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The Self-Generating Language of Wellness and Natural Health

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This article extends Keränen's (2010) application of the concept of autopoiesis, or self-generation, to rhetoric by examining how arguments about wellness and natural health self-generate in public discourse. The article analyzes 20 qualitative interviews on what it means in contemporary culture to be "well"—how wellness differs from illness, how it is distinct from health, and how it can be maintained and enhanced. The analysis shows that wellness discourse is predicated on the entanglement of seemingly opposed logics of restoration and enhancement: those who seek wellness through dietary supplements and natural health products seek simultaneously to restore their bodies, perceived as malfunctioning, to prior states of ideal health and well-being, *and* to enhance their bodies by optimizing bodily processes to be "better than well" (Elliott, 2003). The fusing of these two logics creates an essentially closed rhetorical system in which wellness is always a moving target.

Keywor ds: autopoiesis, dietary supplements, optimization, risk, self-surveillance

> *The person who came up with "wellness" as a product adjective is probably living in a castle carved out of gold right now.*
> Nicole Cliffe (Twitter, March 2015)

> *Thank you for all the suggestions—coconut oil seems to do literally everything. It's the James Franco of oils.*
> Lena Dunham (Twitter, May 2014)

The two tweets above, together, cut to the core of my argument in this article—that the language of wellness contains within itself the resources for its own self-perpetuation; in Keränen's (2010) formulation, wellness is autopoietic, a self-generating discourse. In the first tweet, writer Nicole Cliffe highlights how wellness is, among other things, an excellent sales pitch. No longer confined to a specialty market, the concept of wellness has become ubiquitous in the United States and Canada. Even at big box stores, we can buy wellness teas, juices, smoothies, and cereals, as well as wellness-oriented products such as advice books, aromatic tinctures, candles, magazines, and yoga sets. Online, we can visit wellness blogs and websites, listen to wellness podcasts, and watch wellness YouTube channels. To enhance our wellness, we can visit specialty wellness clinics, spas, and retreats, and we can take our pets to animal wellness centers. To stay productive, we can enroll in workplace wellness programs and visit university wellness centers. And to protect our wellness, we can use natural health products, tracking what we use on our smart phones along with the details of our diets, exercise habits, moods, and even sex lives.

While the first tweet vividly illustrates that wellness sells, the second, from actor-writer-director Lena Dunham, hints at *why*. With a note of sarcasm, Dunham compares public enthusiasm for coconut oil to actor James Franco, who is known for juggling big-studio film work with independent film and creative writing projects, painting, and theatre, all while undertaking a range of concurrent academic degrees, including several master's degrees and a Ph.D. (Anderson, 2010). Just as Franco is widely cited as a polymath of the arts, coconut oil is widely cited as a panacea by celebrities-turned-wellness-gurus such as Gwyneth Paltrow and Kourtney Kardashian, as well as by health and wellness bloggers, naturopaths, mainstream journalists, and just about everybody else. A Google search for the phrase "coconut oil benefits," for instance, turned up more than 1.7 million hits. Among those search results are celebrity cardiologist Mehmet Oz promoting coconut oil as a remedy for problems with cholesterol, digestion, metabolism, thyroid function, weight, and more (LoGiudice, Bleakney, & Bongiorno, 2012) and Oz acolyte Josh Axe, a natural health practitioner with a substantial Internet footprint, who lists coconut oil variously as a medical treatment (for arthritis, diabetes, kidney stones, urinary tract infections, and yeast infections), an agent of disease prevention (of Alzheimer's disease, cancer, gum disease, heart disease, high blood pressure, and osteoporosis), and a boost for overall health (of hormonal balance, immunity,

and memory; "20 Coconut Oil Benefits," n.d.). In these and the legion of similar articles both online and offline, coconut oil—like James Franco—seems to do everything at once.

Now, to put these two tweets together: in what follows, I argue that wellness sells because what it means in contemporary Western culture to be "well" is predicated on the entanglement of seemingly opposed logics that together create an essentially closed rhetorical system where wellness is always a moving target. The first logic is that of "restoration," wherein individuals interested in wellness seek to restore their bodies, perceived as malfunctioning, to prior states of ideal health. For instance, an individual may take a natural health product or supplement to hasten recovery from a cold or infection or to treat a headache or insomnia and return to health. The other logic, of "enhancement," instead captures a person's efforts to optimize their bodily processes such as sleep, mood, and energy level to become "better than well" (Elliott, 2003). By promising simultaneously to cure what ails us (the logic of restoration) and to make our bodies even better than they already are (the logic of enhancement), the language of wellness appears to have no ceiling: when argumentation from one of these logics is exhausted, such as when a symptom such as insomnia abates, the other logic often kicks in—one could always sleep *better*.

By cycling between the logics of restoration and enhancement, the language of wellness circles back on itself, appearing to empower individuals to take charge of their health outside of an illness-centric, pharmaceutically oriented model of medicine while simultaneously reinstalling them in that same system. Examining the closed rhetorical circuit in which wellness operates therefore offers an opportunity to extend Keränen's (2010) initial investigation of autopoiesis, or self-reproduction, as a rhetorical phenomenon. Keränen draws the concept of autopoiesis from social systems theory, where it was in turn drawn from biology to characterize living systems as closed, autonomous, self-replicating units (*auto* means self; *poiesis* means creation). Sociologist Niklas Luhmann (1986, 1992) appropriated this concept, somewhat metaphorically, to describe how social systems operate and reproduce apart from individuals with independent agency (Blashke, 2015; Keränen, 2010). For Luhmann (1992), communication is at the heart of autopoiesis because, as Keränen (2010) explains, "social systems exist by generating more communications, which further the system's evolution and reproduction" (p. 83). Importing the concept to rhetorical studies, Keränen employs autopoiesis heuristically (her term) to examine how rhetorics of

terror preparedness and viral apocalypse spiral and grow as risk discourse expands: heightened perceived risk leads to expanded surveillance and security, which in turn lead to heightened perceived risk (and therefore to expanded surveillance and security, and so on). Applying the concept of autopoiesis to wellness discourse illustrates and expands the concept's explanatory power within rhetorical studies and explains partly how this discourse has become so powerfully persuasive among North American consumers.

In this article, I employ autopoiesis as an analytic framework to examine a set of interviews with individuals interested in wellness and natural health products (NHPs) such as echinacea, gingko, and St. John's wort. Because these products sit uneasily at the nexus between illness and health, biomedicine and alternative medicine (Derkatch, 2016), they provide a window into the discursive traffic between the logics of restoration and enhancement that I argue is characteristic of the language of wellness. In the next section, I begin by describing my interview procedures and analytic framework. Following that section, I explain how the interplay between participants' conceptions of wellness, health, and illness establishes the context within which arguments about wellness self-generate. I then examine the two logics of wellness as they emerged in the interviews, including how they operate in tension as an autopoietic rhetoric. I close with the article's contributions both to a rhetorical understanding of autopoiesis and to rhetoric of health and medicine (RHM) more generally. Most notably, this article addresses a range of questions that have wider implications for the field of RHM. For instance, if wellness is a sales pitch, how, specifically, does it work and why? What are the continuities and discontinuities between wellness discourse and pharmaceutical discourse? And, most importantly, what effect does the language of wellness have on us—as patients, as consumers, and as persons with bodies?

Answering these questions offers insight into how the terms and values of medicine and science inflect our daily lives and lived experience, and how forms of discourse can be imprinted or shaped by other discourses. As I illustrate below, the characteristic emphases of wellness discourse on health and empowerment are imprinted by biomedical modes of diagnostic and pharmaceutical reasoning that allow individuals who seek wellness through NHPs to move seamlessly, and seemingly unconsciously, between the logics of restoration and enhancement. The tension produced through this movement between logics may be a central driver in public interest in NHPs: as

they are figured in the language of wellness, these products, like coconut oil in Dunham's tweet, seem able to do everything at once.

Interview Procedures and Analytic Framework

The analysis that follows is based on 20 interviews about wellness and natural health conducted in 2015 in two large Canadian cities (ten participants in the western province of British Columbia and ten in the east-central province of Ontario).[1] My core research questions as I entered the study were:

- What are the terms that constitute a discourse of wellness, and how are these terms both like and not like those of illness? How do these terms circulate and what are their effects?
- Through what means have the models of wellness and illness become fused in public discourse? How does this fusing of perspectives strengthen and expand the appeal of wellness itself?

The purpose of the interviews was to gain a focused sense of the language that individuals use when thinking and speaking about wellness and to allow me to compare the responses of different individuals to the same set of questions. By comparing across responses, I could identify emergent patterns in the participants' language of wellness, which would offer insight into how that language works more broadly.

Wellness generally refers to the optimization of an individual's daily life across multiple domains (physical, psychological, social, and spiritual), emphasizing positive elements over negative ones: function over dysfunction, agency over passivity, and overall well-being over mere bodily health (Cederström & Spicer, 2015; Conrad, 1994; Kannan, Gaydos, Atherly, & Druss, 2014; Mackey, 2009; Nichter & Thompson, 2006; Rose, 2007; Stokols, 2000; Watt, Verma, & Flynn, 1998). Many conceptions of wellness incorporate an element of reflexivity, figuring the well individual as one

[1]Recent data on regional differences in both the United States and Canada show that public interest in and use of natural health products such as supplements is 10–20% higher in western regions than in eastern ones (Rozga, 2013; Statistics Canada, 2015). For this reason, I conducted an equal number of interviews in Western Canada and Eastern Canada to allow for a potentially broader range of perspectives on wellness and natural health. Due to the study size, however, I did not analyze differences in responses between these two regions.

who is aware of and deliberate in their performance across these domains (see, e.g., Kraft & Goodell, 1993; Schuster, Dobson, Jauregui, & Blanks, 2004; Zimmer, 2014).

The twin emphases in wellness discourse on multidimensional well-being and self-awareness exhort individuals without illness symptoms to monitor bodily states such as digestion, mobility, energy, cognition, and mood, and to intervene in perceived suboptimal states through the use of complementary and alternative medicine (Kannan et al., 2014; Schuster et al., 2004), including NHPs (Derkatch, 2012, 2016; Dickinson & MacKay, 2014; Nichter & Thompson, 2006). These practices of surveillance and intervention are undergirded by recent redefinitions of health as a "semi-pathological pre-illness at-risk state" that must constantly be mitigated through health-protective behaviors (Armstrong, 1995, p. 401) and by larger cultural rhetorics of self-improvement that frame individuals as "health citizens" (Petersen, Davis, Fraser, & Lindsay, 2010; Spoel, Harris, & Henwood, 2014) who are socially and morally responsible for maintaining their own and their family's health, well-being, and productivity (Cederström & Spicer, 2015; Conrad, 1994, 2007; Elliott, 2003; Metzl & Kirkland, 2010; Petersen & Bunton, 1997; Spoel, Harris, & Henwood, 2012). Within this matrix, the "good" health citizen accepts and assumes responsibility for their own self-observation and self-care, even in the absence of illness.

To investigate the rhetorical workings of the language of wellness, I focus on NHPs in particular because of their simultaneous continuity and discontinuity with pharmaceuticals. Like pharmaceuticals, NHPs are typically synthesized and produced in laboratories by large corporations and consumed, often in capsule or pill form, to effect a change in the body; and yet they are perceived as more natural than pharmaceuticals due their association with botanical and mineral substances, and they appear to offer users a greater sense of agency regarding when, how, and why to take them (Derkatch, 2016; Nichter & Thompson, 2006). Examining wellness through the lens of natural health products therefore provides an opportunity to trace how the two logics of wellness interact with and, as I argue below, reinforce each another.[2]

[2]In this article, I use the Canadian regulatory term "natural health product" rather than its U.S. counterpart, "dietary supplement," for two reasons: first, this study was based in Canada and so the term "natural health product" was more familiar to participants, although they did often use

This study received institutional research ethics approval.[3] Participants were recruited in each city through online advertisements (Facebook and Twitter) and posters placed on bulletin boards in public spaces, including community centers, coffee shops, and natural food stores. The interviewees ranged in age from 18 to 63 (average age: 38), with 17 self-identifying as female, two as male, and one as nonbinary. All but one participant had at least some post-secondary education, with the majority holding undergraduate degrees or equivalent (14), and with half of those (7) also holding postgraduate degrees and certificates. Participant demographics were therefore well aligned with those of the general population of natural health product users, the overwhelming majority of whom are educated females (Dickinson & MacKay, 2014; Guo, Willows, Kuhle, Jhangri, & Veugelers, 2009; Statistics Canada, 2015).

Each interview followed a set of standardized open-ended questions about wellness and natural health that were designed to allow both for rich, spontaneous, idiosyncratic responses and for comparability of questions across participants. Participants were asked to reflect on what it means to them to be well, such as how wellness differs from illness, how it is distinct from health, and how it can be maintained and enhanced through the use of NHPs. Brief responses (e.g., a single word or phrase) were followed up with prompts such as "Can you say more?" or "How so?" The interviews were audio recorded and lasted approximately 40 minutes with a range from 17 to 79 minutes. The recordings were transcribed verbatim by a research assistant and checked by another research assistant and by me.[4]

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the terms interchangeably; second, the range of interventions included within the Canadian category is broader, including not only materials ingested orally per U.S. Food and Drug Administration regulations (U.S. FDA, 2013, 2016), but also products delivered topically such as nasal sprays, creams, and ointments (Health Canada, 2016).

[3]This study was approved by the Ryerson University Research Ethics Board (# 2015-074). Prospective participants were screened for inclusion via email according to the following criteria: a) 18 years or older; b) actively interested in wellness; c) use natural health products (e.g., herbal medicine, vitamins other than regular multivitamins, homeopathic remedies) regularly (i.e., daily or weekly, for at least part of the year); d) would be physically present for the interview; e) at arms-length from the researcher (e.g., not first-degree friends, colleagues, or family members). The first ten prospective participants in each city who met the inclusion criteria were scheduled for interviews; all twenty interviews were conducted by paid doctoral-level research assistants in a private office on a university campus. Participants received a $25 VISA cash card as an incentive to participate.

[4]The transcripts include features of spoken language such as repetition, false starts, pauses, and filler words (e.g., "um," "like") but I did not factor these elements into my analysis unless they seemed significant. All quotations have been lightly edited to exclude these elements except

I analyzed the transcripts in NVivo first by participant and question, and then by the themes outlined in my analysis below. I established these themes primarily inductively, using an iterative process that involved identifying overarching themes in the transcripts until no new themes emerged and then re-analyzing all of the transcripts in light of those broad themes, identifying patterns within the materials that explained or added texture to my analysis of each. Although my approach was driven largely by the transcripts themselves, it was not solely inductive: I also brought theoretical frameworks to bear on my inquiry at two key points. To orient and ground the present study, I guided my initial analysis partly by considering whether and how participants' responses accorded with my previous observation that wellness is often figured discursively as a state of incipient illness that requires careful observation and intervention (Derkatch, 2012, 2016)—this figuring constitutes the first of the two logics of wellness I discuss below, the logic of restoration. Additionally, as I came to see that Keränen's (2010) concept of rhetorical autopoiesis offers a robust theoretical framework for explaining how those intertwined logics appear to propel the discourse of wellness, I reanalyzed the materials specifically through that theoretical lens.

Wellness in the Illness Model

The first half of the interviews focused on how participants define and understand the concept of wellness and how they compare wellness to both health and illness. Participants' views corresponded strongly with dominant characterizations of wellness as the absence or opposite of illness, centered on enhancement or optimization of the healthy body rather than treatment of the ill or diseased body (Derkatch, 2016; Nichter & Thompson, 2006). Study participants figured wellness in positive terms as maintaining health rather than treating illness (Derkatch, 2012, p. 3), placing NHPs in binary opposition to pharmaceuticals as natural (rather than chemical or synthetic), safe (rather than dangerous), self-determined (rather than prescribed), and protective (rather than defensive). Viewing NHPs within this positive frame, participants described feeling empowered to pre-empt illness rather than merely to react to it once it occurs. In

where noted. Participants are identified in the text by number and interview location ("E" for east, "W" for west).

this section, I examine participants' responses to three key questions about the meaning of wellness (see subsection titles below) because public understandings of wellness, health, and illness together establish the context within which wellness operates as a closed rhetorical circuit.

When you hear the term "wellness," what do you think it means?

This first question in each interview was deliberately open-ended to capture in participants' own words their candid descriptions of wellness. Interviewees generally felt they understood the concept intuitively but had difficulty defining or describing it concretely. For example, one participant interrupted herself partway through her initial response, saying, "I don't know how else to explain it. I'm probably going to struggle with words here" (W1). The problem of defining wellness may be due in part to the term's inherent ambiguity, particularly given that it encompasses multiple domains (physical, psychological, social, and spiritual) and contexts of use (personal, professional, medical, commercial). Further, the fluidity between the logics of restoration and enhancement may create for individuals a kind of definitional impasse, as it is difficult to explain in concrete terms a dynamic and multidimensional concept that generates different meanings as it moves between logics. This difficulty was reflected in the interviews, where participants were more easily able to explain wellness in relation to other concepts or specific behaviors than on its own terms, perhaps because the act of comparison anchors the concept in a fixed relation to the two logics. Ultimately, this ambiguity may be a key rhetorical resource for the self-generation of wellness discourse, as the concept can mean different things even at the same time and so, like coconut oil, can appear to do everything at once.

Most responses to the question of what wellness means were vague and often circular, with frequent pauses, false starts, and self-interruptions. This, for example, is a typical response, with pauses noted with "(.)" and filler words preserved to illustrate the participant's significant efforts to articulate her ideas:

> Um, (.) I think [wellness] means, (.) um, (.) kind of—(.) a state of (.) well-being across, um, (.) like, cognitive, (.) emotional, (.) and

> (.) physical, (.) um (.) domains. So, (.) I guess (.) not just the lack of (.) something bad going on (.) but in fact (.) wellness, (.) I think, is, you know, (.) a state of well-being or, (.) you know, (.) everything's working properly. (E2)

Note the tautology here of defining wellness as "a state of well-being," a pattern that recurred in many participants' responses. Another participant similarly described wellness as "a feeling of well-being" (W3), and still others defined wellness more specifically as "eating well" (E3), "living well" and "looking well" (E5), and being able to "sleep well" (E6), "feel well" (E7), and "get well" (W2). None of the participants were able to explain what "well" means in their examples or how it could be assessed, illustrating the slipperiness of the concept even among individuals who are passionate about it.

Although participants reported having difficulty defining wellness, two significant trends emerged in their responses. First, nearly all participants described wellness as foremost a state of balance across different domains that sponsors feelings of contentment, as in the following examples:

> I think of [wellness] like a balance between a lot of aspects in life. . . . It's about balance between all our aspects and [to] find an equilibrium and all of that. (E4)
>
> I think [wellness] means a sort of harmony between your mind and body and soul, and sort of in relation to your expectations and reality in life. (W3)
>
> I think [wellness] means health but not just physical health. It means physical, spiritual, and emotional health. It's all—the whole package. (W6)

Throughout the interviews, participants frequently drew on synonyms of balance such as "harmony" (W3, W6), "homeostasis" (E5), and "equilibrium" (E4), as well as terms that evoke a similar idea of integrating multiple domains such as "holistic" (E1, E9, W6, W10) and "synergy" (W3). All of these examples characterize wellness as the ability to juggle the different parts, roles, and demands of one's life. For the study participants, wellness is therefore a state of perpetual activity; just as jugglers must move constantly to reach the next baton or risk dropping it, wellness-seekers' goal is always just beyond their grasp as they try to balance the different, often

competing domains of wellness. All participants felt that they must accept and assume responsibility for trying to achieve that balance, even if it remains elusive.

A second and related trend in participants' understandings of wellness is that it is a state of functionality, of being able to succeed despite the demands of hectic, stressful lives. One participant, for example, described wellness as being "able to get through a day and . . . be able to endure stresses physically or mentally" (E7), whereas another characterized it similarly as "a state in which the body can manage daily existence" (W8). In all participants' responses, *wellness* signified above all the ability to maintain and enhance productivity, with each person "optimized" for their "particular range [of] functionality" (W5). Notably, the participants' overall emphases on responsibility and productivity in their definitions of wellness reflect a particular ideological position that seemed to escape most participants' notice; I return to this point in the conclusion.

How would you compare wellness to health?

Participants found this question almost as difficult to answer as the previous one, although several key threads emerged in their responses. First, they felt strongly that the concept of health focuses solely on the physical body, whereas wellness is holistic, focused on the "whole entire person" (E8), as one participant put it. Another similarly responded that "wellness is . . . a holistic well-being" that balances different aspects of a person's life, including "emotional and psychological and bodily" factors (W9). Some participants saw physical health as a prerequisite for wellness, while others saw the two concepts as related but distinct. One person, for instance, explained that, in her view, one could be physically healthy but still not well: "Wellness . . . encompasses everything. Mind. Body. Soul. Spirit. Everything. So if one part of you is not functioning well, then I would say maybe your wellness is not a hundred percent. Even though your physical being—you know, you might be feeling physically okay" (E3).

For many participants, this distinction between wellness and health runs both ways: just as a person could be physically healthy while not well overall, one could be physically ill but still essentially well. Individuals with chronic illness or cancer, for example, may be able to balance their physical illness with their psychological, social, and spiritual health to feel holistically well.

The second trend in distinctions between wellness and health is that participants generally saw wellness as an *active* state, pursued deliberately and strategically. For one participant, "wellness means that you've taken your health into consideration and *you're looking to be a better or healthier person* in some shape or form in your life" (W10; emphasis added). Overwhelmingly, participants felt that although doctors may provide an impetus for improving health, only individuals can assess and advance their own wellness. Further, they saw it as the individual's responsibility, rather than the state's, to advance wellness, which is fulfilled through consumer choice (e.g., buying natural health products or visiting alternative health practitioners such as naturopaths), diet and exercise, spiritual/religious belief, and other means.

The third trend in participants' understandings of wellness vis-à-vis health is that wellness is *self-reflexive*, a state of self-perception and interpretation rather than something external that can be observed or measured. For example, one person considered health as "more biological, . . . like pathogens or like diseases, but wellness is your state, like *how you view yourself*" (E8; emphasis added). Another described wellness as "a sort of harmony between your mind and body and soul, and sort of *in relation to your expectations and reality in life*" (W3; emphasis added). Some participants tied this difference between wellness and health to different health professions, arguing that medical doctors consider only physical health, such as the "mechanical or chemical aspect" of heart function (W5), whereas other practitioners such as naturopaths are concerned with a person's overall state. In sum, participants saw wellness as distinct from health, existing outside of mainstream medicine, concerned with the whole person (not just the body), and something that individuals must monitor and actively maintain for themselves.

How would you compare wellness to illness?

Participants evinced a much stronger sense of what wellness is, and is not, when considering it in relation to illness. For instance, after describing wellness as more of a feeling than a reality, one participant laughed and said "I guess I have a more clearly defined idea of illness than I do of wellness" (W4). Overall, the two most prevalent responses to this question were that *wellness is the absence or opposite of illness* and that *wellness exists on a continuum with illness*. Both responses rest on an essentially spatial relationship between

wellness and illness wherein, as a participant put it, "one's over here and the other one's over here" (W10).

Whether participants viewed wellness and illness as "polar opposites" (W7) or on a spectrum, they generally viewed the concepts as operating in tension with one another where the lower the value of one, the higher the value of the other. One person described this tension in terms of a see-saw type action: "if you're lower on the wellness [scale], you don't really take care of yourself too much, then illness would be higher" and vice versa (E9). Another participant considered all three terms—wellness, health, and illness—in direct relation to each other: "I think about illness anchoring one end of the spectrum, and then health at 50%, and then wellness at a 100% on the other end of the spectrum. Illness is a state of things not working properly, whether that's cognitively, emotionally, or physically" (E2). In this example, wellness and illness sit on a spectrum with the definite boundaries of zero at one end—presumably the most ill a person could be—and 100 at the other end—a sort of "maximal wellness." Other participants similarly described wellness as a kind of math problem where the goal is to remain as close as possible to 100, with any value below that requiring intervention. In this impulse to quantify wellness, there are traces of biomedical emphases on numeracy and measurement that sit at odds with the principles of holism and balance central to most understandings of wellness. More significantly, this idea of striving for maximal wellness, of being "at one hundred percent" as another participant put it (E3), is pivotal to the rest of my argument: all participants were aware that reaching a maximum value on the wellness scale is a perpetually tantalizing prospect, always just out of reach, and yet they felt compelled to reach for it all the same.

This seems to be the defining characteristic of wellness discourse, that wellness is an "ideal type," as one participant explained it, "not something that's actually in existence or something that's achievable but rather something that you can compare your current situation to" (W8). Another described wellness using a metaphor of a gas gauge on a car: "it would be nice to have it completely full" but the wellness tank requires constant refilling because we get sick, we get run down, and we do not always get sufficient nutrition (W1). In both of these examples, wellness is an aspirational state that prompts constant activity even to maintain the status quo, regardless of where one falls on the wellness spectrum. There is a parallel

here with broader cultural redefinitions of health as a risk-state (Armstrong, 1995; Dumit, 2012; Rose, 2007; Scott, 2003, 2006), where even the healthy are reframed as merely healthy-for-now in the face of elevated disease risk (real or perceived) and expanded diagnostic screening programs that, for all their many positive effects, transform the healthy into the ill.

Ultimately, for this study's participants, wellness is thus not a state to be enjoyed but one to be vigilantly observed and maintained—it is fundamentally precarious, requiring continuous recalibration and intervention. And so, consider again the multidimensional nature of wellness as participants initially defined it: "Wellness encompasses everything: mind, body, soul, spirit. And everything. So if one part of you is not functioning well, then I would say maybe your wellness is not 100%" (E3). Given the low odds of someone successfully and sustainably balancing all of these factors (mind, body, soul, spirit), and given that attaining 100% wellness depends on achieving that unlikely balance, then there is virtually always something else the wellness-seeker could or should be doing for their health. This may be one of the reasons participants found wellness difficult to define: as an ideal state rather than a lived reality, wellness is never quite experienced first-hand. Further, this state of perpetual seeking is a defining component of "good" citizenship under the neoliberal logic of self-care (Cederström & Spicer, 2015; Elliott, 2003; Petersen & Bunton, eds., 1997; Spoel, Harris, & Henwood, 2012), sponsoring a set of rhetorical conditions within which that discourse can self-generate and grow.

The Logics of Wellness

In the previous section, I analyzed participants' understandings of wellness as an abstract concept; here, I examine wellness as it manifests in specific situations, namely how participants describe the natural health products they use, why and how they use them, and how they determine the products' effectiveness. I show that the language of wellness draws on the argumentative resources of two seemingly contradictory and yet mutually reinforcing logics, a pharmaceutical-centric model of illness (the logic of restoration) and a natural health-centric model of wellness (the logic of enhancement). In the interviews, these two logics operated on a loop wherein participants slipped seamlessly, and seemingly unknowingly, from one logic to the other. I begin this section with the logic of restoration, then consider its apparent

opposite, enhancement, and close by showing how the logics are intertwined in the language of wellness and how they reinforce each other in a spiraling fashion.

The Logic of Restoration

Although the concept of wellness is generally conceived as the absence or opposite of illness, centered on enhancement and optimization of the self, participants' descriptions of their own specific wellness behaviors were modeled largely on a model of illness—one that centered instead on dysregulation and dysfunction. In the logic of restoration, the goal of using a natural health product is therefore to return the body, temporarily or permanently impaired, to a perceived prior state of functionality. In explaining the NHPs they use and why, for instance, participants described something going wrong in the body that requires external intervention:

> Instead of Polysporin for a cut, I have natural papaya stuff that I use. (E2)
> If I have pain, need pain relief, I use Arnica. (W6)
> If I get a yeast infection, I don't go out and buy Canesten. I'll use boric acid. (W6)
> [For colds, I use] oil of oregano tincture, which is supposed to be antiviral and antifungal. (W1)
> I take [colloidal] silver . . . to rinse my mouth because it kills bacteria. (E7)
> I had a bladder infection, or a UTI, once and I took cranberry pills for a little while. (E2)

In the first example, the body has been breached by a cut and needs to be protected with an external product. In the remaining examples, the body is figured in an aberrant state of pain or infection that requires external remedy to return it to its former, functional state. In the final example, the participant's self-interjection is particularly noteworthy: in an appositive set off in the text by commas, she reframes the colloquial "bladder infection" in medical terms as a specific diagnostic category, UTI, or urinary tract infection. This act of translation between everyday and specialized medical language illustrates how biomedical ways of thinking and speaking have been imprinted on this individual's everyday experience of her body.

In the logic of restoration, NHPs are figured as roughly coequivalent with biomedical interventions, although participants viewed NHPs as more natural and safer. The participant who described taking boric acid for a yeast infection, for example, said she preferred that treatment over commercial preparations because, in her view, both are equally effective but a commercial product such as Canesten is "messy, it's gross and it's not natural" (W6). This participant explained that she prefers not to use pharmaceuticals, generally, because "I think there's just more chemicals in them. There's more side effects. They're more harsh. It's just, the chemical components of them. I'd rather take something that's plant-based, natural, rather than made in, like, a science lab" (W6). Another participant described her preference for white willow bark over ibuprofen in similar terms: "Advil's . . . an extract of white willow bark made in a lab with other ingredients, whereas white willow bark is just the pain reliever that Advil's from. So, quite a difference in two products" (W10). In both of these examples, natural health serves as a proxy for biomedicine, a one-to-one replacement for interventions that participants perceive as necessary but unnatural. In this perspective, participants see NHPs as essential for restoring the body, using them in place of biomedical pharmaceuticals with fewer perceived risks.

There was a certain irony to participants' beliefs about natural health products because, although they saw those products as freeing them of unnatural and potentially dangerous effects of pharmaceuticals in an illness-centric culture of biomedicine, the logic of restoration that undergirds their beliefs is based squarely in that same culture. This logic figures the body as always at the edge of illness or failure and in need of external intervention to maintain function (Conrad, 1994, 2007; Dumit, 2012; Rose, 2007). That is, wellness-oriented behaviors such as taking natural health products rely, paradoxically, on processes of surveillance and intervention that resemble those of the illness model they are meant partially to displace (Derkatch, 2012). Although NHPs are viewed as freeing individuals from pharmaceuticals, they appear to shift dependence laterally from one type of external health intervention to another.

Furthermore, within the logic of restoration, even risk of illness requires remedy. In keeping with broader shifts toward the medicalization of risk (Armstrong, 1995; Belling, 2012; Cheek & Porter, 1997; Conrad, 2007; Dumit, 2012; Lowenberg & Davis, 1994; Lupton, 2012; Moynihan & Cassels, 2005; Rose, 2007), wellness discourse pivots on a potential for illness that, like illness itself, needs to be surveilled and managed. For example,

participants reported taking NHPs to treat perceived risks, including kelp to prevent thyroid problems (E3), nettle tea to prevent liver problems (W1), and oil of oregano to prevent public transit-acquired infections such as colds (E6). Additionally, participants viewed natural health products as a form of "harm reduction" (Nichter & Thompson, 2006), a means of decreasing risk in a world they perceive as increasingly toxic and harmful for health. For instance, one participant attributed recent rises of public interest in natural health products to "the growing number of health problems . . . that people are having and especially in this more stressful urban environment. People need ways to deal with this stress and the impact it has on your body" (E10). For the participants of this study, risk caused by stress and urbanization itself becomes a symptom that warrants treatment as though it were an illness.

The Logic of Enhancement

Of the two logics of wellness, the logic of enhancement is by far the most rhetorically present in public discourse. Perelman and Olbrechts-Tyteca (1969) define rhetorical presence as the art of making immediately felt or perceived, "by verbal magic alone, what is actually absent" (p. 117). Presence renders a particular perspective over others "foremost in our minds and important to us" (Perelman, 1982, p. 36). As I illustrated in the previous section on the meanings of wellness, the participants in this study primarily defined wellness under this logic, premised on positive valences of health and well-being that figure NHP-users as empowered and responsible health consumers rather than ill patients in need of care. In this perspective, NHPs are a means of optimizing one's bodily systems and processes in a value-added way to become essentially "better than well" (Elliott, 2003). As one participant said, for example, "I think [wellness is] an all-encompassing holistic approach to *being the best you can be in all aspects of your life*" (W10; emphasis added).

The rhetorics of self-governance, self-improvement, and responsibility inherent in the logic of enhancement resonate with similar rhetorics at work in contemporary culture at large (Cederström & Spicer, 2015; Conrad, 1994, 2007; Elliott, 2003; Hyde, 2010; Petersen & Bunton, eds., 1997; Spoel, Harris, & Henwood, 2012), where individuals are implored, often in the imperative mood, to become the best possible versions of themselves. Such imperatives are playfully manifest in the title of Weston Kosova and

Pat Wingert's 2009 *Newsweek* critique of wellness advice on the television show *Oprah*: "Live Your Best Life Ever! Wish Away Cancer! Get A Lunchtime Face-Lift! Eradicate Autism! Turn Back The Clock! Thin Your Thighs! Cure Menopause! Harness Positive Energy! Erase Wrinkles! Banish Obesity! Live Your Best Life Ever!"

In the present study, participants invoked the logic of enhancement by using positively charged language that promotes a sense of activity, engagement, and empowerment. This language was most prevalent in the first half of the interviews, when participants reflected on the general meanings of wellness, but it also occurred in their descriptions of their own wellness activities (italics added for emphasis):

> [I use] Biosil, which is a *collagen builder* for hair skin and nails. Which is really amazing, by the way. (E1)
> Vitamin C has a *boost on my mental health*. Somehow the NAC [N-Acetyl Cysteine] has a *boost on the mental health*. (E5)
> [For] seasonal change, I always take *immune boosting* herbs. . . . Because if your immune system's strong, generally everything's okay. (E1)
> There's herbal tinctures which I take and have found helpful . . . in terms of *stimulating the immune system*. (W8)
> Bell [Lifestyle] Products . . . have this cell stimulator that is said to help *rejuvenate* your cells, so periodically . . . I will take that. It *stimulates your cells* and *builds the red blood cells*. (E3)
> The Omega[-3 oil] I take because I want to *feed my brain*. (E9)

In these examples, participants describe NHPs as enhancing health rather than treating illness—"boosting" the immune system or mood, say, rather than treating a cold or depression. They describe the products' effects using vibrant, punchy terms such as "boosts," "builds," "rejuvenates," and "stimulates," which convey spirited and bountiful activity. These emphases on enhancing function rather than treating dysfunction can be traced at least partly to Canadian and U.S. legislation that limits NHP manufacturers to making claims about their products relative only to the structure or function of the body (e.g., "supports immune health"), but not to disease symptoms or treatment (e.g., "prevents/treats influenza"; see Derkatch, 2012, p. 3).

Many participants also praised NHPs for fostering attributes that are presumably more valuable in higher quantities, such as collagen (E1), energy

(E7), "good" bacteria (E2, E7), immunity (E1, E3, E6, W8), and oxygen in the blood (E7). In the logic of enhancement, if having a little additional energy or oxygen is good, more is even better. Here, the ceiling of wellness moves still higher, further beyond reach, because under the organizing principle of optimization, there is always room to improve our energy levels, cognition, digestion, mood, physical strength, immunity, bone health, heart function, and so on; if nothing else, we will always be progressively aging. And so, although the logic of enhancement promotes a sense of agency among users of natural health products by appearing to liberate them from medicine, doctors, the pharmaceutical industry, and commercial enterprise, ultimately this logic circles back in on itself, tangled inextricably with the illness-oriented logic of restoration.

The Two Logics Intertwined

As in the examples above, the study participants invoked the two logics of wellness separately at different points in the interviews, moving fluidly between them over the course of the discussion. But these logics were also frequently intertwined in a single response. Individuals who at first described their use of natural health products in positive terms of balance, action, and surplus, often slipped, almost imperceptibly, into negative terms—of imbalance, reaction, and deficiency. While praising NHPs for addressing the root causes of health problems to prevent illness before it can occur, these participants described their own experience of using these products in terms of illness treatment and symptom relief. What was most striking about the two logics of wellness, therefore, is that they often operated in the interviews on a loop or circuit: when participants depleted the resources of one logic, they shifted seamlessly into the other.

The following example illustrates how the logics of restoration and enhancement circle back in on each other. When I asked one participant about the NHPs she uses occasionally and what she uses them for, she began with this explanation:

> I found out about this product called Bell [Lifestyle] Product, I don't know if you've ever heard of it? Bell Product. And I found this in the *Vitality* magazine and they have . . . this cell stimulator that is said to help rejuvenate your cells and all of that so, periodically, I will say, "Okay, I'm going to buy and maybe take [it] for

> three months and stop." And then, you know, maybe another time. So, periodically, I will take that. That stimulates your cells and builds the red blood cells and things like that. (E3)

In her response, the participant has drawn on the logic of enhancement by using positively inflected verbs such as "stimulate," "rejuvenate," and "build." In her view, the product helps optimize her red blood cells to strengthen her body and even renew it. As she continued speaking, however, this participant shifted into an idiom of illness when she explained how she decides whether to take the product: "Well, [I decide] based on the instructions. But if, say, for example, my iron is low or something, say if I go to the doctor [and the doctor says], 'Well, the iron is low. You need to build it up.' Because a lot of vegetarians, their iron tends to be low. . . . Then if [the doctor] says it's not at a critical stage, then I'll go and get the Bell Product" (E3). Here, what she at first framed as a positive wellness activity (taking the product to optimize her red blood cells) moves instead into a framework of dysfunction and deficiency as a treatment for low iron or anemia, an illness claim. She explains that she decides whether to take the product based on her doctor's advice, following a medical-diagnostic procedure (a blood test). And yet, as this participant continued, she clarified that her decisions are not based solely on medical advice:

> If I wanted to really build [blood iron levels] at a faster rate, if the instructions says [to] take one in the morning and one in the afternoon, I may decide, "You know what? I will take two and two." Because I know it wouldn't do me any [harm] but it will maybe get the process going faster. So if it's just for ongoing maintenance, I'll take [dosage recommended in] the instructions, one or two times a day. . . . It depends on the situation. (E3)

By this point in her response, the participant has cycled several times between the logics, returning now to enhancement by describing her efforts not only to regain lost levels of iron but to build up a reserve by taking more than the recommended dose (since more is better in the logic of enhancement).

While participants often alternated between the two logics of wellness in a single response (as in the previous example), sometimes both logics were overlaid in a single statement. For instance, one person reported: "I'm

taking Ashwagandha, which is an Ayurvedic herb to help tonify your kidneys and adrenal glands from stress" (E1). Here the goal of taking the product is to tone her organs—a wellness claim that refers to making more energy available to them—but she explains that the need to do so is a consequence of stress, which is an illness claim based on the need to compensate for heightened cortisol production in the adrenal glands. Similarly, another participant explained his reasons for taking a turmeric supplement: "It's supposed to calm down any inflammation or be good for your liver and your general circulation and the whole body, . . . [to] stimulate the immune system, help fight fatigue" (E7). He reported that he chooses to take the supplement "when I feel a lot of fatigue, run down. And when I feel better . . . or when I kind of feel a return to my energy, I stop taking it" (E7). In this example, the participant draws on both logics of wellness simultaneously, blending illness-oriented symptoms of inflammation and fatigue with wellness-oriented structure-function claims of supporting circulation, immunity, and liver function.

To summarize my analysis thus far, participants moved fluidly in the interviews between the seemingly opposing logics of illness and wellness, of restoration and enhancement, each of which cast "wellness" in a different light. Although most asserted strongly at first that wellness and natural health occupy a realm distinct from illness and biomedicine, they often described their own wellness beliefs and behaviors using a language of symptom surveillance and intervention that seems drawn directly from biomedicine itself. For example, interviewees spoke about monitoring states such as immunity, mood, alertness, and aging, much as one would illness-predictive factors such as blood pressure and cholesterol, and treating those states if they fall below a certain perceived threshold of performance. In returning to the question "why does wellness sell?," I explain next how, in promising to do two opposing things at once—restore us to former states of health, and enhance us so that we can be better than we already are—the language of wellness contains within itself the resources for its own self-perpetuation.

Autopoiesis in the Language of Wellness

Over the course of this article, I have illustrated that the concept of "wellness" is mercurial, taking on different, sometimes conflicting significations

while maintaining and accruing cultural and rhetorical significance as a health state worthy of aspiration. I suggest here that this mercurial movement between meanings, between the logics of restoration and enhancement, in fact propels discourse about supplements and natural health. I use the word "propel" deliberately here to note a strong momentum between these logics because the threshold for wellness is ever-receding, always just over the horizon. The rhetorical power of the language of wellness lies in its ability to move fluidly, and invisibly, between seemingly contradictory and yet mutually reinforcing positions. The tension produced in this movement between positions furnishes wellness discourse with the ability to spiral and grow, generating rhetorical force as it simultaneously produces and draws upon its cultural significance.

Lisa Keränen's (2010) investigation of autopoiesis, or self-generation, in rhetorics of terror preparedness and viral apocalypse offers a model for illustrating how some forms of discourse become essentially self-generating rhetorical systems. In the case of bioterrorism, Keränen argues, "the biodefense industry selects information from the larger environment and interprets it in ways that reproduce the biodefense system" (p. 83) by exploiting perceived levels of risk to promote terror preparedness. As bioterror defense infrastructure is enhanced and expanded, public perceptions of risk rise correspondingly, which fuels further security measures and then further heightened perceived risk, resulting in an essentially self-generating rhetorical system that continually expands the value of and market for biosecurity measures.

The concept of risk similarly undergirds the language of wellness, particularly in the logic of restoration where, as the study's interview participants indicated, even risk of illness becomes a "symptom" that warrants treatment. Anthropologist Joseph Dumit (2012) sums up the contemporary impulse to manage illness risk in *Drugs for Life*: "the more we know [about our health and health risks], the more we fear; and the more we fear, the more preventative actions and medications we need to take" (p. 2)." In rhetoric, J. Blake Scott (2006) similarly illustrates that, in the realm of health, discourses of risk proliferate because "even reflexive efforts to contain or control risk often end up increasing it and causing it to spin further out of control" (p. 131). Within this cultural matrix that valorizes risk-avoidance, individuals faced with the belief that they are at increased risk of illness may, in turn, seek ever elusive, ever more qualified, interpretations

of wellness. This is one reason why maximal wellness, or 100% on the wellness gauge, is persistently out of reach—there are always more symptoms of wellness we can track and more health products we can take. Reconstituted as a risk-state that must be surveilled and managed, wellness has thus become, in effect, an "incipient illness" (Derkatch, 2012), a "sickness" (Hanson, 2017), a "syndrome" (Cederström & Spicer, 2015), or even an "epidemic" (Larocca, 2017).

But the concept of risk tells only part of the story about how the language of wellness self-generates and grows: while *risk* (of illness) is a central driver of biomedical discourse and its associated institutional, regulatory, and commercial rhetorics, my analysis indicates that its effects are amplified when paired with its seeming opposite—optimization (of health). This is the core principle that underlies the logic of enhancement, where being "well" is not an endpoint or mode of being, but a state of constant, self-reflexive activity. One does not simply find wellness and stay there; as illustrated earlier in this article, wellness is a process of self-perception and interpretation that calls upon individuals to continually assess and adjust their performance across different domains. In the logic of enhancement, there is always room to improve, and so failure to optimize constitutes a type of risk.

Thus, wellness is, to an extent, both a part and a product of a culture of overtreatment, an environment in which diagnostic categories expand to include not just illness but "pre-illness" (Armstrong, 1995, p. 401) and individuals seek sometimes unnecessary and potentially dangerous health interventions (Brownlee, 2007; Hadler, 2012; Moynihan & Cassels, 2005; Welch, Schwartzl, & Woloshin, 2011). Furthermore, within this culture, wellness becomes the duty of the responsible health citizen, whether through direct remedy (i.e., acts of restoration) or through protective intervention (i.e., acts of enhancement). For example, as participants in this study cycled between the logics of restoration and enhancement, their beliefs that they should be continuously alert to and engaged in their wellness were correspondingly reinforced and strengthened. Consider again, for instance, the participant who reported taking a certain product for her iron levels (E3). Her decision to take the product was driven by two impulses at once: to raise her depleted iron levels to a healthy level (a restoration claim) and to "stimulate" and "build" her blood cells "for ongoing maintenance" (an enhancement claim). In this example, the two logics cycle into each other in

a spiraling fashion that figures the product as the only appropriate choice, whether is used as a remedy for low blood iron or for ongoing cell "maintenance." In wellness discourse, taking action is always the right answer. In this sense, although the concept of wellness seems to empower individuals by offering independence from an illness-oriented biomedical model, contemporary understandings of wellness seem, instead, largely to expand the ways in which we can be ill (or pre-ill) and the forms of intervention we require. Consequently, the idea of wellness may do as much to create medical patients as it does to liberate them.

Conclusion

The concept of autopoiesis is generative for the present study because it helps to articulate how patterns of discourse are reinforced and reproduced not merely at the level of individual rhetors but, more significantly, through systems-level discursive activity. Inflected within the study participants' personal beliefs about wellness are higher-level institutional, regulatory, and commercial-industrial rhetorics that come particularly from biomedicine but also from various alternative health modalities, the pharmaceutical and supplement industries, and a press that relies on anxious consumers seeking the latest tips on how to live their "best life ever." These related rhetorics, which I have not had space to examine here but are critical for future inquiry, are both the source and result of dramatic rises in pharmaceutical consumption and the increasing health anxiety that attends those rises, driven by the goal of maximizing risk (Armstrong, 1995; Conrad, 2007; Dumit, 2012; Moynihan & Cassels, 2005; Rose, 2007). When this risk discourse is paired with neoliberal civic and moral imperatives to optimizatize the body, mind, and self (Cederström & Spicer, 2015; Elliott, 2003; Petersen & Bunton, 1997; Spoel, Harris, & Henwood, 2012), the language of wellness takes on a rhetorical force that becomes both overwhelming and yet difficult to discern.

Viewing wellness as an autopoietic rhetoric can shift our focus beyond individual, intentional agents of persuasion to the powerful ability of organizational and institutional discourse, such as medical-pharmaceutical rhetoric, to shape human life in ways we may not immediately recognize. Further, it allows us to examine how interest in wellness may in part be an expression of broader public concerns about health and healthcare that are

not addressed by doctors, public health agencies, or legislators as we collectively work longer hours, get less sleep, live under increasing financial strain, and spend much of our lives sitting (mostly in front of screens), all in the name of productivity. It should be no surprise that people would be attracted to the idea of taking charge of their health through wellness at precisely the same cultural moment when we have shrinking institutional and structural supports for our ever-failing bodies.

Wellness and natural health offer to circumvent or short-circuit shortcomings of contemporary biomedicine, such as overdiagnosis, overtreatment, and industry involvement in and manipulation of health research and health outcomes; this is at least partly explains why wellness sells. And yet, as a self-perpetuating symbolic system, the language of wellness may not provide a way to opt out of the mainstream medical illness model as much as reinforce that model's central logics and modes of action within a new rhetorical arena, in this case one that has essentially no ceiling. This article illustrates how the intertwining of the two logics of wellness performs a rhetorical sleight-of-hand by embodying, seemingly invisibly, the very values it appears to disavow. As bioethicist Carl Elliott (2003) observes, although (North) Americans "are deeply attracted to the image of the individual throwing off the oppressive limitations imposed by others," the "irony of this particular sales pitch is that it uses deeply held cultural values in order to sell the idea to the individual transcending his or her culture" (p. 113). As both a proxy for and an apparent alternative to the pharmaceutical-illness model, wellness therefore promises to do everything at once.

If one of the central tasks of the rhetorical-cultural critic is to "intervene in problematic practices . . . and harmful effects" at the interface between medicine and culture (Scott, 2003, p. 21), then this study helps illustrate how the contemporary notion of wellness may lock individuals into the same patterns of thinking and acting that they seek to escape, where the notion of wellness may not help and could potentially harm. While the participants in this study are by all measures "good" health citizens, engaging with their health proactively and preventatively, their actual agency within this framework may be more limited than they perceive. As individuals increasingly turn toward health practices they believe to be more empowering, natural, and safe than mainstream medicine, rhetoricians of health and medicine have the opportunity to intervene by illuminating the forms, functions, and effects of discursive phenomena that, by their very nature, are difficult to perceive and yet are fundamentally world-forming.

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