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The salutogenic gaze: Theorising the practitioner role in complementary and alternative medicine consultations

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Abstract

Research on why people use complementary and alternative medicine (CAM) shows clients value the CAM consultation, where they feel listened to and empowered to control their own health. Such 'empowerment' through CAM use is often theorised as reflecting wider neoliberal imperatives of self-responsibility. CAM users' perspectives are well studied, but there has been little sociological analysis of interactions within the CAM consultation. Specifically, it is unclear how user empowerment/self-knowledge relates to the CAM practitioner's power and expert knowledge. We address this using audio-recorded consultations and interviews with CAM practitioners to explore knowledge use in client-practitioner interactions and its meaning for practitioners. Based on our analysis and drawing on Foucault (1973), *The Birth of the Clinic: an archaeology of medical perception* and Antonovsky (1979), *Health, Stress and Coping*, we theorise the operation of power/knowledge in the CAM practitioner-client dyad by introducing the concept of the 'salutogenic gaze'. This gaze operates in the CAM consultation with disciplining

and productive effects that are oriented towards health promotion. Practitioners listen to and value clients' stories, but their gaze also incorporates surveillance and normalisation, aided by technologies that may or may not be shared with clients. Because the salutogenic gaze is ultimately transferred from practitioner to client, it empowers CAM users while simultaneously reinforcing the practitioner's power as a health expert.

KEYWORDS
clinical consultations, complementary and alternative medicine, Foucault, patient empowerment, power/knowledge, salutogenesis

INTRODUCTION

The widespread use of complementary and alternative medicine (CAM) in Western countries continues to intrigue social scientists. CAM modalities typically contrast with the dominant biomedical model and remain excluded from mainstream healthcare systems. In Australia, for instance, 36% of people report visiting an acupuncturist, naturopath, chiropractor or other CAM practitioner, despite needing to pay out-of-pocket for these therapies which are not accessible through the government-funded health system (Steel et al., 2018). Research shows that the CAM consultation holds a particular appeal, being longer than standard medical appointments and more personalised and patient-centred (Broom, 2009; Pedersen & Baarts, 2018; Sointu, 2012). CAM users feel empowered by CAM's emphasis on self-healing, with social scientists linking such empowerment to wider notions of self-responsibility in neoliberal health discourses (Barcan, 2011; Fries, 2008; Sointu, 2012). Notably, this theoretical framing has developed largely from studies relying on interviews with users. CAM practitioners' views are less often included, while the consultation itself is seldom directly studied. Theories of CAM use therefore remain somewhat lopsided, emphasising the user experience without explaining the practitioner's role in facilitating empowerment and self-healing through the consultation.

This article contributes to filling this theoretical and empirical gap by attending to the role of the practitioner in the CAM consultation, asking how client empowerment is enacted and specifically how it relates to the power of the practitioner as 'expert'. Data come from interviews with CAM practitioners and analysis of audio-recorded consultations with clients, with a focus on forms of knowledge used in the interactions. Findings reveal multiple forms of surveillance enacted through the consultation, with disciplining and productive effects, which, alongside empowering clients to enhance health, rely crucially on the practitioner and their expert knowledge. Drawing on Foucault (2003/1973) and Antonovsky (1979), we label this health-promoting surveillance the *salutogenic gaze*, and we illustrate this concept through our data. Before presenting our study, we briefly review literature on the empowering aspects of CAM use and discuss the 'clinical gaze' and its relevance to CAM.

HEALTH, EMPOWERMENT AND THE SELF IN CAM

In the sociology of CAM, users' motivations and experiences remain a longstanding central focus (Gale, 2014). Recurring findings include CAM's emphasis on the pursuit of 'wellbeing' rather than the cure of pathology, holism and mind-body connections and tailoring treatment to the individual (Danell, 2015; McClean, 2005; Pedersen et al., 2016; Sered & Agigian, 2008; Sointu, 2012). Users place special importance on the CAM consultation, reported in one study to be four times longer than biomedical consultations (Weiss & Lonnquist, 2006 in Pedersen et al., 2016). Users particularly value the deep listening, emotional support and dialogue with practitioners and describe being given control over their wellbeing through CAM's emphasis on self-healing (Baarts & Pedersen, 2009; Danell, 2015; Pedersen & Baarts, 2018; Pedersen et al., 2016; Sointu, 2012).

Central to CAM then is a focus on the self, the appeal of which is seen by social scientists to align with discourses of 'choice' and self-responsibility that underpin neoliberal forms of governance (Baarts & Pedersen, 2009; Barcan, 2011; Broom et al., 2014; Fries, 2008; McClean, 2005; Sointu, 2012) or what Foucault calls governmentality (1979 in Rose et al., 2006). It is argued that CAM therapies function, in Foucauldian terms, as 'technologies of the self' (Foucault, 1988) through which individuals seek wellness in a quest to become self-disciplining, 'good citizens' who take control over their health and thereby their selves (Baarts & Pedersen, 2009; Ning, 2018; Sointu, 2012). Eeva Sointu (2012) posits that the quest for individual agency is at the heart of the 'discourse of wellbeing' that underpins CAM use. According to this view, the pleasures of CAM—and the perception of increased wellbeing—derive from the sense of 'mastery' it offers users (Baarts & Pedersen, 2009; Barcan, 2011; Sointu, 2012). CAM users interviewed by Baarts and Pedersen (2009), for example, felt they gained control over their health through mindfulness and acupuncture even when treatments did not relieve physical symptoms. Inga Pedersen (2018) argues additionally that CAM use fits well with Foucault's conception of self-care as an 'enabling' self-technique and that research attending to the enabling capacities of CAM is best positioned to explain CAM's popularity.

Other studies point to the constraining elements of self-responsibility which can become burdensome for CAM users (Broom, 2009; Broom et al., 2014) or place blame on those who 'fail' to help themselves (Flesch, 2007; McClean, 2005). Stuart McClean's (2005) ethnography of a healing centre found that practitioners believed clients had agency over their wellbeing, but this extended to blaming clients' conditions on their 'negative' mental states. Similarly, Sered and Agigian (2008) interviewed CAM practitioners treating women with breast cancer, finding that the practitioners' holistic philosophy included holistic notions of disease causation: cancer was believed to result from environmental factors, social change, clients' character flaws and their food choices. In this world-view, the authors point out, women could never achieve 'wellness'.

There is a degree of tension between these accounts of CAM use as either empowering or disempowering. There is also some disagreement about the power dynamics within the CAM client-practitioner relationship. Sointu (2012), for instance, contends that the client's narrative is central in the CAM therapeutic encounter, with practitioners providing the recognition needed to validate clients' experiences and subjectivity. This, Sointu argues, is different from biomedicine where truth is accessible through the expert gaze of the doctor and where recognition of the patient's subjectivity is limited, their voices 'silenced' (2012, pp. 101–110). For Sointu (2012, pp. 111–112), in the CAM consultation, authority and expertise rest with the CAM user. In

contrast, Sered and Agigian (2008, p. 618) emphasise CAM's similarity to biomedicine and the power of CAM practitioners to frame the illness narrative:

> practitioner narratives have particular clout because of the inherently unequal power relationship between the expert healer—conventional or CAM—and the lay (and sick) patient. In the case of CAM practitioners, that clout may be cultivated via an explicitly articulated mission to educate and encourage their patients to make extensive lifestyle and attitude changes.

Sered and Agigian (2008, p. 621) acknowledge that because they rely on interviews—as does Sointu (2012)—their study fails to capture what CAM practitioners actually say to clients. CAM consultations have rarely been directly studied in sociology and observational fieldnotes have tended to be made rather than audio recordings (e.g., McClean, 2005; Pedersen et al., 2016). The verbal exchanges between practitioner and client have not been the focus. If users are empowered through CAM, how such empowerment occurs within the CAM consultation remains unclear and the role of the practitioner puzzling. If the client's narrative and self-knowledge are central, what is the status of the practitioner's knowledge, and how is their knowledge and power deployed in the interaction? These questions have broader relevance in sociology amid shifting knowledge hierarchies in health care and renewed emphasis on patient-centredness in biomedicine. In the context of biomedicine, these power dynamics have been interrogated through the lens of Foucault's 'clinical gaze'.

THE PROFESSIONAL GAZE IN BIOMEDICINE AND CAM

Foucault saw expert knowledge as central to governmentality because experts define the standards and norms against which individuals are encouraged to measure themselves (Lupton, 1995). In medicine, expert knowledge is bound up in the medical gaze. *The Birth of the Clinic* (Foucault, 2003/1973) describes the rise of the 'anatomo-clinical gaze' in the early nineteenth century: new ways of 'seeing' and, equally, knowing and talking about bodies emerged as medical training was incorporated into hospitals and the science of pathology developed. Doctors learnt to read the signs of internal pathology on the external surface of the patient's body, as medicine became 'a science of the individual' (Foucault, 2003/1973, p. 243). The doctor's expertly developed gaze was not accessible to the patient whose self-reported symptoms came to be regarded as less truthful than signs observed by the doctor. Medical knowledge is therefore a form of power (indeed, Foucault uses 'power/knowledge' to denote their inseparability), the gaze involving a hierarchical assessment of the individual body and an attempt to correct deviations from the norm (Foucault, 1977).

The concept of the clinical gaze has often been used to critique biomedicine's reductionist focus and the power doctors maintain through their specialist knowledge. Efforts to reform biomedical care along more holistic and egalitarian lines have sometimes attracted similar critique. Christopher Mayes (2009), for example, draws on Foucault to analyse the rise of 'patient-centred communication' (PCC) in medicine, arguing that this opens new aspects of patients' lives for medical surveillance. In PCC, the medical encounter becomes a 'technique of confession', and the patient is incited to reveal their inner secrets to the doctor within 'a pastoral relationship in which power subtly induces the patient to think and act towards their self in a particular way' (Mayes, 2009, p. 486). This subtle, *productive* power, in the form of self-discipline,

is what characterises governmentality (Gardner, 2017b; Rose et al., 2006). According to John Gardner (2017a, 2017b), the incorporation of additional professional perspectives into health care also expands the clinical gaze. Gardner shows that the inclusion of allied health practitioners such as occupational therapists and psychologists in a paediatric neurology team extends surveillance from 'the shapes and structures of the body, to the subjective thoughts and emotional state of the patient, to elements of the patient's social context and their ability to act within it' (2017a, p. 243), becoming what he calls the 'broad clinical gaze'.

Gardner's work suggests that different kinds of health professional enact different forms of professional gaze. CAM practice has rarely been analysed through a Foucauldian lens, especially to ask what kind of gaze is exchanged between practitioner and client. Where a 'gaze' is referenced at all in relation to CAM, it is the medical gaze, described either as inapplicable to CAM interactions (Keshet et al., 2012), or (in a similar vein to Gardner) being extended through CAM's focus on the client's mind and everyday life (Fadlon, 2004; Flesch, 2007). Ruth Barcan (2011) provides a more developed analysis of the professional gaze in CAM, focussing specifically on the role of vision in a range of CAM therapies, including the power that attends the practitioner's ability to see the client's inner (physical, emotional or spiritual) state and the pleasure for clients in being 'seen'. Barcan again draws on interviews in addition to her personal CAM experiences.

This article sketches out a fuller characterisation of the gaze in CAM, based on a close reading of recorded consultations and interviews with practitioners. As seen above, the health professional gaze is not restricted to the anatomo-clinical (Gardner, 2017a, 2017b; Mayes, 2009), and it is important to understand what other kinds of gaze arise in different contexts. In our analysis, CAM does not simply extend the medical gaze but has its own particularities, including a focus on fostering health. In this sense, it can be understood as 'salutogenic'.[1]

Sociologist Aaron Antonovsky (1979) coined the term salutogenesis to describe the 'origins of health', arguing that these have been obscured by biomedicine's focus on the pathological. His central argument is that mainstream health-care's preoccupation with disease limits its capacity to produce health. Because of its retroactive and reductive focus on disease-causing factors and the already-sick, the 'pathogenic' paradigm excludes the general (non-diseased) population, the complexity of people's lives and self-care as a form of health promotion (Antonovsky, 1996; Fries, 2020). A salutogenic approach, on the other hand, views wellness and illness on a continuum and identifies and promotes factors that move people towards the well pole (Antonovsky, 1996). For Antonovsky, health is fundamentally related to the extent to which people can mobilise resources (individual, behavioural, environmental and societal) to cope with stress and harmful events (Antonovsky, 1979; Fries, 2020). How salutogenesis can be operationalised in clinical care is less clear, but has been proposed to include person-centred, holistic approaches that strengthen people's resources and encourage self-responsibility for health (Alivia et al., 2011; Fries, 2020). CAM has already been described as salutogenic (Alivia et al., 2011) and this is how we broadly characterise the gaze operating in the CAM interactions we analyse, where power and knowledge are mobilised by practitioners aspiring not to cure illness, but to produce health.

METHODS

Our findings come from a study that—given the contested evidence to support CAM therapies (Brosnan, 2015)—aims to identify the forms of knowledge and evidence that CAM practitioners use in practice. Conducted in an Australian city, the study focusses on acupuncturists and naturopaths, two of the largest and most visited CAM professions in Australia (Steel et al., 2018).

Acupuncture and naturopathy are associated with Asian and European medical traditions, respectively, and contrast in registration status (only acupuncture being statutorily regulated in Australia), thereby capturing some of the diversity of CAM. Part of Chinese medicine, acupuncture involves treatment by needling, and herbal medicines and lifestyle advice may also be offered; naturopaths may also provide advice around diet and lifestyle alongside offering herbal treatments and nutritional supplements. Although we touch on differences between the therapies, our aim here is to develop the broader concept of the salutogenic gaze.

Study design and methods

Working in an interpretivist paradigm, we set out to explore (a) practitioners' beliefs and experiences around knowledge use in CAM, as well as (b) interactions occurring during clinical consultations and (c) the meaning of these interactions for the practitioners. Accordingly, the study involved three phases, the first being semi-structured interviews with practitioners, focussing on their professional background and perspectives on knowledge use in their professional practice. These first interviews established rapport and enabled (in some cases) recruitment and set-up for the second phase, which was the audio recording of clinical consultations. In the third phase, we returned to the practitioners who had participated in phase two to conduct a second, data-prompted interview (DPI) (Kwasnicka et al., 2015), using the transcript of the consultation as a stimulus for discussion and further exploration of their practice.

DPIs using recorded consultations are conducted in general practice research and other medical fields and are useful for understanding participants' decision-making processes and comparing researchers' and participants' interpretation of interactions (Henry & Fetters, 2012; Kwasnicka et al., 2015). These methods are relatively novel in studies of CAM. Among 20 papers published since 2000 that examine knowledge use in CAM consultations, identified via a qualitative systematic review we conducted previously (Davies et al., 2022), two studies use recorded consultations and DPIs, but the resulting papers only include dialogue from the interviews. In this article, our findings are based on analysis of the initial interviews, the content of the consultations themselves and the second interviews (DPIs), and we include data from all three sources.

Recruitment and data collection

Ethics approval was granted by the University of Newcastle Human Research Ethics Committee [H-2020-0101] and all participating practitioners and clients ($n = 18$) gave written informed consent. After constructing a sampling frame using publicly available practice details, naturopaths and acupuncturists were purposively sampled (to include a range of qualifications, years in practice, solo or group practices and a gender mix) and sent the study information. Recruitment took place in 2020 and although COVID-19 rates were then very low in the region, some practitioners declined to participate because of the pandemic. Nine practitioners (five naturopaths, four acupuncturists) agreed to participate in phase one, and these semi-structured interviews lasted 60 min on average. Six of these practitioners (four naturopaths, two acupuncturists) agreed to have a consultation recorded and were asked to pass on the study information to clients. The study information for clients clearly stated that the invitation to participate came from the research team, not the practitioner. When a client indicated an interest in participating, a research team member arranged to meet the person in the waiting room prior to their

TABLE 1 Study participants by phase of study and complementary and alternative medicine (CAM) type.

Study phase	Participant type	Number of participants
Phase 1: First interview	Naturopaths	5 (4F; 1M)
	Acupuncturists	4 (4M)
	Total practitioners	**9**
Phase 2: Recorded consultations	Naturopaths	4 (3F; 1M)
	Acupuncturists	2 (2M)
	Total practitioners	**6**
	Naturopathy clients	7 (6F; 1M)
	Acupuncture clients	2 (2F)
	Total clients/consultations	**9/7**
Phase 3: Second interview	Naturopaths	4
	Acupuncturists	2
	Total practitioners	**6**

appointment to obtain written consent. At the start of their appointment, the researcher placed a digital recorder in the consulting room and then exited. A total of seven consultations were recorded in phase two (two consultations were recorded with Naturopath 1; one each with the other five practitioners), involving nine clients (two consultations involved two clients). Consultation recordings lasted 55 min on average and only include the interactions between client and practitioner—not the sections of acupuncture appointments where the client is left alone after having had needles inserted.

Consultation recordings were transcribed, and the transcript was returned to the practitioner ahead of the second interview. During this interview, the researcher and practitioner had hardcopies of the transcript, which assisted with referring to specific passages. The researcher asked general questions about the consultation (e.g., 'Was this a typical consultation?') and then focussed on specific areas for further exploration (e.g., 'On page X, what did you mean when you said Y?'). All six practitioners from phase two participated in phase three, with DPIs lasting 50 min on average. Like the consultations, interviews were recorded, de-identified and professionally transcribed.

Table 1 summarises the data collection and participation. Clients are diverse in age range (from late teens to approximately their 70s), but not gender, reflecting the higher use of CAM among women (Steel et al., 2018).

Analysis

We first conducted an inductive thematic analysis, looking for recurring patterns and ideas within the data (Willis, 2019). All team members independently coded four common transcripts and together identified and refined codes to produce a codebook that was then used across the data. Qualitative coding software NVivo (QSR International, 2018) was used to organise the process, with coded data arranged into 'nodes'. During this process, especially upon reading and re-reading the consultation transcripts, we became more aware of the surveillance elements apparent in the client-practitioner dyad and turned to Foucauldian literature to develop our interpretation. We returned to the dataset and applied a second layer of coding over the consultations

and selected nodes, this time using a Foucauldian lens and discourse analysis to explore how identities, knowledge and power relationships are constructed through the language used (Starks & Brown Trinidad, 2007), reproducing broader discourses of health and self-responsibility. We attended also to the different techniques and technologies practitioners use to directly and indirectly observe the client. At this stage, the health-oriented characteristics of the gaze enacted within the consultations became clearer and, drawing on Antonovsky and salutogenesis as a theoretical framework, we further refined our analysis before our conceptualisation of the 'salutogenic gaze' began to crystalise.

FINDINGS

A key theme identified across the interviews is the practitioners' view that their central role is to educate and empower clients to take responsibility for their health. Naturopath 3, for example, describes her role as like 'a director of sorts', explaining, 'I'm very big on telling them on the first visit, I do 10%, they do 90. ...I'm here to give them tools, make suggestions...', and later, '[t]hey appreciate that, because that gives them power or control over their own lives, because it's their choices'. This discourse of empowerment aligns with the ways CAM users' experiences have often been interpreted in previous studies, but the recorded consultations offer much greater insight into *how* such empowerment is enacted, namely, through the power of the practitioner as a knowing observer and judge of the client. The client's orientation towards their own health is produced through the salutogenic gaze of the practitioner. We draw on the interviews and consultations to illustrate the salutogenic gaze at work, highlighting: (i) its confessional dynamic; (ii) the role of surveillance technologies; (iii) the hierarchical observation of the body; and (iv) the transfer of the gaze from practitioner to client.

The confessing subject in the CAM consultation

In the consultation transcripts, the confessional style of interaction between practitioner and client is striking, prompting our deeper analysis through a Foucauldian lens. Mayes (2009, p. 488) explains that the 'secrets' that come to light in the confession are 'hidden from the pastor because the individual has yet to utter them, and hidden from the individual as the pastor has yet to interpret their meaning and reveal their truth'. This encapsulates the dynamic within the CAM consultations, which centre on the practitioner asking the client to share intimate details of their habits, bodies and experiences, which the practitioner then interprets and uses to guide the client.

A large proportion of most consultations focusses on the discussion of diet, along with sleep, exercise and a review of medications and supplements (especially in naturopathy), in the context of ascertaining how the client has been feeling. Most clients in the sample have seen the practitioner before and are being asked to report on their progress since the last appointment. Their answers often reveal not just what they have been doing but a desire to show the practitioner that they understand what they *should* be doing, as in the following extract when the acupuncturist asks the client how they have modified their diet:

> ***Acupuncturist 4*:** What have you actually cut out?
> ***Client*:** So I've changed from drinking my No Sugar Coke for my extra burst of energy to a kombucha. ... Watching my breads, my dairy. I haven't really modified my diet as much as I'd like, because I'm so busy at the moment. I'm just rushing like a mad idiot, which is just

not healthy in itself. I'm still being a bit slack on—you know how we talked last fortnight about eating some protein in the morning, not relying on just a coffee and a banana to get me through. I haven't really adjusted that yet.

Here the client lists achievements and admits to certain 'failings' (being 'slack') while signalling that they have listened to and understood the practitioner's advice and aspire to be 'healthy'. Practitioners respond to these confessions with approbation or with further guidance, often using words like 'good', 'better' and 'well done', which imply a normalising judgement on their part—seen below after Naturopath 3 asks a client the same question:

***Naturopath 3*:** So what did you cut out?
***Client*:** I didn't really cut out anything. Oh, I've been eating a bit more properly lately. I'm back on track with the Weight Watchers. ... and I've started walking again.
***Naturopath 3*:** Okay. So you're eating better than you -
***Client*:** I'm eating better, yeah, I'm not eating rubbish.
***Naturopath 3*:** So, diet, tick.

Self-responsibility for health is evident in clients' responses—for example, 'I'm back on track', 'I'm still being a bit slack'—consistent with dominant health discourses. But what we see here is accountability not only to the self but to an external individual. The client's self-discipline is produced, at least in part, through the direct surveillance of another. Practitioners acknowledge and encourage this dynamic. Acupuncturist 1 commends a client for always doing 'what you need to', adding, 'I can't ask for more than that'. Naturopath 4 explains in an interview, '[s]ome of my long-term people, they just keep coming in to check in, to see that they're going okay, or for me to help be accountable, to help—for me to help them stay on track again'.

The client's agency and responsibility are sometimes seen by practitioners to extend into areas not typically understood as being controllable. This resonates with earlier findings about practitioners' beliefs (McClean, 2005; Sered & Agigian, 2008), but also comes through in interactions with the client. In this excerpt, the acupuncturist is asking the client about her last period:

***Acupuncturist 1*:** Okay, now you're saying it was nice fresh blood?
***Client*:** Mm-hm.
***Acupuncturist 1*:** Any clots at all?
***Client*:** No. Yeah, so it's probably the best one I've had for a while I guess.
***Acupuncturist 1*:** Oh right. Well done.

Having judged the quality of menstruation ('nice fresh blood'), the practitioner praises the client for her achievement. When asked about this interaction in the second interview, Acupuncturist 1 confirms that he views the changes as resulting from the client's actions and attitude:

> Her life has changed exponentially in the time that I've been seeing her and her attitude to life and that sort of stuff is significantly different. So for me, it's important to acknowledge that through the process, that when something positive happens with the body, that they're actually part of that process because she was definitely heavily engaged in that.

This philosophy is salutogenic in its view of health in relation to the person's 'total life situation' (Antonovsky, 1987 in Fries, 2020, p. 19) and paints the practitioner's role as making clients

aware of their own salutogenic agency. Intrinsic to the consultation is the message from practitioners that the client is both empowered and responsible for their health/life, and that the practitioner's job is to hold a mirror to the client's acceptance of their agency. Essentially, responsibility is taken on by clients *within the dynamic of the client-practitioner relationship*.

There is evidence of a powerful gaze operating in CAM consultations. It is important to acknowledge, however, that in CAM—perhaps more so than biomedicine—the practitioner's surveillance is not imposed but invited. Users self-refer to CAM practitioners and pay out-of-pocket to participate in the 'confession'. A new client explains to Naturopath 1 her reason for coming:

> ... to find out, is there something I need to be conscious of in my eating with where I'm at in my current position right now. Hormones, everything, age. Because I feel sluggish. I feel gassy. I feel lethargic in the afternoon. All these things. So it was more just trying to find out what I could do to improve that.

This is typical of the clients in our study who are not submitting themselves to a cure for a specific disease, but seeking expert guidance to achieve better health. This client does not expect a diagnosis, but wishes to know how to improve her own health, to move towards the wellness pole of the salutogenic continuum.

This broad remit inevitably broadens the practitioner's gaze. In line with this, the consultations incorporate holistic forms of surveillance, enquiring into a wide range of physical, emotional and social domains. For example, clients are questioned and advised on day-to-day activities, as in this consultation with an elderly couple:

> ***Naturopath 2*:** You both go and get the groceries?
> ***Female client*:** Yeah.
> ***Naturopath 2*:** I think that's good. I think just making that effort to get out and about when you can, and you wear your masks when you're out?
> ***Both clients*:** Yeah.
> ***Naturopath 2*:** But definitely a new bed sounds like a good idea, if you can manage. Quality sleep—sleep's the most important thing and we've talked about that before with you, [male client], about your sleep patterns.

Here we see, as through much of the consultations, attention not simply to pathogenic states or risks, but a more general ethos of promoting health and wellbeing; that is, a salutogenic focus (suggested by the naturopath to include quality sleep and getting 'out and about'). To assist clients to improve health, practitioners depend on them sharing detailed information about their lives. Such knowledge is gained not only via the 'technique of confession' but also through specific surveillance technologies.

Surveillance technologies: Client diaries and devices

An aspect of CAM practice that features prominently in the consultations (and that would have been missed had we relied on interviews, where it is rarely mentioned spontaneously), is the use of information from clients' self-tracking activities. There is much sociological analysis of health-tracking devices like Fitbits as technologies of the self (e.g., Lupton, 2017), but less on

the capacity of self-tracking to shape relations with others (Gabriels & Coeckelbergh, 2019). Our consultation transcripts show that, especially in naturopathy, self-tracking is encouraged by practitioners and serves to widen and deepen the reach of their gaze. Tracking technologies, taking high- or low-tech forms, extend the salutogenic gaze beyond the consultation, capturing detailed client behaviours and responses over a longer time period, rendering them available for the practitioner's inspection.

All of the naturopathy clients are urged to track and record their daily habits and symptoms so they can be shared with the practitioner. In some cases, this is through a structured food diary or menstruation chart that the practitioner gives to the client, and in three of the consultations a significant portion of the conversation involves the practitioner explaining how these tools should be used. Naturopath 4 explains to the client the scope and depth of information required:

> So just make sure you record all your breakfasts, lunches, dinners, snacks, everything that you do consume, beverages. So, any symptoms, just record the things that we talked about were the things playing up for you.

Later in the consultation, the client is told to also include weight, waist measurement, physical activity levels, hot flushes and other symptoms in the same diary.

Gaining awareness of one's own biological rhythms and how to work with them is argued to be an important element of salutogenesis (Alivia et al., 2011). In the consultations, practitioners look over the tracking data with the client to help the client recognise patterns and gain insight into their own health. This excerpt is from Naturopath 3's consultation with a mother and daughter:

> ***Naturopath 3*:** So just looking here at [daughter's menstruation chart], of course, we expect it to be on time, because you're now on the pill and so that was 2 weeks ago. We've had a little bit of dizzy.
> ***Daughter*:** Yes.
> ***Naturopath 3*:** Directly after the period.
> ***Daughter*:** Yes.
> ***Naturopath 3*:** Looking at your notes now, what does that tell us about your iron?
> ***Mother*:** It's low.
> ***Daughter*:** It's low.
> ***Naturopath 3*:** Okay.

The naturopath goes on to say that without the menstruation chart they would not have been able to identify dizziness after the period, 'which is another sure sign that you're anaemic'. Self-tracking therefore serves a double purpose of enlightening firstly the practitioner and through them the client who is guided to understand themselves better.

Beyond monitoring habits/symptoms and sharing knowledge, the tracking tools also serve to keep the client accountable, both to themselves and the practitioner. Naturopath 4 explains to the client that continuing to use the diet diary in tandem with regular appointments will help both parties gain a full understanding of the client's health:

> Because it is really easy to go, 'yeah we know all this' and then if there's, if there's no reason to keep accountable for anything, you can kind of fall off after a little while. Yes. So we'll keep it [regular appointment to review the diary] for that reason too.

In the second interview, Naturopath 4 refers to the diary as a way of '*seeing* if they are keeping on track' (our emphasis), highlighting the surveillance aspects of this tool and its embedding in a disciplinary dynamic between client and practitioner.

Keeping 'on track' includes keeping up with the self-tracking itself. Naturopath 1 tells a client that it is important not to forget to record her diet during the monitoring period: 'Take some notes. And daily'. Clients are praised for the consistency and quality of the information they present to the practitioner:

> I'm glad you're doing that [tracking sleep with a Fitbit]. That's awesome. Please keep going with that. ... That sounds great to me because that's a good way of me benchmarking too if we're having any impact or not.
>
> (Naturopath 1 to client)

> I love your spreadsheets [instigated by the client to track various aspects of health]. They are very impressive.
>
> (Naturopath 2 to client)

Part of being a 'good' CAM user who takes responsibility for their health appears to include being a good self-tracker who is ready to display information on their health and behaviour for the practitioner's judgement. Notably, these activities are not necessarily time-limited—long-term monitoring provides a continuous flow of information that can be used to calibrate behaviour within the 'ongoing pursuit of health and healing' that characterises salutogenic approaches (Fries, 2020, p. 28).

This monitoring is encouraged rather than imposed by the practitioner. Clients participate willingly and have sometimes instigated it themselves, in the hope of gaining the new understanding that comes from sharing the information with an expert. Information and knowledge are constructed collaboratively through these surveillance tools. At other times, the practitioner's gaze is exercised in a more unilateral, hierarchical manner, as demonstrated in the next section.

Observing the body

As outlined earlier, a recurring finding in research on CAM use is the emphasis on listening and dialogue in the CAM consultation, something highly valued by users. By shifting the focus away from the users' perspectives and a reliance on interviews, however, other aspects of CAM practice become apparent. Nicola Gale's (2011) ethnography of osteopathy and homoeopathy training shows that students learn not only to value talk; touch and observation are also central to their practice. Barcan (2011, p. 64) concludes that, like biomedicine, CAM modalities often conceive the body as 'truth-telling' and connect visible signs to internal states of health. Our data also show that, in the consultations, the practitioner's gaze involves much more than eliciting verbal information from the client. All practitioners rely on dialogue and clients' reports of symptoms, but simultaneously, practitioners overlay their expert gaze, using other sensory cues to assess client health and sometimes to override what the client is saying.

Acupuncturists describe the multifaceted ways they evaluate a client's state of health:

> We can read—from a Chinese medicine perspective, it's about interrogation, interview, but also observation. From the moment of the patient coming in through the

> doors, we have a look at what the gait is, where's the—some sort of physical deficiency and also have a look at the patient's face and see where—colour of the face and sometimes—and we go through all sort of, intuitively, through the characteristic of someone's persona, you know?
>
> (Acupuncturist 4, second interview)

> I'm looking for the colour of her skin, the way her voice sounds when she's speaking and her smell.
>
> (Acupuncturist 3, first interview)

Following Chinese medicine's philosophy, the acupuncturists' expert gaze does not only involve vision but hearing, smell and touch. It also extends beyond the physical body, implied by Acupuncturist 4's reference to 'intuitively' understanding the patient's persona. In contrast to the collaborative, egalitarian ethos often ascribed to CAM, these forms of surveillance rely only on the practitioner's expert knowledge. As such, the gaze can be applied at the practitioner's choosing, like when one acupuncturist tells the surprised interviewer, 'as I'm looking at you, I'm making ideas of where there may be some sort of disbalance'.

For most of the naturopaths, an important way of observing the body is the practice of iridology, involving the practitioner observing the patterning and colour of the client's iris through a special scope. Different patterns are believed to reveal aspects of underlying health. Iridology constitutes part of the specialist professional knowledge of naturopaths that is not accessible to clients. Seen as a window into the body's hidden secrets, as well as the client's character (Barcan, 2011), the eyes' signs are revealed first to the practitioner who may choose to share them with the client:

> I do the process of reading their eyes before they tell me anything. I don't want to know. I want to read the eyes and explain to them what I see first.
>
> (Naturopath 3, first interview)

The naturopaths' gaze also typically includes the client's blood, either collected and analysed by the naturopath or accessed through tests ordered from pathology labs. Blood is used to test for a wide range of health indicators, from food allergies to vitamin and mineral levels. Naturopath 1, ordering a blood test, explains to the client:

> So we're going to ask for a zinc and copper. ... I also want to get your B12 done because you don't actually eat a lot of foods that have B12 in them. If your B12 is low, no wonder you're tired. And also your iron.

Both the acupuncturists and naturopaths also question the clients in detail about what their medical doctors have prescribed and what tests they have done and often ask to see medical test results, or ask clients to ask their doctors to order particular medical tests and then share the results. The CAM practitioners' gaze therefore intersects with aspects of the medical gaze. Their observation of the body—its surface appearance, feel, smell and sound—resembles in many ways the anatomo-clinical gaze. But, instead of looking in the body's signs for 'the truth of disease' (Foucault, 2003/1973, p. 195), these practitioners are looking at the client's state of health, aiming to move them further along the continuum towards good health (Antonovsky, 1996). For example, tests are not usually conducted retroactively to identify an

existing problem (Fries, 2020), as Naturopath 2 explains: 'we look at blood pathology from a preventative point of view—not wait until you have it [and] then we'll do something about it' (second interview).

Where our CAM practitioners' gaze does sometimes align with the anatomo-clinical is in the hierarchy of knowledge it constructs, with 'the final, most decisive authority' given to the body (Foucault, 2003/1973, p. 137). This is seen in some of the examples above, where various tests are applied to discover what is happening inside the body, and when clinical signs observed by the practitioner are given greater weight than the client's account of symptoms. In one consultation, the acupuncturist manually checks the client's pulse (a standard diagnostic technique in Chinese medicine) and comments that her digestion is 'a little bit out'. He asks if she is feeling any bloating or discomfort, which the client denies. Later, when examining the client's abdomen, the acupuncturist checks if certain areas are tender and asserts again that the client's digestion is 'a little bit out'. When asked about the interaction, the acupuncturist explains that while Chinese medicine includes listening to what clients report, this is subjective, whereas physical examinations by the practitioner 'give us a more objective perspective on what's going on underneath the surface' (Acupuncturist 1, second interview).

CAM consultations are often depicted as a dialogue between equals (e.g., Sointu, 2012), and CAM is sometimes characterised as focussing on patient-reported symptoms rather than clinical signs (e.g., Dumes, 2020). What we see however is an additional layer to the interaction in which the practitioner uses methods other than talking and listening to obtain knowledge of the client's health. Signs are also important in CAM practice, and for the CAM practitioner, the client is both a subject and an object—the client's words reveal their inner secrets while the body is read to confirm the client's self-understanding or to suggest alternative narratives. The salutogenic gaze, while health-promoting, is a gaze nonetheless, judging the body of the client according to the norms of the expert practitioner.

At the same time, and in contrast to the anatomo-clinical gaze, the salutogenic gaze cannot work—that is, it cannot produce health—if it is held exclusively by the practitioner, because salutogenesis requires ongoing action that extends beyond the time and space of the consultation (Fries, 2020). As described already, knowledge of and agency over one's own health are important elements in salutogenic models and CAM. The final element of the gaze we discuss is its transference from practitioner to client.

Transferring the salutogenic gaze

Eriksson argues that 'salutogenesis can be conceived as a constant learning process, supporting movement towards health … via improving health literacy' (2022, p. 63). Returning to the question of how client empowerment can be reconciled with the practitioner's power, this becomes clear in the explicitly *pedagogical* nature of the salutogenic gaze. We note above that practitioners see themselves as empowering clients. The interviews and consultations show that practitioners try to achieve this by gaining knowledge of the client's health, sharing their insights with the client, and, ultimately, teaching the client to see their own health through the same gaze. Naturopath 3 expresses this clearly:

> You want to stop treating people, so - otherwise you would never go to bed. So, you're looking at what they're learning, because the word doctor actually means teacher.

> So, you're saying to these patients, 'what have you observed?'. Because then, by them learning how to observe their own body, they don't need you anymore.
>
> (First interview)

This suggests that the salutogenic gaze may be held only *temporarily* by the practitioner, before being passed on to the client. Clients begin as the object of the gaze but are taught by the practitioner to become the subject who gazes, learning 'how to observe their own body'. Empowerment includes learning to share in the expertise of the practitioner. This is seen for instance in the use of surveillance technologies. When diaries and records are shared and discussed, the practitioners interpret the data but also teach the client to understand the patterns themselves and to apply the analysis to themselves in future.

With the knowledge they gain from seeing the practitioner, clients are understood as gaining power over their health—power they are expected to exercise responsibly. Consistent with Foucault's general theory of disciplinary power (Foucault, 1977; Gardner, 2017b; Mayes, 2009), the salutogenic gaze is both repressive and productive. It is enacted through a discourse of agency and empowerment that also invokes an obligation to use one's agency to generate health:

> I don't see any of my clients or patients as passive recipients. I'm really keen to correct that thinking if they think that they just come and I treat and they get better.
>
> (Acupuncturist 1, Second interview)

The ultimate goal of the CAM practitioner-client relationship, according to the practitioners, appears to be enabling the client's realisation that they have agency over their health. This is seen in the earlier example where the acupuncturist reinforces for the client that improvements in menstruation are the result of changes she has made in her life. When clients demonstrate this self-understanding, this is rewarded by the practitioner. Acupuncturist 4 opens the consultation by telling the client, 'Look, I was very pleased by your email that you sent last week. There was so much information in that. So much insight'. Later in the consultation, he elaborates on what the client has done well:

> The one thing that impressed me with your email was that you were consciously aware that there is a connection within your gut - what you're eating and information process and heat and feeling hot and hot flushes.

In the second interview, this acupuncturist explains how the client's new insights signify that she has gained the knowledge needed to change her behaviour, fulfiling a key tenet of Chinese medicine:

> The most significant part of this consultation that I found was her insights of the things that she was doing that could possibly have been increasing her distress during her sort of signs and symptoms. Yes. Just having that insight about having to look at diet and having to look at triggers that would sort of manifest signs and symptoms. ... that's really important in Chinese medicine is having a look - having - to educate the clients to look out for signs and symptoms and then let them change those.
>
> (Acupuncturist 4)

In some ways, this 'insight' is constructed by practitioners as being equally important as improvements in health itself, mirroring the previous finding that CAM users like feeling in

control of their health even when their symptoms do not improve (Baarts & Pedersen, 2009). What our findings show is that this sense of power and control over one's health, enjoyed by CAM users, is actively fostered within the CAM consultation and involves the transfer of power/knowledge from practitioner to client, making the client the main actor *inspired* rather than *instructed* by the practitioner.

CONCLUSION

Depictions of the CAM client-practitioner relationship tend to emphasise either CAM user empowerment or the practitioner's imposition of negative judgements. We concur with Baarts and Pedersen (2009) that to frame CAM as 'victim-blaming' and repressive is simplistic, and, with Pedersen (2018), that CAM's enabling aspects best explain its popularity. For Pedersen (2018, p. 218), drawing on Foucault, CAM is more about 'enhancement' than normalisation and best understood through Foucault's later writing as a technology of the self rather than a form of discipline. However Pedersen's goal is to understand user experiences and 'lay empirical-based knowledge' (p. 221); our attention to the practitioner's view and expert knowledge uncovers forms of power and surveillance described in Foucault's earlier work on the clinical gaze. There is no reason both kinds of knowledge/power cannot operate simultaneously, and this is precisely what the CAM practitioner-client consultations illustrate. CAM user empowerment, we argue, occurs through the salutogenic gaze, a gaze that is initially wielded by the CAM practitioner but then transferred—with the knowledge and power it contains—to the client.

Our empirical study has limitations. We focus on only two—albeit quite different—CAM therapies, and further research is needed to ascertain whether the salutogenic gaze operates similarly in other CAM types. Our audio recordings capture the verbal elements of interaction in the consultations but miss other forms of communication and embodied practice. The DPIs help to illuminate non-verbal interactions (and the use of physical examinations and tests in the consultations are also narrated by the practitioners as they occur) but video recording might provide further insights into future studies. We aim to counterbalance the emphasis on user perspectives in previous CAM research, but without interviewing users we do not have insight into their interpretation of the consultations. Relying on practitioners to distribute the study invitation to clients means participants also may not represent the full range of CAM users (for instance, the seriously ill). Importantly, we are not aiming to generalise from this small study to other CAM users and practitioners, nor consultations around the world, but rather to propose a new concept through which to understand power in the CAM consultation that should be evaluated in future work.

The salutogenic gaze we have identified has several key features. It is a broad gaze, in Gardner's (2017a, 2017b) terms, in that it incorporates psychosocial as well as physical elements of wellbeing. It might also be understood as a *deep* gaze, in terms of the level of detailed information yielded to practitioners, and in its appraisal ranging from the client's body to the foundation of the client's knowledge and insight into their own wellbeing. Unlike the anatomo-clinical gaze, its core orientation is towards health promotion. Much of what the CAM practitioners seek to achieve fits with a salutogenic approach, namely a central focus on increasing people's general health and wellbeing, understood to derive from the wider context of their lives and the fostering of self-care. Whether our CAM practitioners are able to fully realise salutogenesis, which ideally includes population-level health promotion (Fries, 2020), is not clear given the study's focus on individual consultations. Notably, there are limitations placed upon CAM as privatised therapy excluded from public health policymaking and implementation.

Our analysis also suggests that salutogenic health care does not emancipate subjects from the surveillance and discipline that have been associated with the pathogenic anatomo-clinical gaze. Indeed, the population-wide scope and permanence of the salutogenic approach (Eriksson, 2022; Fries, 2020) theoretically extend perpetual health surveillance to the well. Although the salutogenic approach avoids viewing people as 'diseased', equally 'no one is categorised as healthy' (Eriksson, 2022, p. 63)—recalling critiques made of CAM and the elusiveness of wellness (e.g., Sered & Agigian, 2008).

The salutogenic gaze is a form of power/knowledge; however, it is power/knowledge that transfers between the expert and the client. Through the CAM consultation, users are guided to take on and display the gaze themselves—to become active agents of their health, not 'docile bodies' (Foucault, 1977). The transfer of the gaze to the client is, nevertheless, predicated on the practitioner's pre-existing and overarching power/knowledge. Mayes (2009, p. 489) makes a similar observation in relation to PCC: 'the relationship is always in favour towards the physician's authority and expertise as the patient implicitly recognises the physician as an authority and expert by making an appointment to meet with them'. In CAM, clients take the trouble to self-refer and pay privately to access the expertise of the practitioner. The self-empowerment and control over health they stand to gain depends on the practitioner applying their gaze first, before sharing it with the client. Nor, with the transfer of the gaze to the client, is the practitioner's power/knowledge fully relinquished. As seen in the section on observing the body, the salutogenic gaze maintains boundaries between lay and expert knowledge, such as when practitioners turn to 'objective' indicators of health and apply their gaze beyond the scope of the client's vision, using specialised equipment and tests to which clients have no access or training. If clients learn to share in the salutogenic gaze, they do not become CAM practitioners. They are limited to applying insights tailored to their own health. Hence, the expert power of the practitioner is maintained.

Our analysis brings the theory of CAM as technologies of the self into dialogue with the theory of the clinical gaze and shows how the user empowerment and self-responsibility associated with CAM is produced in the interaction with the expert practitioner. Although user empowerment is a leitmotif of CAM, the client's narrative is not necessarily the dominant one in the consultation. Their story is parsed through the normative gaze of the practitioner, who, while guiding clients towards self-knowledge, will also judge when self-knowledge has been attained. This is not a criticism of CAM; rather our analysis highlights the process in which expert knowledge is shared to promote health, and how the salutogenic gaze, like any other form of power/knowledge is productive and disciplining. It is possible that the salutogenic gaze applies beyond CAM, to the practice of other professionals aspiring to person-centred health promotion, such as nurses (see, for example, Gottlieb, 2013). We hope the concept will prove useful in future analyses of health care interactions in other contexts.

AUTHOR CONTRIBUTIONS

Caragh Brosnan: Conceptualization (Lead); Data curation (Lead); Formal analysis (Lead); Funding acquisition (Lead); Investigation (Equal); Methodology (Lead); Project administration (Lead); Writing – original draft (Lead); Writing – review & editing (Lead). **Campbell Tickner**: Data curation (Equal); Formal analysis (Equal); Investigation (Equal); Methodology (Supporting); Project administration (Equal); Writing – review & editing (Supporting). **Kate Davies**: Formal analysis (Supporting); Funding acquisition (Equal); Investigation (Supporting); Methodology (Supporting); Writing – review & editing (Supporting). **Milena Heinsch**: Data curation (Supporting); Formal analysis (Supporting); Funding acquisition (Equal); Methodology

(Supporting); Resources (Equal). **Amie Steel**: Conceptualization (Supporting); Data curation (Supporting); Formal analysis (Supporting); Methodology (Equal); Writing – review & editing (Supporting). **Pia Vuolanto**: Formal analysis (Supporting); Writing – review & editing (Supporting).

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are not available due to privacy or ethical restrictions.

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ENDNOTE

[1] We use salutogenesis to refer to an ontological and epistemological approach within CAM (Eriksson, 2022), rather than to describe health effects.

REFERENCES

Alivia, M., Guadagni, P., & Roberti di Sarsina, P. (2011). Towards salutogenesis in the development of personalised and preventive healthcare. *EPMA Journal*, *2*(4), 381–384. https://doi.org/10.1007/s13167-011-0131-9

Antonovsky, A. (1979). *Health, stress and coping*. Jossey-Bass.

Antonovsky, A. (1987). *Unravelling the mystery of health*. Jossey-Bass.

Antonovsky, A. (1996). The salutogenic model as a theory to guide health promotion. *Health Promotion International*, *11*(1), 11–18. https://doi.org/10.1093/heapro/11.1.11

Baarts, C., & Pedersen, I. K. (2009). Derivative benefits: Exploring the body through complementary and alternative medicine. *Sociology of Health & Illness*, *31*(5), 719–733. https://doi.org/10.1111/j.1467-9566.2009.01163.x

Barcan, R. (2011). *Complementary and alternative medicine: Bodies, therapies, senses*. Berg.

Broom, A. (2009). 'I'd forgotten about me in all of this': Discourses of self-healing, positivity and vulnerability in cancer patients' experiences of complementary and alternative medicine. *Journal of Sociology*, *45*(1), 71–87. https://doi.org/10.1177/1440783308099987

Broom, A., Meurk, C., Adams, J., & Sibbritt, D. (2014). My health, my responsibility? Complementary medicine and self (health) care. *Journal of Sociology*, *50*(4), 515–530. https://doi.org/10.1177/1440783312467098

Brosnan, C. (2015). 'Quackery' in the academy? Professional knowledge, autonomy and the debate over complementary medicine degrees. *Sociology*, *49*(6), 1047–1064. https://doi.org/10.1177/0038038513557912

Danell, J. A. (2015). From disappointment to holistic ideals: A qualitative study on motives and experiences of using complementary and alternative medicine in Sweden. *Journal of Public Health Research*, *4*(2), 538. https://doi.org/10.4081/jphr.2015.538

Davies, K., Heinsch, M., Tickner, C., Brosnan, C., Steel, A., Patel, G., & Marsh, M. (2022). Classifying knowledge used in complementary medicine consultations: A qualitative systematic review. *BMC Complementary Medicine and Therapies*, *22*(1), 1–13. https://doi.org/10.1186/s12906-022-03688-w

Dumes, A. A. (2020). *Divided bodies: Lyme disease, contested illness, and evidence-based medicine*. Duke University Press.

Eriksson, M. (2022). The sense of coherence: The concept and its relationship to health. In M. B. Mittelmark, S. Sagy, M. Eriksson, G. Bauer, J. M. Pelikan, B. Lindstrom, & G. A. Espnes (Eds.), *The handbook of salutogenesis* (pp. 61–68). Springer.

Fadlon, J. (2004). Meridians, chakras and psycho-neuro-immunology: The dematerializing body and the domestication of alternative medicine. *Body & Society*, *10*(4), 69–86. https://doi.org/10.1177/1357034X04047856

Flesch, H. (2007). Silent voices: Women, complementary medicine, and the co-optation of change. *Complementary Therapies in Clinical Practice*, *13*(3), 166–173. https://doi.org/10.1016/j.ctcp.2007.03.005

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. Penguin.

Foucault, M. (1979). On governmentality. *Ideology and Consciousness*, *6*, 5–21.

Foucault, M. (1988). Technologies of the self. In L. Martin, H. Gutman, & P. Hutton (Eds.), *Technologies of the self: A seminar with Michel Foucault* (pp. 16–49). University of Massachusetts Press.

Foucault, M. (2003/1973). *The birth of the clinic: An archaeology of medical perception*. Routledge.

Fries, C. J. (2008). Governing the health of the hybrid self: Integrative medicine, neoliberalism, and the shifting biopolitics of subjectivity. *Health Sociology Review*, *17*(4), 353–367. https://doi.org/10.5172/hesr.451.17.4.353

Fries, C. J. (2020). Healing health care: From sick care towards salutogenic healing systems. *Social Theory & Health*, *18*(1), 16–32. https://doi.org/10.1057/s41285-019-00103-2

Gabriels, K., & Coeckelbergh, M. (2019). 'Technologies of the self and other': How self-tracking technologies also shape the other. *Journal of Information, Communication and Ethics in Society*, *17*(2), 119–127. https://doi.org/10.1108/JICES-12-2018-0094

Gale, N. (2011). From body-talk to body-stories: Body work in complementary and alternative medicine. *Sociology of Health & Illness*, *33*(2), 237–251. https://doi.org/10.1111/j.1467-9566.2010.01291.x

Gale, N. (2014). The sociology of traditional, complementary and alternative medicine. *Sociology Compass*, *8*(6), 805–822. https://doi.org/10.1111/soc4.12182

Gardner, J. (2017a). Patient-centred medicine and the broad clinical gaze: Measuring outcomes in paediatric deep brain stimulation. *BioSocieties*, *12*(2), 239–256. https://doi.org/10.1057/biosoc.2016.6

Gardner, J. (2017b). *Rethinking the clinical gaze: Patient-centred innovation in paediatric neurology*. Springer.

Gottlieb, L. N. (2013). *Strengths-based nursing care: Health and healing for person and family*. Springer.

Henry, S. G., & Fetters, M. D. (2012). Video elicitation interviews: A qualitative research method for investigating physician-patient interactions. *The Annals of Family Medicine*, *10*(2), 118–125. https://doi.org/10.1370/afm.1339

Keshet, Y., Ben-Arye, E., & Schiff, E. (2012). Can holism be practiced in a biomedical setting? A qualitative study of the integration of complementary medicine to a surgical department. *Health*, *16*(6), 585–601. https://doi.org/10.1177/1363459312438566

Kwasnicka, D., Dombrowski, S. U., White, M., & Sniehotta, F. F. (2015). Data-prompted interviews: Using individual ecological data to stimulate narratives and explore meanings. *Health Psychology*, *34*(12), 1191–1194. https://doi.org/10.1037/hea0000234

Lupton, D. (1995). *The imperative of health: Public health and the regulated body*. Sage.

Lupton, D. (Ed.). (2017). *Self-tracking, health and medicine: Sociological perspectives*. Routledge.

Mayes, C. (2009). Pastoral power and the confessing subject in patient-centred communication. *Journal of Bioethical Inquiry*, *6*(4), 483–493. https://doi.org/10.1007/s11673-009-9195-9

McClean, S. (2005). 'The illness is part of the person': Discourses of blame, individual responsibility and individuation at a centre for spiritual dealing in the North of England. *Sociology of Health & Illness*, *27*(5), 628–648. https://doi.org/10.1111/j.1467-9566.2005.00459.x

Ning, A. M. (2018). How holistic is complementary and alternative med-icine (CAM)? Examining self-responsibilization in CAM and biomedicine in a neoliberal age. *Medical Research Archives*, *6*(5), 1–11. https://doi.org/10.18103/mra.v6i5.1750

Pedersen, I., & Baarts, C. (2018). Shaping of 'embodied expertise' in alternative medicine. In C. Brosnan, P. Vuolanto, & J. A. B. Danell (Eds.), *Complementary and alternative medicine: Knowledge production and social transformation* (pp. 273–294). Palgrave Macmillan.

Pedersen, I. K. (2018). Striving for self-improvement: Alternative medicine considered as technologies of enhancement. *Social Theory & Health*, *16*(3), 209–223. https://doi.org/10.1057/s41285-017-0052-3

Pedersen, I. K., Hansen, V. H., & Grünenberg, K. (2016). The emergence of trust in clinics of alternative medicine. *Sociology of Health & Illness*, *38*(1), 43–57. https://doi.org/10.1111/1467-9566.12338

QSR International. (2018). *NVivo qualitative data analysis software*. Version 12. QS International Pty Ltd.

Rose, N., O'Malley, P., & Valverde, M. (2006). Governmentality. *Annual Review of Law and Social Science*, *2*(1), 83–104. https://doi.org/10.1146/annurev.lawsocsci.2.081805.105900

Sered, S., & Agigian, A. (2008). Holistic sickening: Breast cancer and the discursive worlds of complementary and alternative practitioners. *Sociology of Health & Illness*, *30*(4), 616–631. https://doi.org/10.1111/j.1467-9566.2007.01076.x

Sointu, E. (2012). *Theorizing complementary and alternative medicines: Wellbeing, self, gender, class*. Palgrave Macmillan.

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*(10), 1372–1380. https://doi.org/10.1177/1049732307307031

Steel, A., McIntyre, E., Harnett, J., Foley, H., Adams, J., Sibbritt, D., Wardle, J., & Frawley, J. (2018). Complementary medicine use in the Australian population: Results of a nationally-representative cross-sectional survey. *Scientific Reports*, *8*(1), 1–7. https://doi.org/10.1038/s41598-018-35508-y

Weiss, G. L., & Lonnquist, L. E. (2006). Complementary and alternative medicine. In G. L. Weiss & L. E. Lonnquist (Eds.), *The sociology of health, healing, and illness* (5th ed.). Pearson Prentice Hall.

Willis, K. (2019). Analysing qualitative data. In M. Walter (Ed.), *Social research methods* (4th ed., pp. 341–364). Oxford University Press.

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