ricoeur 1981, p. 185). These limits or boundaries allow us to understand things in new ways such that we can create an understanding which steers us away from existential burdens of life as a mortal. Emplotment configures the episodes of our life that burden us into one thought and 'grasped together' to form a coherent, developmental whole (Polkinghorne 2010, p. 133). This feature of narrative provides the sense of ending in the face of open-endedness or an infinite succession of events. In simpler terms, a plot has a beginning, and an end and "the gathering together of events in a plot does not remove them from time but places them in a higher, historical, understanding of time" (Polkinghorne 2010, p. 133). The logic of emplotment enforces anticipation of "something that has already happened stretched out between a beginning and an end" (Polkinghorne 2010, p. 133).

Based on the discussion above, this task of identifying distantiality is not a simple one because, in experiencing the world, it is a constraint that we attempt to overcome. The intellectual answer I find is drawing from discourse theory as its applied in consumer research. I can go some way in addressing this deviation from norms by searching for myths, since myths are emploted narrative constructs that relieve anxiety produced by socio-cultural contradictions that exist in the marketplace (Giesler 2012; Holt 2004, 2006; Humphreys and Thompsons 2014; Peñaloza 2000; Thompson and Tian 2008). Myths always exist within discourses as "temporary and partial fixations of meaning in a fundamentally undecidable terrain" (Jørgensen and Phillips 2002, p. 39; Barthes 1972). Drawing from discourse theory, myths suggest "a space of representation" and "a principle of reading of a given situation" that applies the logic of emplotment in the creation of a totality that establishes cohesiveness and produces liveability (Laclau 1990, p.61). A myth is, "on the one hand, a distorted representation of reality, but on the other hand, this distortion is inevitable and constitutive because it establishes a necessary horizon for our acts" (Jørgensen and Phillips 2002, p. 39-40). One task of identifying distantiality within discourse analysis is thus to pinpoint and analyze myths that are implied in talk and other actions. For instance, myths enliven moral protagonists in narrative conflicts that occur when competing brands in the marketplace form groups of rival communities (Luedicke, Thompson, and Giesler 2010). While myths do not feature prominently in the dissertation at hand, they could be of particular

use theoretically for other research attempting to tackle the affective-attunement of discourse.

4.3.3 Attending to Maximal Grip

The final novel aspect I would like to draw out of a phenomenological approach to the affective mode of discourse, involves attending to maximal grip. The affective-attuning mode of discourse refers to how people, in their being, are concerned with or inclined towards having maximal grip of a situation and avoiding deviation from normalcy is an interpretation of this application. As I have already argued, the relationship between the body-subject and the practical and material world in which they are immersed is paramount to the concept of maximum grip, and mostly ignored in consumer research. Attending to this body-world level of analysis, I suggest mobilizing the figure-ground metaphor to study embodied phenomenon where the body and discourse establish gestalt wholes. Here, the movement of the body-subject from figure to ground then reveals the ways the body inhabits discourse. The thematization of the body foregrounds how bodily experience orients and re-orients the authoring body-subjects relation to the world. Researching this dimension of the affective mode of discourse would involve asking two interrelated questions that envelop practices of talk as being both material and discursive at the same time (Kendall and Wickham 1999; Foucault 1972). As described in the previous chapter, the lived body is characterized by its withdrawn state such that it sinks into the ground of our experience. The first question the researchers should ask, then, is "what are the rules or structures that move the body from the ground to the figure?" To answer this question, researchers need to attend to ways the body becomes a focus of attention for consumers' experiences – that is how consumer talk might foreground the felt, object body. For instance, in the experiential event of Tough Mudder, consumers narrate their experience of pain such that they rediscover their corporeality (Scott, Cayla, and Cova 2017).

Similarly, in the experience of getting tattooed, consumers attend to describing pain, but also the contours of their body for which the body art will be applied, as well as the leaking, oozing and healing of the body during and after the tattoo process (Patterson and Schroeder 2010). The foreground of the body affords an experiential immediacy that both enables and constrains the possibilities for action (Fuchs and Schlimme 2009) such that we are solicited in the immediate situation of the here and now to talk and act in particular ways (Merleau-Ponty 1962; Crossley 1996). As described in the sections above, consumers ability to respond to solicitations of immediate situations depends on their habitual bodily skills – such responsiveness also providing sense stability or ontological security at an ongoing basis (e.g., Phipps and Ozanne 2017). A researcher might attend to these embodied skills and their acquisition either through their talk or activities (Hill and Stamey 1990). For instance, in the context of body beautiful (Patterson 2018), disciplinary techniques like harnessing self-control in eating practices become habitual and purposive actions for consumers to

overcome immediate impediments of their appearance that do not conform to social norms of beauty (Thompson and Hirschman 1995).

The second set of questions for attending to maximal grip pertain to connecting bodily feeling to the personal and cultural narratives that help to constitute its meaning (Hughes and Paterson 1997). Here, the question is: what are the rules or structures that move the body back the ground from the figure?" This may involve consumers attending to metaphors that are structured by features of their bodies and the functioning of their bodies in everyday life (Johnson 1981). It should be noted that these metaphors should be grounded in the lived body so as not to lose the conceptual meaning of embodiment. In this way, metaphors become experiential gestalts based on bodily feeling and its relationship with the material and practical environment within which our interactions are thrown. For instance, the metaphors of healing mediated through bodily feelings of memorial tattoos inscribe personal meanings that allow consumers to overcome personal loss of a loved one (Velliquette, Murray, and Evers 2006). Likewise, the metaphors people use to talk about their movement through museums spaces where they "touch, feel, hear, smell and taste art" provides an understanding of embodied aesthetic experience (Joy and Sherry 2003, p. 259). Such metaphors become an important aspect of narrative structures like myth. In the study at hand, I could concern myself with myths constructed to cope with the concern of deviance from norms in their bodily feelings. Consumers are burdened by a sense of wholeness that necessitates discursive conclusions in the form of metaphors that color the myths described in the section above.

4.4 Conclusion

In this chapter, I have proposed that drawing on certain aspects of the Heideggerian tradition of phenomenology can be insightful for studying discourse in consumer research. More specifically, I suggest that this phenomenological approach is particularly useful for understanding the affective mode of discourse that is largely understudied in consumer research. By phenomenology, I wish to distinguish my discursively driven epistemology from classic phenomenology where individual and intersubjective experiences, actions and embodied meanings are largely taken as pre-discursive givens. The affective mode of discourse refers to how we are, as authoring body-subjects, emotively implicated by our environments and attuned towards maximal grip. The body-subjects affective-attunement to maximal grip, refers at once to the deviations from normalcy that disrupt established frames of reference and the ongoing struggle to re-establish sense of equilibrium therein through new modes of reflexivity and gradually internalized bodily habits. I argue that such an approach offers a way of theoretically linking affectedness with (1) the way discourses are contextualized by Being-with-one-another, (2) how discourses are delimited by distantiality, and (3) how the content of discourses is mediated by our tendency towards maximal grip in the context of the body-world nexus. I then offer some suggestions of how these points can be used to study consumer behavior. In the

coming chapter, I will explain how my philosophical framework will help tackle the interests of this dissertation procedurally. This part will expound on practical research aspects such as research context, data collection, analysis, and situating the researcher as an instrument.

5. METHODS

In this chapter, I turn to specific techniques and procedures that I use to answer my central research question: *how do consuming body-subjects cope with lactose intolerance through their talk?* This phenomenological study involves tracing lactose intolerant consumers' reflexive and pre-reflexive embodied experiences and coping means as they share an internal, reciprocal relation with their narratives (i.e., personal and cultural narratives) (Hughes and Paterson 1997, p. 335; See also Askegaard and Linnet 2011). In consideration of this orienting framework, I will first provide an overview of my research context. Next, I will discuss my role as the instrument of research. Then, I will address matters concerning data collection. This will involve such issues such as research boundaries, samples, interview method, and other elements I was responsive to during the collection of data. Finally, I will provide an explication of my data analysis before drawing a brief conclusion to the first half of the manuscript and outlining the coming findings chapters.

5.1 Studying Normalization Work Related to Medicalization

Lactose intolerant consumers in Finland who use functional foods are a particularly useful context for studying normalization work related to medicalization. Finland is situated as a socially and regionally bound setting that foregrounds the normalizing activity of consumers self-talk. In particular, the Nordic welfare state promotes egalitarian consensus, equal citizenship, and universal health care, among other things (Byrkjeflot 2003; Østergaard et al. 2014). Practices of

normalization are intrinsic to the process of consensus making, acceptance of difference, and shared social understandings that constitute "a context of conformity" where power is "systematically legitimized" (Courpasson 2000, p. 157). In Finland, dairy foods are considered to be an ordinary ingredient and staple food found in everyone's diet. The pervasiveness of dairy foods makes the experience of lactose intolerance more pronounced. Functional foods, and their normalizing power, transform the problematic experience of dairy consumption for people with lactose intolerance into an inconspicuous and mundane practice. For consumers with lactose intolerance, functional foods typically refer to either of two things. First, functional foods could refer to lactose-free dairy—which is scientifically modified for health benefits based on medical claims tied the food-related disease, e.g., lactose intolerance (Östberg 2003). Second, functional foods could refer to different consumables (e.g., lactase pills, yogurts, and drinks) that contain probiotic enzymes, characterized as pharmaceutical grade nutrients (Heasman and Mellentin 2001), that help the body break down lactose into glucose, allowing the gut to digest dairy foods. With clear connections to medical language and understandings, I interpret these functional foods to be a concrete empirical example of medicalization—that is, a process whereby things are "defined in medical terms, described using medical language, understood through the adoption of a medical framework, or "treated" with a medical intervention" (Conrad 2007, p. 5).

Further, as a bodily impairment, lactose intolerance allows me to reach beyond the "mind as context" and highlight the experiential and affective dimensions of consumer practices, bringing out contingencies that fall outside of the psychological and representational realms of inquiry (Askegaard and Linnet 2010, p. 391). I will now describe different contextualizing moves that allow me to illuminate the phenomenon of medicalization and develop my theory on normalization work over two themes: 1) health, nutrition, and Nordic governance; and, 2) lactose intolerance in Finland. Together, these themes will background wider social structures, elements of social life, and issues of embodiment that surround the phenomenon of medicalization and illuminate consumers normalization work.

5.1.1 Health, Nutrition, and Nordic Governance

Health and wellness in the Nordics, specifically in regards to nutrition, is making headlines. The popular media reports on Nordic food culture and the ways it has been globally embraced. For example, the New York Times (August 23, 2011) headlines, "New Nordic Cuisine Draws Disciples." The American media giant, Oprah Winfrey, reports that Nordic food culture "could lower blood pressure and cholesterol" (Goldman 2011). Anthropological research on food has picked up on Nordic nutrition and its connections to health and wellness. Nordic food culture is characterized by "technique, health, animal welfare, nutrition, and hygiene" and integrates "people, landscapes, products, climate, and food production" (Bergflødt, Amilien, and Skuland 2012, p. 4). Consumer research has also taken an interest in Nordic food culture. Emontspool and Georgi

(2017, p. 1) argue that Nordic food culture "reflects a more individualized" practice for "improving public health in the Nordic countries" (p. 6). Both Nordic food culture and the welfare state have strong ties to a rural way of life (Esping-Andersen 1998). The urban-rural "cleavage" of Scandinavia differed from the church-state gap found in continental Europe. The Nordic's already homogeneous Lutheran orientation but fragmented small agrarian communities led to the politicization and strong class coalition among the various farming communities (Manow 2008, p. 102):

> *The Scandinavian countries entered the period of mass democratization with still considerable employment in agriculture. It was therefore in Scandinavia where agrarian parties formed and where they left their imprint on the party system, as a few basic numbers may easily demonstrate. The Finnish Agrarian Union (Maalaisliitto), renamed Centre Party in 1965, won between 21 and 24% of the vote in all elections held between 1945 and 1970. In the 1970s and 1980s, the Centre Party never received less than 17% of the vote, and in the 1991 general elections, the agrarians even became the biggest party with almost 25%, 3% more than the social democrats (Manow 2008, p. 107).*

The organization around farming and agrarian protection reflect in the romantic idealization of Nordic food culture and its ties to nature and agriculture. "The connection between a healthy countryside lifestyle and the consumption of fresh milk" inscribes feelings of "social pride and strength" as well as health in Nordic food culture (Kristensen, Boye, and Aksegaard 2011, p. 200). The link between the rural way of life and health ripples through Finnish consumer society. Practices that bring the consumer closer to food production like community supported agriculture are built on health concerns related to industrial food production (Thompson and Coskuner-Balli 2007; Press and Arnould 2011). In the Nordic context, the agrarian link to welfare state creates a bridge between health and social rights where food consumption and production take center stage (Manow 2008; Esping-Andersen 1998; Kristensen, Boye, and Askegaard 2011; Emontspool and Giorgi 2017).

A changing social setting frames my discussion on how a legacy of the Nordic welfare state, egalitarianism, and "commonness in which everybody—high and low—strive to be able to identify with the middle" informs the normalization of medical disorders (Kjeldgaard and Östberg 2007, p. 184). My fieldwork was carried out in and around Helsinki, Finland. Finland shares traits with other Western industrialized nations but stands out as a Nordic social democratic regime where "an ethos of equality and egalitarianism" stands firm (Kjeldgaard and Östberg 2007, p. 184; Esping-Andersen 1998). Social democracy is a political formation within the Nordic welfare states that promotes social rights and allows workers "social resources, health, and education to participate as effective socialist citizens" (Esping-Andersen 1998, p.12). The social democracy frames social policy not in emancipatory terms but rather as a need for

economic efficiency. Thus, "by eradicating poverty, unemployment, illness and disease, and complete wage dependency, the welfare state increases political capacities and diminishes the social divisions that are barriers to political unity among workers" (Esping-Andersen 1998, p. 12). Johansson and colleagues (2017, p. 10) highlight that since the 1990s, Nordic society "has been influenced by the transnational economic process of neoliberalism." While it is argued that "consensus-building dialogue, trust, and a dispersed sense of responsibility" (Tengblad 2006, p. 1442) remain a distinctive feature of Nordic culture, a new type of individuality is emerging around health and wellness (Johansson, Tienari, and Valtonen 2017; Holmqvist and Maravelias 2011).

Finland is said to be "the Silicon Valley of functional foods," and these foods are an instance of medicalization (Heasman and Mellentin 2001). Functional foods are said to help with medical claims like obesity, cardiovascular disease, diabetes, high blood pressure and cholesterol, celiac disease, and lactose intolerance, among others. Finland is a great context to study because issues like lactose intolerance are considered very common in Finland. Indeed, food companies worldwide use health claims against disease and medical disorders as primary marketing devices; for example, Quaker Oats has long communicated its ability to reduce cholesterol with its oatmeal products. Significant investments by the state and major companies have advanced Finland's presence in the functional food world (Heasman and Mellentin 2001). For example, Xylitol, discovered by two Finnish professors, combats cavities and can be found in everything from gum to water. Benecol is a product invented in Finland that uses plant sterols to reduce cholesterol and added to margarine. Finnish restaurants cater to Celiac disease and the gluten-free diet. The Finnish bakery Moilas Oy is the second biggest gluten-free bakery in Europe, offering a massive product range of everything from plain bread to sweet pastries (Heasman and Mellentin 2001). Valio, Finland's largest dairy company, holds its position as a market leader through value-added dairy projects like functional foods (Tillotson and Martin 2015). They have products that increase immunity and digestion health and combat lactose intolerance.

5.1.2 Lactose Intolerance in Finland

Three factors inform my choice of studying lactose intolerance in Finland to investigate the normalization of medicalization in the market. First, dairy is firmly embedded in Finnish consumptionscapes; thus, making lactose intolerance especially pronounced. Second, manifest symptoms of lactose intolerance make people aware of the contested and precarious nature of their consuming bodies. Third, lactose intolerance typically refocuses attention to the hitherto hidden depths of the body such that the experience and negotiation of bodily dysfunction might work differently than conventional studies on health-conscious consumers. In the following section, I explain how each of these factors contributes to lactose intolerance being a fruitful context for building theory on medicalization (Arnould, Price, and Mosio 2006).

Milk is the national drink of Finland (Astley 2014). Finns consume more dairy per person than anywhere else in the world, drinking about 130 liters of milk per capita per year (Dairy Nutrition Council 2013). The Finnish government recommends that every citizen drink or eat half a liter worth of dairy products a day (Astley 2014). A newbie's first visit to the dairy section of a Finnish supermarket can be an overwhelming experience where many kinds of milk, yogurt, cooking cream, dip, soup, ice cream, sour milk each with its own range of probiotic, lactose, and protein content vie for the consumer's attention (O' Sullivan 2014). From at least three different brands, consumers can choose milk labeled whole, semi-skimmed, skimmed, without lactose, with protein, with vitamin D, organic, cooking, for use in coffee, or what is known as 'milk drink' (Schwarzmann 2017). The default state of affairs is such that dairy foods appear familiar, consumption is predictable, and people are anchored in the culture and responsive to relative solicitations. Food consumption produces possibilities for meaningful action like pursuing health, but such possibilities are dependent on the consumer's taken-for-granted bodily abilities—the embodied capacity to consume and digest food. However, In the case of Finland and the consumption of its favorite dairy food, there is a small problem. A significant number of Finns, 1 in every 5 are lactose-intolerance (Astley 2014).

Symptoms of lactose intolerance often include flatulence, bloated stomachs, diarrhea, persistent burping, and in some cases, hair loss. In medico-biological terms, symptoms of lactose intolerance are the manifestation of a missing enzyme (lactase) in the small intestine that helps break down milk sugar into glucose that the body can then digest. While it is necessary to offer minimal descriptions related to lactose and associated functional foods, and so to touch upon related medico-scientific discourse, the key focus of this research is on how lactose intolerant consumers experience and make sense of their illness (Carel 2016). Lactose intolerance is an illness in perpetuity, and the only way to deal with it is to change how one eats and drinks. Lactose intolerance is thus not a conventional, episodic illness that can be cured by a course of antibiotics or removed by undergoing cutting-edge medical treatments. It often disrupts the explanatory systems that people had used relatively unproblematically and makes people aware of the contested and precarious nature of their bodies. Thus, lactose intolerance re-organizes everyday consumption, and relatedly the meanings and experiences flowing from it.

The human body's physical surface envelops a hidden mass of internal organs and processes that also shape the experience and negotiation of everyday life. While the majority of consumer research interested in the body dwells upon the surface, the outside of the body (Patterson and Schroeder 2010; Schouten 1991; Schroeder and Zwick 2004; Thompson and Hirschman 1995), my research context enables me to explore the corporeal depths of the lived body of which people are largely unaware in their everyday lives (Leder 1990; Merleau-Ponty 1962). Events such as disease, illness, and disability direct a person's attention to the centrality of their body as possibilities for meaningful action in

and through that body become impaired (Leder 1990). Embodied experiences of impairment include consumers' experiences of outward manifestations and physical changes due to lactose intolerance, but also the experience of social attitudes towards illness, pain, and the negotiation of one's bodiliness in attempts to regain full participation in consumer culture (Hughes and Paterson 1997; Papadimitriou 2008). These are not experiences reserved only for the diseased or physically disabled (Paterson and Hughes 1999), "illness is a fundamental experience in almost everyone's life" and by surfacing the impact of impairment on consumers' lives this dissertation contributes to a better understanding of consumers' negotiated, embodied consumption (Carel 2016, p. 18).

5.2 Researcher as Instrument

This research offers a critique of a culture and a nation that is not my own. I did not choose to write about medicalization in Finland because I see the Finnish as somehow more prone to the medicalization of life or using medicine as an institution to label deviance, quite the opposite. My home country, The United States of America, offers much more extreme examples of selling sickness and exploitation of consumers in pharmaceutical and medical marketplaces. Medical, insurance and pharmaceutical industries rely on the market in the American health care system. There is some element of chance that this research took place in Finland. My history led me to visit Finland off and on since 2009, as my spouse is a Finnish national. Meeting my wife shaped my life and left me with a fascination for Finnish society and the people spanning almost a decade. The convergence of several factors led to this research. My background and interests converged with Professor Diane M. Martin's appointment at Aalto University from the University of Portland. This happened along with Valio's generosity in forming a doctoral project on consumers in the Finnish dairy market. The original research focus was on understanding how cultural myths influence consumption and shape consumer relationships with Valio's products and brands. I soon realized that Finland was a unique and useful place to ask questions about the entanglement of medicalization and the functional food marketplace. Finland shares features with other Western industrialized nations that exhibit self-care practices (i.e., an increasing presence of neoliberalism); yet, its society sits on the foundation of the welfare state. It is a unique site where neoliberalism and social welfare come together. The welfare state is critical because it offers universal health care and strives for universal equality, flatting the economic structure and operating, in many ways, contrast to the US system. It was at this stage that my theoretical interests began aligning with Professor Sammy Toyoki, a Finnish native, but more importantly, whose ideas and insight into phenomenology inspired and propped up my theoretical scaffolding as I struggled to understand medicalization in context.

As a cultural outsider, I noticed features of society that, perhaps, most Finns took for granted. I set out to foreground these in my analysis. These features are important for my research because discourse analysis operates on the

implicit level of our background orientations. It attempts to expose what we take as a matter of fact by showing the different contingencies that organize our lives in meaningful ways. Finland offers distinct dynamics of social interaction that differ in places that are outside the Nordic context. Finns keep a long social distance between themselves and strangers, which is common among other Nordic countries. It is usual for Finns to prepare you for their "lack of ability for small talk." Finns like to keep to themselves. They don't even like to sit next to each other unless they have to. I often observed scowls on an empty metro as I sat down next to one of the only other passengers in the metro car. They didn't speak, but they gave a look that said everything they needed to say. It is common not to wave or talk to your next-door neighbor. Despite this, Finnish relationships seem to last lifetimes. The friends they make at age 2 or 3 will still get together for coffee or dinner thirty years later. Their relationships are fostered by longtime familiarity with one another. Newcomers are not accepted through simple or brief interactions. For this reason, my lack of network made snowballing interviews difficult.

Although I was familiar with Finnish culture, I was an outsider, and this had advantages and disadvantages. At times it allowed me to appear as the cultural dope or novice and present myself in a far less threatening manner. I was also able to ask questions that a cultural insider might not have gotten away with asking. I could approach strangers in such a way that seemed reasonable only because I was an "outgoing American." I was an outsider; everything I noticed appeared to operate the opposite of what I expected. I was often unsure if I grasped what was happening. I spoke English, and I worried that the meanings were getting lost in translation. I attempted to combat this by having a colleague conduct several interviews in the Finnish language, but my presence kept them reverting to English. Having a Finnish wife and living amongst the Finns in everyday life provided me with some basis for understanding things clearer. I was familiar with the Finnish traits of privacy, self-sufficiency and social conduct. For example, the Finnish social situations and tight-lipped conversations came as no surprise. This tight-lipped style, on the one hand, meant that when my participants did converse, it was well thought through and meaningful, thus a good source of data. On the other, the tight-lipped style did cause me frustration with interviews. The tight-lipped nature of Finnish communication meant that many of my participants were more guarded than I expected. To combat this, I utilized projective techniques and sheer numbers. I used various projective techniques like role-playing, collage building, object descriptions, and letter or blog writing. Also, I knew that the more people I spoke with, the better some of the interviews would be and it was those informants I would go back to for further questions or repeat interviews.

5.3 Data Collection

This interpretive study aims to produce a rich account of peoples' embodied experience. In this study, I have attempted to use phenomenology

methodologically, and the next section will expound on practical research aspects such as research boundaries, sample, data collection, and analysis. The research boundaries are defined as lactose intolerant people who use lactose-free dairy and probiotics (i.e., functional foods) to cope with lactose intolerance. The bulk the fieldwork for this project was done over three years in Helsinki, Finland between 2013-2016. The primary source of data for this study was 57 audio-recorded, semi-structured interviews ranging from 45 to 190 minutes in length, with a mean duration of 90 minutes. Full transcripts of each interview were produced, varying between 2,323 and 62,441 words, with the mean number of words per transcript being 9,952. Altogether, data collection resulted in 2,367 double spaced pages of transcripts. Of those interviewed formally, 30 were women and 27 men. The study's participants included consumers of all kinds, including office workers, shopkeepers, students, insurance agents, scientists, dairy farmers, nutritionists, and nurses, among others (see Table 2). Participants were also at various stages of lactose intolerance, some had been diagnosed recently, and others have been living with the illness for years. This temporal dispersion of lactose intolerance in my research sample gave a unique insight into how people's experiences of lactose intolerance differed over time.

Table 2. Participant information

Nro	Pseudonym	Gender	Age	Profession	Family situation	Education
1	Juho	Male	48	Development Manager	With family	University of applied sciences
2	Patti	Female	42	Entrepreneur	With family	College
3	Antti	Male	37	Project Manager	With family	University of applied sciences
4	Sonja	Female	21	Student	Living together, no children	College
5	Saara	Female	36	Student	Married	Vocational school
6	Taru	Female	43	Bio analytic	With family	University of applied sciences
7	Kira	Female	38	Officer	With family	University
8	Eevi	Female	34	Energy specialist	Dating	University
9	John	Male	62	Product Manager	Living together, no children	University
10	Hugo	Male	30	Nurse	Dating	University of applied sciences
11	Alice	Female	25	Student	Living together, no children	College
12	Aleksi	Male	25	Student	Living together, no children	College
13	Heikki	Male	60	Personnel consult	Living together, no children	University
14	Tapani	Male	37	Designer	With family	University
15	Lea	Female	41	Teacher	With family	University
16	Bruno	Male	43	Entrepreneur	With family	University
17	Pekka	Male	27	Service specialist	Single	University of applied sciences
18	Jacob	Male	60	Retired	Single	College
19	Darin	Male	45	Equipment maintainer	Dating	Institute

20	Iida	Female	29	Customer advisor	Living together, no children	University
21	Jaska	Male	28	Guard	Dating	College
22	Heidi	Female	50	Unemployed	Single	Institute
23	Pihla	Female	36	Product Manager	With family	University
24	Pipsa	Female	41	Practical nurse	Single	Vocational school
25	Tanja	Female	37	Researcher	Single	University
26	Sampo	Male	48	Planner	With family	University
27	Tiffany	Female	25	Guard	Single	High school
28	Ilmari	Male	27	Student	In a relationship	High school
29	Emma	Female	22	Practical nurse	In a relationship	Vocational school
30	Timo	Male	34	Assistant	With family	Vocational school
31	Henrikki	Male	58	Quality engineer	Married, no children	Institute
32	Tiina	Female	35	Telemarketer	Single	Institute
33	Eeda	Female	50	Customer service manager	With family	University
34	Gina	Female	42	House wife	With family	University
35	John	Male	20	Civilian service	Dating	Highschool
36	Sami	Male	40	Officer	With family	University
37	Linda	Female	20	Student	Dating	Highschool
38	Jukka	Male	56	Division manager	Single	Comprehensive school
39	Maari	Female	33	Office worker	Married	Comprehensive school
40	Pihla	Female	45	Assistant	Other	University
41	Maria	Female	18	Student	Married, no children	High school
42	Terhi	Female	41	Office worker	With family	University of applied sciences
43	Lilia	Female	59	Shopkeeper	Single	College
44	Barnd	Male	32	Writer	With family	College
45	Henri	Male	61	Retired	With family	Vocational school
46	Iiro	Male	36	Office worker	Single	University
47	Harri	Male	41	Account manager	With family	University
48	Anni	Female	28	Marketer	Married, no children	University
49	Olga	Female	29	Office worker	Single	University
50	Jouni	Male	41	Teacher	With family	Vocational school
51	Siiri	Female	37	Researcher	With family	University
52	Mikael	Male	39	Office worker	With family	University
53	Aaro	Male	27	Customer service	With family	University of applied sciences
54	Tiia	Female	40	Teacher	With family	University
55	Arto	Male	70	Retired	With family	University
56	Sofia	Female	37	State nutritionist	Single	University
57	Leena	Female	60	Farmer and nurse	With family	University

I utilized long semi-structured interviews as my dominant mode of gathering empirical material (Arsel 2017). My approach to phenomenology is consistent with research that takes embodiment as "the starting point for analyzing human participation in a cultural world" (Csordas 1993, p. 135). I believe embodied experience to be accessible through talk, by way of an intimate focus on first-person experience (Thompson, Pollio, and Locander 1989) as my participants moved between their past and present experiences, bringing their past forward into the present (Merleau-Ponty 1962). I do not claim to arrive at an unproblematic or 'True' account of lactose intolerance; instead, I am committed to understanding my respondents' first-hand points of view by taking their claims seriously and with faith (Josselson 2004; Ricoeur 1965). I began by asking questions in the form of "what is it like to be lactose intolerant?" to undertake an experiential analysis of lactose intolerance. Participants were encouraged to tell their stories and narrate anecdotes, to speak at length, and to do so freely to develop and express their ideas and concerns (McCracken 1988). Questions revolved around participants backgrounds and personal histories tied to dietary practices, nutrition, and lactose intolerance. I enquired into participant's experience of lactose intolerance, their relationships with themselves and those around them both at home and at work, as well as their daily activities in managing lactose intolerance (Denzin and Lincoln 1994). In response to participants accounts, I often followed up with probing questions that invited further elaboration on what seemed to be interesting experiences.

Additionally, one source of data drawn on by this study includes my experience, as an American native, entering a culture that was not my own and taking casual observations of the broader community through a wide variety of public settings (i.e., cafés, schools, recreational organizations, work settings, protests, public celebrations, bars, and sporting events). Once I became more familiar with the setting, general themes emerged focusing attention on sites that yielded the richest source of information: grocery shopping practices, dining experiences, cooking and eating habits, exercise and wellness facilities, boundaries between insiders and outsiders, and the local sense of place and time. Experiential data was particularly valuable because they enriched my knowledge of Finnish disposition, emotion, identity, culture, meaning, and talk about how people make sense of consumption practices associated with lactose-free and probiotic dairy. I treated interviews as situated accounts while actively managing social process and local conditions to produce rich narratives (Alvesson 2003). Informed by observed behavior, I was able to contextualize the responses of formal interviewees, who were using English as a second language. Additionally, experiential observations allowed me to present myself in a far less threatening manner, while also leveraging the construction of a cultural dope or novice as an invitation for participants to elaborate further on what seemed to be interesting themes.

I went into the field with a sensitizing research framework (Thompson 1997), that is, phenomenology of being-in-the-world. I focused on how people

were able to accomplish understandings of their bodies "relationally through direct engagement with the world they inhabit" (Chia and Holt 2006, p. 637), and how the world comes into being as an extension of their own body by treating things and equipment in the world as tools opposed to free-standing object (Tsoukas 2005). The initial focus of the investigation was to understand mythologies that structure consumer experience of dairy foods in Finland. However, as the research progressed to the data-collection stage, the centrality of medicalization and normalization quickly emerged. I realized that my in-depth interviews had a "considerable existential moment" (Smith, Flowers, and Larkin 2009, p. 163), that is, my participants, in their talk, often linked their constrained consumption, such as that which happens in bodily impairments like lactose intolerance, as being normal in Finland; thus, normalization became a salient analytical concept. Further, it emerged that lactose intolerance was defined as a disease within the medical profession, making medicalization a suitable phenomenon for investigation.

5.4 Data Analysis

Data analysis occurred throughout the length of the research project as a multistage process (Denzin and Lincoln 1994). First, while data collection was still going on and in order to figure out what my data was an instance of (Figueiredo, Gopaldas, and Fischer 2017), emergent themes, ideas, and interpretations were discussed on a regular basis between myself and my supervisor or other colleagues. Second, once data collection had been completed, I iteratively read and re-read transcripts, and coded words, phrases, and anything said that related to the research question (Belk, Fischer, and Kozinets 2012). I also stayed attentive to significant emergent themes that could have led to me to reformulate this question. Information about the individual's family, history, culture, ways of relating to oneself, or ways of relating to others was also coded, generating dozens of themes (such as people's talk about "diagnosis," "sickness," "bodily ideals," "health care," "habits," "morals" and so on). Following Alvesson's (2003) instruction, as it is supported by Arsel (2017), I engaged in continual iterations between the data and phenomenological theory in a practical fashion trying to find an equilibrium. While my primary focus was on how people responded to changed solicitations, I also sought out cultural scripts, constructive acts, and examples of power in what people said. It was at this stage that I noticed the productive link between normalization and their phenomenological, lived body. With these focal topics in mind, I engaged in further lengthy discussions with my second appointed supervisor, Sammy Toyoki, where I sought to link dominant patterns in my data to theory on medicalization and normalization (Belk, Fischer, and Kozinets 2012). Under this prism of theoretical influence, data and theory were iteratively and recursively explored, combined, distilled, discovered, thrown out, and cajoled (Arsel 2017). I continued discussions, presenting my research at conferences and seminars, and distilled the coded material into two dimensions. One, talk that is affected by a reification of bodily awareness as it occurs through one's deviation from health norms in their experience of

illness. And two, in need to resolve this tension, to recoup maximal grip, which manifested as participant talk, that is, where the newly erupted, impaired body has to be appropriated, disciplined, and made sense of once again.

Table 3. Coding for normalization work

Dimensions of the Affective-Attuning Mode of Discourse	Being-with-one-another	Distantiality	Maximal Grip
Body-Subject Level	Bodily awareness resulting from affectedness by social situations such that one becomes attuned to acceptable social norms.	Embodied breakdowns challenging one's ability-to-be.	Seeking optimal control and leveraging of circumstances at hand.
Social Level	Feelings of familiarity while coping with bodily dysfunction	Conflicts between familiarity and normative expectations	Establish cohesiveness in the world through skill acquisition and intercorporeality.
Institutional Level	The way people are conditioned by institutions of health care and act towards the institution of medicine and health care on the basis of the meanings that those institutions afford them.	Turmoil and conflict with institutions arise out of deviations of consumers' experience from cultural ideals of health care.	Meanings are handled and modified through talk that helps cope with the appropriation of lactose intolerance as a diagnosis.
Market Level	Dairy as a cultural resource in Finland	Illness being made visible through the marketplace	Making illness invisible again through talk about functional foods

At the fourth stage of analysis, I collected more data, tacking between transcripts and theory in an ongoing fashion. In regards to identifying themes significant to my overall research interests, I coded the data specifically for those embodied practices that disrupted the rhythm of consumption, the feeling of bodily stability as well as the self-disciplinary talk that repaired, revised, and reformed selves to some level of embodied equilibrium. Through discussions with my supervisor, conference presentations, and dialogue with colleagues, alternative readings of the data that emerged sometimes differed in unique and dynamic ways. I came to recognize four interconnected levels of abstraction in

normalization work (i.e., the body-subject, the social, the institutional, and the market level) that helped constitute and organize the meanings of lactose intolerant consumption in the face of bodily experiences that normalize medicalization (see Table 3).

5.5 Conclusion

This chapter concludes the first half of this manuscript that explicates how I have gone about exploring the topic of medicalization. In a review of the literature on medicalization, I establish how there is a need to study how medicalization is taken up, negotiated, or transformed by consumers as it becomes conventional and commonplace. The theoretical framework employs a phenomenological lens, bringing together phenomenology of being-in-the-world and discourse analysis, to theorize the notion of normalization work. More specifically, I aim to establish how consumers' normalization work is grounded in and ranges between the three levels of abstraction of bodily, socio-historic, and existential modes of normalization. To recap, normalization work refers to that dimension of talk is affected by a reification of bodily awareness that occurs through one's deviation from health norms in their experience of illness, while at once attuned to talk that struggles to get a grip on the world in which the body-subject is thrown. Reflective of my phenomenological approach, the current study thus extends certain aspects of Heideggerian phenomenology to understanding discourse and practices of talk in relation to affective bodies. The key axiology (i.e., goal in pursuing scientific knowledge) of my phenomenologically oriented study is to understand how pre-reflexive embodied experience co-constitutes and shows up as discursive practice, namely as talk.

Over the next four chapters, I will empirically explore how a group of consumers grapple with an embodied impairment—lactose intolerance—through their talk. Each chapter will investigate, in turn, a particular theoretical context that spans the body-subject, social, institutional, and market level of analysis. In the coming Chapter 6, I will to orient and anchor normalization work in the body-subject.

FINDINGS: AN INTRODUCTION

The purpose of this introductory section is to describe each findings section succinctly and provide the logic of these sections as a whole. The following findings chapters will highlight the ways consuming body-subjects cope with lactose intolerance through their normalization work. Normalization work refers to that dimension of talk, mediated by the body-subject, that is affected by one's situated normativity, while at once attuned to disciplinary action to overcome immediate impediments therein. When I use the term 'talk,' I am referring to that dimension of talk that reveals normalization work. Further, I often make a methodological choice as a researcher to treat data through the oscillation of 'affectedness' and 'attunement.' However, in individual experience, affective-attunement are inextricably en-meshed and happen simultaneously (Dreyfus 1991).

A broad objective of this study is to understand how authoring body-subjects, in their situated normativity, make possible and perpetuate medicalization. Lactose intolerance is a food-related illness, and as a form of medicalization, is a type of discourse about health suffused with relations of power (Foucault 2006). While extant consumer research has addressed the ways these power relations are productive of resistance to medical intervention through preventative health management and self-care (Thompson 2004, 2005; Moisio and Beruchashvili 2009; Kristensen, Boye, and Askegaard 2011; Giesler and Veresiu 2014), my study focuses on the way these power relations are productive of consumers' consent to medicalization as consuming body-subjects are governed by the normative pull of cultural and practical understandings.

More specifically, this dissertation intends to understand how affective bodies solicit responses to overcome immediate impediments. Embodied know-how and skill in language use are attuned to a normalizing movement towards

familiarity and maximum grip with the broader contexts of significance to which their impaired bodies belong. In order to move the field forward consumer researchers need, I propose, a fuller understanding of the consuming body-subject. We need to know more about how consuming body-subjects orient and reorients peoples' experiences while they negotiate various worldly influences (see chapter 6). We need to know more about how consuming body-subjects promote livability within the intersubjective contexts to which their felt bodies belong (see chapter 7). We need to know how embodied micro-level activity influences and transforms institutional norms and has macro-level outcomes (see chapter 8). We also need to know, as marketing scholars, how consuming-body subjects draw on the market to promote normativity in their lives (see chapter 9).

My findings are illustrated over the next four chapters. The first of these chapters, chapter 6, entitled *Bodily Breakdown: Positioning Illness in the World*, highlights consumers experiences of lactose intolerance as a bodily breakdown. This chapter foregrounds the ways the body functions abnormally and emerges as a thematic object of awareness. A key theme running through this chapter is how the consumers' talk reflects an objectification of the body. Consumers, instead of dwelling in and through their lived bodies and habituated affordance-relations, are subjugated by lactose intolerance as it dominates their lives, emotions, personalities, and mobilities. In short, the consuming digestive body and its co-constitutive affordance-relations become explicitly thematized, and this way, exposing how the dynamics of the body-subject orient and re-orients peoples' experiences.

In chapter 7, entitled *Negotiating Social Life with Bodily Dysfunction*, explores the ways bodily dysfunction positions consumers in a subordinate position to prevailing normative (i.e., social) expectations of body function. In their affectedness, authoring body subjects acquire new skills to cope with normative expectations and intersubjectively furnishing certain ways of talking that line a nest for being-with-one-another at an intercorporeal level. The potential relevance lay in exposing the ways that consuming body-subjects promote livability and familiarity with the social environments to which they are thrown.

Chapter 8, entitled *Lactose Intolerance Inhabiting its Institutional Setti*ng, tackles how consuming body-subjects cope with lactose intolerance within the institutional setting of the public health care system. I find that consumers with lactose intolerance tend to turn to the health care system in order to cope with their bodily dysfunction. In doing so, conflicting meanings and turmoil emerge as the consuming body subjects struggle to appropriate lactose intolerance as a diagnosis. These findings a significant to my dissertations aims because they foreground the role of the authoring body-subject (embodied micro-level activity) in creating, sustaining, and transforming institutional norms (macro-level outcomes).

In chapter 9, entitled *A Health Care Surrogate: Interpreting Illness through the Market*, addresses how consumers turn to the market once the health care system fails them. However, this is not a smooth process because the dairy market directly deploys visibility for the illness of lactose intolerance. Further, dairy consumption is deeply embedded in the fabric of the cultural context. In their talk, consumers attune to consumption schema supportive of their attempts to cope with lactose intolerance. Importantly, these modes of embodied consumer talk reflect a normalization of lactose intolerance that occurs through marketplace resources.

Together these chapters establish the ways normalization work, as a means for coping with lactose intolerance, is ground-in and spread between the three levels of abstraction at the bodily, socio-historical, and existential modes of normalization. However, before discussing the implications for this research, I will open up the findings in more detail over the coming chapters.

6. BODILY BREAKDOWN: POSITIONING ILLNESS IN THE WORLD

So far, in this manuscript, I developed a theoretical framework for normalization work anchored in a phenomenological approach to studying discourse. In this chapter, I want to begin to apply this framework to an empirical context, asking how bodily related norms are experienced, grasped, negotiated, and coped with through talk. To mobilize my proposed conceptual framework and to develop an interpretation of medicalization as it takes place in functional foods, I draw on first-person accounts of consumers' experience of illness, particularly lactose intolerance.

The purpose of this chapter is to orient and anchor normalization work in the body-subject. Throughout this empirical opening, I offer a tentative grasp of talk that is affected by a reification of bodily awareness that occurs through participants' deviation from normativity in the experience of illness. I will address how the body surfaces (i.e., is objectified) and is thematized in illness. Further, I begin to explore the vulnerability of these bodies to the alienating, objectifying gaze of the Other and the power discrepancies involved. When I analyzed answers to questions about "what is lactose intolerance like?" and consumers' descriptions of their experiences in everyday life, I noted that my research participants tended to emphasize the body's illness or failure to function. Bodily breakdown was at times revealed in a single comment such as, "*Basically it is like your stomach is fucked"* (Jouni) or *"when I am not eating the right stuff it just it shows. I feel bad"* (Saara). I explain these bodily situations as the practical and material conditions of existence for the production of norms. These bodily breakdowns identify who is coping and what is being coped with to sustain norms, as well as underlying and making possible social institutions such as medical knowledge of health or disease inherent in medicalization.

In parsing out the way the body-subject grounds participants' experiences of social norms, I borrow from Leder (1990) and categorize embodied breakdown into three dimensions—the dysfunctional body, the disappearing body, and social dys-appearance. Although these are not terms my participants used, I believe it un-conceals their bodily experiences as expressed in their normalization work. *The dysfunctional body* refers to bodily experience when the body functions abnormally and becomes a thematic object of attention such that it appears in the foreground of experience and with great focus. Here, I will highlight three existential meanings that emerge through bodily dysfunction: (1) oppositional force; (2) the disengagement of the body from the self; and (3) the body's malevolent possibilities *The dysappearing body* refers to the way embodied breakdowns challenge our ability-to-be. When the body functions in ways that are not normal, participants shift from states of tacit immersion to conceiving their bodies and the realms in which they are embedded as thing-like structures that must be reckoned with and overcome. In such instances of perceptual reification and heightened sense of reflexivity, participants become attuned to normatively mitigating bodily techniques, such attunement gradually becoming internalized and evermore implicit over time and related learning curves (Dreyfus and Dreyfus 2000). *Social dys-appearance* thus refers to the way the body re-appears as a result of self-consciousness that comes from social situations such that one becomes attuned to action that returns the body to the corporeal background.

6.1 Dysfunctional Body: Embodied Breakdowns Reveal Illness

Overall, lactose intolerance is an embodied breakdown that reveals illness as a consequence of eating and drinking dairy foods. In their normalization work, participants' talk illustrated a dysfunctional body as a result of consuming dairy foods that attunes them to their corporeality. Jouni provided an illuminating narrative:

> *I had been boxing for a long time and I was in shape. But then it started, the pain started coming, and then I started shitting a lot, so it was like 'oh shit, this is not good,' and I went to the doctor and had and tests. I was feeling really shitty, and my stomach was in bad shape. I've found out that I am allergic to milk protein and also lactose, so I can't tolerate either one. My stomach gets fucked if I eat dairy. I might get some rash on my skin, stuff like that, and I have noticed problems ever since I was a teenager. I have been strict with dairy products. I always read everything I eat so I am sure what the ingredients are so that there is no dairy. (Jouni)*

Jouni evoked a typical list of symptoms: pain, diarrhea, rash, and stomach aches. For Jouni, the bodily breakdown linked to lactose intolerance was a seemingly sudden revelation, starkly contrasted against the relationship he had with his body as a competitive boxer. The physical capital, in the form of

conditioning and physical training from boxing, molded Jouni's bodily style in everyday life into a distinct way of being-in-the-world (Wacquant 1995; Wainwright and Turner 2005). That is to say, he physically felt capable and healthy or as Jouni put it "in shape," making the experience of bodily impairment an endangerment to his embodied sense of self. Jouni's normalization work is affected by consumption practices grounded in dairy foods, linking the act of consumption, eating and drinking, with physical malaise (Scott, Cayla, and Cova 2017) and struggles to cope (Adkins and Ozanne 2005). While Jouni's experience provides an extreme example of the way bodily breakdowns reveal illness, many participants foregrounded bodily breakdown in subtler terms but revealed illness through the body nonetheless. Henri provided another example: *"my stomach was getting bigger and bigger when I drank milk."* Maari, self-diagnosed lactose intolerant, similarly notes that *"Sometimes I look like I am six months pregnant."*

In reflecting on the participants' distinct way of being-in-the-world—a way of being that is characterized by bodily disruption—I have come to recognize differing existential meanings based on the character of the disruption and bodily dysfunction. In this section, I will describe the body as an oppositional force; the disengagement of the body from the self; and the body's malevolent possibilities concerning the differing existential meanings. Each plays a distinct role in the constitution of the bodily being-in-the-world with illness.

6.1.1 The Body as an Oppositional Force

The emergence of bodily malfunction acutely disturbs the otherwise relatively cohering relation between body and self. Bodily dysfunction reveals the body to have an opposing will of its own that refuses to surrender to commands, hindering the body-subject's intentionality, obstructing her projects. Disturbances of bodily dysfunction explicitly reveal the oppositional force of the body, as Jouni says:

> *It is a physical feeling, and I can see that food is an important thing and can influence my physical feelings. This I had to learn because when I was younger, I never thought about this. I ate what I liked and did not think about it. But now when my body is broken, I have to think about eating more than I would normally. (Jouni)*

The simplest of actions such as drinking a glass of milk, having a lunch break, eating ice cream at the beach, or indulging in a slice of birthday cake with frosting can disclose the body's overt resistance to the consumption of dairy. Instead of dwelling in the lived body unreflectively, Jouni is forced to think about his body because it is "broken." Rather than enabling Jouni to carry out his projects, the body shows up as an impediment, an obstacle to be overcome, a disruption to normalcy.

In participant's normalization work, the impaired body becomes the focus of attention. The body is the principal means of interaction with the world,

and bodily dysfunction demands it be taken into account. As Antti explains poignantly, *"It was terrible to live with the pain. The pain is so profound that you cannot escape it. It is always throbbing, it was terrible, it was Hell."* Antti now views the world through the medium of an impaired body. The experience of eating is not one of relaxation or communion but rather fear of the potential pain it may inflict. In much the same way, Jaska's attention explicitly shifts towards his body as he says *"sometimes it feels like you needed to go to the toilet to take a dump and sometimes it was just a stomach ache. The stomach pain is usually related to the bloating, and the intestines are expanding."* In his talk, Jaska is revealing the emergence of the body as an oppositional force, his body is shrinking the field of affordances as certain solicitations like the going 'to the toilet to take a dump' feature in the body's relation to the environment with more strength. The possibilities for mundane action shrink and habitual acts like walking can become obstacles to the body. I learned that pain from lactose intolerance could make it *"difficult to move because something is pressing the stomach, it is like having a weight on your waist"* (Pihla). Space constricts not only in the sense that actions become circumscribed, but physical features of the surrounding world like long distances to the toilet assume a restrictive character. For instance, Aaro talks about needing *"to be careful if I am going somewhere where there is no bathroom or anything near like a car drive or long trip."*

The oppositional body can sometimes pose a threat to consumers' identity projects. Our sense of self is intimately related to the roles we play–as consumers or otherwise—and to the goals and aspirations we pursue. Disruptions in these projects can cause one to feel stigmatized and diminished because it excludes people from participating in particular activities (Arsel and Thompson 2010; Luedicke, Thompson, and Giesler 2010; Thompson and Arsel 2004). Lactose intolerance can inevitably pose a threat to particular life projects. Jaska provided one such example in his talk about his ice-hockey hobby:

> *I remember I used to have a lot of stomach aches and sometimes diarrhea. Some of my friends asked me if I wanted to come and play ice hockey. I was afraid of going to the ice hockey fields because there was no toilet near. If I had any stomach aches, I waited at home for them to go away before I went anywhere. If I was going somewhere else outside like cycling or fishing or something, I always was thinking about where the nearest toilet is if I get diarrhea. In that sense, it was pretty irritating. (Jaska)*

Jaska's narrative connects the oppositional body to a disruption of particular identity projects. His normalization work conveys anxiety to participate in particular leisure activities where access to a toilet is constrained. For most, lactose intolerance is an acute illness that is 'irritating,' and involves a *"naggy feeling all the time"* (Eevi). In particular projects like playing ice hockey or cycling, the irritating and naggy stomach ache that gets accompanied with diarrhea can pose a disruption, and the affectedness of materially constituted anxiety poses a

threat to one's project. The future becomes an intrinsically problematic where one can no longer make particular assumptions about their physical capabilities. Similar accounts can be found in Harri's talk about working out at the gym: *"We would have a protein shake afterward, which has milk, I think it is whole milk with some protein…And I would get home and spend half an hour on the toilet. It would go straight through me."* Harri goes on to note that *"I thought it would turn me into Arnold Schwarzenegger, but I was wrong."* Here, the oppositional body disrupts consumers' work on their physical appearance. What was meant to be a consumption practice that enabled the body to be shaped according to a specific identity project became a threat to the functioning of the body.

The oppositional body establishes bodily alienation through the loss of corporeal identity. Everyone possesses unique and familiar bodily way of being. The way we talk, look, walk, and move distinguishes the body as uniquely individual. The oppositional body hinders this unique bodily way of being. Anni describes her experience of lactose intolerance in this light:

> *I was 18 years old when I noticed that I was having huge hair loss. I went to a hair specialist and took a microscope scan from my scalp and found lactose from my hair root…I cannot tolerate the lactose; it goes to my hair root and prevents the hair from growing correctly…For women, their hair is like a crown. I immediately quit drinking all the milk and dairy… I used to drink milk a lot. I loved drinking milk, and I still miss drinking milk. (Anni)*

Anni's talk connects bodily dysfunction to the damage of corporeal identity through the loss of her hair or her 'crown.' Lactose intolerance not only causes physiological difficulties with digestion but also can drastically alter appearance. To remove the crown from the queen is to leave them at once unfamiliar and uncomfortable, a transformation into both an alien corporeal style, where one can no longer do what one 'loved,' and an overwhelmingly negative body image. Anni's experience reflects the vista of consumer culture that glorifies beautiful bodies, stresses physical fitness, sexuality, and youth (Featherstone 1995; Thompson and Hirschman 1995; Walther and Schouten 2016). In a similar vein to Anni's account, I heard frequent stories that emphasize similar bodily attributes in the pursuit of healthy lifestyles. Consequently, the type of changes in corporeal identity that accompany bodily dysfunction is not only an unfamiliar way of being but also one of diminished self-esteem.

6.1.2 The Disengagement of the Body from the Self

The oppositional force of the body and loss of corporeal identity can sometimes be combined with the disengagement of the self. In tacit experiences, the body is implicit and the medium through which one's attention and actions are directed outwards, for example, identity projects: the bodies intentionality aligns with outwardly directed human intentions (goals, motivations, means to carry them out, etc.). Under bodily dysfunction, bodily intentionality misaligns with

those outwardly directed actions, disengaging the body from the self. The felt sense of control and functionality in one's movements and actions is fundamental to the experience of the body as one's own, something phenomenologist's label 'sense of agency' (Zahavi and Gallagher 2008). Harri provides an account of maintaining his *"combat availability"* and *"full functionality,"* as he talks about maintaining motor ability and a general sense of control over his body. However, this is not the case for everyone as *"there are different levels and different stages of lactose intolerance"* (Harri).

Lactose intolerance can disengage the body from the actions of the self and establish intentionality of its own. Through participant's normalization work, I learned that lactose intolerance could often disrupt particular activities in which all consumers engage, namely—sleep. Ilmari describes, *"I bought one of these protein milkshakes, and I remember waking myself up with absolutely horrible farts."* Ilmari's talk highlights that the disturbance of lactose intolerance reveals the body's independence from his intentional actions. Maari emphasizes a similar experience:

> *Usually, in the evening, when I go to bed, I put my head on the pillow, I close my eyes, and I sleep very well. But if I eat something that upsets my stomach, then I have to wake up and take something to help with the stomach. (Ilmari)*

The body deceives both Ilmari and Maari. Before they could sleep peacefully and without trouble, but now lactose intolerance disrupts this activity through involuntary flatulence or pain. The body acts with an intentionality of its own that hinders the consumers' activities and becomes an "*enemy to good health*" (Anni). Sleeping is a skill and technique that must be learned in so far that it is adjusted for bodily dysfunction that disrupts the regular rhythms of everyday life (Rantala and Valtonen 2014).

6.1.3 The Body's Malevolent Possibilities

The disruption of bowel control is the most heinous affective call of lactose intolerance that alienates the self. The body is experienced as a malevolent threat to one's dignity and sense of self (Toombs 1992). To lose control over one's bowels is undoubtedly a profoundly alienating experience that reduces an adult to the status of an infant or geriatric. Jaska account represents talk that reflects this sort of alienation:

> *I remember tens or hundreds of times when I was like fishing or doing something else and I got the stomach ache and I needed to get to the toilet and while walking home or being on a boat and waiting until I get to the shore and so on…or at home when someone else is in the toilet. I remember many occasions where I have to get to a toilet, and I was worried I would dump in my pants. Anywhere, pooping your pants would be embarrassing. Even if people understood, I would be really sad. (Jaska)*

Jaska's talk displays a series of close calls in respect to 'pooping your pants.' The oppositional body is capable of creating deep humiliation and shame reflected in talk that echoes embarrassment and despondency. While society has incorporated certain bodily functions into public discourses and practices (Foucault 1977; Joy and Venkatesh 1994), to 'dump in my pants' is absent from such social liberations. Indeed, strategies exist to minimize this type of assault on self, but their performance becomes a constant reminder of precarious control one has over the body. In a later account, Jaska highlights that *"I always had a toilet paper roll with me"* such that no matter where he went, he could cope with the body's malevolent possibilities.

6.2 Dysappearing Body: Embodied Breakdowns Challenging Ability-To-Be

In this section, I will explore the way embodied breakdowns challenge our ability-to-be. Drawing from Leder (1990), I have named this section bodily dysappearance. Leder proposes that when the body dys-appears, we experience it as "that which stands in the way, an obstinate force interfering with our projects" (1990, p. 84). The dysappearing body removes us from activities in which we are engaged, alienates us from the social world, and collapses experience into the limited sphere of the body.

There is an intimate connection between the body and how we find ourselves in the world normatively that attunes us to make sense of and deal with our situation. As Merleau-Ponty (1962, p. 169) posits, "the body is our general medium for having a world." Like those negotiating the meanings of old age (Barnhart and Peñaloza 2013) and knowledge workers coping with a life of decreased physicality (Scott, Cayla, and Cova 2016), consumers' feelings of normativity often hinge on their able-bodiedness:

> *I change my diet because of the condition. When you feel physically good, you are able to do stuff, and the illness is not a part of my identity. I think it is just like you are able to, physically do, kind of like normal stuff. (Jouni)*

I interpret this metaphor of 'able to do' as able-bodiedness that disposes Jouni to do 'normal stuff.' Here, bodily certainty, the 'I can' feeling of the ability-to-do, implicitly underlies our sense of normativity. This sense of bodily certainty takes place in the context of Jouni changing his diet to quiet his illness. I learned from Tapani that this sense of bodily certainty is only *"something that you notice when you have actually lost it, it is something so mundane, an everyday thing, ordinary, you do not really pay attention to it until you are hurting. When it is lost, you try to get it back."* Tapani's normalization work highlights the absent presence of the body as a corporeal background. As long as it is functioning properly, the body is something people 'do not really pay attention to' and is withdrawn from awareness. I interpret Tapani's description of bodily certainty becoming 'lost' as an affective call that reorganizes our relation with

our body and normative actions. When bodily certainty is lost, one must cope with re-attaining it to grasp normativity once again.

With lactose intolerance, there is an awareness that the experience of bodily disruption is temporary and one anticipates a return to some normal level of functioning. A fundamental way to form normalcy is *"to put less bad things in my diet so I can help the body to feel better"* (Henri). Alternatively, I learned that lactose intolerance is also linked to a wide range of chronic illnesses such as Crohn's disease, rheumatism, and irritable bowel syndrome (IBS). In these extreme cases, the broken-down body takes on a sort of gestalt switch where disruption becomes one's normal and non-disruptive moments are more of a passing irregularity. Jouni talks of such affectedness in the following way:

> *I had depression, and that had a lot to do with the physical disease. It got to me because I've always been into sports so all of a sudden, I would not be able to do that, and you basically sit around at home doing nothing. For some people, it gets real severe, and some people get it a lot easier. It depends. Some people you just take your medicine and that's it, but for me, it is different because lactose intolerance is connected to my Crohn's disease. (Jouni)*

In extreme cases of bodily impairment, meaning systems destabilize and may even collapse (Carel 2016; Toombs 1992). Jouni's narrative connects collapsed meaning systems to a bodily being-in-the-world. I interpret the bodily action to 'sit around home doing nothing' as a manner of inhabiting space, a bodily disposition of the illness. Although this excerpt can be read as a text about depression, it allows us to grasp the socially salient bodily dispositions of illness. In their normalization work, participants are affected by disruptions and attuned to particular actions to assuage corporeal tensions. The loss of significant possibilities from the world, even in cases of depression (Ratcliffe 2008), are not merely the contents of experience but the structure of experience itself. The general alteration of experience changes how one's body and one's agency are experienced and what one becomes attuned to or drawn in by one's surroundings (Ratcliffe 2010). For Jouni, the felt body shades his sense of being-in-the-world the kinds of possibility that the experience of the world incorporates. Jouni further recounts:

> *It was real hard on me. It affected everything. It is kind of like you've got the fever, and you cannot keep anything in, and everything comes out—like you have food poisoning or something. I mean it is a fucking disease that affects your life, real life, in every way: your social life, your work life, your family life. Plus, it is a physical pain, and that affects your mental state of course. (Jouni)*

Jouni's statement illustrates how the oppositional body and its continuous threat to identity establish anxiety that structures his existence. Jouni's talk emphasizes the way embodiment can restrict one's ability-to-be by narrowing the spectrum of activity one can undertake. This restriction is inspired by the type

of actions one's body spontaneously performs such as 'fever,' 'physical pain,' or the inability to 'keep anything in.' Normalization work thus emerges from a recognizable deviation of normal bodily function: affecting one's ability-to-be. The affectedness of normalization work occurs through a reification of bodily awareness that transpires to deviation from bodily norms that, as Jouni puts it, 'affects your life…in every way.'

Though at first glance it is the body that is disrupted, lactose intolerance gains its fullest meaning when related to the broader context. While the significant impact of bodily dysappearence is to challenge one's ability-to-be as that which shakes our bodily certainty, such bodily situations also carry the affectedness of being removed from the social world. One loses the ability to navigate social situations with ease, Ilmari describes, *"the last encounter I had with pure milk was awkward. It is mostly the smell of it. Out and about in public, the bowel movements can be a bit nasty."* While generally, lactose intolerance is not life-threatening, it is world-threatening as the oppositional body hinders one's ability to navigate everyday public situations. The oppositional body can cause interruptions at work that make daily life more arduous, as Heidi explains, *"I hate these stomach problems. When my mornings are difficult, then they are even more difficult if I have to be running into the toilet like ten times."* When you are forced to engage in the social world with a malfunctioning body, it makes life more troublesome.

Various structures of our environment make up our social worlds. The environmental structures can be the architectural landscapes we must navigate like roads or buildings, but also elements of work life, social situations, family relationships or any other dimensions of the immediate physical and social setting that which we engage. It is through our bodies that we primarily couple with environments that frame and sustain activities. However, this coupling is not a given. Drawing on affordance theory (Gibson 1986; Rietveld 2008; Rietveld and Kiverstein 2014), practical and social body-world coupling rests on relevant affordance-relations transpiring between the object realms and humans, as it were. Usually, any given environment has numerous affordances for a variety of potential actions. Whether these affordances show up to a given individual or group depends on the normative match between affordance type and human skill or aptitude, but also the kinds of ends and affective states individuals and collectives find themselves in (Rietveld 2008).

In our most basic actions, we are usually not cognizant of our affordance-relation repertoires as our practically skilled bodies are inextricably coupled with the material and social realms. Tapani describes it as *"a feeling that you do not pay any attention to because everything is good. You do not notice anything wrong, nothing hurts, you do not feel anxious, things are normal."* But when the body breaks down this body-environment coupling becomes constrained and life gets reverted to *"a kind of game of survival where you are training your body a certain way"* (Pihla). While this could be interpreted as

the production of an object body in the Foucauldian sense, I see it as a form of skill acquisition in the negotiation of differentiated environmental affordances. Instead of being about power over the body or making the body subordinate, it is about having the power to formulate new responses to previously taken-for-granted affordance solicitations and assuage disruptions to the body-environment coupling. Tapani highlights:

> *It is like if you play video games or a game of chess, you learn the rules by sort of running into them. It is like you cannot move your horse that way, it goes this way, you cannot use that…. It is like lab rats. Do not go there, you get shocked or something. It is like going through a maze. Your opponent is, I do not know, reality…your limits. (Tapani)*

What was once a body-environment coupling showing up for habituated completion like an intuitive dance, now feels like going through a maze. A maze is a structured architecture where the goal is clear, effects of decisions are calculable, and an objectively verifiable solution exists. Tapani's body is the entry ticket and the means of navigating the maze, and he is forced into playing with rules, not of his own making. Juho also exclaims, *"It goes like a rollercoaster. I do not know why"* - coming face to face with the oppositional body and the instability of his (embodied) being. Summoning the metaphor of the rollercoaster, with its attendant lack of personal control and frequent highs and lows crammed together, Juho's social world is unhinged from any feelings of bodily certainty. People start to feel a loss of self-control as they realize the body-environment coupling that makes up their social world is collapsing.

Metaphors such as 'lab rat,' 'rollercoaster,' 'maze,' and 'video-game' hint at alternate forms of body-environment coupling. While there may be issues of power and control inherent in these metaphors, there is also uncertainty regarding the abilities of the body, the potential affordance-relations thusly perceived as available, and associated anxieties that these metaphors imply (Johnson 1981). For instance, Jaska notes, *"You never know if it is diarrhea coming out or just a fart… you have to learn how to make the distinction."* This loss of control and the demands of acquiring the skills to cope with it establish anxieties that leave one to question *"why do I always have to go without ice cream? Why can't I have this? Why can't I have that?"* even though they *"understand on some level the importance of it"* (Gina). Always already open to interpretation when subject to impairment, the body shows up as a body when backgrounded by a limited field of potential affordance-relations, as is made concrete in consumers talk about metaphors. But lactose intolerant people can also make sense of their incoherent bodies by employing these non-human metaphors in their talk. Such normalization work is attuned to mitigate the tensions that originate in the breakdown of the body-environment coupling that makes up the social world.

To recap, so far in this chapter, I have proposed that the dysfunctional body confronts lactose intolerant consumers, that is, a body that deviates from bodily norms of function. The dysfunctional body reveals itself as an oppositional force, disengaged from self, and as malevolent for which differing existential meanings take hold. I have also addressed bodily dysappearence as the body's inability-to-be. Here, bodily certainty characterized in normal bodily action disappears. The body-environment coupling that is founded on affordance-relations becomes discontinuous, soliciting consumers to acquire new skills in the limited world that is our bodies. These first two sections are meant to emphasize physiological ways the body becomes thematized in our experience. In the coming section, I will explore in more depth the way social experiences establish the body's re-appearance.

6.3 Dysappearence: Embodied Breakdowns Establishing Social Difference

Social dys-appearance takes place when "the gaze of the Other" is distinct or objectifying, thereby affecting social interactions and foregrounding corporeal self-consciousness in the object of the gaze (Leder 1990, p. 96). The body is not only a corporeal background or a tool that enables particular action but also a place of vulnerability that can create a sense of disadvantage. As Jaska explains:

> *Having lactose intolerance, I felt like not being normal in some ways because I had the symptoms. Of course, being embarrassed by them if you take a dump and it is really smelling. The food restrictions have kept me from living my life fully. (Jaska)*

Jaska uses talk that emphasizes the gaze of the Other highlighting how meaning, belonging, and identity is contingent on society's construction of abnormality as the Other of the norm. Jaska constructs a marginalized sense of self through conceptualizations of difference and normality—in the sense that abnormality is linked to bodily breakdowns and the oppositional body (Leder 1990; Ratcliffe 2008; Merleau-Ponty 1962). I learned that specific experiences and circumstances affected their awareness of their bodies. The gaze of the Other sensitizes people to grow self-conscious of their bodies. Jaska also noted that:

> *I remember we were in a church at a confirmation and I got the stomach ache and there was only one toilet. Usually when you get like diarrhea or something, it does not smell too good, and I remember a girl went to the toilet right after me and I was really embarrassed because it smelled so bad. (Jaska)*

As he explains, these instances focused Jaska's attention on his bodily breakdown and ultimately undermined his experience at the confirmation. Here, the body is "defined and delimited" by the "judgments and projects of the Other," and we experience our bodies as alien to the self (Leder 1990, p. 98). The smells that Jaska left for the girl waiting for the toilet made him painfully aware of his body expressed by his embarrassment.

Lactose Intolerance also produces social difference by culturally inscribing the impaired body in particular ways. Social functions, such as weddings, work events, and New Year parties, cease to be places of enjoyment and engaged absorption. They become events to be managed, 'an experience' instead of experience (Tomkins and Eatough 2013). Rather than focusing on the convivial sociality of these interactions, respondents were locked into a guessing game trying to figure out if these spaces incorporated the lactose intolerant's body schema or not. Pihla recounts her experience of weddings:

> *When you socialize with people you can forget about other things that are bothering you…but in some weddings you do not know what is in that food…and you do not want your tummy to be like turvoksissa [bloated]. (Pihla)*

While Pihla wants to forget about other things that are bothering her, her body refuses to blend into the background, especially when she perceives it as puffing-up and making her stand out the minute she consumes lactose. The shadow of the abject is never far from her.

Lactose intolerance also shows up in the social world in more nuanced culturally inflected ways. Those with lactose intolerance often stand out from the non-lactose intolerant population, and in a country where *"any standing out is bad, you want to be just an ordinary person, plain and have nothing special about you"* (Tiia), lactose intolerance shows up as a hindrance to the everyday skills of these people. Ilmari had difficulty making friends when he was a kid because of lactose intolerance. He recalls *"being irritated as a kid when my friends got to eat chocolate bars and stuff, and I could not eat myself"* often ending up in fights with his friends over this perceived injustice. Ilmari's embodied experience of lactose intolerance comes in the way of him being a good school-mate, a vital identity peg in childhood. In much the same way, Maria, an aspiring synchronized skater, who goes on team trips to all corners of Europe as part of her training, speaks about how lactose intolerance comes in the way of engaging in social norms required in her aspired vocation.

> *When I am on a trip with my skaters, we will all eat the same, and I am the only one who cannot eat anything with lactose. It is difficult because I am not comfortable being the only one asking for different things and different order. If you are in a huge group that can be so hard. (Maria)*

Synchronized skating depends on the team being in sync, on the ice as well as off, and in her normalization work, Maria hints that her strange meal choices make it hard for her to become part of the group. The skating team 'will all eat the same,' and naturally at the same time, but Maria, because of her lactose intolerance, is the odd one out. From a phenomenological perspective that is interested in temporality (Fuchs 2010; Wyllie 2005), what Maria describes here registers as experience of non-simultaneity, an instance where a rift emerges

between her personal needs and their time(s) and those of the social realm in which she is embedded. In such cases, not only does the body become an externality but also the time to which such social outings belong, while normally a tacit medium of experience, now takes on explicit form, as intersubjective desynchrony. This suggests the importance of being 'in tune' with the social processes of one's idiosyncratic habit, and the role it plays in cohering with norms at the bodily level of abstraction.

In their normalization work, the people I interviewed were attuned to strategies for avoiding social dys-appearance. The body is always a setting for the "microphysics of power" and, as such, always subject to the intentions of others (Foucault 1980, p.26; Leder 1990). Jaska provided an illuminating illustration saying:

> *I was never farting in public. I always went to the toilet. The smell was one thing but also the sounds. If I was having a movie night at a friend's house, I always went to the toilet if I had a bloating feeling or diarrhea. (Jaska)*

Jaska's quote implies camouflage techniques to hide the oppositional body and its malevolent possibilities while in social situations. Camouflage aims to preserve commonality by blending of difference (Goffman 1963; Hansson 2006; Thompson and Hirschman 1995). Anxieties that occur in social situations push people to consume dairy at times even though they know that it may produce adverse effects. For example, Eevi says, *"I do not want to be the guest that goes [snotty tone] 'oh I cannot eat that, sorry do you have anything else?'"* Lactose intolerance becomes "both a bodily feeling and, at the same time, an experience of worldly possibilities" (Ratcliffe 2012, p. 23) once consumers attune to tacit cultural knowledge of when to conform they can blur the boundary between normal and abnormal. Conformity suggests that one changes their behavior, and even their bodies, to match those within the group (Goffman 1969). There is no better example to show conformity than the military, and Ilmari describes, *"when I was in the military, I did not specifically ask for a lactose-free diet. I ate in a normal way."* Here, obedience and uniformity marked by the demands and regime of the military enact a power dynamic such that the lactose intolerant are forced into normality so as not to stand out.

In sum, the lactose intolerant body erupts and establishes differing existential meanings linked to the body as an oppositional force, the disengagement of the body from self, or the body's malevolent possibilities. People with lactose intolerance reveal a distantiality— the ever-present distance between the Being of the self and the Being of others—from the tacit bodily capacity to eat and drink normally. Lactose intolerance forces a decoupling of the body-environment structure that makes up the field of affordances that characterizes the social world. This destabilization of the body leads consumers to acquire new skills to cope with deviance from normality. Social disappearance solidifies lactose intolerant consumers deviation from bodily norms as they negotiate the

power dynamics inherent in the objectifying gaze of the Other. Within the current chapter, I also begin to qualify normalization work as a construct that is gradually finding its conceptual form through extended analysis consumers experience of bodily being-in-the-world—thus, setting the scene for subsequent analysis of normalization work as it takes place on different analytic levels adding more depth at every stage. First, I will address the socially meaningful distinctions of (ill) health in chapter 7. Next, I will explore moral conflicts between health care and illness in chapter 8, eventually leading to the emergence of the market as a health care surrogate for those with lactose intolerance examined in chapter 9.

7. NEGOTIATING SOCIAL LIFE WITH BODILY DYSFUNCTION

Up until now, the findings of this manuscript have explored the body-subject as an empirical orientation towards understanding the problem of the body as it is experienced in illness. In their talk about eating and drinking dairy foods, participants revealed that the act of consumption is what establishes bodily dysfunction for those with lactose intolerance. Bodily dysfunction directs a person's attention to the centrality of their body as possibilities for meaningful action become impaired (Leder 1990). The body becomes an oppositional force with a directedness and intentionality of its own that challenges the normative experience of able-bodiedness and participant's ability to partake in everyday life. Consumer talk is affected by a reification of bodily awareness that occurs through one's deviation of normal bodily function. Consumers with lactose intolerance are affected by the gaze of the Other, and participants' talk reveals social difference from normative expectations that creates an ever-present distance between the self and others.

The purpose of this chapter is twofold. First, it explores how consumers with bodily dysfunction are affected by normative expectations imposed on them by immersion into social life. Second, it builds an empirical substantiation of how, in their affectedness, consumers are attuned in their talk that brings upon conventional ways of being in the world bodily. I will address how consumers deal with bodily dysfunction on a day-to-day basis. The consuming body-subject negotiates the loss of lived directedness and sense intersubjective synchrony (Fuchs 2005) relative to normative expectations of one's social environment, and the subsequent recourse at an embodied and intercorporeal level. Lactose intolerant consumers' bodily awareness was a profoundly social thing, arising out of intersubjective interaction at a corporeal level (Leder 1990).

Intersubjectivity refers to the understanding of one's body, as reflected in the experience of it by others (Carel 2016; Merleau-Ponty 1962). The gaze of the Other directed upon those with bodily dysfunction establishes normative expectations of what matters and makes sense to do and say. When my respondents began to describe their experiences in the face of lactose intolerance, a particular pattern showed up repeatedly. Participants responded to the situation of being solicited by normative expectations in different ways, as their immediate familiarity with the world sundered into those with lactose intolerance and those without, using talk to get the best grip on the social environment in which they are thrown.

I analyze lactose intolerant consumers' social life through the lens of absorbed coping. Consumers always already find themselves, to '*be there*,' in the world amidst social situations, and only afterward make sense of and cope with such practical and material conditions. In line with Dreyfus (1991), absorbed coping is a mode of engagement and action in which one is immersed in the practical and material context of one's affordance solicitations. Thus, doing things, being with others, and immersion into material and social realms are a priori conditions for how lactose intolerance consumers discover meaning and establish cohesion in the world. In this chapter, I organize my empirical analysis according to different modes of engagement for which consumers negotiate practical contexts amidst solicitations by relevant social norms. I address these modes of engagement through three themes revealed through lactose intolerant consumers' talk that makes sense of social life with bodily dysfunction. The first, *feelings of familiarity with bodily dysfunction*, refers to the lived experience of navigating social environments in ways that present no trouble for consumers. Familiarity refers to dwelling in our social milieu, primarily through our skills and abilities, such that we are immersed in the task of going about our business in the world (Blattner 2006; Heidegger 1962). The second, *conflicts between familiarity and intersubjectivity*, discusses the ways intersubjectivity conceives social life and establishes pressures of conformity. In the public and intersubjective realm, the material and social contexts solicit consumers to act and behave in certain ways—a phenomenon I refer to as normative expectations. Normative expectations may not support consumers familiarity in the world. When skills and characteristics of the individual do no match, normative expectations breakdowns and conflict emerge in social life that must be assuaged. Lastly, *negotiating conflicts between familiarity and intersubjectivity* address the ways consumers establish cohesiveness in the world amidst contention between familiarity and normative expectations through skill acquisition and intercorporeality.

7.1 Feelings of Familiarity with Bodily Dysfunction

As empirically substantiated in the previous chapter, bodily dysfunction, in its affectedness, discloses how we find ourselves in the world (Ratcliffe 2008) and is linked with the norms of civilized society. The individualizing effects of bodily

dysfunction force lactose intolerant consumers to coordinate and organize their everyday life in order to conform with social conventions. In their normalization work, participants work out ways of acting and talking that are afforded through the body-environment coupling. Social environments, to recap from the last chapter, commonly have an abundance of potential affordances, but only particular affordances solicit actions from particular kinds of individuals. When social atmospheres are familiar, reflecting a range of fluid affordance-relations between the environment and the individual, the body-environment coupling is experienced tacitly with bodies exhibiting directedness in action and intersubjective relations in taken-for-granted ways. In breakdown situations of lactose intolerance related bodily dysfunctions, this body-environment coupling, defined here as instances of stable affordance relations, becomes discontinuous. In such instances, the body emerges as a thematic focus of attention, and the once available field of affordances for social interactions become constrained. Familiarity in the world often goes unnoticed and is only revealed in breakdown events between the body-environment coupling. Lactose intolerant consumers with a related emergent need no longer perceive once routine affordances as relevant while establishing new affordance relations requires time and effort (Rietveld and Kiverstein 2014). In this section (Merleau-Ponty 1962), I will utilize specific instances of breakdown between the lactose intolerant body and social life that re-attune consumers to their familiarity in the world. To illustrate, Tiina notes:

> *People do not like to be near me if I drink milk or eat something with lactose because they notice, straight on. I get horrible gas and everything when I use regular milk. But of course, in some cases like chocolates or ice creams, I often take the risk if I am at home or if I am not in the like in a public place. (Tiina)*

Tiina's narrative highlights an awareness of stigma learned through societal values and perspectives on proper behavior (Goffman 1963). Here, to pass 'gas' as a result of eating lactose is inappropriate behavior that is regulated by the consumption of lactose in particular spaces that are familiar. By eating chocolates or ice creams at home rather than 'public places,' Tiina can conform to the norms of civilized interaction and apply social expectations to her local world in such a way that presents no trouble for her. I interpret Tiina's experience of being solicited to act in a certain way at home as a feeling of familiarity with bodily dysfunction. She is solicited by domestic affordances to eat and drink lactose despite her illness; one of the many lived possibilities for actions her private living sphere makes available to her (Rietveld and Kiverstein 2014). Another participant, Aaro, also exemplified this: *"at home, I can drink or eat anything I want and always, be like, in a safety area where it is easy to deal with."* Aaro discloses the safety area of the home as the delineation of a familiar context that is favorable to being lactose intolerant and having a dysfunctional body. The familiarity of home makes no trouble for my participants in the sense that the material context makes lactose intolerance 'easy to deal with.'

The familiarity of home also finds form in the practical context such that bodily impairment does not establish impediments to consumers social interactions with others. While immersed in the practical and material context of home, lactose intolerant consumers can passively consume what they want. In a similar vein, Timo remarked that "*I remember, in a party or a restaurant, I would be more preventative but not at home.*" He goes on saying, "*my eating was more restrictive when I was outside my home. If I knew I was going to stay at home, I would eat the ice cream with everyone else even though I knew I would get the stomach aches.*" Timo does not care so much about the symptoms as long as he was inside a familiar setting, delineated by the home, to be lactose intolerant. He knows the layout and where to go if particular symptoms force him to the bathroom, or he finds comfort in his bed overcoming stomach pains and bloating.

The feeling of familiarity at home sensitizes consumers to a relaxed temperament, participating in the world with ease, such that it becomes important to regulate food preparation. For instance, participants never really know what is in the food at a restaurant because they are not present while it is being prepared. Even though they expect their meals at a restaurant to be prepared without lactose, it can still end up in the food. "*We do not go out to eat much because it is so difficult,*" Lea says, "*this is also another reason for making food ourselves at home because you know exactly what you put in there.*" The familiarity with the ingredients of what informants consume provides comfort and makes life more effortless, and it is easier to regulate food production by 'making food ourselves at home.' This sort of comfort and familiarity creates *"a place where you can relax, a place where you can do whatever you want to, a place where you can be yourself"* (Siiri). Others expressed spending their evening "*really energetic and able to do anything*" (Kira). These and other statements delineate familiarity with particular social contexts, emphasizing the ability to passively, that is, unreflectively, 'relax' and participate in the world without difficulty; captured by Siiri saying 'a place where you can be yourself.'

7.2 Conflicts Between Familiarity and Intersubjectivity

Normalization work is that dimension of talk that is affected by and attuned to how the (authoring) body-subject finds herself in the world normatively. Despite the emphasis on familiarity, negotiating social life while coping with bodily disruption is rife with social conflict and affective tension. I will trace how intersubjectivity establishes normative expectations, that is, the view which other people hold about lactose intolerant people's actions, that create social conflict for consumers with bodily dysfunction. Normative expectations feature in participant narratives in different ways. The first I refer to as *contention in the home.* Contention in the home emerges when other people bring normative expectations of behavior into the domestic spheres' life. Consumers with lactose intolerance are affected by conflicts with their feelings of familiarity and attuned to possibilities of conformity. Second, *meaningful distinctions of (ill) health*,

refers to participants' distinctions of what is 'normal' and what is 'abnormal' in relation to the subject of health. Each theme, subtended by normative expectations, plays a distinct role in establishing contention in the lived experience of bodily dysfunction.

7.2.1 Contention in the Home

Whereas some lactose intolerant consumers accounted for the spatiotemporal rhythms of home as familiar and safe for bodily dysfunction, I learned that lactose intolerant consumers also experience the home in more uncertain terms. The home can be a place of contention for dysfunctional bodies. For instance, Jaska highlights:

> *I have three siblings, so we were six people living in our apartment as a kid, and we had two toilets, but I remember that many times, both the toilets were occupied. Moreover, I had a stomach ache, and I was thinking "how long is it going to take, can I get there on time," and don't think my siblings were too understanding at this time. Like if my sister were doing make-up or something, she would say "you can sit and wait there until I am done." Nobody wants to poop their pants, so I remember that it was difficult and hard at times. (Jaska)*

In this example, Jaska emphasizes a disharmony between bodily intentions (i.e., the need to defecate) and environmental challenges posed by other bodies, of which he highlights that were 'six people living in our apartment.' Jaska's siblings were not 'understanding' of his bodily condition and thus destabilizing the world and making it 'difficult and hard at times.' When harmony does exist between participant's bodily skills and practical environment, as in earlier examples, the body reaches a temporary grip on the world that provides it with a sense of orientation and security. As McCracken (1989) writes, the home "presents a face that is deliberately without defenses or pretenses in order to reassure the occupant that he or she may forgo defenses and pretenses of their own" (p. 174). However, normative expectations imposed by Jaska's sister creates the condition of conflict that challenges Jaska's feelings of familiarity in the home, such that he is unable to cope with the symptoms of lactose intolerance in a way that makes no trouble for him. He is pressured to 'wait' to use the bathroom with the pain of a 'stomach ache' while his sister finished her 'make-up.' While home life is primarily a sacred real and supportive barrier from social pressures (Linnet 2011; McCracken 1989; Wallendorf and Arnould 1991), there are instances where home shows up as discordant. Being-with-others is not always easy, especially when such being is under fixed material constraints.

Normative expectations of others clash with the lived, practical context of the home and its familiarity for lactose intolerant consumers in other ways as well. Participants often describe desynchrony in the regular rhythms of meal times that provide the structure of experience and meaningful family time. Eeda, a mother of two, describes the way family members with different bodily

specificities produce, experience, and feel home as a familiar context. She describes *"both of my boys have a very restricted diet"* and the older one *"he has his own fridge"* for six or seven years. Inside the kitchen sat two refrigerators facing each other on either side of the room. Her son separates his foods to avoid the potential for eating the wrong thing. This practice carries with it a separate consequence of disrupting the togetherness of meal time, as Eeda describes, *"He has not eaten with us all these years now"* because he eats and makes his meals at his own times. The reconceptualization of the kitchen by adding a new fridge to serve restricted diets, due in part to lactose intolerance, intervene in meal preparation and consumption practices by affording Eeda's son a different temporal rhythm for meal time. Her son is invited to make his own meals at his own times and tends to eat separately from, and at a different rhythm than, the family; thus, creating contention within the home as a supportive environment for communal affiliation and togetherness. While Eeda's son may feel familiar at home by having his own fridge, making his own meals at his own time, these expectations of freedom disrupt the communal experience of togetherness symbolic of family mealtime for others. From a phenomenological perspective, what Eeda describes here registers as experience of non-simultaneity, an instance where a rift emerges between her son's personal needs and time(s) and those of the social realm in which he is embedded (Fuchs 2005; 2010). In such cases of normalization work, not only does the body become an externality but also the time to which such family meals belong, while normally a tacit medium of experience, now takes on explicit form, as intersubjective desynchrony (Fuchs 2005). This suggests the importance of being 'in tune' with the social processes of others in one's idiosyncratic habitat, and the role it plays in cohering social norms at the bodily level of abstraction.

7.2.2 Meaningful Distinctions of (ill) Health

In their talk about health, participants made a distinction between what is abnormal and what is normal: healthy being normal and unhealthy being abnormal. The healthy—unhealthy dichotomy takes on normative expectations related to productivity (mainly in the economic sense). Participants equate those who are healthy with those who are productive members of society. Thus, there are those who are normal and pursue being healthy while being lactose intolerant so long as they are productive in the process. Then, there are those who are unhealthy and abnormal because they are unproductive. Often, it is hard to see what is normal until you experience the abnormal such as one might through bodily dysfunction. Normalcy is a tacit everyday experience that sits in the background without our awareness. Despite the dysfunction inherent in lactose intolerance, people experience it as normal in certain social situations. I will explore different dimensions of this incongruity by looking at the ways consumers characterize the unhealthy; then, I will open up a discussion on how lactose intolerant consumers are pursuing health; lastly, I will address the demonizing of the unhealthy.

Bodily dysfunction linked to lactose intolerance can establish impediments to one's ability to work and be productive. Some participants experience severe pain and complications from consuming lactose. Participants spoke, in their normalization work, about having to take time off work to cope with the bodily dysfunction of lactose intolerance and the subsequent deviation from normative expectations.

> *I have stomach issues, awful issues. About ten years ago. I was on sick days all the time, having massive problems, awful pain, diarrhea, everything, and I started to use probiotics, I always take the tablets, Gefilus tablets, and it has helped very much. Of course, I also have to look at what I eat. I do not know if it is in my head or is it the fact that I avoid some food nowadays, but it has helped. I am not able to eat that much in the morning, so if I am going to a morning shift, I take a bottle of Actimel (probiotic yogurts) before I leave to work and then I have breakfast at work, so it's also convenient to have something small before you leave. (Pipsa)*

Pipsa's talk highlights that the way lactose intolerance becomes a barrier to being a productive person. She was on 'sick days all the time' from work in order to cope with 'pain' and 'diarrhea.' Disciplinary practices of 'avoiding some foods' and 'looking at what she eats' become substantiated through the consumption functional foods in the form of 'Gefilus tablets' and 'Actimel' that calm Pipsa's stomach and are 'convenient' amidst the normative expectations of being at work on time.

Participants talk anxiously about others whom they regarded as being healthy. Participants constructed a mythic person who can eat whatever they like and feel and look amazing all the time. Maari describes:

> *It is not so much feeling sad about who I am but more about my lack of self-control. I feel like a weak person. I feel that it is not fair because why do I have to worry about what I eat all the time when others can eat whatever and not feel like crap. (Maari)*

This idea of being a 'weak person' and having a 'lack of self-control' serves powerfully to influence people who experience lactose intolerance. Health moves from being a general idea of feeling good to something that they ought to do to live in the right way versus the wrong way, and it takes on a new meaning. In line with these comments, participants echoed that the experience of illness *"is stressful because I do not really like telling people at work that I cannot come today"* (Pekka). Similarly, Linda notes, *"I do not want to be away from work because I feel bad about myself."* Participants find it *"easier to go to work and live the normal life than being affected by illness"* (Linda). Participants talked about when they have a huge workload, life becomes stressful to tell colleagues because they do not want others to get stuck *"doing the work for me"* (Patti) because *"I cannot fulfill my duties"* (Kira).

In their normalization work, participants articulate versions of their selves by drawing on market resources in their pursuit of health. Market resources often focus on *"getting more healthy"* or *"losing weight"* (Pekka). Health becomes symbolized by techniques people can use to reshape their selves. A person must *"eat well"* (Eevi), *"get a good night's sleep"* (Anni), and *"do exercises"* (Maria). I learned that people are particularly interested in having a flexible work—home balance in their pursuit of health:

> *I would say an ideal version of myself would be athletic. A person who can combine a successful career and also family life…I would emphasize the balance to behave well at home and to be able to fulfill my tasks at work. (Kira)*

Kira highlights that an 'ideal version of myself' would combine a successful career and family life amidst the contention between work and home. The notion of "balance" between work and the home is echoed in other participants' talk such as Eevi, Anni, and Pipsa's. There is an ever-present concern to be able to combine the responsibilities of work and home in life. Kira goes on to say *"I think that my work is threatening my life at home because I don't have enough time to be with my family or give time, especially to my daughter, and that affects my health constantly because I have to worry if I don't spend enough time with her and wonder how does she feel."* This concern harkens back to discussions of juggling mothers (Thompson 1996) and the tension experienced between having to balance many different tasks all at once and the concessions such balancing demands. People are "flexible workers that constitute not a mass of conforming selves but a mass of contending selves…. perpetually stuck in a fluid work-home hybrid" (Cederström and Spicer 2015, p. 18). Work flexibility is an essential component of Pekka's ideal life:

> *I would like to have more power to decide on my own schedule. Right now, I have to be at work at really specific times. I would rather have more flexibility than that; I would probably like to, well, I like my work now, but I mean, flexibility would be excellent so I can help people: my parents, my friends, my brothers, and my nephews. I work for them, also as well as for myself. To do that I need to stay healthy. I would like to work until I am like way past pensioner age nowadays in Finland. But, I would also like to have time to relax a bit, travel much more than nowadays, usually making only one trip abroad per year, so I would like three or four, and then, of course, live abroad one day. The primary barrier is mostly my own laziness, probably. I need to stay stricter with myself and maybe set more specific goals. (Pekka)*

Pekka's talk of 'flexibility' and the 'need to stay healthy' are due to a lack of work-life balance. He describes a contention between being able to help his family outside of work, while simultaneously, he goes to work 'for them.' These findings connect with other research that emphasizes the tensions consumers face as the

male breadwinner and supporter of the family (Holt and Thompson 2004). However, in our case, gender norms are given new texture as concerns over one's longevity in work-life demand attention to health. Pekka also emphasizes that his ultimate weaknesses are personal. He is the ultimate dictator of his health, and there is no barrier beside his own 'laziness.'

The bodily dysfunction of lactose intolerance becomes blurred with other social pressures connected to work life. Work-life balance and the need for flexibility reveals anxieties that structure normative requirements for those who participate in social life. Participants commented on the contentions between the rhythms of work and home life to which were subject and how they mitigated perceived conflict therein. Pihla highlights that *"when I am stressed, my stomach goes round and round; I am not sure if it is more stress or the dairy that I eat."* Rather than focusing attention on their bodily impairment, participants discipline themselves by taking new approaches to everyday life, be that within the realm of work or home, to *"minimize the stress…and make life easier"* (Pihla). People talk about *"leaving my laptop at the office, so I do not take work home"* (Juho), or they may hire a *"caretaker"* (Kira) for their children so as not to worry so much about working long hours. Participants' talk of different balancing techniques between work and home dulls tensions that occur through one's deviation from normative expectations of being a productive family member, friend, or worker.

There are socio-cultural forces that structure what it means to be unhealthy. Participant's normalization work fashions people with ill health to be an expense, an obligation incurred by all within the Nordic welfare model. Pihla works for a pension insurance firm whose primary mission is to keep ill people working by re-educating them in ways that can help give them new professions. She notes *"it is like a million euros if you think that you will not be working for the rest of your life, and you will be getting a pension check like every month, it is expensive."* Taxpayers, the productive and working individuals within society, incur these expenses. Patti notes that *"now when I get sick, I have to be really sick not to go to work because nobody is doing the work for me." Here "wasting time in line at the hospital being sick is unproductive"* (Tiffany). Much of this talk expressed discontent with the ill and demonized them as unproductive members of society who do not carry their fair share of the social burden. Simultaneously, in their normalization work, these participants are expressing discontent with themselves in a self-disciplining way. Such talk also portrays unhealthiness as a morally laden aspect of life, whereas being healthy makes consumers better people and productive citizens.

To summarize, this section highlights conflicts with familiarity and intersubjectivity. Familiarity can be considered a relational arrangement of practical and material processes which are characterized by intersubjective harmony. I have shown that familiarity with the world allows consumers with bodily dysfunction to experience and navigate social life in a way that presents no

trouble for them. However, bodily being-in-the-world always has a concrete there, meaning that participants are affected by sets of practical circumstances and material arrangements to which they are thrown (Dreyfus 1991; Heidegger 1962). Likewise, there are instances where the intersubjectivity inherent in social life carries normative expectations of behavior that clash with participants familiarity. The clash between familiarity and normative expectations creates contentious social experiences and intersubjective discord that extend in places previous felt as familiar, like the home. Social environments that were once unobtrusive become explicit impediments to one's immersion in the world. In this, it is similar to health in that it normally remains unnoticed until we become ill (Fuchs 2010). Normative expectations can be said to create meaningful distinctions for (ill) health; here, I point to participants distinction of what is abnormal in establishing what it is to be normal and healthy while having lactose intolerance. In the coming section, I will look at how these clashes in social life find resolve through skill acquisition and intercorporeal resonance.

7.3 Negotiating Conflicts Between Familiarity and Intersubjectivity

In their normalization work, consumers struggle to get the best grip on the world in which they are thrown, and their absorbed coping creates cohesiveness amidst social conflict and the normative expectations of others. As consumers negotiate the lived experience of bodily dysfunction against the immediate practical and material background of significance, they come to understand social life and its normative expectations that constrain the range of possibilities for being. Consumers' negotiation of social life amidst its normative expectations is addressed through two themes—skill acquisition and embodied intercorporeal norms. Each theme plays an integral part in establishing cohesiveness while struggling to grasp practical and material situations of social life to which participants are thrown.

7.3.1 Acquiring New Skills to Cope with Social Life

Bodily dysfunction and its associated vulnerabilities require the ongoing process of navigating and regulating oneself concerning social norms. The ability to purposively navigate societal pressures to regulate consumption and conform to social norms requires a habitual knowledge—a type of 'know how' about the body and how to cope with its dysfunction (Crossley 2001; Dreyfus and Dreyfus 2000). This habitual knowledge often comes at the cost of identifying the moral dimension of their bodily dysfunction.

> *Jaska: I was fishing once, and I got the stomach ache, and I needed to go home, but it was so far away. I had a friend who lived close by, and I rang their doorbell and asked if I could use the toilet. He said that they had guests there and that I could not. I managed to get home safely, but it was one experience where someone was not understanding. It is possible he did not know about my condition.*

> *Not that many people knew I had the problems. I think if I were open about it, I would be bullied at school. I was already bullied about being overweight, and that would have been just another reason.*

As indicated previously, the bodily dysfunction of lactose intolerance has a certain stigma and marginalizing pressures associated with it. Public places afford or invite certain possibilities for action while constraining others. The bodily breakdown experienced by Jaska creates the potential for his embarrassment and moral injury due to the possibility of transgressing the norms of bodily decorum that are imposed by intersubjective order. These experiences feature into the perspective of possible outcomes that might not even occur such as being 'bullied at school' or pooping one's pants and this begins to limit action like sharing your condition with friends. Jaska was compelled to ask his friend if he could use the toilet. To this end, the field of relevant affordances provided by the practical and material environment was constricted for Jaska. The toilet at home assumed a restrictive character because 'it was so far away,' and invoked concern that he might violate the norms of bodily discharge in public. Further, Jaska's friend's reaction also shows up as an affordance restriction (or 'denial') as the possibility to use the toilet is closed down. In these instances, one must learn what they can get away with, or in other words, how their corporeal schema aligns with the field of relevant affordances. Jaska goes on to describes this sort of 'know how' saying he would often ask the store clerk at the *"grocery store to use the staff toilet"* or *"the nearest place"* like a bar. Similarly, Jouni stated, *"when I travel and go to a new country, the first sentence I learn is "where is the toilet?"*

Coping with lactose intolerance is an acquired skill that can shape the actions of other people, even those who do not directly experience the illness. Intersubjective resonance is created through the presence of the other, through our "simultaneous referral to the world, in our joint actions" as they occur within the immediate physical and practical setting of the social milieu (Fuchs 2010, 8). Participants talked about eating as routinized and habitual action that is instilled at early ages through family meals. Sami notes that *"our meals are quite regular. It is about the family and the kids and keeping a timetable for them. We always make an effort to sit down together around the table every day with food that we have made."* The habitual nature of eating food is seconded by Maari, who explicitly claims, *"eating is a habit."* In talking about eating with others, I learned that consumers could 'tune in' to the habits of lactose intolerance through the intersubjective resonance.

> *Pihla: I use lactose-free dairy because my child has stomach pain, and they took her blood, and it shows that she has lactose intolerance. That was one reason why we have to use these lactose-free products. So, then I thought that maybe I have that gene as well, I haven't been checked, but I have this stomach that reacts to dairy.*

Pihla's normalization work positions her as lactose intolerant despite the lack of medical confirmation. This talk is not only identity constitutive but also specifies normative requirements for family members to engage with one another through the illness. Even people who do not experience bodily dysfunction are affected by the illness and attuned to similar consumption practices through communal affiliation. Pihla disciplines her own consumption practices by consuming lactose-free dairy to establish resonance with her child and bring the family 'in tune' to a common chord. I consistently heard participants describing themselves as lactose intolerant on similar grounds. As Eeda said: *"I am self-diagnosed lactose intolerant….my younger son also has it, so we do not use lactose. He noticed that it is not good for him to drink normal milk. He has always been that kind of person who never drinks milk—ever. I also have always had stomach problems."* This sort of habit formation is not only reserved for home life but occurs in other social settings such as work. When you are eating or cooking with your colleagues, *"there is pressure because people eat different things"* (John). Tiffany highlights:

> *In my last job, my colleague always appreciated that I brought in cakes or, biscuits or other things like that for everyone to eat. Sometimes it is a little bit difficult because there are different kinds of people. There are different kinds of foods that fit different people. For example, there is low-lactose and gluten-free, and that kind of stuff and you have to find the golden road and make food that is suitable for everybody. (Tiffany)*

Tiffany emphasized cooking food for colleagues that are 'suitable for everyone.' This involves recognizing that there are 'different kinds of people' with different kinds of bodies that must be taken into consideration. I interpret the metaphor of 'finding the golden road' as an attunement to harmonious intercorporeal norms and that crystalize habits in others. Indeed, not everyone in the office struggles with lactose intolerance; yet, food brought into the office must fit those who do. As such, lactose intolerant consumption practices become more and more habitual for those without the bodily dysfunction.

Participants find ways of conforming to the bodily experiences of others through talk. De-individualization, in the sense of conventional ways of being-in-the-world (Heidegger 1962), and expansion of embodied mine-ness happen in particular environments where bodies come together, such as workplaces. Pihla finds that she is not the only one at work who experiences food-related embodied dis-equilibriums. Going to the office becomes a means of group therapy when she *"talked with some people in my company"* and discovered that *"there is a lot of people that they have some stomach problems."* In this instance, Pihla becomes aware that her colleagues are embodied organisms too, not just organizational (disembodied) agents with which she must compete. Informed by an embodied awareness, Pihla is able to harmonize with her colleagues in a new, incarnated way, such as discussing the state of their respective

digestive systems, and in the process working towards a sense of interpersonal resonance with them.

Talk about the consumption habits of others was thus normalizing and the power associated with these discursive practices was productive, though what it produced was differentiated based on the habitual norms of one's immediate social situation and whether they resonated with bodily dysfunction or not. In their normalization work, participants said their own dietary requirements *"were not so important"* (Mikael), that they sought to avoid being *"not a good mother"* (Lea), and even avoided dealing with lactose intolerance rather than disturb family coherence: *"Lactose intolerance is annoying and makes me feel bad and causes me stomach problems. However, my two sons do not have any problems, so I have not started dealing with it yet"* (Pihla). People spoke about wanting *"everyone to eat the same"* (Maria). The habits of others establish normative requirements for coping with lactose intolerance. In situations where people without lactose intolerance dominated the immediate social environment, the call to discipline practices according to the illness were tempered by the pull to conform with those around them.

In their talk, I find participants to be generally solicited by their social milieu to act in ways that produce continuity between themselves and normative expectations. However, I also learned that some people do not perceive lactose intolerance, its potentials for social vulnerability, as a source of discontinuity in regards to their immediate social contexts. For instance, Mikael offers an example:

> *I am very flippant about lactose intolerance. For example, I do not know if this is lactose-free milk. I did not even check. I do not know. I cannot have the attitude that…When I am at home, for example, I have lactose-free milk all the time. I have lactose-free products, and I can have yogurt cheese all lactose-free. Most of the stuff we have at home is lactose-free. So, if I come out for a coffee with a friend, then, I do not want to think about lactose intolerance because this is not going to kill me. The worst this is going to do is maybe give me an upset stomach or I have to run to the toilet or something. I can live with that. I do not want to be restrained because I do not do this very often. I do not want to bring that into these few moments I have for myself. So, if I get to go for a coffee like literally once every three months, then I do not want to be bothered with lactose intolerance. If something looks nice, it probably tastes nice, so I am going to have it. That is my personal attitude towards that sort of thing. If I were to find out it had some long-term health concerns, then maybe my attitude would be different, but as far as I understand there's none, it is not going to give me cancer or anything. (Mikael)*

Mikael's resists feeling 'restrained' by the bodily dysfunction of lactose intolerance by projecting a playful and 'flippant' disposition. Such talk functions to situate the body as the center of social practices such that it involves "a set of flexible principles" that provide the possibility for improvised responses (Yakhlef 2015, p. 552; Bourdieu 1984; Holt 1998; Kozinets 2002; Thompson and Hirschman 1995). Instead of viewing the body as passive, it is actively involved in producing congruence between the perceptual capacity to act with what the social environment affords or requires us to do. Mikael reflects this by emphasizing 'I do not want to be bothered with lactose intolerance' in those few instances when he gets to meet my friends for coffee or food. Also, Mikael downplays the severity of lactose intolerance by highlighting it as an acute illness, saying, 'it is not going to give me cancer or anything.' By 'living with' an upset stomach and running to the toilet, his body reaches a temporary equilibrium, enabling him to gain, even momentarily, a sense of control and grip on the environment. As Merleau-Ponty (1962) puts it: "by engaging in the world through stable organs and pre-established circuits, man can acquire the…practical space that will free him, in principle, from his milieu" and thereby gaining a stable way of being-in-the-world (p. 89).

7.3.2 Talk as the Embodiment of Intercorporeal Norms

Intercorporeality is a notion proposed by Merleau Ponty (1962) that enables us to look at social interaction in an alternative way to symbolic interaction (Goffman 1969), by focusing on the relation of one's own body to that of another. As a concept, intercorporeality emphasizes the role of social interactions in the construction and behaviors of the body: "the experience of being embodied is never a private affair, but is always mediated by our continual interactions with other human and nonhuman bodies" (Weiss 1999, p. 5). Typical examples of intercorporeality would draw on contagious yawning or smile. Perceiving one yawning prompts the same actions in the self where "my body and his are coupled, resulting in a sort of action which pairs them" (Merleau-Ponty 1964). Here, social interactions are viewed through motor capacity as opposed to social cognition. In her normalization work, Tanja explicitly highlights how social interactions are mirrored through motor capacity:

> *I have an identical twin sister, who's diagnosed with lactose-intolerance And she told me that we have it so… [laughs] And then I thought I could give it a try, and I noticed that it is better if I avoid it. Before when I would eat milk, I looked heavily pregnant, turvotus (bloated) and it was not lovely so, lactose-free dairy helped with that, yeah. (Tanja)*

Tanja's narrative shows a shift from individual to intercorporeal lactose intolerance. The body of her sister is unable to digest lactose, and she took up a diet without lactose. In grasping this possibility, Tanja took up the same action as her genetic counterpart. It is through her own motor capacity of 'looking heavily pregnant and bloated' when she ate lactose that she understands the meanings of her sister's action to give up dairy foods.

The erasure of the difference between 'lactose intolerant self' and 'lactose intolerant family' in participants' talk highlights the way bodies are always already situated in relation to one another in lived space. Embodiment extends beyond one's individual body to include other's bodies as well. Ilmari recounts the role of social interactions on his bodily condition:

> *When I was once asked if a doctor has appropriately diagnosed me, I did not have an answer to that. Then I called mom, and she said that my big brother got lactose intolerance when he was like one or something. He got symptoms from milk, and then my mother tried to go to the doctor, and they just said that it is not possible for such a small baby to have it. But then she went to a private clinic so he could get tested for lactose intolerance and found out he has it. Then they put my brother on a lactose-free diet, and I got to go along with that as well. If I remember correctly, mother made me drink a glass of regular milk and then poo shot out even more forcefully than usual [laughter]. (Ilmari)*

Ilmari's normalization work highlights how embodiment becomes a target for norms and power to operate. To clarify this point, there is an incorporation of 1) norms of body function; 2) medical discourses on lactose intolerance; and, 3) existing power relations between individuals and institutions. First, the pressure Ilmari's mom felt for her children to have a normal functioning body pushed her to take her son to the 'private clinic so he could get tested.' Second, the trip to the private clinic occurred even after the other doctor told her Ilmari's brother is too small of a baby to have it. The intercorporeal interaction between the family shaped Ilmari's embodied self to become lactose intolerant forever, shaping how he relates to the world and others. Third, his mother contests the legitimacy of the medical institution, testing Ilmari on her own, making him 'drink a glass of regular milk' causing poo to 'shoot out even more forceful than usual.' Expanding on this entanglement, another participant, Gina says, *"I have not been paying so much attention to lactose intolerance, but when I got pregnant, I had to start paying attention to what I am eating because not just for myself but for the child."* Norms, discourses, and power relations are no longer identifiable as things separate from us; they define how we experience our bodies as embodied selves and how we relate to the world of others, or as Gina puts it, my actions are 'not just for myself but for the child.'

Lactose intolerance can also shape and normalize the social practices of the home through intercorporeal norms. I learned that members of the family with bodily conditions like lactose intolerance often cook for the whole family. For example, Lea talks about her daughter with severe bodily conditions saying *"she makes her food and for everyone else in addition."* Much like a typist who incorporates the keyboard space into their bodily space (Merleau-Ponty 1962), the lactose intolerant consumer, through the actions of cooking and food preparation, incorporates the home into their bodily space and establishes eating

practices for the whole family. All members of Lea's family are subjected to lactose-free consumption because her daughter, who has the bodily dysfunction, prepares the food for 'everyone' including herself such that they can all sit together at mealtime. While Lea's daughter's behavior could be interpreted as a form of colonization over the life-worlds of others, I chose to interpret this excerpt through the lens of embodiment because the intercorporeal norms within the family resonate. The space of lactose intolerance is established by the embodied interactions and activities of people coping with bodily dysfunction and the practical knowledge and understanding embodied in those activities (Yakhlef 2015). Simply put, the context of the home does not alone symbolize togetherness and safety, but rather, the body is the condition for their being such a space in the first place (Merleau-Ponty 1962). Space is created and instantiated by the body. Whether or not this space resonates familiarity or contention hinges on the affective calls of the body such that the body extends beyond its own skin and develops spatiality and cohesion as it inhabits the home or any other social environment (Csordas 2008).

Rather than the dominant medical norms of what it means to be healthy—that is, a normal functioning body—dictating social norms, intercorporeality can serve to generate different norms as those with bodily dysfunction interact with other bodies and normalize bodily impairment (e.g., making ill-health more familiar for those whom do not experience it directly). Here, the norm becomes to have lactose intolerance and is based on the bodily actions, or possibilities for actions, of others whom consumers interact with in everyday life. From a phenomenological perspective, affective intercorporeal resonance allows consumers to 'tune in' to the habits of others, which then hold normative sway over their further experiences producing new social norms (Wehrle 2016). Discipline can be understood as a form of harmonization or synchronization of habits that occurs through intercorporeal resonance (Fuchs 2010). While techniques of discipline produce docile bodies and align consumers with prevailing norms and monopolies of power (Cronin, McCarthy, and Delaney 2015; Thompson and Hirschman 1995), there are instances where the normalization process changes. My findings suggest that discipline, mediated by intertwined subject-bodies, purposively works on norms through intercorporeal resonance with the social milieu—a process which differs from purposeful conformity to stabilize a prevailing power.

To conclude this chapter, bodily dysfunction positions consumers in a subordinate position to prevailing normative expectations of body function. This deviation, in its affectiveness, attunes consumers to cope with social life, particularly in regards to how they construct what is normal and abnormal behavior. Normalization is a social practice, through which particular actions are seen as a normal part of everyday life. As indicated in the introduction, I aim to show how lactose intolerance and the consumption of functional foods (as an instance of medicalization) become normal. This chapter is important because it shows how the authoring body-subject negotiates, through talk, normative

expectations to establish cohesion in social experiences. In their normalization work, the affected body-subject becomes attuned to talk that makes sense of social situations as they struggle to get the best grip on the world in which they are thrown. I have analyzed how, as affected beings, always already in given social situations, consumers with lactose intolerance configure their talk to negotiate normative expectations. The consuming body-subject intersubjectively rules in and out certain ways of talking and acting; thus, creating a social space, instantiated by intercorporeal norms, for a stable way of being-in-the-world with bodily dysfunction. In the coming chapter, I will explore how this process of normalization takes place within the institutional setting of health care that defines a normal healthy body and way of life. These institutions promote a culture that emphasizes the socialization of medical disease and medicalization in the marketplace.

8. LACTOSE INTOLERANCE INHABITING ITS INSTITUTIONAL SETTING

This chapter investigates the recursive relationship between cultural ideals and consumer experiences that shape institutional norms and practices. This chapter highlights cultural ideals that exist in the institutional setting of Finnish health care and the experience through which the body-subject responds and negotiates these cultural pressures, shaping institutional norms and practices. Specifically, I examine the discursive dynamics, mediated by the body-subject, that are associated with inhabiting the institutional setting of health care. Throughout this empirical analysis, I will address how coping skills, anchored in the affective-attuned body-subject, create and sustain norms that underlie and make possible social institutions (like medical knowledge of health or disease). Institutions like medicine or health care depend on social norms out of which they evolved in order to make sense to people and so be accepted and perpetuated.

In the following sections, I surface three themes of inhabiting institutions. In the first section, *social practices of health care*, I show two ways in which health care becomes a social activity and macro-institutional pressure that influences behavior—talk about the regulative influence on health care as well as the formation of the orienting cultural ideal that 'health care is working.' I find that the regulative authority of the welfare state attempts to remove social inequalities that occur through private, professional medical practice by way of public policy that provides universal health care to all. A cultural ideal—that is, "rational theory of how" people should behave (Meyer and Rowan 1977, p. 342)—is formed which suggests the public health care system in Finland is convenient, accessible, and offers high-quality health care service. In the second theme, *contested meanings of health care*, I highlight turmoil and conflict that

arise as consumers' experiences of health care ignite an affective-attuned response through contrast and disjunction from cultural ideals in three discursive patterns of talk: 1) patients-in-waiting: the onus of visibility and the problem with severity; 2) issues of diagnosis and being your own doctor; and, 3) privatization of health care: employment, productivity, and the monetary link to good health. Finally, in the third theme, *practical coping and the appropriation of lactose intolerance*, I explore how contested meanings are handled and modified through talk that attunes to appropriation practices that allow consumers to cope with lactose intolerance as a diagnosis.

To study the inhabiting of the institutions, I draw on two emerging theoretical streams within institutional theory: work that uses the 'inhabit' metaphor to understand micro-level embodied interactions within institutions (Hallet 2010; Stowell and Warren 2018) and discourse theory (Phillips, Lawrence, and Hardy 2004; Humphreys 2010b). Inhabited institutionalism is premised on the idea that "institutions are not inert categories of meaning," but rather are populated with bodies whose "interactions suffuse institutions with local force and significance" (Hallett and Ventresca 2006, p. 213). Discourse theory tells us that practices of talk do not neutrally reflect the world (Jørgensen and Phillips 2002). Meaning is contextual and historical, and understanding it depends on interpretation (Maguire and Hardy 2009). Meanings conveyed through our practices of talk are not the only derivative of the practical and material environment, but also play an active role in shaping and transforming experience, behaviors, and institutions (Crawford 2006). Because "institutions are constituted through discourse" and discourse analysis has been often used to theorize institutionalization processes (Phillips et al. 2004, p. 635), my study explores the role of the authoring body subject in creating, sustaining and transforming institutional norms.

My findings in this chapter relate to an overarching theme of 'institutional norms,' a term used to convey the shared or social nature of health care, mediated by the body-subject, and associated with practical and material arrangements that govern people's' daily lives. Institutional norms govern behavior, insofar as departures from rationalized performances of how one is to behave "are counteracted in a regulated fashion, by repetitively activated, socially constructed controls," thus making deviations costly in one way or another (Jepperson 1991, p. 145). Macro-cultural ideals provide the legitimating rationales for how people are to behave and how people comply in symbolic ways (Meyer and Rowan 1977). But what happens when conformity to rationalized cultural ideals of how one is to behave is no longer symbolic but given tangible flesh through the dysfunctional body? Taking bodily experience as the starting point of my investigation, this chapter frames how embodied micro-level activity influences and transforms institutional norms. In the bodily experience of lactose intolerance studied here, I find that consumers' dealings with the health care system surfaced problems and discontent with the public institution. I contend that, in their normalization work, consumers' talk is affected by deviations in

their experience from cultural ideals of health care. At the same time, the authoring body-subject is attuned to market discourse that treats health care services as goods that appeal to patients as consumers rather than fellow citizens. To begin, I will first address the social location of health care in Finland, and then move on to explore contested meanings of health care before finishing with a discussion on consumers appropriation lactose intolerance as a diagnosis.

8.1 The Social Practice of Health Care

This section introduces the institutional setting of health care in Finland and the macro cultural pressures it produces. I will show how health care services in Finland are social practice. The social practice of health care refers to understandings of health that are much more than a matter for individual experience in singular relation with a medical professional; health is constructed through relations with others and is structured by society. One important note, this section discusses the broad health care system in Finland but the analysis is limited by the research broundaries of this study. As such, my interpretation of the Finnish health care system is cast through the prism of consuming body-subjects who experience lactose intolerance.

This section is organized into two sub-sections. The first, *talk about the regulative influence of the welfare state on health care*, will show how health care is provided a social location that balances out social and economic differences through universal health care policy. The second, *"health care is working," an orienting cultural ideal*, refers to the ways regulative influences establish particular cultural ideals of health care that orient the meanings of the public institution.

8.1.1 Talk about the Regulative Influence on Health Care

The regulative authority of the welfare state makes health care services available to everyone in Finland regardless of their financial situation: *"The health care system here is for everybody"* (Heidi). Public health care services are financed through tax revenues, making individual expense for health care treatment minimal, or as Jacob notes, *"in a way, the community takes care of all the costs."* Such talk conveys how the community ensures opportunities for health care to each citizen, and while universal health coverage is a huge benefit, it elevates individual health into a social issue and makes medicine a social practice (Foucault 2006). Consistent with this talk, other participants similarly emphasize: *"the public health care system works on the taxpayers' money"* (Jaska); *"everybody pays for your health care with taxes"* (Anni). As an executive human relations officer, Heikki has had much experience negotiating with various health care services. While interviewing Heikki about his experiences with lactose intolerance, he provides an illuminating historical narrative on the organization of the Finnish health care system:

> *In 1972, we had the law of national health care system [the public health care system]. Before that every county, every city had to have its own system. You had these local doctors who were filthy rich because they were, in a way, private entrepreneurs. They had this doctor's house, and the doctors lived to be like 155 years, they were there when your mother was born and when you were born, and they are there when you die. You know this old story— real spin doctors. All of that came to its end in 1972 with a new law, that arranged for every person in the whole country to have the same opportunity to receive health care. Moreover, that has now worked for 40 years. During these last 40 years, there were some hospitals in Helsinki, Tampere or Turku, which were totally private and only meant for the wealthy people, ambassadors, and things like that, but everything else was municipal. Nonetheless, the public health care became bigger and bigger, and it worked quite well. (Heikki)*

Heikki's talk highlights the reality of social medicine in Finland. The national health care system was erected in order to do away with private, professional practice, or what Heikki disparagingly refers to as 'spin doctors.' As Heikki emphasizes in his story, health care was initially more of a privilege that people paid for that resulted in making doctors 'filthy rich.' Heikki talks about doctors as 'private entrepreneurs' revealed the emergence of privatized health care before the public or 'national health care system' in Finland. The public system was imposed to extinguish the asymmetrical power relations between the everyday man and the medical profession that favored 'wealthy people.' The national health care system or public system provided 'the same' opportunities for health care to 'the whole country.' Patti described a similar sentiment saying, *"The public health care is government owned. It is for everybody. You can go there. You can make an appointment. There's this law that you have to be treated by a certain time."* In Finland, the Primary Health Care Act has outlined specified laws that municipalities offer health care centers with general practitioners and nurses to provide day-to-day medical services which are available to everyone without discrimination, while also acting as gatekeepers for specialized services that people obtain in secondary care (Kosunen 2009).

8.1.2 "Health Care is Working," An Orienting Cultural Ideal

Participants shared a common view of health care in Finland that provided a basis of meaning, and I coded this as the orienting cultural ideal: "health care is working." To describe this cultural ideal, I will draw the concept of institutional logics, which delimit the content and meaning of institutions (Scaraboto and Fischer 2013). They are socially constructed assumptions, myths, values, and beliefs whereby people, situated in practical and material contexts, provide meaning to their social life (Alford and Friedland 1985; Thornton 2004; Thornton and Ocasio 1999). In other words, institutional logics are macro-cultural ideals that provide legitimating rationales and interpretive frames for how people should comply in symbolic, ritualistic, or normative ways (Hallett 2010;

Meyer and Rowan 1977). When asked to describe the Finnish health care, participants generally began their narrative by lauding the health care system and emphasizing values and beliefs about its trustworthiness. Participants from a variety of backgrounds drew on this cultural ideal in their talk about the Finnish health care system. For example, Pipsa, a nurse, said:

> *How it is done in Finland is that everybody gets the best kind of health care and nursing and any help you need. It does not matter if you have lots of money or if you live on the street, you get the help if you need it and health care works here. (Pipsa)*

In line with these comments, I heard other participants with professional careers comment that *"health care is working here in Finland, that is why we pay big taxes, but it is worth it"* (Jouni); *"I trust the health care here"* (Patti). Sami, an officer, and father of three, highlighted:

> *Public health care is working quite well, and it is basically free. Before we had insurances for kids so, we could use private health care, but we stopped them because they were unnecessary. Public health care is working very well. It is a really lovely thing. We can easily set a time for the doctor's appointment through the internet. The place is quite near to us. It is really useful, and I rather like the public system. (Sami)*

This pattern that 'public health care is working' was common and I take it to reflect three things. First, the social practice of health care is dominant, even taken for granted. Such talk expresses the view that health is a basic human right. Everyone should have access to health care whether you have 'lots of money' or 'live on the street.' People will get the health care they need even *"if your poor"* (Maari). Second, it reflects regulatory pressures towards economic redistribution of wealth and equalization of income (Foucault 2006). This redistribution did not depend on taxes, per se, but on the system of regulation and economic coverage of health and illnesses. Therefore, Finnish citizens do not just pay 'big taxes,' they pay taxes so that "health care is working" for everyone. In ensuring that all members of society have the same opportunities for receiving treatment, the apparent baseline for whether or not the system is working, there is a regulatory attempt to correct inequalities in income; thus, providing health and illness a social location, i.e., the social practice of health care (Foucault 2006). Third, this talk reflects the prevailing expectation that public health care is always going to be available. To suggest otherwise, would be to effectively imply some members of society may have to suffer from pain, disease, and illness while others do not.

Cultural ideals are often described as loosely coupled with the activities and practices that occur within institutional structures, thereby alleviating structural inconsistencies and contradictions and, ultimately, reducing conflict (Meyer and Rowan 1977). In the coming sections, I will show micro-level, bodily experiences are implicated in the norms that maintain institutions. Paying heed

to the dynamics of the body-subject, "beyond [the body's] role as a symbolic resource or situated vessel in the enactment of social practices" (Stowell and Warren 2018, p. 786 [brackets added]), I show the emergence of contested institutional meanings when the experience of the authoring body-subject contrasts with cultural ideals. What arises is a local response to institutional pressures that directs attention to the micro-macro interface and highlights how embodied micro-level activity may have macro-level outcomes (Binder 2007; Hallet 2010).

8.2 The Contested Meanings in Talk about Health Care

This section will outline an orienting interpretive frame for understanding the recursive relationship between cultural ideals and the experience through which the authoring body-subject copes with these cultural pressures. In reflecting on participants' talk, as affected body-subjects, I have come to recognize conflicting meanings that lactose intolerant consumers have for health care. This part of the empirical analysis will address contested meanings and problems with public health care. Echoing the notion that micro-level activity can have macro-level outcomes, these contested meanings will provide a foundation for exploring how meanings of institutions are derived from, and arise out of, the turmoil established by the body-subject's deviation from social norms in the experience of illness.

While many participants view health care as positive, others do not. Participants articulated the feeling the public health care service was better in the past. Arto portrays that *"in the '80s public health care was better…it's getting worse."* Many participants recognized the public health care is *"often criticized these days,"* and people complain that *"there are long lines, you have to wait two or three weeks if you are not experiencing severe illness or something like that"* (Jouni). Besides, it can be difficult for people to navigate the public health care system, which exacerbates frustrations with the public system.

> *The experts you need to see are there, but it can be quite an arduous task trying to see one of them. You always have to get past different gatekeepers. When you go to the clinic, you might first see a nurse, and you first need to convince him or her that there is something really wrong with you; then, you can get to the better help. I might be a little cynical when I say this, but I think it is deliberate because they do not want to do unnecessary tests or research on a patient. They need to be certain that there's something wrong with the person in order to offer care. (Tapani)*

Many participants disclosed disquieting experiences of their perceptions the bureaucratic process within the public health care system being insensitive and inhumane (Tian et al. 2014). Tapani's talk evoked this sentiment. I interpret the metaphor of 'gatekeeper' as a sign of immediate impediments towards pursuing health of which consumer talk and actions are directed at overcoming. The

impediment is produced in a 'deliberate' fashion through the regulations in the system, such that they create stress for people who are coping with bodily illness that already constrain their field of affordances to the here and now (Crossley 2004). Taking an objective point of view, participant talk that functions to acknowledge frustrations with the public system often boils down to resource constraints, regarding money and time that keep medical professionals from being thorough and attentive to every patient. Further, from a managerial perspective, having patients first meet nurses is 'good practice.'

Through their talk, participants explained that the health care system lacks necessary resources. Participant talk framed problems with the public health care system around doctors' temporal constraints. Public doctors are busy and *"they cannot afford to put much time into one person,"* and that encourages them to *"just prescribe the first medicine that pops into their mind"* (Saara). When a participant's health is at stake, they want to get treated right away and have the proper attention paid to their illness; they do not just want the easy fix but rather a long-term solution. Participants said, *"the public health care sector is overworked"* (Antti); *"it is just that they do not have enough resources to provide the care that people need"* (Tiffany); and *"with the money they are getting, they cannot hire enough doctors or nurses"* (Jukka). Many people expressed feeling *"angry about the situation because I am a tax-payer, I pay quite a big sum in a year, and the money which I am paying to the government, it is not targeted correctly"* (Antti)

So far, I have outlined an orienting interpretive frame for understanding the recursive relationship between cultural ideals and the experience through which the body-subject negotiates, responds, and takes-up these cultural pressures. Although the cultural ideal expresses that "health care is working" in Finland, people nevertheless found problems in the system: long lines, prolonged wait times, gatekeepers, and lack of resources among others. Much talk that resonates stress, frustrations, and anger with the health care system can be interpreted to reflect asymmetrical power/knowledge relations. Medical professionals are seen to be overworked, which is reflective in consumers' perceptions of neglect of patient needs. When they *"should be discussing with the patient,"* medical professionals are *"typing on the computer for like 15 of the 20-minute time slot"* (Antti). In parsing out how consumer talk is productive of localized forms of subjectivity for which consumers regulate themselves to conform with, my findings are categorized into three emergent themes: 1) consumers as patients-in-waiting who face the onus of providing visibility for their illness; 2) issues related to the diagnosis of lactose intolerance that leads a consumer to become their own doctor; and 3) the monetary link to good health through the corporatization of health care.

8.2.1 Patients-In-Waiting: The Onus of Visibility and the Problem with Severity

A major issue facing consumers with bodily dysfunction is the experience of uncertainty and the pressure to identify what the condition actually is so they can get the help that they need for the body to function normally. This uncertainty occurs while consumers attempt to navigate problems with the health care system. Consumers struggle to provide the necessary visibility for their illness to move past gatekeepers within the public health care services. The concept *patients-in-waiting* refers to those who are subjected to technologies of surveillance as they hover between sickness and health (Timmermans and Buchbinder 2010), or more precisely, between bodily dysfunction and an undistinguished state of normalcy. As foregrounded above, the public health care service is a system that requires the individual to prove that they are unhealthy or sick as they pass through gatekeepers at different stages in order to get the treatment they need. Treatment can get delayed because of the process participant's go through to see a doctor. Participants articulated that *"If something bad happens, if you got really hurt, if you have a heart attack or cancer or get in a bad car crash, then the public sector will see you right away"* (Heikki). The public sector is excellent with regards to extreme health issues such as cancer reflected in Heikki saying, *"there is no place in the world better."* The downsides to public health care are things like *"long waiting times"* for mundane illnesses or impairments like lactose intolerance (Lea). In these cases that lack severity, the onus of visibility of ill-health is on the individual, not the doctor. I learned that people struggle to provide the necessary visibility for their illness to move past various impediments within the health care system; thus, leaving them a patient-in-waiting. Reflecting on the experience of trying to see a doctor, Tapani recounts:

> *We get to see the experts only when we are in dire need. They are cutting down the budget and stuff. I would say, for the last 15 years, there has been some decline in the public health care system because so much falls on the patient himself to get the message through to the nurse or the doctor. (Tapani)*

Tapani's talk suggests needing to provide visibility for his illness in order to get proper help from the medical profession. In their talk, participant's express an increase in the responsibility that 'falls on the patient himself.' This reflects a shift in the obligations between the patient and the health care institution. I learned that the institution of health care is pushing the responsibility for prevention onto individuals through *"constant informational campaigns about being aware of the things you eat, you have to exercise more, stop smoking, type II diabetes, lactose intolerance, and that kind of information"* (Tapani). Such talk reflects how participants are now obliged always to be potentially sick. There are constant social expectations to anticipate illness as a patient-in-waiting. Participants must be sure they are sick before checking-in to health care services.

The institutional norm of what it means to be sick is changing. Sickness refers to the social role defined by disease or who experience illness (Carel 2016). The sick role comes with a set of obligations that surround illness and shape the interactions between medical professionals and patients (Parsons 1951). In order to appropriate the sick role, a person is obligated to get assistance from qualified individuals (i.e., medical professionals) and, subsequently, follow the treatment plans that doctors lay out. My participants revealed, through their talk, that lactose intolerant consumers face impediments towards appropriating the sick role and that the subjective experience of illness or bodily dysfunction is not always enough to get assistance from qualified individuals. Anni, who was losing her hair as a symptom of lactose intolerance, describes this betwixt-and-between state of being a patient-in-waiting, experiencing illness, yet that still requiring action for resolve.

> *I went to a doctor too, but this is a minor problem for them, and it is not dangerous or life-threatening, so they did not really take a look. I think the hair specialist called it 'milk root' but that is not the official name. It is pretty common in Finland, but people do not know the symptom. They said I could not tolerate the lactose in dairy, and it was causing my hair to fall out. (Anni)*

Anni's narrative highlights problems with the severity of her symptoms such that medical professionals would not provide her assistance nor a treatment plan. Anni was forced to seek help from a non-medical expert. Pursuing other avenues for getting help with her bodily dysfunction, she found support in the form of a 'hair specialist.' Despite the 'common' nature of the symptoms, to lose one's hair was only a 'minor problem,' and not severe enough to warrant doctors attention. Sofia, whom has lactose intolerance, but also works as a state nutritionist, postulates that the *"problem is doctors often think that lactose intolerance is so easy of a disease and they do not have time to counsel the patients correctly."* The downplaying of lactose intolerance by medical professionals functioned to disenfranchise people from the institution: *"If you do not get the necessary treatment right away… it seems like they do not care…the public system does not care about you"* (Jukka).

8.2.2 Issues of Diagnosis and Being Your Own Doctor

In the case of illness, the medical professional is assumed to *know* the body that is being presented to him, empirically speaking—that is, the doctor understands the body in an 'objective' fashion. In their talk, participants expressed sensitivity to problems with diagnostic practices of the health care system, saying things like *"doctors do not do the right tests"* (Henrikki). As Tapani recounted:

> *My experience would have been better if the doctors properly examined me. The lactose intolerance test itself came out negative, but he could tell that my problems were linked to the dairy products. Yet, I was not examined any further. It would have been clearer for me if I had known exactly what was wrong. Generally, if*

> *you have problems with dairy it goes under the category of lactose intolerance, and, if the diagnosis was more precise, I could have known more clearly what to do, and it would have helped my way of life. (Tapani)*

Tapani's talk expresses that his expectations fall short of reality, resulting in disappointment with the health care system, and reflects a feeling of alienation towards medical authority that arises as patients present their lived-bodies for examination while doctors only 'see' the object-body (Leder 1984). As long as "medicine assumes that the body is merely a thing which requires fixing, then it is likely to perpetuate the alienation inherent in the collapse of the lived body" (Diprose, 1994, p. 110). Participants often talk about the experience lactose intolerance as an illness, but they *"have never been diagnosed,"* Henrikki recalls, *"twice I have been tested with negative results, but I still get the symptoms."* Under the gaze of the medical professional, participants are subjected to quantifiably having a disease or not. The diagnosis can often contradict the subjective experience of illness. There are cases where people experience sensitivity to dairy, but the lactose intolerance test comes out 'negative.' This person exists in a state of prolonged liminality between normal health and pathology continuing to have to monitor themselves. In severe instances, participants talked of being under medical surveillance for long periods: *"I was taken into many examinations; the nurses have drawn blood from me hundreds of times, and I got used to seeing the doctors. I was going like four times a year to keep track of my health"* (Jouni).

Consumers' normalization work also reflected how the marketplace could alleviate anxieties related to the uncertainty of being trapped between a state of sickness and health, standing in for health care services and, even if only temporarily, offering a form of relief and treatment for symptoms. Henrikki recounted struggling with the lactose intolerance diagnosis:

> *I wanted to get tested because I associated dairy with, growling in my stomach and pain and loose stools and all kinds of problems. The Internet was already around, and I heard about it. I just started to wonder about it and thought I might be able to improve things. I got a doctor's appointment and told them my concerns, and the doctor said: "let's test it." However, it did not show anything. The doctor said that if we cannot see anything, I could come back after a while. However, the tests did not show anything. They made me drink some goo and said that this should show it, but no. Then they did blood tests, they kept inviting me back in, they timed it with a clock, but those tests did not show anything either. If lactose-free products make me feel better, there must be some connection. I remember now; I bought some pills in the pharmacy. They said take this, but it felt so crazy that I take a pill so I can merely eat dairy, can't I just replace it with something else? I bought them, but I felt*

> *they were quite expensive, so instead, I used lactose-free dairy. (Henrikki)*

Henrikki uses talk that function to acknowledge how medical authority narrows rather than expands his room for maneuver in dealing with his dysfunctional body. A sense of uncertainty is expressed through metaphors of 'wonder' that are only exacerbated as visit after visit to the doctor's office and test after test does not 'show anything.' The feeling of helplessness that occurs he is unable to get advice or treatment for the bodily conditions of 'pain and loose stools' put a limit to his discourse of personal freedom and ability to consume certain foods. However, Henrikki also uses talk that expresses how the market steps in and opens up new spaces of possibility. By embracing functional foods like 'lactose-free dairy,' Henrikki is freed from feelings of helplessness, uncertainty, and frustration that occur over his lack of medical diagnosis. The market allows Henrikki the flexibility to diagnose himself and adapt to his bodily condition, or as he puts it, 'if lactose-free products make me feel better, there must be some connection.'

Henrikki's narrative foregrounds the theme of empirical analysis to be covered in the next chapter, that is, the marketplace as a surrogate health care provider. Various concerns that are anchored in the lived body-subject sensitize people to the market and its expanded field of possibilities. For instance, Heidi admitted her *"daily life is already difficult,"* the experience of lactose intolerance only makes it worse, *"if I have to be running into the toilet like ten times,"* and if functional foods like lactose-free dairy are an easy solution. This also connects to earlier accounts of consumers talk that (purposively) makes sense of bodily dysfunction.

The expanded field of possibilities for coping with illness, primarily facilitated by the marketplace, allows consumers to self-diagnose and become their own doctor. Rather than following the classic sick role where a specific state of ill health establishes an authoritative relationship between a medical professional and an individual (Holmqvist and Maravelias 2011), (ill) health is constructed around calculated risks and fears that relate to the way of life that consumers engage and not specific forms of medical intervention. Eevi describes:

> *I have read quite a lot from the internet to self-diagnosed. Candidly, I also talked with a doctor. I had some other reasons to go there, but at the same appointment, I asked what he suggested. He told me to take some pills—something that makes the air move more easily through the guts. He mentioned, if it does not help, then I should come back, and we should do more tests. I know what he wants to do, and I do not want to do that. I will try to solve this myself if I can. I think it is caused by some things that I eat. At the moment, I am avoiding milk and consuming lactose-free dairy. When I was a teenager, I sometimes noticed that if I eat ice cream or something, I get stomach cramps. (Eevi)*

Eevi's normalization work highlights how self-monitoring and surveillance are a common way for people to conform to social norms of health emphasized in her comments, 'I read from the internet to self-diagnose.' Moreover, the lactose-free dairy offered in the marketplace enable the regulation of health and bodily dysfunction in a way that eliminates the need for medical professionals, letting Eevi 'solve' lactose intolerance herself. In a similar vein, Eeda notes: *"Nowadays we are our own doctor. If I get some problem, the Internet is the place where I learn to solve it. I have noticed that doctors even do the same—they take information from the Internet during appointments."* Other participants claim the ability *"to cure yourself of most diseases"* (Siiri).

To recap, participants experience problems with the public health care system. As patients-in-waiting, they must provide visibility for their illness to obtain proper assistance from doctors. Further, lactose intolerance is often framed as a minor problem, and medical professions tend to concern themselves with issues that are more of severe. Patients-in-waiting are plagued by uncertainty that puts a limit on their discourse of personal freedom as they are perpetually in the mode of self-surveillance that, at times, creates an experience of anxiety and helplessness. In response, some participants manage their own health, diagnose themselves as lactose intolerant, as a means of being flexible and adapting to new conditions. Such talk can be linked to a good consumer who governs him- or herself (Giesler and Veresiu 2014) and is active and independent, according to their ability to be their own doctor.

8.2.3 Privatization of Health Care: Employment, Productivity, and the Monetary Link to Good Health

This empirical section explores how the corporatization of health care unfolds as people seek private insurance and medical attention in order to deal with illness and bodily dysfunction. Finland has *"the social democratic welfare regime, no doubt,"* but participants also note that *"there is a huge movement for liberalist values"* (Tiia). A central issue in the public health care system is the prioritization of severe and needy cases, which subjects consumers to being sick and providing visibility for their illness. However, the everyday symptoms of lactose intolerance are often not severe enough for consumers to either 1) see a specialist such as a state nutritionist; or, 2) for doctors to spend appropriate amounts of time counseling patients on how to treat the disease. As such, consumers tend to turn to the private health care system. In a poignant example, Kira describes:

> *I do not believe in public health care because if you are not sick enough, you have to stay in line with those people who are not producing anything. I know this sounds harsh. However, because of course, everybody has a right to have good health care, but I do not think it is right that when I am for example trying to get my blood test I have to wait there a long time and look at those alcoholics who are drinking away his or her lives. They might get in the line*

> *before me because they are maybe just fallen or doing something stupid. Also, we have insurance for our daughter because I want to make sure that if I have the slightest fear that there is something wrong with her I do not have to think that "ok, do I have time to stay in line for five hours with these degenerates." With private insurance, I just pick up the phone and get an appointment with a doctor. (Kira)*

Kira's talk foregrounds two critical issues. First, private health insurance allows you to get through the system quickly. People do not have to prove their severely sick or provide visibility for their illness; instead, they purchase the right to be sick and see a doctor. Second, the normative expectations of the process begin to emerge as Kira talks, in a morally charged fashion, about the unproductive members of society 'who are drinking their lives away' as 'degenerates' whom she should not have to wait behind. Being overly dependent on the welfare system, which was associated by many participants with *"those who just suck the money out of the system"* was itself a legitimate reason to *"use private health care if you can afford the insurance"* (Kira).

The negative stereotype of the welfare state recipient served to influence people to consider other opportunities for health care. In their talk, participants articulate the monetary link to good health: *"if you have money to buy good health insurance then you are fine, but if you do not have the money, then you are in trouble because you are not taking care of yourself"* (Alice). Private insurance is considered to offer better opportunities for health care and establishes a link between employment and the monetary affordances to a healthy lifestyle. Maari explains:

> *I work so that I can use a private doctor through the employer. The sad truth is that the so-called public health care is not as good as the private. If you have private insurance or you are wealthy, you do get a lot better treatment and faster. (Maari)*

In her talk, Maari highlights the link between health and productivity. To have an 'employer' and to 'work' affords participant's 'better treatment' for illness and bodily dysfunction. Unfortunately, many people *"are not in this employer-provided health care system"* (Henri). Jari emphasizes, *"I do not make that much money, but if I need a doctor, I pay for a private one"* (Sonja). For these participants, money becomes a central issue for pursuing health: *"If you have money, then you can get a good treatment"* (Heidi).

8.3 Practical Coping and the Appropriation of Lactose Intolerance

This section examines consumers' practical coping as they navigate contested meanings of health care and appropriate the diagnosis of lactose intolerance. The discontinuity between cultural ideals of health care and the experience of the body-subject sensitizes consumers to talk that regulates particular practices

in order to assuage any perceived conflicts and contradictions therein. Participants deployed different appropriation practices of lactose intolerance in their practical coping with bodily dysfunction. To repeat, the sick role refers to the authoritarian power of the medical profession to relieve individuals of responsibility for illness so long as they pursue treatments to get well (Parsons 1951). Some participants accepted the doctor's diagnosis of lactose intolerance (or not) and implemented medical advice into their everyday life; others struggled with the diagnosis and at the time resisted the authority of health care prognosis. Although distinct, the practices are not mutually exclusive, and lactose intolerant consumers sometimes made use of more than one. These attempts to interpret what medical advice meant is similar to the ways conventional consumers appropriate discourses to particular subject positions in the negotiation and maneuvering of preferred identities (Ahuvia 2005; Peñaloza and Barnhart 2011; Thompson and Haytko 1997).

First, some participants sought to position their selves as typical cases, who accepted the medical diagnosis and associated advice that comes along with it. Mikael accomplished this by eliciting cultural conventions in his talk: *"Finnish people, if something is wrong, have to fix it… as soon as they spot it is wrong or broken, they attempt to fix it."* Mikael describes tendencies towards being strict and well organized. Finns do not let things go; if something is 'wrong' or 'broken,' it must be fixed; this extends to issues of bodily dysfunction. Such talk reflects the expectation that people who experience illness must seek professional advice and adhere to treatments in order to get well. Some participants define themselves in terms of the health care diagnosis and emphasize knowing something was broken and accept the diagnosis and medical advice as confirming of their suspicions:

> *As I recall, I was diagnosed with it in 2002. Before that, I often had an upset stomach and stomach ache and, the kind of problems that, in a way, I started to think that maybe I had lactose or gluten intolerance or something. I recall having pretty intense symptoms at the time. Then, I made a doctor's appointment and sought treatment. They did some tests and, found out that that I had lactose intolerance. After the diagnosis, I completely switched to lactose-free dairy. (Timo)*

Timo's narrative highlights that bodily dysfunction in the form of an 'upset stomach' and 'aches' solicits him towards setting a 'doctor's appointment' to pursue 'treatment' to fix the broken body. Treatments often come in the form of *"not drinking milk"* (Anni) or switching to *"lactose-free dairy"* (Timo). Others are recommended pills, by the medical profession, that break down lactose or probiotics that help with digestion. It was often expressed that *"when I am eating medicine, I can live normal. I do not feel pain like this"* (Jouni). Medical professionals are empowered to absolve people from feeling abnormal in their bodily dysfunction because participants *"trust the doctors and their judgment"* (Eevi).

A second practice used by participants was to resist the diagnosis of lactose intolerance. I learned that participants showed concern that medical professionals are merely prescribing medicine based on symptoms. Laura and Gayle, drew on marketplace mythologies and the discourse of the power that circulate the health care marketplace (Thompson 2004) to maintain that although they experienced bodily dysfunction, they were not treating their illness in the conventional sense: *"people are overly medicated"* (Pipsa); *"I would not go to conventional treatment ever!"* (Siiri). Rather than accept their medical authority, these consumers resisted or contested this dominant medical discourse and the power/knowledge claims associated with it.

Maria, on the other hand, admitted to seeking a diagnosis for lactose intolerance but struggled with the treatment set out by the medical profession: *"The doctor gave me this kind of pill that I have to eat before I eat lactose. It is easier because my stomach is not hurting, but I don't want to eat medicines all the time."* Maria's talk highlights the potentially dangerous consequences of prescribing 'medicines all the time' and concerns that illness or disease may even increase due to medical intervention. In their talk, participants expressed buying *"some pills in the pharmacy. The doctors said take this, but it felt so crazy that I take a pill so I can eat something."* I interpret the metaphor of 'crazy' as a disbelief in the medical institution and its authority over health and the body.

A third and most widely used appropriation practice for dealing with the diagnosis was to emphasize the struggle with the unfolding of lactose intolerance and management of the illness. Avoiding lactose can be difficult *"if you go to a cafeteria, you have to ask if everything is lactose-free because you never know"* (Tiffany). Another participant described: *"Due to this thing with my stomach, the doctor said to take lactose bacteria pills to balance to stomach. I am not sure if they work because it is not an immediate effect that 'wow, I feel excellent right now when I take this'"* (Pihla). I interpret talk that functions to 'ask if everything is lactose-free' or to 'take lactose bacteria pills' as a purposive action in attempts to get maximum grip on the situation as opposed to a goal-oriented purposeful action that would have 'an immediate effect.' These purposive actions are a form of skillful coping with bodily dysfunction that varies from situation to situation (Dreyfus 1991). Participants respond to changing affordances that show up for them based on their past experiences. As Mikael describes:

> *There was this period of, kind of denial. The doctor said I have lactose intolerance, but I would say "I am all right," and then I would eat this brick of cheese or am going to drink this pint of milk. I refused to accept I was lactose intolerant. I would drink the lactose-free milk, but then I'd still have some symptoms. I would use this as, a weapon and say "you see I was drinking lactose-free milk for a week, and I still have these symptoms." You have to think about the*

> *big cream cake that you ate or what about the block of cheese or what about this or that. So, there was this kind of period of only having certain products that were lactose-free. To me, milk was, there was a much clearer connection between, a lactose-free product to milk. Those two seemed to correlate. When I thought of lactose-free, I thought milk. I did not necessarily think of yogurt, cheese, butter, cream, and all those things. I would have lactose-free milk but then have regular cream in a cup of coffee or have that big cream cake which had regular cream in it and then have symptoms and then claims that lactose-free milk is not doing anything. I was not making the correlation. Eventually, over time, I started to figure these things out. The cream has lactose, and "oh yeah, cheese has lactose." Then when I finally realized that everything has to be lactose-free and I do not have any symptoms whatsoever. This was a very long process for me, realizing and admitting that I have lactose intolerance and I, therefore, have to use lactose-free products and then my life, my quality of life, improved. (Mikael)*

For Mikael, the 'refusal to accept' the diagnosis and definition of self as lactose intolerant served as 'a long process' of struggling to get a grip on his bodily situatedness. In Mikael's normalization work, his talk is affected by the diagnosis of lactose intolerance and attuned to medical advice once he began 'realizing and admitting that I have lactose intolerance.' Mikael eventually embraced the lactose intolerant status, not as a mark of stigma, but of freedom that 'improves the quality of life.' The epithet of lactose intolerance reduces blame for not only bodily dysfunction but also particular food choices such that *"it is easier for a normal person to accept that okay, you cannot eat this, and that …you don't have to justify your reasons, but if you're not eating meat, for example, it's just your own choice"* (Gina). The diagnosis of lactose intolerance and consonance with treatment deflects stigmatized meanings linked to the illness. While struggling to cope with medical authority could be interpreted as technologies of self (Foucault 1977), the mobilization of which is "a means of deflecting attention from, and easing the pains associated with, stigmatized meanings" (Toyoki and Brown 2014, p. 11); I see it as a form of maximal grip. Instead of a regulation of self to conform to the dominant medical discourse, it is a struggle to get a 'grip' on the world in which participants are immersed. For example, Gina (above) refutes characterizations of stigma linked to lactose intolerance by explicitly saying that 'you don't have to justify your reasons' for having a lactose-free diet which I further interpret is because her bodily dysfunction demands it.

Participants are sensitized to deviations from the *normal person* that disrupt established frames of reference and disjoint the public unfolding of life from goals and interests. In her talk, Juho highlights: *"A few years ago, I went to the doctor, and he said, 'My stomach is very sick. You have it, and you have to quit everything that has lactose.' It is just not that simple."* Juho's talk is affected by a reification of bodily awareness. It is not the self that is sick, but 'my stomach.' Importantly, the body is given intentionality and directedness that is

somehow separate from the self. The separation of self and body creates complication in adopting the treatment plan to 'quit everything that has lactose' for which Juho emphasizes 'is just not that simple.' The body is deviating and opposing the goals and interest of the self.

Further, it is the body's readiness to act in a given circumstance, in the form of symptoms from consuming lactose, which realigns the self and body into a complete and familiar gestalt. To repeat, food consumption is a habituated and, as Mikael noted above, milk is not the only food that has lactose. Lactose can also be found in bread, yogurt, cheese, butter, cream, among others that make treatment for lactose intolerance disruptive to established lifestyles and consumption practices. Over time, Mikael 'started to figure things out' only as his previous attention to many bodily breakdowns (the active body) incorporates a tradition which attunes people to the appropriate response to 'use lactose-free products.' Participants learn to respond to bodily dysfunction to reduce tension, or in other terms, complete gestalts, or form a coherent whole, and re-align their lifestyles through struggling to cope (Dreyfus and Dreyfus 2000); and, this is distinctly different from participants having in mind a purpose at all. Despite consumers ability to either accept or resist medical authority, there does not need to be any representations of a purposeful goal of 'being lactose intolerant' per the diagnosis.

In sum, consumers' appropriation of lactose intolerance is a form of skillful coping with their bodily dysfunction. In order for one to improve their skill, they must be engaged and get a lot of practice (Dreyfus and Dreyfus 2000). Indeed, in some participant's overt resistance to medical authority and insistence on not pursuing 'conventional treatment,' their defiance that they were in fact afflicted offered resources to sustain an authentic sense of self that is a coherent whole (Holt 2002b). The body not only moves towards a coherent whole with the self but also tends to improve what counts as a whole. As I have described above, the struggling consumer tends to 'tune in' to more and more refined repertoires of appropriate actions that pair with bodily situations. Thus, the body's readiness to act in a given circumstance is enriched by the struggle to take on the diagnosis of lactose intolerance; yet, this is not a goal-directed activity. Of course, one is consciously motivated to acquire skills to deal with their bodily dysfunction, but they do not try consciously to discriminate more and more subtle lactose intolerant situations and pair them with more and more subtle responses. The body's readiness to act takes over and is mirrored through talk that is always struggling to get a maximum grip on their situation and reach an equilibrium between body and self.

To conclude, this chapter is important because normalization always takes place within an institutional context (Peñaloza and Barnhart 2011). Regulative influence positions the institution of health care as a social practice in Finland—that is, society shapes people's understanding of health. The public system establishes a cultural ideal that "health care is working" in Finland.

However, consumers' experiences of illness establish deviations from cultural ideals of health care that bring turmoil and contested institutional meanings. In their affectedness, consumers attune to talk that reshapes institutional norms. The welfare discourse that underlies the cultural ideal of health care becomes dominated by a market discourse that treats health care services as goods that appeal to patients as consumers rather than fellow citizens. Further, those who depend on the public health care system are, as 'cases,' morally inferior and lack the ability to "exercise of free personal choice in the private sphere of everyday life" (Slater 1997, p. 8). Such talk converges with changes in broader social practice toward the marketization of discourse, whereby market discourses colonize the discursive practices of public institutions (Fairclough 1992, 1998). In the coming chapter, I will address how consumers, who struggle to cope and appropriate the diagnosis lactose intolerance, turn to the market as a surrogate health care provider and perpetuate these institutional norms in new fields.

9. A HEALTH CARE SURROGATE: INTERPRETING ILLNESS THROUGH THE MARKET

In this chapter, I focus on how consuming body-subjects interpret illness through the marketplace and find ways of being normal while negotiating bodily dysfunction. Of particular interest is to what extent and how social norms that underlie the institutional setting of health care, particularly the tendency towards the privatization of medicine, are evolved and perpetuated in the market. In the empirical analysis that proceeds, I highlight the disposition in consumers' talk to produce and maintain flexible normative order.

The central argument this chapter makes is that consumers situate the dairy market as a site of conflict. On the one hand, the dairy market deploys visibility for their illness. On the other hand, the dairy market is perceived to have the power to fashion order in their lives through functional foods that resonate invisibility for their illness. The bodily experience of lactose intolerance contrasts with the perception of dairy as a health food and rich cultural resource in Finland, thus making their illness visible. The tension established by disequilibrium with the normative expectations of dairy compel participants to be responsive in a disciplinary manner. Consumers regulate themselves per their situated possibilities for action and ultimately produce flexible order that renders their illness invisible. Talk about functional foods transforms medicalization from a disruptive force to an instinctive normative action in coping with lactose intolerance.

I build this argument through an empirical analysis that unfolds over three sections. The first *is a contextual backdrop: dairy as a cultural resource* and is designed to orient the reader with an appreciation for the importance of dairy and dairy agriculture to the cultural context of Finland. The second *milk in Finland is making people sick*. This section features the affective call of dairy foods in the market, that is, feelings about dairy that resonate through bodily dysfunction attract or repel participants in particular ways that makes lactose intolerance visible and shapes relevant affordances for which consumers talk. The third is *making illness invisible through functional foods* where consuming body-subjects are attuned to self-disciplining talk that produces order and normativity in their lives amidst competing discourses. I identify four contact points where order and normativity are derived: "Talk About Impression Management," "The Effacement of Difference," "Habit-Based Actions," and "Technologies of Consumption." These intersections articulate and develop an understanding of the "practical mastery" in participants' attunement to market offerings that serve the disciplinary function of normalizing medicalization and, more specifically, lactose intolerance (Bourdieu 1984, p. 466). The first two contact points, "Talk about Impression Management" and "The Effacement of Difference," take place at the personal and intersubjective level and demonstrate attunement to disciplining talk that allows the fabrication of prototypically conforming selves. Conversely, the contact points, "Habit-Based Actions" and "Technologies of Consumption" refer to the tools of the marketplace (e.g., functional foods) and the ways they recede into the background of experience as they are swallowed up by consumers' attunement to practical tasks at hand.

9.1 A Contextual Backdrop: Dairy as a Cultural Resource

Dairy has long been a symbolic health food across the globe. Marketing and business scholars alike are probably familiar with famous American advertising campaigns like "Milk Does the Body Good." These campaigns encouraged consumers to drink a few glasses of milk each day to uphold and even improve their health (Holt 2002a). Dairy advertising and public relations efforts can build the ubiquitous belief that milk is good for your health. Several documentaries on the dairy industry deconstruct the ways milk is typified in popular culture as liquid food that satisfies thirst and hunger at the same time (See Lane's (2008) *Got the Facts on Milk?*; Howard's (2012) *Milk?*; or Keon's (2008) *Whitewash: The Disturbing Truth about Cow's Milk and Your Health*). Various advertisements in the California Milk Processor Board "Got Milk?" campaign, harnessing the power of celebrity endorsement, claim milk will help you lose weight; milk makes your bones strong; milk prevents heart disease; milk is good for your skin; milk stops cramps; milk will build muscles; milk will help you grow tall; and, milk will get your teeth healthy.

In Finland, these trends have been no different. Dairy is a long-standing essential raw material and economic pillar. Dairy farmers began to organize into cooperatives in the early 1900s with the sole purpose of exporting high-grade

butter to England. At that time, Finland was an autonomous Grand Duchy within the Russian empire, with around 300 other cooperatives operating within its bounds. Initially, many farmers were doubtful of the success of a centrally organized export driven cooperative. However, confidence snowballed. By 1906, 80 new farms joined and, by 1938, membership rose to 563. The cooperative provided a clear vision that the dairy industry could generate revenue through international exports, and the cooperatives themselves became central to the development of Finland's milk production, the dairy industry, and whole agricultural sector.

Despite the heavy reliance on business abroad, there is still a romantic affinity to dairy in the Finnish domestic market. Research participants talk about Finland having *"rural roots and food is often centered around dairy, especially raw milk, because it has a lot of energy. Historically, most of the people were doing tough farming or logging jobs in the forest"* (Arto). They also expressed dairy to be symbolic of a particular *"way of life"* (Leena). During the 20th century, Finland rapidly moved from an agricultural society through industrialism to a post-industrial society (Heinonen and Peltonen 2013). Simultaneously the country's population went through a huge structural change where the majority of people moved into urban centers including Helsinki, Tampere, and Turku. Kari Ilmonen, a Finnish Sociologist, in an interview with the Helsinki Times noted that this rapid urbanization influenced the development of consumer culture in many ways. People found it difficult to adapt to the urban lifestyle and longed for the fields and forests of their homesteads and the simple and unsophisticated agrarian lifestyles they had left behind (Helsingin Sanomat 31.12.1988). Dairy has become almost mythical in the sense that it resolves tensions and contradictions of the rural-urban divide. Even in the most celebrated of cultural texts, Aleksis Kivi's *Seven Brothers*, depicts Finnish people feeling as though society and its restrictions are too binding (1870). People should be free to do things their way as they have been done in nature and the countryside. Tiia, a sociology professor at a Finnish University, whom I interviewed for a background understanding of Finnish society, talked about *"milk-drinking and the dairy products as one of these traits that goes back. It is a romanticism towards a simple and plain life of the old, traditional, and agricultural times. I think dairy is interesting because it also connects to all these new justifications in nutritional guidelines and governance."* Drinking and eating dairy foods connected the consumer to the rural countryside, a space and way of life that is implied to be healthier (Emontspool and Georgi 2017; Holt 2002a; Kristensen, Boye, and Askegaard 2011).

After the great migration of people from the countryside to city centers post-World War II, the Finnish government, schools, doctors, dairy companies and others began promoting milk as a nutritious drink and necessary component of a healthy diet. Sofia, a state nutritionist, and lactose intolerant consumer commented:

> *Every school has brochures and big posters on display in the cafeterias. Teachers are to guide children that half of your plate is vegetables, and the one quarter is for fish and meat, and one quarter is grains, and then you have your dairy, etc. The idea is that the teachers would guide children, and there would be this material display on how to choose, and the school cafeterias and daycares, they must obey the guidelines. (Sofia)*

The plate model is a common understanding of nutrition recommendation. Tiffany notes, *"It is called lautasmalli [plate model]. Usually, there's a picture of a plate, and then there is like one fourth represented by proteins, one half should be salads and vegetables or something else that is good for you, and the other fourth should be like rice or potato or something that will get you fibers."* Tiffany goes on to say, *"next to the plate, in the picture, there is a glass of milk. In preschools where you have this in the cafeteria walls, a glass of milk always goes with it. So, it is embedded from an early age to the memory."* Tiffany uses talk that expresses how the model gets disseminated not only through schools but also *"it was referred to in many women's magazines like 'Kauneus & Terveys' or 'Fit' and others like that."* Such talk reflects the North American food pyramid as a fundamental building block for understanding how to eat and prepare healthy meals. Another common term for this is *"ruokaympyrä,"* says Maari, which means food circle, and it represents *"what your plate should consist of, how much protein, how much fat, how much dairy."* The food circle shows the importance of different sources of nutrition, not in a hierarchical sense, like the food pyramid, but through proportions on the plate.

In Finland, the current state of affairs is such that dairy foods appear familiar, its consumption is predictable, and people are anchored in it and responsive to its relative affordances. Again, an affordance becomes relevant when it solicits the person to take action that is adequate to the situation such that *"kids are used to drinking milk every time they eat a meal"* (Heikki). Here, the emphasis on being used to rather than getting used to suggests that they have been socialized to this practice from an early age. Finnish citizens have grown up on milk and milk products. It has been an unproblematized, taken for granted part of their childhood. They consider it normal to eat milk products. In fact, some of them have developed deep, emotional feelings for milk, as Anni describes, *"up until I turned 18 years old, I used to drink milk a lot. I loved drinking milk."* In this manner, participant's talk is interwoven through the semiotic device of food, expressing their emotions, beliefs, and values through consumption practices (Bourdieu 1984; Warde 1997). In Finland, people are willing and able to consume dairy with ease. The only problem is that a significant number of Finn's experience lactose intolerance, often designated *"a national disease,"* as Harri says, *"Maybe one out of every four people in Finland have it."* In the next section, I will explore lactose intolerant consumers' perceptions of milk and feelings about dairy that resonate through bodily dysfunction linked to lactose intolerance. I will follow with an analysis of participants,' in their normalization work, attuning to functional foods in Finland.

9.2 Milk in Finland is Making People Sick

The focus of this section is to show how participants assert that milk in Finland is making them sick. Participants discursively delimit lactose intolerance to the social and geographic context of Finland: *"Lactose intolerance is more common in Finland than in other countries"* (Sampo); *"If I recall, every fifth person has lactose-intolerance. It is very common and much more pronounced than other countries"* (Heikki). In their talk, participants claim this visibility to be produced because Finnish dairy companies are *"processing the milk a little bit differently"* (Aaro). I extrapolate that these industrial processes are indeed a form of medicalization against which consumers are attempting to resist. However, I also propose that such narrative sensemaking functions as idle talk, saturated with ambiguity. Participants are immersed in the project of normativity that is imposed by conventional yet ambiguous shared understandings. This means that participants are inescapably finding themselves experiencing lactose intolerance and its embodied constraints on their actions. Participants compensate for this feeling of being ahead of themselves oriented towards a realm of constrained possibilities by finding all kinds of discursive explanations linked to geographical boundaries, food production, wellness, and medicine. These discursive explanations establish order in participants lives such that lactose intolerance no longer stands over and against them in their everyday ways of being. Instead, consumers are immersed in their everyday life, enframing lactose intolerance into coherent contexts as they fall into ways of doing and saying that makes sense given the circumstances.

Particularly interesting were participants assertions that it is milk and dairy primarily from Finland that makes them sick. Harri, for example, is half Cuban on his father's side, and talks about lactose intolerance as a geographically and socially situated consumption practice: *"my dad also has lactose intolerance, and he always tells me he has difficulty drinking milk here [in Finland] but not abroad due to the heavy pasteurization probably."* Tiina described the experience of lactose intolerance as a uniquely Finnish phenomenon:

> *My stomach is sensitive to dairy food, especially in Finland. As I previously said, if I go abroad, I do not have problems with milk products. It is only in Finland that I have been experiencing those issues. I do not even have to go very far away. If I go to like Estonia, there is no problem, no gas or stomach aches, nothing. (Tiina)*

Tiina's narrative highlights a misalignment between the body-environment coupling. Tiina emphasizes, 'my stomach is sensitive,' showing a separation between his corporeality and sense of self. It is not Tiina, but her body that is sensitive. Talk about lactose intolerance thematizes the body. Here, the body in its directedness takes on intentionality of its own. Using a pronoun and referring to 'my stomach' or 'my body' allows recognition of bodily subjectivity that I interpret as an enduring structure of experience (Csordas 1990). Yet, bodily subjectivity emerges through the thematization of the body, a body that becomes

more conspicuous in everyday life, while also constraining worldly possibilities for action.

The body is peoples' "anchorage in a world" (Merleau-Ponty 1962, p. 167). Embodied constraints that draw attention to the body as "ill" or "bad" (Leder 1990, p. 84) require participants to furnish ballast in their lives. Participants' talk functioned to provide stability and order by shifting blame away from the individual and onto the dairy industry in Finland. For instance, Aaro describes:

> *We were traveling with the whole family in Sweden, and I was drinking whole milk and had no problems with my stomach. I think that there is something about the processing of the milk, the quality, or, possibly what the cows are eating that makes milk in Sweden different. I think it is the processing. The Finnish brands are breaking down the milk too much. They are separating the fat, separating all the different elements in the milk, and then adding things like vitamins, and stuff like that. It must be something related because the milk in Finland makes me feel so bad. (Aaro)*

Aaro's narrative highlights that 'the processing' of the milk in Finland is what makes him 'feel so bad.' In their normalization work, other participants talk highlights that *"there are more and more people with this lactose intolerance. In Finland, the milk is processed so deeply that people cannot eat or drink it any longer"* (Emma). Strikingly, the processing and pasteurization of dairy are intended for exactly the opposite, that is, to make the milk and dairy more consumable. These sorts of industrial processes are used to remove foodborne pathogens in the milk and dairy farm environment and purify dairy before circulates through society (Nimmo 2010). Participants' talk functions as a form of resistance towards this sort of medical intervention as it is perceived to be creating illness as opposed to eliminating it. These findings converge with literature that critiques medicalization (Illich 1975; Moynihan and Cassels 2005; Szasz 2007). Talk that expresses the negative stereotype of 'the Finnish brands' serves powerfully to destigmatize lactose intolerance within the cultural milieu, such that blame for this undesirable attribute (e.g., lactose intolerance) is shifted onto the shoulders of corporations and brands (Conrad and Schneider 2010). Such talk functions to position milk as not only bad for them because of lactose intolerance but also *"milk, in general, is not good for anyone"* (Anni). The myth of milk's purity is now defiled to the degree that even in its raw and natural state, it is seen to be ironically tainted (Barthes 1972; Levi-Strauss 1964; Levy 1981).

Talk about milk making people sick positions participants in an offensive antagonism towards the dairy industry in Finland. In their talk, participants regularly associated lactose intolerance *"to the way milk is produced"* (Gina). Yet, this talk is often marked by ambiguity. The association that dairy production makes people sick never reaches a conclusive point and is always loosely "related" to lactose intolerance. For instance, Jouni underlines:

> *This is like a promised land of dairy. For generations, in Finland, dairy has been an essential product in the diet. Surveys show that Finnish people use more dairy products than anybody else. It has a lot to do with, corporations like Valio and their propaganda. They say things like 'you cannot get enough calcium if you do not drink milk or use dairy products.' Nowadays, there are many people, people who know a lot about nutrition, saying that dairy is not good for you. (Jouni)*

Jouni's talk highlights a power disparity between various actors. On one side, you have 'corporations' whose 'propaganda' makes Finland the 'promised land of dairy.' On the other hand, you have those with lactose intolerance who are attempting to form solidarity with people who talk about milk making people sick. Jouni's narrative highlights a pattern of anonymous normativity that lays out a framework in terms of which participants understand themselves, their fellows, and the world in their conventional, everyday way of being. Jouni's narrative provides anonymous prescriptive authority to *"many people, people who know."* These are not specific people, but people in general, whose opinions allow him to establish a difference between himself, as an authoring body-subject with lactose intolerance, and his adversaries who are deemed the source of his pains. Participants inescapably find themselves (thrown) in a world where *"milk gives me stomach pain and loose stools and all kinds of problems"* (Henrikki), which they compensate for by finding explanations for the situation. One way of doing this is to fall back upon conventional morality, custom, current affairs, and so on:

> *I read some blogs, and there is much talk about that you cut off the dairy and stuff like that, and it makes you feel…many people say that they feel a lot better when they do that. I should leave the dairy out of my diet. The talk in the newspapers and blogs and all over the Internet, it affects you in a certain way (Iida).*

In their normalization work, participants' talk assumes a subjection to anonymous prescriptive authority such that they regulate themselves to consume as 'many people' consume. Iida poignantly notes above that *"the talk in the newspapers and blogs and all over the internet, it affects you in a certain way."* The pervasiveness of electronic media, blogging, texting, Facebook, Twitter exchanges, emails, and other kinds of social communication are saturated in ambiguity (Humphreys 2016). This kind of talk, where meanings and developments endlessly discussed without anyone becoming any wiser, imposes a normative demand upon participants to construct conformist selves. Iida goes on to depict a vague, unspecified, plural voice that prescribes and regulates how one perceives dairy consumption in Finland. Karen highlights that *"many people say"* and *"there is much talk"* that leaving dairy out of the diet makes you feel better, so she should also do the same. Lactose intolerant consumers fall back upon conventional understandings of dairy: *"I do not have any scientific proof, but I believe the way they chop the milk into molecules and process it damages people's health"* (Siiri). Here, participants believe that brands, the

industrial processes, and corporations are manipulating the milk, and this is ultimately making them sick. Yet, they lack hard evidence, or as Siiri puts it, *"I do not have any scientific proof,"* such that narratives function to conform with popular opinion and amount to idle talk yet still have the power to prescribe and regulate what is meaningful to say and do.

In sum, this section highlights that lactose intolerance, as an illness, is made visible through the market offering of dairy. An oft-told dictum, *"I associate milk with growling in my stomach, pain, loose stools, and all kinds of problems"* (Henrikki), captures this notion. However, rather than merely taking the body as the sole object of coping, consumers focus on larger contexts for which their impaired bodies belong. I argue that bodily dysfunction linked to lactose intolerance becomes an undesired constraint on participants' lifestyles, activities, and identities organized around the cultural icon of dairy in Finland. Participant's situated normativity, that is, the adequate course of action in the context of a given situation, has a "potentiating and affective allure" (Rietveld 2008, p. 977); such that, participant's talk sought to connect lactose intolerance to geographical boundaries as a socially situated phenomenon such that milk in Finland is what is making them sick. For these people, dairy consumption marks a distinct ideological moment where the corporate sector, brands, and industrial processes that take place in the production of milk are defiling the purity of dairy and creating illness.

9.3 Making Illness Invisible in Normalization Work through Functional Foods

I characterize functional foods to be the concrete materialization of medicalization in the marketplace. To recap, medicalization is a process whereby things are "defined in medical terms, described using medical language, understood through the adoption of a medical framework, or 'treated' with a medical intervention" (Conrad 2007, p. 5). I learned from Patti that when you *"use functional foods like lactose-free dairy or maitohappobacteria [probiotics], it is all good, you do not have the symptoms."* Juho's normalization work highlights two functional foods used for coping with lactose intolerance: *"lactose-free dairy"* and *"maitohappobakteria"*—translated to bacteria obtained from milk (e.g., probiotics). Consuming functional foods provide a sense of coherence and livability with the dysfunctional body. I interpret Juho's description of not having 'the symptoms' as feelings of familiarity with the body and a realignment with the body and self as one obtains maximum grip on the situation.

In exploring the ways consumers use functional foods to cope with lactose intolerance, I have come to recognize that medicalization becomes democratized or deepened to the extent that it becomes invisible and all the more powerful. Unlike other forms of medicalization that are mediated by medical practitioners or pharmaceutical companies (Brennan, Eagle, and Rice 2010), functional foods are a consumer-initiated solution. In light of the consuming body-

subjects dissonance with intersubjective order (Chapter 7), turmoil and conflicted meanings with public health care institutions (Chapter 8), and disequilibrium with normative expectations of dairy (previous section of Chapter 9), lactose intolerant consumers are empowered and liberated by the ability to resolve bodily dysfunction through food choice in the market (Shankar, Cherrier, and Canniford 2006). However, these choices are exercised through self-disciplining talk that construes bodily dysfunction, discursively producing conformity, and rendering medicalization invisible.

The data in this section is organized to represent what I consider to be participants' attunement to self-disciplining talk that purposively produces order and normativity. In the following sections, I will first discuss how participants as body-subjects self-discipline their identities to camouflage their bodily dysfunction through functional foods. Second, I address how participants talk about functional foods establish intersubjective resonance through the effacement of difference with others. Third, I discuss how informants cope with lactose intolerance through acquired habits in the market that form the basis of their being-in-the-world. The fourth and final section focuses on how participants harness functional foods as a technology of consumption that allows consumers to construe bodily dysfunction and articulate preferred versions of themselves that render medicalization invisible.

9.3.1 Talk About Impression Management

Central to the process of medicalization is the shift of an attribute from a human characteristic to that of a physical condition that can be managed or eliminated (Conrad and Schneider 2010). Flatulence is a human characteristic that has an evident stigma in the social context that one is embedded. Antti highlights:

> *The word lintukoto, it means that lintu is a bird, koto is a place where a bird makes their nest. So, birds make their nests only in the place that they consider to be very safe from the predators. I think Finland is a lintukoto still. We are pretty much safe from food threats. We have these probiotics to feel safer. I do not know actually whether it helps, but I remember when I did not have these tablets with me, and that was not very nice. My stomach had not only gas but also like cramps. (Antti)*

By means of functional food consumption, I interpret this metaphor of 'lintukoto,' a place safe from threats and conflict, as the appropriation of medicalization (in the form of functional foods) to promote existential continuity and order in their lives. The 'probiotics' that Antti takes for his stomach's 'gas' and 'cramps' keep him safe from 'food threats' like the industrial processing of dairy. His normalization work functions to disengage the body from the self as he emphasizes it is his body, not him that has gas.

As lactose intolerance impedes participants ability to socialize, participants must manage the body's intentionality and directedness. Engagement

with functional foods was informed by participants' concerns regarding their peers and the related evaluations by them. Jukka frames his experience of going out as easy and without worry once he figured out how to incorporate functional foods, such as taking a lactase pill, before every party:

> *I just don't make a big deal of it because, it's like OK I'm taking these pills every day, a pill in the morning, I believe it helps, I don't know. It's so easy for me, I take the pill, and I'm fine. It's easy like if I'm going to a party or, dinner or a restaurant for lunch or something because this small tablet is very easy to have in the pocket or the rucksack. You don't need water or anything to have it also. Just chew it. Nobody notices that you are eating it. Then I don't worry about anything on the menu. (Jukka)*

The lactase pills help Jukka reacclimatize his unruly lactose intolerant body to the immediate social environment. Having lactase pills produce an alternate embodiment, an object-body that is temporarily lactose-tolerant. The lactase pill makes it possible for Jukka to be absorbed in the immediate social situation in the presence of others. The tablet is also small enough that Jukka can carry and consume lactase pills without others awareness of it. We thus come full circle from participants experiences of being negatively noticed by way of malodor, discussed in chapter 6 and 7, to Jukka's experience of lactase pill consumption—'nobody notices' allowing him to be with his friends and family freely regardless of his impaired corporeality. Incorporating resources such as lactase pills will enable participants to transform the thematized body into an implicit medium of experience again and immediately grasp the gestalt of what's going on within broader contexts of significance. Thus, Jukka is successfully regulating and controlling the perceptions that other people have of him in social interactions.

9.3.2 The Effacement of Difference

Participants talk functions to make their illness comprehensible, and thus controllable, by inscribing a sense of resonance and we-ness with others that establish the effacement of difference. Above, Jukka's experiences lactose intolerance as an easy thing to deal with, something that is not difficult because it is so widespread. Lactose intolerance was new a few years ago when Sonja was first categorized as lactose intolerant, but now it is old news. Relatedly, Emma says,

> *It was OK. Lactose intolerance did not make my life harder. I think because nowadays there are even more products for us. I cannot remember the last time that I would have trouble finding something to eat in a restaurant. Nowadays I think all the restaurants always use, lactose-free products, so you do not even have to think about it in Finland. (Emma)*

Emma, when asked about what it felt like to be lactose intolerant, plaintively said it felt like 'being a Finn.' She experiences lactose intolerance as an 'us,' expanding upon the embodied mine-ness that is a hallmark of situated perception

(Tomkins and Eatough 2013). Sensitized in his talk to possibilities to resonate with others, Emma equates her impaired embodied condition favorably with a vast majority of the Finnish population, thus blending into the collective background. Emma is also able to emplace lactose intolerance in a particular sociobiological context of Finland, where many people have lactose intolerance, and the market has already started taking into account the body-schema of lactose intolerant consumers.

Participants' normalization work connects the prevalence of lactose intolerance in Finland with the extensive circulation of functional foods through the market. *"In Finland, it is something like 20 percent of the population who have lactose intolerance,"* Iiro says, *"more people are lactose intolerant than they actually know. They might just think their stomach is off or something, but they are really lactose intolerant."* He goes on to note, *"there is a large amount of lactose-free products available in Finland. Abroad, in Germany, for example, you might have a section for the lactose-free products whereas here they are freely among the other stuff."* Iiro's narrative highlights the materiality of this instance of normalization work as lactose-free dairy can be found right next to the regular dairy and 'there is no special section,' and everything is in the same place where one would normally go to pick up their products. The functional aspect of lactose-free dairy becomes invisible and does not manifest itself as being outside of normal. The market ceases to make the distinction between functional and regular dairy. The difference between medicalized and not medicalized foods becomes erased as lactose intolerance becomes commonplace and lactose-free dairy saturates the market.

9.3.3 Habit-Based Actions

In their experience of illness, lactose intolerant consumers derive stability in the world through their habits. When my respondents began to describe their consumption experiences in the face of lactose intolerance, a particular pattern showed up repeatedly. Their phenomenological descriptions contained more reflective elements, such as reading the labels of everything that they bought from the supermarket, asking about lactose content in restaurant foods, or making detailed experientially oriented consumption diaries: *"It is easy… you just pick the words from the label"* (Sofia); *"I always write down what I eat… nothing out of the ordinary…it is a long time habit"* (Laura). While reflexivity is substantiated as a transformative process of conscious identity construction (Belk 2013; Giddens 1991; McCracken 1986; Mick and Buhl 1992; Russell and Levy 2012; Schau, Gilly, and Wolfinbarger 2009), there are instances where reflexivity is practical and habitual response to people's situated normativity (Beckett 2013; Thompson, Henry, and Bardhi 2018). The reflexivity required in the regimen of *"checking that the label is saying low-lactose or lactose-free"* (Tiffany) becomes habitual for these consumers, it is nothing out of the ordinary, as Laura notes. The everydayness of writing in a food dairy or checking food ingredients is not a means of self-expression but rather a habituated mechanism through which the individual is self-regulating in accordance with norms that provide a

stable way of being-in-the-world bodily. Pihla likens the entire experience of lactose intolerance to a game, saying *"It is a kind of game of survival. You are training your body a certain way"* (Pihla). Training is a technique of power; one of the key means through which the body is rendered domesticated and docile (Foucault 1977). Pihla manages to regain a sense of 'I can' in experiencing the trainability of her body, that is, she (self) can train her body (organism) to be expertly lactose intolerant. Reflexivity as a habituated response is a mechanism of power, mediated by the body-subject, through which individuals are governed.

Similarly, functional food consumption is very much a habituated response to the situated normativity experienced by lactose intolerant consumers. For example, participants said that any food purveyor provided lactose-free dairy: *"Luckily the facts are pretty well stated so, it is pretty effortless. I think like all the grocery stores, even restaurants, and stuff. I think you can get it from anywhere"* (Timo). When functional foods are everywhere, it becomes more natural for consumers to work on creating continuity between their bodies and the intersubjective world. Consistently emphasized in participants talk was the importance of signs in places like restaurant menus that indicate lactose-free in an explicit manner:

> *In Finland, if you buy some product, it includes a whole list of ingredients, and if you go to a restaurant, they have marks on the menu that shows whether it is lactose-free or gluten-free. In that sense, it is easy to live in Finland. So, if you see L it means lactose-free or VL would be wheat free. Of course, they have the key at the bottom of the menu that tells you what each designation stands for. (Maari)*

These signs are accompanied by regulation through the *"new laws that restaurants have to mark certain foods when it is a common ailment"* (Maari). Maari finds that these signs make it 'easy to live in Finland' when you have bodily dysfunction. Participants expressed that they *"don't usually find it a problem at restaurants. It is fairly easy because restaurants have these signs, and often if you ask, they can make foods lactose-free if they are not already"* (Iiro). Such talk works to position functional food consumption as a cultural sensibility in Finland (Dreyfus 1991), a stable way of being-with-one-another. I interpret these signs as a form of tool that allows lactose intolerant consumers to go about their daily business and pursue various practical activities like socializing at a restaurant with friends or eating lunch with colleagues.

Tools used in practical activity are characterized by their inconspicuous presence (Blattner 2006; Carel 2016; Dreyfus 1991; Heidegger 1962). When participants use lactose-free dairy at a restaurant or cafeteria, it is the friend they want to talk to or the empty stomach that is at the forefront of their mind. The lactose-free dairy, the signs that reference it, and for that matter, lactose intolerance (the illness) itself, recede into the background, and their function is swallowed up by the task at hand. Participants expressed that the inconspicuous

character of their body in relation to their habit-based actions that are undertaken through tools like functional foods or the signs that reference them:

> *Lactose intolerance is just an inconvenience. It does not affect my life. I just take lactose-free and make sure to check out what I eat. Lactose intolerance does not affect me at all because I have had it for so long, so it is not hard. Maybe some people if they are used to monitoring their food they might find it hard at first to avoid that stuff. For me, it is really not a big deal. (Alice)*

In her normalization work, Alice's talk underscores that she is unconstrained by lactose intolerance. She highlights that lactose intolerance does not affect her life because she has 'had it for so long.' Alice notes that the 'monitoring' of her consumption becomes habitualized over time, which allows her to relegate the body back to an implicit medium of experience, emphasized in her talk about how lactose intolerance does not 'affect my life.' Other participants expressed similar habituation saying, *"Nowadays I think all the restaurants always use, lactose-free products, so you do not even have to think about it in Finland"* (Timo). Others note, *"If I have to do, for instance, cake, some kind of celebration of course I buy, non-lactose cream"* (Sanja). Such talk foregrounds it is easier to assume that everyone is lactose intolerant and that way you do not even have to 'think about it' because it is familiar and habitual to use functional foods.

9.3.4 Technologies of Consumption

Market discourses, or what is sometimes referred to as "technologies of consumption" (Rose 1999, p. 271), are both disciplining and liberating (Shankar, Cherrier, and Canniford 2003). Such technologies are liberating in the manner that consumers who stand out with illness can construe bodily dysfunction and work on their selves to fabricate a sense of sameness with others (Kjeldgaard and Östberg 2007). Technologies of consumption may also be theorized as a disciplining process of normalization work, a form of action by which people were urged to regulate themselves, by which consuming body-subjects conformed with conventional ways of being-in-the-world. Participants expressed that *"a few years ago there was nothing, no lactose-free or anything, and it was so difficult because it was so new. Back then, not that many people had lactose intolerance. Now it seems like every other person has it"* (Maria). I continually hear participants say, *"I had these stomach problems. I was tested for lactose intolerance, and I am tolerant. I do not need lactose-free, but I use it anyway"* (Olga). Disciplinary regimes linked to functional foods establish the normalization of lactose intolerance as a subjective experience.

In their talk, participants create norms about lactose intolerance that match the marketplace offering of functional foods such that one can be tested as 'tolerant' but still experience lactose intolerance symptoms. While living in Finland, I observed lactose-free dairy offered in all kinds of settings, the most memorable was at a coffee kiosk in a McDonalds located in a rural part of Finland. The lactose-free milk sat in the carton next to a free-standing coffee

burner. The symbolism of lactose-free milk in a McDonalds is glaring. Fast food is designed to cater to everyone. The nature of the business is to get as many people in the candidate customer set as possible. In this flat set up, lactose-free dairy shows up and reveals how widespread and normal the food-related disease of lactose intolerance has become.

In their talk, participants position lactose-free not as functional but as milk, normal milk that is good for them. The medicalized aspect of lactose-free milk seems to disappear. Siiri highlights that *"lactose-free milk does not cure anything it just allows me to use dairy products."* Others expressed that *"Lactose-free milk is just food to avoid unpleasant symptoms, but I do not consider it to be medicine"* (Timo). Such talk positions lactose-free dairy as dairy that is good, even, dare I say, dairy that is healthy, but it is dairy that is distinctly non-medical. Tiffany emphasizes the normalization of lactose-free milk:

> *I drink a lot of milk. I take two or three liters every time I go to the store, and it is still always gone. I do not drink the regular kinds of milk because, for me, it tastes horrible. I have always drunk the dairy without lactose. Anything with the regular cream or milk, I am like, "ugh that is horrible!" Lactose-free is normal milk for me. (Tiffany)*

Tiffany's narrative highlights that lactose-free milk is 'normal milk for me.' The 'regular' milk not only makes people sick but also tastes 'horrible.' For participants in this study, lactose-free dairy is not functional. It is just milk, good milk. Finns consume 'a lot of milk,' and Tiffany emphasizes this in her own practice of taking 'two or three litres' every trip to the store. In fact, she cannot seem to keep enough milk at home because it is 'always gone.' In this lifestyle, with such heavy consumption of dairy, lactose intolerance would manifest in a pronounced fashion and persistently hinder her ability to do things. Lactose-free dairy promotes livability with the dysfunctional body. Tiffany can eat and drink as much lactose-free dairy as she likes and her body remains inconspicuous; her attention is directed away from the body to the object of the task she is engaged in, even if that task is a simple trip to the grocery to get more milk.

The subjective experience of lactose intolerance renders itself invisible through the consumption of functional foods. Kira says, *"I think lactose-free helps to my stomach, but I am not sure. I do not have lactose intolerance, but I feel better if I eat those kinds of products that are not full of lactose, like lactose-free or low-lactose dairy."* This talk gives priority to the feeling body-subject over the thinking self. Kira expresses that he never mentally 'knows' for certain if lactose-free helps. However, his bodily 'know how' is returned through the consumption of lactose-free dairy, bodily dysfunction disappears, as articulated by his sentiment, 'I feel better.' Such talk positions participants as ordinary functioning consumers and functional foods as normal, healthy milk.

The colonization of the medical discourse by the market contributes to both the normalization of lactose intolerance and the invisibility of medicalization. In their normalization work, participants' talk position lactose intolerance to be *"a minor thing because practically half the population is lactose intolerant"* (Siiri). Consumers talk about self-managing their illness by utilizing market resources. The capacity of the market to service consumers health issues in relation to lactose intolerance occurred over time. Sampo highlights:

> *When these lactose-free dairy products appeared to market, I did not remember it five years ago or more, Valio started this what is now called Eila, but in the first place, they had not any name. It was only lactose-free milk. Nowadays, the milk, cottage cheese, yogurt, quark are all completely lactose-free. I do not think lactose intolerance affects me any more. Even at public cafeterias or some parties, you ask people, is it lactose-free? They say, "Yes, it is." (Sampo)*

Sampo's narrative highlights the market as a surrogate health care provider. There is no solution to lactose intolerance except to change how one eats or drinks. In 'five years or more,' the market developed ways to relieve consumer vulnerabilities related to lactose intolerance. Over that time, the market became proficient in providing resources to lactose intolerant consumers such that Sampo notes lactose intolerance does not even *"affect me anymore."* Siiri suggests that people with lactose intolerance no longer *"need the doctor"* because *"they can treat it themselves"* by using the market.

> *Pretty much anything that would have lactose that I would use as a lactose-free alternative. I think it is more of a problem when you go abroad than in Finland. Here, there are so many lactose-free products, and you can see most of the restaurants use lactose -free products. In Finland, you can pretty much eat anything because every restaurant makes things lactose-free by default. You know that anything you order you can get it in lactose-free. (Iiro)*

In his talk, Iiro suggests that he no longer needs to stop and think about what he is eating and doing because everything is 'lactose-free by default.' While there are instances of marketization that expand consumers sense of agency as self-conscious and intentional actors (Bartlett et al. 2002; Massey 1997; McAlexander et al. 2014; Thompson 2004), the metaphor of 'default' suggest that the marketplace expands the field of affordances for consumers purposive coping, that is, non-deliberate, relationally constituted actions directed towards overcoming immediate impediments. Whether it be 'restaurants' or grocery stores, *"Nowadays, the milk, cottage cheese, yogurt, quark are all completely lactose-free"* (Sampo). Such talk reveals the architecture of conformity such that more often than not, dairy is lactose-free. The market becomes an environment built to incorporate all consumers under the same invisible disciplinary gaze to self-regulate bodily dysfunction with the ultimate end of designating all consumers lactose intolerant and all dairy to be lactose-free (Foucault 1977).

To conclude this chapter, consumers normalization work is affected by a disequilibrium with normative expectations of dairy. The bodily experience of lactose intolerance contrasts with the perception of dairy as health food and rich cultural resource in Finland, thus making their illness visible. The normative tension established in lactose intolerant consumers' situated embodiment compels them to be responsive to such disjunctions in a disciplinary manner. Consumers regulate themselves per their situated normativity producing flexible order that renders their illness invisible. Talk about functional foods transforms medicalization from a disruptive force to an instinctive normative action in coping with lactose intolerance.

SUMMARY OF FINDINGS

The purpose of this section is to conclude and summarize the findings by taking key issues from each findings chapter and synthesizing them into a coherent whole. The findings in this dissertation are novel because broached issues of medicalization and normativity through authoring body-subjects. I have found that consuming body-subjects cope with lactose intolerance by taking-up, negotiating, and transforming discourses of medicalization by which order and normativity are authored; and, thereby promoting livability with their dysfunctional bodies and the broader contexts of significance to which they belong. Consumers appropriate medicalization to cope as body-subjects with the affectedness of their situated normativity while attuning to disciplinary actions that establish stable ways of bodily being-in-the-world.

In chapter 6, I find that consumers with lactose intolerance reveal an ever-present distance between themselves who experience bodily breakdown and bodily dysfunction while consuming dairy, and others who have the tacit capacity to eat and drink normally. I demonstrated three affected modes of normalization work that are suggestive of how lactose intolerance orients and reorients embodied action and forces obsolescence on once fluid affordance-relations. These modes of talk reflect, respectively, how lactose intolerance makes the consuming body-subjects innate structure open for interpretation (Dysfunctional Body: Embodied Breakdowns Reveal Illness), negates simple motor skills and one's ability-to-be (Dysappearing Body: Embodied Breakdowns Challenging Ability-To-Be), and invalidates nuanced cultural and social skill-sets such as conducting oneself with decorum at celebrations or simply being able to make friends (Dysappearence: Embodied Breakdowns Establishing Social Difference). In these ways, consumers' normalization work foregrounds how lactose intolerance can destabilize practical and material situations in which consumers

find themselves, underscoring various instances of discontinuity between urgently needed affordances for lived action ('what matters') and the abilities of lactose intolerant consumers to respond to them in relevant ways ('what makes sense to do'). These discontinued affordance-relations tend to bring to fore the impaired body so that what was once unproblematic and pre-reflective everyday experiences becomes 'an experience' (Tomkins and Eatough, 2013, 262). Talk about the emergence of the lactose intolerant object-body not only draws unto itself the gaze of others and self but also explicates once habituated ways of food consumption into abstract blueprints laden with trip wires and dead-ends for the pained digestive body to learn from.

Chapter 7, substantiates that when consumers no longer possess the embodied ability to consume and digest lactose, the impaired body hinders absorption in the immediate social situation. I have accounted for three kinds of affectively-attuned normalization work that consumers engage within intersubjective contexts to which their dysfunctional bodies belong. Each is focusing on a range of separate but connected aspects of embodiment, as they attempt to render the wreckages of once fluid affordance relations into something minimally manageable in social life. In various instances, consumers talk about their lactose intolerance with regard to feelings of familiarity with bodily dysfunction. In particular social situations, lactose intolerant consumers are sensitized to a relaxed temperament, participating in the world with ease. Conversely, consumers also explicitly foreground their pained lactose intolerant bodies in sites of social conflict and affective tension. Normative expectations create meaningful distinctions of what is abnormal and normal in relation to discourses of health, and lactose intolerant consumers attempt to negotiate these distinctions by remastering their health through new skill acquisition and harmonizing with intercorporeal norms, thus enabling a sense of re-rooting into the social environment.

In chapter 8, I find a recursive relationship between cultural ideals that exist in the institutional setting of health care and the experience through which the authoring body-subject responds, takes-up, and negotiates these cultural pressures shaping institutional norms. I have unfolded the affective-attunement in the consuming body-subjects normalization work as it takes place in the institutional setting of health care over three main themes. While institutionalized practices dictate a cultural ideal that "health care is working" in Finland, the impaired body and experiences of illness establish deviations from cultural ideals of health care that bring turmoil and contested institutional meanings. Consumers struggle to provide visibility for their illness because lactose intolerance is rendered a mild condition through institutional norms and gatekeeping practices within the health care system. Lactose intolerant consumers are thrust into a liminal state of the perpetual patient-in-waiting and acclimatize to the marketization of health care by pursuing practices of self-diagnosis that allow for a re-established sense of livability and rootedness in the world of lived action.

Lastly, in chapter 9, I find that consumers draw on market resources to normalize their illness. Here, consumers normalization work is affected by a dairy market that renders their bodily dysfunction visible, reifying tacit cultural practices of dairy consumption that are sedimented in the culinary setting. In turn, the consuming body-subject attunes to self-disciplining talk that allows for the fabrication of conformist selves (Talk about Impression Management and The Effacement of Difference). The practical mastery of the tools of the marketplace that allow lactose intolerant consumers to relegate their impaired bodies to the background of their experiences and direct their attention outward towards practical tasks at hand (Habit-Based Actions and Technologies of Consumption).

Throughout this manuscript, I propose normalization work to be that dimension of talk that is affected by one's situated normativity, while at once attuned to disciplinary action to overcome any immediate impediments to any contrasts or disjunction therein. In addressing my research question—*how do consuming body-subjects cope with lactose intolerance through talk?*—I identified different ways by which consumers take-up discourses of medicalization to promote order and normativity with their dysfunctional bodies and broader contexts of significance to which they belong. I traced the ways the consuming body-subject resolves normative tensions within social, institutional, and market contexts. I now discuss the implications and collective impact of my work, comparing it to other culturally-oriented consumer and marketing research that have touched upon issues related to medicalization, normativity, and consumer embodiment, before drawing a brief conclusion.

10. NORMALIZATION WORK BY CONSUMING BODY-SUBJECTS

My study has focused on the normalization work that consuming body-subjects undertake as they attempt to cope with lactose intolerance through talk. In addressing my research question, I identify the ways consuming body-subjects' take-up, negotiate, and transform discourses of medicalization to promote normativity and livability with their dysfunctional bodies and the broader contexts of significance to which they belong. I derive these meanings from analyses of health discourses and practices of lactose intolerant consumers in Finland and track their fractures and alleviations with normative order within the social, institutional, and market domains. I will next discuss the implications of my study in relation to prior research and point towards potential directions for work to come.

This chapter is organized to represent what I consider to be the most important areas of contribution developed in this study. Within this dissertation, I offer four main contributions: (1) the construct of normalization work as a means for discerning consumers' attempts at coping with lactose intolerance; (2) approaching medicalization through the body-subject; (3) a theorization of embodied consumer talk, and (4) the role of embodiment for theorizations of consumer needs. By addressing these four major areas in their own section, I will engage with the findings as I seek to carve out contributions amidst existing literature.

10.1 Normalization Work as a Means for Coping with Lactose Intolerance

To answer the primary research question posed in this study—*How does consuming body-subjects cope with lactose intolerance through talk?*—I propose the authoring body-subject to cope with lactose intolerance through what I conceptualize as *normalization work*. To remind the reader, normalization work refers to that dimension of consumers' talk that is affected by bodily impairment and normative systems of meaning related to lactose intolerance, while at once attuned to discursive practices that have as their purposive end the assuaging of such affect. In light of this definition, questions arise such as, what is affectedness and how does it arise within the findings, as well as what is attunement and how does it play out in lactose intolerant consumers talk? I will discuss each of these elements in relation to the findings in a step by step fashion. In addressing these questions, I culminate in the proposition that consuming body-subjects cope with lactose intolerance by producing order and normativity with the broader contexts of significance to which their dysfunctional bodies belong. The relevance of such a proposition sits, I suggest, in offering an alternative analysis of consumer coping, informed by the body-subjects oscillation between affectedness and attunement, that advances discussions on consumer agency, as consumers are drawn in by the normative pull of affordance relations between the socio-cultural environment and the abilities of the authoring body-subject (Arnould 2007; Askegaard and Linnet 2011; Kozinets 2002). It is important to note, this oscillation between affectedness and attunement is manifest in my treatment of the data as a researcher. For the experiencing individual, these are simultaneous, and I make the methodological choice to treat them separately to expound their explanatory power fully.

10.1.1 Expanding Conceptions of Affectivity Through Normalization Work

One insight from this thesis is that consumers' sense of reality, sense of being oneself, is based on the affective foundation of the feeling body-subject in relation to others. I propose that consumers use talk, in their normalization work, that is affected by their embodied relation to the world (Heidegger 1962; Merleau-Ponty 1962). My findings show the affectedness of consumer embodiment, disclosing how entrenched consumption repertoires are disrupted by corporeal impairments associated with lactose intolerance. Food consumption is an inherently embodied act, a motor habit—in that it involves skilled use of extremities, our sense organs, and our digestive system (stomach, gut, intestines, rectum). Eating food then becomes a 'subtle skill' (Dreyfus and Dreyfus 2000) and an ability to make ever subtler discriminations (Murphy, Patterson, and O'Malley 2018). The dysfunctional body impedes skill in consumption and the 'I can' feeling of the ability-to-do that implicitly underlies people's sense of normativity. In their talk, participants experience their body as an obstruction, an entity with intentions of its own. Affected by lactose intolerance, consumers are solicited to reflect on their body's given, innate structure, as when a participant experiences her inner organs as sentient beings.

I extend previous work on consumer coping by detailing how affectedness is essentially felt through the medium of the body. Previous consumer research has identified consumer coping as a strategic process for managing emotional upheavals that might occur through service failures, role transitions, ego threats, or decision-making stress (Duhacheck 2005; Mick and Fournier 1998; Russell and Schau 2013; St. James et al. 2011; see also Weijo, Bean and Rintämaki 2019). Extant consumer research has also touched upon the ways consumers cope with emotions linked to ruptures in their social environment and interpersonal relationships (Archer 1980; Lazarus and Folkman 1984; McKenna, Green, and Gleason 2002; Pennebaker and Harber 1993; Weijo, Bean, and Rintämaki 2019). Much of this research is of limited value to understanding the experiencing body-subject because it divorces the body from the mind by framing emotions as identifiable mental states reduced to various forms of cognition. Overlooking the body-world nexus, neither can these accounts explain how consuming body-subjects, who are responsive to possibilities for normative order, are affectively solicited by affordances.

To elaborate, consumption of dairy forces consuming bodies to erupt, making them conspicuous, an example of the body-subject acquiring awareness of itself. The body moves from a tacit background through which consumer directs attention outward towards the world to an explicit, felt body that becomes the immediate object of their attention. Lactose intolerance thematizes the body through breakdown, establishing the realization of a material body. In their normalization work, participants express the body farting, discharging fluid, bloating, and throbbing with pain. The bodily breakdown situation impedes consumers habitual modes of living described through participant's stories of constraint, loss, and partial living as well as struggles to adopt new lifestyles. Lactose intolerance impairs consumers' embodied ability to digest foods containing lactose. Taken-for-granted consumption experiences become explicit objects of awareness. Neither the food they consume nor the bodies that consume the food show up in talk as affording the act of eating in the same mode of absorbed engagement as before. Bodily breakdown hinders consumers' opportunities for socialization and conviviality. In their normalization work, participants talk about how lactose intolerance makes them stand-out in groups and activities, especially in events where eating is involved like work lunches, weddings, and group travel.

My findings differ from existing research that studies consumer coping at the intersubjective level in additional ways, as well. Previous research acknowledges the importance of the social sphere as a resource for individuals coping efforts (Russel and Schau 2014; St. James et al. 2011; Ward and Ostrom 2006) as well as the source of emotional distress triggering consumer coping (Archer 1980; Lazarus and Folkman 1984; McKenna, Green, and Gleason 2002; Pennebaker and Harber 1993), but falls short of unpacking how rips in the intersubjective fabric render bodies visible, and affected by the gaze of the other

(Leder 1990). My work shows that affective phenomena are experienced through the resonating body, an interpersonal climate that is felt as oppressive or suffocating as well as familiar and relaxed (Fuchs 2015).

In detailing the ways that lactose intolerant consumers are affected by normative expectations imposed on them in social life, I foreground the ways the body-subject experiences loss of directedness and resonance relative to their social environment. In their normalization work, participants' talk emphasizes how bodily dysfunction establishes a contentious home life. In the case of Jaska, disharmony between bodily intentions, that is, the need to excrete, and the social challenges posed by other bodies, fractures the interpersonal climate of familiarity attached to home life. Similarly, in Chapter 10, Harri quickly dismisses the importance of dairy in his own life and begins talking about his father's ongoing difficulties with Finnish milk, isolating and objectifying his stomach as a discrete sentient organ: "*My dad has difficulty drinking milk here but not abroad-Probably due to the heavy pasteurization in Finland. Milk it is less processed abroad."* He goes on to note: *"In Germany, Spain the US he drinks the normal milk. Here, he drinks the lactose-free or the Hyla one because his stomach thinks it is better."* Here, Harri's talk about his father's lactose intolerance reflects a shift from a disembodied 'thinking I' to an incarnated body-self, collapsing the disjuncture between the body and self. It is not his father, but his father's stomach that is doing the 'thinking.' The conclusion that emerges here is similar to that discussed in Chapter 7 where Harri's embodied self is affected by the intercorporeal interaction of the family to become lactose intolerant and forever shaping how he relates to the world and others. The carnal bonds between Harri and his father shape how they view milk in Finland and, subsequently, situate lactose intolerance as a geographically and socially situated phenomenon.

By and large, what we may observe through the above examples is how consumer coping is anchored in the felt body. That is to say, the body-subject denotes a medium that affords our affectedness, i.e., a way of finding ourselves in the world emotively (Ratcliffe 2008). In this sense, emotions and feelings befall us, and they emerge from situations with their expressive features (Fuchs 2015). This is in distinct contrast to current consumer research literature that frames coping as a strategy to deal with affects and emotions that are characterized as tidy mental categories such as irritability, anger, fear, or embarrassment (Adkins and Ozanne 2005; Mick and Fournier 1998). As affected beings, always already in given situations, consumer talk always has a concrete there (Dreyfus 1991; Heidegger 1962), meaning that they find themselves in practical and material circumstances and already affected by things. In my findings, I show that affectedness is fundamentally a bodily phenomenon, and, in the context at hand, the body's eruption caused by lactose intolerance provides a specific directedness that sets the tone of being-there. In parallel, the body-subject is simultaneously always already in a social world. The bodily affectedness is revealed under some public aspect, and as such are not only felt from the inside but also

displayed and visible in expression and behavior (Fuchs 2015). Intersubjectively, bodies are connected and mutually incorporated in their affectedness. The affectively resonating body-subject reaches out and mediates the perceptions of others around them.

10.1.2 Extending Coping Through Attunement in Normalization Work

This thesis also offers an analysis of the attuned relations between embodied experience and purposive practical coping. Again, I am making the methodological choice as a researcher to separate affectedness and attunement so as to explicate their contribution to the field, knowing full well that they are experienced simultaneously. Extant consumer research provides frameworks for understanding how consumers attempt to gain control, by way of their coping, over bodily constraints (Barnhart and Peñaloza 2013) as well as socially embedded marketplace meanings (Adkins and Ozanne 2005) with reflexive agency (Thompson, Henry, and Bardhi 2018). These accounts tend to frame consumption as a tool used to manage emotional impediments and constraints in consumers lives. From the perspective of this thesis, it is the act of consumption itself (specifically that of dairy foods) that is the catalyst of coping, and the primary object of coping is bodily impairment instead of emotional turmoil. While that is not to say that the body lacks emotive capacity, this unique theoretical context illustrates a new and different light (Arnould, Price, and Moisio 2006) on consumer coping that might be found in studies that focus centrally on emotional distress as a cognitive process.

I extend previous work on consumer coping by detailing how attunement designates disclosure of what matters and makes sense to do and say in given practical and material situations and circumstances (Ratcliffe 2008; Schatzki 1996). To be attuned to practical and material situations and circumstances is to be responsive to its relevant affordances (Rietveld 2008; 2010; Rietveld and Kiverstein 2014). Relevant affordances are lived possibilities for meaningful action (Gibson 1986; Merleau-Ponty 1962), solicited by our immediate situation and material arrangements therein, and to which we normatively respond to through skilled, unreflective coping, as we partake in socio-cultural practices in concernful ways (Dreyfus and Kelly 2007; Rietveld 2010).

To illustrate, my findings highlight that bodily conditions inform what types of meanings consumers immediately perceive in a given situation. In their talk, participants reveal how the body-environment coupling is something often unnoticed because their bodies are able to act and perceive amidst environmental structures with little or no thought required. Participants describe the consumption of food as feeling that you don't pay any attention to when everything is good *"You don't notice anything wrong, nothing hurts, you don't feel anxious, things are normal"* (Tapani). Lactose intolerant consumers have to discern objective facts from the situation consciously (e.g., presence of milk) and then act on them according to a new rule (e.g., don't eat milk and milk products when outside home) – but for many this is a precarious road with many lessons

learned by accident, as Tapani says in Chapter 6: *"The rules are made visible… it's plain to see if I eat this, it will cause pain, so I avoid this. It's like lab rats. Don't go there, you'll get shocked or something. It's like going through a maze. Your opponent is, I don't know, reality. Your limits."* Consuming food was once a familiar, habitual perceptual gestalt that John could complete with existing embodied know-how. However, now that this tacit ability is rendered useless, what remains is an explicit, objectified playing field *("The rules are made visible"*). For Tapani, consuming food feels like going through a maze. A maze is an example of spatial architecture where the goal is clear, effects of decisions are calculable, and an objectively verifiable solution exists. However, to successfully complete the maze, running into dead-ends in the form of now defunct affordance-relations is highly probable. Tapani has to learn new rules about what his body can and cannot do the painful way. So, in addition to opening up the consuming body's innate structures for re-interpretation, lactose intolerance negates existing reserves of embodied know-how, breaking down once habituated, fluid affordance-relations into an abstract nexus of possibilities that demands constant reckoning and overcoming. When the body breaks down, the body-environment coupling becomes constrained, and life gets reverted to 'a game of survival' that requires one to train their body in certain way. In a Foucauldian sense, this disciplining could be taken as the production of a docile body. However, I chose to interpret this phenomenon as a form of skill acquisition in coping with differentiated environmental affordances. Whereas some would argue that social and cultural forces are imposing *power over* the body, I argue that coping is about having the *power to* (Dreyfus and Dreyfus 2000) perceive new possibilities to previously taken for granted affordance relations and mitigate disruptions to the body-environment coupling.

It is important to note that these perception-action processes are not static; they are related to activities, and, subsequently, change the relations between the body-subject and environment. A body-subject's perception in an environment influences surroundings—manipulating objects (Kaplan 2011) or affecting other people—as in my findings through bodily discharge. Also, the body-subjects perception in an environment influences their abilities and, in doing so, attunes to possibilities for new actions and thus reshapes affordance relations. Murphy, Patterson, and O'Malley (2018) provide the example of high-speed motorcyclists to show a dynamic relation among the conditions of body-subjects, perceptions of the environment, and riders' abilities. They highlight that the act of riding high-speed motorcycles necessitates repetitive action or practice so as to feel safe on the road amidst an environment of other vehicles, turns, changing visibility, or other obstacles. Skills are embodied and repeatedly practicing things like doing a 'wheelie' or 'getting a knee down' allowed the rider to get a feel for bodily techniques and perceive balance, the weight of the bike, and speed necessary to be a proficient high-speed motorcyclist.

One way consumers cope with lactose intolerance is to ascribe normativity to food-related illness. Participants talk about relating to others through

cooking and eating. In chapter 7, Tiffany notes: *"There are different kinds of foods that fit different people. For example, there is low-lactose and gluten-free, and that kind of stuff, and you have to find the golden road and make food that is suitable for everybody."* Much like the metaphors found above like 'maze,' 'lab-rat' and 'video game' along with Tiffany's attempts at finding 'the golden road' is a way for lactose intolerant consumers to make sense of their situations. Such talk attunes them to mitigate tensions that emerge through bodily dysfunction and disjoint the body-environment coupling that makes up their social world. In Chapter 10, my findings reveal the ways participants become responsive to functional foods like lactose free dairy that allows them to experience lactose intolerance as an easy thing to deal with, something that is not difficult because it is so widespread (Iiro). The large amount of lactose-free products in Finland allows participants to live in ease. Participant's express how being lactose intolerant is 'to be a Finn' (Alice).

Normalization work is a form of talk that is disciplinary in that it is affected by deviations from social norms while attuning, in and through our bodily feelings, to possibilities for purposeful disciplinary action. Much of past research looks at food consumption as a disembodied phenomenon that is unproblematic and taken-for-granted (Baudrillard 1970; Bourdieu 1984; Thompson 2004; Thompson and Coskuner-Balli 2007; Cappellini and Parsons 2014; Emontspool and Georgi 2017). In relation to food consumption, research often imagines a fully agentic consumer (Gollenhoffer 2017; Moisio and Beruchashvili 2009: Wallendorf and Arnould 1991) and elides the possibility of consumption as a future-oriented struggle. I see consumption as not something people simply do, but as something they deal with in their being-in-the-world (Heidegger 1962). Such an approach to consumption is important because, in addition to extant literature' attentiveness to conditions of possibilities for consumption (Kristensen, Boye, and Askegaard 2011; Holt 1998), I focus on the embodied constraints on peoples' freedom and openness to consume. The context for this study is functional foods tied to lactose-intolerance, seen not as a medical state of food-related disease, but rather as an embodied way of life. I believe that talk about their consuming selves is a critically important way people negotiate lactose intolerance, an embodied phenomenon that is largely not of their own making (Csordas 2008). I propose that this perceived wiggle-room relates to what organizational theorists refer to as relational agency. Relational agency (Holt and Chia 2006), I argue, is not simply a matter of consumers or other market agents seeking control over the iron cage the marketplace (Firat and Venkatesh 1995) through emancipatory action (Murray and Ozzane 1991) to break free of constraints on their freedom or choice (Kozinets 2002; Sandikci and Ger 2010; Scaraboto and Fischer 2013). Nor is agency a marketplace myth emerging through consumers' discursively conditioned actions (Holt 2002b; Thompson 2004; Arnould 2007). Rather, agency, in this study, is a bodily matter or 'sense' that manifests through discursive processes that are distributed and self-regulatory and can be best described as immanent in every adaptive action. The contested and precarious nature of the body in illness assaults and challenges

individual's sense of agency and narratives of self (Carel 2016), and I see agency form in a state of absorbed coping and embodied action (that includes talking) as the body is actively immersed in responding to its challenges (Rietveld 2008). Agency by way of embodied action is intelligent, purposive, and skillful. However, its purposivity and intelligence are not predicated upon the prior conception of plans that are then orchestrated to realize a desired outcome, be that emancipation, control or more freedom in relation to the marketplace and its systems of meaning. Purposive refers to embodied actions that are directed towards overcoming immediate impediments or bodily challenges in one's coping with the world (Chia and Holt 2006).

10.1.3 Deepening Theorizations on Coping Through Normalization Work

I propose that affective-attunement, taken together, explicates how consumer coping is mobilized and perpetuated through our embodied relation to the world (Heidegger 1962; Merleau-Ponty 1962). In Chapter 3, I integrated three analytic levels of normalization into the threefold structure of Care where the bodily, socio-historic, and existential approaches to normative consumer experience are given continuity through the tight connection between body and world (Merleau-Ponty 1962; Dreyfus 1991). I conceptualize three intensities of coping in this research (see Table 4), distinguishable by their levels of normative experience: bodily, socio-historic, and existential. Rather than simply taking the body as the sole object of coping, the participants in this study often focus on the larger contexts that their impaired bodies belong.

In the most elemental form of consumer coping, the body becomes an explicit object that needs to be reckoned with and overcome. In simple terms, one does not feel at home in their body, the body feels alien to oneself, and they become an observer of their own body. In Chapter 6, I illustrate three modes of normalization work in which lactose intolerance impairs the authoring body-subject, thus showing how consumer talk is affected by their illness. These are *dysfunctional body: embodied breakdowns reveal illness*, *dysappearing body: embodied breakdowns challenging the ability-to-be*, and *dysappearence: embodied breakdowns establishing social difference*. A key theme running across these modes of talk is how they all reflect an objectification of the body whereby consumers, instead of dwelling in and through their lived bodies and habituated affordance relations, are subjugated by lactose intolerance as it dominates their lives, emotions, personalities, and mobilities. In short, the consuming digestive body and its co-constitutive affordance-relations become explicitly thematised. Normally the body is transparent, an implicit medium through which our attention is directed outwards, but in profound embodied coping, we experience the body as the body. To illustrate such a position, I point towards Tapani's excerpt in Chapter 6: *"[Your body is] something that you notice when you've actually lost it, it's something so mundane, an everyday thing, ordinary, you don't really pay attention to it until you are hurting. When it is lost, you try to get it back."* In his talk, Tomas's body serves as an implicit background and medium of cohering experience until lactose intolerance impairs and constrains him. In

noticing the absence of such embodied implicitness, the body becomes explicated as something external and 'lost' and which is in instant need of recovering *("you try to get it back")*.

Table 4. Coping through broader contexts of significance

Level of Coping	Description	Examples
Existential	In acknowledging our mortal existence, our concerns in our bodies turns towards ourselves and to the question of whether we can foresee ourselves as having the means to live a life of sufficient meaning and value.	Pihla highlights that "when I am stressed my stomach goes around and round'; I am not sure if it is more stress or the dairy that I eat." Rather than focusing attention on their bodily impairment, participants discipline themselves by taking new approaches to everyday life, be that within the realm of work or home, to "minimize the stress…and make life easier" (Pihla). People talk about "leaving my laptop at the office, so I do not take work home" (Juho), or they may hire a "caretaker" (Kira) for their children so as not to worry so much about working long hours.
Socio-historic	The authoring body-subject's thrownness amidst social situations, and the need to generate feelings of resonance with the actions and bodies of others.	Instead of taking their body as the sole object of coping, participant's talk sought to connect lactose intolerance to geographical boundaries as a socially situated phenomenon such that milk in Finland is what is making them sick. Further, participants blame the geographical and social boundedness of lactose intolerance on the corporate sector, brands, and industrial process that take place in the Finnish market.
Bodily	A reification of bodily awareness; the experiencing of the body *as* a body when it makes itself known as felt, feeling, and sentient being.	The body is "something so mundane, an everyday thing, ordinary, you don't really pay attention to it until you get old or hurt. When something is taken away from and you try to reach it" (Tapani); I change my diet because of the condition. When you feel physically good, you are able to do stuff (Hannes)

Unfolded in the above sections, the authoring body-subject is always already engaged in a world shared with others, an interpersonal world (Fuchs 2005). Here, coping is no longer oriented merely in relation to the body, but also towards the ways in which we are, through our doings and sayings, able to generate feelings of resonance with the actions and bodies of others (Merleau-Ponty 1962). In the context of lactose intolerance, however, where people, perhaps unpleasantly, must endure or smell evidence of the body's digestive activity, establishing meaningful intersubjective resonance can be a toilsome task. Involuntary episodes of bodily discharge and associated discomfort can limit one's ability to participate in social activities, be that playing hocking, going skiing, attending a wedding, or being at the office. At this level, coping manifests as a sense of disequilibrium or disjointedness with the habitual environ (Crossley 1996). The temporal frame operationalized here is not a long-term historical

perspective but rather an hour-by-hour or day-to-day baseline where bodily feelings establish stability in relations to the body-subject and the world through its disciplined habits. The habitual body forms the stable foundation upon which relational agency is based as disciplined purposive action (Crossley 1996). Thus, consumers have the capacity to reconfigure their actions and discursive interpretations in ways that harmonize and realign with normative expectations and establish carnal bonds with other bodies (Fuchs and Koch 2014).

As a stifling of lived directedness and intersubjective resonance, the impaired body can emerge synonymous to the absence or lack of meaning (Ratcliffe 2010). The everyday consumer frequently finds herself in the throws of the lived body as a medium through which attention is directed outwards. Take for instance, juggling daily tasks (Thompson 1996), driving a vehicle through traffic (Murphy, Patterson, and O'Malley 2018), or enjoying leisure activities like skiing or paintball (Woermann and Rokka 2015). Here, the snippets of frustrated bodily experience and associated absence of meaning that follows from, say, 'misalignment' of practices (Woermann and Rokka 2015), or not fitting into desired clothing styles in fashion contexts (Scaraboto and Fischer 2013) are commonly lost in such absorbed hustle and bustle of daily life. For consumers who experience illness, however, there are moments when they cannot lose themselves in the hustle and bustle of daily life and its associated meanings. From Chapter 6, Jouni's talk reflects how lactose intolerance can, when severe enough, affect the liveability of life in a total and deeply inflicting manner: *"I mean it is a fucking disease that affects your life, real life, in every way: your social life, your work life, your family life. Plus, it is a physical pain, and that affects your mental state of course."* The sense of existential eclipse that Jouni's talk exudes shows how affectedness and the ability to perceive meaningful possibilities for action are inseparable (Rietveld 2008), with lost affordances evoking no less than a sense of future-less-ness, of no hope (Fuchs 2005; Wyllie 2005). The explicit manner in which bodily dysfunction high-jacks a consumer's personal life reveals the highest level of coping—existential coping—that is grounded in existential feelings related to being-towards-death-ness (Heidegger 1962). In acknowledging their mortal existence, participants in this study often turned to the health care system (Chapter 8) which only reinforced their sense of alienation and angst that leaves them feeling like a weak person (Maari) (Chapter 7). Participants' concerns in coping turn towards themselves and the question of whether they can foresee meaning in their lives. Here, bodily finiteness is what gives the need for directedness and intersubjective resonance their raison d'etre. This is accentuated in lactose intolerant consumers' need to be good parents, efficient workers, a respectable friend, as well as a productive citizen. Bodily dysfunction that disrupts one's life and sense of belonging to the world does not lessen the consumer's need to press on and find new ways of being. Here, functional foods are one example of how consumers find meaning in new ways around the consumption of dairy; milk that was once making them sick is now healthy and good for them and allows them to pursue the existential projects in normative ways (Chapter 9).

Embodied action is purposive rather than purposeful and based on socio-historical bodily habits— the acquired skills, schemas, and techniques that one submits to in order to overcome immediate impediments to action. Bodily feelings are, thus, an ongoing, situated form of affectedness that constitutes a person's mode of being (existential) with others (social) or with certain objects (material) (Crossley 1996) that translates to a form of bodily comportment (Blattner 2006). In consumers' absorbed engagement of being-already-in-the-world, their active body acquires skills. However, those skills are not stored as representations in the mind, but as bodily habits that become dispositions to respond to the solicitations of the social and material situations of the world they are immersed (Dreyfus 1991). Purposive action is thus the habitual body's sense of 'I can' situated amidst particular circumstances (Merleau-Ponty 1962, p. 140). The bodily intentionality directing consumers' purposive action results from "being-ahead-of itself," as s/he lets the things in its environment show themselves according to possibilities determined in reference to herself as a bodily 'I can' (Heidegger 1962, p. 237). Consumers' experience of illness, and thus medicalization, as a bodily challenge and immediate impediment to purposive action, is mediated by the body which is constantly engaged in meaningful, intelligent interaction with the environment (Merlau-Ponty 1964). Through this directedness, the body performs actions that are not merely physical movements, but goal-directed movements that allow us to take the body not as an object to be studied in relation to culture, but as the subject of culture, or in other words, as the existential ground of culture (Csordas 1990).

10.2 Approaching Medicalization Through the Body-Subject

In this manuscript, I have argued that consuming body-subjects cope with lactose intolerance by taking-up, negotiating, and transforming discourses of medicalization. Medicalization refers to the power its constitutive discourses on health have over a person's understanding of his or her own experiences (Starr 2008). Medicine possesses a unique degree of status and power in consumer society (Cronin, McCarthy, and Delaney 2015; Cronin and Hopkinson 2018; Fischer, Otnes, and Tuncay 2007; Kristensen, Boye, and Askegaard 2011; O'Malley 2006; O'Malley and Patterson 2013; Thompson 2004, 2005). Medicine obtains cultural authority in how we frame issues (e.g., lactose intolerance) related to our bodies and behaviors (Conrad 2007). Across work done in sociology and consumer research, medicalization is often viewed as something negative, something to be critiqued, and something to be resisted (Crawford 1980; Thompson 2004, 2005; Tomes 2006). My findings suggest that consumers also normalize processes of medicalization; thus, turning the unacceptable into something acceptable (Rietveld 2008).

I contribute to the growing body of literature on medicalization in consumer research by focusing on the body-subject and the consumption practices of lactose intolerant consumers, as the experience-near realm of possibilities

and constraints on actions mediates an embodied sense of normativity. To date, consumer researchers have touched upon the link between medicalization and the body by largely focusing on the cultural demands that shape consumer identity practices (Cronin, McCarthy, and Delaney 2015; Fischer, Otnes, and Tuncay 2007; Thompson 2004, 2005; O'Malley and Patterson 2013). These studies commonly emphasize the ways medicalization organizes consumers into marginalized groups by way of medical discourse (i.e., healthy and unhealthy) whereby consumers work to resist medical discourse and transform marketplace structures in ways that serve their collective interests. What is missing from this stream of work is knowledge of how consumers *consent to* (or even embrace) rather than *resist the* marginalizing medical discourses of health as a means of coping with bodily dysfunction and interject an embodied sense of normative stability in their lives.

To further elaborate on attaining normative order through the consent to medicalization, I follow Heidegger's (1962) phenomenological duality of being burdened by and devoted to possibilities and constraints to the embodied world of action. Based on my findings, lactose intolerant consumers are burdened by dairy consumption practices in Finland (as the socio-cultural status quo, see Chapter 9) at bodily, social, institutional, and marketplace levels. As outlined in Chapter 6, dairy consumption establishes bodily dysfunction for lactose intolerant consumers in the form of bodily leakage, olfactory symptoms, along with associated pains and discomforts. These bodily eruptions produce unfamiliarity within intersubjective settings that undermine social and cultural skills (Chapter 7). To cope with lactose intolerance, and its associated bodily and social disturbances, consumers turn to medical professionals, through which consumers become burdened by the perceived lack of severity of the disease (Chapter 8).

Within my findings, I further illustrate that lactose intolerance consumers embrace the illness as a means of devoting themselves to an empowering sense of bodily subjectivity that transforms normative expectations at the social, institutional, and marketplace level. In my findings outlined in Chapter 7, the bodily experiences of lactose intolerance resonate through social environments affording possibilities for ill-bodies to reach out and mediate the perceptions of others around them. My findings show how consumers relate their own bodily experiences through others with lactose intolerance. This embodied perception erases the difference between those with lactose intolerance and those without and allows consumers to devote themselves to coping with bodily dysfunction and illness. At the institutional level (Chapter 8), I show that consumers are able to devote themselves to their bodily subjectivities only through appropriating, though often a struggle, the medical diagnosis of lactose intolerance. Through the marketplace (Chapter 9), I find that people engage in the consumption of functional foods linked to lactose intolerance in bodily states where the body is felt, conspicuous, and objectified. Functional foods, as material objects in the marketplace, afford opportunities for disciplinary actions and self-regulation

that allows consumers to replenish their body and thus, relegating it to an implicit medium through which they experience the world.

An interesting implication for my findings in this study suggests that the cultural authority of medicine and has not been converted into economic power by the health care industry, but rather through the agriculture and dairy industry's production of functional foods like probiotics and lactose-free dairy. In contrast, in Brennan, Eagle, and Rice's (2010) study of direct-to-consumer pharmaceutical advertisements, the health care industry gains control over the market for services, which involved both drawing potential patients out of the home and community into a more impersonal market through the tools of advertising and licensure laws. Unlike the Finnish context, the fragmented nature of health care delivery in the United States, allows the health care industry to gain control over financing and insurance (Conrad 2007), whereas, in Finland, the Nordic welfare state acts as a "powerful coordinating authority" (Starr 2008, p.27) that serves as a counter-weight to the neoliberal forces in health care (Giesler and Veresiu 2014).

My findings stress that processes of medicalization are anchored and oriented by the consuming-body subject. Power functions invisibly and anonymously in the background as those who are subjected to it are rendered visible. Like research on health-activism (Cronin and Hopkinson 2018), my study shows that somatically oriented concerns operate to invoke consumer actions that promote health and stability in their lives. The order of visibility is produced by bodily dysfunction and, at the social level, serves to objectify individuals to the underlying processes of power. Like Cronin, McCarthy, and Delaney (2015), who study how consumers with diabetes develop strategies of discipline, I identify the invisible processes of power that occur in the background of bodily dysfunction and dysappeareance as medicalization (Leder 1990).

In this study, my findings highlight a shift in medicalization and the degree of medical authority that exists in consumers lives. My findings show that people are forced to monitor their own medical risks, and this leads to a shift from patients occasionally occupying a binary sick role to patients perpetually occupying a continuous role of being a patient-in-waiting. Where health care services used to focus primarily on helping patients recover when an "illness strikes" (Clark et al. 2013, p. 172), they now focus on helping patients meet the "individual and moral responsibility to remain healthy." In contrast to Parson's notion that doctors treating patients who occupy a sick role at a given point in time, my findings support literature that suggests individuals are now at varying degrees of risk for different conditions and the responsibility to assess that risk falls on individuals through self-surveillance (Cederström and Spicer 2015; Giesler and Veresiu 2014; Fischer, Otnes, and Tuncay 2007).

In the context of my research, there is a tension between two ideal types (Weber 1904) of the medical profession: first, as the deserving object of patient

trust; and, second, the profession as a (somewhat) underserving holder of a monopoly over certain services. In the public sector, patients have a claim on the physician based on their symptoms rather than a special commercial/business relationship that may exist under privatized health care (Parsons 1951). Consumers trust in the benevolence of the medical profession breaks down as they struggle to gain recognition from medical authority. I believe that these findings resonate with those of Thompson (2004); the natural health consumers he studied struggle for greater power and degrees of consumer autonomy within the health care industry. Thus, in his context, as in the current one, broken trust with medical authority shifts power relations in ways that spark political and social struggles. Future research is required to examine the historical trajectory of conflict between the public and private sector health care industry and how the interplay between state institutions (Freidson 1970) and the marketization of health care shapes present-day authority of medicine and other health care professionals.

Consumers are playing an essential and growing role in the spread of medicalization and the increased public attention to disease and speedy access to treatments for those conditions (Conrad 2007). My findings support arguments that patients have adopted a more consumerists orientation towards medical care and no-longer act as passive recipients of medical authority (See Parsons 1951). People are active in pursuing relief for their illnesses and press for alternatives to health care service that they often find through the market. My findings tend to support that consumers are using medical language to define bodily impairments and problems, that there is a decrease in need for medical professionals, and that professional treatment plans are not necessarily applied (Conrad 1992; Eyal 2013; Greene 2007). Unlike King and Bearman (2011), being medically labelled (e.g., lactose intolerant) did no help participants in this study gain access to health care resources but did provide an embodied perception of the world that allowed them to cope with their illness. The findings that emerge from my study resemble those where medical diagnosis corresponds with a lack of treatment options to address the problem (for instance, like terminal cancer yet clearly less severe). Aside from changing the way one eats or drinks, there are few treatment options that lactose intolerant consumers can pursue (Whooley 2010). Amidst the burdens, those anxieties and instabilities in their life (Carel 2016; Toombs 1992), consumers embrace new forms of normative order through devotion to the bodily subjectivity that lactose intolerance implies.

10.3 Theorizing Embodied Consumer Talk

The approach to theorizing the consuming body-subject in this thesis has drawn on the phenomenological premise that being-in-the-world reaches its fullest meaning in and through language (Heidegger 1962; Ricoeur 1980, 1984). In phenomenology of being-in-the-world, human action at its most fundamental level is teleologically directed towards getting maximal grip on the world.

According to Merleau-Ponty (1962), maximum grip refers to the authoring body-subject's struggle to refine responses so as to bring the immediate situation that one finds herself in into a cohesive and digestible whole. In the curret context, embodied consumer talk refers to the ways people are concerned by their deviations from social order, misalignment with the social environment that disrupts established frames of reference and disjoints the public unfolding of life from their goals and interests. Thus, consumer talk, as a mode of normalization work, is directed towards mitigating and refining responses to situations of disequilibrium or imbalance, bringing the current situation closer to normalcy.

Traditional approaches to discourse, the post-structuralist lens, in particular, offer views on the treatment of issues surrounding the body, power, and subjectivity that diverge from the approach taken in this thesis. For example, traditional forms of discourse analysis might view linguistic constructions in particular discourses as ways of representing, formulating, and evaluating the body, as well as materializing it according to requirements of the social system writ large (Gill et al. 2005; Johansson, Tienari, and Valtonen 2017). Also, language is considered a significant "medium of social control and power" (Fairclough 1989, p. 3), and once wielded can shape the ways people construct versions of their selves which reproduce "existing social and power relations" (Fairclough 1995, p. 77). In turn, the manner in which body and discourse are treated in this thesis suggests practices of talk to disclose embodied immediacy appose to representing material significations of the body. The current thesis focuses more on the ways body-subjects' talk actively takes up and uses cultural repertoires and skills, and rather than subjectivity, focuses on analyzing the authoring body-subjects relation to the world. By 'world' I am referring to the specific contexts and situations people are embedded in, sensitized to, and through which their actions and talk are made intelligible to themselves and others (Schutz 1974; Wrathall 2014). I will use the space in the subsequent sections to build a common ground between discourse and phenomenology of embodiment, which will maintain that these seemingly opposing conceptions are mutually informing and compatible, two sides of the same coin, if you will. As such, my discussion on the role of the consuming body-subject in discourse is organized into three thematic areas—embodiment, power, and subjectivity—that together galvanize my theory of embodied consumer talk.

10.3.1 Embodiment

An important foundation of discourse is the inextricable relation between embodiment and the world in which we find ourselves. Extant consumer research argues that discourse plays a central role in the cultural construction of marketing and the consumer (Fitchett and Cauana 2015). This broad body of research has highlighted how consumer accounts (Thompson and Haytko 1997), advertising and media texts (Humphreys 2010a; Kelly et al. 2005; McQuarrie and Mick 1992; Stern 1994, 1996), and cultural artifacts (Holbrook and Grayson 1986; Zayer et al. 2012) are used as discursive resources to makes sense of

culture and cultural practices in marketing and consumer research. I have argued that it is important to complement this stream of research by elucidating how discourses are grounded in embodied relations to the world. The rationale for this relational characterization is that discourse constitutes knowledge of subjects in relationships (Fitchett and Cauana 2015), that is to say, discourses are *relational contexts* (Boje et al. 2004).

Textual approaches to discursive analysis inspired broadly by ethnography and anthropology (Arnould and Thompson 2005; Stern 1998), provided an important foundation for cultural research in marketing and consumption studies. A text is often referred to as spoken dialogue or written 'texts' like policy documents (Fairclough 1992) but can also include semiotic modalities like visual images or even spaces (Floch 1988; Schroeder and Zwick 2004). Here, the text becomes the object of analysis for understanding the influence of discourse on the conditions of consumption. Past consumer research emphasizes the importance of the body as a text produced through consumer narratives and their construction of self (Askegaard, Gertsen, and Langer 2002; Patterson and Schroeder 2010; Thompson and Hirschman 1995; Schroeder and Zwick 2004). For example, the literature highlights that "consumers' view their bodies as a kind of material text that could not be abandoned or easily rewritten and that stood as living records of their personal histories and consumption habits" (Thompson 1998, p. 3). The body becomes shaped and inscribed by the shared social discursive influences around gender, youth, beauty, and health (Borgerson and Schroeder 2002; Thompson 2004; Thompson and Hirschman 1995).

Several attempts have been previously made to introduce phenomenology to the study of consumers' experiential accounts (Thompson, Pollio, Locander 1989; Fournier 1998; Thompson and Tambyah 1999; Goulding, Shankar, and Elliott 2002; Thompson and Troester 2002; Arsel and Thompson 2010; Klasson and Ulver 2015), but in the context of theoretical concerns developed above, I focus on the interplay between phenomenology and embodiment. To work through phenomenology oriented around issues of embodiment "is not to study anything new or different, but simply to address familiar topics"—identity, food, or culture— "from a different standpoint;" as such, this perspective requires a methodological distinction between body and embodiment (Csordas 1999, p. 147). Through prior research, we know that consumer culture is an "interconnected system" of signs and symbols that textually inscribes the body as a cultural and historical phenomenon as well as a biological and material one (Foucault 1977; Schouten 1991; Celsi, Rose, and Thomas 1993; Thompson and Hirchman 1995; Askegaard, Gertsen, and Langer 2002; Schroeder and Zwick 2004; Goulding, Saren, and Lindridge 2013). Understood through the meanings that consumers reflexively attach to themselves (Thompson, Pollio and Locander 1989), experience is constituted by consumers' talk such that the gap between discourse and experience is collapsed (Ricoeur 1980; Widdershoven 1993) and language is *represented as* experience (Askegaard and Linnet 2011).

The phenomenology of being-in-the-world compliments these approaches by taking seriously Heidegger's (1962) pronouncement that language can *disclose* experience. By making this theoretical move, I place being-in-the-world, or more specifically, *being* (as a verb)— that is a mode of awareness characterized by an absorbed bodily intentionality (Dreyfus 1991)— alongside linguistic representation, these two sharing an internally reciprocal relation (Ricoeur 1980) where language can constitute experience as a text, or it can disclose embodied immediacy (Csordas 1999). The central aim of this phenomenological approach is to demonstrate that the subject's body is not solely an object inscribed by cultural practice, but also an experiencing agent, a body-subject (Wyllie 2005), and that it is in and through authorship by such body-subjects that experiencing something abstract like culture is made possible (Csordas 1990). Such a phenomenological account involves tracing consumer experience in and through the body in connection to practices of talk— personal and cultural narratives— that helps constitute its meaning (Hughes and Paterson 1997, p.335). In brief, discourse analysis provides textuality to help us to understand cultural representation, and phenomenology offers embodiment in order to understand being-in-the-world (Csordas 1999).

My findings illustrate the ways these different dimensions of embodied consumer talk methodologically work together, keep each other in check, forming a gestalt whole of consumer experience. Table 5 offers a breakdown and speculative example of how a phenomenological theorization of embodied consumer talk could be applied through my findings on lactose intolerant consumers in Finland. First, outlining the way talk discloses embodied immediacy of being-in-the-world, I highlight that these modes of talk all reflect an objectification of the body whereby consumers, instead of dwelling in and through their lived bodies and habituated affordance relations, are subjugated by lactose intolerance as it dominates their lives, emotions, personalities, and mobilities. In short, the consuming digestive body and its co-constitutive affordance-relations become explicitly thematised and disclosed through talk. Second, emphasizing the role of personal and cultural narratives that constitute their experience, consumers represent the ways they are sensitized to consumption schema supportive of their attempts to cope with lactose intolerance. Importantly, however, these modes of talk do not reflect experiences where the consuming object-body once again becomes the implicit means of being-in-the-world. Rather, in being lactose intolerant, a reflexive and even diagnostic stance towards the impaired body is called for, making lactose intolerance an ongoing but somehow manageable threat to cohering embodied relations to the world.

In sum, existing consumer research provides a framework that helps us understand the role of textuality in regards to the body through discursive constructions of consumer experience. I propose that an important complement to this stream of research is that language not only represents experience but can also disclose embodied relations to the world. The point in this phenomenological rendition of discursivity and embodiment is as follows. Embodiment allows

consumer researchers a way of overcoming the recurring tension around how to conceptualize the role of discourse in framing and inscribing consumer experience on the one hand, and describing the bodily capacity of consumers responsiveness to opportunities made possible "by the fluid potentiality of discourse" on the other (Fitchett and Caruana 2015, p. 15). Rather than applying conventional approaches to discourse analysis, I propose a phenomenological lens to allow for the further development of consumer talk as it is embodied and situated in its relational contexts of significance.

10.3.2 Power

Power is inextricably entangled with the body and requires both a body-subject who acts and an object-body that is acted upon: the body is "a locus of action and a target of power" (Crossley 1996, p. 104). In terms of the former, the body-subject, the body's active relationship with the environment occurs through acquired 'know-how' and skills (O'Malley et al. 2018) or practical mastery that constitutes that world as "ready-to-hand" (Heidegger 1962), namely, the fluid and hardly noticeable foundation of engagement that occurs in the immersion of bodily action (Fuchs and Schlimme 2009). Talk and language is the purposive means by which the body-subject engages in "singing the world" (Merleau-Ponty 1962, 193), that is, a means of receiving and expressing affective-attunement to people's situated surroundings and relationships (Joy et al. 2010). Regarding the object-body, discourse and practices of talk form power relations that constitute the 'nature' of the body, that is "a great many distinct regimes mold the body" (Foucault 1977, p. 153). Regime refers to a discursively constituted normative system (Arsel and Bean 2013) that purposefully regulates bodies into particular forms that the current society needs (Foucault 1988, p. 58; Thompson and Hirschman 1995). The disciplining of the body by these normative systems takes investment, self-awareness, and training that results in forms of bodily mastery where the body will intentionally take up the skills and dispositions that are imposed upon it (Crossley 1996). In the end, power is constituted by the tension between the lived body and the inscribed body, and their point of contact occurs at the practical mastery of bodily skills as self-aware beings engaged in the world in a disciplinary manner (Crossley 1996).

Table 5. Embodied consumer talk: a phenomenological approach

Gestalt dimension of embodied being-in-the-world	Description	Examples
Disclosing embodied experience		
The lived body falling apart	Lactose intolerance thematizes the body, establishing a realization of the material body and identity.	I fart; I have to go to the bathroom many times; I always have pain; I am losing my hair.
Habituated affordance relations defunct	The bodily breakdown situation impedes the consumers' habitual modes of living.	I can't … ; I struggled to adopt new lifestyle; I didn't know how to deal with the problem; I had denial about the diagnosis for a long time.
Undermining complex embodied consumption skills	Bodily breakdown prescribes and proscribes embodied consumption practices that hinder opportunities for socialization or conviviality.	Lactose intolerance makes me stand-out in groups and activities.
Personal and cultural narratives		
De-emphasizing bodily dysfunctions	Consumers talk downplays and tempers the meaning and consequences of lactose intolerance.	Lactose intolerance is easy to deal with; lactose intolerance is the national disease of Finland-everybody has it.
Re-embodying consumption expertise	Consumers talk about expanding the range of habitual skills and creatively refine actions in response to worldly situations.	I read the food labels; I use functional foods; I keep a food diary; I embrace lactose intolerance because my daughter has it; I eat ice cream when I am with friends at the beach despite my lactose intolerance.

In my findings, I have highlighted a tension between the lived body and the inscribed, object body. This tension emerges in clear experiential differentiation between the embodied subject and social norms, resulting in negotiation of power dynamics inherent in the objectifying gaze of 'the Other.' These intersubjective tensions arise through embodied experiences that occur in relation to the social and material environments to which they are embedded (Leder 1990). Consumers experience an anxious awareness of their environments as normative expectations subject them to the field of visibility as a central

principle of power (Foucault 1979). The first way my findings address this question is through the notion of familiarity with the world, the sense of dwelling in our social milieu, primarily through our skills and abilities, such that we are immersed in the task of going about our business in the world (Blattner 2006; Heidegger 1962). In intersubjective experiences, the look or gaze of another is "to experience oneself as no longer belonging to oneself but as belonging, as an object, in the project of the other" (Crossley 1993, p.408). Here, normative expectations that arise within intersubjective experiences establish conflict with consumers' feelings of familiarity in the world. Second, there is no clearer example of objectification of the body than in the experience of being patients in the health care system (Chapter 8). The very nature of medical practice is to treat the body as an object or assemblage of objects to be examined, prodded, or poked; the body is broken down into its constituent elements so as to enable the analysis of their interaction. My findings show a clash between the lived and experiencing body-subject and the objective body that arises as consumers cope with bodily dysfunction, the diagnosis or lack thereof, and treatment for their disease. Many participants experience bodily dysfunction profoundly but struggle with the body-reifying diagnoses and ambiguous results provided by doctors, as highlighted by one participant saying*: "I was taken into many examinations; the nurses have drawn blood from me hundreds of times…I was going to the doctor like four times a year to keep track of my health."* Lastly, my findings address this tension between the lived body and the object-body through the notions of situated normativity and intercorporeality. The notion of normativity applicable to a skilled body-subject's engagement with the world comes from their ability to distinguish "correct from incorrect, better from worse, optimal from suboptimal, adequate from inadequate activities" in a practical and material context (Rietveld 2008, p. 1). The adequacy of an activity depends, in part, "on agreement with what the members of a socio-cultural practice do" (Rietveld and Kiverstein 2014, p. 14). Despite the fact that the gaze of the other involves the experience of objectification, it is intersubjectively situated.

To summarize my argument here, power emerges through the tension between the lived body and the object-body. Power is inextricably linked with knowledge (Foucault 1980), and consumers understand the world through their bodies, and as body-subjects, their knowledge of the world is embodied (Murray 2008). As Merleau-Ponty writes:

> *We have relearned to feel our body; we have found underneath the objective and detached knowledge of the body that other knowledge which we have of it in virtue of it always being with us and of the fact that we are our body. In the same way, we shall need to reawaken our experience of the world as it appears to us in so far as we are in the world through our body, and in so far as we perceive the world with our body (1962, p. 206).*

Merleau-Ponty's account of the body-subject does not position people as puppets or parrots of culturally and historically learned behavior, gestures, and occupation of space. Rather he insists that "in the possibility of our bodies moving towards tasks that may be non-habitual, and the modification of our corporeal schema in this process, a range of possibility and bodily potentialities is opened up for us" (Murray 2008, p. 163). Power, specifically disciplinary power, is a shared condition of possibility for consumers to make sense of their experience of illness.

10.3.3 Subjectivity

Subjectivity can be conceptualized through mutual recognition, which refers to the ways discourses 'call out' or 'hail' people and offer particular subject positions that they accept as natural or obvious (Althusser 1971; Butler 1990; Kozinets 2008). For example, as an individual in need of a taxi ride raises his hand and whistles, and a taxi driver turns on his light and pulls over to the curb to answer the call, these two establish mutual recognition of each other as subjects—one as a patron and the other as the service provider. Discourses not only constitute meanings for terms and practices but also produces personal identities and subjectivities (Meriläinen et al. 2004) like, for instance, mass media hailing out at passive consumers through advertisements (Hackley 2001). Rather than being fixed, subjectivity is actively negotiated, reproduced, and changed in discourse (Holmer-Nadesan 1996; Thomas and Linstead 2002). Language, in this sense, is a social institution, a regulated process that consists of cultural rules and resources that are shared by a community and, through participation in the world, the subject is born by way of mutual recognition and intersubjectivity (Crossley 1993; Merleau-Ponty 1962).

Bodily dysfunction creates tension in cultural practice that tears or hampers such intersubjective fabric. On a very basic level, my findings show how bodily dysfunction hampers people from participating in social activities, the gaze of an 'Other' hails the body-subject as abnormal (Chapter 6). Maria, an aspiring synchronized skater, who goes on team trips to all corners of Europe as part of her training, talks of her experiences of communal food consumption as a divisive experience, not a cohesive one. Synchronized skating depends on the team being in sync, on the ice as well as off, and Maria's incongruent meal requirements make it hard for her to bond with other members of the group. The skating team 'will all eat the same,' and at the same time, except Maria, whose social skills are in misalignment with the affordances presented to her through bodily dysfunction, making her the odd one out. My findings suggest that this sort of visibility, the sight of the other, exposes the body-subject's carnal bonds with others. Chapter 7 builds from these themes by showing how consumers' intercorporeality establishes connections with 'the Other,' a feeling of belonging in the world despite bodily dysfunction, providing consumers with a sense of familiarity in the world that resolves tensions between the lived and inscribed body. In simpler terms, consumers are able to connect with one another through their bodily dysfunction at an intercorporeal level that results in affective

feelings of belonging to the world that renders their bodily impairments socially commonplace and normal.

My findings also discuss how these intersubjective dynamics play out in the institutional context in such a way that the market becomes the key means through which the consuming body-subject resolves intersubjective tension. It is likely not a surprise that someone with a physical ailment and impairment seeks medical attention at some level to make sense of their situation. In this study, consuming body-subjects become frustrated over breakdowns in mutual recognition that occur within the context of the health care system. Lactose intolerance is framed as a mild disease, something that generally does not warrant much recognition by the medical profession that leaves many participants struggling to understand and cope with their illness through other means. In their talk, participants begin ascribing a particular moral order to the public health care system that furnishes privatized and commercial services in a better light. Through the private sector, you do not have *"to wait in line with those people who are not producing anything…and drinking their lives away"* and the idea that productive people *"do not have time to stay in line for five hours with these degenerates…with private insurance, I just pick up the phone and get an appointment with a doctor"* (Kira, Chapter 8). Here, participants take on a subject-position by connecting themselves to socially valorized roles of productive citizens, shielding themselves from the struggles to gain recognition from the medical community. To support this claim, I look not only at my context but also the one studied by Giesler and Veresiu (2014). Although there are differences between the sources of inspiration in my context and theirs, it appears that intersubjectively embedded moralistic discourses hail participants to accept consumer subjectivities that facilitates individual responsibility for health through everyday lifestyle choices that are made available in and through the marketplace.

To conclude this section, I have argued that a phenomenological approach to discourse compliments traditional forms of discourse analysis on key issues connected to the body, power, and subjectivity. First, in regards to the body, discourses both reveal embodied immediacy in experience and inscribe the body from without. The meanings of our lives cannot be determined outside of the stories we tell of them, and in turn, the meanings of our stories cannot be resolved without any reference to the lives we live (Ricoeur 1980; Widdershoven 1993). Second, power is constituted by the tension between the lived body and the disciplined object-body, and practical mastery of bodily skills as self-aware beings engaged in the world occurs in a disciplinary manner (Crossley 1996). Lastly, subjects experience an Other's gaze (Crossley 1993), that is to say, people exist in intersubjective relationships. Even at abstract levels of morality, to experience oneself as being watched or visible to a moral gaze is to experience intersubjectively. In the coming section, I will expound on how consumers embodied talk allows them to cope with lactose intolerance.

10.4 Embodiment and Consumer Needs

In this thesis, I see consumer needs as a cultural construction that is mediated by embodied experience. This is to say, consumer or more generally, human need, and its meanings are not fixed and inevitable, the consequence of human suffering and the pursuit of worldly salvations (Sahlins 1996). We already know that consumer needs are a production of historical events (Karababa and Ger 2010; Foucault 1961), social forces (Applbaum 1998; Giesler and Veresiu 2014), and ideology (Baudrillard 1970; Belk, Ger, and Askegaard 2003; Luedicke, Thompson, and Giesler 2010). Consumer needs, as Sahlins (1996, p. 412) suggests, are based on the ideology that people are "imperfect creature[s] of need and desire, whose whole earthly existence can be reduced to the pursuit of bodily pleasure and the avoidance of pain." Because illness is one of the most tangible forms of suffering, consumers, undergirded by moral imperative, sense that their personal anxieties and bodily pain are best addressed through consumption. Those who accept current canons of affective-attunement and behavior may learn that the ways consumers are obligated to subjectively feel and act are not entirely ordained by human nature or physiological make-up. Consumers need not feel so much personal anxiety or dissatisfaction if they are unable to obey social impositions to stay healthy and be productive citizens. Nor should consumers be so concerned to follow whatever the official health care imperative of the day may be, such as, taking on responsibility for being aware of what you eat, exercise as much as possible, get enough sleep, avoid alcohol, and generally be healthy.

I offer the proposition that consumer's affective-attunement to the world is a means to capture and explain the imposition of consumer needs on people who experience bodily impairment. Consumer researchers and marketing scholars have touched upon the affective link between need and consumer experience by theorizing it as a lack of a certain category of objects (Belk, Ger, and Askegaard 2003). Needs, different from wants and desires, are always anchored in the body, expressed through necessity and naturalized symbolically by social institutions subsumed or reinforced by market activity (Belk, Ger, and Askegaard 2003; Sahlins 1996; Baudrillard 1970). The legitimacy of needs is beached by what are referred to as primary needs, an irreducible ground where individuals choose for themselves since they know what they want to eat, to drink, to sleep, or to find shelter (Applbaum 2004; Baudrillard 1981). Primary needs tend to be anchored in the body and its survival, and colloquial discussions invoke the idea that it is human nature to overcome any means of deprivation to satisfy it; then, secondary needs are social and refer to the ways consumers attempt to actualize self-identity and build self-esteem (Maslow 1943). Yet, we already know that the very needs for survival are built on the social imperatives that demand it (Sahlins 1996; Wilk 1997). In discussing this shift from 'vital' or primary needs to 'cultural' or secondary needs, Baudrillard (1981, p. 75) remarks that "The slaves assurance that he would eat was that the system needed slaves to work. The only chance that the modern citizen may have to see his cultural needs satisfied lies in the fact that the system needs his needs and

that the individual is no longer content just to eat." What is missing from these critiques on consumer needs, I propose, is knowledge of how embodied experience, rather than abstract discursive or cultural systems, solicits responses of a practical kind (Merleau-Ponty 1962), where bodily awareness and competence are implicated in the reciprocal relations between the cultural construction of consumer needs and products that resolve them.

Unlike discussions of consumer needs others have described (e.g., Allen 2002; Giesler 2012; Holt 1998; McAlexander et al. 2014; Scaraboto and Fischer 2013; Thompson 1996), consumer experience of illness is more complex than a two-sided debate between human nature versus the cultural imaginary. What in play here is the body-subject to which I have referred in the findings and illustrate in Figure 2. The authoring body-subject is affected by deviations from normative systems and attuned to the practical and material world: the body-subject perceives the world through its affordance-relations. Affordance-relations occur between the body-subject and the environment, which is made up of the material realm as well as situated cultural and practical understandings. The material world (like products), as well as social and cultural understandings (the imposition of needs and obligations), are said to 'solicit' or 'pull' consumers to produce normative order (Kiverstein 2008). Affordance-relations become evident when the body-environment relation is disclosed to possibilities for meaningful action (Gibson 1986; Merleau-Ponty 1962). One could say that for consumers whom experience illness are governed by the normative pull to regulate and discipline their practices to become healthier, a normalizing pressure that Foucault's (1977) theory of disciplinary power can help explain.

For Foucault (1980), disciplinary power is a construct that is more or less synonymous with the idea of modern governance whereby people are regulated subtly and discretely through everyday activities of self-restraint and control. Subjects decide to restrain themselves so as to become the sorts of people they want to be, a self-construction linked to practices that vary "in different societies and times and involving dieting, physical exercise and other forms of self-control" (Belk, Ger, and Askegaard 2003, p. 331). Disciplinary power is exercised through discursive practices that privilege certain articulations of reality over others (Huber and Brown 2017). Consumer researchers have shown how the bodily basis for consumer needs emerges through discourses of health. Within the realm of food, consumers are solicited to repel enticing but supposedly fattening foods (Hirschman and Thompson 1995), as well as in technologies of self such as self-examination (the constitution of the self as a bodily object to be measured, molded, improved and shaped) (Cronin, McCarthy, and Delaney 2015). These forms of self-control can also be liberating where neo-liberal logic of personal responsibility for health insulates and safeguards the body from harm (Cronin and Hopkinson 2018; Giesler and Veresiu 2014).

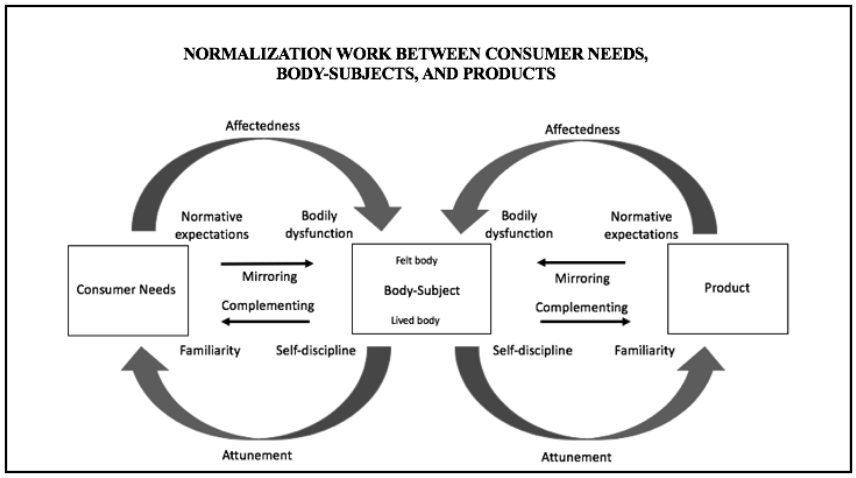

Figure 2: Consumer needs, body-subjects, and products

In my study, lactose intolerant consumers in Finland embrace personal responsibility for health through the market. Yet, consumers do not immediately fall back to the market. After all, dairy foods offered through the market establish bodily dysfunction, which results in most participants first resorting to the public health care system to resolve their bodily impairment. Only after the public system 'fails' them, demarcating lactose intolerance a minor disease not severe enough to warrant significant attention, does the body-world relation open to 'lived possibilities' for meaningful action in the market (Gibson 1986; Merleau-Ponty 1962). While this is not in actuality as clean a process as I present here, I would argue the first set of lived possibilities for meaningful action direct consumers to private health care where they can purchase the right to have visibility for their illness and see a doctor through monetary links to health. As struggles with treatment (giving up dairy) and the appropriation of lactose intolerance as a diagnosis pursue, lactose intolerant consumers find resolve through functional foods like lactose-free dairy, probiotics and lactase pills that allow these consumers to discipline themselves according to cultural practices linked to dairy consumption. This resonates with Sahlin's (1996, p. 403-404) argument that "the human body is a cultural body, which also means that the mind is a cultural mind. The great selective pressure in hominid evolution has been the necessity to organize somatic dispositions by symbolic means. It is not that Homo Sapiens is without bodily 'needs' and 'drives,' but the critical discovery in anthropology has been that human needs and drives are indeterminate as regards the object because bodily satisfactions are specified in and through symbolic values." My findings show that lactose intolerant consumers do not find dairy products disgusting because of their medically defined physiological reactions (Wilk 1997) but the normative work that occurs through the consuming body-subject shape cultural meanings of dairy in accordance to lactose-free disciplinary regimes (Arsel and Bean 2013).

In Figure 2, I illustrate how normalization work establishes reciprocal relations between consumer needs, the body-subject, and products in the

market (also supported by Table 6). Here, expanding on the notion of needs being filled through exchange of a product in the market, I show the authoring body-subject (in its dysfunction) affected by normative expectations, while attuned to disciplinary practices that render a sense of familiarity with the world and its obligations (needs). Let us assume that the authoring body-subject is a person whose *bodily dysfunction* (impromptu farting, diarrhea, pain, bloating, and associated discomforts) manifests in and through the intersubjective world that carries with it particular *normative expectations*. For example, participants in my study expressed obligations to work and be productive citizens and not be a drain on society. These social imperatives, in turn, shape consumers' bodily subjectivity as they identify moral dimensions of their bodily dysfunction. Consumers may resist the restraint of bodily dysfunction through playful and flippant dispositions. Likewise, they may feed themselves appose to engaging with retail and servicescapes so as to control the ingredients in their food (*products*) in a *disciplinary* manner. By substituting dairy with lactose-free alternatives as an ingredient in their meals, the body-subject resonates with familiar, habitual eating routines amidst colleagues, family, and other areas of social life.

Components of the affordance-relations in consumers' normalization work, *mirroring* and *complementing* relations, bring resonance of the body-world coupling to a common chord. At the institutional level, the body-world coupling is constrained through the lack of severity of lactose intolerance as a bodily dysfunction. Normative expectations within the public health care system that severe medical symptoms hold priority leave consumers in a state of disciplinary action— continually monitoring symptoms *mirroring* health care patients in a perpetual state of being potentially sick or 'patients-in-waiting.' *Complementing* the need to provide visibility for their illness, consumers attempt to anticipate symptoms and illness and communicate those dysfunctions and impairments to the doctors and nurses so as to move through gatekeepers. Consumers may test the body through consuming different forms of dairy products to see what causes the worse symptoms (like milk in coffee versus eating a plain yogurt). Dairy products *mirror* as a diagnosis tool for the lay population to self-diagnose, and being a good consumer allows participants to become their own doctor. Consumers may purchase private health insurance so as to be prescribed medicine, *complementing* their dairy consumption so as to live normal and not experience pain.

Table 6. Reciprocal relations between needs, body, and products

Levels	Normative Obligations	Bodily Subjectivity	Product Shaping
Social	To work and be productive, to be healthy, eat well, get a good night's sleep, exercise, etc. To not be drain on society or waist time not being productive	Identifying the moral dimensions of their bodily dysfunction; Self-diagnosing as lactose intolerant based on kinship symptoms Matching the bodily expression of others (mirroring or complementing)	Make food as oppose to purchase meals Watching closely what you eat Leave their laptop at the office; hire a caretaker for their children Establishing habitual eating routines.
Institutional	To pay taxes for public services To work and make money To monitor symptoms as a potentially sick patient-in-waiting. To have severe health problems when you go to the doctor	Provide visibility for your illness and bodily condition Test the body through consuming different products to see what causes the worse symptoms	Purchase private health insurance, and eat medicine to live normal and not experience pain Dairy products act as a diagnosis tool for lay population to self-diagnose Being a good consumer allows consumers to be their own doctor
Market	To drink milk and consume dairy: to be health; to be a good Finn Feel free to do things and live freely like they do in the countryside To be lactose intolerant through a sense of we-ness Conform to self-regulate lactose intolerance	Using talk that reflects "my body", "my guts" reflecting bodily subjectivity Associate milk with pain in the stomach and loose stools The use of functional foods so the body can become an implicit medium of experience once again	Destigmatize lactose intolerance by blaming industrial production of dairy Positioning lactose free as normal milk that is good for them and not medicine; keeps people safe from food threats Functional foods like lactase pill provide invisibility for their illness (nobody notices) All foods in restaurants and cafeterias are lactose free in Finland by default (even McDonalds) Signs on menus for lactose free and low lactose products

My study demonstrates that Finland is culturally imagined to be 'the promised land of dairy' which culminates in obligations for consumers to drink milk not only to be healthy but to be a 'good Finn.' In their normalization work, consumers transform this obligation by conforming to self-regulation of lactose intolerance through the market such that it produces the normative expectation that everyone is lactose intolerant. For lactose intolerant consumers, Finnish dairy, in particular, becomes associated with stomach pain, farts, and loose stools and they position lactose-free dairy as 'normal milk' that is good for them. The market takes into consideration the lactose intolerant body schema, and all foods in restaurants and cafeterias are lactose-free by default (even McDonalds). Signs on menus for lactose-free and low lactose products allow consumers to cope with lactose intolerance in a purposive manner that aligns them with social and cultural systems of meaning.

10.5 Concluding Remarks

Medicalization is a widespread phenomenon in social life but remains understudied in consumer research (Brennan, Eagle, and Rice 2010). Most current literature on medicalization focuses on how consumers resist medical intervention in their everyday lives. Stated, but rarely addressed, is the idea that consumers' experience of medicalization is subjected to their situated normativity, shaped, and transformed by the way people talk about medicine and health. Further, we know little about how consumer embodiment impacts consumption and marketplace phenomenon. The consuming 'I' implicated in consumption actions is often an inner disembodied self, the cogito that is either being enchanted by consumption discourses or struggling against them through acts of consumer resistance. An emerging stream of consumer research does investigate interconnections between body and consumption (Askegaard, Gertsen, and Langer 2002; McAlexander et al. 2014; Sandikci and Ger 2010; Schroeder and Zwick 2004; Schouten 1991; Thompson and Üstüner 2015; Walther and Schouten 2016). However, this stream often theorizes the consuming body as a fruitful site for investment in politico-cultural capital, or as the expressive vehicle of a bounded inner-self.

My dissertation adds a new texture to this stream of research, showing how impaired bodies disrupt sedimented consumption experience, and how such affectedness attunes consuming bodies to practical possibilities for re-establishing cohering consumption experience. Here, consuming body-subjects are not created through strategic orientation to a long-term teleological end. Instead, the consuming body-subject works towards a renewed sense of normativity as it seeks resonance with its immediate social and cultural environment. I mobilize a theoretical framework grounded in consumer embodiment, an approach that necessitates "that the body as a methodological figure must itself be non-dualistic, i.e., not distinct from or in interaction with an opposed principle of mind" (Csordas 1990, p. 8).

My work also opens up fruitful avenues of research that can attend to the contingent and precarious nature of consumption, especially as discourses on consumption have begun to shift from a celebration of individual agency to a form of skillful negotiation under constraints. My dissertation shows how focusing on constraints on consumption – in this case, genetic constraints of a group of lactose intolerant consumers – can help go beyond the ableism that implicitly informs dominant conceptualizations in the literature. This thesis foregrounds affectively attuned body-subjects and illuminates the precarious and contingent nature of consuming bodies.

Future research might focus on bio-medical technology and its overlap with the market. There is an emerging lineage of consumer research that examines the role of technology in the medical marketplace (Fischer, Otnes, and Tuncay 2007; Giesler 2012; Tian et al. 2014). An exciting opportunity for future research would be to examine the role of medical technology in linking issues of temporality, embodiment, and intersubjectivity that arise in consumption contexts. The body-subject, in its directedness, is always already oriented to the future and the implicit temporality of social life (Fuchs 2005). This is to say, the directed body-subject is always also attuned to horizons of intersubjective nature (Merleau-Ponty 1962). When the living body-subject experiences discontinuity with its surrounding intersubjective processes, the once tacitly experienced body becomes an explicit object of attention (Woermann and Rokka 2015). Medical technologies like functional foods have the power to make diseases seem more acceptable and could play an important role in re-orienting the future orientations of embodied subjects (Robinson 2015). Take for example, consumers whom experience postpartum depression whose sense of being-in-the-world is so shaken they are physically unable to leave the house, where the world's solicitations do not incline the body-subject to act (Ratcliffe 2010). Medical technologies that circulate the market could help establish the synchronization with others (Fuchs 2010) and contribute to re-orienting a consumer's bodily sense of being-in-the-world in ways that expand our understandings of consumer depression beyond psychological accounts (Fuchs 2010) and the cultural demands on postpartum bodies (O'Malley and Patterson 2013).

To conclude, this study has set out to understand how consuming body-subjects cope with medicalization through talk. Existing studies claim that consumer resistance to authoritarian systems of western medicine produces new market logics free of this medical gaze. My research shows that people work on and from their bodies to makes sense of their situated normativity. In the act of establishing order in their lives, the lived body and the object body comingle with each other, and my participants come to realize tension between these two bodily modes. While bodily dysfunction linked to lactose intolerance gives rise to this tension, so does the objectification of the dysfunctional body through social interaction. Normalization work is then intimately bound up with modes of embodiment, and the inner-self-outer-body duality comes to the fore not as a stable, natural state but as an often precarious and unstable artifact.

Medicalization rests on the notion that well-informed patients who self-manage their health can curb the authority of medical culture with its tendencies to undertreat, overtreat, misuse, and overcharge. However, in practice, the categorization of oneself based on social norms of health establishes progressively greater consumption of medicalized products like functional foods as normal solutions to manage bodily experience. Further, this research is interesting because it explains how the active body (e.g., consuming body-subjects) produces another form of normalization, not through alignment with a norm, but through discursively working on norms that are not defined in advance by abstract cultural systems but are in the process of being negotiated.

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