A Sociological Investigation of Trust in Complementary and Alternative Medicine Use

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B.Ed.(Hum.); M.A.(Comm. & Cultural Studies)

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Doctor of Philosophy

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Statement of Originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying subject to the provisions of the Copyright Act 1968.

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Dated 21/09/2012
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Abstract

Complementary and alternative medicine (CAM) comprises of a number of clinically and theoretically distinct therapies and practices, many becoming increasingly incorporated into the health care regimens of Australians. The lack of trust in biomedical practices is seemingly contradicted by evidence including from my study, that CAM and biomedical treatments are used concurrently. Despite real concerns over health risk form the adverse effects of pharmaceutical medications the CAM users interviewed for this study, with one exception, have continued using biomedical treatments. Interestingly, the CAM users in my study also express uncertainty in the practices of CAM and establish boundaries over what is acceptable and unacceptable use. For these users, there are clearly tensions between CAM and biomedicine and the interest is how they work with this tension in their everyday lives. To explore this tension, the theoretical underpinnings of the study draw on the sociology of trust.

The research method of constructivist grounded theory is used to produce an interpretative social constructionist account of trust in CAM use. The analysis is based on the accounts of 16 regular CAM users, selected on the basis of being frequent, intensive users of CAM. The interest in this thesis is in exploring the accounts of these users to establish the basis for trust in CAM treatment decision-making. Being self-reliant in their information seeking, desiring a level of self-control and experimental in their use of health treatments the CAM users exemplify Giddens’s concept of a self-reflexive consumer. Utilising the sociological trust theories of Giddens and Luhmann trust is understood to be formed in both interpersonal and institutional contexts. To this end, the central argument of the thesis is that trust is mediated between CAM and biomedical approaches. The thesis argues further that trust is developed through a leap of faith in the practice of CAM, and this represents having faith in the derivative benefits of CAM treatment, rather than faith in CAM as a curative. Trust also arises from interpersonal experiences of health and illness, and from the meanings given to CAM practices. For some the meanings relate to CAM as pleasure and relaxation and as a spiritually embodied experience while for others, in the face of biomedical health risks CAM represents a safety valve. Further, I argue that trust develops according to the context of CAM use; that is, when CAM is used for achieving health outcomes, then trust is mediated between CAM and biomedical approaches, which are used pragmatically, in an ad hoc manner. When CAM is used to experience derivative benefits such as relaxation and feeling good, then trust is based in the construct of faith, and relates to CAM much more in terms of a leisured experience.
Chapter One

Introduction

1.1 Origin and Significance of the Study

One of the notable health paradigm shifts of the twentieth century is a broadening of the definition of health as the removal of disease to an embodied understanding of health as incorporating the mind, body and well-being. This shift is encapsulated in the following definition advanced by the World Health Organization (WHO): ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO, 1946).

Understanding health as a manifestation of an individual’s holistic well-being offers an alternative conception of health to an allopathic, Cartesian understanding of health through a separation of mind and body. Since the World Health Organization advanced the preceding definition of health, a set of assumptions have arisen alongside orthodox biomedical understandings of health which view the attainment of positive health as an individual responsibility. Health in this framework is about individual self-care, self-awareness and control of the inner resources of the body, and maximising one’s health potential becomes ‘a responsible performance in a social script’ (Illich, 1995/1975, p. 195).

The medicalization of those behaviours and practices which can be considered within the self-care and self-awareness ‘movement’ are seen as emblematic of the cultural values and practices of late modernity. As will be shown in this thesis the increasing use of complementary and alternative medicine (CAM) aligns with the growth of this movement, both of which support the ‘cultivation of self’ (Foucault, 1990). There is evidence from several cross-sectional population health surveys of a significant increase globally in CAM use since the early 1990s. In Australia, prevalence surveys reporting CAM use (over the past twelve months at the time of the survey) indicate that anywhere between 52.2 per cent (MacLennan, Myers & Taylor, 2006)¹ and 75 per cent of the Australian adult population (Cardinal Health, 2005; National Prescribing Service, 2008; Xue et al., 2007) are using CAM. The surveys also show a corresponding increase in the use of CAM practitioners (also termed ‘complementary therapists’), with a national survey in

¹ MacLennan’s definition includes over the counter medicines such as vitamins, mineral supplements, soy products, aromatherapy oils, and others, as well as herbal, Chinese and homeopathic medicines. Excluded from the definition of CAM are calcium, iron and vitamins prescribed by a medical practitioner. Although MacLennan’s surveys had been undertaken with an exclusively South Australian population, the findings have been regularly used as a proxy for national prevalence estimates.
2007 reporting that almost two-thirds of CAM users visited a CAM practitioner in the last 12 months (Xue et al., 2007, p. 644). Studies have found the most commonly visited CAM practitioner groups are chiropractors, naturopaths, acupuncturists and bodyworkers (MacLennan et al., 2006; Xue et al., 2007); however, Australians have been rapidly increasing their use of aromatherapy, osteopathy, herbalism and reflexology (Bensoussan et al., 2005; Kermode et al., 1998; Xue et al., 2007).

These prevalence rates are much cited in medical literature and government reports; however, social scientists argue about the difficulty in determining the actual level of use due to conflicting understandings of what CAM is (Zollman & Vickers, 1999, p. 837). As will be shown in section 1.3, there is little uniform understanding of what actually constitutes CAM. For the purposes of this thesis, the term ‘CAM’ is used to designate both complementary and alternative medicines and therapies. This nomenclature is consistent with the dominant formulation in social science literature in which CAM references both medicines and therapies with a non-biomedical orientation, or what Coulter and Willis (2004, p. 587) observe as:

the diversity of practices included under the rubric of CAM…range from very focused therapies such as reflexology to whole medical systems such as Ayurvedic medicine and traditional Chinese medicine.

Despite international differences in the conceptualisation and constitution of CAM, there is a global trend in post-industrial societies such as Australia, New Zealand, the United States and the United Kingdom toward an increase in CAM use. CAM prevalence surveys are likely to under-represent non-English speaking background groups, and with the popularity of culturally specific forms of CAM such as Traditional Chinese Medicine and Korean hanbang among members of those communities, the full extent of CAM use in Australia is expected to be higher than the levels estimated in population health studies.

Notwithstanding these sources of bias, CAM has clearly become a significant component of the health care regime of many Australians. What has caused this phenomenon? Why do Australians engage with treatments with a non-scientific evidence base? What underlies trust in the use of CAM medicines and therapies? These questions enticed me to undertake a sociological investigation of the underlying reasons for CAM use. The investigation is based on

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2 It should be noted that ways of measuring CAM use differ between jurisdictions, for example, the US derive prevalence estimates based on a definition of CAM which includes ‘prayer for health reasons’ (Barnes & Bloom, 2008). When ‘prayer for health reasons’ is excluded from the definition, CAM prevalence in the US based population is lower, with only 36 per cent of adults using some form of CAM in the last 12 months. Despite the international differences in the conceptualisation of CAM, we can see the trend toward an increase in CAM use is consistent across Australia, the US, the UK and other post-industrial countries.
interviews undertaken in 2004 and 2005 with 16 regular, established CAM users and 10 CAM practitioners. Over time the initial research objective has changed from simply asking why people use CAM to a fuller exploration of the experiences and understandings relating to trust in CAM treatment decision-making. The majority of the social science literature on CAM consistently points to dissatisfaction among CAM users with the outcomes of orthodox biomedicine, so it is reasonable to expect that CAM users cease using biomedical treatments in preference to CAM. Some medical anthropologists (Bakx, 1991, p. 33; Cant & Sharma, 1999, p. 25) theorise that the loss of trust in biomedical approaches reflects the cultural distance from their users. Furthermore, biomedical doctors are seen as negligent for individual users reporting negative experiences, including adverse effects from medications and surgery, and this further exacerbates a perception of being alienated from biomedical processes.

This lack of trust is seemingly contradicted by social science evidence (e.g. Adams et al., 2003; Baarts & Kryger Pedersen, 2009, p. 720), including the present study, showing that CAM and biomedical treatments are used concurrently. Accordingly, in spite of concerns over health risk from the adverse effects of pharmaceutical medications, CAM users interviewed for this study still use biomedicine. Interestingly though, they are also uncertain about some practices in CAM. For these users, there are clearly tensions between CAM and biomedicine use and a focus in this thesis is how they work with this tension in their everyday lives. Furthermore, CAM users in my study are episodic in their CAM use; they have a history of using CAM for certain conditions at specific points in time, using biomedicine at specific points in time for specific conditions, and interpolating the two. They experiment and mix and match CAM and biomedical approaches; thus, they are rarely linear in their treatment use.

To explore these tensions, the theoretical underpinings of the thesis relate to the sociology of trust. Giddens (1991; 1995) and Luhmann (1979; 2000) theorise trust at both the interpersonal and institutional level, and, hence, I will show that the explication of trust in the expert systems of CAM and biomedicine is central to my thesis. Through not knowing the ‘truth’ of the knowledge claims of CAM or biomedical experts, expert knowledge is problematised and CAM users forced to traverse between various institutional health discourses. In response, CAM users in my study are found to regularly research for health information in media and other secondary sources and, combined with empirically derived knowledge from experience, use these sources to form an idiosyncratic understanding of their health, their illness, and their body. In sociological terms, CAM users mediate trust in CAM as well as biomedical approaches.

The growth of CAM is seen as reflecting the consumer culture of late modernity. CAM users are seen as typifying the ‘modern’ health consumer who challenges scientific authority and knowledge claims (Kelner et al., 2003; Saks, 1995; Sharma, 1995; Sirois & Gick, 2002), and is
concerned over health risk (Kelner et al., 2003, p. 25; Saks, 1998, p. 204). CAM affords empowerment to the modern consumer through offering personal participation in health treatment (Ballard & Elston, 2005, p. 228; Saks 1998, p. 204; Siahpush, 2000, p. 161) and autonomy and self-control (Baarts & Kryger Pedersen, 2009, p. 725; Sirois & Gick, 2002, p. 14). The relationships between CAM users and practitioners are complex ones, and there is certainly a ‘client/service provider’ relationship in that the user has choices to consult practitioners, whereas the designation of ‘patient’ ascribes less agency in treatment decision making. CAM users in my study have demonstrated to oscillate between the two ‘roles’, exercising agency in their pursuit of a health regimen which often involves a high degree of self-medication and experimentation with both biomedical and CAM treatments. While demanding participation in the patient-practitioner consultation, they seek varying levels of inclusion in treatment decision-making with many entrusting the practitioner with treatment decisions. In this thesis I use the terms ‘client/patient’ or ‘consumer/patient’ in acknowledgement of this dual role, extending this terminology also to generalised discussion of health service clients/patients, the exception being when the context discussed in literature clearly points to either a patient or client/consumer role.

The research questions concern how CAM users establish boundaries of use around CAM and biomedical treatment decision-making, and what CAM users consider to be legitimate CAM practice. Relating to the central argument that CAM use represents an ongoing process of mediation of trust between CAM and biomedical practices, there is the question of how CAM users assess a treatment as worthwhile and effective, and on what basis do CAM users assume that CAM treatment effects a cure. Related to this are questions concerning trust in expert knowledge of CAM, and the extent to which the CAM encounter influences trust in CAM. Given the prominence of the CAM practitioner as an access point to expert systems of knowledge, questions about trust in the CAM encounter are vital to understanding how a CAM user develops trust in CAM. Of further interest is the mediation of trust between lay and expert knowledge. Given that the literature has suggested an association between gender and the CAM use experience (e.g. Sointu, 2006b) a further question arises regarding the influence of gender, as well as other aspects of social location on trust in CAM.

The interest in this topic, and the research questions arose from my own use of CAM which commenced in the late 1990s through a Sydney-based naturopath, specialising in herbalism and acupuncture. Although she had been highly recommended to me by good friends, I became uncertain about the treatment and the naturopath when, after expending a considerable amount of money, I was in no better condition. I inquired of the naturopath as to how many people presenting with the same condition had been cured, and when she was unable to address my
inquiry I ceased the treatment. On what do CAM users base their certainty that the treatments administered by practitioners (or ‘therapists’) are curative? In other words, what is the basis of their trust in these treatments? A preliminary reading of the literature in this area suggested that no study of CAM was possible without factoring in the concurrent use of biomedical approaches, with the vast majority of CAM users continuing to use biomedical treatments.

Deriving from the above, the central argument in this thesis is that CAM use represents an ongoing process of negotiating and mediating trust between CAM and biomedical practices. This interpretative social constructionist study is based on accounts from in-depth interviews with 16 regular, established CAM users and 10 CAM practitioners. The CAM user accounts are the focus of the study with the CAM practitioner accounts providing context for the user accounts, and ‘setting the scene’. The study methodology is based on the constructivist grounded theory (CGT) method, which uses an interpretative approach to develop a social constructionist account of trust in CAM treatment decision-making. A final point is that trust is becoming increasingly important to health care decision-making. In a climate of increased patient participation in health care decisions, of self-responsibility for health, and the plurality of knowledge claims from CAM and biomedical systems, the choice of treatment is inevitably related to trust and certainty. Although there are a few important sociological studies of trust in conventional health care contexts in Australia (see Myer and Ward, 2009; Myer, Ward, Coveney, & Rogers, 2008), sociological studies of trust in CAM are almost absent from the social science literature on CAM. Hence, the present study provides an important contribution to health sociological knowledge on the development of trust in the use of CAM.

1.2 Scope of the Study

The interest in the thesis is in the experiences and understandings of CAM from the perspective of regular users. When I commenced the research, there was little in the sociological literature exploring the socially constructed experiences and understandings of CAM use. Prior to 1975, sociologists who studied CAM viewed it as ‘unlegitimated knowledge, deviant sects or cults’ (Sharma, 1996, p. 231). However, recent studies show that CAM is a legitimate form of health care for many people, not just an insignificant fringe, and that the ‘average’ CAM user is likely to be female, middle class, highly educated, aged 35 to 55 years, employed and a high income earner (see Ernst, 2000; Kermode et al., 1998; MacLennan et al., 2006; Sharma, 1996;). The origins of the study lie in a desire to understand how the experiences of ‘regular’ or ‘established’ CAM users construct knowledge of health and wellness which are commensurate with CAM use. Over the last ten years a considerable sociological literature has accrued (e.g. Broom, 2009a, 2009b; Broom & Tovey, 2007; Kristen & Cheryl, 2007; Rayner et al., 2011;
Sointu 2006a, 2006b; Thorpe, 2009), offering a nuanced and sophisticated theoretical lens into the motivations for CAM use.

I initially set out to provide an interpretative account of women’s use of CAM. My interest arose from both sociological and medical studies (e.g. Adams et al., 2003; Adams et al., 2009; Bensoussan et al., 2005; Connor, 2004; Kermode et al., 1998; Xue et al., 2007), showing that approximately 66 to 75 per cent of CAM users are female, as well as Adams et al.’s (2003, p. 298) claim of Australian women using CAM as ‘part of a repertoire of healthcare consumption’. In consideration of the fact that females are over-represented in both CAM and biomedical treatment use, the study scope was broadened to include male users. From this I was able to more thoroughly attend to an association between gender and CAM treatment decision-making.

The terms ‘regular’ and ‘established’ CAM users are used throughout this thesis, the CAM users interviewed for the study all intensive, high-end users. CAM users are not one large homogenous group; instead, their level of engagement with CAM practices varies from first time to committed, regular use. Regular users are defined as those using CAM for longer than five years, and/or using more than one CAM therapy for three to five years at a high frequency — that is, greater than three times each year per therapy— and are differentiated from less regular users through having high levels of health awareness and particularised values orientation (Adams et al., 2009; Furnham & Forey, 1994; Sirois & Gick, 2002). Notably, regular CAM users report more chronic health conditions, musculo-skeletal pain and cardiovascular problems than less regular and non-CAM users (Lewith & Chan, 2002; Sirois & Gick 2002). Although 10 of the users were experiencing chronic health issues, and CAM is known to be favoured by those with chronic illness (Adams, et.al., 2003), all the CAM users in the study also used biomedical approaches. I decided at the outset to focus on the experiences and understandings of a relatively homogenous group, orientated toward the values and dispositions commensurate with a holistic health paradigm such as spiritualism, lifestylism and environmentalism. There are two reasons for focusing on a regular group of users: first, there are very few sociological studies which explore the experiences and understandings of a relatively homogenous group, orientated toward the values and dispositions commensurate with a holistic health paradigm such as spiritualism, lifestylism and environmentalism. There are two reasons for focusing on a regular group of users: first, there are very few sociological studies which explore the experiences and understandings of CAM use among this selected group of users, with existing studies presenting a psychological perspective (Cartwright, 2007; Cartwright & Torr, 2005) or a chronic illness perspective (Broom, 2009a, 2009b). As such a real gap exists in our understanding, from a sociological perspective, of regular CAM users’ experiences and understandings of CAM use. Second, it was important methodologically to be able to work with a group that shared similar values and beliefs, and to be able to explore the differentiations within that group at the same time.

The CAM users in the present study are also representative of ‘middle class’ health consumers, and although they are not necessarily affluent, they possess high levels of ‘cultural capital’
(Bourdieu, 2007) including university credentials and health literacy. To this end, social class and educational attainment is implicated in a high level of engagement with health and medical literature, this in turn affects lay knowledge of health. Furthermore, the study participants personify Crawford’s (1980, p. 366) ’middle-class stamp’ in that they are preoccupied with attaining good health and longevity, and a fit body as indicated by Greenhalgh and Wessely (2004, p. 202). Consumerist values including the expectation of active involvement in health and protection of rights are seen to be replacing paternalism as the dominant model in medical encounters. Consumerism is related to ‘healthism’, a term coined in 1980 by political economist Robert Crawford (1980, p. 368; emphasis in original), who defined healthism as ‘the preoccupation with personal health as a primary-often the primary-focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles, with or without therapeutic help’.

According to Crawford (1980, pp. 366-367), healthism treats individual behaviour, emotions and attitudes as illness symptoms. Solutions to health problems lie within individual choice, and rely heavily on an ideology of personal responsibility for health. According to Greenhalgh and Wessely (2004, p. 201), healthism derives from ‘a general trend in Western society towards reflexivity and self-awareness (the ‘cult of the individual’) leading to expectations of self-fulfilment and heightened consciousness of minor bodily symptoms and deformities’.

The healthism discourse is seen, ironically, as a function of biomedical success in alleviating disease. Furthermore, although the late twentieth century has witnessed unparalleled success in alleviating disease and illness, individuals are reporting decreased satisfaction with their health (Greenhalgh & Wessely, 2004). As Crawford (1980, p. 365, cited in Greenhalgh & Wessely, 2004, p. 210) contends, ‘by elevating health to a super value, a metaphor for all that is good in life, healthism reinforces the privatisation of the struggle for generalised well-being’.

What Crawford proposes is a new ideology. People are less satisfied with their health because they expect to live symptom free, and view their health as a holistic balance of social, psychological and physical selves (Greenhalgh & Wessely, 2004, p. 202). The values embedded in healthism derive from the consumption culture of late modernity (see Giddens, 1995; Bauman, 2007). Since Crawford developed the healthism thesis, a focus on lifestyle and health maintenance has become more entrenched in Western cultural discourse, with a particular focus on the body as a site for individual self-control (Cant & Sharma, 1999, p. 27; Hansen & Easthope, 2007). The ideology of individual responsibility for health is perpetuated as much in self-care and some biomedical discourse as in CAM.
Crawford (1980:366) notes that the ‘middle-class stamp’ is particularly visible in two popular health movements which arose in the late twentieth century, the ‘holistic health’ and ‘self-care’ movements. Some 30 years on, the holistic health movement comprises the diverse range of non-orthodox medical systems and non-allopathic healers of ‘complementary and alternative medicine’, and the ‘self-care’ movement has morphed into self-improvement industries, self-help groups, therapists and, arguably, some CAM providers. Moreover, these movements are situated in political and social contexts. These social processes are seen as emblematic of reflexivity of modernity, in which people are viewed as self-monitoring, or as Giddens (1995, p. 38) puts it, ‘thought and action are constantly refracted back upon one another’ and these reformed constantly in light of new information. The decline of trust in biomedical expertise is seen as linked to reflexive processes, with modern consumers as increasingly knowledgeable, and sceptical about scientific and medical approaches. The decline in trust in biomedicine is also shown to form part of the reason for the increasing popularity of CAM (Saks 1999; McClean and Shaw 2005). Biomedicine has traditionally disregarded the lay meaning of health and illness, and ‘biomedical knowledge reflects a society that valorises specialised and systematized knowledge systems; indeed, doctors become socialised into valuing expertise and the subsequent objectification of disease’ (McClean & Shaw, 2005, p. 733).

More recently, the position has shifted, and rapid transformations and changes within biomedical systems, and their related understandings, have taken place. The neoliberal agenda and practices which have come to prominence in the last twenty years have been formulated in government health policies which require patients to take responsibility for their health; to be active participants in self-care and to have acquired knowledge and responsibility for their illness (McClean & Shaw, 2005, p. 733). Multi-disciplinary medical teams include professionals from areas such as social work, and these people are often likely to consider wider social determinants of health. Such changes have produced a medical culture of ‘shared decision making’ (Bury, 2005, p. 5) and ‘patient empowerment’. There has also been a noticeable rise in the communication work of healthcare professionals (Iedema, 2007, p. 7). The growing ‘integrative medicine’ movement is lending more weight to a holistic health paradigm. Integrative medicine has seen CAM practices integrated with biomedicine in specialised clinics, and the rhetoric suggests a more ‘knowledgeable’ consumer/patient. These changes have fuelled a debate as to whether CAM knowledge will eventually be subsumed by biomedical knowledge, or whether biomedicine further embraces holistic health knowledge. The next section turns to the meanings of CAM from both sociological and popular perspectives, advancing an argument that CAM needs to be viewed as a variegated set of disciplines and practices, and that CAM groups should be differentiated by their knowledge and philosophical bases.
1.3 The Meanings of ‘Complementary and Alternative Medicine (CAM)’

CAM users and practitioners interviewed for this study have shared a common understanding of CAM as representing a group of practices derived from both culturally specific traditions such as Traditional Chinese medicine (TCM) and from non-scientific origins in Western traditions. In this thesis I take the position that CAM does not present a uniform, homogeneous entity, but instead a number of epistemologically and ontologically distinct disciplines. The statutory definition of CAM is important as it informs, and makes contributions to, the public discourse on CAM. However, at a statutory level CAM has proved difficult to define, partly due to differing understandings of what actually constitutes, and comprises, CAM. For instance, some researchers classify meditation, prayer, minerals and vitamins as CAM, and others do not. Furthermore, there are concerns about the adequacy of the current statutory definition of CAM. Section 1.4.2 discusses the sociological meaning of CAM, from which a classification of CAM systems and practices for analysing the accounts of CAM users and practitioners is developed in this study. From the outset it is important to note two things: Firstly, that the term CAM is a very convenient label for a large number of fairly disparate systems and practices; and, secondly, that CAM is a fluid and dynamic construct, and its meaning changes in response to social and political processes.

1.3.1 Statutory definition(s) of CAM

After the Pan Pharmaceutical event3 in 2003, the Australian Federal government commissioned an inquiry into the scope and nature of the CAM industry in Australia. The inquiry was led by an expert committee and in 2003 the committee released the influential report Complementary medicine in the Australian health system: Report to the Parliamentary Secretary to the Minister for Health and Ageing (Expert Committee on Complementary Medicines in the Health System, 2003). The report contains over 100 recommendations in relation to the provision of CAM in Australia. In line with the Federal Government’s quality use of medicine strategy, I was briefly involved in the process of implementing several of the expert committee recommendations regarding information and labelling of over the counter herbal medicines and health products. My involvement in this process revealed that biomedical professionals are concerned about the use of CAM with a non-scientific evidence base, and are especially concerned about the potential for adverse effects of combining CAM and compound pharmaceutical medicines use.

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3 Pan Pharmaceuticals’ Ltd. is an Australian pharmaceutical and health product manufacturer. Resulting from an investigation into quality control issues in manufacturing, on the 29th April 2003 the Therapeutic Goods Administration (TGA), Australia’s national regulator for medicines and other therapeutic goods, issued a class 1 recall of 1,369 products manufactured by Pan Pharmaceuticals Ltd. This involved mostly vitamins, minerals and herbal products, of which PAN supplied to over 75 per cent of the natural medicines market, and is alleged to have been the largest recall of natural health products in the world (Toms, 2003).
The report of the Expert Committee on Complementary Medicines in the Health System (2003, p. 44) represents CAM in the following way:

The diverse group of health-related therapies and disciplines which are not considered to be a part of mainstream medical care. It further advises that CAM embraces those therapies which may either be provided alongside conventional medicine (complementary) or which may, in the view of their practitioners, act as a substitute for it. The Cochrane Collaboration further describes CAMs as: “a broad domain of healing resources that encompasses all health system, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period”.

This statutory definition of CAM has been widely adopted by the Federal Government in delivering national health policy and is useful for classifying schemas used in national policy; however, it is also seen by social scientists (e.g. Bishop & Lewith, 2010; Coulter & Willis, 2007) as inadequate for understanding what CAM actually is. The considerable debate concerning the constitution and exemplification of CAM practices (Broom & Tovey, 2007, p. 1024; Coulter & Willis, 2004) lends support to the argument that a singular definition of CAM is inadequate for defining the heterogeneous mixture of CAM practices (Kaptchuk & Eisenberg, 2001, cited in Spence & Ribeaux, 2004, p. 118).

1.3.2 The sociological meaning of CAM

Early literature located CAM practices as being firmly outside of the mainstream healthcare system, as comprising ‘alternative’, fringe practices. Since the 1990s there has been widespread sociological support for viewing non-biomedical practices as ‘complementary’ rather than ‘alternative’ (e.g. Willis, 1994), the term ‘complementary and alternative medicine’ (CAM) becoming commonly used in both medical and social science literature (Adams et al., 2009; Baarts & Kryger Pedersen, 2009; Sanderson et al., 2006; Sirois, 2009). Understandings of what constitutes CAM are problematised by the recognition that CAM comprises a set of varied and dynamic practices that are contextualised historically, culturally and politically (Broom & Tovey, 2007; Coulter & Willis, 2004; Kaptchuk & Eisenberg, 2005; Lewith & Chan, 2002). This is further complicated by the growing convergence between CAM and biomedical practices, with so called ‘integrative’ medicine applying the principles of holistic health care in an evidence based model. In line with this trend is the growing pressure for some forms of CAM to demonstrate scientific legitimacy through utilising evidence based medicine (EBM) testing methods such as randomised controlled trials (RCT) (Willis & White, 2004, p.56). This has seen CAM disciplines such as osteopathy become more conscious of the need to provide scientific or clinical evidence of treatment outcome (Saks, 2003). Some groups such as the
Prince of Wales Fund (UK) even classify CAM therapies according to levels of scientific legitimacy, proposing a hierarchy in which ‘alternative therapies’ without a ‘credible evidence base’ are at bottom (Wahlberg, 2007, pp. 2311-2312). The implicit meaning of this is that ‘alternative’ medicine operates outside the wider health system (Spence & Ribeaux, 2004) and has no claim to scientific or clinical legitimacy. In practice the boundaries of medical systems are fluid, and the knowledge claims and institutional boundaries forever changing. For example there are historical instances, such as in homeopathy where the knowledge and practice of CAM have been incorporated into biomedicine (see Cant & Sharma, 1999, p. 87), and equally certain forms of scientific knowledge have become incorporated into CAM (see Saks, 2003). Such pronounced shifts beg the question of what is CAM. For example, is osteopathy still CAM if it is no longer premised on principles of osteopathic manipulative medicine? Or does it remain CAM since shifting its knowledge base, and appropriating more scientific knowledge into practice?

From a sociological perspective, the definitional debate around CAM reflects the perceived incommensurability of holistic health knowledge with scientific medical knowledge (Coulter & Willis, 2007, p. 215). CAM covers a wide range of health disciplines and practices (Kelner et al., 2003, p. 6). CAM disciplines are said to share a common understanding of holistic health, a which views health as incorporating the ‘whole person’ and integrating mind, body and spirit (O’Connor, 2003). Holistic health practices view nature and energy as the tools for connecting the body and metaphysical self (Kaptchuk & Eisenberg, 2005), and when applied by a trained practitioner certain CAM treatments are seen to promote the regenerative, self-healing capacity of the body. Holistic health and the related principle of vitalism, a holistic notion of the regenerative capacity of the ‘life force’ or energy, have traditionally been seen as the basis of CAM knowledge (Di Stefano, 2006). In practice each CAM discipline has a specific knowledge base, and the knowledge claims continuously shifting. For example classical chiropractic knowledge assumes that ill health results from vertebral subluxations, or abnormal spinal joints interfere with the body’s ‘innate intelligence’ or natural healing properties. Chiropractic has traditionally used the principle of vitalism (detailed in section 2.3.3., chapter 2), to explain how vertebral subluxation causes ill health. The knowledge claims behind this concept propose that spinal manipulation influences the internal functioning of human organs (Dew, 2004, p.70).In recent times chiropractic knowledge claims have become more grounded in clinical and scientific data, and this has diminished the importance, at least for some chiropractors, of the ‘innate intelligence’. The shift in chiropractic knowledge reflects, to some extent, political processes which, in some jurisdictions such as New Zealand, have seen the chiropractic association accept biomedical claims that chiropractors lack scientific evidence for treatment outcomes, and succumb to a framework more acceptable to mainstream medicine (Dew, 2004,
The evolution of the political processes influencing CAM disciplines are further detailed in section 1.4 of this chapter. For energy therapies such as reiki, the underlying principle and knowledge are now more rooted in vitalism than chiropractic medicine. Reiki literally means ‘universal life energy’ and is regarded as a spiritual practice (Siegel, 2006) (as chiropractic was once associated with Christianity). For mainstream medicine, there is no scientific evidence of reiki having curative properties, for reiki practitioners it produces an energy healing which cannot be scientifically tested (Siegel, 2006). Given this disparity in the knowledge claims of CAM disciplines and practices, there is a valid argument for not using holism as the basis for a definition of CAM. To this end if CAM treatments are to be classified on a continuum of holism, then osteopathic and chiropractic manipulations would not be included at all.

In fact the knowledge and practice specificity of individual CAM disciplines has led some commentators to argue that CAM should be viewed as a number of separate entities (Cassidy, 1995, cited in Schuster et al., 2004, p. 352; Coulter & Willis, 2007). By way of example I will examine the differing orientations of homeopathic and oriental medicine. Classical homeopathy was developed by German doctor Dr Samuel Hahnemann (1755-1843), and based on a principle of ‘likes cure likes’ (AHA, 2013, p.1). There have emerged many forms of homeopathy, some are specific to a particular culture, and the principles and knowledge on which braches of homeopathy are premised can differ enormously. Western forms of homeopathy are rapidly changing from an esoteric to scientific basis, and principles of classical homeopathy such as the vital force, the extended interview and the individuality of each case are losing momentum as homeopathy aspires to become ‘scientific’ (Frank, 2002b, p. 797). Oriental medicine covers both Ayurvedic medicine, a form of medicine popular in the Indian sub-continent, and Traditional Chinese Medicine (TCM). TCM a traditional, whole medical system in which diagnosis is based on the interrelationships of bodily functions and processes, and health explained relative to the cosmological allegories of yin and yang. There are significant differences between the conception of the body and health between TCM and biomedicine, notably a conception of the body as a microcosm which, according to O’Connor (2003, p. 43) manifests ‘the same processes as those acting in the physical and social environment and in the cosmos’. TCM is interested in the relationships among bodily systems, and the ‘yin’ and ‘yang’ reference the body and its subsystems. In this way TCM is considered as holistic medicine, whereas biomedicine is concerned with anatomy and the structure of organs in the body (O’Connor, 2003, p.43). TCM also views the human body through the holistic principle of vitalism, is which the body is seen as nourished, and regulated through five ingredients, the ‘qi, blood, jing, shen, and fluids’ with ‘qi’ considered the primary force for circulating vital energy through the body (O’Connor, 2003, p.44). Both forms of CAM are holistic in that as the body is viewed as a self-regulating, dynamic system, with complex interconnections.
By contrast, the allopathic knowledge of orthodox medicine assumes that disease and illness have ‘a unique aetiology, or cause’ (Weitz, 2004, p. 126) which is located in bacteria, cellular and pathological processes (Willard, 2005, p. 116). Specifically the allopathic principle refers to the cause of illness as the ‘invasion of the body by toxic materials’ (Easthope, 1986, p. 36) treating disease symptoms in isolation. Allopathic principles have formed the basis of modern or conventional medicine throughout the nineteenth and into the twentieth century, and have been the cornerstone of medical dominance since the 1800s (Willis, 1989). The terms ‘allopathy’ and ‘biomedicine’ are often used in conflation. However the argument in this thesis is that biomedicine is not a unified whole, but is more complex than conveyed by terms such as ‘conventional medicine’, ‘allopathic medicine’ and ‘orthodox medicine’. Certainly biomedical approaches can be differentiated from other health systems through adopting ‘conventional’ or ‘orthodox’ medical practices incorporating medical knowledge, much of which is informed from scientific research and clinical trials (Coulter, 2004; Joralemon, 1999). Furthermore biomedicine is seen to represent medical approaches privileging scientific, evidence-based medicine. Since the 1970’s the movement for evidence-based medicine (EBM) has become prominent in medical institutions, and seen as the ‘gold standard’ for conventionalised medical knowledge (Willis & White, 2004). It is therefore tempting to assume that all practitioners operating within biomedical systems incorporate scientific evidence-based medicine into practice.

This is true for many forms of biomedicine; however, an important point to be kept in mind is that the concept is more complex. Baer and Coulter (2008) discuss the influence of the integrative medicine movement on biomedicine, and how some biomedical practitioners have become more holistic in approach. An important point here is that as with CAM, biomedicine does not constitute one homogeneous set of practices; while orthodox biomedical practices or practitioners such as reproductive health specialists may subscribe strictly to an allopathic model, others are far more holistic in orientation. The complexity here is that biomedicine is not a unified whole, it is a dynamic and complex entity and not necessarily ‘scientific’. To acknowledge this complexity, I aim to use the term ‘biomedical approaches’ throughout this thesis. These approaches or the various practitioners practicing within may incorporate EBM or may not, or may lean toward holistic health knowledge and practice. Similarly, there are many CAM disciplines and practitioners, as outlined earlier in this section, favouring EBM.

What this section argues is that it is not possible, nor even desirable, to provide an umbrella definition of CAM. To make sense of the accounts from research participants in this study, there needs to be a framework for delineating CAM and biomedicine based around knowledge. The classification system presented in Table 1.1 elaborates the five broad CAM systems and their
respective disciplines and practices, and is used to understand the relative position of those CAM disciplines and practices referred to in this thesis. Here, CAM is represented as five broad domains, each incorporating the disciplines and practices aligned with the knowledge and principles of that domain. In the first domain, each of the traditional medical systems is based on a unique body of knowledge and practices specific to that system. The domains represent specific sets of knowledge: the mind-body domain attends to the spiritual dimension of whole person medicine; energy medicine incorporates principles of vitalism and energy; biologically-based practices incorporate knowledge related to lifestyle and health maintenance; and finally, practices in the manipulative domain draw on a plurality of knowledge including Traditional Chinese Medicine and biomedicine. So rather than using holism as the basis for defining CAM, or allopathy for defining biomedicine, the classifications below seek to incorporate specific medical systems and practices into a domains of knowledge.
### Table 1.1: Domains of Complementary and Alternative Medicine

<table>
<thead>
<tr>
<th>Domain</th>
<th>Disciplines and Practices</th>
<th>Elaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional and whole medical systems</td>
<td>Acupuncture, anthroposophical medicine, homeopathy, naturopathy, TCM, Ayurveda, Nutrition and modern dietetics, Kampo medicine, massage therapies, herbal medicine</td>
<td>Traditional and whole medical systems are built upon complete systems of theory and practice, and are separate to conventional medicine.</td>
</tr>
<tr>
<td>Mind-body medicine</td>
<td>Meditation, yoga, tai chi, acupuncture, deep breathing, guided imagery, qi gong, counselling, hypnotherapy, Makahari, Betako</td>
<td>Utilise techniques such as meditation to enhance the capacity of the mind to influence bodily function. The term ‘mindfulness’ has also been used to describe techniques which bring a person’s focus to the internal and external experiences of the present moment (Baer, 2008).</td>
</tr>
<tr>
<td>Biologically based practices</td>
<td>Chinese/Western herbal and dietary medicine, clinical nutrition including multivitamins and minerals, homeopathic medicine, Bach flowers, and non-nutrient substances including aromatherapy oils derived from animal, plant and marine sources. Examples include fish oils, Coenzyme Q10.</td>
<td>Practices used in whole complementary medical systems such as TCM, homeopathy and naturopathy, which involve administering natural medicines such as herbs, foods and supplements, as well as dietary and nutritional advice.</td>
</tr>
<tr>
<td>Manipulative and body-based practices</td>
<td>Aromatherapy, acupuncture, Chinese therapeutic (remedial) massage, chiropractic, osteopathy, reflexology, reflexognosy, kinesiology, Alexander technique, Bowen therapy, Ka-Tone (Deep Tissue Muscle Therapy), Myofascial release, shiatsu, sports therapies, traditional Thai massage, rolfing, integrative therapies, Feldenkrais, Pilates, colonic irrigation, tai chi, yoga, exercise</td>
<td>Practices based on tactile therapies and structured exercise regimes, and include chiropractic and osteopathic practice. Manipulation in these practices involves the application of controlled force to a joint, moving it beyond the normal range of motion in an effort to aid in restoring health.</td>
</tr>
<tr>
<td>Energy medicine</td>
<td>Energy healing, Qi Gong, therapeutic touch, reiki, kinesiology, light therapy, electromagnetic field therapy</td>
<td>Practices involve the use of energy fields, and are of two types, biofield therapies and bioelectromagnetic-based therapies. Biofield therapies affect energy fields that purportedly surround and penetrate the human body, and some forms stimulate biofields through applying pressure or manipulating the body. Bioelectromagnetic-based therapies involve applying pulsed fields, magnetic fields or alternating-current or direct current fields.</td>
</tr>
</tbody>
</table>

**Sources:** Expert Committee on Complementary Medicines in the Health System (2003); National Institute of Complementary Medicine (2009)
The point presented here is that there is no singular understanding of CAM, and the label CAM represents a group of disparate disciplines and practices. With their own knowledge claims and assumptions, CAM disciplines are united by their underlying holistic health principles; however, the holistic basis of some CAM approaches have been relinquished in favour of scientific and clinical principles. Other disciplines as shown in some homeopathic contexts, have sought medical legitimacy through incorporating scientific knowledge into practice. CAM is a fluid enterprise and even the practitioners interviewed for this study are participants in the redefinition of CAM. The meanings of CAM are examined and, consequently, critically explored in this thesis to determine how CAM is socially constructed for its users. The meanings that CAM has for its users will determine whether they regard ‘a particular CAM’ as legitimate practices in which they hold trust — and if they do, in what forms and ways.

1.4 Conceptual Background

To appreciate the reasons for increased public interest in complementary and alternative medicine, we need to gain insights into how CAM has been positioned historically, politically and socially in relation to orthodox medicine. The sociological critique of medical dominance (Saks, 1995, 1998; Wahlberg, 2007; Willis, 1994) shows how strategies of exclusion, subordination and appropriation have been used in the orthodox medicine to maintain dominance over CAM. Over the last 150 years or so, these processes have essentially undermined the legitimacy of CAM practice and subordinated its knowledge claims to those of science and clinical medicine. To re-establish legitimacy, CAM disciplines have been adopting strategies of professionalisation (Cant & Sharma, 1999; McQuaide, 2005; Saks 1998, 1999). These strategies include credentialing and minimum training requirements, self-regulation and ethical codes of conduct. What this means is that CAM is reorganising and CAM disciplines such as chiropractic appropriating more scientific medicine and clinical practice models, while relinquishing their more esoteric principles. Such initiatives have been termed the ‘mainstreaming’ of CAM (Tovey et al., 2004; Wahlberg, 2007) and this is seen as inviting a new medical pluralism (Cant & Sharma, 1999; Wahlberg, 2007).

Within this pluralistic environment, there are certain CAM practices which are considered ‘trustworthy’ and able to be safely used, while other practices are not trusted. This applies as well to the use of biomedical approaches, where both users and practitioners develop boundaries of what they regard as acceptable practice. A particular interest in this thesis is in how scientific medical knowledge claims have infiltrated specific CAM knowledge and practices, and how CAM practitioners and users alike are responding to this boundary shift. Do they resist this process and how? What legitimates CAM for these users, and how is trustworthiness in a CAM therapy produced? What are the boundaries of acceptable CAM practice? This section provides
important contextual information to answering these questions including the evolution, organisation and legitimisation of CAM.

1.4.1 The evolution of CAM

For many centuries up to the Enlightenment, ‘orthodox’ medicine was just one of many healing methods and theories (Willis, 1994, p. 56). Knowledge claims of healing were formulated by religious orthodoxy, and the Church emphasised ‘sacred over profane healing’ (Easthope, 1986, p. 35). With the advancement of scientific knowledge post-Enlightenment, religious healing was no longer the dominant orthodoxy and with the decline of religious healing various other healing systems vied for legitimacy. This plurality of health and knowledge claims, according to Easthope (1986, p. 35), produced an ‘anarchic situation’. By the nineteenth century the work of Louis Pasteur and other prominent scientists ensured that ‘modern medicine’ would be the new orthodoxy, and this would be informed by an allopathic principle. The triumph of modern medicine has been attributed more to the incorporation of scientific medical practices into powerful professional groups than to inherent superiority of knowledge claims (Easthope, 1986, p. 35; Willis, 1994, p. 56). The professionalisation of modern medicine led to scathing attacks on ‘dangerous’ practitioners or ‘quacks’ who were seen as unqualified to practice (Wahlberg, 2007, p. 2309).

Around this time, other health care systems such as homeopathy, acupuncture, hydrotherapy, botany, osteopathy and mesmerism were becoming popular in Britain, Europe and America (Wahlberg, 2007, p. 2309). These non-biomedical practices offered competing theories of disease aetiology, and through the professionalisation strategies of biomedicine such ‘alternative’ practices became excluded and marginalised from biomedical practice (Wahlberg, 2007, p. 2309; Willis, 1994, p. 57). Their practitioners became the new ‘quacks’ and entered a period of hiatus in the mid-twentieth century when biomedicine was arguably at its most powerful.

There are numerous accounts from medical anthropological and sociological debates (for instance, Baer, 2009; Cant & Sharma, 1999; Easthope, 1986; Saks, 1995, 2003; Wahlberg, 2007; Willis, 1994), outlining strategies of exclusion, subordination and appropriation used in biomedical approaches to maintain medical dominance over CAM. Medical anthropologist Hans Baer (2009) provides a case study of the evolution of osteopathy, which is the treatment of musculo-skeletal and spinal injuries. Baer’s account is interesting, because it shows how after relinquishing an esoteric knowledge base, osteopathy has become a legitimate part of health care in the United States, whereas in Australia it remains marginal to the biomedical health system. According to Baer (2009), osteopathy emerged during the nineteenth century as a radical rejection of biomedical understandings and culture. The original osteopathic emphasis
was on manual and osteopathic manipulative medicine (OMM), which involved diagnosing illness through manipulating joints and bones. By the mid-twentieth century, osteopaths were pressured to relinquish manual and osteopathic manipulative medicine in favour of orthodox approaches, and now manual and osteopathic manipulative medicine is rarely used (Baer, 2009; Meyer & Price, 1993). In the U.S. the system of osteopathy now involves the administration of manipulative and body-based practices. Baer (2009) shows how, due to relinquishing its knowledge claims, osteopathy in the U.S. has shifted from a marginal to a professional status, and osteopaths now receive the full practice rights of medical doctors.

In Australia, osteopaths are members of an allied health grouping that includes chiropractors and physiotherapists. Unlike its U.S. counterpart, osteopathy still functions as a heterodox system of manual medicine, applying OMM principles and practice (Baer, 2009). However, while the core principles are still holistic, many osteopathic approaches now (as with other CAM systems) utilise scientific explanations for illness, rather than explanations based on vitalism. For Baer (2009, p. 28), this raises the question of whether osteopathy even constitutes a ‘complementary’ system of health care, or ‘an increasingly conventional component of the biomedical division of labour’. Indeed, the problematic of what actually constitutes CAM is raised by several commentators (e.g. Baer, 2009; Baer & Coulter, 2008), with some suggestions that those CAMs, such as kenogetics, which still adhere exclusively to esoteric knowledge claims are seen more and more, even among CAM systems, as ‘fringe’ disciplines. The organisation of CAM systems is evidently complex, and the precepts of what constitutes a CAM system debatable.

1.4.2 The organisation of CAM

According to the Australian Bureau of Statistics (2008) some 8,600 people are employed as ‘complementary health practitioners’ in Australia. Although some of the increase between 1996 and 2006 is due to classification changes, nevertheless an 80 per cent increase in 10 years is significant. As shown in Table 1.1, the CAM practitioner groups with the highest percentage increase between 1996 and 2006 are naturopaths, acupuncturists and osteopaths, and it is worth noting that the 2004 South Australian Health Omnibus Survey (MacLennan et al., 2006) found naturopaths (5.7%) and acupuncturists (2.1%) to be the most commonly used practitioner groups. Recent studies have also found Australians increasing their use of aromatherapists, osteopaths, massage therapists, reflexologists and herbalists (Bensoussan et al., 2005; Kermode et al., 1998; Xue et al., 2007). The increase suggests increased use of the practitioner groups corresponding to increased availability.
Table 1.2: Number of Complementary Health Practitioners in Australia, 1996-2006

<table>
<thead>
<tr>
<th>Heading</th>
<th>1996 (No.)</th>
<th>2001 (No.)</th>
<th>2006 (No.)</th>
<th>Change 1996-2006 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractor</td>
<td>1,711</td>
<td>2,073</td>
<td>2,488</td>
<td>45.4</td>
</tr>
<tr>
<td>Naturopath</td>
<td>1,910</td>
<td>2,514</td>
<td>2,982</td>
<td>56.1</td>
</tr>
<tr>
<td>Acupuncturist</td>
<td>460</td>
<td>675</td>
<td>948</td>
<td>106.1</td>
</tr>
<tr>
<td>Osteopath</td>
<td>257</td>
<td>429</td>
<td>776</td>
<td>201.9</td>
</tr>
<tr>
<td>Traditional Chinese medicine practitioner</td>
<td>n.a.</td>
<td>n.a.</td>
<td>480</td>
<td>n.a.</td>
</tr>
<tr>
<td>Homeopath</td>
<td>n.a.</td>
<td>n.a.</td>
<td>236</td>
<td>n.a.</td>
</tr>
<tr>
<td><strong>Total</strong>*</td>
<td><strong>4,787</strong></td>
<td><strong>6,343</strong></td>
<td><strong>8,595</strong></td>
<td><strong>79.5</strong></td>
</tr>
</tbody>
</table>

*Includes other complementary health professionals whose occupations were not elsewhere classified or not further defined. In 1996 and 2001 homeopaths and traditional Chinese medicine practitioners were among these occupations. In 2006, some additional occupations were moved into this category, contributing 485 people (or 10 percentage points) to the increase in 2006. These were hypnotherapists and dance, drama and music therapists.


The organisation of CAM disciplines in Australia is rapidly changing with strategies of professionalisation and a move toward integrative medicine. Moreover, practices such as massage are gaining wider acceptance in conventional medicine, making it difficult to classify some health care systems (Lewith & Chan, 2002).

The incorporation of CAM into biomedicine as well as the enormous growth of CAM industries and practices has been conceptualised as a ‘new medical pluralism’ (Cant, 1999; Wahlberg, 2007, p. 194). Medical pluralism implies theoretically a choice of health care systems. An authentic pluralistic model of health provision is, according to O’Sullivan et al. (2004, p. 13) ‘based on the understanding that no single model of health and disease can encompass clinical reality as a whole’. In fact, several researchers argue that historically and geographically, medical pluralism has been the norm rather than the exception (Baer, 2001; Cant, 1999, p. 5). Certainly mainstream biomedical systems have become exposed to increasing ethnic and cultural diversity, and have embedded notions of holistic health care, personal responsibility for health (Adler, 2003; Wyatt et al., 2010) and patient-centred practice. These trends represent the influence of wider social processes regarding consumerism and the rhetoric of patient empowerment as well as the influence of CAM. But pluralism is also influenced by the dominant perspectives and medical norms. Biomedicine, for example, privileges treatments and practices which demonstrate efficacy and effectiveness using scientific evidence testing, and it is unlikely this will be relinquished in favour of more esoteric ‘testing’ and knowledge. This raises questions about appropriate ways of demonstrating the effectiveness of CAM therapies, and ways of offering designs which are flexible enough to accommodate CAM practices. Indeed...
medical literature contains a lively debate about appropriate ways of researching ‘whole
systems’.

Certainly the increased availability and visibility of CAM practitioners, along with a perception
of a more professionalised industry, have influenced the wider acceptance and legitimisation of
CAM practice in Australia and other Western, post-industrial countries. The complexities of the
new medical pluralism, with its debate over evidence testing and the like, have generated and
continue to maintain ‘grey’ zones for the consumer. These tensions are evident in the accounts
of CAM users interviewed for this study, and at the core of these accounts is what constitutes
legitimate knowledge. To this end the CAM user mediates, and negotiates between expert
knowledge of the CAM practitioner and their own or ‘lay’ knowledge. Expert knowledge of
CAM practitioners arises from training and credentialing, and as shown in the previous section
on the evolution of CAM, some groups are becoming more scientific in their orientation. Some
CAM disciplines are incorporating more scientific evidence into their practice, while others
base evidence on non-scientific sources and esoteric knowledge. It is clearly not appropriate to
think of CAM as a homogenous group when each CAM discipline is a professional entity with
its own knowledge and regulations. Accordingly, some of these disciplines are seeking
professional and public legitimacy through integration and incorporation of scientific medicine.

1.4.3 The legitimation of CAM

Medical dominance has been shown by several commentators to be reflective of the historic and
powerful alliance between orthodox medicine and the state (Willis, 1989). Work in the
sociology of health (e.g. Weitz, 2004, p. 330) points to the decline of medical dominance, some
sociologists locate the decline in access to medical knowledge, others in structural changes to
the health care system. The popular health movements and consumer empowerment movement
are seen as encouraging health care ‘consumers’ to be actively involved in health care (Weitz,
2004, p. 331). The proliferation of information about health on the Internet has also stimulated
this movement, and has led to government funded public health websites having become well
utilised. Not all sociologists see this as evidence of a radical decline in medical dominance.

According to Willis (1994, p. 17), medical dominance has become accepted, and control
maintained through ideological processes of coercion. These ideological processes include
professionalism and technological determinism. In this context, professionalism denotes a claim
to occupational control which allows for autonomy, and which is achieved through setting
educational qualifications and practice standards (O’Sullivan et al., 2004); monitoring
compliance; engaging in peer-reviewed research; exclusive professional associations
(Wahlberg, 2007; Welsh et al., 2004); and formation of specialised knowledge. Such strategies
of professionalisation are being adopted by various CAM disciplines such as chiropractic,
naturopathy, acupuncture and osteopathy (Wahlberg, 2007; Welsh et al., 2004). Professionalisation means an occupational group has knowledge claims and expertise, and exclusive control over their work and practice conditions (Welsh et al., 2004, p. 217); CAM disciplines certainly fulfil these requirements.

In addition, there is a body of literature on the professionalisation of CAM showing contestation over knowledge claims between CAM disciplines (O’Sullivan et al., 2004; Saks 1999, 2003). As observed by O’Sullivan et al. (2004, p. 1): ‘In making claims to a knowledge and practice which is sufficiently differentiated and substantial to qualify as “professional” in nature, it is necessary also to consider who legitimises such a claim, as well as what is being claimed.’

In that regard, a point of conflict or concern for the CAM user is negotiating, and mediating for themselves, knowledge claims from differing CAM therapies and interpolating this with scientific knowledge. For example, a CAM user attending a naturopath may be advised that diet is the cause of their illness, whereas a homeopath will locate the cause in emotionality.

What legitimates knowledge claims is the public acceptance of knowledge, and this occurs through public acceptance of a profession as legitimate. Legitimation occurs through statutory regulation, licensing and mainstream acceptance by dominant systems. The professional transformation of CAM has produced a wider gap between ‘competent’ and ‘incompetent’ CAM practitioners. In Australia, for example, CAM practitioners need to be registered with a professional association for members to be registered for health fund rebate, and registration suggests competency. This produces a strategy of separation between registered and non-registered practitioners. Wahlberg (2007, p. 2315) also observes how disciplinary measures to regulate and professionalise CAM are normalising its practice and use. Wahlberg sees this as producing an internalisation within CAM itself, a ‘quackery with a difference’ which is producing a hierarchisation of CAM therapies based on practitioner competency and qualifications, responsibility, professional development; add to this list the production of a scientifically sanctioned evidence base.

The legitimation of CAM is also resisted from members of professional associations and industries associated with conventional medicine. For example, issues of patient safety, information and quality control culminated in Australia in 2003 during the Pan Pharmaceutical event. During this event the Therapeutic Goods Administration (TGA) issued a Class 1 recall of 1,369 products manufactured by Pan Pharmaceuticals Limited. The TGA cited ‘serious concerns’ over the safety and quality of all Pan Pharmaceuticals products, yet the recall involved mostly vitamins, minerals and herbal products, which PAN supplied to over 75 per cent of the natural health market. According to Hillary (2003, p. 2), the action was extreme, as
Class 1 recalls are for products that are likely to cause ‘serious, irreversible health damage or death’. The recall signalled to the public that the vitamins, herb, dietary or any other of the 1,369 natural products they had been taking without any problems were now expected to cause either death or irreversible health damages.

The media moral panic created interest in the role of CAM in Australia’s health system, and raised questions about safety and benefits of the Pan Pharmaceuticals products recalled (Expert Committee on Complementary Medicines in the Health System, 2003, p. 7). This resulted in the Federal Government convening an expert committee to inquire into the role of CAM into Australia’s health system. The 18 member committee comprised largely of government bureaucrats, academics and medical industry representatives; only two CAM industries representatives were on the committee, a fact which did not escape the notice of CAM practitioners I interviewed for this study. According to these practitioners, the committee served only the interests of the Australian Medical Association (AMA) and its members. The considerable public debate which ensued after the Pan event led to a government inquiry into CAM, with a view to a co-regulatory model for CAM systems. This model is still being developed, with some statutory provisions now made for more detailed consumer medicine information leaflets with CAM medicines; however, the regulation of CAM practice is being largely driven by the CAM industry.

Certainly, the move toward integration of CAM with biomedical approaches has been viewed, for CAM as a legitimisation strategy (Schuster et al., 2004; Spence & Ribeaux, 2004). Integration involves the convergence of biomedical approaches and CAM in the provision of a treatment plan for an individual client. The integrative medicine movement does not have one particular style, rather, there are different models of integrative health care, and the Australian model has developed in an ad hoc way and much like the U.S. system (Coulter, 2004, p. 104). Some commentators (e.g. Hollenberg, 2006) argue that it is unlikely that conventional medicine will readily appropriate CAM unless CAM becomes more medicalised. Cant and Sharma (1999) further argue that the integration of CAM with orthodox medicine will see a convergence between the holistic health principles with scientific medical knowledge.

Despite the valid concerns of some CAM groups regarding integrative approaches to health, an equal platform with conventional medicine is also regarded as the means for ensuring the survival of CAM (O’Sullivan et al., 2004). Integration with mainstream medicine is also perceived as a means of promoting CAM to the wider population, and maximising positive health outcomes for a greater number of people (O’Sullivan et al., 2004). Despite the benefits of integration, in practice some CAM groups have found it difficult to balance autonomy and integration (O’Sullivan et al., 2004). Furthermore, independence seems to be highly valued by
CAM disciplines; in Australia CAM disciplines and practices have essentially remained separate entities, and there are over 100 professional associations accommodating CAM practices. There are wider concerns that practices becoming more integrated in biomedicine are making it difficult to classify a practice as CAM (Lewith & Chan, 2002). Indeed, there is a blurring of scientific into traditional CAM knowledge, and this has produced tensions between biomedical and CAM approaches, and tensions within CAM disciplines. In this chapter it is shown that the knowledge underpinning some CAM approaches such as in chiropractic medicine is premised more on orthodox scientific knowledge than on esoteric CAM knowledge. This lends weight to the argument that both CAM is comprised of heterogeneous groupings, with each grouping having particularised knowledge claims. In summary and building from section 1.3, it is argued that CAM and biomedical approaches are not homogeneous, discrete entities but represent a plurality of differing practices, based on shared and disparate knowledge claims.

1.5 Overview of the Thesis

The starting point of the thesis is the way in which sociologists of CAM have theorised the experience and understandings of CAM use, from the perspectives of CAM user and practitioner. Chapter Two sets out the theoretical framework of the thesis, and offers a theoretical orientation toward trust, followed by a review of the health sociological positions regarding lay and expert health knowledge which assists in framing the CAM user’s lay understandings of health and illness, and how these understandings contribute to their trust in CAM and biomedical systems.

Chapter Three reviews the social scientific literature on the use of CAM treatment decision making including the ongoing tensions of consumers/patients to adopting CAM and biomedicine, and the perceived health risks of biomedicine and CAM. This chapter moves into a full review of the emerging body of literature concerning CAM as an embodied experience, in which CAM is used as a strategy for achieving well-being, pleasure and other derivative benefits. Related to this are holistic understandings of CAM including concepts of harmony and balance, energy flows and spirituality, and how these also contribute to embodied understandings and experiences of CAM. This chapter also considers approaches to the body through the lens of disciplining the body through CAM in order to attain the maximum health benefits. The last section of this chapter reviews studies of interaction and communication in the CAM ‘therapeutic encounter’ and contrasts this with the medical encounter.

Chapter Four outlines the constructivist grounded theory (CGT) method for the study, which is used to construct an interpretative, social constructionist account of CAM use and trust.
Chapters Five to Seven present the findings of the thesis, each chapter presenting the findings from a master theme of the CGT analysis. Specifically, these themes are trust in expert knowledge; mediating trust in the CAM encounter; and trust and the bodily experience of CAM. Chapter Eight provides a conclusion to the study.
Chapter Two
Theorising Trust, Uncertainty and the Construction of Knowledge

2.1 Introduction

The central argument in this thesis is that CAM use represents an ongoing process of negotiation of trust between CAM and biomedical practices, and the interest is in how trust is mediated among multiple treatment options; also how trust in the expert systems represented by CAM and biomedical approaches is formed. This chapter outlines the theoretical framework used to assess this argument, in which engagement with the sociology of trust is primarily based in the work of Giddens (1991, 1995) and Luhmann (1979, 2000). Health sociological studies focus on trust at two levels, the institutional and the interpersonal (Brownlie & Howson, 2008, p.3). At an institutional level there is widespread recognition of a decline in public trust in biomedicine which is seen to undermine trust in the social order. At an interpersonal level, the exploration of trust concerns treatment decision-making and health information seeking, and there is considerable interest shown by social scientists in trust in the doctor and patient encounter (e.g. Cook, 1997; Lupton, 1997). The decline of trust in the biomedical system extends to the interpersonal domain, with an erosion of trust in the medical encounter being well documented. Some commentators suggest that the significant decline in public trust in biomedicine is responsible for the increased popularity of CAM (Saks, 1999; McClean & Shaw, 2005). This framework draws conceptually from Giddens (1984) theory of structuration, in which the structure of science and medical institutions is seen to have guided the development of formalised rules and knowledge in biomedical systems, and these rules are interpreted in both CAM and biomedical encounters.

In relation to knowledge construction, the decline in trust is evidenced through decreasing confidence in the contingencies of scientific authority, along with challenges to expert knowledge claims; also processes of individual reflexivity have led to a privileging of lay knowledge (Giddens, 1991, 1995) and engagement with health information sources, with both authoritative and popular sources seen as constitutive of the modern health ‘consumer’. Health literate consumers are seen as having sophisticated understandings of health and the body, expressing confidence and trust in their health beliefs. Lay health ‘knowledge’ is seen to compete with multiple sources of authority and what Giddens (1991, p. 3) calls ‘systems of accumulated expertise.’
Theorists such as Beck (2010) and Giddens (1991, 1995) recognise how uncertainty arises through negotiating multiple, and often diverse knowledge claims, and that the modern health consumer engages reflexively with these systems in order to make sense of their health and illness. It is argued in this thesis that the CAM user mediates expert knowledge with lay knowledge and beliefs which are largely derived from phenomenological experiences of health and illness. Expert knowledge is represented by the holistic health discourse of CAM and the scientific medical knowledge of biomedicine. This chapter begins with theorising trust then moves into a consideration of the formation of expert and lay knowledge. The contribution of this chapter to the thesis is in setting out the sociological theories of trust used in the analysis of CAM user accounts, and to enable conclusions to be reached about the way trust is mediated between expert and lay knowledge.

2.2 Theorising Trust

According to Brownlie and Howson (2005, p. 222), sociology has largely focused on the cohesive function of trust in society, and ways in which trust creates solidarity and cohesion among members of society. The majority of these studies theorise trust in relation to governance (e.g. Carter, 2009) and social capital (e.g. Putnam, 1995, cited in Mollering, 2001, p. 404). In response to this some health sociologists (e.g. Cook, 1997; Meyer et al., 2008) have argued for an embodied theory of trust which treats trust as a multifaceted, complex process which is mediated between affective and cognitive domains, and which represents an accommodation of both expert knowledge and self-knowledge. This section outlines the theories of Giddens and Luhmann who, as observed by Meyer et al. (2008, p. 178), are consistently cited in the sociological literature on trust (Cook, 1997; Brownlie & Howson, 2005; Khodyakov, 2007; Lee-Treweek, 2002; Lupton, 1997; Meyer & Ward, 2009; Mollering, 2001). The trust theories of both Giddens and Luhmann are employed for analysing trust at both institutional and interpersonal levels. Moreover, both theorists conceptualise trust as a product of late modernity, which is characterised by risk and uncertainty.

2.2.1 Theories of trust: Giddens and Luhmann

Giddens (1995) theorises that institutional trust is dependent on interpersonal trust relations, whereas Luhmann’s functional systems theory views trust in the institution or system as necessary for interpersonal trust. Both theorists discuss the inherent tension facing an individual who, when faced with expert knowledge systems, must navigate between trust and uncertainty. Citing the complexity of these interactions, Luhmann (1979) argues that when knowledge is acquired that personal trust becomes system trust, thus reducing the complexity caused by mistrust. Luhmann argues in Trust and Power (1979, p. 13) that trust is actually a means for negotiating future uncertainty and complexity; that the problem of trust relates to its perceived
security in the present, the future containing more possibilities than the present can realise, and that therefore, ‘the uncertainty which is bound to exist is simply a consequence of the very elementary fact that not all futures can become the present and hence become the past’.

In Luhmann’s specification, trust only functions with uncertainty about the future, for where there is total control of the future then ‘trust is not necessary’ (Luhmann, 1979, p. 15). Similarly Misztal (1996, p. 18, cited in Brownlie & Howson, 2005, p. 223) claims that ‘to trust is to believe despite uncertainty’, that it relates to future and unknown events. While also seeing trust as operating from a position of uncertainty, Giddens (1995, p. 30) more explicitly relates trust to an awareness of risk. For Giddens, an inevitable condition of late modernity is that we live within a culture of risk, with risk represented through inherent uncertainty and anticipation of future events. By risk culture, Giddens (1991, p. 3) does not mean that the world is more risky, rather that:

> The concept of risk becomes fundamental to the way both lay actors and technical specialists organize the social world. Under conditions of modernity, the future is continually drawn into the present by means of the reflexive organization of knowledge environments.

It is impossible to discuss the concept of risk without mentioning the work of Ulrich Beck whose most recent book *World at Risk* (Beck, 2010) discusses relations between risk, uncertainty and ‘not knowing’. Like Giddens, Beck sees risk as concerning ‘the possibility of future occurrences and developments; they make present a state of the world that does not (yet) exist’ (Beck, 2010, p. 9).

For Beck (2010, p. 11) we live in a ‘risk society’ where the ‘staged anticipation of disasters and catastrophes obliges us to take preventative action’. This staging occurs by experts including scientists who are seen to manufacture uncertainty around health risks. While Beck does not explicitly theorise trust he makes a useful contribution to understanding the nexus between lay and expert knowledge which is central to the theorisation of trust in this thesis, and this contribution is later reviewed in this chapter.

While trust is acknowledged as dependent on a perception of risk, it is not necessarily linked to a perception of threat or inherent danger (Luhmann, 2000, p. 100). To this end weighing up risk is part of the decision to trust, described by Luhmann (2000, p. 100) as ‘a purely internal calculation of external conditions which relates risk’. In other words, if you take no action you have no risk. Luhmann (2000, p. 10) also illustrates that the perception and evaluation of risk is
subjective and individualistic, that individuals apply specific boundaries of risk-seeking and risk-avoidance, and that trust and mistrust is generated within these boundaries. In summary, Luhmann conceptualises trust as having a circulatory relationship with risk, and as being conceptually distinct risk.

Another key concept related to trust is that of confidence, which Luhmann also sees as conceptually distinct from trust, but inherently related. Several sociologists (e.g. Brownlie & Howson, 2005; Giddens, 1995; Meyer et al., 2008; Misztal, 1996; Mollering, 2001) credit sociologist Georg Simmel with establishing the foundations of a sociological theory of trust. Although Simmel (1950) did not explicitly theorise trust, he is seen to provide rich insights into the nature of trust, especially trust as interpolating ignorance and expert/institutional knowledge (Brownlie & Howson, 2005, p. 225; Mollering, 2001, p. 405). Simmel (1950, p. 318) states that to trust is to have confidence in someone else’s knowledge: ‘…confidence is intermediate between knowledge and ignorance about a man. The person who knows completely need not trust; while the person who knows nothing can, on no rational grounds, afford even confidence.’ For Simmel, trust is interactional in nature. We need know no more than we have to know about a service provider to have confidence in that service.

While Simmel appears to equate confidence with trust, others differentiate between the two. For Luhmann (2000, pp. 97-98) confidence occurs when we expect an event to occur in a certain way and when there is no need of alternatives to consider. Watching television for example is not a behaviour with which we generally associate risk, so we do not consider alternative strategies of television viewing. This for Luhmann would constitute an example of confidence. Giddens (1995, p. 31), concurs that confidence does not presuppose risk and that a person is experiencing confidence if they need not consider alternatives. Relating confidence and risk to trust, Giddens notes that, ‘Someone who does recognise these alternatives is in a situation of confidence, whereas someone who does recognise those alternatives and tries to counter the risks thus acknowledged, engages in trust.’ Luhmann argues that trust differs from confidence as it ‘presupposes a situation of risk’. In these situations we have a choice of strategies, and we select the strategy which involves less risk. Elaborating further, Luhmann (2000, p. 98) observes that:

… trust is only possible in a situation where the possible damage may be greater than the advantage you seek (Deutsch, 1958, 1962, p. 302ff.). Otherwise, it would simply be a question of rational calculation and you would choose your action anyway, because the risks remain within acceptable limits. Trust is only required if a bad outcome would make you regret your action.
What Luhmann is saying is that we can regret a trusting choice, but that we do not regret confidence where an unfortunate occurrence relates more to external attribution. Of course, if it becomes possible that we can avoid a relation, then confidence can turn to trust, and vice versa (Luhmann, 2000, p. 98).

For Giddens (1995, p. 34) confidence provides the link between trust and faith, with trust then defined as ‘confidence in the reliability of a person or system, regarding a given set of outcomes or events, where that confidence expresses a faith in the probity or love of another, or in the correctness of abstract principle (technical knowledge)’.

In an exposition on confidence Simmel (1950, pp. 318-319) sees faith as being a form of confidence. Drawing from a religious discourse, Simmel sees faith as an act of believing in the unknown (such as God) even without proof, and often ‘in spite of proofs to the contrary’. Extending this, Giddens (1991, p. 3) notes that as a ‘medium of interaction’ with modern, globalising systems and when dealing with expert systems trust requires a ‘leap of faith’. The leap of faith concept arises from Simmel’s (1950, cited in Brownlie & Howson, 2005, p. 222) proposal that leaps of faith occur within interaction. This leap of faith relates to risk, and involves a sort of bracketing out of ignorance or lack of information (Meyer et al., 2008, p. 179). For Giddens (1995, p. 33) trust is not the same as faith in ‘the reliability of a person or system’; instead, it derives from such faith. In presupposing trust as a form of faith, Giddens (1995, p. 34) notes:

We can speak of trust in symbolic tokens or expert systems, but this rests upon faith in the correctness of principles of which one is ignorant not upon faith in the ‘moral uprightness’ (good intentions) of others. Of course, trust in persons is always to some degree relevant to faith in systems, but concerns their proper working rather than their operation as such.

The difference between the theorists is that for Giddens a ‘leap of faith’ is implicated in trusting relations, an act of knowing without understanding rational processes, while for Luhmann trust is evidence based. Extrapolating to health contexts, a leap of faith can be applied to treatments which have no ‘proof’ or evidence base, whereas for Luhmann trust in health is based on evidence and calculation of risk. It is the nature of what constitutes ‘evidence’ that interests us further.

In summary, both theorists situate confidence as related to, but different to trust. In Luhmann’s theory confidence is a result of a situation in which there are no alternative strategies, whereas decisions to trust involve a consideration of risk. For Giddens, confidence is more clearly embedded in trusting relations and involves faith in the reliability of someone else’s knowledge.
2.2.2 Trust and knowledge

The theories discussed in this chapter suggest that trust has an intrinsic, complex relationship with knowledge construction. The fact that we engage daily with codes of knowledge which are not our own, such as transport, engineering and health, requires that we have faith in what Giddens (1995, p.28) calls the ‘authenticity of the expert knowledge which they apply’. Cant (1996b, p. 46) argues that it is not just the content of knowledge which legitimates trust, it is also the professional endorsement of knowledge. As outlined in Chapter One, orthodox medical knowledge has become legitimated through medical dominance and state sanctioning of medical knowledge, and this process can be more influential than claims to essential ‘truth’. Giddens (1995, p. 27) proposes that trust represents faith in expert systems, whereby:

The confidence vested in probable outcomes expresses a commitment to something rather than just a cognitive understanding. Indeed…the modes of trust involved in modern institutions in the nature of the case rest upon vague and partial understandings of their ‘knowledge base’.

What Giddens suggests is that the lay public need the expert knowledge systems so as to frame their lay understanding. At the same time, adverse experiences with biomedical treatments are challenging the modern health user’s faith in scientific evidence (Cant, 1996b, p. 47). For Cant (1996, p. 47) the secure choice of a professional who appears ‘safe and trustworthy’ is important. As an institution which influences our everyday lives, and which valorises professional expertise, medicine constitutes an expert system. What Giddens suggests is that we have no choice but to exercise ‘faith’ in the knowledge of these medical experts.

A related concept of Giddens (1995, p. 115) is that of ‘access points’ whereby trust is generated through the people who represent abstract systems, and these are the meeting ground of what Giddens calls ‘facework’ and ‘faceless’ commitment. To this end having faith in symbolic tokens or expert systems is seen as based on faceless commitment to strangers, and in interaction and encounters with strangers, balance between trust and power is being mediated, with politeness tactics as protective devices. Giddens also refers to facework commitment, in which trust relations are expressed and sustained in social connections established in co-presence, built through personal interactions, and are critical in sustain system-level trust in faceless commitments. Giddens argument is that access points of individuals representing these systems affirm the trustworthiness of the system. This sort of commitment can be applied to encounters between CAM users and practitioners, especially at the start of a relationship. In this thesis the interaction between a health practitioner and client/patient who by virtue of their position, represents an abstract system is termed, following from Goffman’s (1961) discourse,
the CAM or bio/medical ‘encounter’. The abstract system itself comprises of symbolic tokens and expert systems, so CAM disciplines and practices can be seen to be abstract systems.

The notion of trust developing in interaction between health practitioners and clients/patients has been taken up in several studies, and the overall consensus seems to be that trust in a CAM practitioner is not necessarily the same as trust in therapeutic efficacy or treatment decisions. What is important, says Luhmann (2000, pp. 95-96), is that trust is developed in familiar contexts, and that changes to these contexts will impact on the development of trust. For example, the media represents the familiar, and a means of entering an unfamiliar world through the familiar (Brownlie & Howson, 2005). At the same time we introduce into the unfamiliar symbols from the familiar lifeworld, which become forms of self-reference, and serve the basis of our meaning making of knowledge.

Luhmann (1979, p.73) also argues that past history is also important to how trust is expressed, ‘for the distribution over time of the various attitudes (familiarity, trust, and distrust) the existence of thresholds [original italics] is important’, these denoting an artificial discontinuity which levels out experience before and after the threshold, and rests on the setting of boundaries, making for simplification of the complexity of trust. These boundaries can turn trust into distrust, so distrust tends to endorse and reinforce itself in social interaction.

In summary, how CAM users engage with non-evidence based knowledge of CAM is of particular interest to this thesis. Theoretical concepts of non-knowing, faith and trust provide a way of understanding the CAM user’s engagement with CAM expert knowledge.

2.2.3 Studies of trust in health sociology

A health sociology literature has been emerging which engages theoretically with trust (e.g. Brownlie & Howson, 2008; Cook, 1997; Meyer et al., 2008). The literature provides a useful conceptual framework in which to empirically investigate trust in CAM treatment decision making, and examining these in relation to institutional aspects of health care.

At the interpersonal level, health sociologists have investigated trust in the doctor-patient biomedical encounter. Lupton’s (1997) quantitative study of health service use by 300 Australians found frequent expressions of ‘trust’ and ‘faith’ in doctors. Lupton’s (1997) follow-up qualitative study of 60 health service users found that doctors considered less trustworthy were those perceived as ‘uncaring’ or abrasive. Due to the enormity of their institutional power, Lupton found these doctors are rarely challenged even when they had breached ethical boundaries. Lupton (1997, p. 377) also elaborated a set of characteristics distinguishing a ‘good’ from a ‘bad’ doctor including communication skills and flexible treatment options.
Lupton noted that even for people using CAM and biomedicine concurrently, ‘faith’ in biomedicine remains strong. Moreover, people generally believe that scientific medicine provides effective cures. Lupton proposes that, in the medical encounter, health users experience diminished sense of independence and personal agency. The ensuing dependency relationship that patients experience with doctors can, to a certain extent, negate Giddens notion of a ‘reflexive, autonomous consumer’.

Another notable health sociology study of trust is Brownlie and Howson’s (2005) empirical study of lay and expert accounts of immunisation for measles, mumps and rubella (MMR). This is one of the few studies to theoretically engage Giddens’ notion of ‘leap of faith’. Focusing on perceptions of health risk from immunisation the researchers explored parental concern about vaccination and identified ‘good reasons’ for vaccinating and counter-reasons for not vaccinating their children. In situations of uncertainty, parents sought a level of familiarity with health professionals, and health professionals also sought familiarity with their patients. The degree of familiarity with vaccination processes, whether gained from the practitioner or from other information sources, was theorised as the key to trust in expert knowledge. The findings from Brownlie and Howson’s study reaffirms Luhmann’s (2000, p. 96) position that trust is developed in familiar contexts, and that changes to these contexts will impact on the development of trust.

Brownlie and Howson (2005, p. 235) also found that written vaccination information was considered unsatisfactory, and that the more ‘familiar’ the health professionals were considered to be, the more legitimate their information sources. In this study trust in the choice of treatment options was influenced through social trust in personal networks, with a preeminent influence from friends and family. Treatment decision-making was further influenced by a lack of trust in the willingness of the government to protect people’s health, and general anxiety about science and technology. As such Brownlie and Howson (2005, p. 222) conclude that ‘leaps of faith’ are always social acts, occurring within interaction and mediated by ‘socio-political contexts’. Furthermore, Brownlie and Howson argue that trust cannot be understood outside of interactional and institutional contexts, however interpersonal trust can and does influence the level of trust in an abstract system.

Similarly, a study by Scott et al. (2003, p. 24) of CAM and biomedicine use for inflammatory bowel disease found that social support from friends, family and health professionals, particularly from those in the support network speaking positively about CAM, will assist the client/patient to manage the symptoms of inflammatory bowel disease (IBS).
Studies of patient decision making have found that individual health beliefs influence the level of confidence in their choice of biomedical or CAM treatment. A community health study (Scott et al., 2003) investigating CAM use among people with IBS found that health beliefs, as expressed by assessment of health risk and illness severity, self-efficacy and perceived benefits of treatment strategies, determined if preference is given to CAM or biomedicine. In this study what emerged from interviewing 14 patients about their treatment experiences was that the degree of ‘confidence’ in biomedical treatments, as well as personal responsibility, were influenced by the client/patient health beliefs. Tellingly, all the study participants perceived health risks from CAM to be less than the risks from steroid treatments prescribed by a doctor. The study researchers did not theorise confidence, nor refer specifically to ‘trust’. Drawing from sociological theory a personal interpretation is that the study participants based their confidence mainly on perceived level of health risk arising from treatment options, and trust that treatments would not produce adverse side effects such as fatigue and nausea.

In summary, these studies show that the need for trust in health provision reflects the uncertainties of health conditions; the perceived risk of professional expertise and skill; the nature of the relationship between health professional and patient; and according to Brownlie and Howson (2008), the vulnerability of the client/patient.

2.2.4 Trust in CAM use

My review of CAM literature locates several studies (notably the work of Broom & Tovey, 2007) in which notions of risk and uncertainty are prominent themes; however, only one sociological study of CAM (Lee-Treweek, 2002) engages theoretically with trust. While other social science studies address trust in CAM systems (Cant, 1996b), CAM-related information (Robinson & Cooper, 2007) and nutrition (Ward et al., 2012), they fail to engage trust theoretically.

Lee-Treweek (2002) interviewed 16 patients of a cranial-osteopathic practice in Scotland and their osteopathic practitioner, and based on phenomenological analysis concludes that ‘the practitioner and their therapy is not the basis for patient trust’ (Lee-Treweek, (2002, p. 49). Rather, patients work to find meaning in their experience of CAM, and this produces trust in the treatment. According to Lee-Treweek trust relies on the phenomenological work of the patient, rather than the work of the practitioner. Tensions between self-knowledge and expert knowledge are also raised in Lee-Treweek’s study. Here trust appears to be based on minimal understanding of CAM and its effects and, as pointed out by Lee-Treweek (2002, p. 52), trust in CAM is even based on mystification. CAM users also have specific, individualised knowledge of their health condition and some common knowledge of health and health systems, so trust is derived from this knowledge.
Although not based on theoretical understandings of trust, it is usefully suggested that the formation of trust between CAM practitioner and client is based on the way knowledge is conveyed, and the impression of an ‘equal’ relationship. Based on her research, Cant (1996b, p. 60) claims that due to professionalisation strategies employed in the last 20 years by these CAM groups, the initial trust in the charisma of a CAM provider is no longer evident. Rather, Cant (1996b, p. 60) argues that, ‘The legitimacy of alternative medical knowledge thus seems to have been achieved through the establishment of a relationship of trust between the practitioners and their consumers and sponsors, based on the transmission and presentation of their knowledge.’

This supports theories showing that trust is based more on the promotion of specific knowledge than content per se. Studies of interactions between practitioners and clients (Chatwin, 2009; Chatwin et al., 2008) show how a perception of being equal players can build trust. Chatwin’s (2009) observational studies of the homeopathic encounter found that trust is built when treatment choice is explained to the consumer/patient using ‘accessible language’. According to Chatwin, accessible, informal, even colloquial language makes the process more transparent and equitable. Chatwin (2009, p. 179) also found that the homeopathic encounter needs to be grounded in trust and mutuality in order for a more familiar, open format interaction to take place (such as telling the client what they are feeling).

CAM use is also associated with having ‘faith’ in the derivative benefits of CAM. Here another ‘non-theoretical’ study, but offering insights into trust, is that of Mehl-Madrona and Chan (1999) who conducted a longitudinal study of 140 HIV-positive men receiving CAM treatment. In this study the researchers assess the extent to which the patients’ ‘faith’ in treatment influences its efficacy, finding faith is associated with treatment efficacy, and is important regardless of whether the treatment is efficacious.

Other studies have focused on uncertainty, which is conceptually related to dis/trust. Broom’s (2009a) study of 20 medical oncology outpatients explores the tensions, scepticism and engagement of these patients with evidence from both biomedicine and CAM. Broom (2009a) found that knowledge from both systems is drawn on, sometimes concurrently, to make pragmatic decisions around therapy, a process Broom (2009a, p. 1054) terms the ‘embodied assessment of therapeutic effectiveness’, this assessment being based on the phenomenological work of the patient.

An interesting aspect of the dialectic tension among Broom’s (2009a, p. 1055) cohort of cancer patients is that, in the face of ‘therapeutic uncertainty’, the patient mediates between group and individual subjectivities in constructing a notion of treatment ‘effectiveness’. As well as oncologists and other biomedical practitioners, the source of information around effectiveness
include informal communication (‘rumour, hearsay and gossip’) with other patients concerning treatment effect. Informal communication emerged as a key sense making strategy through which cancer patients generate solidarity with other patients. This communication involves informal tips around CAM therapies such as Chinese medicine and effectiveness thereof. This information is used as a barometer for assessing the patient’s own subjective sense of wellness, which affects the combined use of CAM and biomedicine.

Broom (2009a, p. 1055) theorised that ‘embodied knowledge’ is used to legitimise therapeutic trajectories for cancer patients and that these trajectories differ to the life-expectancy norm calculated from epidemiological data, and that patients rationalise themselves as being exceptional to the norm. This rationalisation appears to be based on subjective interpretations of expert medical knowledge, and is also based on from the patient’s bodily response to treatments. Broom (2009a, p. 1056) uses the term ‘bricolage’, which is a useful concept for referencing the shifting parameters of treatment decision making among these cancer patients. It is evident through the cancer patients’ negotiation of therapeutic knowledge in Broom’s studies that patients oscillate between a sense of uncertainty about their life course, and a sense of confidence, or more rightly faith in defeating the odds. These tensions are possibly more pronounced among people with fatal illness than for those with milder forms of illness.

In summary, sociological studies of trust in CAM are almost non-existent in the literature. The only study engaging Giddens’ and Luhmann’s theories of trust suggest that trust is generated from meaning making of the treatment experience. Broom’s study of uncertainty in treatment decision making of cancer patients tends to confirm this in showing how patients make statistical evidence to mean something specific to their illness experience. Chatwin’s studies of micro-interactions between homeopaths and their clients brings the practitioner into the foray through showing how trust is built through equitable interaction. What Chatwin shows is that trust emerges from familiarity and rapport with the practitioner, rather than trust in a treatment regime per se. What is inferred from these studies is that trust in CAM emerges from lay knowledge and experience, and this is interpolated through the expert knowledge of CAM and biomedical professionals. The next two sections look critically at the socially constructed nature of expert and lay health knowledge.

2.3 Expert Health Knowledge

It is important to understand the socially constructed nature of medical and CAM knowledge, both figuring prominently in the accounts of CAM users. While CAM users in this study use CAM as a resistance strategy to biomedicine, they also continue to use biomedicine. This section examines the construction of scientific and medical knowledge, and how CAM
disciplines are appropriating scientific and medical discourse as a legitimating strategy. This is changing the knowledge base of CAM disciplines from esoteric to scientific knowledge. However, the shift is more discernible in disciplines such as homeopathy which are under public attack, even then not all practitioners have relinquished esoteric knowledge. Lastly, CAM practitioners are found to be unanimous in their opposition to using randomised controlled trials (RCT) for demonstrating treatment effectiveness.

2.3.1 Constructing ‘expert’ medical knowledge

Chapter One has shown how processes of legitimation have made biomedicine the dominant health care system in Australia, and how this position is maintained through professionalisation strategies and the harnessing of expert knowledge. Biomedical ‘expert’ knowledge has from the outset been based on clinical practice and scientific evidence based medicine (EBM), and despite debate over which of these two knowledge sources most influences doctors, scientific knowledge is seen as more legitimate than non-scientific knowledge (Willis, 1989) and ‘lay’ knowledge’. As outlined in several accounts of the history of modern clinical medicine (e.g. Bury, 2005; Easthope, 1986; Foucault, 1994; Willis, 1989) during the late 19th and early 20th century, the clinical paradigm advanced a scientific knowledge concerning the aetiology and causes of disease. The *allopathic* model became the underlying basis of orthodox biomedicine, and explained the cause of illness as the body being invaded by toxic materials (Easthope, 1986). This is not simply a cause and effect dichotomy; according to Foucault (1994), this knowledge was philosophical in that it does not include a symptom that is discovered, or a visible cause, instead is a ‘very simple’ knowledge of the observable. In this specific knowledge system disease is perceived in only one space and time: ‘The *distance* that separates one disease from another can be measured only by the *degree* of their *resemblance*, without reference to the logico-temporal divergence of their resemblance’ (Foucault, 1994, p. 6).

What Foucault is saying is that preferred medical knowledge emerged as observable causes and signs of disease, rather than non-observable manifestations of disease. The germ theory of disease linked disease to the pathology of human tissue, with bacteria and other pathogens seen as the underlying cause of illness. Eliminating bacteria from the body as well as avoiding the risk of contamination became the preferred medical routes to ensuring positive health (Bury 2005, p. 3). Alternative theories of disease such as restoring the body to a natural, balanced state therefore lost favour with medical practitioners.

According to Gergen (1999, p. 18), as scientific communities grew stronger, they developed ‘specialized vocabularies, methodologies, modes of analysis and practices of reason’ which led to the emergence of a new ‘knowledge class’ of scientific, medical practitioners. As shown in the accounts of the history of medical dominance (Gergen, 1999; Willis, 1989), initiation into
This knowledge class and the authorisation to administer practice based on specialised knowledge claims is granted to those who acquired specialist medical credentials and qualifications: ‘As social theorist Jürgen Habermas demonstrated in his influential volume Knowledge and Human Interests, all knowledge-seeking privileges certain interests over others, favours a certain political and economic configuration to the detriment of alternatives’ (Gergen, 1999, p. 22).

Widespread acceptance of medical knowledge by the state and lay public alike has maintained the dominance of biomedical expertise (Friedson, 1970 in Bury, 2005, p. 5). However, in the era of late modernity, there has been widespread questioning and challenging of authoritative scientific and medical knowledge claims and assumptions, and this invariably is producing mistrust and scepticism. This has formed a ‘legitimation crisis’ in which worldly knowledge claims have lost credibility. This has been compounded by bureaucratic strategies such as time management which are used to maintain clinical authority, resulting in disembodied personal interaction with the patient (Lupton, 2003, pp. 127-128). Some of these processes, as will be seen in the next section, are now incorporated into CAM.

2.3.2 Expert knowledge of CAM

As shown in Chapter One, a legitimisation of CAM practices is achieved through professionalisation processes including statutory regulation, minimal training requirements and credentialing (Saks, 2003). For some forms of CAM such as chiropractic and homeopathy, the basis of practice has turned more toward incorporating scientific discourse and medical knowledge. In response to this several commentators (e.g. Frank, 2002b; Wahlberg, 2007) have documented the internal battles and tensions when the principles of ‘medical science’ are embedded into the expert knowledge of a natural health discipline. Reflecting the prevailing influence of scientism in medicine, several commentators (Hirschkorn, 2006; Saks, 2003; Willard, 2005) observe how ‘scientific’ and ‘medical’ discourse has been appropriated into CAM discourses, for purposes of achieving biomedical legitimacy. Professionalisation is seen as a strategy for making CAM knowledge exclusive, and science as the basis for exclusivity (Hirschkorn, 2006, p. 549).

Legitimation is based on having acceptable knowledge, and this is seen to be knowledge embedded in medical practice. The form of appropriation is seen to include scientific language, a high level of abstraction, systems of meaning, competing rhetoric and technical jargon (Mizrach, 2008; Willard, 2005). However, the appropriation of scientific discourse is not uniform, with Baer et al. (1998) (in Mizrach 2008) identifying a rift between the ‘professionalisers’ who are seeking legitimisation through scientific discourse, and the ‘counter culturalists’ who seek to change this process, including disavowing scientific explanations. To
assess how the appropriation of scientific knowledge and practice is actually occurring, we need to turn to empirical studies.

As Coulter and Willis (2007) emphasise, CAM is not one homogenous set of practices and there are significant variations in knowledge claims and practices between CAM disciplines. As professionalisation proceeds, the knowledge base of some practitioner groups is shifting as certain practices and principles are favoured over others. In a study of the legitimacy of CAM knowledge claims, Hirschkorn (2006, p. 535) attends to the form that knowledge that takes in both biomedical and CAM practices, positioning knowledge forms as intermediary to the professional contexts of knowledge production and specific knowledge content. What this means is the constitution of knowledge is used to construct boundaries around what is discipline specific knowledge, and this process by which professional groups harness their knowledge is referred to by Cant (1996b, p. 57) as ‘boundary construction’. Moreover this knowledge is fluid and changing, and this process of change creates tensions among those practitioners involved in interpreting knowledge.

In studies of boundary construction in CAM (e.g. Toms, 2004), there are found to be expressions of concern over ‘co-optation’ where one disciplinary group embraces the practices and knowledge of another CAM discipline (Welsh et al., 2004, p. 217). My own paper (Toms, 2004) based on accounts of CAM practitioners in this study found that homeopathic practitioners hold concerns over the dispensing of homeopathic remedies by naturopaths, whom homeopaths regard as insufficiently trained in dispensing homeopathic medicines. Accounting for the ongoing boundary collision between homeopathy and naturopathy in Australia, Willis (1994, p. 57) has shown how early twentieth century medical dominance meant that homeopathy struggled to maintain a client base, and subsequently became incorporated into the emerging natural therapies practice as a ‘submodality’.

Exploring historical tensions between homeopathy and biomedicine shows that homeopathy, which once had a status similar to biomedicine, is rapidly losing its client base. Australian and British data reveal that homeopathy is the only CAM therapy with decreasing reported use, and it is speculated that this could be due to the questioning of homeopathic methods in public health and political discourse (The Science and Technology Committee, 2010) and overall construction of homeopathy as ‘quackery’. This is compounded by the alleged appropriation of homeopathic remedies into biomedical practice including immunisation, and the ensuing

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4 The trend toward decreasing use of homeopathy are mirrored in Britain where the number of National Health prescriptions for homeopathic remedies dropped by over 85% between 2000 and 2010, and one of five homeopathic hospitals closed in 2009 due to a drop in referrals (The Science and Technology Committee, 2010). Evidence check 2: Homeopathy. Evidence check. London, House of Commons: Science and Technology Committee, 1-275.
marginalisation of homeopathic practice (Cant & Sharma, 1999, p. 87; Willis, 1994, p. 57). The history of homeopathy’s appropriation by biomedicine has well documented in sociological accounts, which also detail a similar experience for other ‘effective’ CAM therapies (Baer, 2005; Cant & Sharma, 1999, p. 87; Easthope, 1986).

Through studying the impact of professionalisation of homeopathy in Britain, Cant and Sharma (1999, pp. 87-88) argue that through processes of incorporation homeopathy in Britain has relinquished some esoteric concepts, and that increasingly formalised education and standardised knowledge means the premise of individuality of each patient, the extensive case histories and the concept of vital force are losing significance. As Frank (2002a, p. 797) observes: ‘Homeopathic organizations no longer present homeopathy as an alternative to biomedicine, but rather as a means of complementing biomedical treatment. They aspire to scientific evaluations of efficacy and precise mechanism of homeopathic remedies.’

However, professionalisation strategies are not necessarily upheld in practice. Frank’s (2002a) interviews with 20 homeopathic physicians in Germany located three homeopathic practice patterns: 1) separating homeopathic and biomedical patients; b) introducing biomedical diagnostic strategies while retaining mainly homeopathic practice; c) outright rejection of biomedicine, with the exception of emergency and surgery. Frank examined the homeopathic appropriation of medical knowledge, and found that for those practitioners introducing some biomedical strategies, the homeopathic concept of the vital force is still very important, the concept influencing the practitioner’s choice of homeopathic or biomedical medicines. Frank notes that if the vital force is perceived as low, homeopathic medicines are prescribed instead of biomedicine, which is seen as too ‘weakening’ for the body. Importantly, Frank identified that treatment choice is ultimately made by the homeopath, who also has a clear diagnostic role. For those practitioners rejecting biomedicine outright, biomedicines are seen as weakening and having side effects, as being unscientific and dangerous. These practitioners were also more likely to draw on the ‘spiritual’ dimensions of homeopathic knowledge. Frank’s interviews overall show that central principles of homeopathy were not abrogated for the sake of scientific legitimacy.

CAM is seen as undergoing a ‘divided legacy’ in which the empirical basis of disciplines such as homeopathy are giving way to the rationalist medical basis of biomedicine (Mizrach, 2008). Empirical medicine, Mizrach (2008, p.4) explains, is based on ‘induction through direct, concrete observation and experimentation’, while homeopathy, drawing on the experience of the homeopath and taking the life history approach, is empiricist. Rationalist medicine by contrast is ‘essentially deductive, searching for logical, abstract’ (p. 4) procedures for treating
illness, such as medical training equipping a doctor to treat a person using formal, logical methods.

One of the primary systems of meaning in biomedical discourse is the adherence to scientific evidence as the basis of legitimate, medical knowledge. Since the 1970’s, conventional medicine has used evidence based medicine (EBM) as the gold standard for determining legitimate medical treatment. In health policy ‘evidence’ is linked to a methodological design and form of knowledge production based on randomised controlled trials (RCT) and systematic reviews (Broom & Tovey, 2007, p. 1023), and proponents of EBM are likely to view CAM as ‘unproven’ and therefore illegitimate.

The irony is that although CAM disciplines are seeking public and professional legitimacy through incorporating scientism into knowledge and practice, they are heavily resistant to incorporating scientific testing method (Mizrach, 2008). The homeopaths in Frank’s (2002a, p. 810) study reject RCT as a method for evaluating practice, and were unanimous that testing methods should be adapted to homeopathic principles. What the homeopaths favour is clinical knowledge based on years of experience. This is echoed by practitioners of other CAM disciplines, who support more subjective notions of effectiveness including patient feedback on healing and well-being (Broom & Tovey, 2007, p. 1024). Even CAM practitioners interviewed for my study opposed randomised control trials for scientific evidence testing, claiming the method is inappropriate for understanding the effectiveness of a long-term treatment which is tailored for an individual person. Those opposing the use of RCT and scientific testing in CAM further argue that the positivist tradition underpinning Western scientific medicine is Eurocentric (O’Sullivan et al., 2004, p. 8) and reductionist (Broom & Tovey, 2007, p. 1024). As O’Sullivan et al. (2004, p. 8) note, TCM and Ayurvedic medicine are scholarly traditions, based on ‘centuries of empirical evidence drawn from multiple documented case studies’. These schools of medicine have originated in Asia which have transmitted and validated Oriental medical knowledge for many years, and allegedly use rigorous and effective practice (O’Sullivan et al., 2004, p. 9).

From the biomedical perspective there is a paradox is that scientific evidence based on RCT has been shown to be abrogated by medical practitioners, who favour clinical evidence. Following this, doctors have also been found to have understandings of lifestyle and health risk which have more in common with lay than expert conceptions (Hansen, 2003). At the same time, biomedical concerns over safety and efficacy of CAM practices such as herbalism, natural remedies, and vitamins and acupuncture have led to more scientific evidence testing and there is a growing scientific evidence base emerging from randomised controlled studies of CAM.
In summary, these studies show how CAM disciplines are changing; however, the change is not uniform and while some disciplines are quickly appropriating scientific discourse (Mizrach, 2008) as a means of legitimation, others remain based on esoteric knowledge. Moreover, an institutional shift in expert knowledge does not mean that individual practitioners relinquish traditional knowledge. The interest for this thesis is in the compatibility between CAM user and practitioner knowledge claims, and the negotiation of trust and uncertainty in ‘new’ expert knowledge claims of CAM and the more esoteric knowledge.

2.3.3 The principles of CAM knowledge

In Chapter One the concept of holistic health is introduced as the basis of principles of CAM practice. Although holistic health concepts emerge from the naturalistic beliefs of Ancient Greek physicians, it was not until 1927 that the term ‘holism’ became listed in the Encyclopedia Britannica as ‘a viewpoint additional and complementary to that of science’ (Di Stefano, 2006, p. 3). Holistic health is also referred to as ‘whole person’ medicine (Cant & Sharma, 1999), using principles based on the interrelationship of mind, body and spirit (Goldstein 2003, p. 619; Grant, 2007; Sered & Agigian, 2008, p. 619). Core principles of holistic health are balance and harmony, vitalism, and spirituality. It is argued that these principles are understood and applied differently by CAM practitioner groups, and that the incorporation of scientific discourse has relinquished much of the holistic basis of practice for some groups. There appear to be two sets of CAM practises, those operating more from a scientific, biopsychosocial model and those favouring esoteric knowledge such as mysticism and other forms of spirituality. This section examines the various understandings of CAM practitioner groups.

2.3.3.1 Holistic health

CAM is said to view the body as a self-regulating system with inbuilt immunity allowing it to regenerate (Fulder, 2005, p. 5; Lewith & Chan, 2002), which in theory means recruiting the body’s self-healing ability through amplifying natural recovery, and increasing energy stores (Lewith & Chan, 2002, p. 74). Others claim it is not so much the therapies which recruit the body’s healing capacity, but the practitioners. These commentators (e.g. Easthope, 1986; Fulder, 2005; O’Connor, 2003) see practitioners as having a significant role in identifying the underlying source of bodily disharmony, and restoring an individual’s normal state of health.

Central to holistic health knowledge is the concept of ‘balance’ which sees illness is a result of the imbalance between ‘insensate elements of humors in the body’ (Anderson et al., 2010, p. 153S). Various CAM disciplines have extended these concepts to their own practice (O’Connor, 2003, p. 51; Schuster et al., 2004, p. 352). An example is traditional Ayurvedic practice in which hot and cold foods are prescribed medicinally to balance a sick body, and ‘hot’ illness is
treated with cold food and hot food treats cold illness (Anderson et al., 2010, p. 155S). Another example is TCM which conceptualises yin and yang as generating bodily harmony. Drawing on a naturalist discourse, the Ayurvedic practitioner helps the ‘patient’ learn to recognise their individual nature, and what causes ‘imbalance’ in their body, and guides the patient through the process of natural bodily balance. Balance in this discipline refers to reduced stress and anxiety, body weight, sleep maintenance, immune system, digestion, minimisation of pain and strengthening the healing capacity of the body (Greene, 2010). Not every CAM discipline offers the same conception of harmony; naturopaths may more factor in social contexts for disharmony such as environmental impurities and food intake.

The *individuality* of the consumer/patient is important to CAM practice with the understandings that each person has unique, individual contexts for health and illness, and that individuals are in constant change (Hughes, 2004, p. 33). My own analysis of interviews with CAM practitioners found that while practitioners employ a rhetoric of individualism (involving regimentation and discipline) which appears to empower a client, it also subjugates them (in a similar way to medical surveillance) and demands users adhere to strict regimes (Toms, 2004). CAM regimens are not necessarily as individually tailored as the rhetoric would suggest. This invites a consideration of the extent to which the holistic health platform of CAM is different from the holistic health ‘paradigm’ being increasingly incorporated into public health and medical discourse. Based on the bio-psychosocial model of health areas of medicine, certainly integrative health, appropriate ‘holistic medicine’ (Gordon, 1990) and ‘holistic health care’ create divergent forms of health care. Much like CAM, the model is seen as accommodating the centrality of the therapeutic encounter, the ‘self-care’ approach to healing, individuality and spirituality.

### 2.3.3.2 Vitalism and energy flow

Vitalism sees the body as animated by invisible force or energy, essential for regulating bodily balance and harmony (Canaway, 2007). The principle is seen as relating to life and sensory experience, an energetic, self-generating life force (Lash 2006, p. 323). This clearly differs from the medical concept of *mechanism* which locates the source of illness in tangible, external factors (Coulter, 2004; Lash, 2006). Vitalism draws on a metaphor of ‘flow’ which sees the vital force, this intangible dynamic, as sustaining all organisms (Coulter, 2004, p. 113; Hirschkorn, 2006, p. 545; O’Connor, 2003). As demonstrated in section 1.3.2, vitalism is expressed through concepts such as ‘life force’, ‘energy’ and the TCM concepts of *Chi* (or ‘Qi’) (Canaway, 2007; Coulter, 2004; Fulder, 2005), and practitioners see their job as harnessing the ‘life force’ to heal and restore energy to the body. In TCM acupuncture needles facilitate *Chi*
(Fulder, 2005); small doses of medicine administered by the homeopath reenergise the body
(Kaptchuk & Eisenberg, 1998) and energy is harnessed through reiki.

A by-product of the appropriation of scientism to CAM is the loss of esoteric knowledge and
the once core principle of vitalism has, it seems, become peripheral to CAM (e.g. Baer &
Coulter, 2008; Canaway, 2007). Canaway’s (2007) interviews with Australian naturopaths
found the concept of vitalism to be no longer central to naturopathic knowledge. The concept
has also been found to be absent from chiropractic, acupuncture and integrative medicine
practice (Baer & Coulter, 2008, p. 338). What this means is that vitalism is less used as a key
explanation for illness so the CAM consumer/patient is less exposed to the concept. Given the
importance of the CAM practitioner in conveying information and knowledge, and with the
exception of esoteric and energetic modalities, we could expect vitalism to be less prominent in
the accounts of CAM users.

2.3.3.3 Spirituality

From a sociological perspective the concept of spirituality is notoriously difficult to define,
representing as it does a diversity of disciplinary perspectives and subject positions (Holmes,
2007, p. 24). If there is one defining feature of spirituality, it is the search for personal meaning
(Grant, 2007; Reeve, 2005), expressed by Speck (1998, cited in Reeve, 2005, p. 1) as ‘a search
for an existential meaning within a life experience, with reference to a power other than the self,
which may not necessarily be called “God”’.

A substantial literature has been published on spirituality and health, largely addressing the role
of spirituality for terminally ill people. Historically this has taken the forms of prayer, séance,
ritual, placing objects in the sick room and other observances (Grant, 2007). In CAM
spirituality is seen as a key component of the holistic philosophy; however, social science
literature (Grant, 2007; Hildreth & Elman, 2007; Ho, 2008; Reeve, 2005; Zuess, 2005) shows
how CAM practices vary widely in the incorporation of spiritual concepts. Some literature
suggests that spirituality is important in CAM practice (Goldstein, 2003; Grant, 2007, p. 107;
Zuess, 2005, p. 73), particularly in ethnomedical practices such as Ayurvedic medicine which
derive from religious systems, and that spirituality is manifested through transcendence, holism
and vitalism (Ho, 2008). In addition new age spiritualism techniques such as meditation are
used in mind-body therapies, making some forms of CAM inherently spiritual (Ho, 2008). Baer
et al. (1997) point out that the word ‘healer’ as commonly referred in discussions of Indigenous
medicine, has been linked to notions of spiritual medicine or the ‘spiritual origin of disease’,
faith healing, shamans and other Indigenous healers (Baer et al., 1997, p. 193). While
Indigenous medical systems have drawn on metaphysical concepts such as the soul and ancestry
to explain illness and disease, spiritualism in CAM generally takes a different form.
Part of this difference is in locating spirituality in client/practitioner interaction. In a study of practitioner/client interactions in U.S. acupuncture clinics, Ho (2008) observes that the terms ‘spirituality’ and ‘spirit’ are frequently used in professional consultations, and can be appropriated into the linguistic repertoire of a acupuncture client. Although Ho found that there were differing understandings of ‘spirituality’ between acupuncture practitioners and users, she found spiritual ‘talk’ to be a unifying discourse. Ho (2008, p. 5) argues that this spiritual talk underscores a wider holistic critique of biomedicine.

According to Zeus (2005, p. 78) some forms of CAM have taken a similar role to religion, by providing solidarity and stability to large groups of people. While this seems a far-reaching claim, we can see how Durkheim’s (1965 [1915], p.223) concept of the ‘collective conscience’ has application for certain CAM disciplines. Reiki is described by Barcan (2011, p. 169) as a ‘universal energy’ based on a universal harmonious consciousness. In reiki, healing is seen to occur when the practitioner acts as a conduit for healing energy, and the client/patient lets go of resistance to a universal consciousness. The symbolic practice of reiki and the universal manifestation of consciousness can be linked to Durkheim’s (1965 [1915]) idea of religion as ‘a unified systems of beliefs and practices relative to sacred things’ (p. 47). Moreover, there is a strong sense of a linked consciousness with people who practise reiki, the theory accommodating a link between each atom in the universe. Again using Durkheim’s theory, this consciousness creates solidarity between practitioners and users.

Another study (Grant, 2007) suggests that, with the exception of energetic medicines and mind-body practices such as reiki, spirituality is weakly incorporated into CAM disciplines, particularly manipulative disciplines such as chiropractic, and also in natural therapies and homeopathy. Grant found that CAM practitioners perceive themselves to be inadequately trained to deal with spirituality and regard it as inappropriate to ‘coerce’ a client into having a spiritual assessment. Grant also found that brief consultations prevent the practitioner from being able to ‘delve into deeper more mysterious/less accessible aspects of disease’ (2007, p. 209).

Both Ho’s and Grant’s studies offer different, insightful understandings of the incorporation of spirituality into CAM practice. Given the idiosyncratic practice modes between countries, the studies cannot be used to draw inferences about spirituality in Australian practice. It is likely, given the ongoing professionalisation strategies of CAM including formalised training and credentialing, that spirituality will be a less integral part of the teaching of CAM (Grant, 2007). This will further diminish spiritual assessment in CAM practice, particularly in disciplines such as naturopathy and homeopathy which are actively incorporating scientific knowledge into practice. As with vitalism, the knowledge and practice boundaries of CAM are fluid, and they
also differ substantially between disciplines. In summary, there is an increasing divide between ‘esoteric’ and more scientifically oriented CAMs.

2.4 Lay Health Knowledge and Beliefs

2.4.1 Lay health beliefs

Health sociologists see ‘lay health beliefs’ as representing the personal understandings of health, and as individual constructions of the cause of illness (Bolam et al., 2003; Williams & Popay, 1994). Health beliefs are seen to be formed and enacted within our cultural and social contexts. Drawing on Bronfenbrenner’s (1977) developmental model, Andrews et al. (2010, p. 152S) argue that health beliefs are learned, and evolve over time, while Illich (1995/1975, p. 273) shows how meanings of health are culturally framed within systems of belief and action. Health beliefs are not static, people adapt to illness and disability, and are continuously redefining thresholds of health (Bury, 2005, p. 10). Furthermore, lay people’s understanding of the cause and pathology of their disease and illness is seen as complex and multifaceted. Studies cited by Bury (2005) show how lay understandings of health have a ‘moral dimension’, including maintenance of a healthy lifestyle, and that the cause of ill health can hugely affect a person’s self-identity; moreover, people associate the cause of both physical and mental illness with stress. Bury also shows how lay meanings of health are normative, with some chronically ill people regarding themselves as ‘healthy’, and relatively healthy people seeing themselves as ill. Health is subjective, and related to personal feelings of wellness framed within cultural narratives of health. To distinguish biological illness from the subjective experience, medical anthropologists have regarded ‘disease’ as the physical, observable health condition, and ‘illness’ as the experience of the disease (Andrews et al., 2010, p. 153S).

Proponents of the health belief model have, as observed by Bury (1997, p.20), regarded lay health beliefs as ‘irrational’: ‘Beliefs in this context are treated as irrational, and counterposed to rational scientific medical knowledge. Put simply, lay people have beliefs and doctors have knowledge.’ According to Bury (1997, p. 19), the model fails to provide a clear analysis of the relationship between beliefs and knowledge, and as discussed in section 2.4.2 sociologists of health are attending more to the socially constructed nature of lay health ‘knowledge’.

2.4.2 Lay health knowledge

For health sociologists (e.g. Bolam et al., 2003; Bury, 2005; Conrad & Barker, 2010; Kangas, 2002; McClean & Shaw, 2005; Williams & Popay, 1994) lay health knowledge derives from the interpretation of expert health knowledge, largely biomedical, in the social, physical and material contexts of everyday life. Lay health knowledge is acquired from personal experience, word of mouth, written information and health providers (Stacey, 1988, p. 142). Relevant to this
thesis is how CAM users use the explanatory theories of health and illness to generate trust in CAM treatment decision-making. I acknowledge the concerns of social scientists (Gergen, 2003; Locker, 1981) about the incorporation of incomplete medical knowledge, including generalised use of redundant biomedical terms into lay understandings of health and illness. However, my interest is not in the ‘correctness’ of lay health knowledge, but rather in how lay users of CAM both embrace and resist expert knowledge, demonstrating trust and uncertainty in the knowledge claims of CAM practitioners.

In efforts to understand the points at which lay people embrace or resist expert health knowledge, social scientists explore the lay and expert knowledge nexus from various perspectives, including the privileging of personal experience in lay explanations of health and illness, and the incorporation of lay knowledge into expert health knowledge.

Lay explanations of health and illness are seen to incorporate personal experiences of health and illness. While lay people see their personal experience as important ‘information’ for the health professional, patients still report that health providers fail to take serious consideration of their illness perspective (Bury, 2005, p. 4; Lupton, 2003, p. 28). The tendency to valorise one’s personal experience as ‘knowledge’ has partly arisen from the women’s health movement. Feminists have encouraged women to legitimise their subjective understandings of health and illness, and challenge the dominant biomedical discourse (Willard, 2005, p. 117; Williams & Popay, 1994, p. 120). The proliferation of biomedical information in the public sphere, and the incorporation of this knowledge in lay health accounts, has caused several sociologists (Bury, 2005; Kangas, 2002; McClean & Shaw, 2005) to question the relevance of an ongoing ‘lay/expert’ knowledge divide. Sociologists supporting this (e.g. Wilcox, 2010) claim that information and communication technologies have facilitated access to authoritative sources including current research findings, technical information and social interaction via chat rooms and social media, to share ideas and experiences of health and illness, and that this means that lay understandings of health involve quite specific medical knowledge. Kangas also argues that over the last 30 years, and especially for the increasing number of people living with chronic illness, medical knowledge has become ‘common sense’ (Kangas, 2002, p. 302). Kangas asserts that as a consequence there is no longer a ‘clear cut dualism’ between expert and common sense knowledge, and that positioning ‘lay’ against ‘expert’ obfuscates the complexity of the relationship between the two. Along these lines social science researchers propose reconfiguring lay knowledge as either a multifaceted construct, in which people are acknowledged to have ‘different’ knowledges (Kangas, 2002, p. 301; McClean & Shaw, 2005, p. 730); or in recognition of the active participation of lay people in the development of medical knowledge, several researchers (e.g. Wilcox, 2010, p.46) argue for ‘lay expertise’:
The concept of lay expertise has been used both narrowly, to refer to lay people’s active participation in the development of scientific and medical knowledge, and broadly, to refer to the general cultural stock of knowledge held by everyone in society.

Wilcox proposes that medical knowledge is partly constructed through lay people. This idea is not new; one of the earlier proponents of the idea that lay people participate in the construction of medical knowledge is Ludwik Fleck (1979/1935). In his pioneering work *Genesis and Development of a Scientific Fact* Fleck develops the idea that medical knowledge is constructed through interaction and communication between scientists and lay persons. Anticipating later work on the social construction of medicine, Fleck (1979/1935) observes the abatement of human agency in medical knowledge construction:

> Moreover, we have even lost any critical insight we may once have had into the organic basis of perception, taking for granted the basic fact that a normal person has two eyes. We have nearly ceased to consider this as even knowledge at all and are no longer conscious of our own participation in perception.

Fleck’s argument suggests that lay health consumers participate in the construction of medical knowledge. Using Fleck’s theory, Arksey (1994) studied accounts of patients with repetitive strain injury (RSI) attending medical consultations, and concluded that through relaying their RSI experience to doctors, patients actively contribute to medical knowledge on RSI. Vested interest groups such as pharmaceutical companies and medical specialists can circumvent the legitimation of the lay constructions as medical ‘facts’. It is argued that only through having consumer representatives on expert bodies can lay constructions contribute to medical discourse (Arksey, 1994, pp. 463-464). Fleck argues that scientific and medical ‘facts’ are historically and socially constructed by collectives of specialists and non-specialists.

Critiques (Prior, 2003, cited in Wilcox, 2010, p. 65) of the ‘lay expert’ theory suggest that while lay knowledge may be fluid, biomedical knowledge claims are largely immutable; furthermore, lay people are not properly qualified to advance ‘specialised’ medical knowledge. Here ‘expertise’ is seen as the acquisition of specialist knowledge, and is a foundation of professional authority, and that knowledge cannot be simultaneously specialist and held by non-specialists. Notable sociologists have emphasised that lay people cannot assume the same knowledge as experts (Berger & Luckmann, 1967), and that lay health understandings should not be substituted for expertise (Bury, 2005, p. 11). According to Gergen (1999, pp. 12-14), without codifying our knowledge, or having ways of identifying and understanding the criteria for assessing our mental and physical knowledge, the problematic of self-knowledge concerns the capacity for our mind to ‘know its own contents’. Fleck (1979/1935) himself observes that the
lay person, although important to the social construction of medical knowledge, is far less central to the production of a medical fact than a medical ‘expert’ who has acquired specialist knowledge through training. I am inclined to adopt Wilcox’s (2010, p. 65) ‘middle ground’ which acknowledges an uneven social distribution of collective knowledge in which some lay people are seen to have acquired specialist knowledge; that support and action groups can transform experience into collective knowledge; and that many lay people remain uninvolved in the production of health knowledge. According to Gergen (1999:12-14), the ‘problem’ of self-knowledge concerns the capacity for our mind to ‘know its own contents’ or how we come to identify and understand the criteria for knowing our mental and physical state.

A more appropriate way of conceptualising the interrelationship between expert and lay knowledge in CAM is through acknowledging the differing forms of knowledge among the lay populace as evidence of changing our knowledge base, accepting that this knowledge is fluid and subject to change, opposed to the less fluid basis of expert knowledge. Drawing from evidence from two qualitative health studies, one of which concerns the practice of CAM, McClean and Shaw (2005, p. 730) propose that the boundary between lay and expert knowledge is fluid and changing, and rather than a divide there is a continuum of different forms of knowledge. Here McClean and Shaw cite their own ethnographic study of spiritual healers and patients of an alternative medicine centre in the north of England. Through observing and interviewing healers and patients, McClean and Shaw develop ideas about what constitutes knowledge and expertise in the alternative medicine setting, showing how healing practices reflect the lay health agenda. Moreover, healers sought legitimacy of their practice through incorporating biomedical scientific practices and terminology, and juxtaposing this with ‘intuitive’ self-reflexivity.

2.4.3 Lay knowledge of CAM users

Empirical studies focusing on the health beliefs and knowledge of CAM users are few and far between. However, there are several social science studies of CAM treatment decision making which discuss information/knowledge acquisition of CAM users. The interest in studying CAM user engagement with information/knowledge sources is that CAM practices are seen as having a poor scientific evidence base, and the extent to which this influences people’s decisions to use health care treatments. Furthermore, CAM information is seen as based on anecdotal experience, accumulated worldwide.

CAM users have been found to obtain the majority of their health information from both doctors and CAM practitioners. Robinson and Cooper (2007) administered a self-completion questionnaire survey to Australian health service users; 52 per cent of respondents (totalling 240 respondents) currently used CAM. The researchers found that CAM users obtain the majority of
their health information from both doctors and CAM practitioners, and regard online and health food stores as the least useful information sources. Some of the more notable findings are that CAM users obtain less information from doctors than non-CAM users; and there is wide variation in the level of trust in information sources between users of different modalities, with users of chiropractors and magnetic therapy trusting more in doctors than clients of homeopathy and naturopathy who favour information from CAM practitioners. Users of osteopathy and mind-body medicine were found to utilise doctors less as information sources, and users of aromatherapy and acupuncture obtain less information from CAM practitioners. Moreover, CAM users talk extensively to their doctors about health, though not necessarily about CAM (Robinson & Cooper, 2007). The reliance on CAM practitioners for information is seen by Robinson and Cooper to reflect the lack of evidence-based information available in the public sphere, who conceive of practitioners as representing ‘authority’ extending beyond evidence-based knowledge.

In relation to media as information, Robinson and Cooper (2007, p. 129) found self-help books the highest rated media by CAM users, especially by users of naturopathy, homeopathy, meditation and aromatherapy, perhaps reflecting the prescribing of self-help books by practitioners of these therapies. Despite reference in other studies (e.g. Bakardjieva, 2010) to the Internet as an influential source of health information, Robinson and Cooper’s study found Internet the least useful source of health information by CAM users (and non-CAM users), speculating that difficulties in assessing the credibility of online sources accounts for reduced trust in online material. When information is used from the internet it is more likely to be by users of naturopathy, homeopathy, yoga and reflexology. Family, friends, colleagues and social networks were rated as moderately reliable sources of information by CAM users in Robinson and Cooper’s study. However, according to Robinson and Cooper (2007, p.133), users obtain a lot of information from these ‘experiential information’ sources.

Robinson and Cooper have not theorised reasons for such wide-ranging variations between users of different CAM therapies. Practitioners of mind-body medicine, acupuncture and manipulative therapies are less used for information due to the non-verbal nature of their practice. This difference has clear implications for trust in expert CAM knowledge. For a start, it shows that CAM users and therapists are not a homogeneous group, and that knowledge derived from these information sources is heterogeneous. It is also important to note that information provided by biomedical doctors is mediated with the information from CAM practitioners.

Users of natural remedies as found in health food stores and pharmacies have been found to be the most proactive information seekers and users and, according to Robinson and Cooper’s
(2007, p. 134), of most concern to biomedical providers due to potentially adverse interactions between medical and natural remedies. In terms of the fluidity of lay health beliefs and knowledge, the proliferation of information about natural remedies, including from product suppliers, is seen to assist in assessment and evaluation of the benefits and risks of these products. Perhaps due to the self-experimental nature of natural remedy use, these users are seen to reflect the most on information from evidence and non-evidence based sources, including anecdotal ones and practitioners, when making treatment decisions. Unfortunately Robinson and Coopers do not report on the use of information sources by eclectic users of more than one modality, nor do they theorise trust sociologically, instead using ‘trust’ in a normative sense. As such the users’ underlying tensions and uncertainties regarding health information and knowledge are less able to be understood. The study does provide clear evidence though of the heterogeneous nature of CAM treatment decision making, making the point yet again that CAM users are not all the same, but engage differently with information sources on health. These differences have implications for lay health belief and knowledge construction.

2.4.4 Understandings of holistic health

Taking the holistic health principles articulated earlier in this chapter, balance and harmony, vitalism, and spirituality, this section explores how CAM users articulate these concepts in beliefs and knowledge of CAM, and how these concepts hold meaning for users. Lay explanations of the cause of ill health often blame physical and mental stress. Stress is related to bodily disharmony, which in turn relates to individual social, environmental and spiritual contexts (Easthope, 1986; O’Connor, 2003). CAM users are said to understand the embodied linking of psychological and physical health with ‘deeper’ explanations of health and illness (Cartwright & Torr, 2005, p. 564). Citing a participant from Gunnarsdottir and Peden-McAlpine’s (2004, p. 127) study of hydro-therapy spa users in Iceland, ‘when people feel bad mentally they will develop stiffness and muscular tension. I know that these things interact because when I get anxious, I get terribly sore.’

What this shows is that CAM is perceived as addressing underlying problems, not just symptoms of illness. An interpretative study (Cartwright & Torr, 2005, p. 564) of CAM use found common themes among users to be the interrelationship of body parts, and the provision of ‘holistic benefits’. Cartwright and Torr’s (2005) study also found that CAM users appropriate terminology and concepts from CAM such as ‘energy’, ‘balance’ and ‘qi’, and recirculate these in explanations of illness and health. The study suggests that a primary information source on CAM is the CAM practitioner, and that CAM knowledge is reinterpreted by CAM clients through holistic health discourse.
CAM studies also reveal that the concept of ‘balance’ is central to lay constructions of health. In fact, social scientific studies of CAM use (e.g. Baarts & Kryger Pedersen, 2009; Cartwright & Torr, 2005; Gunnarsdottir & Peden-McAlpine, 2004; Lewith & Chan, 2002; Nichter & Thompson, 2006). A phenomenological study (Gunnarsdottir & Peden-McAlpine, 2004) of the experiences of eight CAM users attending an Icelandic hydro-health spa notes that all participants claimed ‘a greater awareness of their inner balance’ after receiving hot and cold hydro-therapy treatments. Similarly, Cartwright and Torr (2005, p. 567) found that ‘restoring physical and psychosocial balance’ to be an important reason for CAM use among the people they interviewed. Nichter and Thompson’s (2006) anthropological study of North Americans’ use of dietary supplements found balance to be a ‘strategy for harm reduction’ whereby taking ‘healthy’ supplement balances unhealthy activity such as cigarette smoking. Nichter and Thompson’s study participants located balance within a moral narrative where a ‘bad’ health activity is balanced with a ‘good’ activity. Drawing on a somewhat different narrative, Gunnarsdottir and Peden-McAlpine’s (2004) study participants see balance as healing of both mind and body, whereby the body is regulated through balancing vigorous activity with rest and relaxation. What does this actually mean? These studies show that balance is in fact understood in different ways, suggesting that once users internalise the concept of balance, physical sensations are related to the concept.

2.4.4.1 Vitalism/energy

Drawing on a naturalistic understanding of health and illness, participants in Baarts and Pederson’s (2009, p. 727) exploration of the bodily experiences of 46 users of reflexology, acupuncture, and mindfulness training conceptualise the body as essentially healthy, and that illness communicates to the body the need to be ‘utilising its natural resources’. Through this embodied understanding of health, the body is seen as a vehicle for ‘speaking’ to the ill person. Here the body is presented as a mindful subject. Baarts and Pederson’s (2009, p. 727) study participants further view the body as containing ‘potential self-healing resources’ in the form of energies, and that these energies can create or restore ‘balance’ to the body.

The metaphor of energy relates to several bodies of knowledge including the concept of vitalism which, as stated above, is becoming less prominent in CAM discourse. The energy metaphor is not defunct, indeed it is central to TCM and energetic medicine practices. Some CAM studies show that while energy is located within a holistic health discourse by CAM users, it is understood differently. Gunnarsdottir and Peden-McAlpine’s (2002, p. 126) study of CAM users attending an Icelandic hydro-health spa found that, after one month of treatment, ‘energy in the form of tiredness, stiffness, and pain in body had gradually loosened and dissipated’. This embodied experience of energy was related to self-healing and relaxation, the participants
feeling especially good from this ‘energy’ experience. Cartwright and Torr’s (2005, p. 566) interpretative phenomenological study found CAM was often perceived as ‘increasing energy levels and giving a “boost”’, and that this was linked to increased happiness and well-being. The researchers did not delve further into what constitutes ‘energy’, and overall lay understandings of energy are not well explored in CAM literature.

2.4.4.2 Spirituality

The search for personal meaning is emblematic of the ‘new age’ movement, which promotes a form of spirituality which connects people with others, with nature and the universe, and with a divine presence (Burkhardt & Nagai-Jacobson, 2002). The metaphysical, matters of the soul and the spirit, the supernatural, the ephemeral, alternative cultures including food, mantra and ritual such as meditation, all are embedded in new age philosophies. The increased use of CAM is said to be influenced by new age philosophies, with CAM practices such as reiki borne out of the new age movement.

The majority of social science literature focuses on spirituality in CAM practice rather than spirituality and CAM use. This is surprising given the voluminous health psychology, medical and nursing literature on spirituality and health (Grant, 2007). It is suggested that individual interests in spirituality reflect people living in a state of remission from chronic illness (Frank, 1995), inspired by their illness to reflect on the meaning of life.

My interest resides in the meaning and role of spirituality among CAM users; however, with the exception of Ho’s (2008) study of interaction between CAM practitioner and client, the majority of social science literature focuses on spirituality in CAM practice. The few studies on CAM use and spirituality suggest CAM users identify as spiritual. A cross-sectional study of 1,672 health services clients in the U.S. (Hildreth & Elman, 2007) found that compared to non-users, CAM users identify strongly as ‘spiritual’. Curiously choosing to conceptualise spirituality as a ‘health belief’, Hildreth and Elman (2007, p. 79) offer an important distinction between ‘spirituality’ and ‘religiosity’, with religiosity embedded in ‘institutional forms and collective activity’. CAM users did not identify more as ‘religious’ compared to non-users, the researchers speculating that secularised CAM techniques may be less attractive to religious people. This theory is supported by Zuess (2005, p. 79) who argues that CAM use is associated with an increased interest in spirituality, and that CAM has appropriated some of the functions of religion.

Spirituality is also seen as a means of coping with pain in illness, and bodily dysfunction. Zuess (2005, p. 75) proposes that spirituality offers a form of bodily renunciation in the form of the ‘immaterial self’, the mind and spirit as transcending the physical body. In an extreme form
spiritual disembodiment sees pain, even experience, as illusion. The attraction, suggests Zeus, is a sense of affiliation with other ‘advanced’ spiritual people, a sort of universal consciousness of the immaterial self. For CAM users, the concept of the immaterial self is helpful for relieving stress from illness, and for experiencing unification with people using similar forms of spiritually infused CAM.

2.5 Conclusion

The decline of trust in biomedical expertise has been shown to form part of the reason for the increasing popularity of CAM (Saks 1999; McClean and Shaw 2005). Biomedicine has traditionally disregarded the lay meaning of health and illness, and ‘biomedical knowledge reflects a society that valorises specialised and systematized knowledge systems; indeed, doctors become socialise into valuing expertise and the subsequent objectification of disease’ (McClean & Shaw, 2005, p. 733). CAM users have been shown to have sophisticated and complex explanations for health. These explanations are derived from a number of sources, with CAM practitioners seen as a major information source. It is somewhat ironic then that user studies have found that trust in CAM treatment lies less with the practitioner than with the phenomenological work of the CAM user in making meaning about a treatment. Broom’s (2009a; 2009b) studies have shown that there is a lot the CAM user does not reveal to health professionals, that there is much uncertainty around scientific evidence and that people individualise expert knowledge to their own taste. This suggests that personal understandings of CAM reflect the lived experience of the CAM user. It is also appreciated that lay accounts of health and illness contain situated knowledge and explanatory frameworks of health which express individual understandings (Kangas, 2002, p. 303). Such accounts differ from professional accounts in that they are drawn from everyday life experiences, with health and illness being localised at the social and personal levels. For the established CAM user, a social construction of CAM use also involves appropriating CAM language and discourse to develop explanations for illness and wellness based on the explanatory frameworks of CAM. This partially occurs through interaction with CAM practitioners who have particular sets of professional knowledge. This chapter has explored the role of expert knowledge and lay beliefs in developing trustworthiness in CAM and biomedical practitioners, these people representing abstract expert systems. This chapter has shown that trust is developed in interpersonal and institutional contexts, and this approach to trust, with its derivatives of faith, confidence, and boundaries, are the theoretical lens through which trust is explored in this thesis. Chapter Three reviews social science literature relating to the conceptual development of the thesis.
Chapter Three

Literature Review

3.1 Introduction

3.1.1 Purpose of the literature review

Following from the previous chapters which outlined literature influencing the theoretical development of the thesis, this chapter provides a review of the literature which has influenced the conceptual development. The review addresses the research questions, and the scope of the study in that it reviews studies of the experiences and understandings of CAM use from user and practitioner perspectives. Relating to the central argument that CAM use represents an ongoing process of negotiation of trust between CAM and biomedical practices, there is the question of how CAM users assess a treatment as worthwhile and effective, and on what bases do CAM users assume that non-evidentiary CAM practices, employed by practitioners with specific knowledge claims and skills, will actually work. A secondary area of interest is whether the social location of the CAM user influences CAM treatment decision-making.

From a social science perspective, the underlying reasons for CAM use are, broadly, an expression of dissatisfaction with biomedical approaches (Goldstein, 2003; Lewith & Chan, 2002; Rayner et al., 2011; Sharma, 1995) and an attraction to the personalised, therapeutic encounter with a CAM practitioner (Lupton, 1997; Sharma, 1995). Social science literature also explains the growing popularity of CAM as an expression of values congruence (Bakx, 1991; Robinson et al., 2007), which some commentators refer to as ‘postmodern’ values (Rayner & Easthope, 2001; Siahpush, 2000). The theory arises from the assumption that we live in a ‘postmodern’ society which values symbolic consumerism (Rayner & Easthope, 2001, p. 158), individualisation, aesthetics (Baudrillard, 1998) and a rejection of meta-narratives. The approach taken in this thesis is that the reasons for using CAM are more complex, and nuanced than suggested by the ‘postmodern’ thesis, and that articulating a postmodern thesis as a reason for CAM use is, in itself meaningless. That is not to say that the hallmarks of postmodernity such as the rejection of a biomedical meta-narrative, the commodification of knowledge, and the shift of authority from expert to lay person (see Lyotard, 1984) are not influential in the social phenomenon of increasing CAM use, indeed these are all implicated in the increased popularity of CAM. Rather the approach taken in this thesis is that individual reasons for trust in the use of CAM must be explored from a more nuanced perspective.

Sociologists have in recent times explored the subtle distinctions and variation in CAM use including investigation of risk and trust (Connor, 2004; Lee-Treweek, 2002; Tovey et al., 2005;
The tensions between the use of CAM and biomedicine (Broom, 2009a, 2009b; Cartwright, 2007; Cartwright & Torr, 2005; Pawluch et al., 2000; Thompson, 2003; Thorpe, 2009); well-being (Mark & Lyons, 2010; Sointu, 2006a, 2006b); lifestyles, wellness and identity (Goldstein, 2003; Nichter & Thompson, 2006; Schuster et al., 2004); spirituality and healing (Baer, 2005; Gunnarsdottir & Peden-McAlpine, 2004; Ho, 2008; Hsiao et al., 2008); and embodiment (Baarts & Kryger Pedersen, 2009; Barcan, 2011; O’Connor, 2003).

This chapter critically reviews social science studies which contribute to our knowledge of CAM as a cultural and social process. In line with the conceptual orientation and research questions guiding this thesis, the studies reviewed in this chapter focus on the tensions between CAM use and biomedicine; the communicative action between CAM users and CAM practitioners; the embodied experiences of CAM use, including the use of CAM for derivative benefits and well-being; and CAM as part of a disciplined lifestyle routine, involving self-care of the body, health maintenance and wellness. This chapter concludes with an identification of the knowledge gaps in the sociology of CAM, and assesses the review findings in relation to the theoretical framework of trust. I will begin with a theoretical consideration of the subject of the present study, the CAM user. This aims to provide an understanding of the subject position of the CAM user who, depending on the context, is positioned both as a patient and a health services client.

3.1.2 Theorising the CAM User

As shown in Chapter One, the consumption of CAM is increasing rapidly, and Australian CAM consumers are alleged to have spent an extrapolated total of AUD$1.8 billion in 2004 (MacLennan et al., 2006, p. 27). There is no doubt that, in many ways, a CAM user personifies the ‘reflexive’ consumer of late modernity (Giddens, 1991; Giddens, 1995, pp. 36-40). Reflexive consumers are sceptical of expert knowledges, and do actively assess the merits of scientific knowledge claims (Broom & Tovey, 2007, p. 1026). Reflecting high levels of cultural capital around health knowledge and information, CAM users assess the veracity of health information including medical consultations, and the hegemonic position of the biomedical expert is diminished in the process (Lupton, 1997). To this end the CAM user is seen to exercise a great deal of personal agency in their health consumption, and ultimately sees the medical expert as one of many authorities. The result of this ‘reflexive appropriation of knowledge’ (Giddens, 1995, p. 53) is a repositioning of authority, and an ongoing search for knowledge as self-improvement (Lupton, 1997, p. 374).

The health consumer of late modernity is also seen as engaging with a reflexive ‘project of the self’ (Lupton, 1997, p. 374), involving constant reflection of the social and cultural practices engaged in relation to the body and the self, and this process generates self-trust through
maximising the benefits to oneself (Giddens, 1995, p. 122). Health and well-being are therefore implicated in the formation of self-identity (Giddens, 1995, p. 123), and the body as a visible marker of continuity and effort is not only a signifier of social status, but a means of rediscovering oneself (Baudrillard, 1998, p. 131).

In his polemic work on health and the medicalisation of everyday life, Crawford (1980, p. 366) argues that the modern preoccupation with health has a decidedly ‘middle-class stamp’. This argument, made over thirty years ago, is still salient. In 2004, Greenhalgh and Wessely argued that striving to attain health through healthy lifestyle behaviours is most visible in culturally and economically empowered middle classes. This group is seen as desiring good health and longevity, a fit body combined with healthy lifestyle, and these desires are associated with economic globalisation (McMichael & Geaglehole, 2000, cited in Greenhalgh & Wessely, 2004, p. 202). The ‘middle class’ values preferences, it could be argued, are in themselves reflective of one’s cultural and social location including gender, age and social class.

For Crawford (1980, p. 366) the ‘middle-class stamp’ was particularly visible in two popular health movements which arose in the late twentieth century, the ‘holistic health’ and ‘self-care’ movements. Crawford (1980, p. 366) maintains that the holistic health movement comprises the diverse range of non-orthodox medical systems and non-allopathic healers which fall under the banner of ‘complementary and alternative medicine’, while the ‘self-care’ movement supports health prevention, coping strategies for illness, and transferring ‘medical competence’ to lay people. Thirty years on this movement has morphed into self-improvement industries, self-help groups, therapists and, arguably, some CAM providers; these movements, moreover, are situated in political and social contexts.

A health phenomenon of the late twentieth century is that individuals are reporting decreased satisfaction with their health (see Greenhalgh & Wessely, 2004). As Crawford (1980) contends, ‘by elevating health to a super value, a metaphor for all that is good in life, … reinforces the privatisation of the struggle for generalised well-being’.

What Crawford proposes is that the significance accorded to health as a societal value, and the medicalisation of health-related behaviours, have produced a new ideology. People are less satisfied with their health because they expect to live symptom free, and view their health as a holistic balance of social, psychological and physical selves (Greenhalgh & Wessely, 2004, p. 202).

The values embedded in healthism are derived from the consumption culture of late modernity (see Bauman, 2007; Giddens, 1991). Since Crawford developed the concept of healthism, a focus on lifestyle and health maintenance has become more entrenched in Western cultural
discourse, with a particular focus on the body as a site for individual self-control (Cant & Sharma, 1999, p. 27; Greenhalgh & Wessely, 2004). The ideology of individual responsibility for health is as prevalent now in biomedical approaches and public health as in the wider CAM discourse.

Quantitative social scientific studies investigating the congruence of CAM user values with those of CAM (e.g. Robinson et al., 2007, p. 104; Sirois & Gick, 2002) show how values predict CAM use (Coulter & Willis, 2007). Robinson et al. (2007) surveyed 459 Australian CAM users, concluding that ‘holistic’ health beliefs are strongly associated with CAM use. This literature has been useful for understanding the variations between ‘groups’ of CAM users. It has been shown, for example, that above average levels of self-rated ‘spirituality’ can be associated with the use of yoga, homeopathy, acupuncture, kinesiology, prayer and magnet therapy; that users of homeopathy, herbalists and naturopaths and Chinese medicine practitioners, reiki, shiatsu, osteopathy and tai chi more likely than non-CAM users to attend to nutritional habits (Robinson et al., 2007, p. 110). These studies suggest that people involved more exclusively with certain CAM practices may exhibit differing beliefs and actions from users of other CAM practices (Robinson & Chesters, 2008; Sirois & Gick, 2002). The insights from such studies are a useful starting point for developing sociologically-based research designs which can explore these variations in a more nuanced fashion. For a start, we know there are variations in use between groups of CAM users, and users of certain CAM modalities exhibit beliefs and characteristics which differ from users of other therapies.

As a form of consumption, health has been analysed in relation to lifestyle (Rayner & Easthope, 2001, p. 160), which some argue is related to social location including gender, age and social class. Of these constructs, the most relevant to my study is that of gender. To this end the representation of female to male CAM users in the study is 13 females to 3 males, in other words approximately 19 per cent of CAM users in the study are male. This percentage is fairly representative of population health studies which have found that up to 75 per cent of CAM users are female. CAM researchers have consistently found that females are significantly more likely to use CAM services than males (Adams et al., 2009; Bensoussan et al., 2005; Bishop & Lewith, 2010; Connor, 2004; Kermode et al., 1998; MacLennan et al., 2006; Rayner & Easthope, 2001; Robinson et al., 2007; Xue et al., 2007). Women are particularly over-represented in the use of CAM therapists; for example one longitudinal study of women’s health consumption found that 28 per cent of Australian women aged between 45 and 50 years of age had consulted a CAM practitioner in the last twelve months (Adams et al., 2003, p. 297). An interesting point of analysis in the study from Adams et al. (2009, p. 97) is that older women tend to use CAM sporadically and not continuously, and the researchers speculate this may
reflect the high cost of CAM which is more prohibitive for older women who are retired or living alone.

The issue of gender is further complicated by literature suggesting that women are more intensive users than men of both biomedical and CAM services, and that we cannot assume it is CAM which attracts women, rather that women appear to be generally attentive to healthcare for self and family members. This is borne out by a study of CAM use in Australia by MacLennan et al. (2006) which found that almost a third of Australians with children had administered CAM to their children, and the majority of those administering CAM to children are female. It is also possible that women engage more with health providers because they have more confidence in health providers than men; however, this has not been explored in the CAM sociological literature.

Sociological literature pays little attention to the specificity of women’s CAM use. The work of sociologist Eeva Sointu (2006a, 2006b) provides insights into the mode of female engagement with CAM. Sointu interviewed 31 CAM users and practitioners, and based on the interviews, theorised that women employ ‘tactics’ of well-being to manage embodied emotions. Sointu (2006b, p.500) also theorised that women feel accepted, understood and validated through the CAM encounter, and that CAM practitioners play a key role in facilitating women’s sense of authenticity. Willard (2005) found from a critical analysis of integrative medicine texts, that CAM is a form of feminist intervention which challenges the power relations inherent in the paternalistic medical encounter. Biomedical power is viewed as disempowerment for women in that it invalidates self-knowledge of the body. Sointu (2006a) also found that women share with their CAM therapist a feeling of being marginalised in the biomedical system. Sointu (2006b, p. 499) theorised that for women, being recognised in the CAM encounter as an ‘active being’ generates agency in health care treatment use. While these experiences are generally thought of as ‘empowerment’ strategies for women, as will be shown later in this chapter some commentators critique the extent to which the empowerment discourse of CAM really does empower.

3.2 Biomedical Resistance and Uncertainty

Social science researchers have found dissatisfaction with orthodox medicine and some biomedical approaches to be a dominant theme in CAM user accounts (Adler, 2003; Bishop & Lewith, 2010; Cant & Sharma, 1996a; Connor, 2004; Goldstein, 2003; Gunnarsdottir & Peden-McAlpine, 2004; Lewith & Chan, 2002; Rayner et al., 2011; Sharma, 1995; Siahpush, 2000). Dissatisfaction is viewed as arising from two broad factors: first, concerns over the effects of biomedical treatments including adverse reactions and pharmaceutical drug side effects (Foote-
Ardah, 2003; Lewith & Chan, 2002, p. 72; Pound et al., 2005; Sharma, 1995); second, a dissatisfaction with treatment efficacy (Ayers, 2008; Furnham & Forey, 1994; Lewith & Chan, 2002; Sharma, 1996; Siahpush, 2000; Rayner et al., 2011). In addition CAM users are reputedly sceptical of the knowledge claims of clinical evidence and biomedical technologies (Broom & Tovey, 2007; Goldstein, 2003, p. 27; Lupton, 2003, p. 136). Lewith and Chan (2002) have also found anxiety among CAM users over secondary illness resulting from biomedical treatment, also termed iatrogenic illness. This section reviews the social science literature on concurrent use of CAM and biomedicine; the uncertainties around scientific knowledge and evidence-based medicine; and perceived health risks.

3.2.1 Concurrent use of Complementary and Alternative Medicine and biomedicine

Despite disenchantment with their experiences of biomedical approaches, the vast majority of CAM users continue to use biomedical approaches (Adams et al., 2003; Gunnarsdottir & Peden-McAlpine, 2004; Hok et al., 2007; Rayner et al., 2011). Based on analysis of CAM use by older Australian women, Adams et al. (2009, p. 97) conclude that CAM is not used ‘in opposition to or as outright rejection’ of biomedicine, in fact, these women attended significantly more consultations with biomedical providers than non-CAM users. CAM appears to be used pragmatically and as part of a wider repertoire of pluralistic health consumption (Adams et al., 2003, p. 298; Connor, 2004), with multiple use of CAM and biomedical providers, and self-experimentation with different forms of treatment. An ethnographic study (Connor, 2004) of ‘mixed therapy regimens’ in an Australian suburb found therapeutic pluralism was the norm and that residents treated the same symptoms by consulting more than one biomedical and/or CAM provider. The term ‘mixed therapy regimen’, from the perspective of CAM users, is seen as properly conceptualising the phenomenon of seeking health care from different providers (Connor, 2004).

Different patterns emerge from studies of mixed therapy use. Several social science studies (Adams et al., 2009; Hok et al., 2007; Thorpe, 2009) support a theory that decision making around health service use is idiosyncratic, and determined by pragmatic considerations such as the severity of illness. In a narrative study of health service use by cancer patients, Hok et al. (2007) found that while patients use a multiplicity of CAM therapies, biomedicine is an important frame of reference for CAM use. Thorpe’s (2009, p. 385) study of CAM use among Australian HIV patients indicate that chronically ill people develop a lay critique of scientific medicine after an illness diagnosis, and subsequent engagement with the conventional medical system. This suggests that it is not biomedicine per se which lures people to CAM, but a particular mode of engagement with conventional medical systems when a person is chronically ill. Certainly researchers have found that CAM users are more likely than non-CAM users to
have long-term chronic illness and conditions (Adams et al., 2009; Gunnarsdottir & Peden-McAlpine, 2004; Zollman & Vickers, 1999, p. 836), and that many patients have not been ‘cured’ using biomedical approaches (Gunnarsdottir & Peden-McAlpine, 2004; Rayner et al., 2011).

Some studies reveal a strategic use of CAM after failure to achieve an outcome or cure from a biomedical approach. A systematic review (Rayner et al., 2011, p. 688) of CAM studies for fertility enhancement found women using CAM after intensive use of unsuccessful assisted reproductive technology (ART). Other studies find concurrent use of CAM and ART to ‘maximise their chances of becoming pregnant’ (Rayner et al., 2009, p. 4). From a cultural perspective, the ‘desperation’ to be a mother reflects societal expectations of parenthood, particularly for women. According to Rayner et al. (2009, p. 4), pressure also arises from the stigma of infertility. As such, the strategic use of CAM and biomedicine is not only perceived as maximising chances of pregnancy, but for those facing a fertility crisis it invites hope for a ‘normal’ life.

Although consumers/patients still trust enough to use conventional medicine, negative experiences from medication and other adverse effects further distance them from biomedical process. This reflects Bakx’s (1991, p. 33) perception that CAM users feel ‘culturally distanced’ from the technological and scientific basis of biomedicine. Compounding this sense of alienation, CAM users have been shown to receive an unfavourable response from biomedical providers, especially medical specialists, when disclosing CAM use (Adler, 2003; Broom & Adams, 2009; Rayner et al., 2009). Due to previous negative experiences, women using CAM to enhance fertility refused to disclose this to medical fertility specialists (Rayner et al., 2009). Similarly, Broom and Adams (2009, p. 324) found the approaches from medical oncologists to patient CAM use range from ‘negative or dismissive’ to ‘tentative acceptance’.

As outlined in Chapter 1, not all biomedical approaches incorporate allopathic medicine, nor EBM, and some are more holistic in orientation. Sociological studies document nurses as supportive of CAM use, even actively promoting CAM to their patients (Broom & Adams, 2009; Cant et al., 2011; Tovey & Adams, 2003; Tovey & Broom, 2007). This can be somewhat subversive as Cant et al.’s (2011) qualitative interviews with nurses and midwives in UK public hospitals suggest that the implementation of CAM approaches are mitigated by the scepticism of medical authorities to non-evidence based medicines; also the absence of a collectivised strategy.
3.2.2 Reflexivity and uncertainty in evidence-based medicine

Several researchers theorise that resistance among CAM users to scientifically based biomedical approaches are really expressions of concern over the contingencies of scientific knowledge and an ambivalence toward biotechnology (Goldstein, 2003; Ho, 2008; Lupton, 2003; Verhoef et al., 1990). The exact basis of this is not entirely clear; some studies report concerns about the allopathic, treatment focus of some forms of biomedicine (Goldstein, 2003, p. 31), scepticism of clinical testing of compound pharmaceutical medicines (Pound et al., 2005), and a general lay critique of evidence-based medicine (EBM) (Broom & Tovey, 2007; Lupton, 2003). According to Willis and White (2004, p. 51), EBM as a progressive social movement has infiltrated public health, psychiatry, nursing and now some forms of CAM. As the ‘gold standard’ for establishing scientific legitimacy, evidence-based medicine is seen as privileging some evidence over others. Willis and White (2004, pp. 50-58) argue that the hierarchy of authority ranges from expert opinions based on clinical experience and knowledge to RCT and systematic reviews of RCT. Clinical legitimacy, on the other hand, refers to anecdotal reports of treatment effectiveness and ongoing patronage of a treatment modality. Accordingly, Willis and White (2004, p. 58) propose that evidence-based medicine is likely to have minimal impact on CAM.

Clinical legitimacy is valued in many CAM disciplines such as kinesiology and naturopathy (Willis & White, 2004, p. 59). CAM users also appear to value clinical legitimacy over scientific, with Connor (2004, p. 1698) observing scientific legitimacy to be less important to CAM users in an Australian suburb than improved health and other anecdotal markers of effectiveness, which is interesting as scientific legitimacy has far more rigour attached to its methods. Very few sociological studies have thoroughly explored CAM user engagement with these forms of expert knowledge. The work of Broom and Tovey (2007) is exceptional in this regard, with the researchers exploring 80 cancer patients’ engagement with scientifically legitimate evidence.

Broom and Tovey (2007) found that a significant number of participants viewed biomedical knowledge and evidence as problematic, and were sceptical that clinical ‘evidence’ could demonstrate individual treatment effect. Broom and Tovey reported this line of thinking as ‘crucial’ in making decisions around CAM use (Broom & Tovey, 2007, p. 1030). Similar to HIV patients (Thorpe, 2009), Broom and Tovey’s cancer patients view scientific expertise as important to their overall care, and willingly seek advice from biomedical experts. What Broom and Tovey suggest is that rather than reject scientific knowledge outright, CAM users apply scientific evidence selectively to their individual circumstances. Broom and Tovey (2007) found that cancer patients readily accept, for example, biomedical data showing cure rates from cancer. However, they do not necessarily relate this to their specific individual situation.
Furthermore, Broom and Tovey found that the ‘sceptical’ response of some cancer patients to scientific evidence lies in the meaning they make from scientific data, and not the data itself. This finding contributes to the researchers theorising the existence of a dialectical tension among cancer patients between those therapeutic processes which encourage individuation (such as CAM) and the depersonalised treatment approach commonly associated with some biomedical approaches. This concurs with research showing that CAM treatments are seen as more individualised than biomedicine to the specific needs of the patient, and that individuation is missing in evidence-based medicine (Park, 2005, p. 235).

Another reason for scepticism toward scientific evidence may be the certainty with which such evidence is presented in the biomedical encounter. Biomedical practitioners extrapolate epidemiological findings to the individual patient. However, there is always a level of variability in the data (Park, 2005, p. 232) which, for CAM users, may produce more doubt and uncertainty over treatment efficacy for their situation. This doubt arises also from the ‘mediatisation of science’ which has reported more divergent views of medicine and science and a growing critique of science, all of which increase viewer uncertainty (Ward et al., 2012, p. 28). Beck (2007, p. 122) argues that expert knowledge is distorted by media translators, thereby ensuring the lay person has partial knowledge; besides, expert knowledge has its own limitations and uncertainties. In short, the more expert knowledge we have and the more fragmented and ‘non-linear’ it is, the more uncertainty persists.

### 3.2.3 Perceptions of risk and uncertainty

Anthropological researchers Cant and Sharma (1999) found the fear of side effects and adverse events from pharmaceutical medicines to be prominent themes in CAM user accounts. A systematic review of qualitative health and social science studies on lay experiences of medicine taking (Pound et al., 2005) found considerable resistance to taking compound pharmaceutical medicines (known colloquially as ‘drugs’) and consumer preference for taking as few as possible. To this end concerns over adverse events and side effects such as nausea, vomiting, distress, kidney stones, insomnia, headaches, rashes, diarrhoea, dizziness, anaemia, fatigue, stiffness, mood swings, visual problems, hair loss, liver damage and loss of appetite were crucial in making a decision to use medicines (Pound et al., 2005, p. 138). As well as the intrusion on social life, the unpleasant reactions created uncertainty and mistrust in the medicine. Moreover, women have been found to be more resistant than men to pharmaceutical medicine taking (Pound et al., 2005). This symbolic view of pharmaceuticals as toxic (Connor, 2004, p. 1700) has constructed a cultural narrative of biomedical pharmaceutical medicines as health risk.
Resistance to compound pharmaceutical medicines supports a belief that CAM medicines are less harmful than the compound pharmaceutical medicines of biomedicine. A belief in ‘natural’ medicines and health products as safe and harmless (Connor, 2004; Molassiotis & Xu, 2004; Pound et al., 2005) signifies trust in CAM. The sociologist Deborah Lupton (2003, p. 136) explains that the word ‘nature’ has powerful symbolic meanings relating to metaphors of ‘virtue, morality, cleanliness, purity, renewal, vigour and goodness’. Coward (1989, cited in Lupton, 2003, p. 136) explains the implication of certainty in the nature metaphor: ‘Its use as the dominant element of alternative therapies’ ideology is a major attraction for client, for [n]ature by implication is that which is safe, gentle and has inherent properties which will benefit individuals.’

Lupton (2003) argues that by selectively symbolising natural as safe, biomedicines are positioned as artificial and bad for health. The conceptualisation of CAM as natural and safe has been uncovered in several social science studies of CAM (Cartwright & Torr, 2005; Connor, 2004; Pawluch et al., 2000), including the dichotomising of ‘toxic’ pharmaceuticals to ‘natural’ CAM medicines (Connor, 2004, p. 1700). Connor’s (2004, p. 1700) ethnographic study found CAM users symbolise natural medicines as having potent healing properties which can prevent illness, with Vitamin C signifying a ‘resistance to disease’. Of further interest is that these natural medicines users did not necessarily expect the medicine to ‘work’, yet they are valued as much as biomedicine for effective symptom relief. Pawluch et al.’s (2000, p. 257) interpretative study of the accounts from 66 people diagnosed HIV-positive found participants unconcerned about the safety of CAM medicines, perceiving them as ‘harmless’ and ‘non-toxic’. By contrast, pharmaceutical biomedical medicines were seen as unsafe, ‘toxic’ and ‘powerful’. Similarly, Cartwright and Torr’s (2005) interpretative phenomenological study of 11 frequent CAM users perceived CAM to be both ‘natural and traditional’. A study of the content of advertising of CAM medicines and health products found advertisers exploit the symbolic meaning of ‘nature’ with images of purity and mother earth (Rayner & Easthope, 2001, p. 170). The symbolic meaning of nature appears to have resonated strongly with CAM users, with natural medicines being seen to fortify the immune system and body against social and environmental hazards of modernity. As such, they are theorised as being used in response to the risk society (Connor, 2004, p. 1703).

While CAM users may perceive a health risk from using compound pharmaceutical medicines, there is evidence (Broom & Adams, 2009; Cant et al., 2011) that some biomedical practitioners view CAM as a health risk. Consumer notions of natural medicines as safe differ from orthodox medical perspectives of the potential toxicity of ‘untested’ natural substances (Easton, 2006; Lupton, 2003). Broom and Adams (2009, p. 325) interviewed 25 oncology specialists and
nurses about their patients use of CAM, and found that for oncologists, risk was the key issue in CAM use. For oncologists, risk was conceived of as adverse events from CAM medicines and interactions with oncology medication and treatment. Cant et al.’s (2011) study of public hospital nurses and midwives in Britain found biomedical providers in hospitals tolerate CAM when it is perceived to be ‘low risk’ or the therapy is providing something not available in the hospital, such as pain relief. Autonomy to practise CAM, however, is bound by practice spaces and bureaucratic policies developed around notions of risk.

In summary, the literature reviewed in this section shows that CAM is used concurrently with biomedical approaches, and that CAM users are idiosyncratic in their use of both biomedical and CAM approaches. Even for regular users, CAM is used pragmatically to treat specific symptoms ad hoc. Sociological studies show uncertainty over health risks associated with invasive treatment and compound pharmaceutical medicines, and studies support also the idea of uncertainty over scientific knowledge and evidence-based medicine. CAM users have been found to develop a critique of biomedicine after an illness diagnosis, suggesting that biomedical providers have not met their expectations.

3.3 Complementary and Alternative Medicine, Embodiment and Well-being

Sociological literature on the body (Howson, 2004; Maiiese, 2010, p. 10; Shilling, 2007; Turner, 2008) contains two broad approaches. The first approach views the body as a regulated site for self-control, vigilance and discipline, and subjected to discourses of power. The second approach as reviewed in this section concerns ‘embodiment’ or the body as subject, which sees the body as central to human experience (Merleau-Ponty, 2002/1962). Embodiment invites a synthesis between an ‘exterior and institutionalised body and the sensual, subjective, animated body’ (Howson, 2004, p. 15). Embodiment challenges the ‘subject/object’ dichotomy, the ontological separation of consciousness and brain (Csordas, 1990, p. 7; Maiiese, 2010). CAM users have been found to continue to use CAM even when it does not effectively ‘cure’ their illness (Coulter & Willis, 2004). Rather CAM users have been found to derive alternative benefits and pleasure such as enhanced bodily functioning, increased energy and vitality, and feeling relaxed. These forms of emotional embodiment are related to well-being, a subjectively embodied experience incorporating bodily harmony and balance (Sointu, 2006a). Embodied feelings of pleasure derive from use of some forms of CAM such as bodywork. Embodiment is also represented by the experience of pain; however, the modern narrative of pain is one of avoidance. This section examines the growing literature on CAM and embodiment.
3.3.1 Embodiment and CAM

Embodiment is seen as an important component of self-identity, and CAM modalities which provide an embodied experience as intertwined with subjectivity. CAM users have been found to continue to use CAM even when it does not effectively ‘cure’ their illness (Coulter & Willis, 2004). Rather CAM users have been found to derive alternative benefits such as enhanced bodily functioning, looking and feeling better, increased energy and vitality, and relaxation. The evidence from the literature is that CAM is found to provide symptom relief (Cartwright & Torr, 2005; Foote-Ardah, 2003); however, this is not to say it is curative (Baarts & Kryger Pedersen, 2009). CAM users can also be outright sceptical of therapeutic claims of cure (Balneaves et al., 1999). Rayner et al. (2011) in a review of CAM use for fertility enhancement found that although women and couples had become sceptical of the ability of CAM treatments to produce pregnancy, they continued to use CAM for relaxation. This is supported in a medical study of breast cancer patients (Balneaves et al., 1999), where the majority of clients/patients expressed doubt that CAM could provide clinically effective cure. What especially interests CAM researchers (Baarts & Kryger Pedersen, 2009; Balneaves et al., 1999; Cartwright & Torr, 2005; Coulter & Willis, 2004) is, in spite of a low possibility of cure and scepticism over claims of cure, people keep using CAM for other benefits.

One study which explored the phenomenological experiences of CAM users in depth is Baarts and Kryger Pedersen’s (2009) study of 46 CAM users residing in Copenhagen, Denmark. The researchers found that CAM users derive ‘derivative benefits’ such as improved secondary health (Cartwright & Torr, 2005, p. 565), increased energy (Cartwright & Torr, 2005, p. 565), and stress reduction and relaxation (Foote-Ardah, 2003; Cartwright & Torr, 2005, p. 565) which constitute an embodied experience of CAM. Furthermore, Baarts and Kryger Pedersen (2009, p. 721) found that bodily experiences are differentiated between users of different CAM therapies and practices, with stress reduction and self-development to be common expectations among users of mindfulness training, whereas for users of acupuncture and reflexology the minimisation of pain and improving general health are more common. This finding reinforces the argument advanced in Chapter One, that CAM represents a diverse range of knowledge claims and practices rather than a homogeneous set of practices. It also appears that CAM users may engage differently with different therapies and practices, depending on the expectation of the user of a therapeutic outcome. Supporting the derivative benefits theory, Balneaves et al. (1999) noted that breast cancer patients, while cognisant of the limited scientific evidence on CAM as a curative, continued CAM use along with biomedical treatment.

Pain is another embodied experience, involving emotionally inscribed bodily sensations. Culturally inscribed meanings of pain are outlined in Ivan Illich’s famous work on
medicalisation *Limits to Medicine: Medical Nemesis, the Expropriation of Health*. In this book Illich (1995/1975) sees the experience of pain as culturally inscribed: ‘This experience, as distinct from the painful sensation, implies a uniquely human performance called *suffering*. Medical civilisation, however, tends to turn pain into a technical matter and thereby deprives suffering of its inherent personal meaning.’

Medicalisation of pain has broadened the social construction of pain into representing a number of biological and socio-cultural narratives, including the Cartesian construct of pain as a physiological manifestation which sends ‘messages’ to the brain, and pain as an event of the central nervous system (Audette & Bailey, 2008). According to Illich (1995[1975]), the medicalisation of pain means we no longer see pain as natural; pain has become politicised, which has generated an industry demand for anaesthetics and compound pharmaceutical medicines.

The sociology of pain has focused mostly on the experience of pain in chronic illness. Few studies have examined how socio-cultural factors influence the experience of pain among health care users. One exception is Bendelow’s (1993, p. 278) research with health centre clients in North London in which Bendelow interviewed 11 centre clients in-depth about their phenomenological experience of pain. Bendelow’s (1993, p. 287) research found repeated views that the female reproductive role equipped women with the ‘natural’ pain endurance, physically and emotionally. Men were also seen as discouraged from an emotional expression of pain, with men socialised into seeing pain as abnormal, and less able to deal with it. The perceived superiority of female pain endurance may, speculated Bendelow, produces expectations of more pain, or not being taken seriously. People of working class background and ethnic minorities felt their symptoms of pain were also taken less seriously.

Bendelow’s (1995) participants distinguished between emotional, psychological and physical pain, attaching a stigma to emotional pain, and particularly the men, with physiological pain seen as more ‘authentic’. Women were more likely to have a ‘holistic’ view of pain, and acknowledge emotional vulnerability as part of the pain experience. Spiritual and existential dimensions of pain were also emphasised, and pain was not necessarily viewed as negative, rather as a ‘sign’ from the body regarding health or development of strength from emotional pain. Chronic and terminal pain was regarded more negatively, and linked to depression and mental illness. Explanations of pain of this sort involved, at times, self-blame. Pain was also linked to punishment from God. Bendelow also found control to be a central issue; the more knowledgeable about their condition, the more in control and sense of power was felt by study participants.
While Bendelow’s study was not specific to CAM treatment use, several studies note the use of CAM for minimising pain (Baarts & Kryger Pedersen, 2009; Sibbritt & Adams, 2010; Sirois & Gick, 2002) and a higher incidence of chronic pain among CAM users than non-CAM users. CAM users with back pain appear to be frequent users of both biomedical and CAM services. A longitudinal study of 8,910 young Australian women with back pain found women with long-term back pain are more likely to consult chiropractors, and that overall the women frequently use a range of biomedical and CAM providers and are high users of self-prescribed CAM (Sibbritt & Adams, 2010). Several medical books have also been published in recent years on pain management in ‘integrative medicine’. While these certainly do not address pain as a social construct, nor pain in CAM treatment, they provide a perspective of pain from the professional level including the division of pain into two categories: ‘good’ or ‘protective’ pain which is acute and short lived; and ‘bad’ or ‘maladaptive’ pain which is chronically recurring (Audette & Bailey, 2008, p. 20). There are no studies on the experience of pain in CAM treatment, other than two studies (Baarts & Kryger Pedersen, 2009; Cartwright & Torr, 2005) which note in passing that pain has been experienced in CAM treatment.

3.3.2 Relaxation and pleasure

Managing stress and anxiety can be cited as reason for CAM use (Baarts & Kryger Pedersen, 2009; Foote-Ardah, 2003; Rayner et al., 2011). Both medical and social science studies of CAM use (Bishop et al., 2008; Feldman & Laura, 2004; Foote-Ardah, 2003, p. 489; Rayner et al., 2011) have found lay beliefs of stress being linked to illness, and that relaxation techniques such as yoga, meditation, massage and reflexology are commonly used to manage emotional stress. Sociological studies (Baarts & Kryger Pedersen, 2009; Bishop et al., 2008; Broom, 2009b; Cartwright & Torr, 2005) have found that relaxation is also perceived as a derivative benefit of CAM. Some even consider CAM therapies such as aromatherapy, massage and reflexology to be simply relaxation, with Bishop et al. (2008, p. 1701) identifying these therapies as used for personal enjoyment and not clinical outcomes. Similarly, a study of 20 Australian oncology out-patients with cancer (Broom, 2009b, p. 78) has implicated narratives of self-healing which involve peace and/or relaxation with continued CAM use.

Others receive combined pleasure and treatment efficacy. Mentally ill patients of massage and aromatherapists in the UK (Wallcraft, 2005) received relaxation from massage, but also claimed it assisted mental illness recovery. This claim is upheld by clinical research showing that massage triggers an autonomic nervous system, enabling automatic relaxation (cited in Wallcraft, 2005). For these mentally ill patients, the mind-body therapies also generated bodily awareness and self-trust.
Pleasurable feelings from CAM treatments also manifest sensually (Barcan, 2011). Users of mindfulness, massage, reflexology and acupuncture have been found to regularly experience pleasurable feelings (Baarts & Kryger Pedersen, 2009; Cartwright & Torr, 2005). CAM users have linked increased energy levels to pleasurable bodily sensations. In Gunnarsdottir and Peden-McAlpine’s (2004, p. 125) study of eight users of an Icelandic hydro-health spa, participants perceived some therapies as ‘pure work, some are relaxation’. Whatever their perception of treatment, all Icelandic participants felt increased relaxation and energy after one month of treatment. These patients also experienced increased mobility, less pain and inner peace. Somewhat supporting Barcan’s (2011) theory of CAM as new cultural practice, the Icelandic study participants (Gunnarsdottir & Peden-McAlpine, 2004, p. 125) experienced both bodily, emotional and cognitive change.

CAM practitioners have observed less stress and anxiety among clients/patients after CAM treatment, but have not been found to reference their treatments as pleasure. Interviews with CAM providers in the United Kingdom (Wallcraft, 2005) observed less stress and anxiety among mentally ill clients/patients, and increased relaxation and less insomnia after receiving massage and aromatherapy. In this study, aromatherapists claimed that essential oils can reduce stress, anxiety, fatigue, ease tension and anger, restoring energy and balance. The aromatherapists perceived their clients to receive only positive benefits from treatment, with no side effects. Interviews with these clients supported the practitioner accounts; however, symptom relief and other residual effects of treatment were often short-lived (Wallcraft, 2005, pp. 330-332).

3.3.3 Well-being

Some social science literature sees ‘well-being’ as a function of health maintenance, lifestyle and fitness (e.g. Fries, 2008, p. 359) which is essentially a construct of ‘wellness’. Although some social science studies of CAM (Baarts & Kryger Pedersen, 2009; Cartwright & Torr, 2005; Foote-Ardah, 2003) differentiate between ‘psychological’ and ‘bodily’ well-being, others see it more as a convergence between the two domains (Cartwright & Torr, 2005; Sointu, 2006a, 2006b; Mark & Lyons, 2010). Sointu’s (2006a, p. 335) definition of well-being arose from the experience, conceptualisation and evaluation of CAM of 31 CAM users and practitioners: ‘Well-being is seen to touch all areas of life, ultimately manifesting in a sense of harmony with one’s surroundings. This kind of health is, furthermore, often conceptualised as something natural or inherent to the person.’

Sointu’s participants talked about finding balance and harmony in the body, ultimately relating physiological health to a broader notion of well-being. A notable perception articulated by the CAM practitioners in Sointu’s study is that well-being is available to everyone, even to
terminally ill people. A similar understanding of well-being is expressed by Baarts and Pedersen’s (2009, p. 727) study participants, who perceive well-being ‘in terms of harmony, fulfilment and a “natural contentment”’. For Sointu’s CAM users (2006a, 2006b) well-being is also a subjective assessment of emotionality, of feeling ‘at peace’. Similarly Broom’s (2009b) study of cancer patients found that seeking peace is a core therapeutic value. A focus group study (Daaleman et al., 2001) of diabetes and non-diabetes patients by U.S. based health researchers found that ‘subjective well-being’ is implicated in notions of spirituality. The researchers (Daaleman et al., 2001, p. 1509) further found well-being to have two components: a ‘cognitive’ component where a ‘balanced’, ideal state of self was compared with the current state, and ‘affective’ feelings of being ‘whole’ and ‘at peace’.

Other meanings of well-being to emerge from Sointu’s study participants are the experience of fulfilment in finding meaning and inner truth in life, and accepting the uncertainties of ill health. According to Sointu, acceptance is also a strategy for ‘asserting the power of the self as the author of its own authentic destiny’ (Sointu, 2006a, p. 337). Importantly, Sointu emphasises that personal conceptualisations of well-being relate to wider cultural understandings of self.

CAM is shown to increase bodily awareness and a sense of bodily mastery (Baarts & Kryger Pedersen, 2009, p. 729; Rayner et al., 2011, p. 688). Utilising Merleau-Ponty’s (1998, cited in Baarts & Pedersen, 2009, p. 723) phenomenological account of language as a bodily process, the researchers argue that participating in CAM practices increases ‘bodily awareness’ through attending discursively to the body. Baarts and Pedersen’s (2009, p. 724) study of bodily experiences in CAM use also found users, particularly in mindfulness training, sought to gain agency and control over their mind and body and, by extension, their lives. The researchers termed this ‘bodily mastery’, explaining this concept via accounts of mindfulness training:

...coming to terms with their personal situations in ways that provide meaning and maximize health...various meditation exercises promote bodily mastery through a pre-established series of repetitions. These repetitions enhance bodily awareness in ways that also produce in participants a sense of psychological well-being. (Baarts & Pedersen, 2009, p. 725)

The researchers propose here that mindfulness training, through lessening anxiety, can maximise feelings of centredness, of bodily self-control. This is similar to the concept of ‘flow’ which is the focused channelling of feelings of happiness from active engagement in technique such as meditation, and used to relieve anxiety and stress (Ckszintmihalyi, 1975). When an individual experiences pain or loss of control, the body is seen as ‘speaking’ to the individual, so individuals become more attuned to ‘signals’ from the body. In short, CAM users were
positive about treatments which provided feelings of psychological control, and positive emotions encouraged treatment continuance.

In summary, well-being is more than health; it is a subjectively holistic experience which involves feelings of peace, control, harmony and fulfilment. Well-being is one of the derivative benefits of CAM use, and CAM users have been found to use CAM for achieving non-medical benefits such as being relaxed and stress free. Embodiment theorists see the self as embodied through emotions which are exemplified through neurobiological systems and bodily organs (Maiese, 2010, p. 12). Validation of embodied emotions and feelings also affirms self-identity, CAM users in Sointu’s studies being shown as developing affirmation through self-fulfilment.

3.4 Lifestyle, Wellness and the Cultivation of Self

This section looks at the other dominant tradition in the sociological study of the body, namely, the representation and practice of the body (Turner, 2008, p. 15). In this tradition, the body is constituted through disciplinary regimens which seek to adhere to socio-cultural notions of health, fitness and aesthetics. Conforming to these norms requires the individual to adopt a certain lifestyle, of which CAM has been found to be part. CAM practitioners have been found to promote an empowerment discourse which encourages users to take personal responsibility for health. The decision to use CAM has been shown to be a strategy for taking personal responsibility for health, and makes users feel like they are taking action against perceived health risks. In this sense, an individual is actively constructing a sense of self-identity as someone who responds to health risks through active engagement in strategies of health and lifestyle (Baarts & Kryger Pedersen, 2009, p. 728). For users CAM forms part of a ‘wellness’ narrative in which a healthy, disciplined body represents health. Here, adopting CAM as part of a healthy lifestyle is linked to cultivating self and identity. Central to this are notions of self-control and regulation. As such, CAM is perceived not just to be a curative, but a means to fostering a positive self-image. This section examines how CAM discourse supports a rhetoric of empowerment, wellness and lifestyle, and how these rhetorics are embedded into the self-care regimens of CAM users.

3.4.1 Empowerment

CAM discourse supports a notion of holistic transformation through self assembly of the body (Sharma, 1996, p. 248). To encourage holistic transformation in the patient, a CAM practitioner uses an empowerment discourse. The empowerment discourse encourages personal responsibility for their health, meaning the individual is asked to make choices and assess lifestyle risk from a number of sources. Ward et al.’s study (2012) of the negotiation of 47 South Australian health consumers with information on food and nutrition found that people
experience uncertainty from the conflicting information on food and health eating. Moreover, the researchers argue that consumers are required to identify and respond to food risks in ways which maximise wellness (Ward et al., 2012, p. 27). Although the modern consumer is meant to be a responsible, reflexive decision maker, the reality is many are concerned with having to use media reports on which to base their understanding of food risk. The speed of information, combined with the ‘reflexive nature of risk’, means it is difficult to make decisions with any certainty (Ward et al., 2012, p. 28). Given this, it is no wonder that patients have been found to comply with the advice of the health professional.

Critiques of the empowerment discourse (Gingras & Aphramor, 2010; Veinot, 2010; Wyatt et al., 2010) note there is little evidence that accessing more health information actually ‘empowers’ patients or encourages better self-care (Gingras & Aphramor, 2010; Wyatt et al., 2010, p. 24). Implicated in this critique is the idea that empowerment is really about generating compliance with treatment, rather than determining health through access to information (Gingras & Aphramor, 2010). The discourses are also critiqued for producing a form of morally inscribed governmentality of what is ‘proper’ health conduct, and shifting the burden of health care to self-care (Veinot, 2010, p. 31). There are also concerns by some health professionals over the positioning of patients as ‘lay medical experts’.

CAM users are found to experience a ‘sense of control’ (Spence & Ribeaux, 2004, p. 128). Control in this sense is rarely explored, and there is limited understanding from the sociological perspective. Studies have found that CAM users incorporate lifestyle advice into their daily life, whether it is from the CAM practitioner and/or media. One sociological study of CAM medicine users in Australia and the advertising of CAM medicines and health products found individual control an important value for consumers (Rayner & Easthope, 2001, p. 172). These consumers reported high levels of participation in exercise and overall health and body consciousness. The consumers in the study were found to focus on exercise, especially individual sport like swimming, and were theorised by the researchers as actively involved in ‘self-assembly’ of the body. Supporting this, Goldstein’s (2003) comparison of CAM and the fitness movement shows a surprising number of common values including ‘restraint and vigilance’.

Lifestyle for CAM users includes adopting a preventative health agenda including regular medical examinations, managing stress and emotions, and eating natural dietary foods and health supplements to prevent the onset of illness and disease (Schuster et al., 2004). CAM use also emerges from a sense of taking personal responsibility for health (Baarts & Kryger Pedersen, 2009, p. 728). According to Schuster et al. (2004), a distinction exists between CAM as part of a healthy lifestyle for preventative health care, and CAM to promote wellness. People
who are already wedded to practising some healthy lifestyle behaviours become attracted to the holistic self-care orientation of CAM practices. Moreover, CAM practitioners may promote self-care and healthy lifestyles to their patients, instilling wellness related values, beliefs and behaviours (Schuster et al., 2004, p. 353).

CAM practices are not the only ones promoting the empowerment discourse; new medical pluralism has seen the emergence of discourses of ‘autonomy’ and ‘empowerment’, ‘shared decision making’ and ‘consumer health information’, facilitated by empowerment strategies such as teaching patients to self-manage health conditions, diminish knowledge imbalance and equalise power in health interactions (Veinot, 2010, p. 30). Moreover, health information provided through government funded initiatives is seen as ‘empowering’ lay health consumers to take more responsibility for their health choices, and to be actively engaged in health care (Wyatt et al., 2010, p. 24). A critical examination of patient empowerment discourses draws on Foucault’s (1980, cited in Veinot, 2010, p. 30) ‘commodity’ model of power, in which power is seen as an object to be acquired or given to someone.

Does the CAM regimen really provide power to the patient? Certainly, CAM practitioners believe in the empowering basis of their practice. A study by Sered and Agigian (2008) explored explanations and understanding of breast cancer amongst 48 CAM practitioners. Invariably practitioners perceived CAM as a strategy for encouraging self-awareness of the body, a routinisation of healthy lifestyle practices and a spiritual connectedness to self. From the CAM practitioner perspective, empowerment does not just occur through prescribing a regimen for the client, but from tailoring an individualised regimen. Tailoring the regimen is seen as encouraging the client to have ownership of their health and body. Scott (1998, p. 200) observes that it is not in the economic interest of CAM practitioners to locate the cause of illness outside of the control of the patient. This partly explains why CAM practitioners are so focused on the social context of their patient and, if biomedical practitioners are not competing for patients in the same way, then they do not need to have the same concerns for social contexts of the patient, nor other individual factors.

3.4.2 Wellness

Schuster et al. (2004) introduced the idea of CAM as an aspect of a wellness lifestyle or a ‘lifestyle in pursuit of wellness, which also subsumes typical elements of a healthy lifestyle’. Although wellness is being increasingly discussed in studies of CAM (e.g. Nichter & Thompson, 2006; Schuster et al., 2004) the sociology of CAM has little to say about wellness. Moreover, there is a tendency, even among social scientists, to use the term ‘wellness’ interchangeably with ‘well-being’ (Ward et al., 2012) when, from a sociological perspective, they are different concepts. In Section 3.5, well-being was theorised as an embodied experience
of the body, whereas wellness relates to the perceived control of health and body through appropriating a ‘wellness lifestyle’ (Schuster et al., 2004).

Wellness is seen as a ‘higher order’ concept which integrates physical, psychological, social and spiritual domains with personal understandings of health. Public health discourse in particular has incorporated lifestyle and behavioural risk factors (such as smoking, poor diet, lack of exercise, lack of medical examination, stress) into ‘wellness’ narratives. What this means is that wellness is a different concept to ‘health’; a person can see themselves as having good health, but experiencing low levels of one of the wellness domains (Schuster et al., 2004, p. 351). When CAM literature (e.g. Goldstein, 2003, p. 37) cites ‘health as wellness’ as a reason for CAM use, it undermines the complexity of wellness as a concept.

Researchers (Nichter & Thompson, 2006; Schuster et al., 2004) also find CAM to be used as a ‘wellness’ strategy. Nichter and Thompson’s ethnographic study of 60 American supplement users aged between 20 and 70 years found they used supplements to manage illness and enhance lifestyle (Nichter & Thompson, 2006). Nichter and Thompson (2006, p. 188) found that resisting illness was a common theme among supplement users, particularly in regard to boosting the immune system, thereby strengthening the body’s resistance to illness pathogens. The characterisation of the immune system as the ‘sentry of the body’ is seen as widespread, and as part of a wider discourse of health risk in a globalised world (Nichter & Thompson, 2006).

Supporting Schuster and Dobson’s thesis, this finding links personal understandings of wellness with a public discourse on lifestyle. The researchers found supplements to be part of a larger self-governance project, in which individuals seek to both manage health risk and enhance well-being. Such projects of self inscribe social roles around gender, ageing and the body. In terms of ageing, Nichter and Thompson found that baby boomers are taking supplements to reduce aches and pains in the joints, but also for enhancement: to promote memory (fish oil being a case in point), improving vitality and sexual function, enhancing beauty and the reduction of ageing.

### 3.4.3 Lifestyle

Lifestyle is a fairly ambiguous concept which relates individual health to certain ‘lifestyle factors’. While these factors are seen to constitute a ‘healthy lifestyle’ it is not exactly clear what a healthy lifestyle is, and the extent that lifestyle factors work to prevent disease and promote longevity (Hansen & Easthope, 2007, p. ix). Lifestyle as a sociological concept is, according to Schuster et al. (2004, p. 352):
related to social status, which is associated with modernity and consumerism (Weber, 1978), a sense of individuality (Simmel, 1950), class culture (Bourdieu, 1984), and lifestyle choices as a means of producing self-identity (Giddens, 1991). Lifestyle provides an important framework for analyzing the interplay between structure (social forces affecting individual’s life chances) and agency (individual’s life choices).

Moreover, lifestyle understandings of health and disease have been shown to be used by doctors as explanatory frameworks for illness (Hansen & Easthope, 2007, p. xi). According to Hansen and Easthope (2007, p. 34), medical understandings of ‘lifestyle’ are different to sociological understandings. Biomedical understandings of lifestyle are conceptualised by Hansen and Easthope (2007, p. 35) as the medical notion that lifestyle changes will prevent disease. The sociological concept of lifestyle is related to Weber’s (1978, cited in Hansen & Easthope, 2007, p. 38) concept of choice, which sees choice as the major factor in implementing lifestyle changes, but also sees the capacity to exercise choice as related to social location and position in life.

Medicalised lifestyle rhetoric can be seen to have dominated public health and epidemiological discourse since the 1990s. Healthy lifestyle includes factors such as natural/healthy diet, moderate alcohol consumption, regular exercise, regular medical examinations, stress management, taking supplements and engaging in self-help.

Social scientists (Sered & Agigian, 2008) have argued that the rhetoric of personal responsibility is extended by some practitioners to a moralistic narrative of a ‘good patient’ as one who accepts some responsibility for their illness. For CAM practitioners, personal responsibility is part of a generalised health discourse, with particular emphasis on self-care of the body and lifestyle modifications around diet, exercise and alcohol consumption (Goldstein, 2003; Scott, 1998; Sered & Agigian, 2008; Wyatt et al., 2010, p. 24). Through studying the history of diet and food governance, Turner (1992, p. 178) observes that disciplinary regimens of diet and lifestyle are an instrument for governmentality of the body (Turner, 1992, p. 178). For example, naturopaths routinely advise a client to decrease consumption of caffeine and alcohol, to exercise, to relax and to follow a healthy, organic diet. This suggests that the CAM practitioner is actually regulating their client through enforcing a prescriptive regimen of behaviour modification, and implying the CAM client is somehow morally defective if they do not comply.
3.5 Client/Patient Interaction in the Complementary and Alternative Medicine and Biomedical Encounters

3.5.1 Studies of interactional processes in the ‘medical encounter’

Several sociological studies (Lupton, 1997; Frank, 2002b; Chatwin et al., 2008; Stevenson, 2008) have looked at interactional processes in the ‘medical encounter’. Such studies reveal that the nature of the interaction between doctor and patient affects not only patient satisfaction and the level of commitment to treatment protocols, but the health outcomes of patients (Chatwin et al., 2008; Kelner, 2005). Lack of satisfaction is said to influence treatment concordance, and is linked to use of multiple doctors (Kelner, 2005, p. 109). In a large study of the consultation process between doctor and patient, Stevenson (2008, p. 67) interviewed 53 patients prior to their consultation and a week later and audio recorded consultations between 20 doctors and the patients. The interviews explored how patients assessed a ‘good’ or ‘bad’ consultation.

Although clients/patients may be more satisfied with a negotiated, egalitarian style of communication with their health professional, they do not necessarily want full responsibility for treatment decision making. A review of studies of patient and doctor interactions reveals that many patients have become actively involved in decisions about who to consult, and when to discontinue treatment; however, involvement in decisions occurring within the consultation such as decisions over medications, are ‘far less actively sought’ (Chatwin et al., 2008, p. 84). Patients these days are faced with a multiplicity of truth claims which, rather than enabling decision making, may in fact complicate treatment decision making. If we realise that, in active participation models, patients are required to make ‘active judgements about the veracity of particular claims’ (Tovey & Broom, 2007, p. 2553) then the task can look more daunting than liberating. As such, patient resistance to active involvement in treatment decision making could reflect a desire not to assess the knowledge claims of multiple therapies, or to have to immediately assess treatment approaches.

This has led to questions regarding the extent to which the doctor and patient relationship is ‘active’. According to Thompson (2008, cited in Stevenson, 2008, p. 67), a distinction exists between patient involvement and participation, with participation concerning the degree to which patients take part in decision making. The term participation ‘connotes a degree of transfer of power from the professional to the patient in the form of increased knowledge, control and responsibility’ (Stevenson, 2008, p. 67).

Whilst there are moves afoot to have doctors invite more active participation in consultations (Stevenson, 2008), there is evidence that patients, even those using CAM, are happy to abrogate responsibility for choice of treatments to their doctor (Kelner, 2005).
Dissatisfaction with the biomedical encounter is cited in several social science studies as a reason for CAM use (e.g. Adler, 2003; Rayner et al., 2011). Commonly cited are the lack of time spent with a doctor, and the tendency for doctors to prescribe medication rather than communicate (Bakx, 1991, p. 29). This conflict is said to relate to the unsatisfied demand for patient participation in healthcare, and the alienation of the authoritative consultation style of the medical practitioner style against the patient’s need for more equal participation and self-validation (Cant & Sharma, 1999; Sharma, 1995, p. 246; Sirois, 2002). As a result of these conflicts, there is less trust or confidence in a GP, and patients feel their legitimate lay knowledge to be invalidated by the practitioner. Broom and Tovey (2007) found that one of the attractions of CAM use was the way in which medical doctors depersonalized the individual cancer patient. Cancer patients in their study felt a need for therapeutic intervention which would recognize individual agency, self-responsibility and individualized healing in healthcare.

A group of Australian health researchers conducted focus groups with both women who were using or had used CAM concurrently with ART, and with CAM practitioners specializing in natural fertility management. Women found their interactions with ART medical professionals to be impersonal and distressing; they felt ‘reduced to a series of body parts, subjected to technical and dehumanizing procedures’ (Rayner et al., 2009, p. 5). Words such as ‘destructive’ were used by these women to describe the ART experience; furthermore, they described to the researchers feelings of loss of control and isolation.

### 3.5.2 Communicative action in CAM and biomedical encounters

Patient participation has been viewed as integral to CAM encounters, inviting active patient involvement in treatment decision, incorporating individual and holistic contexts for health in the consultation process (Chatwin et al., 2008, p. 85). The relationship between CAM practitioner and patient is said to resemble shared decision making and, in some aspects, the consumerist model of informed consent, whereas the biomedical consultation is seen as more likely to still adopt a paternalistic model (Kelner, 2005, p. 109). To evaluate these assumptions, Kelner (2005, p. 109) surveyed 300 Canadian residents consulting either orthodox biomedical or CAM and biomedical doctors combined. Kelner’s study (2005) found CAM practitioner relationships with their clients were surprisingly similar to the doctor and patient relationship, with high levels of satisfaction for both practitioner groups in providing empathetic listening and offering explanations for illness. To a lesser extent, both groups invite shared decision-making.

CAM studies (e.g. Cartwright & Torr, 2005), unlike studies micro-interactions in orthodox medical encounters, focus more on the area of empathetic listening, holistic communication and the evolving therapeutic emplotment between practitioner and client/patient. This is because the
literature reports that the attraction of the therapeutic encounter between CAM practitioner and client/patient is a primary reason for CAM use. Interactional elements of the CAM practitioner and client interaction are seen as having features based on a model of collaboration or ‘holistic’ communication, individualised treatment (Chatwin, 2009) and empathetic interaction (Bakx, 1991; Chatwin, 2009; Joske & Segal, 1982, cited in Sherwood, 2000, p. 194; Lupton, 1997; Sharma, 1995). Social scientific literature (Bakx, 1991; Cartwright & Torr, 2005; Chatwin, 2003, 2009; Lupton, 1997; Reeve, 2005; Roberts et al., 2005; Rayner et al., 2009; Sharma, 1995) has documented the significance of the interaction between CAM practitioner and client in maintaining CAM use. It has also been proposed that the good relationship and rapport between practitioner and client produces a placebo effect, and is a key factor in healing (Kelner, 2005).

One exception to this is Frank and Stollberg’s (2004) interviews with 12 patients and 14 medical doctors in Germany who practise acupuncture. The researchers found that patients did show evidence of increased participation in the medical encounter with the acupuncturist, and were conscious of the quality of the service. However, none of the patients in the study exhibited any desire to understand the details of acupuncture or Traditional Chinese Medicine. Instead they remained ignorant of Chinese medical knowledge, collected no detailed information on acupuncture, expecting the practitioner to have done this instead. This suggests that decision making was not as ‘shared’ as could be, that the acupuncturist physicians made all the decisions regarding practice such as position of needles. The only decisions made, according to the researchers, were between biomedical or alternative treatment modes (Frank & Stollberg, 2004, p. 365). Patients appreciated the quiet, relaxing time lying with needles in their body, and while consultations were ‘pleasant’, the encounter did not involve much verbal communication. Rather than appreciate long consultations, patients were more appreciative of quick diagnosis, reliability and home visits. The researchers concluded that the patients appropriated a more ‘passive’ form of health participation than expected (Frank & Stollberg, 2004, p. 364).

3.5.3 Holistic communication and ‘therapeutic emplotment’

The CAM encounter is said to be based on a participatory communication model, which is characterised by an egalitarian relationship with the practitioner, and devoid of the expert-lay power relationship inherent to the paternalistic model (Cartwright & Torr, 2005, p. 569). Studies report the use of a holistic communication model in the CAM encounter (Kelner, 2005). Chatwin (2009, p. 166), of which the underlying structure is represented in the ‘classical’ patient-centred homeopathic interview, and such communication generates a rapport and collegiality between the practitioner and client/patient. Not all CAM disciplines and practices utilise these approaches; rather there are specific CAM practices such as homeopathy and
naturopathy supporting patient-centred approaches such as holistic communication, while other modalities such as massage and reiki are characterised by non-verbal communication and bodywork. Manipulative practices such as chiropractic focus on gathering symptomatic information from clients/patients, which has led some social scientists to question whether the term ‘holistic’ is an adequate representation of these practices (Thompson, Ruusuvuori et al., 2007).

Social science researchers (Baarts & Kryger Pedersen, 2009; Cartwright & Torr, 2005; Chatwin, 2009; Joske & Segal, 1982, cited in Sherwood, 2000, p. 194; Lupton, 1997; Sharma, 1995) have found that holistic communication offers for the CAM user the psychosocial needs and empathetic interaction seen as lacking in many biomedical encounters. Having empathy and support from a practitioner in a context of patient participation and empowerment, has been found to facilitate the management of illness in daily life (Cartwright & Torr, 2005). Holistic communication also allows for a sense of inclusion in one’s own health care and treatment, and a sense of ownership of the healing process (Willard, 2005, p. 116). Whilst involvement in their healing process has been shown to be important to CAM clients/patients, it has been argued that having a continuum of care in chronic illness management promotes the long-term use of CAM rather than experiencing empathetic and intimate interaction (Kelner, 2005, p. 112). According to Reeve (2005, p. 2), CAM philosophies allow patients to find meaning in their health experiences, and this meaning making is generated by the evolving mutual construction between the practitioner and client/patient of a meaningful story about the person’s illness. This ‘therapeutic emplotment’ is according to Reeve, so powerful that it is able to stimulate naturally occurring healing (Cartwright & Torr, 2005; Chatwin, 2009).

It is also found that CAM practitioners are used to augment a positive self-identity, to reduce anxiety and develop confidence in self (Cartwright & Torr, 2005, p. 569). This is especially the case for women using assisted reproductive technologies (ART) for reproductive enhancement, in which medical specialists appear as remote and authoritative, assuming a paternalistic model of care (Kelner, 2005, p. 113). In contrast, Kelner (2005) reports that these women experience a sense of bodily ‘control’ in the CAM encounter, appreciating both the individualised, health focused treatment regimes, and the ‘nature of the relationship they formed with their CAM practitioners’ (Rayner et al., 2009, p. 6).

Trust in the CAM encounter is addressed in several social science studies (Cartwright & Torr, 2005; Rayner et al., 2009). Given the intimate nature of fertility treatment, the women in Rayner et al.’s (2009, p. 7) study appreciated a trusting, respectful relationship with their CAM practitioner. CAM users interviewed by Cartwright and Torr (2005, p. 569) also appreciated time to discuss their health issues in the context of ‘an open and trusting relationship’. Rayner et
al. (2009, p. 8) have made incisive observations about the significance of trust for women seeking fertility enhancement. Citing recent literature which suggests trust in a health provider is integral in the face of ‘uncertainty’, the researchers mount a case for increased trust among women seeking fertility enhancement:

Experienced a loss of certainty in their body’s fertility, and may also have experienced psychologically stressful medical encounters that do not result in guaranteed outcomes. The relationship with a CAM practitioner may therefore represent an integral way of regaining trust in one’s body and the therapeutic encounter.

Trust was a factor in Kelner’s (2005, p. 112) study of 300 biomedical and CAM patients in Canada. Only a small number of the patients were getting positive outcomes from biomedical treatment; however, most demonstrated trust in the ‘skills and expertise of their doctors’ with whom they also had rapport. Furthermore, Kelner found that patients that only went to biomedical practitioners favoured a paternalistic model, trusting their doctor’s choice of treatment implicitly, whereas those using CAM and biomedicine concurrently more likely to expect shared decision making and to take responsibility for their own health care. Kelner (2005, p. 112) concludes from this that ‘CAM patients more often favoured self-control and placed their confidence in themselves, or in themselves in partnership with their practitioners’.

Kelner’s (2005) study suggests that CAM clients/patients favour egalitarian models of health consultation such as shared decision making in both CAM and biomedical practices. Countering this, there is evidence from studies of CAM encounters that patient participation is less visible than the rhetoric would suggest. For instance, Scott (1998, p. 198) found that homeopaths do not tell their patients what homeopathic remedy is being prescribed.

Studies of micro-interactions or communication in the CAM encounter have studied homeopathic encounters more extensively than other forms of CAM (e.g. Chatwin, 2003, 2009; Chatwin et al., 2008; Frank, 2002b; Scott, 1998). This may be due to the homeopathic ‘interview’ tradition, a lengthy verbal exchange in which the homeopath asks about a patient’s health and illness, personality, nutritional intake, sleep, lifestyle, family and emotions in order to determine symptoms of the treatment, not the illness (Frank, 2002b, p. 1286). Sociologist John Chatwin (2003, 2009) employed micro-interactional conversation analysis and ethnography to explore transactional interactions between homeopath and their patient. Chatwin et al. (2008, p. 85) audio recorded over 40 homeopathic consultations alongside orthodox biomedical consultations, and conducted interviews with health practitioners and patients about their experiences of patient participation.
The theme of self-control of the body is reinforced in a study based on documentary evidence and interviews with 12 practising ‘feminist’ homeopaths in the UK. Scott (1998, p. 197) demonstrates how in line with the homeopathic charter to match the patient through supporting the patient’s bodily mode of healing, or mimicking the patient’s illness, homeopathic remedies are designed to allow the patient to have personal agency of their body. This reflects the homeopathic understanding of the body as ‘an active and knowing agent’ (Scott, 1998, p. 197) and, as Scott points out, this contrasts with biomedical approaches. Scott claims that the homeopath is the secondary agent in the patient’s healing, and that the overall process is designed to ‘empower’ the patient.

Supporting the derivative benefits thesis, a study found that due to the perceived value of the client/patient-practitioner relationship experienced in CAM encounter, females continue to use CAM irrespective of its curative value. Patients of CAM and biomedicine in Kelner’s (2005, p. 112) study also emphasise derivative outcomes such as minimisation of pain and discomfort, as the basis of satisfaction with CAM.

For a holistic communication model to be effective, it presupposes a congruent set of holistic health values between practitioner and patient. Homeopathy, for instance, promotes ‘individualism’ in practice and prescribes a remedy embodying the patient’s individual social, emotional and physical environment (Scott, 1998, p. 200). The patient is responsible for following the individualised treatment protocol, and for returning to the practitioner on a regular basis. Scott (1998, p. 204) observes that homeopaths make ‘social and moral judgements with regards to their patients’, and these judgements can be social or political such as locating illness in sexual and physical abuse.

Not only is the power and control dynamic of the doctor-patient relationship absent in the homeopathic encounter, the relationship is cast as one of equality (Scott, 1998, p. 198). Scott’s analysis of interviews with 12 feminist homeopathic practitioners in the UK showed that the homeopaths understood the inherent power relationship in the medical encounter, and that the homeopaths support honesty, empathy and sharing of their own experience. Although Scott’s study was unable to contribute to a detailed understanding of micro-interactions in consultations, an interesting theme to emerge was the awareness of a ‘wounded healer’ syndrome in which the homeopathic healer can use the client/patient interaction as a means of self-healing (Scott, 1998, p. 200).

3.6 Discussion and Conclusion

This conclusion presents a summary of the salient findings from each of the sections in Chapter Three, and assesses the gaps in knowledge arising from a critical review of the social science
literature on CAM relating to the research questions. In Chapter One and again in the introduction to Chapter three, I set out that the central argument guiding this thesis is that CAM use represents an ongoing process of negotiation of trust between CAM and biomedical practices, and the research questions from which this argument developed. The aim of this review has been to assess literature which can contribute to a fuller understanding of how trust is developed and negotiated in CAM treatment decision-making. Chapter Two of this thesis includes a review as part of the broader theoretical discussion of trust, of social science literature on trust in health care contexts including CAM; Chapter Two also includes a substantial review of the literature contributing to an explication of the formation of lay and expert knowledge in CAM, and Chapter One reviews literature pertaining to the institutional contexts for CAM systems and disciplines, including discussion of the professionalisation strategies adopted by CAM practitioners to legitimise their practice, while this literature from Chapters One and Two is not restated in Chapter Three, it is considered important to the research questions will be represented in this conclusion.

CAM users are seen as generally representing the reflexive middle class health consumer of late modernity, and it is argued that their mode of reflexivity is associated with health beliefs and values (as shown in chapter 1, a process known as ‘healthism’). These values are seen as congruent with CAM, however CAM users no doubt have understandings and sense making around health and illness which differ to those of orthodox CAM practice and knowledge. Literature demonstrates unequivocally CAM users’ dissatisfaction with several aspects of conventional medicine namely paternalistic medical encounters, side effects of compound pharmaceutical medicines and scepticism over the claims of scientific knowledge and technologies. As discussed earlier in this chapter, studies consistently show that the majority of CAM users are women, so it is surprising how few social science studies focus on women’s use of CAM. The few studies such as those by Sointu (2006a) and Willard (2005) provide refreshing insights into female modes of engagement with CAM including the need for well-being, and a desire for self-knowledge of one’s health and body to be validated in interaction with health professionals. Notwithstanding these insights, there are clearly gaps in knowledge of the association between gender and trust in the modern, pluralistic health care environment.

The literature reviewed in this section has found that CAM use does not represent an outright rejection of biomedical approaches. Rather CAM users have been shown to make considered choices about use of health systems based on disease and illness specificity, and these choices reflect their individual beliefs and knowledge of health and illness. Studies of this nature reveal that rather than outright rejection of conventional medicine, the vast majority use CAM
concurrently with biomedical approaches, or as an adjunct to conventional treatment; furthermore the pluralistic use of CAM and biomedical approaches see different patterns of use, from strategic, outcome oriented multiple therapy use to achieve pregnancy; to the continuous experimentation reflecting modern consumption. Even for regular users, CAM is used pragmatically to treat specific symptoms ad hoc. Theoretically, patterns of CAM and biomedicine use can be seen as artifacts of liquid modernity, whereby CAM and biomedicine therapies are used episodically and discontinuously. There are also moral imperatives encouraging the mixed therapy regimens, such as those who ‘try anything’ to optimise the chances of a ‘normal’ life.

Sociological studies have also shown resistance to aspects of scientific orthodox medical approaches; namely perceived risk of adverse events and side effects, uncertainty over scientific knowledge and EBM, and the paternalistic medical encounter. CAM users have been found to develop a critique of conventional medical approaches after an illness diagnosis, And CAM users in general may feel culturally distanced from biotechnology and evidence-based medicine. Their critique is a hallmark of the uncertainty facing modern health consumers, who negotiate between multiple forms of health expertise. These knowledge conflicts underlie Beck’s (2007) concept of non-knowing, which reflects uncertainty of different expert knowledge claims. Scientific knowledge based on evidence-based medicine (EBM) represents a dominant knowledge claim in biomedicine, and provides for scientific legitimacy.

Many commentators agitate against using EBM to evaluate effectiveness of CAM, preferring instead to demonstrate clinical legitimacy. CAM users and practitioners alike are critical of the extrapolation of scientific evidence to show individual effectiveness, but will apply scientific knowledge selectively to their individual case. This led Broom and Tovey (2007:1027) to identify tension between processes of ‘individuation’ such as personal responsibility, agency and well-being, and the depersonalising processes of epidemiological facts, probabilities and the like. Concerns over adverse effects of pharmaceutical biomedical medicines have positioned pharmaceutical medicines as toxic, and constructed a narrative of health risk. This construction supports a belief in the safety of ‘natural’ medicines, which signifies trust in CAM. By way of contrast, the institutions of conventional medicine have been shown to construct CAM as a health risk. It is also important to note that not all biomedical providers are dismissive of CAM, with nurses and midwives shown to be well disposed to using CAM approaches with patients. Also, social science studies show that in some circumstances, scientific medical advice is accepted by CAM users without censure.

Chapter Three also reviewed literature concerning a growing area of interest in studies of CAM
use, the bodily experience of CAM. Although the literature in this area has increased in recent years, Barcan (2011) notes that few studies explore the relationship between CAM use and embodiment. Studies exploring this concept discuss CAM as an embodied experience in which well-being and the derivative benefits of CAM are major themes. These studies show how CAM users manifest sensory embodiment through feelings of relaxation and pleasure. Drawing from embodiment theorists who theorise the self as embodied through emotions (Maiese 2010:12), this review has shown how validating embodied emotions and feelings serves to affirm self-identity, and CAM users shown to affirm a sense of self through using self-fulfilling modalities. What this means is that CAM practices affirm the embodied feelings and emotions associated with CAM treatment, and this acceptance is important for ill people who experience dissociation from their body and emotions in orthodox biomedical contexts.

While there are few social science studies of CAM analysing the embodied experience of CAM use, Barcan (2011) is one of the few offering an embodied framework for understanding CAM use. In this conceptual framework CAM itself is seen as generating new forms of perception, experience and thinking. The work of Sointu (2006a; 2006b) is also exceptional in this regard, and contributes a sound theoretical understanding of well-being as an embodied concept for CAM users. Well-being is a holistic concept, incorporating the psychological and physical self, and is linked to feelings of peace, contentment, harmony and balance.

The literature contains no elaborations on embodied trust and CAM, here one must turn to studies from the broader health sociology literature, which show how trust is embodied in the patient-practitioner encounter through the bodywork and therapeutic interventions of the practitioner. Embodied trust is also about having belief in the restitutive power of the body, and seeing the body as having a communicative function. In this sense, the holistic health narrative is implicitly linked to embodied trust, which its precepts of self-regeneration of the body and healing capacity. An alternative theoretical orientation to CAM use arises from this review of CAM as a *leisured* experience. This orientation differs from CAM as a health experience, and offers a more solid theoretical understanding of the use of CAM for derivative benefits such as stress reduction, increased energy, instead of for cure.

CAM practice is seen as a form of bio-power, establishing corrective measures through lifestyle modifications, surveillance and control via advice, information and health ‘education’. Studies of consumer engagement with media on food risk show that consumers become uncertain when presented with multiple information, much of it contradictory. Similarly, CAM consumers are exposed to this information, as well as the information of their CAM practitioners, and need to negotiate multiple information sources on CAM and health. Despite their uncertainty, CAM
users are found to experience a sense of individual control. CAM practice offers the means of achieving greater control and assemblage of the body, and aesthetic enhancement through various lifestyle initiatives. This seems to create a sense of self-control for user, even if this is illusory. Another point of interest is that practitioners of CAM, particularly those involved in nutrition advice will encourage empowerment through information seeking, yet only utilise their expert knowledge in consultation with the client. Studies reviewed in this area show important insights into the way CAM users exercise control, but fail to really engage with the points at which CAM users reveal certainty in the discourse and knowledge of CAM, and at what points do CAM users construct their boundaries around acceptable use. Studies of the interaction between consumers/patients and health practitioners show how the expert advice of practitioners is appreciated, and will acceded to that (for certain conditions) rather than self-trust in information seeking. However, these need to be considered in relation to studies by people such as Broom (2009a) and Lee-Trewick’s (2002) important study of trust in CAM use, which show that trust in the knowledge of practitioners is built from the phenomenological work of the CAM user, rather than the practitioner.

Finally, little is known about interactional dynamics in medical encounters, and how patients make sense of these and use them in actions. Some studies of micro-interactions (e.g. Chatwin, Collins et al. 2008) illustrate the nature of client/patient participation in the CAM encounter, however there is certainly scope for more work on interactional dynamic of the CAM practitioner encounter and the development of trust in treatment decision-making, and how CAM users negotiate the multiplicity of knowledge claims around treatment from in CAM and biomedical approaches. Knowledge of this is important our understanding of how the CAM practitioner-patient relationship effects trust in treatment preferences and decision-making.

The most prominent gap in the social science literature on CAM is an almost complete absence of a theoretically informed exploration of trust in CAM treatment decision-making. Trust emerges in several of the studies such as Broom (2009a), Baarts and Pedersen (2009) which explores the uncertainties and tensions inherent to decisions concerning the use of CAM and biomedical treatments, and provides insight into the individualised engagement with scientific evidence, and such insights would be usefully explored in studies of CAM. Given also the prominence of the health practitioner as an access point to expert systems of knowledge, then studies of trust in practitioner encounters are vital to understanding the points that a client/patient develops this trust. Such studies are almost absent from the CAM sociological literature, and the present study provides an important contribution in this regard.

Chapter Four
Methods

4.1 Introduction

This chapter provides an overview of the qualitative research design and data analysis for the study, and includes detailed discussion of the recruitment and sampling of research participants, methodological and ethical considerations. The research was designed to generate an interpretative social constructionist account of the experiences and understandings of CAM users. An interpretative social construction design has been proposed by researchers as an appropriate research design for identifying the construction of meaning and of knowledge and power relations in discourse (Gubrium & Holstein, 2009, p. 12; Harris, 2008, p. 233). The constructs of interest to this thesis are the lay knowledge constructs of CAM users and the expert knowledge of CAM practitioners. In their influential book *The Social Construction of Reality* (1967) Berger and Luckmann set forth a treatise on the socially constructed nature of knowledge. According to Berger and Luckmann our knowledge results from interactions with others and although our everyday understandings differ inter-subjectively from each other, our meanings reflect a common ‘social stock of knowledge’, which is the cumulative commonsense knowledge of everyday life. Our capacity to interact with others are ‘constantly affected by our common participation in the available social stock of knowledge’ (p. 41). Moreover, Berger and Luckmann (1967, p. 46) argue that knowledge is socially distributed:

I encounter knowledge in everyday life as socially distributed, that is, as possessed differently by different individuals and types of individuals…The social distribution of knowledge of certain elements of everyday life can become highly complex and even confusing to the outsider. I not only do not possess the knowledge supposedly required to cure me of a physical ailment, I may even lack the knowledge of which one of a bewildering variety of medical specialists claims jurisdiction over what ails me. In such cases, I require not only the advice of experts, but the prior advice of experts on experts.

In this thesis the knowledge constructs of research participants are seen to represent socially distributed and particularised knowledge; as such the research design allows for exploration of the socially constructed nature of lay and expert knowledge. The constructivist grounded theory (CGT) method is ideal for producing a social constructionist account linking the empirically derived knowledge of the CAM user’s lived experience with the knowledge derived socially in interaction with CAM practitioners.

Qualitative semi-structured interviews are the primary research method, and are supported in literature as a means of exploring the social constructs of research participants, and their
situated versions of reality (Denzin, 1989; Barry, 2002). This chapter begins with a discussion of the methodological considerations of the thesis with an overview of the constructivist grounded theory (CGT) method, then proceeds to detail the recruitment, sampling, data collection and data analysis for 16 CAM users and 10 CAM practitioners interviewed for the study.

4.2 Methodological Considerations

Denzin (1989, p. 4) defines methodology as a representation of the ‘principle ways in which sociologists act on their environment’. Indeed, and as Denzin points out, the research method chosen for social construction research will assist to illuminate a different aspect of social reality. The methodological design of this thesis explores how a regular CAM user makes sense of health and illness in relation to expert knowledge. Central to this negotiation is the argument that trust in the use of CAM is represents an ongoing mediation of trust between CAM use and the use of biomedicine. The interpretative approach to analysis adopted in this study draws from two social construction traditions: the phenomenological tradition which allows the researcher to understand how a CAM user experiences health and illness; secondly, the symbolic interactionist tradition which allows for the exploration of CAM user meanings actively constructed in social interaction (Blumer, 1969, p. 5; Bendelow, 1993, p. 277). The method of inquiry guiding the analysis of in-depth interview data with 16 regular CAM users is constructivist grounded theory (CGT). The CGT method has its origins in symbolic interactionism and has allowed myself as researcher to see how CAM users mediate trust in social interactions with medical and CAM practitioners, and with individuals in social networks. The phenomenological experience of CAM use is also explored through the constructivist grounded theory method, especially in the earlier stages of analysis when the health and illness experiences of CAM users are identified.

4.2.2 Constructivist Grounded Theory (CGT)

The grounded theory method is popular in health social science studies for its inductive approach to data analysis. The method allows for the reinvigoration of data and cross-correspondence of emerging data with themes arising from the data. It is also seen as lucrative for the construction of a theory grounded in understandings and experiences of CAM users. Moreover by drawing on study participants language and understandings in the development of conceptual coding, the method is seen as privileging the authenticity of CAM user accounts. The grounded theory platform of inducting theory from participants accounts was first developed by Glaser and Strauss (1967) as a theory and method of research with thematic analysis, analytical memos, constant comparative method, theoretical saturation, and iterative coding. The method was, according to Dyson and Brown (2006, p.23) developed out of
symbolic interactionism, and from this Glaser and Strauss developed a ‘substantive theory’ in which theory stays close to the data, prioritising concepts, and words used by participants. Strauss and Glaser have since taken different methodological paths in relation to grounded theory, and researchers generally align themselves to one or other’s position. For my analysis, and keeping with the social constructionist framework of the thesis, I adopted a form of grounded theory which derives more from the constructivist thread found in the grounded theory of Strauss, and later Strauss and Corbin, and which is well suited to identifying the constructed meanings and knowledges of CAM users. Furthermore although classical grounded theory had possibilities, I found it lacked the interpretative framework necessary for social construction work.

To this end the constructivist grounded theory (CGT) method deriving from Strauss and Corbin, and further developed by Charmaz (2006) seemed a more promising option. CGT is notable for its sophisticated theoretical coding, and its rendering of individual’s experiences into grounded theory (Mills et.al. 2006, p.1). Drawn from concepts inherent to phenomenological social constructivism and symbolic interactionism, CGT analysis offered insight into the ontological and epistemological orientation of participants accounts through identifying knowledge constructs and how they made sense of these. Analytical coding as discussed later in this chapter, was used to identify language which was used by CAM users to convey socio-cultural meanings of CAM, and also to analyse for knowledge based discourses underlying the CAM user accounts.

CGT is not without its critiques and several concerns about the authenticity of CGT as a grounded theory method are raised by Glaser (2002) as architect of classical grounded theory, in a provocative article titled Constructivist grounded theory? While Charmaz sees interview accounts as representing a socially constructed version of events, Glaser argues ‘this data is rendered objective to a high degree by most research methods and grounded theory in particular by looking at many cases of the same phenomenon’. Charmaz (2006, p.180) counter argues that it is imperative the role of the researcher be part of the analytical process, and that it be recognised that ‘we stand within [original italics] the research process rather than above, before, or outside it’. What this debate suggests is that grounded theory methods have become variegated, with CGT offering a sophisticated method for understanding the social processes and actions constituting the modern person. As such grounded theory uncovers emergent and multiple processes instead of a single social process.

My own approach to CGT in this thesis is faithful to the interpretative constructivist grounded tradition elucidated by Charmaz, and I have used the analytical approach outlined in Constructing Grounded Theory (Charmaz, 2006). The CGT method has allowed for a
rewarding engagement with interview texts which have offered rich, thick description. From this process developed the central argument of the thesis that trust in CAM treatment is mediated between CAM and biomedicine use. The reader should note that the process of CGT analysis has been applied only to CAM user accounts, the CAM practitioner accounts which are based on a thematic analysis, and designed to support the CAM user accounts.

4.2.2 Discourse and narrative

Throughout this thesis the categories of ‘narrative’ and ‘discourse’ are applied as tools of analysis, and a frame of reference for the interpretative social construction analysis. The experiences of lay people are articulated and understood using socio-cultural narratives, in which the concept of narrative refers to a ‘story’ or ‘account’. According to Williams (1984, p. 178) narrative has two aspects, the routine and the reconstructed. The routine narrative is the observable form, the comments and the ordering of everyday life, the cognitive confirmation of self and biography; whereas the reconstructed narrative consists of explanations and interpretations, the explanation of illness perhaps, and the interpretation of ‘profound discontinuities in the social processes of their daily lives’ (Williams, 1984, p. 178). Take for example a chronically ill person who uses aromatherapy for managing treatment side effects. A reconstructed narrative here consists of two narrative threads: first, a cultural narrative of illness as requiring treatment; and second, an illness narrative (Frank, 1995; Kleinman, 1988), which is an individualised interpretation of the cause of illness in relation to the biographical self, defining a historical relationship between self, body and society at large (Bury, 1982).

The regular CAM users interviewed for this study are already committed to CAM and this would influence their narratives around health and illness, specifically the expression of holistic health values, moreover their cultural narrative is influenced by their social location, the majority of CAM users in the study are white middle class. Their preconceived idea of health and their culturally formed narratives of health would lead to their construction of a particular identity as a client, patient or consumer with a particular relationship to health, to food and related behaviours. This becomes more particularised when considering how the institutional discourse of health and medicine intertwines with the reconstructed narrative of the individual CAM user.

According to Steinberg (2000) our narratives are constructed discursively, and lay knowledge of health and illness is constituted through the expert discourses of medicine. Typically, institutional discourses are examined using a Foucauldian discourse analysis which examines ‘a type of language associated with an institution, and includes the ideas and statements which express an institution’s values’ (Danaher et al., 2000, p. x). To this end, Foucault acknowledges that discursive formations such as choice of concepts or themes, will regulate our everyday
knowledge (2011/1972, p. 41). The discursive formations of study participants in this thesis are drawn from a social stock of health and medical knowledge including scientific medicine, and from this the participants frame personal meanings and understandings such as the legitimacy of CAM.

In CGT theoretical coding is undertaken to identify such narrative and discursive constructs, and to elucidate the meanings these hold for study participants. In so doing the analysis must also consider the metaphorical use of language, and the particularised meanings conveyed through metaphor. To this end Sontag (1983) set forth a treatise on the cultural meanings conveyed by metaphors of illness, in which she identified these metaphors as powerful mechanisms for transmitting cultural meanings in everyday interactions. Sociologists of health (see Lupton, 2003, p. 62; Turner, 1992, p. 182) have paid particular attention, for example to how lay understandings of the body are influenced by the mechanistic and military metaphors of orthodox medicine. In this thesis, the analytical tools comprise of narrative, discourse and metaphor.

### 4.2.3 The reflexive interviewer

The interviewer is seen to be involved in the social construction of participant accounts, meaning that the interviewer is involved in the process of constructing the events narrated by the CAM users and practitioners (Charmaz, 2007). During the interviews of around 45 to 60 minutes’ duration, my interviewees were actively engaged in a narrative reconstruction of events and not simply answering questions. For example, an illness experienced 15 years ago can be remembered through the narrative lens of tragedy, or of humour. The reconstruction of experiences and events such as health encounters, are central to the interviewee’s phenomenological sense making. There is a tendency for interviewees to recall these experiences and events in a way which positions the self as morally responsible, for example as a ‘good’ parent, a ‘good’ patient, and in seeking the approval of the interviewer. While the interviewee is simply presenting a particularised version of reality, as an experienced interviewer I am acutely aware of my role in the interviewee’s construction of their account. Charmaz (2006) states that analysis is a co-construction of a story between the interviewer and interviewee. The interview is a reflection, an account of one’s experiences and is interpreted by the interviewer in a particular way. The research participant is co-constructing a story, a particular version of their reality, and this according to Charmaz is important to understanding the constructed nature of the data.

To simultaneously control for the inherent power differences between myself and the interviewees, and allow for their expression of subjectivity, I adopted Bourdieu’s (1999, p. 609) approach to ‘active and methodical listening’ [emphasis in original]. This approach involves...
positional thinking, submitting to the biography, language, views, verbal and non-verbal cues of an interviewee. According to Bourdieu, this allows the interview to become a ‘spiritual exercise’ [original italics] and an immersion into another person’s perspective, and an abandonment of self-interest. To level the status difference between researcher and participant, some qualitative researchers (Reinharz, 1992) advocate the researcher share demographic characteristics and/or experiences with interviewees, thereby creating a more comfortable environment for the participant to speak honestly about sensitive issues such as illness. Conscious of my academic role, I sought to reduce this alienation through collaborating with interviewees, empathising and sharing common experiences of CAM use. Being mindful of Bourdieu’s observation that the research investigator ‘starts the game and sets up its rules’ (1999, p. 609) and acknowledging the high cultural and linguistic capital of the researcher, my collaborative style was a way of mediating this authority. My own experience in academic research projects has borne this out, and not uncommonly I am asked by research participants to verify the ‘correctness’ of their interpretations. This can also work the other way, when several of the CAM practitioners assumed I held the same expert knowledge as they. As an interviewer I consciously took up Bourdieu’s recommendation to understand the interviewee’s field of practice by learning about CAM practices, and visited practitioners of various disciplines to acquire an ethnographic understanding of the CAM experience. I also consulted with one of the naturopaths referred to in interviewer accounts, allowing me to relate directly to the experiences of CAM users. As outlined in the previous section I also chose to adopt certain modes of speaking, language and so forth in accordance with the communication style of the participant.

4.3 The Research Design: Recruitment, Sampling, Interviews and Data Collection

The research is embedded in an interpretative framework which allows for the detailed investigation of lay knowledge of CAM users. A qualitative methodology guides the investigation, which incorporates qualitative in-depth interviews with 16 CAM users and 10 CAM practitioners and inductive analysis thereof. Section 4.3 outlines the research design, sampling and recruitment strategies of both CAM users and CAM practitioners, and section 4.4 details the data analysis for each group. CAM users were recruited through the CAM practitioners interviewed for the study, the practitioners agreeing to have a set of recruitment questionnaires in their waiting rooms, along with a privacy box for CAM users to place their questionnaires. Due to the central role of the CAM practitioners in the study for recruiting CAM users, the discussion commences with this group.
4.3.1 Complementary and alternative medicine practitioners: Recruitment and sampling

The CAM practitioners interviewed for the study were selected from a member listing of the Australian Traditional Medicine Society (ATMS), which is Australia’s largest professional association for CAM practitioners. The association claims to represent 65 per cent of CAM practitioners and have over 9,000 members (Australian Traditional Medicine Association, 2010). The association represents various disciplines including naturopathy, homeopathy, massage, herbalism, kinesiology, acupuncture, hypnotherapy, Traditional Chinese Medicine (TCM), reflexology and aromatherapy. One of the limitations is that being members of the ATMS in contrast to non-formalised practitioners, increases the likelihood of the practitioners to be professionalised, have formal qualifications and work in established practices. It is noted that members of this formalised professional organisation are relatively well trained, and are regularly informed of current developments in CAM. As such, this sample is likely to be more favourably disposed toward increased professionalisation than a sample of less formalised practitioners.

Potential participants had been systematically selected from an ATMS membership directory, the practitioners practise in specific regions in New South Wales (NSW). The reason for this is partly practical it was not worthwhile due to issues of time and resourcing, and given the relatively few practitioners in some regions of NSW, to interview practitioners in every region of NSW; second, given that the majority of practitioners are based in the Sydney metropolitan area, the representative sampling frame favouring practitioners living in the Sydney metropolitan region including the Central Coast and Blue Mountains. In addition some four practitioners are based in rural and regional areas. The regions chosen for recruiting practitioners, and ultimately CAM users, outside of the Sydney metropolitan region include a husband and wife naturopathic team based in the largely working class area of Maitland in the Hunter Valley; a naturopath based in the wealthy and established rural town of Orange, and a homeopath based in Tweed Heads which is in the north coast of NSW, an area well known for its long association with alternative health practices. The reason for purposively selecting some rural and regional areas was to represent the high number of Australians in rural and regional areas reported to use CAM (Adams et al., 2003; Sherwood, 2000). The wider sampling method is considered purposive (Bryman, 2001) in that CAM practitioners were drawn from the ATMS directory, and this meant that chiropractors and osteopaths are notably absent from the practitioner cohort. This is considered a limitation of the research design, in that it would have been useful to include the perspective of members of these groups, who are commonly regarded as more ‘mainstream’ than the more esoteric CAM disciplines (see Chapter One).
Once a practitioner was systematically selected, that practitioner was sent an information statement (see Appendix B) and informed consent form, and was later contacted by telephone to invite participation in the study. Using the sample selection process around 40 practitioners were eventually contacted. If a selected practitioner did not qualify for the study, meaning they no longer practiced CAM, or if the practitioner was not interested in the study, or not able to be contacted, then the next listed practitioner was contacted. The overall refusal rate was surprisingly low, with only two qualifying practitioners declining to be part of the study. There were 20 CAM practitioners interviewed from the recruitment pool and some 10 of these were selected for inclusion in the final sample.

4.3.2 Interviewing complementary and alternative medicine practitioners

Taped, in-depth interviews were conducted by myself between January 2004 and May 2005, and transcribed in accordance with University of Newcastle Ethics Protocols. As such the interviews were conducted come six years prior to analysis and reporting. Nevertheless, the interview data is considered to be current in that CAM is still popularly used, and the regulatory and professional context for the practice of CAM have changed little since the interviews were conducted. The primary difference in the context of CAM use is the emergence of integrative medicine clinics in some parts of Australia, however this is not considered to bias the account of the regular CAM users and practitioners interviewed for the study, as CAM users still patronise individual CAM practitioners for the most part. Given the static contexts for CAM use the data is considered as relatively current; moreover the nature of the exploration of trust between CAM users and their practitioners is only touched on in sociological literature, and the findings represent an important contribution to the sociology of complementary and alternative medicine literature.

The interviews were conducted mostly at a practitioner’s work place, and lasted between 45 and 90 minutes. Interview tapes were transcribed in accordance with ethics protocols, tapes de-identified and securely stored. Names were not transcribed, rather practitioners are referred to by a number such as ‘Naturopath, 1’. A profile of the practice and demographic background of the 10 practitioners is summarised in Table 4.1. In summary the practitioners comprised of:

- Two naturopathic teams (husband and wife) and two individual naturopaths in private practice,
- Two homeopaths, including the head of a homeopathic college.
- One acupuncturist and TCM practitioner, specialising in natural fertility management.
- A reflexologist/bodyworker working from a private home based practice.
The questions in the interview schedule (see Appendix D) represent the institutional contexts for practice and the interpersonal relations of practice. Institutional contexts for practice include professionalisation strategies such as credentialing and minimum practice requirements, the moves toward integrative practice, the push for evidence-based testing of CAM medicines and therapies and the involvement of pharmaceutical companies in the manufacture of CAMs. Interpersonal relations of practice include the nature of the therapeutic encounter with clients/patients, treatment decision-making and the operationalisation of holistic health principles such as individualism, spirituality and vitalism.

The purpose of having two broad areas was to be able to situate CAM use and practice in both situational and broader contexts. Developing questions about professional aspects of practice allowed me to understand the expert system through the knowledge claims of the practitioner, who forms an ‘access point’ (Giddens, 1995) between the client/patient and the expert systems of CAM. The knowledge boundaries and specific practice based knowledge for each practitioner were gleaned from the interview which produced a narrative account of CAM practice and theory; the resulting accounts from practitioners set the scene for understanding the professional contexts for practice. This includes elucidation of CAM practice in Australia, the practitioner’s role in current debates around regulation, evidence based medicine, professionalisation and so forth. The interviews also allowed insight into the micro-interactions between client/patient and practitioner.

The original proposal included in-depth interviews with 20 CAM practitioners and up to 20 CAM users, in addition the proposal included audio-recording of consultations between CAM clients and their practitioners, and for these audio-recorded consultations to be with the original 20 CAM practitioners interviewed for the study. Ultimately I decided not to proceed with audio-recorded consultations of client/practitioner interactions, as important information regarding client/practitioner interactions had emerged from the CAM practitioner interviews, and it was clear that the interviews would provide enough data to proceed with the thesis inquiry. Moreover, as the analysis proceeded, and the area of trust emerged as theoretically important, CAM user accounts became more empirically relevant to the thesis. As such the original cohort of 20 CAM practitioners was reduced to 10 including two husband and wife teams, these 10 practitioners being chosen on the basis of their clients/patients being one of the 16 CAM users interviewed for the study. As the focus of the study became more about the CAM users, the practitioner accounts have become more integral to setting the scene, understanding the professional discourse of CAM practitioners, and this provides a meaningful interactional context to understand CAM user constructs.
4.3.3 Complementary and alternative medicine users: Recruitment and sampling

Some 16 CAM user accounts were used as the basis for qualitative data analysis. CAM users were recruited via the CAM practitioners interviewed for the study. CAM practitioners agreed to having a ‘privacy box’ available for the posting of completed recruitment questionnaires, and these were placed in the practice waiting room, provided one existed. The recruitment questionnaire (see Appendix A) was completed by over 100 CAM practitioner clients. Those respondents fulfilling the ‘regular user’ criteria, that is using more than one CAM modality for more than five years and being relatively frequent users, and agreeing to be contacted for further research, were enumerated based on their frequency of CAM use, and use of multiple modalities. Practitioners without a waiting room were not generally able to assist in recruitment. An attachment to the recruitment questionnaire allowed potential participants to provide name and contact details, if they were interested in further study participation. The recruitment strategy was developed after conducting a preliminary review of social science literature in which similar strategies were used to recruit for a representative sample of CAM users (see Lewith & Chan, 2002; Sirois & Gick, 2002).

CAM users were selected from responses to the recruitment questionnaire, and potential participants contacted by telephone. Those that were interested in being interviewed were sent a letter inviting them to be part of the study. The letter contained an Informed Consent form, a Revocation of Consent form and a letter outlining the purpose of the study (see Appendix B). Participants also signed a Consent Form for audio taping. Using this process, some 17 CAM users agreed to be interviewed for the study. These participants returned the signed consent form in a pre-paid envelope prior to the interview. The consent form and information statement outline the University of Newcastle’s ethical protocols on privacy, anonymity and confidentiality, and participants were also made aware they were under no obligation to remain involved with the study should they choose to withdraw, and were free to have their audio recording discarded from the analysis. In order to protect participants’ anonymity, pseudonyms have been used to identify CAM users. Upon receipt of the signed Consent Form, an interview time and place convenient to the participant was established. The interviews were audio recorded, and took between 45 and 90 minutes. The participants were interviewed at their place of work, at home or in a club or cafe. There was one interview which was not able to be deciphered in transcription, and which needed to be discarded from the sample, so the total sample is 16 CAM users.

As common to sociological studies using qualitative methods, the sample was purposively recruited to support a theoretical analysis, rather than generalise findings to a broader population of CAM users. As defined by Rice and Ezzy (1999, p. 48), theoretical sampling
involves a process where ‘the representativeness of concepts, not of persons is crucial’. Interviews were conducted until they reached theoretical saturation, which is denoted by continued sampling and data collection until no new conceptual categories emerge from the data (Bloor & Wood, 2006). In CAM this involves theoretically validating themes and categories as they emerge from the data.

Table 4.2 outlines the socio-demographic characteristics, the illness and health conditions, and the type of CAM practices used by each CAM user. Socio-demographic background is also provided for each user, and the sample of 16 CAM users is male and female, but includes significantly more females than males. The CAM users are aged from late twenties to early seventies, with the majority of users aged between 30 and 50 years. The CAM users are, for the most part tertiary educated and exhibit other characteristics of the ‘middle class’. This demographic profile it should be noted is representative of the ‘typical’ CAM user in social science literature (Adams et al. 2003; MacLennan et al., 2006; Sherwood, 2000).

4.3.4 Interviewing complementary and alternative medicine users

Social scientists in general have supported qualitative interviewing as a way of understanding people subjectively (Bryman, 2001; Bury, 2001; Sharma, 1995). Interviews are developed to understand the complexity of meanings, attitudes and understandings constructed by individuals regarding everyday experiences (Grbich, 2007; Rice & Ezzy, 1999). For these reasons in-depth interviewing is the method preferred by many health sociologists (e.g. Broom & Tovey, 2007; Lupton, 1997; Sharma, 1996). For my study, I determined a number of factors in favour of using in-depth interviewing as the exclusive research method. First, it is the most appropriate method for an interpretative study of the experiences and understandings of complementary and alternative medicine use. Second, as advocated by medical anthropologist Ursula Sharma, to properly explore the use of CAM we ‘surely need to examine the circumstances in which individuals first turn to alternatives’ (Sharma, 1996, p. 234). In other words, social studies of health and illness should not start just with the decision to consult a practitioner, but rather with the interviewee’s story of how they came to use a treatment. Taking up Sharma’s advice, the interview began with a biographical reflection of CAM use.

Qualitative in-depth interviews were conducted between December 2004 and August 2005. The interviews were transcribed in accordance with the University of Newcastle Ethics Protocol assuring anonymity and confidentiality. Interviews were audio recorded and study participants assigned a pseudonym. The tapes were de-identified and securely stored in a locked cabinet. The interview took the form of an loosely structured in-depth interview, falling somewhere between semi-structured and unstructured terrain and based on topics in an interview guide (see Appendix C). Acknowledging that people have different ways of speaking and understanding,
questions were phrased to suit the individual participant, allowing for a more naturalistic interview style, also topics were introduced throughout the interview in no particular order.

The interview also allowed for new topics to be introduced, according to the needs and interests of each participant. Iterative inquiry meant that as new topics arose from each interview, new topics were able to be explored in interviews with other users. From experience, my preference then is to use less structured, conversational styles while at the same time following prescribed interview topics. As an experienced interviewer I was able to establish a rapport with participants, which in turn encouraged stories and anecdotes. Adopting such an interview style was also a way of alleviating the concerns raised by commentators regarding the forced production of socially acceptable accounts (Lewith & Chan, 2002) and the effects of ‘unnaturalness’ of the interview encounter (Bryman, 2001, p. 330).
Table 4.1 Profile of the 10 Complementary and Alternative Medicine Practitioners in the Study

<table>
<thead>
<tr>
<th>Practitioner</th>
<th>Discipline</th>
<th>Type of therapies</th>
<th>Location of practice</th>
<th>Gender of practitioner</th>
<th>Social class of area of practice</th>
<th>Training</th>
<th>Type of practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Naturopath</td>
<td>Naturopathy, homeopathy, iridology, nutrition, reflexology, aromatherapy, massage, hydro-massage, reiki</td>
<td>Maitland, Upper Hunter region</td>
<td>Female</td>
<td>Working class, regional town</td>
<td>Practicing for over 30 years, overseas university degrees in naturopathy &amp; reflexology (O/S).</td>
<td>Private practice with naturopath practitioner 2 (husband &amp; wife team)</td>
</tr>
<tr>
<td>2</td>
<td>Naturopath</td>
<td>Naturopathy, homeopathy, iridology, nutrition, reflexology, aromatherapy, massage, hydro-massage, reiki</td>
<td>Maitland, Upper Hunter region</td>
<td>Male</td>
<td>Practicing for over 30 years, trained in homeopathy initially, then overseas university degrees in naturopathy &amp; reflexology.</td>
<td>Private practice with naturopath practitioner 1 (husband &amp; wife team)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Naturopath</td>
<td>Herbalist, nutrition, iridology, bach flowers, homeopathy and massage therapy</td>
<td>Sydney Inner West</td>
<td>Female</td>
<td>Middle class, left-wing, well educated</td>
<td>5 years practice; trained as a naturopath in UK</td>
<td>Private group of natural therapists</td>
</tr>
<tr>
<td>4</td>
<td>Acupuncturist, natural fertility and TCM</td>
<td>Acupuncture and Chinese herbs, natural fertility</td>
<td>Sydney East/ Sydney CBD</td>
<td>Female</td>
<td>Upper middle class, professional workers</td>
<td>15 years practicing, trained at local college and in China</td>
<td>Private group of natural therapists</td>
</tr>
<tr>
<td>5</td>
<td>Homeopath</td>
<td>Homeopathy</td>
<td>Sydney Inner West</td>
<td>Female</td>
<td>Middle class, professional, culturally diverse</td>
<td>25 yrs practice</td>
<td>Head of homeopathic college</td>
</tr>
<tr>
<td>6</td>
<td>Homeopath</td>
<td>Homeopathy, herbalism, nutrition</td>
<td>Tweed Heads</td>
<td>Female</td>
<td>Middle class area, retirees and families</td>
<td>19 yrs practice; homeopathy college</td>
<td>Private practice</td>
</tr>
<tr>
<td>7</td>
<td>Naturopath</td>
<td>Naturopathy including iridology, nutrition mainly, herbal medicine, homeopathy, counseling</td>
<td>Springwood, Blue Mountains</td>
<td>Female</td>
<td>Regional centre; middle class, elderly population</td>
<td>8 yrs practicing naturopathy, trained in nutrition and as a secondary science teacher. Six years training at naturopathic college in Sydney</td>
<td>Private group CAM practice and in practice with husband (practitioner 8)</td>
</tr>
<tr>
<td>8</td>
<td>Body-worker and naturopath</td>
<td>Body-work, massage, naturopathy</td>
<td>Springwood, Blue Mountains</td>
<td>Male</td>
<td>Regional centre; middle class, elderly population</td>
<td>Bachelor of Science and six years training at naturopathic college in Sydney</td>
<td>Private group CAM practice</td>
</tr>
<tr>
<td>9</td>
<td>Naturopath</td>
<td>Naturopathy and homeopathy</td>
<td>Orange</td>
<td>Male</td>
<td>Rural</td>
<td>University degree</td>
<td>Naturopathy and homeopathy</td>
</tr>
<tr>
<td>10</td>
<td>Reflexologist</td>
<td>Reflexology</td>
<td>Sydney North</td>
<td>Female</td>
<td>Upper middle</td>
<td>Over 20 years as a reflexologist</td>
<td>Private, home based practice</td>
</tr>
</tbody>
</table>
Table 4.2 Profile of the 16 Complementary and Alternative Medicine Users in the study

<table>
<thead>
<tr>
<th>CAM user</th>
<th>Age</th>
<th>Years of CAM use</th>
<th>CAM therapies used</th>
<th>Location of residence</th>
<th>Interview location</th>
<th>Occupation/education level/social class</th>
<th>Marital status; cultural background</th>
<th>Health issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Jan</td>
<td>39 yrs</td>
<td>15 years</td>
<td>Acupuncture, TCM, herbs, naturopathy, massage, chiropractor, psychic</td>
<td>Sydney West</td>
<td>Home</td>
<td>Part time receptionist in hospitality industry, full time Social Work uni student</td>
<td>Married, one step son; Caucasian Australian</td>
<td>Fertility; Weight loss; Bad back</td>
</tr>
<tr>
<td>2 Bonnie</td>
<td>51 yrs</td>
<td>30 years</td>
<td>Acupuncture, naturopathy, homeopathy</td>
<td>Sydney East</td>
<td>Public place</td>
<td>Middle class and tertiary educated</td>
<td>Married, young children; Caucasian New Zealander born</td>
<td>Inducing a pregnancy, back pain, children’s health</td>
</tr>
<tr>
<td>3 Annie</td>
<td>43 yrs</td>
<td>23 years</td>
<td>Acupuncture, Naturopathy and herbs, Betako method, natural fertility treatment, homeopathy, kinesiology, TCM, osteopathy, massage, bodywork</td>
<td>Sydney East</td>
<td>Private office at her workplace, alone</td>
<td>Marketing professional; tertiary educated</td>
<td>Married with children; Caucasian Australian</td>
<td>Fertility; sinusitis; mental health; smoking cessation; family use</td>
</tr>
<tr>
<td>4 Sharon</td>
<td>58 yrs</td>
<td>17 years</td>
<td>Acupuncture, naturopathy, Chinese herbs, colonic irrigation, chiropractor, osteopathy, meditation, massage, reiki, homeopathy, kinesiology</td>
<td>Sydney East</td>
<td>Home</td>
<td>Education course writer consultant; Tertiary educated</td>
<td>Single; Caucasian Australian</td>
<td>Hep C; on interferon treatment when interviewed; Bad back</td>
</tr>
<tr>
<td>5 Corinne</td>
<td>35 yrs</td>
<td>7 years</td>
<td>Naturopath, herbs, Bowen therapy, acupuncture, iridology, osteopathy, kinesiology</td>
<td>Sydney Inner west</td>
<td>Home, husband and child in house</td>
<td>Professional background, now a full time mother</td>
<td>Married with children (6 yrs and baby); Caucasian English born</td>
<td>Bad back</td>
</tr>
<tr>
<td>6 John</td>
<td>55 yrs</td>
<td>20+ years</td>
<td>Homeopathy, TCM, chiropractor</td>
<td>Tweed Heads</td>
<td>Club (public space)</td>
<td>Consultant in business and finance; middle class and tertiary educated</td>
<td>Divorced and living alone</td>
<td>Chronic fatigue</td>
</tr>
<tr>
<td>7 Andy</td>
<td>36 yrs</td>
<td>9 years</td>
<td>Massage, herbs, TCM, reiki, acupuncture,</td>
<td>Sydney inner west</td>
<td>Home</td>
<td>Tertiary educated</td>
<td>Homosexual, single; Australian born, Cypriot ancestry</td>
<td>Back injury, sinusitis, insomnia</td>
</tr>
<tr>
<td>8 Marcia</td>
<td>60 yrs</td>
<td>25 years+</td>
<td>Ayurvedic medicine, vitamin therapy, herbs, chiropractic, physiotherapy, naturopathy, TCM, homeopathy</td>
<td>Summer Hill, Sydney</td>
<td>Home</td>
<td>Retired. Was previously a research and policy officer in government.</td>
<td>Sri Lankan cultural background; middle class and highly educated</td>
<td>Thyroid, cancer, menopause, previously PMS</td>
</tr>
<tr>
<td>9 Isobel</td>
<td>27 yrs</td>
<td>Approx 5 years</td>
<td>Naturopathy, homeopathy, osteopathy, acupuncturist</td>
<td>Sydney East</td>
<td>Home</td>
<td>University student</td>
<td>Single; Caucasian Australia</td>
<td>Chronic fatigue syndrome (CFS), anxiety and skin problems, back pain</td>
</tr>
<tr>
<td>10 Bella</td>
<td>58 yrs</td>
<td>25 years+</td>
<td>Acupuncture, yoga, vitamins, Chinese and Western herbs, osteopathy</td>
<td>Sydney East</td>
<td>Home (partner sat in)</td>
<td>Retired. Former district officer for the Department</td>
<td>Same sex de facto relationship</td>
<td>Hepatitis initially, autoimmune disease, muscu-</td>
</tr>
<tr>
<td>CAM user</td>
<td>Age</td>
<td>Years of CAM use</td>
<td>CAM therapies used</td>
<td>Location of residence</td>
<td>Interview location</td>
<td>Occupation/education level/social class</td>
<td>Marital status; cultural background</td>
<td>Health issues</td>
</tr>
<tr>
<td>---------</td>
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<td>------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
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<td>----------------------------------------</td>
<td>-------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>11 Amy</td>
<td>49 yrs</td>
<td>9 yrs</td>
<td>Nutrition; naturopathy, herbs, homeopathy, acupuncture, colonic irrigation</td>
<td>Upper Hunter Valley, NSW</td>
<td>Home</td>
<td>Working class background, well educated</td>
<td>Single, no children, Latvian background (parents)</td>
<td>Arthritic knee</td>
</tr>
<tr>
<td>12 Lucy</td>
<td>33 yrs</td>
<td>Around 7 yrs</td>
<td>Naturopathy, hypnotherapy</td>
<td>Maitland, NSW</td>
<td>Home</td>
<td>Home duties/working class background, higher level economic status</td>
<td>Married with two young children</td>
<td>Mental health (alcoholism and depression); Fertility; Family use</td>
</tr>
<tr>
<td>13 Ben</td>
<td>45 yrs</td>
<td>25 years+</td>
<td>Osteopath, chiropractor, Chinese herbs, massage, homeopathy</td>
<td>Sydney Inner West</td>
<td>Home</td>
<td>Small business owner; middle class background, year 12 educated</td>
<td>Single, no children, living alone; Caucasian Australian</td>
<td>Knee and back problems; headaches</td>
</tr>
<tr>
<td>14 Fifi</td>
<td>47 yrs</td>
<td>10 yrs</td>
<td>Makahari, reiki,</td>
<td>Lower Blue Mountains</td>
<td>Combined home/work premises</td>
<td>Middle class, Tertiary educated. Practicing dentist with own dental practice</td>
<td>Caucasian Australian</td>
<td>Chronic fatigue syndrome (CFS)</td>
</tr>
<tr>
<td>15 Kate</td>
<td>40 yrs</td>
<td>7-8 yrs</td>
<td>TCM, acupuncture, homeopathy, osteopathy</td>
<td>Inner Sydney</td>
<td>Work place</td>
<td>Manager; self employed</td>
<td>Caucasian Australia</td>
<td>Endometriosis, fertility, dizziness</td>
</tr>
<tr>
<td>16 Mads</td>
<td>79 yrs</td>
<td>7 yrs</td>
<td>Supplements like fish oil; herbs; nutrition</td>
<td>Lower Blue Mountains</td>
<td>Home</td>
<td>Previously a teacher, and still a practicing, full time psychologist in a prison. Middle class, highly educated</td>
<td>Divorced, three adult children; Caucasian Australian</td>
<td>Arthritis, Hip replacement</td>
</tr>
</tbody>
</table>
4.4 Qualitative Data Analysis

4.4.1 Complementary and alternative medicine users

The inductive, qualitative analysis used in this study is based on the principles of constructivist grounded theory (CGT). This involves four stages of analysis, namely, making preliminary comments observations, coding for emergent then subordinate themes, and engaging in abstract theoretical coding (Charmaz, 2006). The theoretical coding of CGT in the later stages of analysis, allowed for the identification of higher order sociological constructs for theorising CAM use.

The analysis has revealed how the abstract concept of ‘trust’ was grounded in the accounts of CAM users, and formed an identifiable theme of the analysis, as the coding process proceeded to higher levels of theoretical abstraction it was clear that ‘trust’ was a major theoretical construct of the analysis. I took some liberties in the early stages of preliminary analysis, by drawing on the interpretative phenomenological analysis method (Smith & Osborn, 2003) to identify phenomenologically grounded themes and concepts embedded in the data. Charmaz (2006, p. 9) herself supports an innovative, flexible CGT approach which can be complemented by other qualitative methods and my infusion of the IPA method being only at the preliminary stages of analysis, provided a useful means of monitoring the production of not just codes, but also themes arising from the data.

Supported by extracts from the data, this section examines CGT stages of analysis in detail. The analysis was guided by the principle of iterative inquiry, meaning coding activities and data analysis occurred concurrently, with each informing the other. The iterative process involves building theory which is faithful to the participants’ accounts, and the coding framework underwent multiple revisions as my understanding grew, codes were conflated and new codes developed, with this process occurring also at the theoretical coding level. Having empirically grounded data meant that ‘in vivo’ codes could be developed from the language used by the CAM users. Examples of in vivo codes were the use of ‘elimination metaphors’ and not being ‘listened to’ by medical practitioners.

*Preliminary comments and open coding:* All the interview transcripts were subjected to preliminary comments based on observation from the data. This was the first step in the overall process of developing an analytic framework. Open coding was undertaken following from the preliminary comments, which was based in the experiences and meanings of CAM users. As stated above and without the line-by-line coding associated with grounded theory. Preliminary comments were therefore exploratory, involving observations on language and highlighted quotations from the interview. From this initial coding stage, over 100 emergent themes were
identified. To demonstrate the relation between the preliminary comments and emergent themes an extract from analysis of the interview with ‘Bonnie’ is in Appendix E.

**Focused and axial coding:** The most frequent and most significant open codes were used to develop conceptual focused codes (Charmaz, 2006, p.57). In the excerpt from the coding book in Appendix F some 52 open codes are listed which relate to a broader theme of engagement with biomedicine. A focused code was developed when at least 25 per cent of CAM users articulated a similar theme. Codes such as ‘being misdiagnosed’, ‘resisting biomedical advice’ (refer Appendix F) and ‘experiencing pain in CAM treatment’ were developed, representing experiences, knowledge and meanings of CAM users. Axial codes developed subordinate themes, converging focused codes into one theoretically distinct category. These categories accommodated at least 50 per cent of CAM users, except where the code was particularly significant such as ‘meanings of spirituality’. It was also at this stage of analysis that theoretical coding took a more constructivist approach, with codes such as ‘resisting/challenging biomedical approaches’ and ‘anticipating health risk’ evolving. Appendix F contains an extract from the coding book, showing the development of codes related to the biomedical experience.

**Theoretical coding** was the last stage of coding, and involves constructing codes into an ‘analytic story’ (Charmaz, 2006, p. 63). The theoretical coding categories developed for my study arose from sociological categories such as ‘interaction’, ‘agency-structure’, ‘narrative and biography’, ‘power and control’, ‘experience’ and ‘identity’. From this process emerged four master themes, uncertainty and trust in biomedical approaches; mediating lay and expert knowledge in encounters; self-care and the bodily experience of CAM use; and exercising personal agency. Through processes of validation, the most implicit theoretical code addressing the research questions, and one also grounded in data (see for example Bonnie, Appendix E) was that of ‘trust’. Again based on the analysis an argument emerged that trust in CAM is mediated between CAM and biomedicine use, that we cannot divorce one from the other. Secondary arguments concern the development of trust in interaction, with an argument that trust in the CAM practitioner is central to treatment decision-making, and a further argument concerning trust in the bodily experience of CAM.

**4.4.2 Complementary and alternative medicine practitioner analysis**

Interview accounts from CAM practitioners, being based on a more structured interview guide than CAM users, were subjected to a process of thematic analysis. This form of analysis is recognised as a ‘process of segmentation, categorisation, and relinking of aspects of the data prior to final interpretation’ (Grbich, 2007, p. 16). The data is analysed to generate understandings of institutional and interpersonal aspects of practice. As an example, a prominent theme concerns the opposition to evidence-based clinical trials for demonstrating
clinical effectiveness of CAM. Here CAM practitioners demonstrate strong concerns in applying scientific methods to holistic practices, and call for more holistic testing methods. The form of thematic analysis used to analyse practitioner accounts is similar to the initial, emergent stages of CAM user analysis, but did not involve the rigorous process of abstract coding. So while the analysis supports an interpretative framework, no attempt was made to theorise to higher levels of abstraction. This level of analysis is appropriate given the role of the practitioner to set the scene for CAM user accounts.

4.5 Conclusion

This chapter demonstrates the appropriateness of CGT to providing an interpretative social constructionist account, and generating a theory of CAM use. From this methodological framework has emerged an argument that CAM use represents an ongoing process of negotiation of trust between CAM and biomedical approaches, and that trust in treatment decision-making is based on this mediation. Secondary arguments concern the development of trust in interaction, and in bodily experiences of CAM. The findings detailed in Chapters Five to Seven cover each of these arguments.
Chapter Five
Trust in Expert Knowledge

‘MORE believers, MORE trust’,
A Blackmore’s natural medicines advertisement, September 2012

5.1 Introduction

Social science studies of CAM have cited dissatisfaction with biomedical approaches as a primary reason for CAM use (Adler, 2003; Bishop & Lewith, 2010; Cant & Sharma, 1996a; Connor, 2004; Goldstein, 2003; Gunnarsdottir & Peden-McAlpine, 2004; Lewith & Chan, 2002; Rayner, Willis, & Burgess, 2011; Sharma, 1995; Siahpush, 2000). Experiences with biomedical treatments figure prominently in the CAM user accounts, and many users attribute CAM use as response to negative experiences with biomedical treatments and practice. As Giddens (1995, p. 88) points out, we are socialised into respecting and valorising the technical knowledge of science; however, we also approach scientific and technical knowledge with ambivalence. The language and sophisticated knowledge claims of some medical professions create distance and alienation for the client/patient of these expert systems, and this depersonalisation can lead to scepticism. We have little choice, however, when dealing with abstract biomedical systems, but to exercise trust in the practitioners and their institutionalised knowledge. When the system has not upheld its side of the bargain, and when trust is dissolved through misadventure, CAM users in the present study have turned to non-biomedical approaches. Trust is a recurrent theme in CAM user accounts. In a discussion on the importance of trust to public health, Meyer et al. (2008, p. 178) note that a decline in trust may lead to more anxiety and self-focus. In the face of such anxiety, it is theorised that individuals adopt a reflexive mode of conduct (Nichter & Thompson, 2006). This reflexive conduct is demonstrated in the act of CAM use. For the research participants the biomedical experience creates uncertainty, and CAM use is a strategy for minimising risk from invasive biomedical procedures.

This chapter examines the development of trust in CAM and in decisions to use CAM treatment, and begins looking at the initial illness and other health contexts for CAM use. In this chapter CAM users are not shown, however, to abrogate the use of biomedical treatments in favour of CAM; instead both biomedical and non-biomedical approaches are used concurrently, negotiating trust between expert systems and using both in a pointillist and discontinuous manner. However distrust in biomedical treatment can result from misdiagnosis, and there are few examples of this among female study participants. The most dominant themes are experiences of misdiagnosis, experiencing adverse side effects from biomedical treatments,
frustration with the curative capacity of some forms of biomedical treatment, and uncertainty over scientific knowledge claims. In particular, CAM users strongly resist the use of compound pharmaceutical medicines, and this is a core part of their construction of health risk. This section presents the findings as they relate to these themes, beginning with misdiagnosis. The findings in this chapter also seek to assess why CAM users have engaged with practices of which they lack expert knowledge. On what basis do CAM users accept the contingencies of CAM knowledge claims? Where do they express certainty and uncertainties between CAM and biomedical forms of knowledge? This chapter explores the boundaries for using both CAM and biomedical approaches, focusing on interpersonal trust in both CAM and biomedicine practices.

5.2 Concurrent Use of CAM and Biomedical Approaches

The CAM users in my study have generally come to CAM use through illness, and many of them managing chronic illness in their everyday life. A higher incidence of illness among CAM users than non-CAM users is reported in social science literature (Adams, Sibbritt, Easthope, & Young, 2003; Thorpe, 2009). Accounts of CAM users show that CAM is used in two distinct contexts, for managing symptoms of illness and other health condition, and for health maintenance and derivative benefits. A single CAM user will tailor their CAM use to one of these contexts, and engage with both contexts in a discontinuous manner. To this end, they may use a treatment such as acupuncture to alleviate muscular pain, and continue to use CAM to prevent further pain. When used concurrently with biomedical approaches, CAM is generally, though not exclusively used for managing illness and other health conditions. This section considers this specific contextual use of CAM. The most commonly cited reasons for CAM use are musculo-skeletal conditions including osteoarthritis (e.g. Ben, Mads, Corinne, Sharon, Jan, Andy, Amy, Isobel), followed by chronic illness management including chronic fatigue syndrome (CFS) (Sharon, Fifi, John, Isobel), cancer (Marcia) and hepatitis (Sharon, Bella). Some seven female users used CAM for reproductive and hormonal health, including five specifically for fertility issues (Lucy, Annie, Bonnie, Jan, Kate). CAM has also been used for treating alcoholism (Lucy), migraine headache (Ben), insomnia (Andy), sinusitis (Andy, Annie) and for smoking cessation (Annie).

Consistent with findings from social science literature (Adams et al., 2003; Gunnarsdottir & Peden-McAlpine, 2004; Hok, Wachtler, Falkenberg, & Tishelman, 2007; Rayner et al., 2011), and in relation to illness management, CAM is used concurrently with biomedical approaches by the majority of users, most notably for chronic illness management, hormonal and reproductive health and musculo-skeletal conditions. The development of trust in both systems is found to differ, with CAM users demonstrating differing levels of confidence between biomedical and CAM practitioners. This, coupled with the perception of health risk in
biomedical treatments, produces uncertainty in biomedicine. CAM appears to be approached from a more trusting position, with a generalised perception of safety in the naturalness of CAM. Trust, however, is still implicit in the use of certain biomedical treatments, particularly those for routine health checks, screening and examination, managing specific symptoms of chronic illness, and for diagnostics. CAM is more commonly used as primary care for chronic illness with non-specific symptoms such as chronic fatigue, and for alleviating the side effects of biomedical treatments. CAM users become disenchanted with biomedical treatments when they are not effecting a cure or result, and turn to CAM at this point. Biomedical treatments are also discontinued when adverse effects produce a phenomenological disruption to everyday life. The relationship of trust between the two systems is complex, and the decision to use one or other system is not straightforward. CAM users are shown to gravitate between CAM and biomedical practitioners and treatments, and demonstrate a discontinuity in their treatment decision making. Let me examine some of these contexts for concurrent CAM and biomedicine use more carefully.

A feature of late modernity is that scientific and technological innovations have allowed for more people to be living with chronic illness in their everyday life, and as noted by social scientists (see Bury, 2001; Kleinman, 1988; Williams, 2000) this represents a biographical disruption to ‘normal’ life. Williams (2000, p. 49) notes that biographical disruption is about experiencing, on a daily basis, discernible shifts from ‘normal’ to exacerbation and disruption in daily routines. Biographical disruption is experienced by several CAM users managing chronic illness in daily life. At 79 years old Mads still works full-time as a prison psychologist. She is beginning to experience symptoms of arthritis, and is managing arthritis and hip pain through the combined use of CAM and biomedical treatments:

Interviewer: *What sort of conditions do you treat?*

Mads: *I think I have the beginning of arthritis, and I had a hip that was not too good, but eventually better.*

Interviewer: *So, how have the CAM products helped?*

Mads: *Well, they help the joints. And I have another product that I only discovered two years ago being a cautious person, these are different because they are actually produced by research doctors.*

Interviewer: *Do you also use conventional medicine?*

Mads: *Oh, panadol. I only use what’s safe.*
Interviewer: *What do you mean by safe?*

Mads: *When I had that hip replacement it was marvellous, the operation was wonderful, but when they gave me the drug at night my body reacted so violently I thought I was going to die, it stopped my heart, I found I couldn’t move and I didn’t know what had happened to me then. The nurse came in to check what I was getting, it was a worry. I was in a lot of pain. The problem is now I need to get the hip done sometimes, but the man turned me away wouldn’t even consider it, the surgeon.* (Mads, 79 years)

Mads’ account supports the concept of mixed therapy regimens (Connor, 2004) and CAM and biomedicine used pragmatically (see Adams, Sibbritt, & Young, 2009) to manage symptoms and long-term management of pain. The multiple use of health providers and self-experimentation with treatment shows a normalisation of the therapeutic pluralism. Coping strategies have a particular saliency for people like Mads, for whom using multiple therapies involves *learning* how to tolerate the effects of chronic illness, even normalising the experience by bracketing off the impacts of illness and enabling a ‘normal’ self-identity. Her self-experimentation is part of this strategising, Mads wants to feel normal and her identity relates strongly to being independent; restitution from illness would allow Mads to fully participate in work and social life. Her pragmatic, episodic use of multiple treatments is congruent with Bauman’s (2007) theory of liquid modernity, in which time is pointillist, and marked by discontinuities, rather than comprising a series of linear and continuous treatment approaches. Mads also shows boundary construction, or the development of boundaries around safety. Due to the perception of safety CAM medicines are preferred to compound pharmaceutical medicines. Importantly, trust in these medicines relates to their manufacture, with the product legitimatated from its manufacture by ‘research doctors’. CAM practitioners interviewed for the study were more circumspect about scientific and biomedical involvement in the manufacture of CAM:

*When the dollar takes over ... it’s not a pure link, so to speak. And it loses sometimes, you don’t get a set formula...all the herbs I do are individualised formulas, I don’t use set formulas like Blackmores.* (Acupuncturist/herbalist, 4)

For this practitioner, trust in the efficacy of a treatment is compromised by commercial interests in manufacture, and these interests necessitate a production line formulation of herbs. By contrast Mads expresses an innate, institutional trust in scientific knowledge and expert systems, by saying that a research doctor will manufacture a safe and reliable product, dichotomizing this with uncertainty from products manufactured without scientific mandate. Trust in the efficacy
of a manufactured health product is then negotiated and mediated by uncertainty over perceived health risk.

Although CAM users demonstrate more resistance to biomedical approaches than CAM, none have ceased using biomedical approaches. The importance of understanding patterns of therapeutic pluralism is that there are particular boundaries and thresholds enacted around the acceptable use of health practices, and these thresholds relate to trust. Luhmann (1979) argues that thresholds are important to the development of trust and distrust, if our thresholds are compromised, then distrust can form swiftly. Biomedical approaches are used effectively for specific illness and health conditions, and in preference to CAM, such as Sharon’s use of chemotherapy to treat Hepatitis C, or Mads having an operation for hip replacement, in such cases CAM is used to alleviate side effects from treatment. Others cease using biomedical treatments if and when the treatment is non-curative. This pattern is supported in CAM practitioner accounts, with a naturopath and bodyworker both noting that clients/patients come to them as a ‘last port of call’. Elsewhere in this chapter, women’s experience of using CAM and biomedicine for reproductive health and fertility is considered in detail, and what emerges is tolerance for assisted reproductive technologies (ART), and when these technological approaches do not result in conception, the women turned to natural fertility. Some accounts, such as Annie’s, show the pointillist use of reproductive health care; she had used natural fertility for her first pregnancy, and now that she is over 40 she is again using ART.

I recently went to IVF to talk to someone again, and he said you just got lucky, that was all he said. And he was my age, but he did not believe that a natural course of treatment helped me at all. (Annie, 43 years)

Although Annie despises the ART experience, she decided to try it again. This decision reflects an innate confidence in clinical expertise; she has internalised the success rates on ART, and she is certain it is successful for some people. What she does not know is if it will be successful for her. In comparison the use of natural fertility treatment requires a high level of trust, as there is not the same evidence relating to success. Although CAM users in their accounts will privilege non-scientific evidence, it is the evidence-based treatments they first approach. This shows that trust is generalised to the expert system of medical knowledge, and based on lay familiarity with outcomes of reproductive technologies. CAM in comparison is an unknown. CAM practitioners involved in natural fertility acknowledge the need to cite factual evidence of pregnancy; the following account from an acupuncturist practising natural fertility shows how her clients/patients use combined in-vitro fertilisation and natural fertility management to optimise their chances of pregnancy, and cites evidence in support:
Take for example the patient I have now, she’s had two [IVF] cycles, two transfers and both of them didn’t work, and the last one was ectopic so she actually lost one of her ovaries in that procedure. What I’ve done with her is, I now see her on a weekly basis for two months, and she goes in tomorrow. When they’re on the IVF we don’t give them any herbs because it interferes with hormone levels. What we do is a mixture of Eastern and Western acupuncture because there is a study out at the moment from Germany of pre and post transfer. And she’s going for a transfer tomorrow so I’ve put both the needles in those studies, so you utilise different studies coming out...that’s where the research is coming out, IVF and acupuncture, that’s where the money is to be made from a researching point of view. It’s a good study done by some major medical centre in Germany and they’re going to double the women next time. They are finding with the acupuncture a forty per cent success rate, the women gets needled before, has a transfer and needled afterwards, the endometrium, the eggs stick better.

(Acupuncturist/herbalist, 4)

Several legitimation strategies are articulated here through establishing scientific credibility of practice, including acknowledging potential for clinical interaction between herbs and hormonal treatments. This in itself establishes the practitioner’s willingness to comply with the biomedical model, and to alleviate their fears of medicine interactions. The practitioner’s account provides insight into the construction of professional expertise. At the same time that she attempts to legitimate her practice with scientific evidence, she is also critical of the way ART specialists alienate women from the process. The interest here is not so much in the construction of professional expertise in CAM, but how trust in the natural fertility approach and its knowledge claims are embodied by CAM users. This is taken up in Chapter Six in the development of trust between CAM client/patient and practitioner.

As supported in other studies on CAM (Adams et al., 2009; Hok et al., 2007; Thorpe, 2009) decision-making around treatment use is shown to be idiosyncratic, and determined by pragmatic considerations such as the severity and specificity of illness. Experiencing non-specific symptoms of CFS is implicated in the preference for CAM over biomedical treatments by three CAM users (John, Fifi, Isobel). Fifi has been living with CFS for many years, and experienced biographical disruption from loss of work, sleep and quality of life, and using multiple therapies including reiki to manage CFS:

Did I get through it? It lasted for years and years...I only really come through it, you do it in stages, you don’t really go up like so...a little bit better, it’s only the last twelve months that I’ve really come up. I wouldn’t say 100 per cent but I’m probably about 75 per cent. Reiki hasn’t got that, so I was quite happy doing reiki and I joined a group. ...
Every fortnight we met and you’d have 5 or 6 people putting reiki into, you, energy, that’s what reiki is... I don’t know if you’re familiar with it, but when you have chronic fatigue you’re like a flat battery and you’re cells don’t want to charge. They don’t want to charge. Like an old battery you throw it away and get another one, refuse to charge, that’s the body has got to such a state that energy trickles into it but it won’t hold it. So once a fortnight I was needing it again, and it wasn’t that it made me 100 per cent but allowed me to get up in the morning, my usual time every day. (Fifi, 47 years)

John has experienced symptoms of chronic fatigue for many years, and the disruption of his everyday life caused him to move to a regional area. John has self-experimented with a number of medicines including CAM and pharmaceutical compound medicines, and is sensitive to foods. Full satisfaction has not been gained from CAM or biomedical approaches, although he cites varying levels of success with combating food allergies. Here he explains the differing approaches of what he calls ‘natural medicine’ and biomedical doctors:

John: One of the things that’s very important and GPs don’t understand, it’s not as simple as ‘give an antibiotic’. Antibiotics are only for extreme bacterial virus, they don’t look for the secondary cause. With my ears, for example if someone had said to me to have a course of antibiotics, green mucus running down your nose, we’d go and look for an allergy. If they said that, I may have saved a little bit of the liver. But my liver has always been high, I worked for [name of company] wines for 12 years and always had a free issue of wines. Anyway, they don’t look for ...natural medicine look for sympathetic courses where as traditional medicine are ‘oh, we’ll fix him, here’s a pill’. Right? There’s a difference between fully generated things, I get flu injection but if I get signs of the flu I overload the system with water and flush it out and rest. I mean I have to rest a lot more than normal people because of chronic fatigue,...

Interviewer: Was the chronic fatigue treated?

John: No. (John, 55 years)

In these accounts the biographical disruption caused by CFS is recounted through a chaos narrative, and CAM used as a strategy for coping with the disruption. A common theme is continuing CAM use when it is not curing an ailment. Although Fifi claims to have ‘about 75 per cent’ relief, after years of CAM treatment she still suffers CFS. This is similar for John, who continues to experiment with multiple CAM and food regimens. CAM is essentially part of a suite of coping strategies, which inspires hope for the user for improved health, and for restitution to normality. For people like John and Fifi their lifestyle has been changed significantly to accommodate illness, especially chronic conditions. This is consistent with one
of Kleinman’s (1988, p. 8) arguments that the trajectory of a chronic illness becomes a life course, and illness becomes inseparable from life history. CAM then becomes part of what Frank (1995) terms a restitution narrative. CAM in this narrative represents faith in becoming healthy, in relieving symptoms and, importantly, faith in being restored to a normal life. When constituted in faith, trust develops from belief in the restorative ability of CAM. Fifi’s account also points to another aspect of trust which relates to social capital theory, and that is trust in the process of the group. Fifi engages in reiki with a group of people, where trust functions to facilitate collective action, produce social cohesion and symbolically convey social values. As Misztal (2011, p. 366) states, trust functions as a remedy for vulnerability, and the chronic illness experience undoubtedly produces vulnerability, with reduced physical, cognitive and effective reserves for dealing with the contingencies of everyday life. Forming generalised trust in a group for Fifi alleviates some of the vulnerability associated with illness.

Only one CAM user, Amy, demonstrates an almost outright refusal of biomedical treatments, although she attends biomedical practitioners such as dentists, she refuses to have dental anaesthetic in her body. Amy’s mistrust is associated strongly with her core values of natural health:

> And from a holistic point of view, I’m a holistic sort of a person, I’m not religious I’m spiritual, from a holistic point of view I thought ‘I don’t like what I’m seeing in mainstream medicine’. I had a very arthritic knee, the last operation I had was in December 1997, the orthopaedic surgeon said ‘you’ll be back in 12 to 18 months’. I thought over my dead body, I won’t be back here in a hurry. So I started to look for what I called at that stage alternative treatment and I had a couple and I have a multipronged approach to what I do, I don’t rely on any one single thing. I found that very beneficial and I suppose it was a progression of thought, that I want to go more into complementary medicine because the couple of experiences I’d had were alternative, what I’d call alternative at that stage, were beneficial and quite good. I guess that’s what sort of headed to me looking more at, a more holistic view of my health, complementary rather than mainstream medicine. (Amy, 49 years)

Amy demonstrates here altruistic trust (Gilson, 2003, p. 1456), which is emotionally based and derived from a belief that people involved in CAM share her moral values. The decision to trust CAM, in other words, is a moral, altruistic choice, which stems from ‘holistic’ beliefs. The relevance of values, which have been defined by Kluckhohn (cited in Parsons, 1968, p. 136) as ‘conceptions of the desirable’, lie in the affirming of commitment to a belief. This belief represents certainty in the rightness of one’s value, and the value system as Parsons (1968) terms it, and legitimises one’s belief and commitment. It is this, according to Parsons, which
produces trust. Certainly this is born out in Amy’s account. As a symbolic medium Amy’s value system represents her health beliefs, and these differ from the values of biomedical systems as she sees it. To this end, Amy’s distrust of biomedical approaches derives from the symbolic representation of biomedical treatments as invasive, unnatural and dangerous for the body. Biomedical treatments are constructed as a health risk, and this belief underscores Amy’s resolve to use ‘alternative’ approaches when able. Constructing health risks is a dominant theme in CAM users’ accounts, and examined in the next section.

5.3 Distrust in Biomedical Treatment

Some six female CAM users recall a clinical misdiagnosis, the most common being thyroidal. These users suggest that the experience of misdiagnosis has encouraged more self-responsibility for health management, and has lessened their confidence in biomedical expertise. According to Bella, she was misdiagnosed with thyroid cancer, and this has caused disruption to her everyday life:

*Well I had a lump in my throat and the doctor said ‘I need to send you for a biopsy’, the pathologist rang up and said ‘you’ve got cancer’ so then I went ‘oh, what do I do?’ and ended up spiralling into the medical system and at the same time ended up using other therapies to complement. They said ‘you have to have your thyroid out’. Then when they took my thyroid out they said ‘no, you never did have cancer, you had an auto-immune disease’...Yeah, misdiagnosed. Which has had a huge impact on to my general well-being. I’ve had to take thyroxine, there’s been weight gains, controls...I don’t have much faith.* (Bella, 58 years)

Since her misdiagnosis Bella has extrapolated a loss of ‘faith’ in the wider biomedical system. This suggests that Bella may have already held generalised anxieties over biomedical procedures, and such anxiety according to Giddens (1995) reflects the complexity of life in late modernity. Yet trust in health systems is seen as important for increasing a person’s willingness to engage with health services (Meyer et al., 2008), and to entrusting the system with accommodating personal vulnerabilities. A loss of ‘faith’ in biomedicine is also articulated by Annie in her account of a thyroidectomy:

*I was starting to lose my faith in conventional medicine. I don’t think I got good treatment a couple of times because I had nodules on my thyroid gland when I was 20 and nothing helped...and anyway they made a botch of it and I ended up having a thyroidectomy. So I sort of lost faith in it ... I sort of regret not knowing there were alternatives then, so I’d sort of had a years’ troubles and were dissatisfied. It seemed to
me in retrospect that if I had a problem it sort of got whipped out, you know. A lot of my experience, problems with respiratory systems, whip your tonsils out. (Annie, 43 years)

It is important to note that both Bella and Annie refer to a loss of ‘faith’ and not trust, in biomedicine, they also use the word ‘faith’ in relation to CAM. Drawing on Simmel (1950), trust is seen as a subjective state of mind, and as reflecting the affective state of humans, or faith. Furthermore, the process of trusting inspires a ‘leap of faith’ (Brownlie & Howson, 2005; Giddens, 1995), and this leap of faith bridges the gap between trust and expectations. For these female CAM users the bases of trust are in the correctness of biomedical procedures and expert knowledge, and when these expectations were not met they experienced a crisis of faith. Such interpretation presupposes the view that a leap of faith, as Mollering (2001) and Giddens (1995) observe, allows for trust to occur. Their changed relationship with biomedicine now incorporates an element of risk, which for Luhmann (2000) is the basis of (mis)trust. The impact of misdiagnosis on lay people is also articulated in CAM practitioner accounts. In a lengthy account of the health risks of biomedicine, a male naturopathic bodyworker recalls the case of a woman with pain in her feet, who had been wrongly misdiagnosed by a number of doctors:

This woman today I had was very depressed, and basically because she had something wrong with her foot. One doctor said ‘oh, yes, you have...’ a disease which causes fractures in the foot, we’ll put you in a plaster cast’, and they did that. She was in this plaster cast and nothing seemed to be getting any better, the pain was still there, so she went to another doctor, he said ‘oh rubbish, you haven’t got that. You’ve got, um, something quite different anyway, he said you have an infection in your foot’. So she was put into hospital and four weeks intravenously, they decided that didn’t make any difference. ‘Oh sorry it wasn’t an infection after all, it was inflammation’. So, she came out...wouldn’t you get depressed after that? If she was so depressed she didn’t know if she was coming or going. One said ‘oh your Achilles tendons are too tight and that’s what’s causing the pain in your foot’. And this was all over a pain in the foot. And basically she’s diabetic and her circulation is poor and she has neuropathy in the feet. She needs to lose weight...if we did even half that we’d be called quacks. (Bodyworker, 8)

This account shows how holistic health principles underlie the bodyworker’s professional understanding of the patient’s reason for the painful foot. The account also shows the practitioner developing empathy with the patient. We can see from this how in interaction with the client/patient the practitioner co-constructs a narrative of biomedical negligence. This reinforces a lack of trust in biomedical approaches; at the same time the process of lay reskilling
(Giddens, 1991; 1995) in which the CAM practitioner and client or patient are engaged, provides for a measure of control in their health care.

In the accounts from Annie and Bella, the metaphorical language of both participants conveys the sense of a depersonalised biomedical experience. CAM users draw from orthodox medicine metaphors and terminology, which is seen to employ the language of warfare (Sontag, 1983) when describing allopathic medical processes. Such metaphors accentuate the social distance from the biomedical process, such as Annie having her thyroid ‘whipped out’ and Bella ‘spiralling into the medical system’. The controlling metaphors of biomedicine are, for CAM users, dichotomised with their own metaphors of powerlessness and lack of control. Their accounts also signal resistance to what they perceive to be the invasiveness of biomedicine. This is articulated in the following account from Bonnie:

...as soon as you go back into Western medicine and have something hideously invasive happen to you, you sit there wondering what the hell you’re doing there, to your system. So they send you to yet another specialist, who is going to inject me with yet another poisonous injection. I just happen also to be allergic to penicillin, and that I found out in my early 20s. And may be that has something to do with, going back to your first question, maybe that has something to do with knowing that I couldn’t have conventional medicine. (Bonnie 51 years)

Bonnie’s obvious anxiety concerning treatment reflects a sense of disempowerment in the biomedical process, as well as a lay belief in the toxicity of treatment. Bonnie, like other study participants, had experienced ‘biographical disruption’ from chronic illness. Biographical disruption removes from the ill person a sense of self-control and direction in life, and the negative experience of biomedical approaches, particularly misdiagnosis, has exacerbated this by removing control of the body. Biographical disruptions are also implicated in self-identity formation, with Williams (2000) theorising that chronic illness diminishes the ability to sustain everyday role play, thereby eroding self-confidence and self-identity. As such, people living with chronic illness may have a sense of self being de-stabilised through invasive biomedical interventions, and this arguably occurred for CAM users in the study.

Misdiagnosis is also related to regret and the need for attribution of blame. After years of infertility treatment, Jan was eventually diagnosed with a hormonal condition:

Had I realised there were a problem with ovulation, then at that stage what I would have done is Chinese medicine practitioner, which is more what I’d be going toward and gone on something for years before trying the IVF. (Jan, 39 years)
Jan’s account advances a belief in the efficacy of Chinese medicine treatment for infertility. Whether Chinese medicine can actually perform this function is irrelevant, her disappointment being more about a crisis of confidence in biomedicine. Being conditioned to believe in the authority and supremacy of the science, a misdiagnosis exposes the fallibility of this form of expertise.

In summary, the accounts of female CAM users, as mentioned above, demonstrate how the feelings associated with misdiagnosis have produced a loss of confidence in some biomedical treatment practices, and this constructs a lack of trust. This loss of confidence is implicated in the decision to use CAM treatments, which are also used to reconstitute one’s self-identity after the biographical disruption of illness and biomedical intervention.

5.4 Constructing Health Risk and Safety

A prominent theme in 11 CAM user accounts is a perception of health risk from compound pharmaceutical medicine (also termed a ‘drug’) in biomedical approaches. This mirrors other social science studies which report considerable patient/consumer resistance to ‘drug’ taking (Cant & Sharma, 1999; Pound et al., 2005). A prominent theme of health risk emerges from nine CAM users in the study, mostly relating to drug side effects including nausea, fatigue, mood swings, skin rashes and other forms of iatrogenic illness. CAM users also express concerns about what they perceive as over-reliance among biomedical practitioners on pharmaceutical drug treatments. CAM practitioners interviewed for the study have echoed these concerns::

They don’t even know they’re on them [drugs]. They come in and tell us which drugs they’re on, we look at it and say ‘this is anti-depressant’. They give them for pain, because they can’t sleep, because they’re anxious, they’re not told. Generally, in our business, everyone that comes has some emotional thing because they’re life is a mess. Like an addiction, they don’t get told properly what it is. (Naturopath, 7)

The resistance to biomedical drug treatment emerges from the experience and the perception of adverse side effects. To this end, CAM users claim to have experienced significant disruption to their daily life from treatment effects; Bella, for example, gained considerable weight from the use of thyroxine to regulate thyroid production. CAM users such as Bonnie, Amy and Bella having their quality of life compromised from drug treatment, all attribute these ‘negligent’ biomedical experiences to their initial uptake of CAM. The experience, from a theoretical perspective, shows that the trust and ontological security developed from an early age in relation to biomedical treatment had been compromised by negative experiences. These people perceived biomedicine as unreliable, and when a calculation of the risk of drug treatment
outweighed the benefits, they turned to CAM. Adverse drug reactions are also shown to effect changes in health values and beliefs:

_Early on in my life, got dengue fever once and they gave me tetracycline, I came up with a severe allergic reaction to tetracycline. After that stage I don’t take headache tablets, I don’t take anything I don’t take any drugs at all in terms of medication, I just don’t. The holistic view of myself has come from my life experiences, I guess and I like to be an experiment._ (Amy, 49 years)

Amy’s resistance to using drugs is linked to her identity – she identifies as a person who takes no drugs. This identity contributes to her confidence in using CAM which, in comparison to pharmaceutical drugs, are seen as natural and safe. The anxiety surrounding pharmaceutical drug taking extends to the emotional side effects of treatment, with no fewer than three female users experiencing emotional impacts. Mistrust in pharmaceutical drugs is compounded by uncertainty regarding the motives and future actions of the pharmaceutical industry, a point raised also by several of the CAM practitioners.

Related to this is the perception of drugs as unsafe, this perception arising from lay knowledge. The sources of this knowledge are varied and include friends and family, media and health-related literature, as well as CAM practitioners. Some CAM users have developed sophisticated conceptual knowledge and understanding of health and illness, and this reflects their subject position as reflexive consumers. Accounts show evidence of using this knowledge in contexts of treatment decision-making, for example, in the following account from Fifi:

_I have to have pain for three days before I put up with a painkiller, I’ll give in the end because I can’t sleep…I’ll go the distance before I pop it. Because I know that actually effects your liver and I’m not interested in that, so that’s the type I am._ (Fifi, 47 years)

Like Amy, Fifi strongly identifies as a person who resists drug use, opening up the possibility that a subject position available to late modern consumers is of ‘drug’ user non-drug user. Although CAM users resist taking biomedical drugs, they will continue to take them if necessary. Mads, for example, has found biomedical drugs relieve her arthritis symptoms, but they are not necessarily seen as effective in the long term. At least four CAM users exhibit tensions over the continued use of compound pharmaceutical medicines for family, and for Bonnie and Corinne this conflict is particularly evident in accounts of their children’s health management. Bonnie has experienced personal conflict over whether to immunise her child, citing an ‘enormous amount of pressure’ to do so. Although she wanted her child to be drug-free, she acceded to the social pressure to immunise:
So I sort of made a decision, oh well, ‘yes the boy can have that injection’, but I don’t want the injection to help you remove the placenta or whatever. I’d done a drug free birth anyway, that was my big thing. I’d done this drug free thing, why would I want someone coming along to pop me in the arm? But then as soon as you get into preschool and school system, you realise there is an enormous amount of pressure for immunisation. But I also felt he should be immunised on my own. But then when he got to five, and you to get that preschool one, I then felt really kinda funny about it because in the meantime I had read up about autism, and the research happening in the UK which scares the hell out of you I can tell you. (Bonnie, 51 yrs)

It is obvious from Bonnie’s account that phenomenological meaning is made from her research into processes of immunisation. To this end Bonnie sees immunisation as a health risk, and her account reveals a distrust of pharmaceutical medicines and adverse effects, based on information sources from independent research and the meanings she attributes to this. These concerns and tensions are manifested in the decision as to whether to immunise her child. Here Bonnie demonstrates tension between conforming to a cultural norm of being a good parent, who is providing protective care to her child through immunisation. For Bonnie though, the phenomenological meanings of immunisation meant that she saw herself as a bad parent for immunising her child. Showcasing the tensions in late modernity between autonomy and protection in the discourse on children ‘at risk’ (Scott et.al., 1998), Bonnie eventually immunised her child due to social pressures, however is still bothered by this decision. Corinne on the other hand, while wary of pharmaceutical medicine ‘I don’t jump to antibiotics’, supports immunisation as a protective health measure for her children:

*I don’t really understand the ins and outs of it, but I think if you live in a country where there are lots of people coming and going to other countries, which is probably true of everywhere now, you just don’t know what’s coming in. My understanding of it isn’t brilliant but I guess I do it to feel safe, protection.* (Corinne, 36 years)

Corinne’s meanings of health risk differs from that of Bonnie, and both positions reflect particular moral narratives around good parenting, and inherent uncertainties arising from multiple and conflicting knowledge claims. The differing positions presented by Bonnie and Corinne demonstrate one of the points of tension between biomedical approaches and CAM, and illustrates the nature of the uncertainties around risk faced by health consumers in late modernity (see Giddens, 1995). The issue of immunisation is an example of the inherent risk anxiety which is a feature of our daily consciousness (see Scott et.al., 1998); perhaps in this case the anxiety inflamed by public opinion on immunisation but the individual parent left to find their own way of handling the prevailing uncertainty. The uncertainty which surrounds the
issue, compounded by differing expert positions on immunisation, raise questions of trust in expert knowledge and trust in authority, such as the validity of medical understandings of immunisation. Utilising Hier’s (2003) analysis of risk in late modernity, this issue is an exemplar of where the heightened risk consciousness of late modernity converges with a strong moral discourse on parenting. Moreover, this convergence reinforces Giddens’s (1991 cited in Williams & Calnan, 1996, p. 1611) notion of ‘manufactured uncertainty’ in which the various expert positions on immunisation have, for the study participants, become internalised knowledge, and this knowledge constitutes their reality. This form of social reflexivity is reflected for example, in Corinne’s acceptance of the pro-immunisation position, a discourse which is intertwined with her conventionalised understandings of parental norms. Corinne demonstrates a need to be accepted as a good parent (the moral narrative), and need to develop trust in the medical knowledge on immunisation she appropriates, and which accords with her social reality.

Construction of a discourse on health risk is also apparent through the choice of language for describing compound pharmaceutical drugs. Three CAM users (two of these males) reference the drugs as ‘poisonous’ and ‘dangerous’, constructing the drugs as unsafe and toxic. Ben explains the comparison between the impact of Chinese herbs and biomedical drugs:

*I think they [Chinese herbs] work, but are pretty subtle...I would assume they are made from organic chemicals, carbon based compounds, naturally occurring things, not petroleum based compounds. Naturally occurring you know. Sure they can kill you but are not so foreign as chemicals. Like even cholesterol reducing drug is probably petroleum based or some form of acid, really your body, it’s going to be working against your body not with it.* (Ben, 43 years)

For Ben the risk associated with drugs is the long-term use of ‘chemicals’, which for Ben involves ‘petroleum-based compounds’. The term chemical is used also by five other CAM users to distinguish compound pharmaceutical medicines from natural medicine. Compared to biomedical products, CAM users raise relatively few concerns over health risk from CAM medicines and products. Using Giddens’ (1991) and Beck’s (2010) notions of risk, we can see that an anticipation of long-term health erosion, or the potential thereof, underlies the construction of health risk from chemical drugs. By contrast CAM medicines are constructed as safe, with no anticipated long-term health risk. Here naturally occurring medicines are seen as far less toxic than non-natural, petroleum-based medicines. For Andy what is ‘unnatural’ is ‘I suppose all the synthetic stuff that’s manufactured’ and, for Andy ‘...I think our bodies weren’t made to pump so much chemical into them, for me that’s not natural’.
As Lupton (2003) points out, the word ‘nature’ has powerful symbolic meanings of vigour, purity, cleanliness, morality and goodness, and the nature metaphor generates certainty and trust in the gentleness and safety of natural medicines. Without knowing or understanding the constitutive properties of natural medicines, they are assumed by CAM users to be safe. The metaphorical meanings of nature are present in several CAM user accounts, and form a core part of their beliefs and values. In other words, having trust in natural medicines is about having values around naturalness and purity, and these values are constructed as safety.

Trust then is re-embedded (Giddens, 1995, p. 87) in beliefs and values around the constitution of natural versus chemical. As Lupton (2003) argues, by selectively symbolising natural as safe, biomedicines are positioned as artificial and bad for health. CAM practitioner accounts are somewhat more circumspect. While reinforcing the lay belief that pharmaceutical drugs are not safe, a Sydney-based naturopath (3) cautions against the fallacy of equating natural with safe:

> And herbs have, I mean there’s a problem with people saying ‘natural equals safe’ and they’re not. They are a lot safer than a lot of things available on the market but I do really worry about people self-prescribing medicines and herbs, in the supermarket. I’m not calling to question the product itself but people’s ability to get their hands on it.  
> (Naturopath, 3)

By openly recognising the potential for natural medicines to produce side effects, interaction with other medicines and iatrogenic illness, the practitioner validates concerns of the biomedical community over CAM. This is a legitimising strategy in which CAM, rather than being adversarial, accommodates the concerns of biomedicine. CAM users, on the other hand, are more likely to have faith and trust in the safety and benefits of CAM medicines, and take homeopathic, naturopathic and herbal medicines with no knowledge of their constituents. This tacit acceptance of naturalness and safety in CAM is part of a wider discourse on naturalness, and using Beck’s (2007) risk theory reflects a general unawareness of the unintended consequences of CAM, and for CAM users it can be speculated, an unwillingness to know. In comparison, constructed knowledge about dangers of biomedical drugs are widespread and articulated as risk.

In summary, CAM users demonstrate anxiety over adverse reactions and side effects of biomedical treatments, in particular drugs. This fear is associated with an experience of adverse effects and iatrogenic illness. It is also based on seeing the impact of biomedical approaches on family members. The scepticism toward drugs arises from personal experience and perceptions of health risk, which are polarised with the trust in the safety of natural medicines and CAM treatments. From a gendered perspective, male CAM users are more concerned with toxic long-
term effects of chemicals in the body than are the female study participants, while female participants demonstrate more concerns over drug side effects (and particularly for family members). While sociological literature in this area is sparse, a possible explanation for this phenomenon emerges from a Dutch study (van Kammen & Oudshoorn, 2002) of the discourse on risk assessment and the side effects of contraceptive use for men and women. The study found that experts and policymakers take the lay perspectives of men more seriously than those of women, that policymakers represent the side-effects for women as mild, whereas emotional and sexual side-effects for men are a central part of the research agenda. Contrary to the political discourse of the policymakers in the Dutch study, women in the present study did not assess the side-effects of pharmaceutical medicines and clinical method as ‘mild’, rather they tolerate side-effects when the treatment is perceived as necessary. It could be theorised that women in the present study are drawn to CAM practitioners, in part for the practitioner’s willingness to acknowledge the impact of side-effects from pharmaceutical treatment on well-being (see Sointu, 2006a, 2006b).

CAM users commonly refer to compound pharmaceutical medicines as chemical medicine, and this is the point of differentiation between ‘drugs’ and natural medicines. Finally, tensions are evident for CAM users presently using drugs for symptom relief in the use of these drugs as health risk, and also conflict with their moral narrative which identifies as a non-drug user, and positions natural medicines as safe in comparison to compound pharmaceutical drugs. The next section explores trust and uncertainty in the expert knowledge claims of both CAM and biomedical systems. This relates specifically to meanings of ‘evidence’, and how understandings of evidence develop trust in CAM treatments.

5.5 Uncertainty in the Expert Knowledge Claims of CAM and Biomedicine

5.5.1 Meanings of evidence

Social scientists report that CAM users express uncertainty over scientific and orthodox medical knowledge (Broom & Tovey, 2007; Goldstein, 2003, p. 27; Ho, 2008; Lupton, 2003, p. 136). Broom and Tovey (2007) found that cancer patients do not outright reject biomedical knowledge, rather they apply elements of scientific evidence to their individual circumstance and reject others. Similar tensions and uncertainty are expressed in the accounts of no fewer than eight CAM users, with obvious tensions around evidence-based medicine (EBM). CAM user accounts offer a challenge to knowledge claims of scientific medicine, and these challenges are supported by CAM practitioners.

Several CAM users have sophisticated understandings of scientific evidence-based testing. Four CAM users provide lengthy explanations of the inadequacy of scientific testing for
demonstrating outcomes in CAM. In the following extract, Bonnie expresses her concern over the relevance of scientific testing to demonstrating holistic health:

Bonnie: *But this, as you probably know, Western medicine has spent quite a lot of money to show homeopathy as a loads of old codswallop. And there’s that American guy who offered what was it, a million dollars or something not long ago...but if any of those people had children and they were sick, and took them off, I mean it’s to do with the evidence in your own life.*

Interviewer: *Meaning?*

Bonnie: *Yeah there is no way of testing it, in a way it’s more holistic to do with your relationship in the planet.* (Bonnie, 51 years)

This account shows an understanding of treatment effects as highly individuated, and meanings around ‘evidence’ as based on subjective interpretation of the benefits and effects of a treatment on the individual’s life. In Broom and Tovey’s (2007) study of CAM use in cancer patients the researchers could demonstrate the point where CAM users engage with scientific evidence. Similarly my interviews with CAM users detected a shifting dialogue, in which scientific evidence is both legitimate, and inspiring treatment use, but is also regarded with suspicion. Of further interest are CAM practitioner accounts, in which there is more support for incorporating scientific concepts in practice:

Years ago when I was training one of the main criticisms was ‘oh, it’s so anecdotal’. As you know, homeopathy doesn’t actually respond to that clinical testing. There were some quantitative researchers which do show that it is possible to respond to homeopathy...Qualitative research is more widely used for us because every case is different, an evaluation absolutely. I think not so much in Australia but auditing, to keep really close tabs on how your cases are going, so they then become useful scientific documents. (Homeopath, 5)

Here the homeopath demonstrates a strong need to demonstrate clinical legitimacy, and to validate the experience of homeopathic clients/patients through documenting individual case studies. Similar approaches are used by some biomedical providers, many of whom privilege clinical legitimacy over scientific evidence. CAM practitioners however, do not support EBM testing methods, preferring instead to demonstrate the legitimacy of practice through other clinical methods.
Trust literature (see Gilson, 2003) pointing to the existence of multiple forms of trusts shows how forms of trust are simultaneously developed and maintained. It is quite evident from the interviews with CAM users that these people trust both scientific and non-scientific evidence base sources, and that this evidence relates to health treatment efficacy and outcomes. For example, several females in the study had undergone in-vitro fertilisation (IVF) to achieve pregnancy, the decision to use this invasive, conventional medical technique based on clinical data showing successful pregnancy rates. These women begin their IVF treatment with confidence that they will be one of the successful women who fall pregnant, and as much as they dislike the treatment they maintain this trust. After several cycles of IVF and no ‘success’, it is at this point that natural fertility becomes the viable option. Again faith emerges that they will have a pregnancy from doing the ‘right thing’, using natural fertility treatments, changing their diet, abstaining from alcohol, and minimising exposure to radio activity. By using CAM medicines and engaging in healthy lifestyle routines, that they will be one of the minority of women (especially for those women aged 40 and older) who fall pregnant. Consider the following dialogue with Annie:

Interviewer: *Was she [natural fertility therapist] able to give you any indication of how many people it had worked for?*

Annie: *There was no statistics available, but from her own personal experience and observation the rate of getting pregnant was higher and higher, she was having less disappointed patients, she said once they’re pregnant you don’t see them.*

Interviewer: *How did you feel when she said that?*

Annie: *Sometimes I don’t understand statistics, unless it’s a black and white question. You see in marketing how things can be manipulated.* (Annie, 43 years)

What Annie means is that natural fertility provides additional hope for achieving pregnancy, and where conventional IVF treatment has failed. With seemingly little knowledge about the actual natural fertility treatment, Annie’s understanding of the treatment comes from the practitioner, whose role is as access point to the expert knowledge of natural fertility. Here Annie shows facework commitment (see Giddens, 1995) to the natural therapist, and an intuition that the therapist is trustworthy, and is applying a healthy natural treatment. This sense of hope in CAM is articulated by other CAM users, whereby the basis for trust is based on the knowledge of the CAM practitioner, as well as experiential knowledge. This is corroborated by Weitz (2004, p. 143) who in a study of chronic illness management, found that for ill people: ‘In addition…especially those with chronic rather than acute conditions, … have found mainstream
health care of limited benefit and who therefore rely mostly on their own experience and knowledge and that of other non-medical people.’

Although CAM users like Annie may express scepticism over statistical claims, the accounts also show real tensions between the claims of scientific and CAM-based knowledge. This represents the complexity identified by both Giddens (1995) and Luhmann (1979) that modern consumers need to mediate between multiple knowledge claims, then negotiate how relevant each claim is to them. For these users the contingencies of scientific knowledge are simultaneously challenged and respected:

*I think I have a mistrust of that scientific mind, even though I respect the knowledge, I think it’s very one tracked and I don’t think, it’s not that I wouldn’t do it, I would. I don’t think it exhausts every avenue before it goes to an extreme.* (Annie, 43 years)

While concerns over the nature of evidence testing are articulated in CAM practitioner accounts, not all CAM practitioners resist this approach. In the following account from a Hunter-based naturopath, we see support for evidence-based testing of CAM:

*I will make it more acceptable. Since it’s been done, there’s more support for everything. Gives ground to the people to see what is working and why, more proof than just saying ‘I’m feeling better’. Then hard proof is now being written down, and case histories being studied by independent studies which is great.* (Naturopath, 2)

For the naturopath, scientific testing legitimates and ‘proves’ the curative properties of naturopathic and herbal medicines. The lack of a scientific evidence base in CAM is also seen by some CAM users, as the point of differentiation between CAM and biomedicine. This is demonstrated in the following dialogue with Jan, when articulating a lay conception of the difference between biomedicine and CAM:

*Jan: I guess things that are much more practical, medical based, GPs obviously, I guess things like physiotherapists and chiropractors because their stuff is dealt with on a very practical level, whereas some of the others, and the other stuff you don’t know is practical because there isn’t any ABC. They learn for years and know, acupuncture you know, when they plug you with those needles you know they are feeling. Like there’s this great Chinese guy, Richard, he’s fantastic. You just know when they’re doing it, like he’s had years and years of experience of it, and he’s just feeling it. That’s not in the text book stuff, those sorts of things.*

*Interviewer: So practical means you can see what they are doing?*
Jan: ...Yes yes, and less supporting evidence. Less research into it. Like a lot of medical stuff has a lot of research, whether that research is correct or not, for all sorts of reasons. The medical stuff tends to be sort of researched.

Interviewer: How do you feel about seeing someone who is non-practical?

Jan: I don’t mind, like I’ve gone off to see bloody psychics. Yeah so, I don’t actually mind. I find it titillating. I hope that stuff is like. (Jan, 39 years)

There are several layers of meaning in Jan’s account: firstly, ‘mainstream medicine’ for Jan is based on the clinical evidence disseminated in biomedical texts; second, the meaning that such evidence constitutes ‘practical’ medicine. In contrast to biomedicine, CAM is not ‘practical’ as it is not based on clinical evidence. For Jan, CAM is assessed by intuition. This is supported in other CAM user accounts which see having ‘faith’ in the benefits of CAM as more important than scientifically derived evidence. In the following extracts from her interview, Annie explains how her Christian beliefs support faith in CAM treatment, and that this has produced a lack of trust in scientific thinking:

I think it’s because I grew up in a Christian family, my mother was deeply spiritual so I don’t think things needed to be proved, she didn’t have that sort of a mind, she had a lot of faith, and understood that it’s the cause and effect sometimes that influences how the world works. I didn’t necessarily grow up in that sort of environment where everything needed to be explained. And when you have that sort of ...black and white personality actions and words and all that sort of stuff is important to me, it’s the whole mystery of life I think. I think that’s why, and I still don’t necessarily need to have things proved to me. (Annie, 43 years)

As noted earlier in this chapter, the word faith appears recurrently in several CAM user accounts, and more commonly so than ‘trust’. Ultimately this suggests that for CAM users like Annie and Jan, intuition and experience are as legitimate as scientific data as the basis for choosing a health treatment.

A final observation is that the Western cultural narrative of individuality has produced developed beliefs in an individual’s ability to combat statistics, to prove them wrong and be the person who will survive terminal illness, will get pregnant at any odds, will cure the arthritis, and a sizeable number of accounts implicate CAM in these beliefs. Andy, for example, ‘proved’ wrong the statistical evidence on recovery from back surgery when, after using reiki, he walked again after ten days. In contrast, biomedical approaches are seen to apply a ‘one size fits all’ model, rather than an individualised, tailored treatment regimen. Here it is observed by John
that doctors fail to take into consideration an individual’s diet when rebuking their use of vitamins:

*It’s up to a practitioner to ask someone to go in a particular line of things. Advice people to take a particular thing because it works for me... ‘you shouldn’t have to take all these vitamins if you eat a normal diet’, well I take them because I don’t have a normal diet. A person eating normal foods wouldn’t normally go through the same regime that I am, but put the body under extreme stress.* (John, 55 years)

Assumptions relate to individual health practices, and the notion of taking responsibility for health is so entrenched in holistic health, and now in biomedicalised discourse, clients/patients assume that if they do enough they will defeat the odds. In this sense CAM appears to valorise a form of personal trust, or self-trust, which as Giddens (1995, p. 122) observes is established through self-inquiry, and the self as project. For Luhmann (1979, p. 41) personal trust is founded more on daily interactions, and is about our presentation of self in daily life. However, for some CAM practitioners, providing individualised regimens is more rhetorical than reality. In a conference paper (Toms, 2004) based on the CAM practitioner interviews, I argue that practitioners employ a rhetoric of individualism to facilitate client/patient empowerment, and that empowerment for the practitioner is the point at which the client/patient appropriates holistic health discourse. In contrast to a rhetoric of individual tailored treatments, CAM practitioners interviewed for the study reveal that similar treatments are often disseminated, with minimal regard for the individual contexts of a client/patient. This finding mirrors Braathen’s (1996, p. 158) finding that although the CAM gaze employs more idiom of freedom and empowerment, it in fact has strict control and surveillance, applying firm control measures over its clients/patients.

This section reveals how anecdotal, evidence-based lay knowledge is privileged over formal, scientific evidence, but also shows the tensions between this form of lay knowledge and the embedded appropriation of scientific evidence-based knowledge when choosing to use biomedical approaches. The next section examines how trust develops from individual understandings and meanings of CAM.

### 5.5.2 Lay constructions of CAM

CAM is shown to be distinguished from biomedicine, mainly on the basis of scientific evidence and knowledge claims. CAM users are shown to perceive biomedicine as a homogeneous set of practices, and as operating from one allopathic paradigm. For Annie the point of difference between biomedicine and CAM is in the level of personal responsibility; she feels biomedicine does not encourage any self-responsibility for health. The majority of users see CAM as
representing a number of individualised practices and systems, rather than a homogeneous set of practices. Medical pluralism as understood by CAM users is equated with plurality of choice within CAM and not in biomedicine. Extending this perception, several CAM users (e.g. Kate, Annie, Jan) perceive CAM as ‘alternative’ rather than complementary to biomedicine.

CAM users offer various interpretations and definitions of what CAM is. Several users define CAM through its systemic knowledge base, variously describing it as having ‘mysterious’, ‘old’ and ‘traditional’ knowledge; others position CAM against biomedicine, conceptualising it as natural, non-invasive and risk free. For others, the definition of CAM derives from its cultural context. In the following account, Kate questions whether TCM is a ‘natural therapy’ or is a form of conventional medicine:

_I’m not sure I would find Chinese medicine as natural therapy because it’s been around for hundreds of years and there are Chinese doctors. I know there is a level of frustration in this country where you can’t really be classed as both. Take drugs that a doctor prescribes, that people willingly trust and take. But people are very sceptical of herbs prescribed from an Eastern practitioner._ (Kate, 40 years)

Here, Kate challenges the Western assumption that drugs prescribed by a medically qualified Western doctor are more trustworthy than those prescribed through a qualified Chinese medicine doctor. For Kate, based on their professional training and status as doctor, a Chinese medicine practitioner is more conventional medicine than CAM, due to their training and their status as GPs in China. Similarly, Marcia was raised within the Sri Lankan Ayurvedic medicine tradition, and does not regard Ayurvedic medicine as ‘traditional’ or ‘alternative’. Ayurvedic practitioners in Sri Lanka have the status of doctors, and are well regarded as healers.

CAM users hold conflicting ideas about what constitutes legitimate practice. Chiropractic is the most contested system, three users support chiropractic (and osteopathy to a lesser extent) as a legitimate CAM system due to it being drug-free and non-invasive. A further three challenge chiropractic as legitimate CAM on the basis of degree of integration with biomedicine and appropriating a scientific, biomedical knowledge base; to a lesser extent, osteopathy and kinesiology are similarly contested. Jan is one of those perceiving chiropractic as ‘mainstream’ as shown in this extract:

_Interviewer: Do you think psychics are complementary therapy?_

_Jan: Hmm [pause]. No because I guess complementary therapy…well actually yes, because I wrote the terms down complementary therapy, not complementary medicine. A therapy is complementary to other sort of things, and people can use them to help_
well being. Psychics generally make people feel a bit better. General being. Physical, emotional, spiritual. Not just physical it’s emotional and spiritual. And that can help our wellbeing, because if you’re really happy, you have some sort of spiritual connection like you’re a Christian or something. I mean happier people tend to have better things happen in their lives. (Jan, 39 years)

Jan assesses evidence by intuition, and the perception of feeling better is what constitutes evidence of efficacy in psychic healing. Another meaning of evidence to emerge from Jan’s account concerns happiness. Happiness for Jan arises from having a balance of spiritual, emotional and physical ‘well-being’. At face value it appears that the point of difference between CAM and biomedicine is in knowledge and practical applications of treatment. A more developed sense of difference between CAM and biomedicine emerges from Jan’s account, in which the embodied experience of ‘well-being’ is what demarcates the two systems.

CAM practitioners interviewed for the study acknowledge a boundary collision between naturopathy and homeopathy. The appropriation of homeopathic knowledge has concerned many homeopaths, with a long-standing boundary between the two systems. The main concern of homeopaths is the teaching in naturopathic colleges of homeopathic dispensing, without knowledge of homeopathic principles and practices. With naturopaths continuing to dispense homeopathic medicines with homeopaths, arguably the less powerful of the two groups, advocating against this appropriation of their practice, this is clearly a contested terrain. Largely unaware of this knowledge boundary, Corinne is typical of lay consumers/patients when she sees it as ‘great’ that CAM practitioners are interested in different modalities. CAM users such as Isobel and Bonnie have more awareness of the work of homeopathy, having both studied it. This generates several interesting insights; first, the willingness of lay users in accepting practitioner prescribing practices; second, we see that almost half the CAM users in the study have actually practised and trained in CAM. CAM users establish parameters for what they regard as acceptable knowledge, and this helps them construct knowledge boundaries. What emerges is that CAM users accept the knowledge of CAM as articulated through the CAM practitioner; and that the development of this form of trust in the knowledge claims of CAM requires developing facework commitment to the practitioner. CAM users are seemingly indifferent to the boundary collisions within, and between CAM disciplines, and seem to accept the knowledge claim of the specific practitioner as valid.

At an institutional level we can see that CAM systems have far less exposure to mechanisms of public scrutiny than does biomedicine, so the symbols and knowledge of CAM expert systems remain uncontested mystery to lay users. According to Giddens (1995) scepticism in scientific knowledge is formed in part by the alienation we have to that knowledge, CAM on the other
hand presents as a more accessible form of knowledge. However as shown in this section, lay knowledge of CAM is at best incomplete and we would assume that in instances of less visible knowledge, we would have less trust. Another point of interest is that CAM practitioners being a less formalised group than biomedical practitioners, are more able to interpret their specialised knowledge in their own way, and to apply this variously. The basis of lay trust in CAM is complex, and more so from this phenomenon.

5.6 Conclusion

One of the forms of trust to emerge from this chapter is the active negotiation of boundaries around the use of CAM and biomedical approaches. Several CAM user accounts show how users actively negotiate boundaries of biomedicine and CAM use, with biomedical approaches constituted as a necessary evil. For Luhmann (1979) a boundary serves to reduce the complexity for trust, and it also provides a demarcation between trust and distrust. For Luhmann boundaries are the building blocks of thresholds, and these allow for the distribution in time of trust, distrust and familiarity. The findings in this chapter show the construction of boundaries on several fronts: for CAM practitioners it is the establishment of knowledge boundaries between other CAM groups; differing boundaries are constructed around the appropriate evidence base for demonstrating CAM and biomedical outcomes, in which a decision to use CAM is more easily embraced, and less contingent on scientific evidence; boundaries are constructed around what is a safe treatment, and what represents a health risk; and boundaries are constructed around the very meaning and understanding of CAM. These boundaries lead to thresholds based on different sets of expectations around CAM and biomedical treatments. When biomedicine did not fulfil the client/patient expectation of accurate diagnosis, then in line with Luhmann’s supposition that boundaries abruptly turn trust into distrust, the client/patient quickly becomes distrustful and turns to CAM. CAM users do not necessarily have the same expectations of CAM, and their trust develops within different boundary constructions.

Another form of trust relates to constructing frameworks for embedding expert knowledge into lay understandings of CAM. Trust in science and medicine is ambivalent. Certainly we see in this chapter that alternative forms of evidence, such as anecdotal and clinical, can be preferred to RCTs. The scepticism also arises from suspicion of scientific testing, and when the reality of biomedical approaches did not concur with the promised outcomes. Interestingly, interviews with CAM practitioners show slightly more acceptance of scientific processes. Although CAM practitioners are equally vociferous in their support of non-scientific testing methods, they are also keen to legitimate practice through developing a clinical evidence base. The interviews with practitioners show the tension between faithfulness to their traditional practices, and the need to appropriate scientific knowledge and testing methods. As such there are interesting
continuities and discontinuities between the accounts of CAM users and CAM practitioners regarding medical scientific knowledge.

Using Giddens’ (1995, p. 88) concept of trust and expertise, it can be seen that trust in practices of biomedicine are innate, that they are socially inscribed. Science, as Giddens observes, has long maintained an image of reliability, but due to a level of alienation from the processes of science and medicine, lay attitudes remain ambivalent. CAM is seen as the new kid on the block, and the interest here is in why people use CAM when evidence for effectiveness is slight? According to Giddens, trust is only demanded when there is ignorance so for the disciplines and practices which constitute CAM, and of which the majority are not common knowledge, this theory suggests there needs to be trust. It also suggests that there needs to be scepticism or caution; however, CAM users tend to embrace CAM more than biomedicine. Nevertheless they still have caution around CAM. One way to address the problematic of trust in unknown expert systems is to become a practitioner of a particular therapy. A surprisingly high number of CAM users, some seven in total, had undergone studies, both formal and informal. This re-skills them with expert knowledge to better understand the field of practice and as a reinforcement of trust. According to Giddens, this strategy would actually require of these users a reduced need to trust in CAM at all.

Lastly, trust is constructed relative to risk. Health risk is constructed from biomedical approaches, particularly around the use of compound pharmaceutical medicines or drugs. The resistance to biomedical pharmaceutical medicines is supported by a review of qualitative studies addressing lay experiences of medicine taking in the wider population (Pound et al., 2005) whereby adverse effects were a key criterion in the evaluation of medicine taking, and researchers finding that, as with my review, that these unpleasant reactions cause distrust in medicine. Consequently, people often view medicines with disdain, especially women. Resistance to pharmaceutical medications is also apparent among the CAM practitioners who construct a similar narrative around risk. For Giddens (1995), risk represents an awareness of the limitations of expert knowledge and practice; however, CAM users have a similar awareness of the limitations of CAM. Risk for CAM users relates to real and perceived threats to health, and CAM, which is perceived as safe and natural, does not represent the same health threat. CAM users have to calculate the risks versus the benefits, and few benefits are related to medicine taking.

Trust has been shown in this chapter to be developed at access points, which is Giddens’ (1995) term for when a representative of an expert abstract system engages with a lay person. In Chapter Six the mediation of trust between CAM and biomedical practitioners is considered, and Giddens assumptions about trust in abstract expert systems assessed in relation to CAM.
Chapter Six extends the argument presented in this chapter that trust is developed in situations of interaction with a practitioner, and Chapter Six shows that therapeutic emplotment and holistic communication encourage faith in a practitioner, however trust is temporal and also changes over depending on contexts. Moreover there are multiple forms of trust, meaning that a CAM user can have faith in a practitioner, but have little trust in the likelihood of a treatment cure. Chapter Six also shows how the idea of trust develops from an idealised representation of the CAM practitioner as healer and Goddess, as a familiar and as the ‘Other’.
Chapter Six
Mediating Trust in the CAM Encounter

6.1 Introduction

This chapter examines the development and negotiation of trust in CAM encounters, with the term ‘encounters’ referring directly to Goffman’s (1961, p. 17) definition of the encounter as ‘a type of social arrangement that occurs when persons are in one another’s immediate physical presence’ and involving both gesture and talk (Giddens, 1984, p. 71). This chapter directly addresses the research question concerning how expert knowledge of the practitioner interpolates with the lay beliefs and understandings of CAM users in the development of trust in CAM. Using Giddens’ conceptualisation of trust in ‘abstract systems’, the CAM practitioner represents an ‘access point’ to CAM expert systems, and the development of a trustworthy relationship with a CAM practitioner involves ‘facework commitment’ or trust relations established in co-presence of a CAM practitioner.

Shared decision making and patient centred communication are said to be favoured by CAM practitioners and users; however, CAM practitioners interviewed for my study showed clear evidence of taking a fairly dominant role in treatment decision making. Moreover, and as will be discussed in Section 7.3, CAM users are shown to be in some contexts, more passively involved in treatment decision making than their personal beliefs suggest. Section 6.1 reports the meanings of female CAM users for therapeutic emplotment and holistic communication in both CAM and biomedical encounters. Section 6.3 shows how CAM users mediate the expert knowledge of CAM practitioners, who represent the abstract expert CAM system. Moreover, it is argued here that these abstract systems are less securely positioned than for biomedical systems, and that this differentiates them CAM from biomedical systems, and this implication for personal trust constructed in interaction with the practitioner. In section 6.4, it is argued that CAM users develop faith in CAM knowledge through subjectively recasting the practitioner into a specific role, namely, the practitioner as healer, as friend and as ‘Other’. It is argued that these representations produce different forms of trust in the expert knowledge of CAM.

6.2 Negotiating Trust in Complementary and Alternative Medicine and Biomedical Encounters

Several social science studies of CAM use (Lupton, 1997; Sharma, 1995; Siahpush, 2000) propose that the CAM encounter, being based on empathetic interaction and holistic investigation of a client/patient’s psychosocial needs, is a primary reason for CAM use. The findings presented in this section generally support this argument, particularly for female CAM...
users for whom the centrality of the therapeutic encounter in their ongoing use of CAM is a recurrent theme. As found in other sociological studies (Chatwin, Collins, Watt, & Field, 2008), CAM users see patient participation as integral to facilitating trust in the therapeutic encounter. The CAM therapeutic encounter is characterised by empathetic listening, and a holistic mode of inquiry known as ‘holistic communication’. Holistic communication involves detailed investigation of the health and social contexts of the client/patient (Cartwright & Torr, 2005; Chatwin, 2009). Supporting these studies, CAM users in my study are found to favour a holistic communication style, and to support the consumerist models of active participation and shared-decision making.

6.2.1 Embodied trust

CAM user accounts show a polarised view of the CAM and biomedical encounter. Female CAM users feel that CAM practitioners are more accommodating of their needs, and more willing to engage in strategies of participatory communication such as active listening, and in utilising the client/patient’s own assessment of their condition in treatment. For these women, the idea of a shared decision-making model involves the health practitioner individualising a treatment program to incorporate their self-assessed health needs. Some clues as to why women place particular emphasis on being heard in consultation lay in the nature of their illness and health conditions. A large number of the women in the study had used CAM for reproductive and hormonal health; such conditions offer an embodied experience in that women are relating to their bodies as the start of a new life, for example menopause for women may symbolise the transition to another stage in life, and the bodily experience becomes part of self-identity. These bodily experiences may be profoundly emotional and may undermine the sexually specific identity of a female (Shilling, 2005, p. 67). As seen in Chapter Five, the experience of biomedical treatment is a largely disembodied experience, in which invasive treatment produces an uncomfortable relationship between the client/patient and practitioner, lessening the opportunity for trust. Similarly for the experience of misdiagnosis and pharmaceutical drug use; and in all these contexts the voice of the female patient is perceived as invisible. Emotional responses are an important characterisation of the experience of illness and other health conditions (Brown, Alaszewski, Swift, & Nordin, 2011, p. 283), and women are seen as needing to express these emotions through talk. As such female CAM users disparage what they perceive as a paternalistic, authoritative style of communication in which they have no voice:

A lot of people in the medical profession are quite difficult to talk to, they get to the point they know, whereas you have to tick the box and that’s it. Whereas that’s not my idea, I want to be able to have a fairly full discussion with people about what’s wrong with me, what the treatment is to take some part in that, I want to be able to suggest
alternatives and have those considered reasonably. I don’t want to be treated like an idiot. (Sharon, 57 years)

For Sharon the desire for a participatory communication approach is paramount, while Corinne observes, ‘they’re meant to be the expert, you don’t ask too many questions. That’s my history of doctors anyway…treat you like you’re stupid’. From these accounts it transpires that what really matters is respect, having negotiated communication and being seen as intellectually robust. For Sharon and other female CAM users, a CAM practitioner with these characteristics provides a sense of being taken seriously:

Yeah, I feel I’ve been treated very seriously by more than one naturopath, been treated very seriously by them, and haven’t had any trouble talking to them or being treated as a reasonably intelligent human being. (Sharon, 58 years)

Supportive interactions are not just confined to CAM encounters; biomedical and integrative medicine encounters are also seen as offering emotional and communicative support for at least five CAM users. As example, when experiencing emotional responses from pharmaceutical medication, Mads (79 years) discussed the side effects with her doctor, ‘I felt so darn depressive. I went back to the doctor and told him I didn’t want it and what happened and he said “OK we’ll try something else”’. Here Mads felt her needs were met and, reflecting the pressure on doctors to involve patients in treatment decision-making (Stevenson, Britten, Barry, Bradley, & Barberd, 2003), she became a co-participant in her treatment decision-making. The meaning inferred from these accounts is that trust can be generated in a biomedical encounter if a participatory style of treatment decision making is adopted; however, the biomedical practitioner is still in control, with Mads for example the medication level is simply reduced and she is not offered alternative treatment. Trust in a participatory style of communication does not involve fully shared decision making, and this seems to suit CAM users, who develop their trust from the nature of the interaction. The general theme in CAM user accounts is that interpersonal trust in health treatment is more developed in CAM than in biomedical encounters. For Corinne there are also suggested gender difference in the communication style of female and male health practitioners, regardless of whether a biomedical or CAM health system, and in this quote Corinne expresses her comfort with the empathetic style of communication experienced with several female practitioners:

Interviewer: When you came to see [herbalist name] what was the difference with her?

Corinne: She gave me such a thorough, like that whole initial interview was an hour or something, just asked liked of aspects of everything, like a totally holistic experience,
you know. Everybody likes to talk about themselves [laughs]. I really like [herbalist name] too, I really felt comfortable with her.

Interviewer: In what way?

Corinne: She just puts you at ease, knows her stuff...

Interviewer: Since you’ve been to her, seven years now, have you been to any other practitioners?

Corinne: No…for herbal stuff. I did get something once off [practitioner’s name] who works there. I was getting acupuncture and Bowen Therapy off [practitioner’s name]. She’s an all rounder as well, a lot of knowledge in different areas. Got some herbal stuff off her which was a different herbal thing that [herbalist name] does. After I had baby, it was something like ‘turning the blood’, the blood after having a baby. I guess I took it thinking it was a good thing. But I didn’t quite understand what it was or what I was taking it for.

Interviewer: Did you ask her?

Corinne: Not really [laughs] I just trusted her…I just trusted [practitioner name], and it made me feel better. I can’t remember now.

Interviewer: This area of trust…what brings that about?

Corinne: I felt like [practitioner’s name] knew me very well. I had Bowen Therapy and acupuncture all the way through my pregnancy with her. (Corinne, 35 years)

Several aspects of personal trust emerge from Corinne’s account, of which the most prominent is embodied trust. As discussed in several studies of embodied trust in health environments (Brown, et al., 2011; Goldberg, 2008), the embodied work of a health practitioner involves tactile and emotional engagement with their work and by the nature of their practice, many CAM practitioners are particularly engaged with their clients/patients at the tactile and emotional levels. This form of communicative action is as important to trust as the institutionalised knowledge and skills of practice. This form of ‘bodywork’ (Brown, et al., 2011) involves reassuring clients/patients, empathising with them, affirming them, and we see with Corinne how trust is generated through a sense of comfortability, and emotional rapport with the CAM therapist. This creates for Corinne a personal trust in the naturopath, and a confidence that the naturopath knows her well. Knowing her ‘well’ refers to knowing the personal aspects of Corinne’s health, her life and overall vulnerabilities. This form of
interpersonal trust is so well established with her naturopath, that Corinne entrusts pre-natal care
to her naturopath. This action on Corinne’s behalf signifies a ‘leap of faith’ (Giddens, 1995)
from trusting the practitioner in the personal context, to engaging trustworthiness at an
institutional level. Trust is also demanded in this context when a herbal medicine of which
Corinne is completely ignorant is used in her post-natal care. According to Giddens (1995),
ignorance of the institutionalised knowledge and symbols of the expert system can be grounds
for scepticism; however, for Corinne and other CAM users, the personal relationship with the
CAM therapist is a trusting relationship, developed over time. The time element in trust is also
significant (Luhmann, 1979) in that as trust changes over time, so does the basis for distrust. For
these CAM users, the trustworthiness developed in the CAM encounter led to expectations,
belief and hope (Brown, et al., 2011, p. 285) for a healthy pregnancy. In this structuration, trust
is positioned as having a positive expectation for future actions, as well as in the past and
present. Another observation from CAM user accounts of client/practitioner interactions is that
while the CAM encounter is patient-centred, it does not necessarily invite shared decision-
making. To this end, the mode of treatment, and its application lay firmly with the practitioner.

6.2.2 Holistic communication

Corinne’s account also sees the naturopathic consultation as a ‘holistic’ experience. For Corinne and
other users, holism is about accounting for the whole person and ‘treating the emotional side,
lifestyle, history all into account, so you’re not just a symptom’. These understandings of
holistic health (e.g. Sharon, Annie, Marcia, Bella, John) anticipate holistic communication in
which the practitioner inquires into biological, mental and emotional aspects of health and well-
being. In this model of holistic communication, interactional elements of the CAM practitioner
and client interaction are seen as having features based on a model of collaboration ‘holistic’
communication, individualised treatment (Chatwin, 2009) and empathetic interaction (Bakx,
1991). CAM users criticise their doctors for not approaching the treatment of their illness
holistically, and not applying a ‘whole person’ approach. Holistic communication is, by
definition, an embodied form of communication in that the role of emotions in bodily
experiences of health and illness are acknowledged, and this is supported in CAM user
accounts:

A doctor just talks one-sided conversation and as quick as they can do it. And there’s
none of that other stuff going on, and it’s that other stuff that’s very important...let’s get
down to the symptoms, not dealing with the person as a whole I suppose. (Fifi, 47 years)

Not only is Fifi saying she wants to connect with a health practitioner, she also wants a holistic
communication. Embodied trust in the practitioner occurs then from the ‘other stuff’, the
interpersonal interaction, the contextualising of health and illness, and the participatory
involvement of the client/patient in the conversation. CAM user accounts and those of practitioners show that holistic health has a multiplicity of meanings, from spirituality and healing to energy flow and vitalistic principles, and the adoption of healthy lifestyle practices, with attendant stress and emotion management. Holistic health also means an individualised approach to health, and taking personal responsibility for health, with Corinne describing her biomedical doctor as ‘holistic’ because ‘he doesn’t just whack down the drugs’. As seen in Chapter Five CAM users have little trust in compound pharmaceutical medicines, which they interpret as health risk. A holistic model of communication diminishes the perception of risk associated with biomedicines, and trust further develops from a perceived lack of attendant health risk. Paradoxically, the practitioner of CAM is less embedded in the abstract CAM system than biomedical practitioners.

6.2.3 The empathic, therapeutic encounter

Certainly the personality of the practitioner links to continued use; Corinne has rejected chiropractors and other CAM practitioners with whom she cannot communicate, and whom she regards as ‘pushy’. If someone has the right combination of empathy and knowledge, then Corinne trusts that person implicitly. So there is evidence that when the encounter is perceived as supportive, the expert knowledge of the practitioner is legitimated. While there is noticeably more evidence of this in accounts of CAM practice, it also occurs in biomedical encounters. Biomedical and integrative medicine doctors are also seen as supportive. Again it is empathy, listening techniques and a sense of inclusion in the treatment regimen which constitute a supportive doctor. Bella is currently seeing a ‘lovely doctor and she’s very caring, and also a very thorough doctor’. Bella further reveals how the doctor supports her using CAM treatments, which is seen by Bella as supporting her autonomy in treatment decision-making. Five CAM users with experience of integrative medicine or holistic health doctors and have found them more amenable than other biomedical doctors. Amy had an integrative doctor who was ‘brilliant, also did acupuncture’. Amy notes that this doctor was also ‘a very spiritual person’ and understood how she wanted to manage and control her health. These doctors are also seen as using holistic communication in their work, so embodied trust develops in these biomedical practitioners. When asked what expectations they have of a CAM practitioner, participants said they needed to feel a connection with the CAM practitioner who attends them, as well as to feel understood and validated.

Holistic communication is seen to have therapeutic potential (Kelner, 2005), such as in the classical homeopathic interview: when all social and biological contexts of the client/patient are investigated, then the consultation becomes meaningful (Chatwin, 2009). For Annie, the important part of the therapeutic encounter is the emotional engagement with the CAM
practitioner. As long as the practitioner asks about her emotional history, then Annie feels ‘as though they have a better understanding of me rather than “have you had this?”’. The need to be understood is also articulated by Corinne, who found that the style of communication with a CAM practitioner is what produces confidence and trust: ‘when you talk to people and they’re asking you questions about you and your health, I guess you feel like they have some kind of understanding of who you are.’

This suggests the experience of inclusiveness, of empathy and regard for the whole person, provides the CAM user with a disposition to trust. This is supported in literature on CAM (Cartwright & Torr, 2005; Rayner, McLachlan, Forster, & Cramer, 2009) showing that trustworthiness in the practitioner is based on the intimacy of the encounter, and the feeling of mutual respect between practitioner and client/patient. Although literature has found that empathetic interaction is not a reason for continued CAM use (Kelner, 2005), CAM users in my study have reported staying long-term with an empathetic therapist; also the impression of receiving individualised treatment is important to CAM users. Here a sense of inclusion and participation in individualised treatment decision-making also provokes trust in the bodywork of a practitioner.

Based on the accounts from CAM users, the perspective of CAM practitioners are revealing, and while supporting holistic health treatment, they do not necessarily uphold the level of inclusiveness perceived by the users. The CAM practitioners in this study see their role as facilitating ‘empowerment’ with the client/patient. Empowerment for practitioners is the point at which the client/patient embraces the holistic philosophy, and accepts responsibility for health (Toms, 2004). Essentially, this occurs when a client takes on the role of a committed user. Overall, participants expect their clients/patients to benefit from the regimes, including non-specific effects such as increased well-being. Like CAM users, they promote a discourse of individuality which involves contextualising a person’s health and illness status for their treatment, and this discourse also sees the individual as personally responsible for their health (Hughes, 2004, p. 33). This self-responsibility is, according to Beck and Beck-Gernsheim (2002, p. 23), a ‘culturally binding mode of attribution’ which reflects a general perception in society that individuals are the creators of their own destiny, and are actively involved in shaping their life outcomes. They are also accountable for the ‘failure’ of their life, which involves shifting the burden of risk on to the individual. Taking responsibility for unanticipated events also invites a control of this risk. As Beck and Beck-Gernsheim (2002) point out, building this individual life of one’s own is, paradoxically, dependent on institutions. A homeopath interviewed for my study demonstrates how the individuality of the client/patient is embedded in asthma treatment:
There are a lot of questions in order to make a clear description. But diagnostics are important, of course, they are. We do lots of training here in basic medical sciences, when they hear a diagnosis from a GP or consulting, they will write it down of course. They don’t necessarily take a huge amount of notice of it, depending what it is. If someone comes in and says they have asthma, well there are various basket terms, I call them basket terms. Asthma has loads of things in it, we have to write down asthma but then they’ll … know about asthma has all kinds of different aspects to it, and basically it’s respiratory difficulty and always has a clear aetiology. We can see 10 different asthma cases in a day in the clinic, and each a different remedy. Whereas we all know we have to take account of a diagnostic, outside, we can make our own based upon the physical symptoms. Nevertheless, a diagnostic isn’t that important to us. (Homeopath,
5)

In a sense this is little different to the doctor who prescribes a medicine based on patient feedback about the cause of illness, and presenting symptoms. As found in another study of the homeopathic encounter (Scott, 1998), patient input is minimal, and patients are not consulted about the remedies. CAM practitioner accounts also reveal an interesting paradox where a client/patient is expected to follow a prescribed regime to achieve a successful outcome, and the individual context for a client/patient wellness is in the background of treatment. To this end, practitioners rarely inquire into the client’s/patient’s tolerance threshold, and all the practitioners see their treatment programs as efficacious for their clients/patients, as long as the client takes full responsibility:

We can give a person the tools, the dietary advice, the empowerment is us saying, this is basically what you need to physically heal, you can take the herbs it’s up to you, or take the stand for your health and responsibility. It’s your body…they feel like they’re doing something extra for their health, they’re supporting their body. (Naturopath, 3)

This supports evidence from a social science study of CAM encounters which found minimal patient input in homeopathic treatment decision making (Scott, 1998). Braathen (1996, p. 157) sees this as a new kind of medical surveillance in which CAM practitioners are agents for self-disciplining technologies. The surveillance requires a disciplined regime of dietary and other lifestyle changes. It can be likened to Foucault’s (1990) ‘cultivation of the self’, in which the individual cultivates their mind or body in a disciplined, regimented way and often with a mentor. So what emerges here is that for some practitioners the model of practice is less participatory and individualised, than CAM user rhetoric suggests.
Of course trust is not always present in CAM encounters, and several CAM user accounts detail the development of mistrust when a paternalistic model is applied. Consider the following dialogue in which Sharon recounts her experience with kinesiology:

Sharon: I’ve been to see the kenesiologist a couple of times, I felt that was a little bit on the one way street.

Interviewer: In what way?

Sharon: That I didn’t really want, they were diagnosing me from the responses of my body and they didn’t really want my...ah

Interviewer: Your input?

Sharon: Input, yes [laughs]. I didn’t really find it very effective with me. Very much in the short term, I might feel better for a couple of hours, then I would feel the same again. (Sharon, 58 years)

Sharon’s experience with this particular kenesiologist is that she was not included in the diagnostic process, which was primarily based on physicality. As such she felt alienated from the treatment process, and ultimately found kinesiology treatment ineffective. This reflects a recurring theme throughout the interviews with CAM users that a CAM treatment is perceived as less effective when the client/patient is not involved in treatment decision making. For Giddens (1995, p. 92) trust in others evolves, among other things, from mutuality of experience. For Sharon, a lack of trust in the kenesiologist was reinforced by alienation encountered in treatment, she was sceptical of the claims of kinesiology as articulated through the practitioner, and this scepticism reflected her uncomfortability with the practitioner. The practitioner’s integrity was therefore in question, and the lack of trust in kinesiology a combination of feeling her self-knowledge of body was invalidated in treatment, and she was alienated from the diagnostic and treatment process.

Based on the preceding accounts, it can be speculated that having active engagement in the practitioner/client process can stimulate treatment benefits, even if this inclusion is illusory. This speculation is based on literature showing a good relationship and rapport between practitioner and client/patient produces a placebo effect, and is a key factor in healing (Kelner, 2005). Another important point is that a practitioner’s communication style may vary over time, and the style experienced in the initial consultation change to a more shared decision-making style (Charles, Gafni, & Whelan, 1999). CAM users in the study are at different stages of treatment by individual practitioners, and this context needs to be understood in relation to their
perceptions and understandings of CAM. The following extract from Corinne’s interview demonstrates the importance of the quality of the therapeutic encounter to regular practitioner engagement:

Interviewer: *In what sense?*  
Corinne: *I didn’t really know that he understood me, and I didn’t really understand him.*  
Interviewer: *Because of the language?*  
Corinne: *I think so. And also I think I felt that he was a guy and I wanted a woman, at least she’d know what I meant….. He was like real old traditional Chinese medicine which I wanted to give a go at, but you know, it was just a bit difficult for me because I didn’t really know that he understood what I was saying. And I didn’t understand what he was saying, so I didn’t feel that confident with it all.* (Corinne, 35 years)

Corinne’s account reveals a multiplicity of meanings around CAM use, notwithstanding the way herbs are constructed as exotic and mysterious, a product of the ‘Other’. Corinne’s account suggests she requires more than a traditional treatment to sustain her use of CAM, she requires a rapport with the practitioner. It is this confidence in the practitioner which actually stimulates trust in the treatment. Corinne proclaims a lack of confidence based on the different languages spoken by her and the practitioner, thereby creating the potential for miscommunication. According to Luhmann (2000), confidence differs from trust in that there is no awareness of risk, whereas for Giddens (1995, p. 32) trust *is* confidence in the ‘reliability of a person or system’, and that confidence is based partly on faith in the correctness of expert and technical knowledge. So when Corinne speaks of having confidence in a TCM practitioner, it is more in keeping with Giddens’ understanding of trust. Using Giddens further, the TCM practitioners represent the access point to TCM knowledge and practice, which is a rather mysterious whole medicine system to Western consumers. Developing trustworthiness in such a system requires a high level of facework commitment in the practitioner, who essentially symbolises TCM in totality. When she experienced difficulties in ingesting the herbs and in understanding the practitioner, Corinne’s confidence waned. This led to her constructing, and enforcing a boundary around acceptable use of TCM (see Luhmann, 1979). The argument that develops from Corinne’s account, and similar ones, is that developing trust in a CAM practitioner will generate some sort of faith in the actual treatment.

In summary, the paternalistic, authoritarian style of communication undermines trust in biomedical and CAM approaches. CAM users feel that the doctor or practitioner has not
properly listened to them, nor obtained a holistic understanding of the whole person. The data also shows that on occasion CAM practitioners are just as liable as biomedical practitioners not to listen to the client/patient, and that active participation is desired by CAM users. Ultimately, we can conclude it is not the ‘biomedical’ and ‘CAM’ encounter which attracts, rather the model of communication, and CAM users evidently support the shared decision-making approach. When seen through the lens of the CAM practitioner, the extent to which CAM users actually participate in treatment decision making is contestable. Holistic communication is favoured by CAM users, and generates trust in the practitioner. This in turn produces faith and trust in the treatment. So far, I have not referenced the experiences and beliefs of CAM users; however, these forms of self-knowledge emerge as an important component of their trust in treatment decision making. The next section explores the contribution of lay experiences and beliefs to trust in the CAM encounter and treatment.

6.3 Negotiating Expert and Lay Knowledge in Interaction

6.3.1 Validating self-knowledge of health and the body

According to Goldstein (2003, p. 31), the form of health knowledge preferred by lay people is derived from the ‘wisdom of the body’. The self-knowledge of the body is a recurring theme in CAM user accounts, with users clearly negotiating trust in self-knowledge of the body with the expert knowledge of the practitioner. When asked how she knew a treatment was effective, Sharon responds, ‘I don’t know I feel the results…that suit your body’. Self-knowledge of the body arises primarily from one’s bodily experience, but also from beliefs and values:

If we look at mind, body and spirit, I’m looking at the mind and spirit of the person, the soul and aura, who they are and how they present. I think all that transmutes into the physical as well, depending what the energy is, I can see that in a person’s physical body, if their stiff and stuff it indicates other stuff happening. (Andy, 36 years)

No, they test me for white rice, came up the size of a 50 cent piece on my arm … and didn’t go away for three weeks. Normally if you get an allergic reaction you get a small reaction, they say ‘oh yeah’. What have I done to the body? I’m not eliminating things I’m causing the body to go into crisis. Thank you very much, I’m not coming back…one of the things that’s very important and GPs don’t understand, it’s not as simple as ‘give an antibiotic’. Antibiotics are only for extreme bacterial virus, they don’t look for the secondary cause. (John, 55 years)

Andy articulates a belief in the embodied nature of health, and that illness manifests in a stiff body. John’s knowledge of his body is based on experience, on attending to the reactions of his
body to food and medicines. John’s use of elimination metaphors shows the complexity of the relationship with his body, it is also shown how distrust in the capacity of the medical profession to understand his body, and to know the cause of his illness. This understanding of illness, and the need to eliminate toxins from the body, actually arises from early allopathic conceptions of the body, based in rational scientific knowledge which privileged the idea of eliminating bacteria from the body, and avoiding contamination risk (Bury, 2005, p. 3). What these accounts indicate is a form of embodied trust (Brown et al., 2011) whereby trust is placed in the power of the body to perform and to eliminate illness, essentially to serve a communicative function. This form of trust is reinforced in accounts from both users and practitioners of CAM, where the body is said to be ‘speaking’ and communicating when something is wrong. This form of embodied trust leads to a privileging of self-knowledge, John in particular has lost faith in biomedical and, to a lesser extent, some forms of CAM, in the search for the right combination of food and natural medicines for his body. If the body is a vehicle for living in (Shilling, 2005, p. 69) then chronic illness can be profoundly destabilising, and serve to undermine a conception of the normal body and self through the symbolic presence of bacteria and other ‘toxins’ in the body. Embodied trust is holistic in that it allows for a regeneration of the body, and offers the possibility of a disease free future, and a positive sense of self.

Biomedical practitioners are alleged to be likely to discount an individual’s local knowledge of their body in favour of ‘objective’ scientific knowledge of the body (Cant & Sharma, 1996a, p. 15). It is common for CAM users to report a dismissive response from doctors toward their localised knowledge. Fifi, for example, had a mental schema of a doctor as being ‘there to help you’, but instead found their approach belittling, and ‘almost crucifying you for having something wrong’. Marcia also experienced negative feedback from doctors, relating how a doctor refused to perform a pap smear on her, because she was too old and ‘all shrivelled up’. This interaction also undermines Marcia’s subjectively formed identity as an independent and attractive woman. Such experiences are supported in an Australian study (Lupton, 1997) of interaction in medical encounters, in which Lupton found that patients are harsh judges of doctors who appear uncaring, insensitive and unable to listen. These experiences have encouraged users to challenge biomedical assumptions, especially those regarding localised lay knowledge as less legitimate. These experiences challenge trust once held in the abstract medical system.

CAM practitioners by contrast are seen as validating localised, lay knowledge and understandings of the body. For many CAM users, a primary reason for the continued use of CAM is the establishment of a rapport with a CAM practitioner (e.g. Annie, Corinne); this
rapport is based on shared values. CAM encounters can involve a co-constructed narrative about a client’s/patient’s illness, and this mutuality can produce an understanding of illness as being part of a ‘journey’:

Interviewer: So she [the iridologist] sort of had the symptoms down?

Annie: Yes she did, she was sort of very much onto it. A lot faster than conventional medicine. I think too in the journey [my italics] to meeting her I’d had a series of chronic illnesses, nose and colds that never got better. Also, I was starting to lose my faith in conventional medicine. I don’t think I got good treatment a couple of times because I had nodules on my thyroid gland when I was 20 and nothing helped...manipulate the thyroid factors and anyway they made a botch of it and I ended up having a thyroidectomy. So I sort of lost faith in it, I was 20 then or 21. (Annie, 43 years)

The wider narrative structure employed by Annie is a quest narrative in which she seeks a meaning and purpose to illness (Frank, 1995). Journey metaphors like Annie’s have been analysed as providing meaning to socially significant interactions (White, 2002). For Annie, the meaning of illness is that it introduced her to her iridologist. The function of a journey metaphor is to create faith in the unknown, to trust the future will be alright, this reduces anxiety about the future and helps to create ontological trust (Giddens, 1995). The practitioner’s role is not just in supporting hope, but being part of the journey. This supportive relationship can occur through what Reeve (2005) terms ‘therapeutic emplotment’ the evolving mutual construction of a meaningful story about the person’s illness, and this emplotment assists the sick person to find meaning in health experience. The prerequisite to developing this sort of trust in a practitioner is having a congruent belief system; in CAM this belief system is based on the holistic health philosophy. Several CAM users’ accounts show evidence of therapeutic emplotment, which can emerge from validating the cause and severity of illness, especially an illness with non-specific symptoms:

Yes, it is still ongoing. It was caused through trauma and had only been happening for a very short while, but nevertheless, by going to a naturopath and her discussing things I then learnt how much body sugar and whatever, if it’s not looked after and maintained for certain things it has a very big effect on body. And because that was my weakness through stress, and also dealing with stress, I would keep succumbing to it all the time. (Lucy, 33 years)
For Lucy alcoholism is experienced through having an uncontrolled compulsion to drink. Here Lucy describes the format of the encounter with the naturopath, when discussing treatment for this disorder:

*She asks how I’m generally feeling, any problems with any part of the body, she always wants to know that sort of stuff. Then she always looks at the eyes and the before and after and we sit there and discuss what’s improving, what’s not improving.* (Lucy, 33 years)

The naturopath did not judge Lucy’s drinking; instead together they investigated the cause of her drinking, locating the cause in stress arising from trauma. The naturopath put Lucy on a natural, sugar free diet, and taught Lucy how her body reacts to sugar; however, Lucy still identifies as an alcoholic. In this account Lucy has faith in the advice of her naturopath, and in her own ability to combat her drinking. This reflects the modernist discourse of individualism, which mirrors the wider cultural narrative of taking self-responsibility for health, and combating illness and disease through exercising self-control and restraint (Greenhalgh & Wessely, 2004). Lucy understands alcoholism as attributed to both psychological and holistic causes, the holistic being the attribution of stress, the association between stress and illness being prominent in the accounts of six CAM users.

Stress is perceived to be a primary cause of illness in accounts from both CAM users and practitioners. A Blue Mountains-based naturopath (7) observes that ‘most people are very stressed about a lot of things’, and that ‘a lot of stressed people have been wrongly diagnosed with depression, and shouldn’t be on anti-depressants’. In literature on CAM narratives, stress has been shown to be implicated in the cause of illness, and in creating imbalance in the body. Williams (1984, p. 188) observes that the discourse of stress is firmly entrenched in modern thinking and stress is also a feature of the female relationship with the modern world, with narratives of stress relating to loss and confusion, and self-retribution.

The stress of modern life is compounded with the plurality of authorities and expertise, lifestyle choices and consumption, are of which are part of the constitution of self (Giddens, 1991). This also affects self-identity. This reflexivity of self is evident in Lucy’s account, in which Lucy constitutes herself through the plurality of knowledge claims available to her. To this end Lucy demonstrates trust in both the rational, scientific knowledge claims and in the natural, holistic explanations of her illness. Her uncertainty represents the conundrum of the modern health consumer, who is faced with a multiplicity of knowledge claims, and the task of figuring out which one suits. At a wider level, Lucy’s understandings of alcoholism reflect the tensions between ‘rational’ psychological explanations for mental illness, and alternative theories based
on Aristotelian principles of restoring the body to a natural, balanced state. In terms of self and identity, the natural holistic explanations are more empowering, and constitute Lucy as actively involved in her recovery.

The culturally inscribed concept of illness as arising from stress is evident in other CAM user accounts, and forms a core part of holistic health narratives (Sered & Agigian, 2008) which, as shown in the discussion above, is part of the formation of self. Central to holistic health knowledge is the concept of ‘balance’ which sees illness as a result of the imbalance between ‘insensate elements of humors in the body’ (Andrews Anderson et al., 2010, p. 153S). For the CAM users in the study, the most common understanding of health is ‘balance’. Balance is understood variously, with some CAM users referring to balance as a balanced lifestyle with proper diet, exercise and minimal stress, while others conceptualise balance as a synergy between emotional, spiritual and physical domains of self. Ben’s account also positions holistic health as the synergy between emotional and physical health domains:

Oh yeah, everything’s related, absolutely. If you are emotionally shut down and working really long hours, then the obvious physical aspect was the headaches. Headache tablets never worked, pretty much nothing worked because there was no point treating the symptoms, the problem was I was working 18 hours a day to the exclusion of all else. That was the problem and there was no point changing that till I changed the physical side of things. (Ben, 45 yrs)

Ben sees himself as holistically ‘ill’; however, he has the ability to apply self-restraint and control and to change the ‘physical side of things’. The promotion of bodily and mental restitution through change is part of the empowerment discourse promoted by CAM practitioners. CAM practitioners explain health and illness through a holistic framework, and this informs the practitioner’s construction of professional (‘expert’) knowledge. For the practitioners in my study a ‘whole person’ approach treats the physical, mental, spiritual and emotional health of a client/patient. Consider, for example, the following account from a Sydney-based naturopath:

Treating the whole person, whether it is physical, mental or emotional in approach. For example, a person ...has irritable bowel syndrome..., and sure that’s a physical symptom but what’s causing it ...could be stress, could be emotional drain...unless you address that aspect of the disease or the person you won’t be dealing with the constipation long term...From a holistic point, that’s what we tend to do. (Naturopath, 3)
In this account, the naturopath articulates a holistic illness narrative, which links irritable bowel syndrome to emotions. An aetiology narrative such as this provides a causal explanation for an individual’s health state. Here, the naturopath links a physical symptom to an underlying emotional cause.

The facework commitment of these users is facilitated by the therapeutic emplotment between the client/patient and practitioner. Also, from the discussion in Section 6.4 there are indications that CAM practitioners respect the self-acquired knowledge of the CAM user. Whether they trust is another matter; as there is no clear trend in the data. At best, we can conclude that lay knowledge is valorised in rhetoric, and in some situations the CAM user is a co-contributor to their treatment protocol. More often though, it is the user who appropriates the institutional knowledge of the CAM practitioner, and circulates CAM language, concepts and understandings, reiterating these understandings in their own individualised, interpretative framework, with little evidence of users influencing the explanatory framework of practitioners.

The next section explores how expert knowledge communicated through a practitioner is circulated in understandings of health and illness, and seeks to understand further how trust is negotiated between the expert knowledge of the practitioner and lay knowledge.

6.3.2 Circulating expert knowledge

The CAM user comes to the consultation with a developed health belief and, at times, a sophisticated understanding of their illness. CAM users (e.g. Bonnie, Kate, Isobel) are shown, for example, to discuss medicinal drug use in consultation, and while a consensual decision may be made to use or not use a drug, on other occasions the CAM user simply seeks confirmation of their belief. Bonnie made a decision in consultation with her homeopath not to use a thyroid medication:

*I think it’s [illness] something related to menopause and the reading I have done about it suggests in fact it’s a thyroid condition, it can banish a number of years after you’ve been through menopause and it may not reoccur, whereas the first diagnosis was ‘yes, you have this disease’ you should take this drug’.*

*Initially I had some problems about two years ago, so I went through the Western medicine process of examination, nuclear medicine, x-rays the whole thing. Got told to take the drug. Looked at the drug and freaked. Read a little bit about it on the net. Went to my homeopath and said ‘what do you reckon about this drug?’ and he said ‘please, please, please don’t take this drug!’ [both laugh]. He said ‘do anything but don’t take this drug’. And then when we went back and looked at the evidence, the drug actually creates, it cuts through your thyroid gland so your thyroid stops functioning, totally. It*
just does it. So if you decide to get off the drug, you have to teach your thyroid how to work again. It’s not going to work perfectly, is it? (Bonnie, 51 years)

Although Bonnie presents the decision making as combined, it is she who had done the initial research, and the role of the homeopath is essentially to confirm the dangers of the drug. This way the two parties enter into the zone of shared values and beliefs, this appears as the construction of knowledge. However it is actually the phenomenological work of the CAM user which creates meanings and trust in the actual knowledge. This was also found to be a key feature of the trust relationships examined by Lee-Treweek (2002) in her study of consultations between CAM users and cranial osteopaths.

Over half of CAM users offer sophisticated interpretations of how CAM practices actually work. Consider Bonnie’s account of homeopathy as a case in point:

*The thing with homeopathy is very specific, it’s about treating like with like. So if you’ve got a headache and a sore stomach then that’s the cure you’ll be given. It’s specifically targeted of that. Or it will be targeted to your constitution. Those are the two sorts of schools. Some homeopaths will treat you, and others will treat that plus a constitution remedy which is related to your personality and your history, your history of health. Try and pinpoint what they call a ‘constitutional remedy’ which will help you out and build you up to help make you stronger.* (Bonnie, 51 years)

Bonnie’s explanation of homeopathy reveals an appropriation of professional homeopathic knowledge. Referencing such terms as ‘constitutional remedy’ suggests that Bonnie has readily appropriated homeopathic understanding of health. Bonnie, like other CAM users, has gone on to study homeopathy and this underlies her detailed knowledge of its practice and principles. It is also surprising to note that six other CAM users have undertaken studies of CAM, with reiki being the most commonly studied discipline. This suggests not only a degree of commitment to understanding a discipline, but also a desire to exercise more personal agency in health. It also shows how abstract knowledge associated with CAM practices are constructed as accessible to lay people. This suggests that a different relationship exists to CAM than to biomedical systems, that CAM is seen as relatable. When the client/patient and practitioner boundary is shifted, and the CAM users took on a role of advocate for CAM, defending the efficacy of CAM, this suggesting a committed user with a high degree of confidence in CAM.

Explanations of CAM reveal that no specific CAM system or practice is referred to more than others, with CAM users explaining a diversity of CAM practices from the esoteric, energetic practice of Makahari, to more conventional practices such as acupuncture. The two most common emergent themes involve the ‘placebo’ effect of CAM, and how reiki heals, relaxes
and produces other derivative benefits. It is also notable that five CAM users said they were unable to explain how certain CAM practices worked, but trusted their practitioners enough to proceed with treatment. The area of faith in the practitioner emerges as important to the continued use of CAM, and it is important to note that CAM users do not necessarily see CAM itself as effective, but rather the belief in CAM.

The practitioners are more likely to see their treatment as effective, as producing outcomes, and when a client did not return for treatment, the practitioner assumes the treatment has worked. Explanations of health and illness show that CAM users have appropriated the discourse of whole medicine systems of CAM, particularly the terminologies associated with TCM practices. Four CAM users make specific references to TCM terminologies such as experiencing too much or too little ‘qi’, identifying as being a ‘cold and damp’ and a ‘hot and dry’ person. Consider the following account from Sharon of her use of Chinese herbs for hepatitis treatment:

Interviewer: *What made you try Chinese herbs?*

Sharon: *I was trying them any home because I’ve always felt a lot of benefit from acupuncture...what I’ve found with them is they have fixed certain things I have used them for, they have been very good. But nothing stopped the bleeding or got rid of the hepatitis. I like to mix and match.*

Interviewer: *Did you try special herbs for the hepatitis?*

Sharon: *No because various Chinese herbalists told me they were not what they would really recommend. There are two types of hepatitis, and two types of people or disease, one if the person is a hot person, a hot one, and if the person is a cold person. I’m cold and damp, not hot and dry.*

Interviewer: *How do they tell this?*

Sharon: *I think it’s the pulses and a whole lot of things like that...* (Sharon, 58 years)

What this account shows is that Sharon has appropriated Chinese medicine’s dualistic positioning of people as being either ‘hot and dry’ or ‘cold and damp’; she also trusts the knowledge of TCM and has followed the advice of a practitioner. At the same time she exercises her personal agency and likes to ‘mix and match’. Sharon also has a finely developed physiological understanding of her body, and her account shows how she endeavours to make sense of the relevance of biomedical and TCM systems to her individual health context. Through identifying as being a ‘cold and damp’ person, this becomes part of Sharon’s narrative reconstruction of self, and developing trust in this knowledge reduces some of the complexity
of negotiating between both knowledge sets. CAM terminologies and knowledge claims are often conveyed to CAM users in interaction with their practitioners. Consider Corinne’s account of her interaction with a Chinese medicine practitioner:

Interviewer: *What made you think at that point ... I will go to a natural therapist?*

Corinne: *Um, I think they were recommended to me by a friend. And I have actually been to a Chinese man, it wasn’t like a consultation, it was like a bit of a consultation, it was a bit strange. There’s a guy in [suburb] who’s got a shop on [road name] who’s got all these amazing herbs which you boil up in a pot and drink them.*

Interviewer: *Yeah, raw herbs.*

Corinne: *I was taking those before, and that was a similar thing, I had too much qi or something. Maybe it was a language thing or it wasn’t like a thorough consultation, I just trusted he knew what he was doing with these disgusting herbs. I guess I needed something more than that.* (Corinne, 35 years)

Through interaction with the practitioner, Corinne is being exposed to new ways of thinking about her health and body. In this account Corinne has tentatively appropriated a TCM understanding of how her body operates within a system of ‘qi’, which is an active principle of the underlying life force or energy of any living thing. Corinne’s account also indicates a level of trust in the knowledge of the practitioner, who is the access point to the abstract symbols and knowledge embedded in the TCM system.

This section confirms how personal trust in the practitioner is developed within an open, participatory and holistic communication which is empathetic in nature; however, this trust involves little risk of uncertain health outcomes, and is more related to a confidence that the practitioner will provide a holistic, well-being oriented experience. A CAM user internalises both lay and expert knowledge claims in an ad hoc manner, at times privileging their lay knowledge and understandings, and at other times co-constructing knowledge and affirming their beliefs with the practitioner. CAM accounts also show how CAM knowledge and language are appropriated in discourse. Having trust relates also to the way a practitioner is constructed by a CAM user. The next section addresses how personal trust is generated through subjectively constructed images of the CAM practitioner, namely, the practitioner as healer, as friend and as ‘Other’.
6.4 Constructing the Complementary and Alternative Medicine Practitioner as ‘Subject’

Trust in the practitioner relates to the role of that person in the eyes of the client/patient. In the presentation of self in everyday life (Goffman, 1959), individuals are seen to perform a role in keeping with their status. This section explores interpretations of the roles and impressions of the CAM practitioner, which affect the construction of trust in the practitioner.

6.4.1 CAM practitioner as ‘healer’ and ‘Goddess’

The CAM user accounts demonstrate that having a supportive relationship with a CAM practitioner, including an integrative medicine doctor, produces derivative benefits. This is supported in social science literature showing how having a high level of belief and expectancy of a healing encounter is associated with positive health benefits, and that the level of rapport and bonding between a ‘healer’ and client/patient is a significant factor in healing (Wirth, 1995, p. 249). For a number of CAM users, the most rewarding aspect of the CAM encounter is the confessional. In this sense, perhaps unwittingly, the CAM practitioner appropriates the original healing function of the medic or clergy. Illich (1995, p. 159) states that historically ‘the sudden emergence of the doctor as saviour and miracle worker was not due to the proven efficacy of new techniques but to the need for a magical ritual.’ Assessing the accounts of CAM users against Illich’s proposition, we can see that the CAM practitioner fulfils a number of therapeutic roles such as counselling, confessional and testimonial, and this alleviates some of the complexity of the modern world. For some CAM users, healing is transmitted effectively through non-verbal channels:

First of all, it’s about them [clients/patients] wanting to give something and in doing so they receive something. Secondly, it’s about their belief system and whether it matches yours. I mean I connected with my healer quite a lot. Two different people, the initial person was different to the second person who I saw repeatedly. I actually went and saw someone twice a week for about six weeks and was getting reiki, because I was wearing a brace, I was walking like a robot. So it was something I could lie down with the brace on, and received the healing, because I couldn’t take it off. (Andy, 34 years)

Andy’s account focuses on the ‘connection’ with the healer, and it is this connection which facilitates trust. The healer in literature (McClean & Shaw, 2005) has been found to promote an ‘alternative form of expertise’ which privileges and trusts in individualised knowledge, rather than the knowledge of abstract expert systems. The attraction to this form of knowledge is prominent in several CAM user accounts, particularly for users such as Andy who engage
regularly with spiritually-based disciplines. For some users the CAM practitioner represents a symbol of perfection:

She’s [the naturopath] a walking, talking goddess as far as I’m concerned. And I look at her and think ‘God, if you can go from eating meat to being a vegan’, um, she’s done so well. And just looking at her and her husband and her family, how healthy they look. I keep telling myself ‘there’s gotta be something in that’. (Lucy, 33 years)

Lucy’s faith in CAM is directly related to the impression management of the practitioner, whose presentation has exerted a powerful influence over Lucy. The practitioner looks healthy and fit, a visual testimony to living a healthy lifestyle. The form of knowledge based on attraction is another form of individualised knowledge. We also see evidence that the process of healing is related more to a positive experience of CAM than to an effective cure:

Interviewer: When you go to a practitioner, is there any set of expectations you take with you?

Annie: A positive set of expectations that there will be something they can treat and heal.

Interviewer: And that occurs for you?

Annie: Most often, yeah. While I may have enjoyed the experience, it may not have had such a great effect. (Annie, 43 years)

Is it that modern CAM is less regarded for its efficacy and more as ‘feel good’, an indulgence, as relaxation with magical rituals? Most healing, says Illich, is ‘a traditional way of consoling, caring and comforting people while they heal’ (1995, p. 131). In traditional cultures, health care encompassed eating, drinking, breathing, loving, exercising, singing, dreaming, working and suffering. In this sense, modern CAM practice is a means of reclaiming this traditional mode of healing. This point is taken up further in Chapter Seven, in which it is argued that CAM is used as much for its derivative benefits, contextualised as a leisureed experience, as it is for its curative health properties. The form of trust that exists in treatments which facilitate ‘healing’ is about having faith, in the sense that there is no risk attached to relaxation and mind-body techniques like reiki, unlike herbal medicine and homeopathic, which comes with a sense of risk (real or imagined). Faith lay the belief in the treatment producing an outcome, some sort of derivative benefit. This is shown in the preceding account where Annie articulates an expectation that a practitioner can heal her condition, even though the treatment has not always worked. In line with Illich’s identification of the ‘magical effect’ of the healer, there is a belief
in the supernatural properties of treatment. This sort of language suggests an almost supernatural effect from the CAM treatment, although most CAM therapists are keen to dispel the ‘witch doctor’ image (Lupton, 2003, p. 137). Indeed, the professionalisation of CAM practice has generated some sort of stigma around healing, with a naturopath practising in a rural area noting:

[laugh]. No, spare me. If people want to identify with that image, that’s fantastic. I grew up in a conservative family and my brother in laws a doctor and I can’t imagine saying ‘I’m a healer’. I think it’s good, it’s a bizarre area, there’s a lot of research to do on it. (Naturopath, 9)

The professionalisation of CAM, and the move to university-qualified practitioners with specific knowledge, has caused some practitioners to feel stigmatised by the label of ‘healer’. For practitioners interviewed for this study, a subjective sense of self is strongly embedded in the role of health professional. Yet not one of the CAM users discussed the professional context for CAM practice as a basis of trust. Although CAM users made observations along the lines of ‘he/she knew what they were doing’; the word ‘professional’ was not mentioned at all, suggesting that trust is not necessarily constructed through professional legitimisation strategies.

A notable aspect of these accounts, also noted in another study on CAM healing (McClean & Shaw, 2005), is that the CAM user does not need to understand how these treatments work, rather the level of faith in the treatment efficacy becomes a belief over time, with Andy articulating a leap of faith that reiki cured his back injury. This faith does presuppose, according to Giddens (1995, p. 85), that the ‘real repository of trust is in the abstract system’ rather than in the individual representing the system. This point was raised above in this chapter, as there is certainly evidence to the contrary in the accounts of CAM users such as Andy, where the abstract CAM systems are very much in the background of practice, and even more so for the practitioner who is interactively isolated from his/her colleagues. While this point is discussed in the conclusion to this chapter, Section 6.5, it is important to this thesis to understand how in isolated practice contexts such as a sole practice, or in obscure practices, the practitioner fully represents the system, and in these contexts the practitioner has flexibility to interpret institutional knowledge idiosyncratically. This also invites a more relaxed and negotiated engagement with the therapeutic encounter, which in itself produces faith in the treatment.

6.4.2 The CAM practitioner as ‘Other’

CAM user accounts demonstrate uncertainties over CAM practice. Trust is not a given, rather it is based on the type of therapy and its knowledge, the practitioner skills and the mode of practice. CAM users use words like ‘weird’ and ‘strange’ when uncertain of a treatment, and
their confidence is waning. In this way, language is used to set a boundary around acceptable
CAM therapy. In CAM user accounts, the system of TCM contains the most contested set of
practices. We will see in Chapter Seven that the experience of pain in TCM and other forms of
acupuncture pushes the boundaries of users. CAM user accounts also show confidence in TCM,
and how this confidence is based on the longevity and traditionalism associated with TCM:

You get this feeling they have mysterious knowledge about something. ... Old Chinese
knowledge. It’s about the wisdom of the ages, the mystique of the Orient. That sort of
stuff. ... Like with Chinese it’s generational. Like I do think knowledge has to be passed
on from your family, your culture where you come from. ...It’s also been practiced a
really long time, thousands of years, you have to think a lot too, of people doing
something for thousands of years there’s a lot of information comes down form it. (Jan,
39 years)

Jan’s narrative shows confidence in ‘traditional’ practices and knowledge and based on its long
history and longevity, at least three other CAM users perceive TCM as legitimate. TCM is also
legitimised through its mystery and difference, combined with its history seen as conferring
wisdom. This discourse is a European representation of Orientalism (Said, 2003), and one
which constructs TCM and its practitioners as the ‘Other’. These perceptions are not exclusive
to TCM; wisdom is also related to other CAM practices, and there is a sense in which all CAM
practices are mysterious and different. Drawing on Giddens’ (1995) theory of disembedding
mechanisms in expert systems we can see TCM as representing a localised system of health
knowledge and practice, and this expert system is disembedded from its historical time and
location and re-embedded in the Australian health system. Trust in the abstract expert system of
TCM develops from an idea of TCM, so there is trust in the idea rather than the experience. Is
this really trust? As Luhmann (1979) observes, the antonym of mistrust is not necessarily trust.
CAM user accounts show how when confronted with the experience and reality of TCM, faith
shifts to mistrust. An example of this occurs in Corinne’s account in section 6.2.3, in which
Corinne had confidence in the traditional knowledge of the Chinese herbalist, but found him
difficult to communicate with. Corinne indicates that she really needs a connection and
identification with the practitioner, and lacked confidence in the Chinese medicine practitioner
who did not speak English and, correspondingly, did not understand her needs, and how due to
cultural and linguistic difference, a lack of confidence developed in the practitioner. Familiarity,
according to Luhmann (1979, p. 19), is a precondition for trust, and in accounts such as
Corinne’s, we see how the unfamiliar environment, being situated within a different cultural
discourse, can result in treatment cessation. This functional equivalence of trust (Luhmann,
1979, p. 71) relates to the incapacity of the practitioner to earn the trust of the client/patient. The
expectation of the client/patient was not fulfilled once treatment began; Corinne was alienated from the practitioner-client relationship which she exited. What emerges from this account is that trust in Oriental traditional knowledge is present when there is trust developed in the practitioner. For Jan, trust emerged in that the practitioner was very experienced, appearing to practise with ‘incredible confidence’. Similarly for Bonnie, her faith in a TCM practitioner was based on the impression he gave of being experienced in diagnosis:

*I had total faith in this guy because he was Chinese and you could walk in there and go ‘this is the problem’ and he would go ‘da da da da’. (Bonnie, 51 years)*

Bonnie’s faith in the efficacy of acupuncture was so great that she sought out an acupuncturist for helping her induce her first pregnancy, ‘because I knew they could bring on labour’. Bonnie’s lay knowledge of acupuncture had been acquired from her ongoing sessions with a TCM practitioner in Adelaide, whom she greatly trusted. A discourse of the ‘other’ is visible in the accounts of several female CAM users, whose trust in Oriental knowledge and practice derives from their perception of the inherent mystery and wisdom of the East. In later accounts, we will see that this trust is compromised when Chinese medicine practices conflict with the CAM user’s boundary of acceptable practice. Such boundary construction is evident in Corinne’s account where she found the language of the Chinese medicine practitioner alienating, and confronted the sense of familiar which underlies Luhmann’s concept of trust.

### 6.4.3 Being familiar with the CAM practitioner

This chapter has shown that trust is constituted in social interaction. It is a state of mind, an expectation that someone is non-harmful. Social trust occurs through holding similar beliefs and moral positions to other people, and is most strongly developed in social networks, where intentions, motives and beliefs are more congruent (Thiede, 2005, p. 1456). On the basis of these attributes, individuals assess each other for trustworthiness. This thesis has shown that the values held by CAM practitioners are congruent with those of CAM users, and this in itself mediates trust between the two groups.

Some CAM users, such as Jan, see this form of social trust as a necessary ingredient in the CAM client/practitioner interaction. Possibly due to the strong values alignment between regular CAM users and practitioners, CAM users in the study demonstrate greater trustworthiness in their CAM rather than biomedical practitioner. Recommendations to a CAM practitioner from a trusted friend or another practitioner are crucial for the development of interpersonal trust. For CAM users in the study, initial CAM use is generally prompted by the recommendation from a friend. A similar finding in a social science study (Biddle, Wilkinson, & Simpson, 2003) of CAM use supports this, with friends being found to be the most influential
source of recommendation to CAM. Not only are the majority of CAM users introduced to a specific practitioner through a friend or other personal relation whom they already trust, on commencing CAM use they continue to seek recommendations. This form of ‘network trust’ is identified in Lee-Treweek’s (2002, p.56) study of trust in the use of CAM, in which Lee-Treweek observed that patients circulate referrals to each other, and that social trust is formed by association. Saks (1998, p. 207) argues the desire for an intimate relationship between a CAM therapist and client/patient reflects the disintegration, in late modernity, of a personal relation between doctor and patient. This is seemingly corroborated by the female CAM users in my study, who show an overwhelming desire for intimate, negotiated communication with their practitioner, and one which extends into their personal sphere.

While my theoretical concern is how trust is negotiated between CAM and biomedical approaches, when CAM practitioners are seen as part of one’s social network, or become more central to the social life of the user, then this form of social capital influences the development of trust in CAM. As seen in the quote from Bonnie in section 6.3.2 the relationship between Bonnie and her homeopath, which has been built over a 10-year period, involves mutual respect for the other’s knowledge, and this inspires trust and confidence. As mirrored in other CAM user accounts, Bonnie’s homeopath also treats her children, this demonstrating another dimension of trust. The most important aspect of Bonnie’s account in 6.3.2 is the co-construction of a mutual understanding of her illness and the available treatment and one in which ‘we [my italics] went back and looked at the evidence’. As noted in 6.3.2 Bonnie comes to the homeopath with the research already done, and her beliefs are reinforced by the homeopath. Although it is Bonnie’s phenomenological work which places meaning in the information she has researched, it is still important to her to have affirmation from her homeopath.

For four CAM users namely Annie, Mads, Marcia and Isobel the initial exposure to CAM was made through the family of origin. Annie recalls that her mother attended ‘some sort of naturopath’. In Annie’s account, it is clear that her mother’s use of CAM influenced her personal use:

_"I can’t remember what she initially went for, I think she went for general health issues throughout the years. She wasn’t getting better and she tried everything, and there was someone, someone a big deal in it, he lived at [suburb name]. A big deal, interesting and alternative. I remember discussing it, but I also remember the commitment she had to make. All the vitamins and changing the diet. So I followed that path. (Annie, 43 years)"_
What this shows is that Annie’s experience of her mother’s CAM use formed part of her primary socialisation around healthcare, and influenced her attraction to a charismatic practitioner. References to charismatic and celebrity naturopaths have been made by other CAM users, and this again invites social trust in that these users feel part of a wider network of people using CAM.

It is not uncommon for CAM users to be on familiar terms with their CAM practitioner, and for some CAM users (e.g. Lucy, Bella, John, Fifi, Andy) the CAM practitioner has appropriated the role once occupied by a family doctor. Symbolically, there is an initial wariness between the client and practitioner as a level of familiarity develops on both sides. This even extends into the CAM users’ personal networks with two CAM users involving their CAM practitioner in social events, such as Lucy who observes of her naturopaths, ‘They’ve actually now become very good friends of our family, I can’t speak highly enough of her’. This form of familiarity with the practitioner is, according to Luhmann (1979, p. 20), at the basis of interpersonal trust. Through having a long-standing relationship with the practitioner, there is a continuity of time in which trust presupposes familiarity, and familiarity presupposes trust.

The final question of interest is the extent to which the practitioner develops trust in the client/patient. As seen in the account from Bonnie in 6.3.2, a practitioner can have confidence in the lay knowledge of a client/patient if that knowledge arises from professional information sources, and aligns with the practitioner’s own knowledge. A pertinent question for the study then is the extent that a CAM practitioner trusts in the lay beliefs and knowledge of the client/patient. CAM practitioners interviewed for the study did not demonstrate particular trust or confidence in the lay knowledge of a client/patient, seeing their role as more of an educator than co-learner:

> Through the years we have realised that it’s a matter of educating your client, and I really think it’s very important if they come here. It’s a lot to do with the approach, you always try to tell them why, and tell them what’s happening in the system - why they should follow a special diet, why they should change their lifestyle, that is how that works, that depicts that, that is why you have certain symptoms, you are changing that. It is guidance, it is education, if they are using the stuff it will help. They walk out of here and have an idea. Once they understand, they think ‘yes, I can make these changes and it makes a difference’. (Naturopath, 2)

It appears from this that trust is not as mutually constructed as the client/patient rhetoric suggests, at least not for the practitioners in the study who are a highly professionalised group. In summary, the findings suggest that network trust facilitates the initial use of a CAM
practitioner, and from there social trust may develop between a client/patient and their practitioner as the relationship becomes more entrenched. For the client/patient trust is further developed in a context of familiarity, with the CAM practitioner adopting the role once held by a family doctor. The formation of trust in circumstances of co-presence or facework commitment (Giddens, 1995, p. 80), evolves in a complex way, and in relation to the role that the practitioner represents to the client/patient. This section has shown these roles to be diverse, and construct the practitioner variously as healer, as friend and as ‘Other’.

6.5 Conclusion

CAM user accounts reflect lay beliefs based on experience, and secondary understandings of health and the body. These understandings derive from having values congruent with those of the practitioner, and this is essential for trust to develop between practitioner and client/patient. Literature also notes patient desire for therapeutic intervention which recognises individual agency, self-responsibility and individualised healing (Broom & Tovey, 2007). The findings in this chapter demonstrate how CAM users develop a relationship of trustworthiness with the CAM practitioner; this is based on an understanding that the practitioner validates their self-knowledge of the body, and explores individualised contexts for health. The trust is not necessarily mutual, however, and CAM practitioners are found to be less inclusive in some contexts than the user rhetoric suggests.

Through the interactive process of therapeutic emplotment, a CAM user incorporates the beliefs and knowledge of the practitioner, and is encouraged to incorporate strict regimens to facilitate wellness. This mirrors a modernist notion of individualism, self-responsibility and the belief in the power of the mind to facilitate bodily wellness. It is notoriously difficult to demonstrate empirically the derivation of lay knowledge. CAM user accounts demonstrate how knowledge circulates, and that there are linkages between knowledge formed in interaction with family and friends, in encounters with health professionals, through secondary information sources and from knowledge of self. Knowledge is also circulated through cultural narratives, as we can see through CAM user explanations for illness which include references to popular theories linking health and stress, health and balance. These explanations are also based on holistic health principles, so CAM users select from narratives and beliefs which support these explanatory frameworks, and this is found in the CAM encounter – support for one’s beliefs and values. This trust is then shown to exist if the individual practitioner is relatable, and the data in this study points to the development of trustworthiness as related to the individual practitioner, their style and personality, their perceived experience and skill, demonstrations of empathy, and so on. The practitioner it is argued here, is seen more as an individual working in a specific context
of practice rather than as a representative of an abstract, expert system. This phenomenon needs to be assessed against Giddens’ (1995, p. 85) proposition that:

At access points the facework commitments which tie lay actors into trust relations ordinarily involve displays of manifest trustworthiness and integrity…Although everyone is aware that the real repository of trust is in the abstract system, rather than the individuals who in specific contexts “represent” it, access points carry a reminder that it is flesh-and-blood people (who are potentially fallible) who are its operators. Facework commitments tend to be heavily dependent upon what might be called the demeanour of system representatives or operators…It is understood by all parties that reassurance is called for, and reassurance of a double sort: in the reliability of the specific individuals involved and in the (necessarily arcane) knowledge or skills to which the lay individual has no effective access.

CAM, however, is not an abstract expert system with which people need to engage; quite clearly it is a choice, and one which resonates with the values of CAM users. Arguably, CAM systems are less publicly ‘visible’ than biomedical systems; there is not the common knowledge and understanding of the symbols and claims of CAM disciplines as in conventional medicine. As such they come to the CAM encounter with less scepticism than is common in complex abstract systems like conventional medicine (Giddens, 1995). So CAM systems are more individuated, the knowledge and symbols variegated, and the regular CAM user exposed to these primarily through the work of the practitioner. While Giddens claims that trust in the reliability of people representing expert systems is important because lay people do not have access to knowledge and skills of expert systems, CAM users seem to find the knowledge and skill of CAM accessible if they want them, evidenced by the seven users who chose to engage in study of CAM. This aside, trustworthiness in CAM practitioners certainly exists, and the evidence presented in this chapter shows how CAM users over time develop faith in the knowledge and skills of the practitioner, and believes that the treatment decisions made, sometimes consensually, with a practitioner are tailored to their individual context. In fact, there is evidence from the practitioner side that this occurs less often than generally thought, this reflecting partly the professional orientation of practitioners, which results in less exercising of faith in the client/patient than the other way round.

The findings related to biomedical communication also need to be considered as a female phenomenon. Gender differences in health communication contexts are acknowledged in public health literature (e.g. Street, 2002). Females are said to favour an empathetic, negotiated style of communication, and feel they are listened to. For the male CAM users, communication with health practitioners was not as prescient. Lastly, trust also evolves from the meanings of CAM.
Oriental forms of CAM are constructed as the ‘Other’ and trusted on the basis of mystery, longevity and difference, with the CAM practitioner conceptualised variously as a healer, Goddess and friend. These symbolic representations of the CAM practitioner offer alternative subject positions, and this chapter has shown how trust is formed variously in relation to these subject positions. CAM is demarcated by the extent to which a practice such as chiropractic is perceived to incorporate practical, scientific practices, and this creates a different trusting relationship with those forms of CAM. Trust in CAM, it is speculated, also accrues from the expectation of derivative benefits from CAM, rather than trust in the curative effects of CAM. As a means of exploring this further, Chapter Seven addresses the development of trust in the bodily experience of CAM.
Chapter Seven

Trust in the Bodily Experience of CAM: Pain and Pleasure

7.1 Introduction

This chapter looks at the bodily experience of CAM, and how trust in CAM is mediated through the relationship to the body. A relationship to the body arises through the various subjective notions of self related to the body as a subject, as well as through experiencing well-being and pleasure and through instituting practices of self-care and self-discipline. Embodiment has increasingly been studied in relation to CAM use, and sees the body as central to human experience. According to embodiment theorists, our bodies are not simply objects we have, but instead we are our bodies, we experience the world through our bodies. Thus, we are not only considered objectively in reference to our bodies by others, but we are subjectively engaged with and through our bodies as well. We engage socially through them and with them, and we are socially responded to by others in regards to our bodies as well. For Merleau-Ponty (2002[1962], pp. 105-106) the body is not permanent, nor tangible in the way of being perceived as an object, but instead rather a sensory vehicle by which we communicate with and experience the world, in other words a subject perceived by others and experienced with. Experiences such as illness interrupt the natural synergy of mind and body and produce a ‘phenomenological disruption’ to subjective bodily experiences, and also affect the inter-subjectively constructed self (Howson, 2004, p. 37).

Sociologists of CAM have discussed well-being as an embodied concept (Baarts & Kryger Pedersen, 2009; Cartwright & Torr, 2005; Mark & Lyons, 2010; Sointu, 2006a) and the findings discussed in this chapter relate well-being to Sointu’s (2006a) definition as a holistic experience of health, with the mind, spirit and body in natural harmony. The embodied experience of CAM is also manifested through feeling peace and deep relaxation from CAM treatment, and from other sensual and pleasurable feelings. It also manifests in play and fun, including enjoying the interaction with a CAM practitioner. Embodied experiences of CAM are discussed alongside bodily experiences of CAM in general, including the experience of well-being. An argument advanced in this chapter is that well-being is a derivative benefit of CAM use, produced by bodily sensations such as increased energy and bodily functioning, relaxation and pleasure, and that CAM users demonstrate faith in the derivative benefits of CAM over its ability to cure.
7.2 Developing Boundaries around Complementary and Alternative Medicine Use

7.2.1 Derivative benefits

CAM user accounts reveal that regular users continue to use CAM even when it does not cure an illness. Instead CAM use is continued in response to derivative benefits such as feeling relaxed, and these benefits constitute an embodied experience of CAM. This phenomenon is supported in other social science studies of CAM (Baarts & Kryger Pedersen, 2009; Cartwright & Torr, 2005; Coulter & Willis, 2007). Such studies indicate that consumers/patients use different CAM therapies for differing experiences, and the accounts support this for users of mind-body therapies, bodywork and energy medicines whose users report more sensual, relaxing experiences than for the use of musculo-skeletal practices. CAM users are found to be less likely to continue a non-curative CAM treatment if there is a lack of rapport with the treatment practitioner, and if they do not derive derivative benefits.

Several users emphasise the short-term nature of treatment effects, particularly for acupuncture, herbal medicine and naturopathy:

> It didn’t actually change the problem. That’s what I find with a lot of them, that they help me in the short term but don’t get me further than that...but you know, I believe it makes a difference to me and I believe I’m a lot healthier, but I also believe that in some ways, you know, you have to do a lot of the work. My liver improved a lot after I lost a lot of weight and till then, no matter how much something would make me feel better, it just kept getting bad again until I actually bit the bullet and tried that. (Sharon, 57 years)

When a treatment is found to have temporary symptom relief, or is simply ineffective, a user adopts one of two strategies: they either continue using that treatment for its derivative benefits (e.g. Kate, Annie, Lucy, Sharon, Jan, Isobel), or voluntarily change to another CAM practice (e.g. John, Corinne).

This theme is recounted in at least three female user accounts of natural fertility treatment for reproductive health in which despite not getting pregnant, these women claim to have experienced benefits to the body and on an emotional level. Now a mother of two children, Lucy initially fell pregnant after having natural fertility treatment noting ‘it [naturopathy] didn’t help me to get pregnant and stay pregnant, but it helped me get a lot healthier’. Kate’s use of CAM for fertility began after surgical treatment for endometriosis (a condition which affects fertility in women) did not produce a pregnancy. She was subsequently recommended by a
friend to a ‘successful’ natural fertility specialist. Kate was put on to a strict regimen of acupuncture, Traditional Chinese medicines and daily boiled herbs for twelve months until, in her words, ‘I just couldn’t do it anymore’. Through ceasing the daily herbal treatment, Kate had developed a boundary around what she considered a tolerable use of CAM. CAM practitioners spoke about the long-term commitment required for CAM treatment; however, considerable tension is experienced between using a long-term therapy which is distasteful to the user, and continuing to use it for derivative health benefits.

Continued use of a treatment is more likely if the experience is intrinsically rewarding, such as in Annie’s need for a ‘positive’ experience of conception:

> It was important to me that the experience of trying to conceive was positive. When I went through the conventional channels I felt vulnerable, very teary, I felt out of control, I felt like the post had been closed and well, maybe they’d try and help me but they were just going through the motions. With CAM, the people were supportive, no question was too stupid. They were very positive, very honest. They included my partner in all of the treatment. The whole experience, even though it took 14 months, I felt good about it. Even if I didn’t conceive I was more reconciled. (Annie, 43 years)

For Annie, feeling good about the treatment process is clearly an important component of fertility health care. Annie’s account suggests also the tensions between using biomedical and CAM approaches for fertility management. Only after failed IVF attempts does she entrust the help of a CAM practitioner, and this practitioner supplies the emotional support not received in IVF treatment. Here Annie is rejecting the practices of scientific rationalisation which in assisted reproductive health care can be seen to render the female body as a scientific object (Howson, 2004, p. 46). For Annie, having support also means a belief in the possibility of pregnancy. With its focus on scientific reductionism, the expert knowledge of assisted reproductive technology renders a female body as an object of scientific scrutiny, and enforces a separation between the person and the female anatomy. Annie found this clinical gaze uncomfortable and, combined with the phenomenological disruption (Merleau-Ponty, 2002/1962) of treatment, led to confidence in the CAM approach. To this end Annie’s account supports Simmel’s (1950) understanding of confidence as faith in the unknown, and she was willing to try CAM approaches of which she had no real evidence of success. The tensions between using biomedical and CAM approaches are present throughout Annie’s overall account, and her decision to turn to natural fertility shows a confidence in the support from the practitioner. In summary, these accounts show that CAM has been ineffective for a number of illness and health conditions, especially those concerning hormonal, reproductive and gynaecological conditions. Of interest is that CAM users continue treatment for derivative
health benefits, and although they are regular and committed CAM users, the fact that none had ceased CAM based purely on ineffectiveness. It takes more than that for the committed, regular users in the study to cease CAM use, interestingly, it is when CAM treatments challenge the bodily toleration of pain that a boundary is exercised around CAM use. This process is further explored in the next section relating to pain in CAM treatment.

7.2.2 Experiencing pain

A subordinate theme from the accounts of nine CAM users is the experience and resistance to pain in CAM treatment. Over half the CAM users, the majority being female, had experienced some form of pain in CAM treatment, particularly in acupuncture and musculo-skeletal systems including chiropractic and osteopathy. For women, even the perception of pain in treatment such as acupuncture prevents its use. The articulation of such pain thresholds is seen as a socio-cultural construct, whereby individuals develop ‘pain beliefs’ (Bendelow, 1993, p. 273). Having a pain belief resonates with Illich’s (1995/1975 identification of four functional factors, all shaped by social processes, which ripen the experience of pain: ‘culture, anxiety, attention and interpretation’. According to Illich, even if a painful event also invites pleasure such as in sexual intercourse, or working out at the gym, then these contexts determine how pain is suffered. Other studies have noted the emergence of pain during CAM treatment (Baarts & Kryger Pedersen, 2009; Cartwright & Torr, 2005); however, they do not situate pain in a socio-cultural framework. This section outlines the embodied experience of pain in CAM treatment, and articulates the pain beliefs of users, and concludes with observations around CAM as a strategy for pain reduction.

Four CAM users (Kate, Corinne, Bonnie, Jan) found acupuncture to be effective, but ceased treatment due to the pain. Bella recalls the ‘torture’ of the acupuncture needles and having the practitioner apply a ‘machine on me and they made me black out with needles’. Cultural meanings of pain as avoidable are reflected in several female user accounts, with intense pain from acupuncture needles experienced by six users, such as Jan and Kate:

I almost feel the sicker I am the more they hurt. It only hurts for a minute...there could be a dull ache or something, and it’s not like pain... I hate it...I’m scared of the needles. (Kate, 40 years)

...the zing. It hurts when you move it’s a zinging thing. I didn’t want it to hurt so much, it hurts. (Jan, 39 years)

Pain for these women is embodied through bodily sensations and emotional response, and Kate’s account reveals a normative understanding of pain. Acupuncture needles do not elide
with this normal experience of pain, so the experience is unfamiliar to Kate. This relates to Luhmann’s (2000) theory of trust being developed in familiar contexts, and that changed contexts influence the development of trust. At a systems level, CAM practices are unfamiliar to a user such as Kate whose early exposure to health care is biomedical. When the already unfamiliar practice of acupuncture is performed, and there is pain involved, then the user has no reference point for understanding this pain, other than the practitioner. It is at this point then that trust in the use of CAM for derivative benefits is compromised. Other CAM users (Marcia, Bella, Fifi, Ben, Sharon, Corinne) report painful experiences in chiropractic and osteopathy, with Marcia finding osteopathy a ‘horrible’ painful experience to which she never returned. This contrasts with two users (Sharon, Isobel) who experienced pain relief through osteopathy.

The practitioner has an important role in facilitating trust in treatment. If the practitioner is not relatable to the user, then trust is renounced. Jan’s account reveals tensions between her lay belief and the expert knowledge of the practitioner, with her culturally framed belief in the avoidance of pain (Illich, 1995/1975) and the cultural belief of the Chinese medicine practitioner in the centrality of pain in health care:

Jan: ... He said some people like it better when it hurts a lot. The Chinese. He said the Chinese like it to hurt a lot.

Interviewer: Did that make you think ‘well, he hurts other people too. It’s should be OK’? What went through your mind?

Jan: I don’t care how good it is, I don’t want this pain. (Jan, 39 years)

For Jan the conflict over whether to continue painful treatment was resolved by seeking a second opinion. The second opinion supported her lay belief that pain is not essential to treatment, this pain belief based on a cultural expectation of pain minimisation from a practitioner. This sentiment is echoed by other CAM users such as Fifi and Ben, Ben perceiving as ‘incompetent’ a practitioner who inflicts pain. CAM practitioners interviewed for this study supported the avoidance of pain in treatment, and several strong criticisms were levelled at the biomedical response to pain including the over-prescription of pain relieving drugs. A male practitioner noted that a core part of his role as a bodyworker is attending to pain, and claimed that many of his clients have been wrongly diagnosed by doctors and put on medication that does not identify the real cause of pain. In a strong critique of TCM practice, a reflexologist made the following observation:

The other thing that worries me is these quick fix little centres at the shopping centres these little Chinese men, they don’t ask any questions, they go in there hammer and
tongs, fist and thumbs, they don’t know if people have surgical problems or diseases... you’ve got all these people who have nobody looking at what they’re doing at all. I went to one just to see how they went and he nearly killed me, I was in pain. And I said to all my clients, ‘please, don’t ever go to those places’. Absolutely dangerous. (Reflexologist, 10)

There are several narratives to arise from this practitioner’s account: firstly, that it is ‘dangerous’ for a body worker to inflict pain on a client; secondly, that prior to treatment the body-work practitioner needs to communicate with the client so as to treat the client in accordance with their overall health status. The practitioner also infers that bodywork should involve a degree of pampering and relaxation, as well as the minimisation of pain. For the practitioners, the biomedical response to pain management is related explicitly to health risk, as is unfamiliar practice of TCM massage. Positioned against the uncertainty of these health practices are confidence and certainty in their own treatment. Central to these constructions is Luhmann’s concept of trust developing from a familiar context. Jan was in unfamiliar territory with a practitioner whose own cultural narrative supports pain as essential to treatment efficacy. As with Kate, the unfamiliarity of pain in healthy treatment compromised Jan’s trust in the treatment and in the knowledge claims of the practitioner.

The concept of pain being inflicted in treatment is, for some users, incongruent with their concept of a CAM practitioner as healer. Another narrative concerns the healing function of CAM. Several participants regard a CAM practitioner who inflicts pain as ‘incompetent’, while others have constructed the notion of a ‘healer’ as someone who does not inflict pain. Consider Fifi’s and Marcia’s understandings of the healing function of CAM:

Fifi: I’ve been to a physio, osteopath in [name of location], he was awful OK. And he twisted my leg and back and hurt me quite a bit and trying to get it rid, he never did but in the attempt, you know, he just unsettled me so much that halfway home I just burst out in tears.

Interviewer: Were you able to tell him at the time?

Fifi: No! I never went back to him, he didn’t have what is needed. He wasn’t a healer. You see, to be a healer you have to have the connection with the person because you’ve got to help me get well, that’s your job. If you don’t want that then you shouldn’t be in the job, you know. (Fifi, 47 years)

I wonder if you can damage someone, mess and sometimes I get angry and think it’s not respecting traditional healing. (Marcia, 60 years)
The healer is constructed as someone who connects with you, and for whom to inflict pain is wrong. (Illich, 1995, p. 159) shows how historically:

The sudden emergence of the doctor as saviour and miracle worker was due not to the proven efficacy of new techniques but to the need for a magical ritual that would lend credibility to a pursuit at which a political revolution had failed.

The belief that a CAM ‘healer’ does not inflict pain mirrors a traditional notion of doctor as a ‘miracle worker’. Such a person is interested in nurturing and curing a patient, and not inflicting pain. In one sense CAM therapies occupy the position of healer that doctors once held. Indeed, research about ‘healers’ reinforces Fifi’s belief around healers. Barnum’s (1999, p. 221) study of healers and healing found that healing is concerned with the whole person, bringing a person into a relationship with themselves emotionally, spiritually and physically, as distinct from ‘curing’ the body. Aligning with the concept of derivative benefits of CAM, Barnum notes that healing is a broad term, encompassing both experiences of being cured and not cured. For Fifi the healer is also someone you have a connection with, and by inflicting pain her faith in treatment is compromised.

Three users (Corinne, Mads, Isobel) discussed CAM as part of a strategy to assist with physiological pain from illness, in which CAM is part of a restitution narrative. In this narrative CAM restores them from illness-related pain to a familiar, pain-free existence (Frank, 2004, p. 210). The familiar emerges again as a site for developing trust, with trust in CAM associated with it producing a natural, and familiar state of wellness. Isobel’s account shows how she found the osteopathic technique of cranial sacral5 to be efficacious for pain in chronic illness:

Isobel: The naturopathy helped, it kind of supported me but I didn’t necessarily feel like I was cured. I had work done by an osteopath and had work done by an acupuncturist on my back. The osteopath did a lot of cranial sacral which helped a great deal.

Interviewer: In what way?

Isobel: Kind of had a little bit of back pain at the same time, and just made me feel like the energy was flowing a lot better. Didn’t feel so bogged down and depressed about it, a bit more uplifting ...yeah. (Isobel, 27 years)

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5 Cranial sacral technique is one of the older techniques used in osteopathy, massage and chiropractic. It involves the practitioner placing their hands on a patient, and attuning to the ‘cranio sacral rhythm’.
Isobel reveals that the osteopathic work promoted energy flow; from this she experienced derivative benefits and it was also effective. A different pain belief emerges from Amy’s account, in which her commitment to natural health prevails, and she chooses to endure pain:

> Oh, there were times of pain, sure. But I’d prefer to handle the pain than have that stuff put in my body. I feel sick after that, I react to that, often I don’t want it, I just don’t want it. I had a little abscess taken out on my tooth years ago ... my sub-conscious was too strong it wouldn’t allow me to open my mouth for the needle ...to give me nitrous oxide so I could relax. ... I just don’t want needles, so I had the mercury taken out of my head. I feel heaps better for it, heaps better. I can think clearly. (Amy, 48 years)

With reference to trust, Amy’s account reveals a marked distrust in biomedicine. For her there is a profound health risk involved in having biomedical treatment involving implants and fillings, with biomedicine as health risk.

A final observation on pain is that the meanings of pain from the CAM users differ markedly to those reported in the literature; specifically Bendelow’s (1995) North London study of health centre clients found that participants held beliefs that pain is natural for women due to childbirth, and men were socialised into seeing pain as abnormal. This view of the gendered experience of pain is echoed by an acupuncturist and herbalist interviewed for the study. As explanation for having females comprising over 90 per cent of clients, the practitioner observed that ‘men don’t like needles’ and explained that:

> Women have a better pain tolerance, they can see the end result, and they get monthly periods so there’s been an element of pain, fellas haven’t had that experience. (Acupuncturist and Herbalist, 4)

The point of difference may lie in social location, with Bendelow’s (1995) clients representing a largely working class population, whereas my participants are largely middle class, health aware, reflexive health consumers/patients, and may hold a different set of assumptions about the avoidance of pain.

In summary, CAM users cease treatment when pain is experienced and even when they are experiencing positive outcomes. In fact, CAM users are more likely to tolerate pain in biomedical treatment than in CAM. The experience of CAM for derivative benefits means that CAM users do not see CAM as a necessity, and that different boundaries of treatment tolerance exist between CAM and biomedicine. Pain is generally viewed in relation to pleasure, with Aristotle (384-322 BC) locating both in a moral narrative about human actions (Bendelow, 1993, p. 276). The next section shows how CAM is experienced as pleasure.
7.3 Experiencing Complementary and Alternative Medicine as Pleasure

CAM user accounts reveal that for users of some treatments, decisions about CAM use are embodied in experiences of fun, relaxation, energy and peace. Serenity and tranquillity sought through CAM are theorised to be constituted in well-being (Sointu, 2006b). This section explores narratives of enjoyment through CAM, in which users enjoy CAM as play, and as a relaxing and calming experience which induces flow and well-being. Spiritual embodiment is also discussed in this section, this involving a holistically embodied experience of attaining peace and heightened relaxation through what are perceived as spiritually-based CAM practices such as reiki.

7.3.1 Experiencing enjoyment in CAM

A theme of play is evident in some user accounts, with CAM representing an enjoyable experience. Jan, for example, consulted with a psychic healer and did not expect any clinical health outcomes from the experience, yet she found the experience to be mysterious and fun. Bella found that iridology, which she received through a naturopath, was both ‘weird’ and ‘fun’; she also found it efficacious for diagnosing illness.

Some users are drawn to the enjoyable and inviting physical atmosphere of the practitioner. Bella found in aura therapy, for instance, that the sensory experience of having ‘little bottles, beautiful perfumes’ contributed to her enjoyment of this therapy. Enjoyment is also experienced in interaction with a practitioner. Bonnie describes her homeopathic encounters as ‘fun’, describing the encounters as involving a relaxed, conversational style of communication. For Bonnie the consultation is like meeting a friend; there is sociability involved which is enjoyable, and she compares ‘notes’ with her homeopath. This suggests the enjoyment is located in a perception of equality with the practitioner, of being taken seriously, and this differs from the authoritative model found commonly in biomedicine. Mads also enjoys her naturopathic sessions, and the opportunity to discuss a wide variety of topics covering ‘anything and everything’.

A theme of relaxation is evident in accounts by several users (e.g. Sharon, Fifi, Corinne, Andy). Sharon has found meditation and reiki relaxing, reducing feelings of stress and anxiety. Reiki in particular is found to soothe the muscles:

Find it very relaxing and if they’ve got something that involves, if they’ve put something out and all the muscles are bunched up, it’ll relax the muscles. (Sharon, 58 years)

Fifi describes reiki as ‘most peaceful, almost go to sleep’, while Andy notes that giving reiki to other people is simultaneously exhausting and invigorating:
The way I see it is you receive it from the universe and then you give it out. It comes in much, much stronger than what I’m giving out so I’m buzzing sometimes so, OK, cool. (Andy, 36 years)

Corinne also finds consultation with a Bowen therapist as ‘calming…you feel more relaxed’. The sense of surrealism is articulated in Annie’s account who compares her experience of acupuncture treatment to being on an ‘an acid trip’:

I was very conscious, laying on the table having had acupuncture. I would just describe what was going on in my mind to her and some amazing things occurred. I don’t know whether or not it was imagination. I don’t know. Whether it was tapping into a world I don’t understand, I don’t know. (Annie, 43 years)

Annie’s experience offers a form of happiness, which occurs through bracketing out other stimuli and focusing on the experience at hand. Others users also recall experiencing surreal sensations through CAM, the associated mystery of which is enforced through the recurrent use of terms such as ‘weird’ which creates a sense of detachment from the practice, and differentiates it from the user’s everyday experience. References to ‘weird’ CAM treatment also signifies disengagement between the way the therapy works, and the outcomes of its application. In other words, CAM users simply do not need to know how it works, and trust relates to faith that it works to produce derivative benefits, and that it will feel good and not harm. It also imposes a sense of normality on the user; one can experience a ‘weird’ CAM treatment without compromising a ‘normal’ self-identity.

The use of herbal remedies to ‘de-stress’ is articulated in several accounts. Using CAM medicines and herbs to de-stress may also, as suggested in Nichter and Thompson’s (2006) study of CAM medicine use, be used as a strategy for harm reduction and to minimise perceived health risks. Health beliefs around stress proliferate in the CAM user accounts, and are echoed by the CAM practitioners. Lucy also finds the naturopath appointments to be relaxing, or at least the practitioner to have a ‘relaxed’ style which comforts her. These accounts show trust developing through having faith in the knowledge of the CAM practitioner. For these users a ‘cure’ is not expected, rather enjoyment of the experience. In the following extract, Lucy explains that hypnotherapy and naturopathic treatments have been very calming and relaxing:

Yeah, with what she’s had me on its helped calm down the stress levels and I also do hypnotherapy which worked really well. There’s a lot to be said for hypnotherapy and listening to positive style music, not music, talking and what have you, it’s very very effective…. Yeah, you get put in a different place. You’re there, but every time I went under, apparently I went under very very well. So every time I went under, I came out of
it and would not know half of it, but she would always comment as to how well I did. And I would always walk out on a natural high. I found that very very effective, but I don’t do that anymore, now I maintain through naturopathy. A balance through the medication she prescribes to keep me on an even keel. (Lucy, 33 years)

Lucy explains further in her account that CAM treatments have not cured her alcoholism; however, she enjoys the experiences and as shown above can ‘walk out on a natural high’. This sort of focused engagement produces the experience of flow, which results from being immersed in a fulfilling activity and experiencing happiness and a lessening of anxiety (Csikszentmihalyi, 1975).

This suggests that the experience of deep relaxation through CAM treatment, which can produce flow, are related to health benefits. Health benefits are about improved long-term functioning of the body, and about feeling good, rather than having immediate clinical cure and outcome. This mirrors Sointu’s (2006a, 2006b) theoretical understanding of well-being as available to anyone, even terminally ill people. The experience of relaxation and peace are also related to the spiritual experience of CAM.

7.3.2 Spirituality

Spirituality was a dominant theme in four CAM user accounts (Andy, Fifi, Ben, Amy) and as shown in the following extract from the interview with Amy, spirituality is for these users about metaphysical beliefs and experiences rather than organised religion:

*I don’t believe in Christianity, I don’t believe human beings are all born sinners, I just don’t believe that it’s possible. I believe we are all divine beings and do what we can to improve that divinity.* (Amy, 49 years)

Although not all CAM users are wedded to spirituality, a majority of CAM users (Ben, Fifi, Annie, Amy, Andy, Marcia, Jan) do articulate a holistic narrative which represents a *spiritual embodiment*, in which the body, mind and spirit are interconnected manifestations of wholeness, and the spiritual world is experienced through a physical self (Burkhardt & Nagai-Jacobson, 2002, p. 117).

Several narratives wed health and spiritual beliefs of the user. Two users refer to the notion of *universal consciousness* (Andy, Fifi), which is the connection with a greater force. Andy, for example, through the mindfulness technique of meditation feels at one with the universe. This faith in the universal consciousness is for Andy a core reason for his quick recovery from surgery. Andy’s lay beliefs are expressed further in this extract:
...every treatment for me is saying a little payer on the massage table or whatever, so I say I accept this healing or all of it and it just sort of happens. (Andy, 35 years)

Fifi needs to be actively working with the universal conscience to facilitate healing, and explains here how reiki expedites that process:

That’s what reiki did, and looking back ... it is actually spiritual, OK because even though it’s pretty uncanny things that happen in my life and someone probably might say it’s your psychic or whatever, it’s more you’re working now with the universe. (Fifi, 47 years)

The feeling of peace arising from meditation, reiki and other mind-body practices produces a form of well-being for these CAM users which manifests in inner harmony and peace, and which extends well beyond a focus on health outcomes (Sointu 2006a, 2006b). The articulation of a ‘universal consciousness’ also represents Ho’s (2008) concept of spiritual talk, which produces a spiritual discourse, understanding and solidarity between users and practitioners of these modalities. For Ho this also underscores a wider holistic critique of evidence-based medicine, and when seen through the lens of trust, their collective faith and spiritual embodiment overrides other health-related perspectives.

As with the resistance to pain, the CAM practitioner as ‘healer’ is also discussed, and in two accounts the metaphor functions symbolically to connect Jesus and healing in CAM:

Interviewer: So who came to treat you?

Andy: Friends. A very good friend at the time gave me the reiki, and of course my own belief system, that helped.

Interviewer: Tell me more about that.

Andy: I believe in spiritualism so I accept all traditional beliefs and religious beliefs, but I don’t accept or believe what the church has to say about stuff. I believe in Christ consciousness.

Interviewer: What does that mean?

Andy: I believe that a man called Jesus came to this earth and through his belief system of the greater power was able to heal people and was able to practice miracles which assisted people in their way. And I believe in his teachings which are love for one
another and we need to love ourselves and accept ourselves and therefore we connect with every living human being and thing on this planet. (Andy, 36 years)

Andy’s account suggests a metaphorical link between reiki, the energetic work of touch, with the healing power of Jesus. Andy associates the teachings of Jesus with self-love, and learning to heal the body. Spiritual beliefs in the power of medicine to heal have long been associated with a placebo effect, with literature suggesting that it is placebo which causes derivative benefits from CAM, especially those related to spiritual effects (Galanter, 2005, p. 56). Andy uses reiki to connect spiritually with other people, articulating a belief that healing occurs through spiritual beliefs. The concept of the healer as inherently spiritual can be linked to the indigenous notion of the ‘faith healer’ as someone in whom you trust to locate the spiritual origins of illness (Baer, Singer, & Susser, 1997). The manifestation of a universal consciousness as expressed through reiki sees healing occurring from opening up the consciousness to healing, and this can be linked to Durkheim’s (1965/1915) concept of the collective conscience. Whether healing occurs through placebo associated with beliefs is not of interest to this thesis; our interest is more in how the collectively linked consciousness of those engaged in spiritually-based practices such as reiki or Makahari help to construct trust in CAM.

Taking up Luhmann’s (2000) proposition of trust being developed in familiar contexts, the spiritual contexts of these forms of CAM engage with familiar practices of group dynamics, so even though the esoteric knowledge claims of these practices may be unfamiliar, the group dynamic is more familiar to users. In other words, the CAM users have faith in the power of the group conscience, and this constructs trust in that treatment. Also relating to Giddens’ (1995) notion of the access point of expert systems, it can be argued that for these users spiritually-based practices such as reiki and Makahari constitute expert systems, and the practitioners, and in some cases, the group are the access points. Such systems have constructed boundaries around their expert knowledge, this knowledge being available to practitioners. (It is worth noting here that two CAM users have become reiki practitioners.) Unlike biomedical systems, these systems do not have an inherent authoritarian power relationship with the client/patient, rather the group and the collective conscience represent an egalitarian approach to healing. Within Giddens’ framework of trust in modernity, the group forms the access point of trust.

Although there is a sense of fatalism in the spiritually embodied accounts of CAM users, spiritual techniques are employed to gain control over their mind and body, to channel thoughts into bodily mastery and control. This strategising is supported by Baarts and Kryger Pedersen’s (2009) study of derivative benefits and well-being in CAM use. Additional to this is the experience of happiness associated with these practices, which results from the playful experience of flow, and flow produced as a means to control bodily stress and anxiety.
Another form of flow is that of energy, which is believed by some CAM users and practitioners to be represented through a life force in the body. Four CAM users speak about the energy and light arising from CAM approaches such as kenogetics and reiki; Annie received energy when she connected with others, while for Andy energy is the physical manifestation of the embodied spirit, and physically stiff people lack energy. The next section considers the experience of energy flow in more detail.

### 7.3.4 Experiencing energy flow

In holistic health discourse the body contains an energetic life force. CAM practices such as those engaged in by bodyworkers, TCM providers and energy workers, all seek to replenish the life force of an ill person’s body through energy flow (Fulder, 2005). Metaphors of energy flow are articulated in several accounts (e.g. Fifi, John, Andy, Isobel, Sharon, Bonnie) of TCM, energy medicine and reiki use, modalities in which energy is a central organising principle. Mirroring the knowledge of practitioners, a prominent lay belief is that energy flow provides for optimal health:

> There’s all this scientific data supporting the notion that your body is made up of electrical messages sent through liquids anyway, so we know that is the reason acupuncture actually works. (Bonnie, 51 years)

Bonnie’s account shows a particular narrative of the body which is not dissimilar to the allopathic construct of the body comprised of atomised, separate entities. Bonnie’s trust in the knowledge claims of acupuncture represents a leap of faith in that she has not empirically tested the concept of electrical messages, but accepts the holistic knowledge. This particular form of holistic knowledge is known as vitalism, which sees the body and health sustained by a life force (Coulter, 2004, p. 113; Hirschkorn, 2006, p. 545). The energy metaphor is central to some forms of CAM such as TCM, homeopathy and energetic practices such as kenogetics. The following explanation of energy as a rational process was conveyed to me by a Sydney-based homeopath:

> And it’s sooner or later than quantum physics will explain it completely, it’s an energistic medicine. You know, we all agree that if you use Kurleon photography you can see the energy around you, if we can see from Kurleon energy when somebody’s going to get sick, can also see when they already are sick. The ...leading up to when they are sick is also apparent before a symptom appears, it’s all bits of evidence than accumulate and assimilate. Somebody will come up with and say ‘this is how it works, this is how it works with the strength of the energies’...as it was, when I was in training we were learning about susceptibility. (Homeopath, 5)
The homeopath does not sacrifice the central homeopathic principle of vitalism in order to gain legitimacy. She does, however, situate vitalism in a biomedical, evidence-based narrative, with references to scientific concepts such as ‘genetic markers’. Suffice to say that these conceptual tensions between homeopathy and biomedicine have been noted in other studies of homeopathy (Frank, 2002a). However, and as has been observed in other studies (Canaway, 2007), vitalism is barely referenced by the CAM practitioners I interviewed, and energy when it is discussed, appears to have a minor role in holistic health discourse.

CAM users are more forthcoming in their energy beliefs, the most prominent connecting energy with illness (Andy, Fifi, John, Bonnie, Annie). For Andy energy is embodied in a person’s soul and aura, and this is manifested in bodily well-being. Having blockage to energy flow is a prominent explanation for illness, and was cited by four users (Fifi, John, Isobel, Andy). This blockage is suggested in the following extract from the interview with Fifi:

*If you could liken it at, at the beginning, I was actually full of negative energies myself with an ego like you wouldn’t believe and so sickness was the only avenue there completely, so it happened.* (Fifi, 47 years)

CAM users draw also on metaphors of the body as ‘system’ (John, Isobel). John explains that Tai Chi unblocks the system through channelling energy. Other mechanical metaphors of the body such as ‘unblock’, ‘system’, ‘shutting down’, ‘quick start’ are used in explanations of health and illness. These metaphors position the body as a compost, a vehicle for recycling. Other metaphors are apparent in explanations of energy flow, e.g. in Fifi’s account of Makahari:

*Makahari is, um, it’s not a religion, I’m not quite sure how to describe what Makahari is, it’s just a group of people who get together and it’s Japanese, and it’s all about the light of the universe and the light of God and using that light to heal. It’s a purification thing and with it comes attitude as well.* (Fifi, 47 years)

Here Fifi’s metaphor of purification suggests self-renewal or rebirth. Such metaphors of energy derive from the principle of vitalism, which as already noted is a less prominent narrative in accounts of the CAM practitioners. The metaphor of energy flow is linked also to spirituality and health, and is part of a wider holistic health inquiry. The embodied experience connects the body and metaphysical aspects of self. In summary, energy flow is an embodied experience offering pleasure and relaxation, and a renewed self-identity.
7.4 Conclusion

The findings reported in this section demonstrate that CAM is used for its derivative benefits. The exploration of derivative benefits leads to an interesting observation, namely, the fact that CAM does not always work is less relevant than its derivative benefits. People such as Annie are happy to have a ‘positive’ experience of health care that feels good, and that validates her self-knowledge of body. This is more important than a successful outcome, or at least users are reconciled to the outcome. The derivative benefits include feelings of peace and relaxation, and provide for an embodied experience of CAM. CAM is also part of a ‘healing’ process, facilitating emotional and physical well-being. This is especially so for a small handful of users desiring a spiritually embodied experience. These benefits are based in holistic health beliefs such as energy flow. The findings reported in this section also point to the use of CAM for pleasure, and related feelings of peace, flow, relaxation and fun. There is also strong evidence of CAM users exercising boundaries around CAM treatment, with a number of CAM users in this sample showing intolerance to treatment-based pain.

The research questions posed in the study seek to understand how CAM users establish boundaries of use, and how CAM is assessed as worthwhile. The argument arises that CAM users, specifically females develop firm boundaries around tolerable levels of CAM use, and that these boundaries reflect the use of CAM as leisure. When pain is experienced in CAM treatment such as acupuncture, the CAM user feel they have a choice to continue or cease with the treatment. In a popular modality such as acupuncture, it is clear that many users will continue with treatment despite the pain, however what is suggested in the analysis of regular CAM user accounts is that when CAM is not sought for a specific cure, and when the outcomes are more generalised to well-being, that CAM users more readily exercise a choice to cease painful treatment. This also lends support to a thesis that CAM use is, in some contexts and for some users, a leisureed experience. CAM users have been shown in this chapter to seek more pleasurable bodily experiences such as relaxation. Themes of relaxation and pleasure are identified in other social science studies of CAM (Baarts & Kryger Pedersen, 2009; Bishop, Yardley, & Lewith, 2008; Cartwright & Torr, 2005) with Bishop et al. 2008) classifying the experience ‘therapy as treat’. The trust in CAM treatments used for pleasure and derivative benefits is built around leaps of faith, both in confidence in the practitioner and their knowledge, and faith in the health properties of a treatment.

When CAM users view CAM as a spiritual experience, then faith represents belief in a universal consciousness, and this consciousness pre-empts natural healing. Of course, this is a discourse which is supported in more esoteric, and often energetic CAM therapies such as reiki, and is restated most fervently, though not exclusively by those CAM users engaged in CAM study.
The most dominant spiritual narrative equates spirituality with light and energy, with energy seen as a physical manifestation of the embodied spirit. Energy is also seen as representing optimal health and vitality. Such meanings suggest faith in the healing properties of CAM and its practitioner, and also faith in the safety of CAM. Two users extend these understandings to a symbolic connection with Jesus and healing. This connection represents an ultimate leap of faith, with Jesus a symbolic mediator between the CAM practitioner and the treatment itself. Neither of these users revealed a need to understand how reiki treatment works from a scientific perspective, rather they had their own developed beliefs and understandings of reiki as a powerful mechanism for spiritual embodiment. Spiritual and other bodily techniques are employed to gain control over the mind and body, to channel thoughts into bodily mastery and control. This strategising is supported by Baarts and Kryger Pedersen’s (2009) study of derivative benefits and well-being in CAM use. Additional to this is the experience of happiness associated with these practices, which results from the playful experience of flow, and flow produced as a means to control bodily stress and anxiety (Csikszentmihalyi, 1975). Another form of flow is that of energy, which is believed by some CAM users and practitioners to be represented through a life force in the body.

Barcan (2011, p. 4) is one of the few researchers who situate CAM use within the ‘hedonistic, pleasure-seeking drive of consumer culture’, arguing that regular CAM use can generate new forms of perception, experience and thinking. The argument I propose is that the leisured experience of CAM supports a new form of experience and understanding. Leisure is defined broadly as non-work activity undertaken in relative freedom, and in addition to its activity and free time bases, leisure also has an attitudinal basis in which people experience a feeling of intrinsic motivation and a sense of perceived freedom (Lynch & Veal, 2006, p. 27). The form of trust constructed in relation to this use of CAM differs from that required for CAM use as a curative. A further argument is examined in a broader context for some CAM practices, that there are conceptual and empirical connections not only with health, but also with leisure, play and in particular physical forms of leisure. The embodied experience of these regular users of CAM is argued to be a leisured, rather than a health experience.
Chapter Eight
Conclusion

This chapter begins by reviewing the aim of the study, and the development of the research questions, then moves into discussion of the conclusions from the study and how these support social theory. The contribution of the study to a more nuanced understanding of complementary and alternative medicine (CAM) is discussed as is the contribution of the thesis to the sociology on trust in contexts of health care. The limitations of the research design are also canvassed and recommendations made for further research. This chapter includes personal reflection on the issues raised in the study, concluding with a discussion of the significance of the study for health sociology.

The thesis has made several important contributions to sociological knowledge of processes of trust in the use of CAM. As stated at the outset of the thesis, there is a meager number of studies of trust in CAM in the social science literature, and the majority of these do not theorise trust from a sociological perspective. My interest in the area of trust was stimulated by personal experiences of CAM use. When I developed the original research question, my interest was in why people use CAM. After reviewing several studies in particular the work of Meyer and Ward et al. (2008) in which Giddens and Luhmann are used to theorise trust in biomedical contexts, I discerned a case for analyzing the theories of Giddens and Luhmann in relation to trust in the decision to use CAM. Both theorists consider trust as a sociological phenomenon, meaning they relate trust in interpersonal contexts to the wider institutional contexts of abstract expert systems. As such the thesis is not just significant for its contribution to the sociological literature on CAM, but also in the engagement with a sociological conception of trust. Trust has been shown in this thesis to be mediated through processes of personal agency, through making meaning about medical and CAM knowledge, which is used in encounters with the representatives of those systems, and through experimentation with CAM and biomedicines. Trust is based also in the knowledge of expert systems of CAM and biomedicine, and this knowledge is circulated through CAM user accounts in their lay explanations of health and illness.

The scope of the study has explored the experiences and understandings of treatment decision making from the perspective of a group of 16 relatively committed and regular users of CAM. Preliminary reviews of the literature clearly demonstrate that CAM users are differentiated by their relationship and engagement with CAM, that regular users differ in their beliefs and motivations for use, and that their illness episodes are more profuse than non-CAM users. They are also shown to be intensive users of health services overall, utilising biomedical as well as
CAM approaches. For this reason, and as befitting the interpretative and qualitative methodology, I decided at the outset to focus on the experiences and understandings of this relatively homogenous group of CAM users. My study group is largely representative of the ‘typical’ CAM user portrayed in social science studies of CAM, being female, middle aged, professionally employed, and as likely to live in an urban metropolitan area as a regional rural area.

My personal observation of the CAM users and practitioners interviewed for the study is that, as well as representing the demographic profile of an ‘average’ CAM user, they typify the reflexive consumer of late modernity. Much has been written about reflexivity and its importance to social processes of late modernity (see Giddens, 1991; 1995), these processes include challenging scientific and technological knowledge claims, and this challenge linked to the high levels of health literacy characteristic of well educated people. While studies have often seen CAM use as representing an outright rejection of biomedical authority, the findings presented in this thesis support alternative theories (see Broom 2009a; 2009b) that CAM users are pluralistic and discerning in their use of practices inherent to both biomedical and CAM expert systems, that they use CAM and biomedicine in an ad hoc fashion, with one or other preference from particular conditions and procedures. To this end, I concur with Bauman’s (2007) theorisation of the ‘pointillist’ use of time, in which the modern consumer is discontinuous and idiosyncratic in their health consumption patterns.

The consumerist ethos is also apparent in the high number of users discussing their self-experimentation with CAM and biomedicines. CAM users are reflexive and consumerist in their approach to health care, and the sophistication of their explanatory frameworks for health and illness suggest they spend dedicated time and reflection to researching their treatment options. Trust is also a reflection of the social location of these users, who are middle class, reflexive consumers, with high expectations of self-controlling their health maintenance. The findings show that this group of CAM users believe that regular use of CAM will, over time, provide for sustained good health, or at least will insulate them from more illness episodes. This belief is not unique to this group of people; however the CAM user constructs this as a unique and individual attribute of self-control and discipline.

Commensurate with the reflexive nature of lay people in late modernity has been sociological interest in the decline of medical dominance, and in the professional authority of doctors. Doctors now face challenges to their political, economic and cultural influence (Cook, p 12), and these structural changes have seen the emergence of more patient participation in biomedical encounters with the rhetoric of the fully informed patient now commonplace. The
point of this is that biomedical authority has waned, and this has simultaneously influenced and been influenced by public representations and perceptions of medical and scientific knowledge. Models of shared decision-making are supported, though as shown in this study not necessarily realised, in the construction of patient empowerment.

CAM practitioners interviewed for this study strongly support professionalisation processes which are seen to legitimate their practice as a viable health care option. Legitimacy is being pursued through credentialing, professional associations, and self-regulation of practice. The practitioners interviewed for this study represent a highly professionalised group, they value credentials and qualifications, many hold university degrees or diplomas in natural therapies, health and science, and as such they value credentials, and their perspectives reflect a middle class social location. They also support working collaboratively with biomedical professionals, and some are doing this through referral networks, however they are wary of being subverted by the dominant medical system, and they unanimously reject the idea of CAM having to adopt the scientific testing principles of evidence based medicine (EBM) for demonstrating the effectiveness and efficacy of CAM treatment. Ironically, studies show that many doctors are also resistant to EBM, and in this sense are in sync with the reliance of CAM practitioners on clinical, anecdotal evidence. Having worked myself in a bureaucratic government health institution which supported EBM, I see the critique of CAM most strongly articulated amongst pharmacists, medical specialists and professional medical associations, and this critique is based on concerns for consumer safety. For the regular CAM users in this study however, there is evidence of scepticism toward scientific testing methods and a wariness of statistical data. CAM practitioners show slightly more acceptance of scientific processes and information, although they are as equally vociferous in their support of non-scientific testing methods for CAM as are regular CAM users. This produces a tension with the desire of CAM practitioners and CAM groups overall to legitimate their practice, and be accepted by the mainstream medical community, but to retain their practice and innate knowledge.

For CAM systems such as homeopathy whose practices have been scorned and vilified in the public domain, achieving widespread public acceptance and professional legitimacy is a tall order. The CAM users in my study constructed health risk through a different lens. This is not to say there is no general public perception of homeopathic risk; studies in the UK for example have shown a marked reduction in the use of homeopathy in the last ten years, but that these perceptions did not emerge from the accounts of the 16 regular CAM users. Several accounts were in fact quite defensive, appropriating the role of CAM advocate in some cases; more importantly almost half the CAM users in the study had taken up study or practice in one form of CAM. From a sociological perspective these users have straddled a boundary from
client/patient to practitioner. It is at this juncture between client/patient and practitioner, that the concept of lay expertise becomes most salient. This is an important point; however there is limited social theory to frame this phenomenon. A possible theory is Gidden’s (1995, p.144) notion of ‘re-skilling’, whereby:

technical expertise is continuously re-appropriated by lay agents as part of their routine dealings with abstract systems. No one can become an expert, in the sense of the possession either of full expert knowledge or of the appropriate formal credentials, in more than a few small sectors of the immensely complicated knowledge systems which now exists. Yet no one can interact with abstract systems without mastering some of the rudiments of the principle upon which they are based.

Of the CAM users interviewed for this study, a sizeable number have appropriated CAM expertise though studying to be a CAM practitioner and, in this process, re-skilling. This is not only made possible through the ease with which one can study some forms of CAM such as reiki, it also reinforces the trust of these users in the abstract systems of CAM. They become advocates for CAM as they engage in a re-skilling process, and risk becomes more associated with the biomedical ‘drug’ culture, which becomes constructed for these users as the toxic ‘other’.

An important conception of trust relates to Luhmann’s (1979, p.73) concept of ‘thresholds’. Thresholds are constituted in the distribution over time of familiarity, trust and distrust, and the establishing of a threshold develops from boundary construction. CAM users in the study are shown to construct boundaries around their biomedicine and CAM use, their construction of acceptable practice in biomedicine is based in experiences of medical negligence, and adverse effects of biomedical treatments including iatrogenic illness. This boundary is clearly demarcated, and supports Luhmann’s (1979) assertion that trust in the system is necessary for interpersonal trust. In both CAM and biomedical approaches, lay people rely on diffuse trust in expert knowledge, which assumes our expert systems have built in controls. Either way, there is little choice but to trust that these controls exist. The CAM users found that the orthodox medical ‘system’ let them down, and their experience of negligence compromised their boundary, and led to profound and immediate distrust. So the institutional trust which did exist was compromised by representatives of the system, which supports Giddens (1995) conception of trust in abstract systems. This makes coherent and rational sense, however it is harder to apply the same logic to the mediation of trust in CAM.

Boundaries are also constructed around the use of CAM. As shown in Chapter Seven the
experience of pain in acupuncture and musculo-skeletal treatments caused CAM users, particularly females, to cease treatment. A boundary was constructed, or enforced, that pain is unacceptable in treatment. In Chapter Seven it was argued that this reflects a Western cultural narrative of pain avoidance (Illich, 1995[1975]), whereby pain is an embodied experience involving powerful emotions, and this boundary did not always elide with that of the CAM practitioner. At this point then, as with negligence in biomedicine, the representative of the expert system has instigated their distrust. Not only does this show there are certain points at which CAM is not trusted, using Giddens’ and Luhmann’s respective theorisations of trust in expert systems, this suggests CAM users have some measure of trust in the expert system and its knowledge. This is shown to be the case in TCM practice, where CAM users base their trust in TCM knowledge on its longevity, its traditionalism and on the very nature of its difference; also there is an understanding that chiropractors and osteopaths are trained to understand the body. The experience of pain does not sustain trust in those systems, in institutionalised knowledge, instead it creates suspicion and anxiety. Conversely, pain in biomedicine is tolerated, the idea of pain has been built into the stock of common knowledge (see Giddens, 1995) about what to expect in biomedical practice. This expectation differs for CAM, and different boundaries enacted.

Another contribution of the thesis is in understanding the influence of gender in assessing trust in CAM. The 16 CAM users in the study comprise of three males and 13 females, the disproportionate number of female CAM users has consistency been shown in both quantitative and qualitative studies of CAM. Some researchers (Adams, Sibbritt et al., 2003) speculate that this simply reflects the disproportionate number of females attending health care services in general, and with the very sparse sociological literature on CAM use and gender, it is difficult to assess this proposition. The few empirical studies with reference to gender make differing assumptions, some studies see gender as having minimal impact on motivations for CAM, others recognize that positive relations with the CAM practitioner are instrumental for validating a female patient’s sense of self-worth and pride in their body (Willard, 2005), and women feel empowered when they sense their condition is taken seriously and when personal feedback seems to be included in treatment protocols. All these constructs are reinforced in my analysis, and women unanimous in a desire to be ‘listened to’. This may reflect the illness context of treatment, many of the females had used CAM for reproductive and hormonal conditions, and found biomedical treatments for these conditions invasive and difficult. Women are vulnerable in these situations, and Misztal (1996; 2011) has discussed at length how trust develops in situations of vulnerability. Women in this study favour a supportive, empathetic encounter, and embodied trust with the practitioner means they feel connected to their body, their emotional self and the ‘bodywork’ of the practitioner whether it be tactile or
communicative, and the affirmation allows them to develop a subjective self-identity. The irony is that, for many CAM practitioners in the study, the treatment applied to a client/patient is less individually tailored than the client may believe to be the case.

The thesis also set out to understand the mediation of trust in the CAM user-practitioner encounter. A substantial literature exists on health communication in biomedical contexts, and a valuable project would be reviewing this literature to inform a wider study of micro-interactions between CAM users and practitioners in different therapeutic contexts. For this thesis, sociological theories of trust have been applied in assessing the research question concerning the mediation of trust between CAM user and CAM practitioner, and in relation to lay and expert knowledge. The findings do not support a clear position, rather it is clear that trust develops in some therapeutic contexts and not others, and that trust in the knowledge associated with the expertise of the CAM practitioner is nefarious. There are however, some clear trends and themes which emerge from the data worth noting. An argument emerges from Chapter Six that the practitioner is seen more as an individual, that he or she is related to and trusted on the basis of not just perceived expertise and skill, but also on having an empathetic disposition, on being supportive and validating, of working in a specific context of practice rather than as a representative of an abstract, expert system. All these operate as what Giddens (1995) calls ‘facework commitment’ which is based on the demeanour of the health practitioner, and, in contrast to the biomedical practitioners encountered by user in the study, CAM practitioners win hands down. It is not just their demeanour which exalts them in the eyes of their clients/patients, but for users in this study, the practitioner represents a certain role. For practitioners the trust in their practice relates to their professional legitimacy and skill, and not to being a healer, a goddess, an exotic ‘other’. So this demonstrates one of several disjunctures between CAM user and practitioner accounts.

Embodied trust in CAM use is also demonstrated among CAM users in this thesis. Embodied trust arises through bodywork, including the communicative actions of practitioners, it relates also to a construction of faith in the ability of the body to heal, to ‘talk’ to the user. An important construct to emerge from chapter Seven is the association between CAM, spirituality and faith. Spirituality in CAM use is confined to a small number of CAM user accounts; however, spirituality in these accounts is central to the decision to use CAM. A spiritually embodied experience of CAM involves healing through touch, connecting to a universal consciousness, and experiencing energy and light. These meanings of spirituality reflect the forms of CAM identified by Ho (2008) as inherently spiritual, and manifested through embodied experiences such as transcendence, universal consciousness and energy flow. Trust in spiritually-based CAM practices is constructed in several ways; for practices such as reiki which
invite collective and universal consciousness, trust is accessed through the collectivity of other practitioners and through individual practitioners. What emerges from the spiritual and energy forms of CAM is the importance of faith in the healing power of these modalities. Trust is presupposed by Giddens (1995) to be a form of faith, and faith is the mechanism for engaging with healing practices such as reiki and other mind-body medicines. Importantly, this is a different way of constructing trust from that encountered in Chapter Five, where the concurrent use of CAM and biomedicine is shown to require trust as existing in relation to a situation of health risk.

Related to the experience of embodied spirituality is the idea of CAM as a leisured experience. A contribution of this thesis is in theorising some forms of CAM use as a leisured rather than as a health experience. A central argument developed from the findings is that the bodily experiences of CAM use represent a leap of faith in CAM. The leap of faith extends beyond CAM into the realm of a universal consciousness, and appears to involve little sense of health risk. Decisions to cease a painful treatment show the boundary development of CAM users, especially for females, and reflect the Western cultural narrative of pain avoidance (Illich, 1995/1975). Pain is shown as an embodied experience involving feelings of anxiety and sadness, and it is no wonder that CAM users enforce a boundary around this experience when they are essentially choosing to use CAM to alleviate anxiety. Pain avoidance is also shown to create tension for the CAM user in aligning their lay pain belief with that of a practitioner. While Western trained practitioners interviewed for the study saw their job as minimising pain, TCM practitioners are seen to incorporate the pain experience in treatment. To understand this in relation to trust, it needs to be understood that there are differing sets of expectations between CAM users regarding the role of the practitioner. Chapter Five demonstrates that the biomedical provider and certain CAM providers are expected to effect a cure; these expectations will not only tolerate the experience of pain, but trust in these forms of treatment is around health risk and uncertainty. Trust is a more reflexive exercise, demanding critical engagement with expert knowledge. When CAM is used for derivative benefits and not for cure, when the purpose of the experience is more concerned with enjoyment, then there are different expectations of the practitioner role, and trust relates to having a leap of faith (Giddens, 1995; Simmel, 1950) in CAM treatment.

This represents an interesting disjuncture between lay and professional constructions of CAM use, with the CAM practitioner accounts in this study stressing the curative properties of CAM treatment, and seeing their role as clearly health related. This demonstrates the salience of the medicalisation thesis (Illich, 1995[1975]; Willis, 1989) in the professional practice of CAM. Rarely do CAM practitioners speak about treatment as pleasure, except when to illustrate how
their treatment relaxes the body. Furthermore there is clear evidence from literature that CAM practices are generally conceptualised as a health-related experience, and this is supported by CAM users in my study in their use of specific therapies and for specific conditions. However, this chapter shows that when examined in a broader context for some CAM practices, such as mind-body therapies, bodywork, aromatherapy, acupuncture and naturopathy, there are empirical connections not only with health, but also with leisure and play, in particular physical forms of leisure. The pleasured experience of CAM also extends to the therapeutic encounter and the relaxed, sensory experience of consultation rooms, and for some users the interaction with a naturopath or homeopath is convivial and fun. When used as an embodied experience for derivative benefits, and relaxation, CAM users demonstrate confidence in the practitioner’s knowledge. This aligns with Simmel’s (1950, p. 318) notion that trusting involves confidence in someone else’s knowledge: ‘confidence is intermediate between knowledge and ignorance about a man. The person who knows completely need not trust; while the person who knows nothing can, on no rational grounds, afford even confidence.’ It is this confidence which provides the link between trust and faith, with leaps of faith in the embodied CAM treatment experiences evident throughout CAM user accounts. This leap of faith also involves a sort of bracketing out of ignorance or lack of information (Meyer et al., 2008, p. 179), also evident in CAM user accounts. If CAM users are so able to embrace leap of faith in CAM treatments from which they expect no clinical outcome, and which they are so willing to reject when pain is involved, then what does this ultimately suggest?

Barcan (2011, p. 36) observes CAM use as being embedded in ‘pleasure-seeking, individualist, body-focused drive’ of the consumer culture which is tied to the ‘aestheticisation of everyday life’. CAM therapies such as body-work, aromatherapy and reflexology can be understood as part of this aestheticisation of everyday life, offering a sensual, pleasurable bodily experience. Given this, is it any wonder then that CAM users in the study have been found to use non-curative CAM treatments? When CAM is understood as a leisured experience involving relaxation and pleasure, experimentation and self-medication it makes more sense that efficacy is a less prominent expectation than for biomedicine.

To begin to explore the connections between leisure and CAM, the findings reported in this thesis show there are many forms of CAM which are themselves regularly undertaken as a form of leisure – freely entered into in non-work time, perhaps for therapeutic reasons, or the motivation may also be intrinsic. The experience of enjoyment is central to leisure as Csikszentmihalyi (1975) has demonstrated in his extensive research on the concept of ‘flow’. The propositions being advanced is that many elements of leisure, and of some forms of CAM, are convergent, in particular where the CAM users are committed users and where the forms of
CAM involve physical activity rather than some form of ‘medication’. With the convergence of CAM and leisure, one of the benefits of CAM, at least in part, is to allow people to ‘feel good’, which is a core element of the pursuit of leisure.

Future research could be directed in several directions, one of which concerns ethnographic work with CAM user and practitioner encounters, through recording or video recording these communication interactions, more understanding will be conveyed about the construction of trust in the CAM encounter. The findings from this study have provided invaluable knowledge and understanding of the processes of trust, and the construction of trust in communication encounters with practitioners, and there is evidence of multiple forms of trust, and trust developing over time as the relationship develops with a practitioner. This also applies to self-trust, as CAM users become more confidence in their use of CAM and their self-experimentation, they have traversed the client/patient and practitioner boundary and proceeded to study and become practitioners themselves. The processes of trust need to be studies more intensively through longitudinal study designs, and studies of micro-interactions. Another potentially useful method comes from the field of information studies, in which interviews are designed using a ‘sense-making’ method which aims to identify gaps in information seeking and knowledge construction.

In summary, the thesis has shown that trust is certainly mediated between CAM and biomedical approaches; it is also interesting to see the differing perceptions of CAM between client/patient and practitioner groups. In the face of the uncertainties and risk involved in modern life, trust in expert systems is more difficult to sustain. The study suggests that trust in CAM is not only a health experience for users, but a leisureed experience, an expression of faith in health practices which are perceived to nurture the body, soul and the mind in an increasingly complex world.
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Appendices
Appendix A: Recruitment Questionnaire

THE USE OF NATURAL THERAPIES IN AUSTRALIA STUDY

This questionnaire is on the use of natural therapies, also referred to as ‘complementary and alternative medicine’, ‘traditional’ or ‘holistic’ medicine. This questionnaire is part of a study by Michelle Toms, PhD research student in the School of Social Sciences, the University of Newcastle. The survey is conducted separately to your natural therapist, and the confidentiality of your responses is assured. Only the researcher reads the questionnaire and your contact details are not essential for the study. The questionnaire will take less than 5 minutes and can be placed in the completed questionnaire in the secure return box.

Q 1 For how long have you used natural therapy services?

- Over 5 years
- 3 - 5 years
- A year or less
- First visit

Q 2 Which of the following types of natural therapies have you ever used? [Tick as many as apply]

- Naturopathy
- Traditional Chinese Medicine
- Vitamins
- Homeopathy
- Herbalism
- Kinesiology
- Acupuncture
- Alexander Technique
- Aromatherapy
- Chiropractic
- Colour Therapy
- Reflexology
- Osteopathy
- Hypnotherapy
- Reiki
- Physiotherapy
- Iridology
- Massage (e.g. remedial massage)
- Natural Fertility Management
- Nutrition
- Other (please state) ………

Q 3 The following are reasons people give for using a natural therapy. Which of these are reasons apply to you? [Tick as many as apply]

- Natural therapies let me take an active role in my health
- Natural therapies make me feel better
- Natural therapies make me feel worse
- I am dissatisfied with the side-effects of conventional medicine
- I am more comfortable with a doctor than a natural therapist
- I enjoy the personalised consultations with my natural therapist
- I am not sure if natural therapy services or products assist my condition
- Natural therapy products are non-chemical and safe

Finally, some questions about yourself to ensure we obtain a proper cross-section of natural therapy users.

Q 4 My sex is: Male Female

Q 5 My age group is: 18 - 25 36 – 45 56 - 65 76+ 26 - 35 46 – 55 66 - 75
Q 6  I live in:
   An urban or regional area (i.e. city with more than 100 000 people
   A rural area (i.e. town, village, property less than 100 000 people)

Thank you for completing this questionnaire which is part of a wider study on the use of complementary and alternative medicine in Australia. People who participate in the wider study will be interviewed about their attitudes and experience of natural therapies. The accompanying Information Statement provides details of the study. For further information, please contact the researcher, Michelle Toms on XXX or XXX (University of Newcastle). If you are happy to be interviewed for the study, then please provide your name and contact number below. You may detach this section from the questionnaire if you wish, and place separately in the return box.

Name:…………………………………Contact number:………………………………………………
Appendix B: Information and Consent Forms

INFORMATION SHEET: CAM Users

Research Project: The Use of Complementary and Alternative Medicine in Australia

You are invited to take part in the research project identified above which is being conducted by Ms Michelle Toms, a PhD research student and supervised by Professor Linda Connor of the University of Newcastle.

The purpose of this project is to explore the perceptions and experiences of people who use complementary and alternative medicine (also known as ‘natural therapies’). While some research has explored the motivations of complementary and alternative medicine users for particular illnesses, there is no Australian study with a detailed focus on complementary and alternative medicine users. In addition, no previous work has included the interaction between complementary and alternative medicine user and practitioner. This study will be the first to achieve both of these aims.

What would you be asked to do?
If you provide your contact details on the attached questionnaire, you may be contacted by the researcher. If so, you will be invited to be interviewed in-depth at a location of your choice. For the study, we are seeking frequent and infrequent users of natural therapies including naturopathy, homoeopathy, herbalism, acupuncture, Alexander technique, reiki, Chinese herbal medicine, vitamins, colour therapy, hypnotherapy, iridology, natural fertility management, osteopathy, chiropractics and massage therapies.

The study involves two stages. Stage 1 involves an interview with the researcher at your home or other location of your choice. The interview will take up to one hour and will be taped. In addition, some stage 1 participants will be asked if they are willing to have a taped consultation with their natural therapist. Stage 2 involves a second interview with the researcher some six after the initial interview, to explore your natural therapy use over time.

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. If you decide to participate, you may withdraw from the project at any time without giving a reason. The interview questions will focus upon a number of areas including your reasons for natural therapy use, and how you acquire knowledge of health and natural therapies. If you also agree to a taped consultation session with your natural therapist, the transcript will be used to explore the communication between user and therapist.

How will your privacy be protected?
All information you give as part of the research will be treated in the strictest confidence and steps are taken to honour your privacy and autonomy throughout the research, such as pseudonyms. In addition, you will be given the opportunity to review, edit, or erase the recordings and transcripts. Only the research team listed in this information form will have access to the data collected. All information will be transcribed from tape, and identifiable information (e.g. names) will be de-identified. The transcripts are stored in password protected computer files, and eventually destroyed.

How will the information collected be used?
The information collected in the study will help form our understanding of why people use complementary and alternative medicine, and how knowledge is transferred in this area. Please note: the research is not funded by any person or organisation and is not affiliated with any organisation or persons outside of the University of Newcastle. The data and its analysis will be reported in academic and professional journals on completion of the research. Individual
participants will not be identified in any reports or papers arising from the project – all effort will be undertaken to ensure participants are guaranteed confidentiality and anonymity throughout the research. Individual participants will be sent a summary of findings on completion of research.

What do you need to do to participate?
Please read this Information Form and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher. If you would like to participate, please complete the accompanying consent form and the researcher will contact you to arrange details for an interview.

Further information
For further information regarding this project please contact:
Michelle Toms, School of Social Sciences, University of Newcastle, Phone: (02) 9797 2963
Mobile: 0413 279792

Many thanks for your consideration,

Professor Linda Connor               Michelle Toms, PhD student
Principal Supervisor                  School of Social Sciences
School of Social Sciences              University of Newcastle
University of Newcastle

Other member of research team:
Dr Jon Adams, Lecturer Health Social Science, University of Newcastle

Note:
This project has been approved by the University of Newcastle Human Research Ethics Committee, Approval No. H-697-1103. Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308. Telephone: (02) 49216333. Email: Human-Ethics@newcastle.edu.au.
The Use of Complementary and Alternative Medicine in Australia Research Study

Information Form: CAM Practitioners

2nd December, 2003

Dear …………

This letter is an invitation to participate in a research study on the use of complementary and alternative medicine in Australia. The study is part of a PhD in Social Science at the University of Newcastle, and the principle researcher is Michelle Toms, PhD student. The study is being supervised by Professor Linda Connor, School of Social Sciences, the University of Newcastle and Dr. Jon Adams, School of Medical Practice and Population Health, the University of Newcastle. Your name has been accessed from the Australian Traditional Medicine Society (ATMS) 2003 directory of ATMS registered practitioners.

The information collected in the study will help form our understanding of why people use complementary and alternative medicine, and how knowledge is transferred in this area. It provides a unique opportunity for practitioners to voice their opinion on all areas of complementary and alternative medicine practice, and enhance communication practice with clients. This will be the first in depth Australian study of complementary and alternative medicine users and practitioners in Australia.

The first stage of the study requires up to 20 complementary and alternative medicine practitioners to be interviewed by the researcher. The interview will take up to an hour, and will be taped. The interview will canvass topics such as the place of complementary and alternative medicine in conventional medicine, your values around the use of complementary and alternative medicine and the professionalisation of forms of complementary and alternative medicine. The interview will occur at a time and location of your choice.

The second stage of the study involves interviewing a self-selected sample of clients of participating practitioners about their use of complementary and alternative medicine. The study is also seeking up to 5 complementary and alternative medicine practitioners to have a consultation session taped with one or more participating clients.

The ATMS has been informed of the study and supplied the researcher with a directory listing of ATMS registered providers in Australia. Participation in this research is entirely your choice, and only those who give their informed consent will be included in the project.

The study is an independent university study and is not affiliated with any commercial organisations or medical institutions. All information you give as part of the research will be treated in the strictest confidence and all identifiable features of your discussion (i.e. names etc.) will be de-identified. In addition, you will be given the opportunity to review, edit, or erase the recordings and transcripts.

If you are interested in the study, the first thing to do is read the Information Statement. If you agree to be in the study, you will need to sign the attached Consent Forms and return in the reply paid envelope or at the time of interview. Please note that there are two copies of each consent form and one is retained by you.
The researcher will call you in the coming weeks to check that you have received this invitation. Alternately, you can call the researcher, Michelle Toms on 0413279792 or 02-97972963 for further information on the project.

Yours sincerely,

Michelle Toms

Michelle Toms, PhD student
School of Social Sciences
University of Newcastle
Phone: (02) 9797 2963 Mobile: 0413 279792
Consent Form for Complementary and Alternative Medicine Users in the Use of Complementary and Alternative Medicine in Australia research project

Researcher:
Ms. Michelle Toms, PhD student, School of Social Sciences, University of Newcastle

Project Supervisors:
Prof. Linda Connor, Professor, Anthropology, School of Social Sciences, University of Newcastle; Dr Jon Adams, Lecturer, School of Medical Practice and Population Health, University of Newcastle

• I agree to participate in the project: The Use of Complementary and Alternative Medicine in Australia and give my consent freely.

• I understand that the study will be carried out as described in the Information statement, a copy of which I have retained.

• I agree to the tape-recording of my interview by the interviewer or practitioner.

• I know that if I wish to stop the tape and/or review, erase or edit any of the tape recording I am free to do so at any time.

• I know that the tape will be erased after being transcribed.

• I understand that my personal information will remain confidential to the researchers.

• I realise that I can withdraw from the study at any time and do not have to give any reasons for withdrawing.

• I have had all questions answered to my satisfaction.

- I am aware of the type of questions to be asked in the interview/s
- I have read the Information Statement

Please circle as applicable:

I consent to being interviewed by the researcher (Stage 1): Yes / No
I consent to being re-interviewed by the researcher 6 to 9 months after the first interview (Stage 2) Yes / No
*For people participating in taped consultations with natural therapist:
I consent to having one consultation with my natural therapist taped by the researcher (Stage 1) Yes / No

Name………………………………………………………………….(please print)
Signature…………………………………….. Date……………………………
CONSENT and RELEASE FORM FOR AUDIO TAPING

The Use of Complementary and Alternative Medicine in Australia Study

Researcher:
Ms. Michelle Toms, PhD student, School of Social Sciences, University of Newcastle

Project Supervisors:
Prof. Linda Connor, Professor, Anthropology, School of Social Sciences, University of Newcastle
Dr Jon Adams, Lecturer, School of Medical Practice and Population Health, University of Newcastle

I give consent to the audio-taping of my interview and/or consultation with complementary and alternative medicine practitioner/client. I also consent to the archiving of my tapes for five years in the School of Social Sciences, University of Newcastle. I also consent to the release of data from recording transcripts in publications or other papers released from the project.

I understand that:

- I will have the opportunity to review, edit or erase the recording/s and/or transcript/s.
- I will not be identified on the audio tape, and will be able to use a pseudonym if I wish.
- Publication of results will be in general terms without the use of specific information which could identify individuals and pseudonyms will be used.
- I am aware of the type of questions to be asked in the interview/s
- I have read the Information Statement

Name………………………………………………………………….(please print)
Signature……………………………………………… Date…………………………
Appendix C: Interview Guide – CAM User

IN-DEPTH INTERVIEW GUIDE

The Use of Complementary and Alternative Medicine in Australia

BACKGROUND
History of illness
History of CAM use

HEALTH CARE
Health care decisions and expectations: in general
- How do you choose the kind of healer to consult? Medicine to use?
- Which are preferred for what kind of problems?
- Explore the expectation user has about health care modalities for certain conditions
- Level of use of biomedicine

PATTERNS OF CAM USE
Health care decisions and expectations: CAM
- How do you choose the kind of CAM therapist to consult? Medicine to use?
- Which are preferred for what kind of problems? Find parameters of usage
- Explore the expectation user has about CAM modalities for certain conditions

Level of CAM use
- History of CAM use
- Frequency and patterns of use
- What is acceptable? What isn’t?

Motivations for Choice
- Why choose CAM?
- Why undertake treatment not submitted to rigorous scientific testing or not efficacious?
- Have ever contradicted the advice of health professional?
- Perceptions of CAM medicines/therapies: non-invasive/invasive, self-healing/curative

Interaction with Therapist
- Describe how it feels in a consultation with CAM therapist? Recall last visit with a therapist. Explore.
- Compare to medical encounter.

SOCIO-CULTURAL CONTEXTS FOR USE

Social networks
- Use of CAM by friends, family, culture etc.
- Information networks: how knowledge of CAM is cultivated
- Explore other cultural values and contexts

Concept of the body
- Explore attitudes to body
- Values on individualism and participation in own health

Lifestyle
- Values on lifestyle choice

Capitalist Relations of production
- Perception of CAM cost and willingness to pay

**Surveillance**
- How do you see your identity in relation to your body? How do you feel when your body lets you down?

**Status of Knowledge**
- Values on scientific knowledge
- Values on education

**Consumerism**
- Values on consumerism and choice

**Self-perception**
- How do you feel about taking on new experiences?
- Personality questions - extroversion etc.??

**SOCIAL RELATIONS OF HEALTH CARE**

**Biomedicine**
- Disclosure of CAM use to GP and allied health professionals: why or why not
- Attitudes to the role of biomedicine in producing health

**CAM profession**
- Disclosure of GP use to CAM therapist: why or why not
- Attitudes to the role of CAM in producing health

**INFORMATION AND COMMUNICATION ACQUISITION**
- How information or knowledge on health issues is sought
- How information or knowledge on health practitioners and procedures is sought
- How information or knowledge on CAM is sought
- Specific questions on health condition treated by CAM practitioner
- Which questions answered, which ones not
- Gaps in information seeking or knowledge on health condition and CAM practice for condition
- Explore communication process with CAM therapist
- Who else is consulted or communicated with? Why that person or group?
- At what point did respondent feel empowered in CAM treatment?
- Explore notions of concern for wellbeing in CAM therapist and health practitioners
Appendix D: Interview Guide – CAM Practitioner

IN-DEPTH INTERVIEW GUIDE-CAM Practitioners

The Use of Complementary and Alternative Medicine in Australia

INTERPERSONAL CONTEXTS
The first set of questions concern the nature of your practice.

1. Background
What sort of natural therapies do you practice? How long have you been involved in this area? Can you briefly describe what you do? How would you describe your job title? Do you prefer the term practitioner, natural therapist, healer or something else? Why? What is the difference? What attracted your interest in this area?

2. Method of Practice
   a. How does a consultation work with a client? How long is a consultation?
   b. How do you diagnose and treat an illness?
   c. How do you keep up to date with changes to practice? How do you keep informed about practice? Where did you study? How do you acquire knowledge of practice?

3. Users/Clients
   a. What are your clients like? What are the typical age, gender, background? What sort of illnesses do they present with? Could you describe a typical client?
   b. For what reasons do clients come to you? Why do they use [insert modality] rather than others? What draws them to natural therapies?
   c. What is your role in facilitating wellness? How do you define success with a client? Can you give me an example? Do you monitor clients?
   d. Suppose a client is treated for mild back pain, but does not respond to treatment. What happens when this occurs, when a client does not respond to a regime?

4. Holistic Philosophy
   a. The basis for complementary medicine is said to be holistic practice. Could you explain what holism means to you?
   b. How does [modality or natural therapies] empower a client? Do they take responsibility for their own health? How does this work?
   c. How does it relate to other lifestyle factors? What are your expectations of clients? Of yourself [as practitioner and your own health]?

INSTITUTIONAL CONTEXTS OF PRACTICE
Now, some questions about the professional aspect of your practice.

5. Professionalisation of CAM
   a. How do you feel about the professionalisation of [modality or natural therapies], for example, registration, professional associations, degree courses, codes of practice and so on? Is it good for the practice? Why? Is it bad for the practice? Why?
   b. Do you meet with others in your field? What is that like?
   c. How do you feel about the umbrella term ‘traditional medicine’?
   d. Can [modality or natural therapies] work comfortably with conventional medicine? What are the pluses? What are the minuses?
   e. How do you feel about GPs using natural therapies? What do you think of the relationship between natural therapies and medicine? Should natural therapies integrate further with medicine? What will [modality] look like in five years?
f. What is the place of natural therapies in society? Are you respected? How do you feel society sees your profession? What is your place in the health care system?

6. Commodification
   a. In the past year, there’s been unfavourable media reporting on natural therapies, particularly around PAN pharmaceuticals. How do you feel about the media reporting of natural therapies? What is the public image? How does media, politicians etc. affect this?
   b. What impact did PAN have on your practice? The industry? How did you feel about it?
   c. How does your practice compare to five years ago? 10 years ago?
   d. How do you feel about the involvement of pharmaceutical companies in natural therapies?

7. Regulation and Policy
   a. The natural therapy industry is self-regulated in some areas such as licensing, pricing, demonstrating outcomes and so on. Do you support self-regulation or a more regulated system? Why?
   b. The government is proposing tighter changes to alternative medicine, how do you feel about this?
   c. Natural therapies are criticised by some in the scientific community for lack of ‘effectiveness’, or not proving efficacy with clinical trials and the like. What are your feelings on this? Is it possible to show effectiveness? Why?

Finally, are there any other comments you’d like to make about your practice?
Appendix E: Excerpt from Data Analysis

<table>
<thead>
<tr>
<th>Preliminary comments</th>
<th>Bonnie: interview extract</th>
<th>Open coding &amp; Emergent themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not easy to define non-conventional</td>
<td>I: So what makes something non-conventional?</td>
<td>Fluid definition of CAM</td>
</tr>
<tr>
<td>It’s a fluid definition that depends on the cultural context</td>
<td>B: For me, it’s hard, it’s a kind of subliminal…if you travelled you wouldn’t see those things as unconventional. Because they are located in a particular culture and seen as very ordinary. Interesting if you were in China and were ill, you would immediately find yourself at the local acupuncturist. I don’t really know in my head what makes those things exotic. I’m just looking for an efficacious result, nothing else. I think the only things I’d considered a little bit out there are things like iridology. I find it interesting and went to iridologist for pure fun, and she pinpointed a couple of things which I had for a while so that was kind of interesting. Also my partner went to this [unclear]. And this was 20 years ago, and she put him on a wheatgrass juice and this was very interesting because it was 20 years ago, and she put him on wheatgrass. We had to organize to grow the wheatgrass ourselves.</td>
<td>Cultural context of CAM is important for defining it</td>
</tr>
<tr>
<td>Can’t explain what makes a health practice “exotic”</td>
<td></td>
<td>Exoticisation of CAM</td>
</tr>
<tr>
<td>She wants results</td>
<td>I: Did you do that?</td>
<td>Expecting positive health results from CAM</td>
</tr>
<tr>
<td>Iridology pushes the boundary of what is acceptable CAM</td>
<td>B: Yeah, she was considered to be kind of a witch. I like that aspect of it myself, because the kids do witchcraft, the woman with herbal medicines has knowledge. Herbal cures and knowledge.</td>
<td>Some CAM practices are not serious, less acceptable or fringe [e.g. iridology]</td>
</tr>
<tr>
<td>Iridology was used for “fun”</td>
<td>I: You were prepared to go to great lengths, even then, to take it on?</td>
<td>CAM can be used for pleasure</td>
</tr>
<tr>
<td>Although the iridologist correctly diagnosed a health issue</td>
<td>B: The payoff is so fast, you are instantly converted. I had Western medicine as a child, then you are faced with this dilemma, ‘if you get ill, what are you going to do about it?’. Now actually because I used to live in Adelaide and use acupuncture all the time there, I had total faith in this guy because he was Chinese and you could walk in there and ‘go this is the problem’ and he would go ‘da da’ da da’.</td>
<td>Iridologist image of being a “witch” / mystery</td>
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<tr>
<td>Reflecting on previous use of iridology</td>
<td></td>
<td>Old image of CAM as quackery has shifted gear</td>
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<tr>
<td>Used wheatgrass juice, considered ‘out there’ 20 yrs ago</td>
<td></td>
<td>Mysterious, traditional [herbal] CAM knowledge, how does it work?</td>
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<tr>
<td>Contrasts what is acceptable now to 20 yrs ago</td>
<td></td>
<td>Acupuncturist was quick, effective, results oriented</td>
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<tr>
<td>Iridologist image was of a “witch”</td>
<td></td>
<td>“Faith” and trust in CAM practitioner</td>
</tr>
<tr>
<td>She was drawn to the witch image</td>
<td></td>
<td>benefit from acupuncture</td>
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<tr>
<td>The mysterious knowledge of herbal medicines, how they cure</td>
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<td></td>
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<tr>
<td>Self doubt emerges–which health system best for me?</td>
<td></td>
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<tr>
<td>Total “faith”</td>
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<td>In Chinese acupuncturist</td>
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<td>He diagnosed very quickly</td>
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<tr>
<td>This was important to her</td>
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### Appendix F: Excerpt from Coding Book

<table>
<thead>
<tr>
<th>Master themes</th>
<th>Selective coding and superordinate themes</th>
<th>Axial coding and subordinate themes</th>
<th>Open coding &amp; emergent themes</th>
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</thead>
</table>
| **Negotiating trust in biomedical and CAM treatments** | Assessing experiences of biomedicine | 1. Developing mistrust in biomedical approaches (Annie, Mads, Amy, Lucy, Sharon, Jan, Bonnie)  
2. Positive experiences with biomedical treatment (Ben, Mads, Sharon) | 1. Keeping health condition under control (Mads)  
2. Negative experience/ (Annie, Mads, Amy, Lucy, Sharon, Bonnie)  
3. Anti pharmaceutical drug therapy (Mads, Kate, Amy, Fifi, Marcia, Andy, Jan)  
4. CAM use is reaction to negative BM experience [higher order concept] (Mads, Amy, Bonnie, Annie, Sharon)  
5. Resisting [negative] BM prognosis/advice(Sharon, Lucy, Kate, Amy, Andy, John, Annie, Bonnie)  
6. Becoming self reliant [linked to CAM use] in response to BM (Annie, Sharon, John, Andy)  
7. BM as safe/effective (Mads)  
8. Misdiagnosis wrong (Bella, Fifi, Bonnie, Annie, Jan)  
9. BM as a positive experience (Ben, Mads, Sharon)  
10. Lack of trust in BM/ wariness in BM (Jan, Sharon, John)  
11. Loss of faith in BM (Annie)  
12. Iatrogenic illness (Kate, Amy, John)  
13. Adverse effects/reaction to drugs (Bonnie, Kate, Mads)  
14. Side effects from drugs (Kate, Mads, Fifi, Bonnie, Sharon)  
15. fear and anxiety about BM(Bonnie, Amy, Mads)  
16. Resisting ‘drugs’(Kate, Bonnie, Annie, Sharon, Marcia, Andy)  
17. Anti- ‘chemicals’ (Jan, Ben, John, Andy); ‘synthetic’ (Andy)  
18. BM drugs not working long term (Annie)  
19. Feeling bad about self from medicines (Jan)  
20. not natural (Jan, Andy)  
21. Needing to be self reliant (Bonnie, John)  
22. BM as Invasive (Bonnie, Annie, John)  
23. BM drugs as ‘Poisonous’ (Bonnie, John)  
24. Wariness of pharmaceutical drugs for family (Corinne)  
25. BM over reliant on prescribing drugs (Annie, Corinne, John)  
26. Experiencing conflict over whether to use drugs (e.g. immunization) (Corinne)  
27. Using BM for routine investigations for preventive health (Bonnie) |
| **Resistance to biomedical/scientific approaches and knowledge** | 1. Resisting biomedical knowledge/advice(Sharon, Lucy, Kate, Amy, Andy, John, Annie, Bonnie)  
2. Assessing effects and evidence of biomedical treatments | | |
| **Health risk & uncertainty** | 1. Experiencing side effects and adverse effects of pharmaceutical ‘drugs’ (Mads, Kate, Amy, Fifi, Marcia, Andy, Jan, Bonnie, Annie, Sharon, Corinne, Ben, Lucy, Bella)  
2. Misdiagnosis (Bella, Fifi, Bonnie, Annie, Jan) | | |
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<tr>
<td>28.</td>
<td>Resisting evidence based medicine (Bonnie, Annie)</td>
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<tr>
<td>29.</td>
<td>Resisting BM medicine knowledge /assumptions /explanations (Bonnie, Annie, John, Andy)</td>
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<tr>
<td>30.</td>
<td>Critique of ‘scientific mind’ (Annie)</td>
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<td>31.</td>
<td>Feeling invalidated by GP (Bonnie, Annie, Corinne)</td>
<td></td>
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<tr>
<td>32.</td>
<td>Being treated as a ‘moron’, belittled, treated badly etc. (Bonnie, Annie)</td>
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<td>33.</td>
<td>Feeling vulnerable or emotional in BM treatment (Annie)</td>
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<td>34.</td>
<td>BM treatment impersonal (Annie)</td>
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<td>35.</td>
<td>BM dangerous to health (Bonnie, John)</td>
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<td>36.</td>
<td>Experiencing pain from BM (Bonnie)</td>
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<td>37.</td>
<td>Critique limitations of GP knowledge or training (Bonnie, John)</td>
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<td>38.</td>
<td>BM ineffective for illness or health condition (Annie, John)</td>
<td></td>
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<td>39.</td>
<td>GPs as cynical (Annie)</td>
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<tr>
<td>40.</td>
<td>BM unable to assess condition (Frustrated) with BM (Annie, Sharon, John)</td>
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<td>41.</td>
<td>Feeling stuck in BM, not getting anywhere (Sharon)</td>
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<td>42.</td>
<td>GP just treats the ‘symptoms’ (Corinne)</td>
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<td>43.</td>
<td>GP as ‘difficult to talk to’ (Sharon)</td>
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<td>44.</td>
<td>GP affirming (Sharon)</td>
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<td>45.</td>
<td>GP communication style as ‘expert’ (Corinne)</td>
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<tr>
<td>46.</td>
<td>GP communication ‘don’t ask too many question’ (Corinne)</td>
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<tr>
<td>47.</td>
<td>GP non negotiated/ non exploratory communication (Sharon, Corinne, John)</td>
<td></td>
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<td>48.</td>
<td>Having a ‘good’ doctor (Corinne)</td>
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<td>49.</td>
<td>Integrative medicine doctor or doctor with holistic approach as positive experience (Fifi, Amy, Corinne, John)</td>
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<td>50.</td>
<td>GP treats everyone as the same- homogenous treatment model (John, Andy)</td>
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<tr>
<td>51.</td>
<td>Mistrust of profit making motives of pharmaceutical companies (Andy)</td>
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<tr>
<td>52.</td>
<td>Avoiding GPs except when really sick (Andy)</td>
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