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**Lauren Brooks B.A. (Hons), M.A.**

**Looking for Alternatives  
Risk, Reflexivity and Complementary  
Therapies**

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**A thesis submitted in fulfilment of the requirements for the degree of  
Doctor of Philosophy**

**School of Applied Social Sciences**

**Durham University**

**September 2005**



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## Looking for Alternatives: Risk, Reflexivity and Complementary Therapies

### Abstract

This thesis explores individuals' motivations for using complementary and alternative medicines (CAM). More specifically, the thesis explores the relationship between the use of CAM and wider social and cultural changes which have altered individuals' expectations about their health and their understanding of risk and embodiment. The thesis draws on data from 24 in-depth interviews with individuals using a range of complementary and alternative health practices. Building on previous literature in this field this thesis not only explores individuals' initial motivations for using CAM, but also the reasons why they remain engaged with such practices and how their motives change over the course of time. I argue that the use of complementary and alternative medicines should be understood in terms of a career. As individuals progress along the CAM career trajectory their motives for using any given therapy not only change, but they also acquire further justifications and rationalizations for using CAM. One of the main motivations for using complementary therapies, amongst the participants of this study, was because of concerns over the safety of Western medicines, which were associated with potential risks to the health of the body. In contrast, so-called 'natural' remedies or other types of complementary therapies were seen to represent a relatively 'risk-free' alternative. In this sense I argue that complementary therapies are adopted as part of a strategy of risk avoidance and as a means of coping with the anxieties associated with caring for health and body within late modern society. The thesis also explores individuals' use of complementary and alternative medicines for self-care purposes. I argue that such practices should be viewed as a form of resistance to medical control and an attempt to regain control over the self. The thesis not only adds to our current understanding of complementary therapies within contemporary society, but also makes a significant contribution to key sociological debates.

## **Acknowledgements**

There a number of people who I would like to thank, all of whom have been involved in the production of this thesis in some way. Firstly, I would like to thank Sue Scott for her supervisory expertise. I am enormously grateful for her continual support, encouragement and the invaluable comments she gave throughout the project.

I would also especially like to thank all the complementary therapy users and practitioners who agreed to take part in the research, in particular those individuals who went out of their way to help enlist people to take part in the study. I would also like to thank friends and colleagues in the department of Sociology at Durham, who have provided support and encouragement, as well as welcomed distractions, throughout the course of the PhD.

Finally, special thanks to my family, and to my husband James, who provided much needed emotional support through the ups and downs of the past three years. Without their love and support I would never have been able to finish my PhD. I therefore dedicate this thesis to them.

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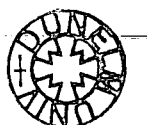


## Introduction

### Introduction

On the 26<sup>th</sup> August 2005, following an evaluation of the results of 110 trials involving homeopathy and placebo treatments for a range of health problems, Shang et al (2005) published an article in the *Lancet* concluding that homeopathy is no more than a placebo and any effect is 'all in the mind'. In the same edition of the *Lancet* a scathing editorial, entitled 'The end of homeopathy', contends that such findings are 'unsurprising'. 'Of greater interest', it is argued, 'is the fact that this debate continues, despite 150 years of unfavourable findings. The more dilute the evidence for homeopathy becomes, the greater seems its popularity' (*Lancet*, 2005: 690). Some patients, unhappy with their treatment within the impersonal and hurried NHS, may well see in homeopathy 'a holistic alternative to a disease-focused, technology-driven medical model', it says. But they could be endangering their health. This editorial demands that doctors must now recognize the absence of real curative powers in homeopathic medicine: 'Now doctors need to be bold and honest with their patients about homeopathy's lack of benefit, and with themselves about the failings of modern medicine to address patients' needs for personalized care' (ibid: 690).

Shang et al's (2005) findings received considerable attention in the media, and most mainstream British newspapers featured articles on the subject, with headlines such as 'Effects of homeopathy 'are all in the mind'' (*The Independent*, 26<sup>th</sup> August 2005) or 'As a fourth study says it's no better than a placebo, is this the end for homeopathy?' (*The Guardian*, 26<sup>th</sup> August 2005). The age-old debates about placebo, the efficacy of alternative therapies, and discussion about why poor deluded individuals would want to waste their money by using them, were once again thrown into the limelight. The BBC news online website invited members of the public to comment on the findings of the report and give their opinions about homeopathy in general. The responses presented



where mixed. Some individuals were supportive of the research and extremely critical of homeopathy and other alternative therapies, which were seen as 'hocus pocus', 'medieval medicine' and completely 'unscientific'. The consensus of opinion amongst such individuals was that if people 'want to waste their money on homeopathy', and other 'absurd' practices, then fine, but such treatments should not be made available on the National Health Service (NHS) (especially at a time when resources are scarce). For example, one individual writes:

'The issue with homeopathy is not just that rigorous scientific studies have found no evidence that it works. On top of that there is the problem that there is to the best of our scientific knowledge, simply no way in which it could work. Homeopathy belongs in the dustbin of history with the other obsolete medical theories. Spending health service money on it in a time when some highly necessary treatments cannot be provided, is screechingly immoral' (BBC news online, 2005).

However, many other individuals had emailed in, giving numerous personal accounts of the benefits of homeopathy. These individuals were not at all interested in 'scientific evidence' to prove whether or not homeopathy works, the fact that it had worked for them was sufficient, as the following quote indicates:

'I have used homeopathy on various occasions and have felt that they have worked. Even if it is a placebo, at least in this culture that we have of popping pills to help our ills, we have a choice. We have always looked to nature to provide our medicines, but why now do we poo poo natural therapies? We once had knowledge of what plants and natural things could do for us, but now we have lost it, in favour of lab created medicines, where the natural version can be on our doorstep! I believe that we need more education as to what we can do for ourselves before running to our local GP or chemist' (BBC news online, 2005).

Whilst it is not clear what the future will hold for homeopathy, it is unlikely that we are about to witness the 'end of homeopathy'. Over recent years the public have become increasingly interested in homeopathy and other complementary health practices and there is every indication that this interest will continue to grow, even in the face of further 'scientific' studies proving that such practices 'do not work'. Indeed, as the above example suggests, patients themselves may be less concerned with scientificity, not feeling that they need to understand the basis of the knowledge in order to benefit from it. Interest in complementary and alternative medicine (CAM) is sweeping the United Kingdom. CAM has become one of the fastest growing fields in health care. Millions of people are spending millions of pounds, mostly out of their own pockets, on therapies that until just recently were marginal activities. Although segments of the medical community (and public) remain sceptical, even dismissive, of these practices, more research, whilst not always complementary, is being conducted. The Prince of Wales, a supporter of complementary medicine, has recently commissioned a report on the benefits of complementary therapies, which he hopes will encourage the Government to fund more treatment on the NHS. Along with the growing interest in such practices a number of questions have emerged, what is CAM, why are so many people using it, does it work, is it just a placebo, is it safe, should it be made freely available within the National Health Service. The motivation behind this thesis emerged as a response to such developments and questions. However, this thesis is not concerned with ascertaining whether or not such healing practices are efficacious, this thesis is about the individuals who use them.

## **The Research**

This thesis is about the reasons why people turn to complementary and alternative medicines (CAM), and the factors that influence their choices. More specifically, this thesis explores the relationship between usage of CAM and wider social and cultural changes which have altered individuals' expectations about their health and their understanding of risk and embodiment. The increasing availability of complementary and alternative medicines has meant that individuals now have a range of health-seeking

options to choose from. This research investigates the experiences of users of CAM in order to explore their motivations, and asks the following questions: what brings a particular individual to consider using CAM in the first place, and on the basis of what information and advice? How do individuals develop knowledge and understanding of CAM? What affect does usage of CAM have on future health care decisions? What can an examination of CAM tell us about the role of expert knowledge and professionals in modern societies? And how does the issue of risk relate to the decision-making processes? How far is the use of CAM seen in terms of consumer choice? Have we seen the traditional patient of health care also becoming a 'consumer', choosing the services they desire and seeing themselves as active decision-makers? This research will add to our understanding of how people make decisions about where to seek help and advice in relation to health problems. It will also help to explain the ways in which people develop knowledge and understanding of alternative therapies and how they relate these to wider cultural understandings of the body and health. In order to comprehend the different reasons underlying the use of complementary and alternative medicines, this thesis includes an intentionally wide selection of complementary health practices.

Existing studies that focus on individuals' motivations for using complementary therapies have revealed a great deal about the type of people who use CAM, and the explanations they provide for a particular consultation. However, such research has been unable to indicate how people make decisions about CAM, in relation to their knowledge and understandings of them. As a result little is known about whether usage of CAM might be derived from or even bring about broad changes in ideas about health and illness. This research will explore the way in which changes in perceptions of health impact on behaviour. By uncovering the ways in which knowledge of CAM is incorporated into individuals' own understandings of health and the body and the subsequent effect this has on decisions they make about health care. This thesis departs from previous studies, by exploring the relationship between usage of CAM and social change. This thesis seeks to make a substantive contribution to the CAM literature whilst also considering more formal sociological concerns, referencing work on risk, reflexivity, individualization, the sociology of consumption and the body. As complementary and alternative therapies

grow in popularity the need for further research is increasingly necessary. Particularly in relation to the experiences of those using these services. A report ordered by the House of Lords (Select Committee on Science and Technology, 2000) identified the motivations of those patients seeking CAM as a priority area for social research. Furthermore, as Siahpush (1999b: 173) points out 'the sociology of alternative medicines is a very young field of inquiry in that it is neither theoretically developed nor empirically investigated adequately'. It is to this further development that this thesis makes an original contribution. The final section of this chapter provides an overview of the structure of the thesis.

### **Structure of the thesis**

In exploring the influence of social and cultural changes on the usage of complementary and alternative therapies this thesis marks a departure from previous studies of CAM use. It offers a broader and more theoretically informed approach. It addresses key questions of risk and trust in relation to experts, the role of biomedicine in producing health, changing attitudes to the body and personal responsibility for health. Throughout this thesis two key questions resound: First, how can we explain the increased usage of CAM? And secondly, how do individuals' motivations to choose CAM relate to wider social and cultural changes which have altered their expectations about health and their understanding of risk and embodiment? This thesis, therefore, not only seeks to add to our understanding of the nature of complementary and alternative therapies, but also to make a theoretical contribution relating to the sociology of the body, the management of risk and the relationship between lay and expert knowledges.

Chapter 2 provides an overview of the main issues that shape our current understandings of complementary and alternative therapies. The chapter begins by discussing the problems associated with defining which practices and medications constitute complementary and alternative therapies. Here, the terms 'complementary' and 'alternative' are understood as socially and culturally specific categories. What constitutes such practices is also viewed as historically contingent. This chapter provides a brief historical account of the development of orthodox and alternative medicine in

Britain from the mid 19<sup>th</sup> century onwards. This overview indicates that whilst many of the therapies that are currently popular today are not new in historical terms, it is possible to show that in the UK alternative medicine was popular but then experienced a period of decline to be followed by a revival from the late 1960s onwards. The chapter gives an overview of the recent survey data on the use of complementary and alternative therapies. This data reveals that the use of complementary therapies is no longer a marginal activity and is now becoming a major part of healthcare in many Western countries. Finally, this chapter ends with a discussion of the biomedical responses to the rise of complementary therapies in the UK and the prospects for their integration into the National Health Service.

The central aim of this thesis is to examine the reasons why people turn to complementary and alternative medicines. There already exists a wealth of empirical research considering this issue and in chapter 3 I provide a critical review of this literature. However, the thesis departs from previous research in three main respects: first, most research in this area has considered individuals' *initial* motivations for using CAM, rather than the reasons why they *return* to/continue with such practices. Nevertheless, reasons for using CAM are likely to alter over the course of time and throughout the course of using complementary therapies (Sirois and Gick, 2002). Thus, in addition to exploring individuals' initial motives for using complementary therapies, this thesis also focuses on the reasons why individuals remain engaged with such practices and how their motivations change over the course of time. Secondly, this thesis adds to the existing literature by considering self-care aspects of CAM use, an area which to date has received little attention. Thirdly, and perhaps most importantly, this thesis seeks to build upon the existing literature by providing a more theoretically nuanced understanding of the use of complementary and alternative health practices. In order to do so the thesis engages with a diverse, yet overlapping, range of contemporary sociological literature, including theories of risk, reflexive modernity, individualization and consumption. Indeed, whilst previous research in this field has revealed a great deal about the type of people who use CAM, and the explanations they provide for a particular consultation, such research has tended to skirt over more sociological concerns. This

chapter provides an overview of the theoretical literature that was used in the analysis of the data, and which is drawn upon throughout this thesis in order to understand the rise of complementary and alternative therapies and individuals' motivations for using them.

The research presented here is based on semi-structured in-depth interviews with 24 CAM users. In chapter 4 I describe the methodological approach of this thesis and justify the choice of methods that have been employed to conduct this research. In this chapter I focus on the research process itself, including issues relating to access, the selection of the sample, the process of data collection, ethical issues and the analysis of the data.

The next three chapters present the main findings from the research. In chapter 5 I explore participants' motivations for using complementary and alternative therapies. However, by adopting a developmental approach, drawing on the Chicago theorizations of career and status passage (Becker, 1963; Glaser and Strauss, 1971; Goffman, 1968), I not only explore individuals' initial motivations but also their reasons for remaining engaged with such practices and how their motives change over the course of time. In this chapter I argue that by adopting this particular theoretical framework I am able to distinguish between different 'categories' of users, but also demonstrate that such positions are not fixed in time. In this sense, this approach allows for a more fluid and dynamic understanding of CAM use and thus moves away from the more restrictive typologies which fit individuals into rigid 'types' (e.g. Sharma, 1998). Four 'categories' of users or stages in the CAM career are identified: 'new users'; 'occasional users'; 'regular users' and 'committed users'. As individuals progress along the CAM career trajectory their motives for using CAMs not only change, but they also acquire further justifications and rationalizations for using them. This chapter concludes by arguing that these changes should be understood as moral in the sense that the experience of using CAM provides a 'turning point' in the way individuals view themselves and the world (Goffman, 1968).

In chapter 6 I reintroduce some of the theoretical perspectives outlined in chapter 3, most notably the work of Beck (1992) and Giddens (1990; 1991) on risk and reflexive

modernization. This chapter takes up some aspects of these theoretical perspectives in relation to the consumption of complementary and alternative therapies, and examines how the issue of risk relates to individuals' motives for using complementary therapies. One of the central themes to emerge from the data was a reluctance amongst participants to use orthodox medicines, which were associated with potential risks to the health of the body, such as long-term side effects and iatrogenic illness. In contrast, so-called 'natural' remedies or other types of complementary therapies were seen to represent a relatively 'risk free' alternative. In this sense, I argue that complementary therapies are adopted as part of a strategy for risk avoidance and viewed as a possible solution to the uncertainties associated with Western pharmaceuticals. If individuals feel that the medicines they use are 'natural' rather than 'chemical', 'artificial' or 'unnatural', then they feel better about taking them. This chapter concludes by arguing that whilst the data provide some support for Beck and Giddens' theorizations concerning the nature of risk in contemporary society, the data also demonstrate that the ways in which individuals make sense of and respond to risks is far more contradictory and contingent than Beck and Giddens allow for.

As mentioned above, one important respect in which this thesis departs from previous research on CAM use is through its consideration of the consumption of over-the-counter (OTC) CAM products used for self-treatment. Chapter 7 focuses specifically on this aspect of CAM use. As this is a relatively new field of inquiry this chapter begins by providing details relating to patterns of usage; how individuals obtain information and develop knowledge about using CAM for self-care and about the extent to which such practices are used as either an alternative or a supplement to formal health care. The chapter goes on to explore this 'hidden' aspect of CAM use in relation to debates about the role of expert knowledge and professionals in modern Western societies. Giddens (1991) has suggested that the public have become increasingly informed and reflexive, as knowledge has become pluralized. In such a context it is likely that individuals will attempt to 'reskill', by taking back some control from experts and searching for alternatives. In this chapter I consider whether the use of CAM is part of this reflexive aspect of late modern societies. This chapter concludes by arguing that the use of CAM



on a self-help basis can be seen as a form of resistance to medical control and a rejection of biomedical hegemony. Individuals use such practices in an attempt to take back control over their health and reduce their reliance on medical practitioners. However, the data also suggests that there are limitations to the re-skilling process and the notion of the 'reflexive consumer'. Indeed, the data suggest that in certain situations individuals may need to consult with an expert over a particular health problem, although that might be a CAM practitioner rather than a medical practitioner. This suggests that rather than being a rejection of authority and expert knowledge, there has been a repositioning of authority and an emergence of new experts.

In the concluding chapter the main findings of this research are summarized and evaluated. This chapter also discusses the broader implications of the findings. I argue that this thesis has demonstrated that there is a relationship between wider social and cultural shifts and individual motivations for using complementary and alternative therapies. I also focus on the issue of choice and agency in relation to health. The limitations of the study and the possibilities for future research that have emerged from the research are also discussed in this chapter.

## The (Re)emergence of Complementary and Alternative Medicines

### Introduction

This chapter begins by providing a discussion of the problems associated with defining what healing modes constitute 'complementary' or 'alternative medicine'. There are many conflicting interpretations of complementary and alternative medicines, making it difficult to ensure a common understanding. There is confusion about which therapies to include or exclude from the definition and how to classify the multitude of therapies in some coherent way. There is also confusion about what such therapies should be called, 'alternative', 'complementary', 'unorthodox', 'unconventional', 'fringe' and 'marginal' are only some of the many terms that have been used to describe these health practices. Some commentators choose to define complementary therapies in terms of the similarities in characteristics of the therapies themselves. Yet, as I will demonstrate non-biomedical modes of healing found in Western countries are highly diverse. More recently a number of scholars have drawn attention to the socially constructed nature of complementary and alternative medicine (CAM) (i.e. Saks, 2003; Kelner and Wellman, 2003, Tovey et al., 2004). Indeed, not only are the terms 'alternative' and 'complementary' culturally specific categories (Saks, 2003), but also what constitutes such practices and medications is historically contingent (Tovey et al., 2004). Turner (2004) maintains that we need to understand the current rise of CAM against the historical backdrop of the development of orthodox medicine, the consolidation of medical dominance, and the subsequent marginalization of alternative medicines. This chapter therefore provides a brief account of the development of orthodox and alternative medicine in Britain. Whilst many of the therapies that are currently popular today are not new in historical terms, and some practices, such as herbalism can be traced back to

antiquity, it is possible to show that in the UK alternative medicine was popular but then experienced a period of decline to be followed by a revival in the late 1960s (Cant & Sharma, 1999), and has continued to increase in popularity since then. The chapter then presents a review of recent survey data, which provides details relating to the prevalence of CAM use, information regarding the sorts of health conditions complementary and alternative therapies are most commonly used to treat, as well as an indication of the characteristics of CAM users and patterns of usage. Finally, the chapter finishes with a discussion of the biomedical responses to the rise of complementary and alternative medicines.

### **Defining complementary and alternative medicine**

There has been much debate surrounding the definition of those therapies/medicines that are found outside mainstream conventional medicine. Such confusion is exacerbated by the fact that complementary and alternative therapies are highly diverse both in character and origin. Some have been imported more or less wholesale from non-Western cultures<sup>1</sup> others originated in the West. While some have persisted from the nineteenth century (e.g. chiropractic, naturopathy, osteopathy and homeopathy), others are of fairly recent origin (e.g. biofeedback and rolfing). A few have diffused from the Far East (e.g. acupuncture and yoga); and others are traditional or folk remedies which can be traced back to antiquity (e.g. herbalism) (Anyinam, 1990). Indeed in practice, complementary and alternative medicines are not a unified group historically, philosophically or in terms of the therapeutic techniques used.<sup>2</sup> They encompass practices such as acupuncture and aromatherapy, which are based on the therapeutic use of needles and essential plant oils respectively. Therapies such as homeopathy that involve giving extreme dilutions of remedies and are based on the principle of 'like cures like', and different types of manipulation of the spine and other joints embodied in chiropractic and osteopathy (see

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<sup>1</sup> It is true that many of the therapies and therapeutic systems in operation today clearly originate from outside the Western world. However, when they are transplanted into the West they have typically been adapted to Western cultural conditions. For example, numerous forms of Oriental medicine, such as acupuncture and shiatsu, have been imported to the West and have been 'naturalized' (Cant and Sharma, 1999).

<sup>2</sup> The diversity of complementary and alternative therapies has led some commentators to question whether they should indeed be considered as a single category (see for example, Wardwell, 1994).

for example Fulder, 1996, Zollman and Vickers, 2000). Practices also vary in terms of their standing in relation to the medical establishment. For example, over recent years osteopathy and chiropractic have become more accepted by orthodox medicine,<sup>3</sup> in contrast to other therapies such as crystal healing and reflexology which continue to be marginalized. Moreover, what counts as 'alternative' or 'complementary' in health care varies culturally. This is highlighted in cases where medical practices, seen as alternative in Western contexts, are viewed as orthodox in others (Cant and Sharma, 1999; Bodeker, 2001; Kelner and Wellman, 2003). For example in China, traditional Chinese medicine in various forms has largely been integrated into the state-run health care system. Similarly, in India the government is involved in the promotion of both Ayurvedic forms of medicine and homeopathy through, for example, regulation, clinical trials and the education of medical practitioners (Bodeker, 2001; Porter, 1999). In other words, medical practices that might be considered alternative in the West form a part of the established and conventional health care systems in other cultural contexts.

The terms 'complementary' or 'alternative' medicine should be understood as social constructs, which vary according to the social context in which it is defined (Kelner and Wellman, 2003, Tovey et al., 2004). For example, for the medical profession, complementary or alternative medicine is defined by its location 'outside accepted medical thought, scientific knowledge, or university teaching' (Ernst, 1996: 244). In this sense, the definition is derived from its differences to the dominant mode of health care, which at this point in time is biomedicine. However, such a definition has been criticized for its *residual* form (Kelner and Wellman, 2003), in other words it is defined by what it is not (Doel and Segrott, 2003b). The term 'complementary medicine' defines these health practices as a complementary adjunct to medical care. Suggesting the possibility of cooperation with conventional medicine and also signifying the fact that the majority of individuals who use 'complementary' therapies often also visit their doctors (see for

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<sup>3</sup> However, it has been suggested that such complementary medicines have had to de-radicalize their claims and limit their practice to gain legitimacy, status and state regulation (Cant & Sharma, 1999). For example, once osteopathy had relinquished its claims as a generic form of medicine and achieved a form of professional organization acceptable to the medical profession (through the 1993 Osteopaths Act) it was no longer seen as a threat but as a modality that could usefully supplement medical care in the difficult area of musculoskeletal problems (Cant and Sharma, 1999).

example, Sharma, 1995). However, the term 'complementary' medicine has been criticized for indicating an acceptance of a more limited position, subordinate to biomedicine. In contrast, the term 'alternative medicine' has been used to convey the fact that these therapies stand on the edges of the established health care system and receive almost no support from the medical establishment or the government (Saks, 1992). The term is also often used to reflect the notion that there are fundamental and irreconcilable differences between most alternative therapies and conventional medicine with regards to such central conception as disease, symptoms and treatment (Siahpush, 1998). More recently, the term complementary and alternative medicine and its acronym CAM, have become the accepted terminology in academic writing on the topic, used to incorporate both those therapies that share a more co-operative relationship with biomedicine, as well as those that are regarded as complete systems in their own right, operating in opposition to biomedicine. Indeed, according to Kelner and Wellman (2003: 5-6) CAM is defined as: '[A]n approach to health care that while different from conventional medicine, is sometimes complementary to it and at other times is distinctively alternative'. In this thesis, I use terms such as complementary and alternative medicine (CAM), complementary or alternative therapies, and complementary and alternative health practices interchangeably, whilst at the same time recognizing that no terminology is without problems.

There have been several attempts to classify and categorize the various CAM therapies. For example, Pietroni (1991) develops four categories based on their knowledge claims. 'Complete' systems of medicine refer to those therapies that claim to offer a whole system of medicine. In this category, Pietroni includes homeopathy, herbal medicine, acupuncture, osteopathy and chiropractic. However, this is not to imply that such therapies would claim to be able to treat all medical complaints. For example, this is not the case with modern osteopathy and its concentration on lower back problems (Cant & Sharma, 1999). The next category, 'diagnostic' includes therapies such as kinesiology and iridology. 'Therapeutic' modalities refer to therapies that do not claim to be diagnostic, but do claim that their treatment can and do work. In this group Pietroni includes reflexology, aromatherapy, hydrotherapy and massage. Finally, 'self-help'

approaches, those where patients are encouraged to undertake certain practices and exercises, often without the presence of a practitioner, includes meditation, yoga and breathing and other relaxation techniques. There are a multitude of ways in which to classify complementary and alternative therapies, in terms of their historical origins (Cant and Sharma, 1999); based on the extent of legitimacy and public acceptance; or according to the context in which they are delivered (Kelner and Wellman, 2003).

The House of Lords report (2000) separated complementary and alternative therapies into three distinct groups: The first group is composed of acupuncture, chiropractic, herbal medicine, homeopathy and osteopathy. These therapies are centred on individual diagnosis and treatment, and are seen to possess the most credible evidence base and the most organized group of practitioners.<sup>4</sup> The second group of therapy, including aromatherapy, counselling, hypnotherapy, massage and reflexology, are held to complement conventional medicine. The defining feature of the third group was felt to be that the therapies concerned have philosophical principles counterposed to those of mainstream medicine, as well as the weakest research base. However, this group encompasses long-established health systems such as Ayurvedic Medicine and Traditional Chinese Medicine, together with more marginal therapies such as crystal therapy, iridology and radionics. This sparked off a great deal of controversy from within the 'CAM community' and is understood as problematic for a number of reasons. According to Doel and Segrott (2003b) the typology was adopted in order to pacify the concerns of several professional associations already under statutory regulation, i.e. chiropractors and osteopath, who did not want to be associated with what they considered to be less credible and less professionalized practices.

Nevertheless, whilst it is undoubtedly the case that alternative therapies are derived from diverse geographical, cultural, social, philosophical backgrounds and historical periods (Anyinam, 1990) there are a surprising number of commonalities in the ideas of healing involved, even between therapies that emerged quite independently. Fulder (1996: 5-7)

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<sup>4</sup> The inclusion of homeopathy within this category is interesting in light of the continuing debate about its efficacy, as discussed in chapter 1.

sums up the ideas of healing involved in complementary and alternative therapies within eight themes: <sup>5</sup>

1. 'Working with, not against, symptoms' – symptoms are to be managed not suppressed; they can be a guide to the origin of an upset, and serve as milestones on the journey to a cure.
2. 'Individuality' – each person, condition, constitution and treatment is different; unlike conventional medicine, it does not rely on statistical norms.
3. 'The integrated human being' – there are no barriers between mind, body and spirit, or between society and individual; all are relevant in both diagnosis and therapy.
4. There is 'no defined or determined state of illness where treatment must begin or wellness where treatment must end' – CAM operates with a broad definition of health in terms of physical, mental and spiritual well-being.
5. 'Safety is sacred' – therapies are 'minimally interventionist' and harmless, by working with rather than against the normal functioning of the body.
6. 'Areas of competence' – CAM is better equipped to deal with 'chronic, psychosomatic, early-stage, musculoskeletal, immunological, non-specific/multi-origin, environmental conditions as opposed to acute, traumatic, infections, genetic, tropical conditions'.
7. 'Patient is partner' – 'the status differential is less than in conventional medicine, and the tone of the consultation is more of a dialogue, less of a pronouncement by the dominant professional'.
8. 'Alternative world views' – therapies posit patterns of relationship between creatures and their environment, which can be subtle and energetic.

Summarizing, Fulder suggests that complementary and alternative therapies work by stimulating the body's self-healing powers, work with rather than against symptoms, and regard human beings as 'part of the flow of nature and not necessarily as its control

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<sup>5</sup> Fulder acknowledges that not all of these themes will apply to all complementary and alternative therapies.

centre' (Fulder, 1995: 51-2, 55). Others who have written about CAM emphasize the processual understanding of health and illness in complementary medicine. Illness itself is a process of transformation (Duff, 1994). Diagnosis is an art, involving reading the particular sequential patterns of events and symptoms (see Sharma, 1995; Fulder, 1996). Cure involves the creation of order out of personal narratives more than it does the physical alleviation of symptoms (Lebeer, 1993). According to Kelner and Wellman (2003), no matter how complementary and alternative therapies are defined, it is important to recognize that, compared to conventional medicine<sup>6</sup>, they operate under very different paradigms of theory and practice:

'Conventional medicine typically treats disease as a breakdown in the human body that can be repaired by direct biochemical or surgical intervention. The theoretical underpinning is frequently claimed to be rational and scientific. The model on which it is based conceives illness as arising from specific pathogenic agents, and views health as the absence of disease. The concept of CAM, on the other hand, covers a diverse set of healing practices, which do not normally fit under the scientific medical umbrella. Instead, these practices emphasize the uniqueness of each individual, integration of body, mind and spirit, the flow of energy as a source of healing, and disease as having dimensions beyond the purely biological' (Kelner and Wellman, 2003: 5).

Turner (2004: xiii) maintains that any sociological investigation of CAM must situate these healing practices against the historical backdrop of 'the development of scientific, allopathic medicine<sup>7</sup> and the consolidation of medical dominance, the early erosion of

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<sup>6</sup> It should be noted that in the same sense that CAM represents a diverse field of therapies and thus does not constitute a homogeneous group, neither is conventional medicine monolithic (Gabe et al., 2004; Tovey et al, 2004). It is generally accepted that biomedicine is far from unified, encompassing a variety of knowledges and healing practices (Gabe et al, 2004).

<sup>7</sup> The term allopathy is used to refer to the treatment of disease with drugs having the opposite effects to the symptoms. This is in contrast to homeopaths treat an illness with a highly dilute form of some substance which is held to produce similar symptoms to those which the patient manifests, according to the principle of 'like cures like'. The term 'allopathic medicine' is often used by homeopaths to stress this difference in the principles of the two systems.



alternative systems of care, and their slow but steady revival'. Indeed, as Tovey et al (2004) add analyses need to start by recognizing that the growth of CAM in recent decades is historically contingent and, like orthodox medicine, it is also a social product. However, unlike orthodox medicine a key aspect of that contingency is that during its development, it faced an already firmly entrenched medical orthodoxy supported by the state (Willis, 1989). In the following section I will provide a brief account of the rise of the medical profession and orthodox biomedicine and the subsequent marginalization of alternative medicine. I will then discuss the revival of complementary and alternative medicines, which began in the 1960s.

### **The marginalization of alternative medicine**

The existence of a range of healing systems and therapies is by no means a new phenomenon. Many practices that are today considered to be complementary or alternative have been part of systems of caring for health for centuries if not millennia (Sharma, 1995; Porter, 1987, 1994, 1999; Saks, 2003). Indeed, prior to the nineteenth century the provision of health care in Britain was characterized more by its diversity and plurality, than by any kind of uniformity (Stacey, 1988),<sup>8</sup> making it difficult to classify any particular group of health care practitioners as representing the 'orthodoxy' (Saks, 1996).<sup>9</sup> However, with the development of the modern medical profession the ambiguity surrounding what constituted orthodox or unorthodox medical practice began to disappear (Saks, 1996). The nineteenth century saw important changes in health care delivery and the official status accorded to different medical practices. In Britain, the pivotal legislation that led to the professional privilege of doctors over and above all

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<sup>8</sup> During this period a wide range of approaches to health care were available, including astrology, herbalism and healing on both a self-help and practitioner delivery basis (Larner, 1992). According to Porter (1989), herbalists, bonesetters and the like competed with the occupational forerunners of the emergent medical profession on a far more level playing field than today.

<sup>9</sup> However, as Larner (1992) suggests from the sixteenth century onwards it was possible to identify a regular medical community, based on the establishment of the Royal College of Physicians and the licensing of surgeons and apothecaries. Nevertheless, these groups did not appear to have enjoyed the kind of therapeutic success that would have made them the automatic choice of all or even most patients who could pay for treatment (Cant & Sharma, 1999). Porter (1987) suggests that individuals during this time were likely to shop around for health care, as well as 'regular' medicine, they would also have 'made free use of quack and unorthodox remedies as well, following a try-anything mentality which gave no automatic privilege to regular medicine' (Porter, 1987: 56).

other health care practitioners was the Medical Act of 1858 (Stacey, 1992; Saks, 2003). Effectively the Act established that only certain practitioners, those medics holding an approved licence, could claim to be a 'qualified medical practitioner' (Loudon, 1987: 106).<sup>10</sup> The Act granted doctors state registration for the first time and in doing so laid the foundations for an alliance between biomedicine and the state which was to grow and strengthen, with the medical profession gaining the status of privileged 'insider' group (Cant & Sharma, 1999). The Act also contributed to the very definition of the boundaries of biomedicine itself, for it established the General Medical Council, which had oversight of the content and scope of medical curricula and training (Cant & Sharma, 1999). As Porter (1987: 51) writes:

'The significance of the register lay of course in those it excluded. For all ranks of regular practitioners now appeared together as 'insiders', lined up against all the 'outsiders' – the unqualified homeopaths, medical botanists, quacks, bone-setters and the like, who were automatically constituted, by exclusion, into the 'fringe'. Parliament had achieved what the doctors never could; it had – symbolically at least – united the much-divided medical profession, by defining them over and against a common Other, not to say enemy' (Porter, 1987: 51).

It is not surprising therefore, that Waddington (1984: 96) has suggested that the Act represented 'a major legislative landmark – perhaps the major legislative landmark – in the development of the medical profession'. Following this landmark, the antagonism towards competitors that had been evident in establishing the medical monopoly was perpetuated in the drive to maintain and extend the privileges of the profession (Saks, 2003). The state-legitimated professional boundaries that were established through the Act provided a sound basis for intensifying the attack on what was now officially categorized as 'unorthodox medicine' (Saks, 2003). Indeed, at this time such practices continued to pose a threat to the medical profession, as they still remained a popular part

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<sup>10</sup> However, as Saks (1992) notes it did not in principle exclude outsiders from practicing, as they were still entitled to operate under the common law as long as they did not represent themselves as medical practitioners.

of private sector health care.<sup>11</sup> Subsequently, the medical profession launched an attack on rival health groups through medical journals such as the *Lancet*. This journal commented on ‘the crass stupidity’ of sick persons who ‘place themselves in the hands of men who rob their victims of both money and life’ (*Lancet*, 1871: 598 cited in Saks, 2003: 69). It also distinguished the scientific ‘rationality’ of the medically qualified from the scientific ‘irrationality’ of alternative therapists (*Lancet*, 1889 cited in Saks, 2003: 69). According to Saks (1999), such attacks enabled doctors to position themselves as representatives of a profession safeguarding the health needs of the wider public, in contrast to their unorthodox competitors, who were accused of engaging in superstitious practices in an increasingly secular society.

However, although the status of scientific medicine was strongly consolidated during the nineteenth century, modernization and the rise of scientific medicine also had their opponents. According to Porter:

‘[T]he nineteenth century was distinctive for introducing new healing movements based on the principled rejection of orthodox medicine in favour of alternative healing philosophies’ (Porter, 1999: 389).

Indeed, despite its attempts orthodox medicine never actually achieved a total monopoly of medical services in Britain, even during the time when it was increasingly gaining strength from the mid-nineteenth century to the mid-twentieth century (Saks, 2003). There is evidence in Britain, for example, that homeopathy continued to attract considerable support in the years up to the turn of the century, and was practiced by some doctors themselves, despite opposition from the leaders of the newly forged medical profession (Nicholls, 1988). Similarly, the use of a variety of unorthodox self-help remedies continued into the first part of the twentieth century for many common conditions (Stacey, 1988). Other therapies were also developed during this period.

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<sup>11</sup> According to Nicholls (1988) many alternative medicines were popular with richer clients – including members of the nobility and royalty, especially as they were often seen as a gentler alternative to the heroic therapies that were still prevalent in orthodox medicine.

Osteopathy for example, was introduced in America in 1917, and naturopathy become popular in the 1930s (Sharma, 1995).

Nevertheless, in the first half of the twentieth century the numbers of alternative therapists declined quite considerably (Saks, 2003). Alternative practitioners became further disadvantaged by the passing of the 1911 National Health Insurance Act and the 1946 National Health Service Act, which underlined the ascendance of the biomedical approach associated with the heightened dominance of the medical profession in the twentieth century (Saks, 1994). These reforms placed the medical profession in an even more pre-eminent position as a supplier of health services in the greatly expanded state sector, subsequently confining non-medically qualified alternative practitioners to the increasingly marginalized private market (Saks, 2003). While such developments did not totally drive alternative practice out of existence they had largely faded from view by the 1950s (Saks, 1995; Cant and Sharma, 1999). Take for example, the case of homeopathy. Homeopathy had been a strong force in the latter half of the nineteenth century, however, according to Nicholls (1988: 207), went into 'dramatic decline after the turn of the century'. This was reflected by the fact that by 1930 the number of homeopathic practitioners in Britain had reduced to less than two hundred (ibid). There was also a steep decline in the number of homeopathic hospitals and dispensaries up to the mid-twentieth century.

Medicine has assumed a powerful position within contemporary society (Foucault, 1973). Despite there being some resistance to scientific models of illness and disease, the growing prestige of scientific medicine changed the ways health and illness were perceived, treated and evaluated (Harrison and Ahmad, 2000; Stacey, 1997). The power of biomedicine, informing many present day understandings of health and of health practice, relates to its institutionalized hegemony, which has conferred, and continues to bestow upon biomedical knowledge an authority status unrivalled by other forms of medicine. The power of biomedical knowledge is specific. Through its dominance, this knowledge possesses the power of assessing other forms of knowledge according to its own internal criteria. Because of its dominance, biomedical discourse has come to hold

the power of telling the ‘truth’ of conditions and concerns subjected to it in a social context valuing rationality, objectivity and science (Stacey, 1997). As such, biomedical discourse ‘marks out a field of knowledge, it confers membership, and it bestows authority’ (Tonkiss, 1998: 248), and often denies value and status to knowledges that do not conform to scientific understandings. Accordingly, the power of biomedicine also underlies the kinds of demands made of complementary and alternative medicines in present day policy initiatives in terms of scientific efficacy, regulation and standardization.

Nevertheless, despite the hegemony of biomedicine, since the 1960s complementary and alternative therapies have become increasingly popular in the West (Cant and Sharma, 1999; Kelner and Wellman, 2003), and CAM is now considered to be a major part of the healthcare system in many Western societies (Tovey et al., 2004). In Britain, this has not only included the revival of many older therapies such as homeopathy and herbalism that had previously been popular, but also the arrival of new therapies from differing cultural contexts (Cant and Sharma, 1999). Today, there are a wide range of therapies available from osteopathy, homeopathy and acupuncture to crystal healing, reflexology and aromatherapy, as well as a multitude of over-the-counter herbal remedies and CAM products. The remainder of this chapter will focus on the rise of complementary and alternative therapies, including survey data on current levels of use amongst the population of the UK and other Western countries, as well as information regarding the sorts of health conditions complementary and alternative therapies are most commonly used to treat, and an indication of the characteristics of CAM users and patterns of usage.

### **The growth of complementary and alternative medicine**

Survey data has revealed that there is considerable interest in complementary and alternative medicines and that the number of consumers of these services continues to grow.<sup>12</sup> The House of Lords Select Committee on Science and Technology (2000)

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<sup>12</sup> Although there has been some suggestion recently that levels of CAM use may have peaked, at least in the United States and Canada (Kelner, 2005).

estimated there to be 15 million users of complementary and alternative medicines within the UK. More recently data from a national survey of CAM use estimated that 10.6% of the adult population of England had visited at least one therapist in the last 12 months, rising from an estimated 8.5% of the population in 1993 (Thomas et al., 2001).<sup>13</sup> The majority of visits to CAM practitioners are paid for privately (Zollman and Vickers, 2000). Thomas et al (2001) estimated consultations with acupuncturists, chiropractors, homeopaths, hypnotherapists, medical herbalists or osteopaths to be worth £22 million in 1998, with only 10% of these services being accessed through the NHS. However, such figures do not include all therapeutic modes or self-prescribed remedies purchased over the counter. The percentage of the population thought to be using complementary and alternative health practices rises to 28.3% when use of alternative remedies purchased for self-care purposes are also included (Thomas et al., 2001). The sale of alternative remedies via many health food stores, chemists, supermarkets as well as the Internet is a multi million pound industry. Data from a recent Mintel report (2003) estimated the sale of over-the-counter preparations to be worth £130 million in 2002, having increased by 45% since 1997. Mintel (2003) also predict that these figures will rise sharply over the next few years and the market will be worth almost £200 million by 2008.<sup>14</sup>

Another way to demonstrate the growing popularity of complementary and alternative therapies is to look at the increasing numbers of CAM practitioners. A small, but increasing, number of therapists are paid directly by public finance, and work for the National Health Service (NHS) in the hospital sector. However, the overwhelming majority of complementary and alternative therapies are paid for privately by clients (Sharma, 1995; Zollman and Vickers, 2000). Most private practitioners operate independently, either practicing alone or in shared facilities, whilst a small number are based in GP surgeries and in health centres. Indeed, nationally, the sector may enjoy a considerable financial turnover, but the organizational nature of the sector remains one of

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<sup>13</sup> However, studies have also shown that there are regional differences in use, the North of England and Scotland generally having much lower levels of use than the South (Cant and Sharma, 1999).

<sup>14</sup> These figures only include the consumption of homeopathic remedies, herbal medicines and aromatherapy essential oils, excluding Chinese herbal products, Ayurvedic medicines, natural supplements, vitamins and minerals and Royal Jelly, suggesting, therefore, that consumption of over-the-counter remedies is likely to be even more significant.

small private business, essentially a cottage industry (Sharma, 1995; Fulder, 1996). The exact number of complementary practitioners in the UK remains disputed because not all complementary medicine disciplines are regulated and practitioners regulated. Nevertheless, Zollman and Vickers (2000) estimate the numbers of therapists to have more than trebled from 13,500 in 1981 to 40,000 in 1997, whilst Fulder (1996) and The House of Lords Select Committee on Science and Technology (2000), estimate there to be approximately 50,000 therapists in the UK.

Survey data in other countries such as the United States, Australia, Canada and Europe reveals similar increases in the prevalence of complementary and alternative medicines. For example, in the United States use of complementary and alternative health practices is said to be as high as 46% of the population (Eisenberg et al., 1998), having risen from 33% in 1991 (Eisenberg et al. 1993).<sup>15</sup> Similar patterns of use have been recorded in Australia, where a survey of 3004 randomly selected adults revealed that 48.5% had used at least one non-medically prescribed form of CAM (MacLennan et al., 1996). In Canada figures on levels of use have been found to vary between rural and urban areas. For example, in rural Alberta 32.3% of the population are said to have used complementary and alternative therapies (Verhoef et al., 1995), whereas elsewhere survey data indicates that only 15% of the population use CAM (Millar, 1997). Elsewhere in Europe similar figures can be found, and surveys indicate that one in five people has used alternative healing approaches (*British Journal of Medicine*, 1996; Fulder, 1993; Menges, 1994). In Germany, a 1998 law gave alternative health treatments the same status as conventional medicine. It required insurance to cover approved alternative treatments, such as herbal remedies and acupuncture and changed standards for review of research on alternative therapies (Hinman, 1998, cited in Freund and McGuire, 1999). In Japan, some two-thirds of patients use nonmedical alternatives, many of which were derived from their Asian traditional approaches to healing, in combination with Western biomedicine (*British Medical Journal*, 1996).

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<sup>15</sup> As Eisenberg et al.'s surveys also included dietary supplements such as multivitamins and herbal medicines they have been criticized for overestimating CAM use, through having too wider definition of CAM practices (Ruggie, 2004).

Importantly, not all forms of complementary and alternative therapies share the same levels of popularity. Survey data in the UK indicates that there are a relatively small number of therapies that attract the most public interest and support (Cant and Sharma, 1999). These include acupuncture, homeopathy, herbalism, osteopathy and chiropractic, although reflexology and aromatherapy are now also experiencing much greater levels of support than before (Cant and Sharma, 1999). Thomas et al. (2001) found osteopathy to be the most popular type of therapy used, with an estimated 4.3% of the adult population having used it in the last 12 months, this was closely followed by chiropractic (3.6%), then acupuncture (1.6%), homeopathy (1.2%), medical herbalism (0.9%) and hypnotherapy (0.7%). Such findings have been replicated in America, where it was found that 10% of a national sample had used one of only four therapies, namely chiropractic, relaxation therapy, acupuncture and therapeutic massage (Paramore, 1997). Interestingly, it is the use of alternative medicines, such as herbal and homeopathic remedies purchased over the counter for self-help purposes that represent the most popular form of complementary and alternative health practices (Saks, 2003). Thomas and colleagues estimate that 19.8% of the adult population use over-the-counter herbal remedies and 8.6% homeopathic remedies (Thomas et al., 2001). There are also differences between countries in terms of which therapies are most popular (Cant and Sharma, 1999). For example, in Denmark alternative therapies became more popular in the 1970s but this was especially the case for reflexology (Staugard, 1993). In contrast, in Iceland (Haraldsson, 1993) and Holland (Fisher and Ward 1994) there has been an exponential increase in the usage of spiritual healers, whereas in France acupuncture and homeopathy have become very popular (Traverso, 1993). The revival of alternative medicine in Australia and the United States parallels developments in Europe although there is much evidence that in the United States therapies such as chiropractic, osteopathy and naturopathy maintained a strong presence throughout the century but experienced further rejuvenation in the 1970s (Cant and Sharma, 1999).

The types of health problems that individuals seek help from complementary and alternative health practitioners for have been considered by a number of studies. There is a general consensus that CAM is most frequently used to treat chronic and non-life



threatening conditions that are not easily cured by orthodox medicine (Eisenberg et al., 1998; Kelner and Wellman, 1997; Vincent and Furnham, 1996). In contrast, survey data has revealed that complementary therapies are used less frequently for acute traumatic infectious and genetic conditions that are more effectively treated by orthodox medicine (Thomas et al, 1991; Sharma, 1995; Fulder, 1996). Of all conditions, musculoskeletal, aches and strains are by far the most common types reported by users, representing 71% of visits to either an acupuncturist, chiropractor, homoeopath, medical herbalist, hypnotherapist or osteopath (Thomas et al., 2001). However, Thomas et al. (2001) found that these figures altered substantially for aromatherapy and reflexology use, where only 25% of problems were for musculoskeletal problems. There are also a growing number of users of complementary and alternative therapies with diseases such as cancer (Ernst and Cassileth, 1998; Harris et al. 2003) and HIV/AIDS, (Pawluch et al., 2000; Foote-Ardah, 2003) who use the therapies to relieve their symptoms and pain. In a recent survey of complementary and alternative medicine use by patients with cancer in Wales, Harris et al. (2003) found that 49.6% of participants had used at least one type of CAM. In addition to those who present with specific health problems, there are also those who are essentially healthy, but who use complementary and alternative therapies for preventative reasons or for the maintenance of their general well-being (Andrews, 2002). For example, Thomas et al (2001) found that a large percentage of visits to both reflexologists and aromatherapists were for reasons other than to treat a specific health problem. Reasons given included 'stress' and/or 'relaxation', or for non-health reasons such as for a 'treat', 'present' or just 'for pleasure' etc. (Thomas et al., 2001). In the United States studies have found that the number of people using CAM for general well-being, rather than to treat a particular health problem, has expanded. Eisenberg et al. (1998) found an increase from 33% of respondents in 1991 to 58% in 1997. This can perhaps be seen as reflecting changes in ideas about what kinds of activity can be defined as 'health care' (Cant and Sharma, 1999). As Cant and Sharma (1999) note:

'Consumers may not necessarily be unwell in a biomedical sense and consequently we may need to re-define what constitutes health related

behaviour, the disease model now seemingly inadequate' (Cant and Sharma, 1999: 33).

Significantly less is known about the sorts of illnesses and health conditions that individuals use alternative substances purchased over-the-counter for. However, in a recent small-scale study exploring the health choices of British Asian mothers, Reed (2003) found that the women were more likely to use complementary and alternative medicines for general illnesses such as colds and flu, whilst drawing almost solely on Western medicine for serious illnesses such as diabetes and cancer (Reed, 2003; see also Thorogood, 1990). This corresponds with findings from the 2003 Mintel report on use of complementary medicines. Data from this research revealed that the conditions that alternative remedies are most likely to be used for are those not easily treated by conventional medicine, such as back pain, sleep problems and stress. However, complementary medicines may also be chosen where the conventional option is considered to be too strong or have too many side effects. Complementary medicines were also used in the treatment of minor ailments, such as migraines, coughs, colds and flu and hayfever, as well as being used for preventative measures (Mintel, 2003). Nevertheless, studies on CAM use amongst people with diseases such as cancer and HIV/AIDS have also found high levels of use of over-the-counter products, such as herbal medicines. In Harris et al's (2003) study 42.3% of cancer patients reported using over-the-counter diets, remedies or supplements. O'Connor (1995) found that in addition to their conventional medical therapeutics, many people with HIV/AIDS were using a range of herbal and nutritional supplements to help boost the immune system, control infection, help with pain relief and other symptom control, control adverse side effects of conventional medicines as well as for emotional or spiritual well-being and the general enhancement of health. Studies indicate that the majority of individuals who use complementary medicines for such diseases use them in addition to conventional forms of treatment. Nevertheless, some critiques have argued that often individuals use complementary medicines without the knowledge of their general practitioner and therefore run the risk of negative interactions with conventional medicines (see for example, Ernst, 2001).

## **Patterns of usage**

Research has established the general patterns of use of complementary and alternative health practices. One of the most consistent findings within this body of literature is that individuals using complementary medicines do not cease to use orthodox medicine totally. Most research indicates that complementary medicine is generally used alongside orthodox medicine, rather than as a complete replacement of it (Thomas et al., 1991; 2001; Sharma, 1995). Indeed, Eisenberg et al (1993) suggest that most users consider a range of orthodox medicine and complementary medicine options, making use of the different types of health care on different occasions, and implement their own planned mixing, rather than an either/or approach to their care. Users therefore obtain the most out of both complementary and orthodox medical systems concurrently (Eisenberg et al, 1993; Fulder, 1996). Sharma (1995) found that despite the fact that a large number of participants in her study were critical of biomedicine none had turned their back on it altogether. All could think of times when they had consulted their doctor in the past or could foresee a time would they would perhaps consult them in the future. A number of participants claimed that they would go to their doctor to obtain a diagnosis and then decide for themselves the most appropriate course of action to follow – i.e. whether to follow the doctor's advice, treat themselves or seek help from a complementary practitioner.

Sharma (1995) identifies four distinct groups of complementary medicine users based on her research in the West Midlands: 'one off users'; 'earnest seekers'; 'stable users' and 'eclectic users'. 'One off users' are individuals who discontinue treatment after a limited experimentation; 'earnest seekers' are those who are desperately seeking a successful remedy to an intractable health problem and will try any number of complementary and alternative therapies until relief is obtained; 'stable users', the most common type, are those who have experienced initial successes with complementary medicine and have developed a fairly regular relationship with a particular practitioner or type of treatment; finally, 'eclectic users' tend to shop around with a consumerist attitude to specific health

problems. Little research has specifically considered the frequency of CAM use. Kelner and Wellman (1997), however, in a comparative study of Canadian users of CAM and family physicians, claim that users of CAM saw their therapists almost twice as frequently, with 55% visiting their therapist more than once a month.

### **Profile of users**

A number of studies have contrasted users with non-users of complementary medicines and a divergence of opinion has emerged in terms of the socio-demographic characters of users. Some authors argue that users of complementary medicines and those using orthodox medicine do not differ significantly in terms of their sex, education, marital status, religion and income levels (Furnham and Smith, 1988; McGregor and Peay, 1996), or political views and ethnic grouping (Furnham and Forey, 1994). Other research however finds that CAM users have more education and higher incomes (e.g. Sharma 1995; Fulder, 1996; Kelner and Wellman, 1997; Astin, 1998; Wiles and Rosenberg, 2001; Andrews, 2002) and are more likely to be female (e.g. Sharma, 1995; Furnham and Kirkcaldy, 1996; Kelner and Wellman, 1997; Thomas et al, 2001; Wiles and Rosenberg, 2001). In a recent UK based survey on CAM use, Thomas et al (2001) found that 56.9% of users were female, compared to 43.1% of males. Use of complementary and alternative therapies has also been shown to vary between different age groups, being most common among 45-64 year olds (12.9%) and then among people aged between 18 and 44 (11.0%) (Thomas et al, 2001: 7). On the whole these differences are perhaps not too surprising. As Cant and Sharma (1999) point out the large number of women is quite possibly a reflection of the fact that women are more likely to experience chronic illness and are also prepared to consult biomedical services more extensively than men. Furthermore, as Adams et al. (2003) note, women, as 'family care givers' are most likely to be the ones purchasing complementary and alternative remedies for members of their family as well as for their personal use.<sup>16</sup> The fact that users usually pay privately for complementary therapies may account for the fact that users have been found to have

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<sup>16</sup> See also Graham (1985) for discussion of the important role women play as 'providers' of health care within the family context.

higher incomes (Cant and Sharma, 1999). Furthermore, Wiles and Rosenberg (2001) suggest that individuals from higher socio-economic groups are used to having more control over their lives and are therefore more likely to be able to question conventional practices and authorities:

‘[P]eople who are of higher socio-economic class (and more resources) are used to having some control over their lives, and choosing where they go for health services and how to approach various health problems is one more example of control’. (Wiles and Rosenberg, 2001: 211).

It has also been suggested that users of complementary and alternative medicines are less willing to accept the quality and character of treatment within biomedical services (Vincent and Furnham, 1996). Studies have found that compared to non-users, users of complementary medicines feel a stronger sense of control over their health. Many users claim ‘that they take a proactive role in maintaining their own health and in preventing illness’ (Kelner and Wellman, 1997: 210). Kelner and Wellman (1997) found that compared with ‘non-users’, users of complementary and alternative medicines were more likely to follow a regular exercise regimen, monitor their diets, regularly take vitamin supplements and claim to rely mostly on themselves for help when ill, rather than on a general practitioner.

### **Responses to the rise of complementary and alternative medicines**

The increasing consumer demand of complementary and alternative medicines has been troubling for conventional doctors and policy makers (Parusnikova, 2002). The reactions to CAM within the biomedical sector are not unified. The acceptance of complementary and alternative health practices varies considerably between different professional groups within the NHS. Indeed, research indicates that, whilst nurses tend to be ‘overwhelmingly enthusiastic’ about complementary and alternative medicines, consultants have been found to be ‘characteristically dismissive’ (Tovey, 1997: 1129). Nevertheless, whilst there have always been a small minority of the medical profession

who use complementary therapies alongside more conventional approaches, on the whole the medical profession has generally been dismissive and at times hostile towards alternative medicines (Nettleton, 1995). The British Medical Association (BMA) report of 1986, *Alternative Therapy*, was widely understood as an attempt to discredit alternative medicine in general.<sup>17</sup> In this document the medical profession claimed the right, on the grounds of its scientificity, to act as arbiter of alternative therapies' claims. The scientific basis of modern medicine is contrasted to alternative therapies, which involve 'a reversion to primitive beliefs and outmoded practices, almost without basis' (BMA, 1992: 216). The report required alternative therapies to prove their efficacy through the means of the medical 'gold standard', the randomised double blind trial (BMA, 1986).<sup>18</sup> However, several years later a second report was published, entitled: *Complementary Medicine: New Approaches to Good Practice* (BMA, 1993). In this report the BMA adopted a more moderate position and was supportive of the legislating to register osteopaths and chiropractics in the early nineties (Sharma, 2003).<sup>19</sup> This report no longer implied that non-orthodox therapies were simply at odds with orthodox medicine, but rather they could function alongside, or indeed 'complement', conventional medical practice. The report highlighted the need for 'good practice' among what it referred to as 'discrete clinical disciplines', which includes systems such as acupuncture, homeopathy, herbalism, osteopathy and chiropractic (Nettleton, 1995). It stresses the moral and professional authority of the doctor to help the public judge the competing claims of alternative medicine. The role of the BMA was to establish:

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<sup>17</sup> However, at the same time that this report was being prepared, researchers were amassing a body of evidence, which suggested that GPs attitudes to alternative medicine were far from uniform. A considerable number claimed to be practicing alternative medicines themselves, interested in training to practice one or more of them, or interested to know more about them so they could refer patients (Sharma, 2003).

<sup>18</sup> The doctrine of evidence-based medicine (EBM) holds that the appropriate criterion for the provision of intervention, either in the NHS generally, or in the treatment of an individual patient, is its effectiveness, as demonstrated by biomedical research evidence (Harrison, 2004). As a methodology, EBM privileges certain types of evidence over others and arranges these in a hierarchy with randomized controlled trials at the top (Willis and White, 2004). Since its emergence, there has increasingly been a push towards EBM within orthodox medicine (Sackett et al. 1997). See Hunter (1996) for a critical discussion of EBM.

<sup>19</sup> In some countries, such as the United States and Sweden, national medical associations have continued to take a more confrontational attitude to complementary and alternative therapies (Cant and Sharma, 1999).

‘The principles of good practice in non-conventional therapies which would safeguard the individuals against possible harm to health and maximize the potential benefits of particular methods’. (BMA, 1993: 2).

Nevertheless, within biomedical settings, CAM is still often subjected to fierce criticism with some biomedical practitioners remaining defiant and aggressive towards complementary and alternative health care:

‘Proponents of alternative medicine can be compared to cuckoo chicks in that they are using false signals to gain nourishment from a legitimate scientific and medical frame. Rather like the reed warbler parent, the guardians of this frame are not equipped to recognize [their] loud signals as false’. (Leibovici, 1999: 1629).

Many conventional practitioners continue to oppose the lack of strict (scientific) regulation within the sphere of CAM. In order to be more acceptable, the ‘CAM community’ is frequently being pressurised to address issues like evidence, through the use of randomized controlled trials (Sharma, 2002; Broom, 2002; Jonas, 1998). Indeed biomedical practitioners frequently criticise complementary and alternative medicines through the notion of scientific validity. At the same time, the lack of scientific ‘proof’, in the form of, for example, evidence of efficacy provided by randomised controlled trials, is seen to indicate that complementary and alternative practitioners are not only incapable of finding proof for their practices but also unwilling to seek appropriate scientific validation.<sup>20</sup> The gullible public, susceptible to the ‘fallacy’ of complementary and alternative therapies, are also to be blamed, with popularity being attributed to ‘anti-scientific attitudes meshed with New Age mysticism’ (Beyerstein, 2001: 230).

The emphasis on efficacy and evidence is also evident in the recent government initiatives regarding the production of more regulated provision of complementary and

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<sup>20</sup> In response to such criticisms it is argued that randomized control trials are not always appropriate to complementary therapies, most of which assert the variability, and primacy, of the individual making standardized treatments impossible (Willis and White, 2004).

alternative medicines (see for example, House of Lords, 2000). For instance, in 2000 the House of Lord Select Committee report made a number of recommendations to the government (Saks, 2003). Among these are the following: First, that the National Health Service should ensure access to complementary and alternative therapies through medical referral where there is evidence of efficacy and/or robust regulatory mechanisms. Second, that professional regulatory structures should be developed for such therapies. Third, the report recommended, that training should be linked to higher education and incorporate understandings of research methods and biomedical knowledge. Fourth, orthodox health professionals should be more systematically familiarized with CAM. Fifth, there should be more government funding for research into complementary and alternative medicine. Finally, more information about CAM therapies should be available to the public. (Adapted from Saks, 2003: 157-8). Clearly, this represents a certain degree of progress in terms of the position of certain complementary and alternative therapies in relation to biomedicine.

Research suggests that many biomedical practitioners now recognize the appealing aspects of CAMs, in particular for palliative care and the management of chronic diseases. Studies have identified increasing interest in, referral to, and practice of CAM by primary care physicians in a number of countries (Adams, 2004). Many are aware of the failures of the biomedical framework which has been, for example, criticized for failing to provide person-centred care (Rees and Weil, 2001). The solution is often seen to lie in adopting a more integrated approach to health:

‘Motivated by opportunistic interests, the integration movement lacks the cognitive enthusiasm to examine with an open mind how alternative medicine works and why it achieves its results. Integration looks like an attempted co-option of CAM rather than a constructive interaction between two different approaches to health and illness’ (Parusnikova, 2002: 187).



The term 'integrative medicine' is used to refer to virtually any situation in which alternative and orthodox medical knowledge or practitioners interact beyond the level of simple impersonal referral. It can, for example, refer to the use of CAMs or therapeutic techniques by biomedical professionals (Cant and Sharma, 1999). More specifically, it is used to refer to clinics where biomedical and alternative practitioners collaborate or work alongside each other; or the integration of alternative medical knowledge into biomedical education (Cant and Sharma, 1999). Much has been made of this in recent years. The *British Medical Journal* devoted considerable space to these matters in a special issue entitled 'Integrated Medicine: Orthodox Meets Alternative' (BMJ, 20 January 2001). For example, articles in the education and debate section, included the need for undergraduate education in complementary therapies in order to familiarize tomorrow's doctors with CAM therapies (Owen et al. 2001); the need for regulation in CAMs (Mills, 2001); the problems involved in conducting research on CAMs (Nahin and Straus, 2001); and the lessons on integration from the developing world (Bodeker, 2001). However, there are a number of practical difficulties to integrative medicine (Coulter, 2004). For example, what does integration mean and who initiates it, or more importantly, will it lead to greater equality or simply new forms of medical dominance.<sup>21</sup> Indeed, as Williams (2003) notes, in the case of those CAM practitioners who have been 'integrated' into the National Health Service, the situation is more akin to 'bolting on' than true integration. Furthermore, such integration may come at the expense of considerable dilution of CAMs principles and practices.

Nevertheless, increasing patient demand, as well as the recommendation for increased provision of CAM therapies for NHS patients from the House of Lords report (2000), have raised important policy research questions regarding the provision and commissioning of complementary therapies within the NHS (Thomas et al., 2003). Many complementary and alternative medicines are currently available through the National Health Service in Britain. Homeopathy is unique among all of the therapies as it has been part of the NHS since 1948 and is available at five NHS Homeopathic Hospitals:

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<sup>21</sup> There are plenty of instances where previously unorthodox healing practices were incorporated into orthodox medicine and the original practitioners shut out, anaesthesiology is one example, and X-rays are another (Willis and White, 2004).

The Royal London, Glasgow, Liverpool (Mossley Hill), Bristol and Tunbridge Wells. The use of CAM in primary care is also becoming more widespread (van Haselen, 2004), however, little is known about the scale and scope of its use. In a survey of English general practices, Thomas et al. (2001) found that 35-43% of GP partnerships provided access to some form of complementary therapy for their NHS patients. An estimated 21.4% were offering access via the provision of treatment by a member of the primary health care team, 6.1% employed an 'independent' complementary therapist, and an estimated 24.6% of partnerships had made NHS referrals for complementary therapies. Acupuncture and homeopathy were found to be the most commonly available complementary therapies. In a more recent study, based on findings from a survey of primary health care workers in Northwest London, van Haselen et al. (2004) found that 83% of respondents said they had previously referred patients for CAM treatments. Again, acupuncture and homeopathy were the main therapies for which patients were most frequently referred, followed by manual therapies. Musculoskeletal conditions, headache and other chronic pain conditions were most commonly believed to benefit from CAM. Nevertheless, van Haselen and colleagues acknowledge that the high levels of referral amongst their sample may be attributed to the urban location of the GP population. Indeed, the attitudes of GPs in other areas towards CAM may be different and this is likely to influence the levels of referral.

## **Conclusion**

This chapter has outlined the increasing significance of complementary and alternative medicines, which have moved from a marginal position to becoming an important part of the health care system in most Western societies. Indeed, survey data indicate that in most of these countries complementary therapies are used by at least 20% of the adult population. This means that, more than ever complementary and alternative medicine now constitutes a topic worthy of study in its own right (Tovey et al, 2004). As I have shown survey data on CAM use has revealed a great deal about the numbers of individuals now using complementary and alternative therapies, which therapies are most popular and what they are more commonly used for. Furthermore, such data has also

indicated the 'type' of people who use complementary therapies, in terms of their socio-demographic characteristics – i.e. the fact that users tend to be middle-class, well-educated women. However, such data does not reveal why it is that increasing numbers of individuals are turning to complementary and alternative health practices. In the next chapter I will focus specifically on how we can explain this increase in usage of CAMs. This chapter will also explore the relationship between the growth of CAM and wider social and cultural changes in contemporary Western societies, that may have altered individual's expectations about their health and their understanding of risk and embodiment.

## Theorizing the consumption of CAM

### Introduction

Social scientific research on the use of complementary and alternative medicines is still relatively new. As Tovey et al. (2004) note, the majority of research within the field of complementary and alternative medicines has tended to focus on establishing an evidence base for CAM practices, by evaluating the effectiveness of particular treatments. Such research is strongly driven by the need to update health policy and 'safeguard' the public against non-efficacious modalities, in the face of the growing use of CAM practices. Nevertheless, over the past few decades there has been a proliferation of social scientific works investigating different aspects of this phenomenon. Within what some commentators have referred to as the 'sociology of CAM' (Tovey et al., 2004), complementary and alternative medicine is treated as 'a topic worthy of study in its own right, as a historically specific social product' (ibid: 1). Research in this field has primarily been concerned with three groups of social actors. First, a number of studies have focused specifically on complementary medical practitioners. Research here has mostly been concerned with issues relating to the professionalization of practitioners (e.g. Cant and Sharma, 1996; Sharma, 2002; Saks, 2003; Welsh et al, 2004). Secondly, a significant body of research has been concerned with physicians, in particular their views on and professional relationships with CAM practitioners (e.g. Tovey 1997; Easthope et al, 2000; Shuval et al. 2002; Parusnikova, 2002), the efficacy of therapies (e.g. Easthope et al., 2000; Perry and Downwick, 2000), the knowledge base of therapies (e.g. Pirotta et al., 2000; Schmidt et al, 2002) and research focusing on those clinicians who also practice complementary therapies (e.g. Thomas et al., 1995; Botting and Cook, 2000;

Lewith et al. 2001; Thomas et al., 2001; Adams, 2004).<sup>1</sup> Finally, a substantial number of studies have focused on those individuals who use complementary and alternative health practices. Research in this field seeks to ask questions about individual motivations underlying the growing use of CAM (e.g. Sharma, 1995, 1996; Lloyd et al., 1993; Vincent and Furnham, 1996; Siahpush, 1998, 1999a; Wiles and Rosenberg, 2001; Sirois and Gick, 2002). More recently a number of studies have narrowed the focus and examined individual's reasons for using complementary therapies to treat specific illnesses, such as cancer and HIV/AIDS (e.g. Pawluch et al., 2000; Foote-Ardah, 2003, Harris et al., 2003). Although it is undoubtedly the case that different therapies attract individuals for diverse reasons and that the willingness of people to use these therapies varies according to the nature and aetiology of their affliction (Anyinam, 1990), three main areas of explanation have emerged from the literature.<sup>2</sup> These are: dissatisfaction with the medical encounter; dissatisfaction with orthodox medicine; and the emergence of a new 'postmodern' value system (Siahpush, 1998).

In this chapter I will draw on these three explanations to analyse the appeal of complementary and alternative medicines to the people who use them, while also assessing what we can derive about the relationship between the growth of CAM and wider social and cultural changes in contemporary Western societies. However we choose to interpret these recent developments, as Kelleher et al. (1994) recognize, it is essential that they are seen against the background of wider social and cultural changes which have altered individuals' expectations about their health and their understanding of risk and embodiment. The issue of how individuals make decisions about their health requires an exploration of definitions of health and illness (Freund and McGuire, 1999), at the level of both individual and society. The concept of health itself needs to be explored in terms of what it has come to mean to individuals. Indeed, one of the central

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<sup>1</sup> There have also been a number of studies focusing on use of CAMs within the nursing profession (see for example, Rankin-Box, 1997; Adams and Tovey, 2004).

<sup>2</sup> Although I have chosen to focus on the three reasons most often invoked for using CAM a number of other explanations have been provided. In a review of the literature, Furnham and Vincent (2000) discussed 9 different but related reasons for patients favouring CAM over conventional medicine. Including 'beliefs about health', 'health consciousness', 'mental health', 'perceived susceptibility to illness', 'beliefs in the efficacy of treatment', 'personal control over health', 'medical history and career', 'beliefs about scientific medicine', and 'attitude to physicians'.

aims of this thesis is to make a substantial contribution to the CAM literature, whilst at the same time attempting to understand the use of complementary and alternative medicines in the context of more formal sociological concerns such as those relating to changing understandings of the body, personal responsibility for health, the role of biomedicine in producing health and questions of risk and trust in relation to experts. I begin this chapter by providing a critical evaluation of the literature on individual motivations for using complementary and alternative therapies. I then move on to discuss the increasing use of complementary therapies within the context of debates about the nature of health and illness in contemporary society, risk and reflexive modernity and the emergence of informed, bodily-conscious consumers of health care. Over the last decade, in particular, these themes have become prominent themes in sociology and are now widely recognized as important health issues (Nettleton, 1995; Shilling, 1993; Turner, 1995; Williams et al, 2000).

### **Motivations for using CAM**

#### *Dissatisfaction with the medical encounter*

A number of commentators have suggested that the reason why individuals turn to complementary and alternative medicines is because they have been driven to them through dissatisfaction with their interactions with doctors (Furnham and Smith, 1988; Furnham and Forey, 1994), and have subsequently been more satisfied with the attention and service obtained from alternative practitioners (Lloyd et al, 1993; Furnham and Smith, 1988). Analyses of modern medicine reveal that while medicine is at a technological high point in its development, patient satisfaction with medical care seems to be at an all time low (Balint et al., 1993). Research on patient satisfaction with biomedical care (Lewis, 1994; Greene et al., 1994; Lupton, 1996b) suggests that patients today want to have more personal, less distant relationships with their physicians; with more sharing of information; more time for consideration of their individual needs, including psycho-social issues, and greater opportunities to participate in the decision making process. However, the current economic pressures within the National Health

Service have made it difficult for physicians to give patients the amount of time and attention required to deliver care in this way (Kelner, 2003).

Research indicates that lack of satisfaction with the medical encounter not only influences the extent of adherence to therapeutic advice (Linn et al., 1982; Haug and Lavin, 1983) and to changing doctors (Marquis et al., 1983). In the context of an ever-expanding flow of information about complementary and alternative therapies and practitioners, along with personal testimonials from countless satisfied clients of complementary practitioners, some patients who are dissatisfied with their relationship with their doctor are prompted to consider changing from conventional medicine to other forms of care. Proponents of this line of argument maintain that there are strong differences between the two types of medical encounter (Sharma, 1994; Johannessen, 1996), and that these differences are the source of complementary medicine's current popularity. Taylor (1984) has suggested that dissatisfaction with the medical encounter and the hierarchical and disempowering modes of consultation within biomedicine, are by far the most important factors in explaining the rise in popularity of complementary and alternative medicines:

'The one consistent theme...in consumers' responses and in observers' speculations is dissatisfaction with the *relationship* which obtains with conventional physicians...and the attraction of a different kind of relationship with alternative practitioners' (Taylor, 1984: 204).

For instance, in an Australian study on CAM use, Siahpush (1998) found that one of the main reasons why individuals had turned away from orthodox medicine was because they were dissatisfied with the medical encounter and the way they had been treated by doctors. According to Siahpush CAM users feel that:

'[D]octors have little respect for them, do not give them enough time, do not listen to them, act too authoritatively, and do not give them a chance to actively participate in the process of healing' (Siahpush, 1998: 68).

In this sense, Siahpush (1998) maintains that it is the quality of doctor-patient interaction and the power differential in the medical encounter that is responsible for increasing public interest in complementary and alternative medicines. In other words, people who consult complementary and alternative practitioners are contemporary consumers rejecting a Parsonian sick role by voting with their feet (Kelner, 2003).

Certainly, there are a number of differences between the two types of consultations that have been shown to influence individual's decisions to use CAM.<sup>3</sup> For example, the length of time spent in consultation with a complementary or alternative practitioner is significantly different. In contrast to general practice consultations, which average about 6 minutes (Morgan, 2003)<sup>4</sup>, most first consultations with CAM practitioners last well over an hour (Sharma, 1995; Cant & Calnan, 1991).<sup>5</sup> Evidence suggests that this extra time allowed during consultations with alternative practitioners represents a significant part of their appeal (Sharma, 1995; 1996; Lloyd et al., 1993; Siahpush, 1998). Studies have revealed that individuals are drawn to consultations where they have more opportunity to discuss their problems in depth (Cant and Sharma, 1999). For example, Sharma's (1996) study of users of alternative medicines found that they believed that clinicians spend too little time with patients. Lloyd et al (1993) found that when asked to compare the treatment received from complementary therapists and their doctors, 13% of respondents included longer consultation time as a significant factor. Nevertheless, the attraction of time is not peculiar to alternative medicine and studies of the private

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<sup>3</sup> Although, as Cant and Sharma (1999) highlight it is not clear whether individuals only come to appreciate these differences after visiting an alternative practitioner.

<sup>4</sup> It should be noted that there is considerable variation in the actual length of consultations ranging from about 2 minutes to over 20 minutes (Morgan, 2003).

<sup>5</sup> The first consultation with a CAM practitioner usually takes longer as the practitioner needs to obtain a medical history from the client, many also explain the treatment and offer general advice on the prevention of further problems. Subsequent consultations usually last between 30 and 45 minutes (Sharma, 1994). However, the length of the consultation also varies between complementary therapies. For example, chiropractic consultations usually last between 15 and 20 minutes (Cant and Sharma, 1999) and some participants from my research, who used chiropractic regularly claimed that a consultation could last as little as 5 minutes.



biomedical sector have revealed this to be an important reason for individuals choosing to pay for health care (Calnan et. al. 1993).<sup>6</sup>

It has also been suggested that patients of complementary practitioners desire more control during the consultation, and in general want to be more involved in the healing process (Cant & Sharma, 1999). Studies have revealed that patients prefer being treated as equal and want a more participative relationship with their practitioner (Sharma, 1995). In contrast with the traditional passive role attributed to the patient in biomedical consultations (Stacey, 1997), complementary and alternative therapies are often thought to allow the sick person a more active role in his/her health care (Sharma, 1994). Johannessen (1996) suggests that because consultations with alternative practitioners are longer they allow patients the opportunity to provide more information about their complaint, as well as to take on board more information from the practitioners. This in turn creates a more mutually based relationship between patient and practitioner. As most complementary and alternative practitioners seek to understand individual's symptoms in the context of their total health profile, rather than treating them in isolation, it requires an individualistic approach to treatment (Johannessen, 1996). Patients are required to provide detailed information about the circumstances of their illness and their feelings about it. In addition, alternative practitioners often spend a long time questioning the patients about their family, their lifestyle and environment. Consequently, the patient has an important role to play in the consultation, by providing valuable knowledge about their illness and their lives more generally (Cant & Sharma, 1999). Sharma's (1995) study found that many patients enjoy this aspect of the consultation, as they feel they are being treated as an equal.

Despite such evidence of a mutually based practitioner-patient relationship existing within complementary and alternative medicine, according to Mitchell and Cormack (1998) the assumption that CAM patients have more positive and valuable relationships with their practitioners has not yet been subjected to rigorous research. In fact, very little

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<sup>6</sup> A number of studies have also shown it is often the speed with which patients are seen rather than the length of time spent in consultation that is most appealing in private health care (Calnan et al., 1993; Wiles and Higgins, 1996).

is known about the nature of the relationship that exists between patients and their CAM practitioners, and whether, for example, different types of CAM practitioners have different kinds of therapeutic relationships with their patients (Kelner, 2003). More recently several commentators have questioned the notion of a purely consensual interaction within complementary medicine consultations (Frank, 2002; Kelner, 2003). In a study of physician-patient interaction in homeopathic physicians encounters in Germany, Frank (2002) found that whilst there was a certain degree of partnership between practitioners and patients, there was also a significant amount of negotiation and disagreement as well.<sup>7</sup> In a Canadian study comparing the nature of the therapeutic relationship between patients of family physicians and patients of alternative practitioners, Kelner (2003) questioned the notion that individuals choose CAM practitioners because of dissatisfaction with the medical encounter. A number of similarities were found between the two groups, for example, both groups appeared to be satisfied with their health care providers and claimed to have found practitioners who would usually answer their questions, give them explanations, understand their perspective and to a lesser extent involve them in decisions concerning their health care (Kelner, 2003). However, one key difference to emerge between the two groups of patients was in the basis for their satisfaction. While only a small percentage of the biomedical patients were getting positive results from their current treatment, most of them nevertheless expressed trust in the skills and expertise of their doctors. In contrast, the CAM patients placed most emphasis on positive results such as less pain and discomfort. Their relationships with their practitioners were largely pragmatic, if the practitioners could help them, they continued to see them, if not, they would move on to try another practitioner or kind of therapy. According to Kelner, this indicates that, rather than the more intimate and sympathetic style of interaction employed by CAM practitioners explaining their current popularity, it is the search for relief from persisting chronic conditions that motivates individuals to turn to CAM. In other words, these

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<sup>7</sup> The specific areas in which disagreement and negotiation arose related to the revelation of homeopathic remedy, patient's expectations, the physician's fees and differing views on the appropriate duration of consultation. It is also worth noting that the practitioners interviewed as part of the research were also physicians and it is possible that different findings may have emerged if this had not been the case.

patients 'want a practitioner who can help them cope with their ongoing problems' (Kelner, 2003: 92).

It has also been suggested that the nature of the doctor-patient relationship itself, has changed over the last few decades (see for example, Bury, 1997; Nettleton, 1995; Tuckett, et al., 1985).<sup>8</sup> The contribution that 'lay' people make to the nature of interactions has been acknowledged, and it has been suggested that their participation has increased. Indeed, Bury (1997) points to the emergence of a 'contractual model' of the doctor-patient relationship, taking into account changes in population and healthcare since the 1980s. According to Bury 'such a model is emerging from the long-term trend in the reduction of power of professionals, related to the erosion of hierarchical relationships in late modern cultures more generally' (ibid: 101). In this model, the patient and doctor may be more open to each other's perceptions and to each other's role in managing ill health, especially chronic illnesses. Specifically in the case of chronic disorders it is argued that patients themselves may become 'experts', who know more about their health problem than their doctor and are more confident during the consultation (Tuckett et al., 1985). The increasing availability of information relating to health through media sources such as the Internet have also been linked to these changes. Nevertheless, several commentators have stressed the need for caution when generalizing about the scale and scope of these developments. Lupton (1994: 116) claims that it is 'doubtful that the new breed of patient described in consumer guides – armed with medical knowledge and ready to challenge the doctor's authority or even to litigate if things go wrong – is in the majority'.<sup>9</sup>

### *Dissatisfaction with orthodox medicine*

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<sup>8</sup> The doctor-patient relationship has been of sociological interest since Parson's (1951) work on the sick role. See Bury (1997) for full discussion of this literature.

<sup>9</sup> Empirical research on the doctor-patient interactions suggested that people of higher social class may feel more empowered and qualified than people of low social class to evaluate the services of the doctor, and to change to another if they are displeased. However, studies have also revealed that whilst individuals from less privileged backgrounds may not demonstrate equal assertiveness in the medical encounter, they may react to their position of powerlessness by becoming non-compliant, uncooperative or helpless, or by exercising small acts of defiance (Lupton, 1994).

A further explanation of why individuals consult with complementary practitioners suggests that they do so because they are dissatisfied with orthodox medicine in a more general sense (McGregor and Peay, 1996), lack confidence in its ability to effectively treat a range of prevalent chronic conditions (Furnham and Forey, 1994, Furnham and Kirkcaldy, 1996; McGregor and Peay, 1996), or are concerned about potential side effects of drugs (Verthoef et al., 1998; Wynsong, 1998). For example, McGregor and Peay (1996) found that whilst users of alternative medicine were not necessarily dissatisfied with their recent visits to their general practitioners, they expressed lower levels of confidence in biomedicine in general. They argue that whilst this may have been provoked by a set of adverse experiences with biomedical services, it may also be aimed at no particular individual disorder, or medical treatment and based instead on a set of general beliefs or values (McGregor and Peay, 1996).

It has been suggested that individuals have become increasingly sceptical about the value of modern medicine (Gabe et al. 1994) and that faith in the medical profession has declined.<sup>10</sup> Dissatisfaction with the medical profession is not new and can be traced back as far as the medical profession itself (Ruggie, 2004). It has been rivaled by dissatisfaction with alternative remedies, some of which were no more than quackery and viewed as harsh or dangerous as orthodox heroic methods (see Gevitz, 1988; Young, 1992). Nevertheless, whilst distrust in medicine is not new, as Scott and Freeman note: 'it is a new experience for late twentieth century citizens raised on promises of scientific progress and trust in experts' (1995: 159). It has been suggested that public faith and trust in medicine and experts in general has been waning since the 1970s. According to Bakx (1991) biomedicine has lost the support of the lay public:

'[B]iomedicine is in danger of losing both its actual and ideological hegemony: firstly, it has culturally distanced itself from the consumers of its services; secondly it has failed to match its propaganda policies with real breakthroughs; thirdly patients have become further alienated by

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<sup>10</sup> The issue of distrust in modern medicine will be discussed in detail in chapter 6. Furthermore, the issue of declining faith and trust in expert systems will be discussed later in the chapter, specifically in relation to the work of Giddens (1991) on risk and reflexivity in late modernity.

negative physical and psychological experiences at the hands of the biomedical practitioners themselves'. (Bakx, 1991: 33).

Consumers of complementary and alternative medicines have been shown to be concerned about the safety of orthodox medicines. Studies have revealed that many users are genuinely concerned about the side effects of drugs and are anxious about taking medication that seems to them to be made of artificial substances and chemicals (Britten, 1996; Cant & Sharma, 1999). In contrast, the apparent harmlessness of alternative medicine and the belief that it is 'natural' is part of the attraction (Sharma, 1996). Sharma (1995) found that those who choose alternative therapies are conscious of the side effects of drugs and think that orthodox treatments are too invasive and aggressive (Sharma, 1995). According to Verthoef et al., (1998) chronically ill patients report that they seek care because of what they see as the serious side effects of conventional medical treatment, or that they feel that while conventional treatments do not help, complementary therapies are safe.<sup>11</sup>

A number of studies have found that many individuals using complementary therapies are dissatisfied with the outcome over a specific ailment and subsequently seek help from CAM practitioners. Here, the turn to alternative medicines has been seen as prompted by dissatisfaction, desperation and hope. Biomedicine's explicit emphasis on curing disease rather than managing or explaining chronic and untreatable illness has been seen as a factor pulling people towards alternative and complementary health care options (Ernst, 2002; Coyle, 1999). For instance, Sharma (1995) found that an overwhelming majority of her respondents said that they had used complementary medicines for the first time in order to cure some condition for which orthodox medicine had been either unable to offer any relief at all, or unable to offer a cure which was deemed satisfactory by the patient. Sharma points out that in such cases individuals were generally using complementary medicines to deal with chronic rather than acute problems. Similarly, Lloyd et al (1993) found that CAM users were critical about the efficacy of orthodox medicine. Mostly they

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<sup>11</sup> However, this perception of the safety of CAMs and the 'risks' of modern medicines has been criticized by some commentators, who argue that such beliefs are at best naïve and at worst dangerous (see for example, Ernst, 2001).

had experienced chronic illness conditions for which orthodox medicine had been unsuccessful in providing relief and were wary about taking conventional drugs. In this sense CAM use may be understood as a by-product of health status, with patients of complementary practitioners positioned as 'refugees from conventional medicine' (Fulder, 1988:30), in desperate need of help. Indeed, as McGregor and Peay (1996) note:

'Since the sufferers of these conditions generally receive no cure and often limited help from conventional medicine, it is not surprising that many of them look elsewhere for relief' (McGregor and Peay, 1996: 1318).

Indeed, a number of theorists have suggested that the rise of CAM is related to changes in the disease structure and demographic patterns, which has led to an increase in the number of chronic diseases (see for example, Taylor, 1984; Berliner and Salmon, 1980). The second half of the twentieth century saw a shift from predominantly acute, life-threatening infections to chronic conditions such as heart disease, cancers, diabetes and asthma etc, which it is argued medicine is less equipped to deal with. The suggestion is that CAMs are more responsive to the requirements of such diseases and more in touch with consumer demands than orthodox medicine (Taylor, 1984).

The criticisms of orthodox medicine made by people using complementary and alternative health practices are fairly familiar ones and certainly not exclusive to this group. The notion that biomedicine has too little time for the patient, is invasive, relies too heavily on drugs and technology, focuses on symptoms rather than causes, all of these criticisms have been made by others, and some have been the subject of much public debate (Sharma, 1995). This seems to suggest that the only difference between those who use alternative medicines and those who do not is that they are prepared to act on their dissatisfactions and have the confidence to seek out some unfamiliar form of practice in the hope that it will prove better (Sharma, 1996). Whilst, it is likely that complementary and alternative therapies have benefited from the various 'failures' of biomedical care, the reasons for the growth of such practices needs to be situated in terms of the popularity of the norms and ideals inhering in complementary and alternative

conceptualizations of health and illness. According to Cant and Sharma (1999) positioning the rise of CAM in relation to biomedicine may serve to attribute unquestioned authority and power to biomedicine over the complex lay perspectives on health that have always existed, and to contribute to the ignoring of the significance of wider societal conceptualisations of health and illness in the rise and fall of different therapeutic knowledges and practices. Indeed, as Wiles and Rosenberg (2001) note:

‘[U]se [of complementary and alternative medicines] should not be seen only as a resort for passive, victimized refugees from the biomedical system (women, chronically or terminally ill people), but also as a means of asserting identity, of maintaining control and power over the self and decisions made about the body, or exploring out of curiosity’ (Wiles and Rosenberg, 2001: 222).

### *Beliefs, values and philosophies*

A number of commentators have suggested that many people use CAM because it is more consistent with their own personal values and philosophical orientations towards health (Astin, 1998; Siahpush, 1998, 1999a), or because it forms part of a wider identification with an alternative ideology or subculture. Proponents of this thesis argue that in the late modern era, a new value system has emerged that offers new ideas about: nature, science and technology; health; authority; individual responsibility; and consumerism (Easthope, 1993; Bakx, 1991; Siahpush, 1998, O’Callaghan & Jordan, 2003).<sup>12</sup> The growing popularity of complementary and alternative therapeutics is seen as challenging modernist understandings of the self, based on biomedical science and a Cartesian separation of body and mind (Kumar, 2003). The plurality of self-help and self healing ‘communities’ which has emerged consists of heterogeneous and partially overlapping knowledges, languages and practices, often based upon eclectic borrowings of non-Western knowledges and customs (Bakx, 1991; Easthope, 1993; Coward, 1989;

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<sup>12</sup> At present only a small number of empirical studies have tested out these ideas and these have been quantitative.

Siahpush, 1998). Proponents of the postmodern-values hypothesis argue that it is the congruence of these ideas with the philosophies and remedies of most complementary and alternative therapies that is responsible for their recent growth and popularity. Indeed, one of the main proponents of this thesis, Siahpush (1998) argues that:

‘Those who value natural remedies, do not believe in chemical drugs prescribed by doctors, believe that technological developments create an environment harmful to people, and hold consumerist values are likely to favour alternative medicines’ (Siahpush, 1998: 68).

One aspect of the postmodern values thesis maintains that the increased prevalence of CAM use is linked to a popular rejection of authority, especially scientific and professional authority, and demand for participation (Bakx, 1991, Siahpush, 1998). Bakx (1991) has suggested that alternative medicine should be seen as part of a postmodern rejection of authority and an attempt by individuals to reclaim control over their health.<sup>13</sup> According to Bakx (1991):

‘Self medication and alternative practices are not new...what is different is the extent to which they are practiced and their location within the broader cultural framework of self-determination ie [*sic*] reclaiming control over the self and environment’ (Bakx, 1991: 30).

Certainly, a number of studies have found that individuals are attracted to complementary therapies because they desire more control over the healing process (see for example, Cant and Sharma, 1999; Siahpush, 1998, 1999a). It is argued that patients want to participate in the process of healing and no longer accept the power differentials that exist between them and their health practitioners. People want to take a more active part in consultations and want the chance to have an input in their own treatment. Furnham and

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<sup>13</sup> It should be noted that in certain respects people have always enjoyed a considerable measure of autonomy for their own health care, especially for non-acute conditions (Ruggie, 2004). Self-care practices such as eating nutritious foods, exercising, taking vitamins, use of OTC medications for various minor ailments and so on are just some of the ways in which individuals take care of themselves in their everyday lives.



Smith (1988: 687) found that patients of CAM, in comparison to other patients, are less likely to want to leave their health in the 'hands of professionals'. A number of studies have found that many patients are using CAM on their own, and making this and other health care decisions without informing their physicians (Ruggie, 2004). In a study of CAM use amongst older people, Andrews (2002) found that participants expressed feelings of control and empowerment in relation to their health problems.

Nevertheless, some commentators have questioned whether such developments represent a postmodern rejection of authority. According to Rayner and Easthope (2001) rather than seeing use of complementary and alternative medicines as being part of a postmodern rejection of authority, consumption of alternative medicine is associated with a 'repositioning of authority'. They argue that when obtaining information about complementary medicines individuals rely on different sources, both lay and expert for help and advice, other than their GP. Indeed, whilst individuals may be rejecting the authority of the general practitioner, through their decision to consult a CAM practitioner, control is effectively then transferred to another expert, the complementary therapist. As Kumar (2003) notes, whilst complementary and alternative therapies may allow for greater participation on the part of the client, and reinforce notions of control of the self, it nevertheless reinforces the notion of control:

'Perhaps, then, the only thing that may be postmodern about complementary therapies is that the client now has the ability to choose the expert, to transfer legitimacy from one expert to another who operates in a more personalized and less synthetic therapeutic framework, but a medicalized therapeutic framework nevertheless' (Kumar, 2003: 17-18).

Indeed, some commentators have suggested that complementary and alternative therapies involve both de-medicalizing and re-medicalizing tendencies (Lowenberg and Davis, 1994). In this sense, the rise of complementary therapeutics could be perceived as signifying a different way of practicing power (Braathen, 1996; Kumar, 2003). Complementary therapeutics, it is maintained, reinforce a normative order with their

stress on individual responsibility, self-discipline and the creation of disciplined bodies and minds. Thus, rather than being liberating, complementary therapeutics have the capacity to effect a self-responsible, self-policing and politically conformist subject (Crawford, 1980; Coward, 1989, Foucault, 1988). It is argued that underpinning the philosophies of complementary and alternative health practices, is the assumption that every human individual is essentially capable of perfect health and mental adjustment if only she/he is prepared to take responsibility for her/his own health (Crawford, 1980; Coward, 1989). People tend to believe that it is ultimately the individual who is responsible for his/her health and that health requires hard work, commitment and a change of lifestyle (Coward, 1989). Such a philosophy, it is held, is responsible for the increasing trend in people paying privately for CAMs (Coward, 1989). It is argued that people's expectations about their role in their health and healthcare have changed, and this role is something CAMs are predicated on: namely, a proactive, empowered and responsible 'client' role (Hughes, 2004).

Consumerism is another trend argued to have been responsible for the recent interest in CAMs that offer people a range of modalities from which to choose (Riessman, 1994; Easthope, 1993; Bakx, 1991). It is argued, people are more readily inclined to change their consumer choices to options with which they are more satisfied. Kelner and Wellman (1997) suggest that we are seeing increasing numbers of 'smart consumers'. That is people who are well informed about health issues and up to date on the latest 'infomessage' from the media. These are consumers who prefer to use their own judgement and the guidance of personal referrals to make health care decisions, rather than relying on the medical profession to make decisions for them. 'Their decisions are individual ones, in which they act as concerned consumers rather than compliant patients' (Kelner and Wellman, 1997: 211). According to Kelner and Wellman, 'smart consumerism' is encouraged by several factors: the increased interest in health and the body in contemporary Western countries; the idea that we can now do something to postpone deterioration and mortality; the wide range of health care options currently available, increasing choice and people have also been influenced by testimonials about successful alternative treatment. In a recent study, Andrews (2002) claimed to have

found support for Kelner and Wellman's (1997) description of users as 'smart consumers', as participants had a great deal of market knowledge about the treatments that they were purchasing, and the treatment options open to them. I shall return to the issue of consumerism and health in more detail later on in the chapter.

To summarize, the literature on individual reasons for using complementary and alternative medicines discussed throughout this chapter appears to fall into two broad camps. That is to say, individuals are either 'pushed' towards using complementary and alternative therapies because of varying degrees of dissatisfaction with biomedicine. Or, alternatively, they are 'pulled' towards CAM because it is more consistent with their own personal values and philosophical orientations towards health, or because it forms part of a wider identification with an alternative ideology or subculture. In practice it is likely that a combination of factors influence an individual's decision to consult a CAM practitioner or purchase a complementary medicine at any one time. Reasons may vary according to the particular type of CAM under consideration, as well as the illness for which treatment is sought. CAM users are not a homogeneous group. Indeed for some the decision may be made out of curiosity, for others it may be out of desperation, it may be spontaneous, or long considered and researched, it may be recommended by family, friends or even a GP, or influenced by the media. Some individuals are positively attracted to complementary therapies, others are more sceptical, while some gain a positive experience and propagate its usefulness, others experience no improvement. In Kelner and Wellman's (1997) study some individuals had chosen CAM purely for pragmatic reasons i.e. nothing else had worked. Others claimed that their choice was based on a belief system that includes such tenets as holistic care, diet and natural forms of healing. In short, the reasons why an individual may turn to complementary and alternative medicines are complex and contingent.

Furthermore, reasons for using CAM are likely to alter over time and throughout the course of using complementary therapies. Most research in this area has considered individual's *initial* motivations for using complementary therapies. Only a few studies have considered the reasons why individuals *return* to complementary therapies (Vincent

and Furnham, 1996; Sirois and Gick, 2002). According to Vincent and Furnham (1996) studies should separate the reasons for starting to use CAM from reasons for continuing to use it, as this may change over the course of time. Similarly, Sirois and Gick (2002) found reasons for using CAM to differ depending on the length of time individuals had been using it. In contrast to most other studies, they distinguished between new/infrequent CAM users and established users and found different patterns of predictors of CAM use emerged between these groups. They conclude that CAM clients need to be looked at in more sophisticated ways, rather than being treated simply as a homogeneous group with similar beliefs, motivations and needs. This thesis aims to build on such studies by not only exploring individuals' initial motivations for using CAMs, but also the reasons why they remain engaged with such practices and the ways in which their motivations change over the course of time.

The research on individuals' motivations for using complementary and alternative therapies has focused exclusively on their reasons for consulting with CAM practitioners. This thesis intends to extend current understandings of CAM use, through an exploration of the adoption of complementary and alternative medicines for self-care purposes. Here I am referring to the wide array of over-the-counter CAM products, such as herbal supplements, homeopathic remedies, aromatherapy essential oils, which are now widely available for individuals to purchase and use at home. As has been demonstrated this is a significant area of CAM use, with dramatic increases in the sales of such products available from health food stores, chemists, supermarkets as well as the Internet. Yet, to date research within the field has tended to sidestep this area of CAM altogether. None of the studies discussed in this chapter have considered self-care aspects of CAM use. Consequently, very little is known about individual's reasons for using complementary therapies in this way, and whether their reasons may differ in any way from the motives of those consulting with CAM practitioners. Furthermore, very little is known about how individuals choose these products, what they are used for, where they obtain information about them etc. Focusing on this area specifically will also add to our understanding of self-care practices more generally. An area, which as Freund and McGuire (1999) illustrate constitutes a 'hidden health care system'.

Most importantly, this thesis seeks to build upon the existing literature by providing a more theoretical understanding of the use of complementary and alternative health practices. In order to do so this thesis engages with a diverse, yet overlapping, range of contemporary sociological literature, including theories of risk, reflexive modernity, individualization and consumption. Whilst some of the social scientific literature on CAM use discussed above, in particular the 'postmodern values thesis', has sought to make a connection between the use of CAM and wider social and cultural changes, on the whole this literature has tended to skirt over substantive and formal concerns. As Siahpush (1999b: 173) notes: 'the sociology of alternative medicines is a very young field of inquiry in that it is neither theoretically developed nor empirically investigated adequately'. It is to this further development that I wish to make a contribution. For the remainder of this chapter I will discuss the theoretical literature that is used in the analysis of the data, which is drawn upon throughout this thesis in order to understand the rise of complementary and alternative therapies and individuals' motivations for using them. This includes the theorizations of Beck (1992) and Giddens (1990; 1991) on risk and reflexive modernization and the debates relating the emergence of informed, bodily-conscious, consumers of health care. However, before doing so, I will provide a brief outline of the nature of health and illness in contemporary society.

### **Health and illness in contemporary society**

According to Cant and Sharma (1999) there have been a number of critical changes occurring in late modernity that carry implications for the way that biomedicine is perceived and the role of the public as consumers of health care. Such developments, they argue, help provide an insight into the recent growth of CAM and individual's motivations for using complementary therapies. Health has become an increasingly important concept within modern Western societies (Nettleton, 1995). Indeed, as Nettleton (1995) highlights, health and health care are now identified with more than hospitals and medical bureaucracies, health matters are to be found in a whole array of agencies, institutions and settings. Health issues are now frequently a topic for media attention, in television programmes, magazines and newspaper columns. Health

maintenance involves the consumption of a range of goods and services that are increasingly marketed for their life enhancing properties, such as food, exercise machines and fitness clubs, to which I would also add complementary therapies and products. In this increasingly healthist society (Crawford, 1980), individuals are encouraged to adopt pro-active, 'vigilant' approaches towards the healthy body (Shilling, 2002).

Since the mid-1970s, there has been a clear ideological shift away from the notion that the state should protect the health of individuals to the idea that individuals should take personal responsibility to protect themselves from risk (Scott & Williams, 1991), prevention has become paramount (Scott & Freeman, 1995). Health is now thought to be something that lies within the control of the individual. Information and knowledge about health and illness are no longer simply the property of health experts, everyone has at least some experience and knowledge (Nettleton, 1995). Information and communication technologies, including the Internet, provide new scope and possibilities for information to be sought and exchanged between lay people and professionals (Nettleton and Gustaffson, 2002; Hardey, 1999). As a consequence, it has been suggested that new relationships have developed between individuals and experts and the boundary between lay and expert knowledge is increasingly blurred (Bunton, 1997). Individuals are no longer simply told how to behave, they are provided with information and a range of options so that they can decide for themselves what is best for them. Giddens (1991) suggests that the lay public is increasingly informed and reflexive, in the context of pluralized knowledge. In such a context it is likely that individuals will attempt to re-skill, by taking back some control from the experts and by searching for alternatives (Giddens, 1991). It seems that in general people now tend to be ambivalent about the value of modern medicine (Calnan & Williams, 1996) and when assessing their own lifestyles, are discriminating in the ways in which they assess information.

The production of social reflexivity in health matters, relates to the increasing uncertainties associated with medical knowledge and medical practices. Among medical experts decisions are rarely clear-cut and evidence is invariably contentious. Debates about scientific medical knowledge are no longer simply restricted to medical circles, the

public are now also prepared to question and examine scientific knowledge, and do not accept it uncritically. The recent example of the controversy surrounding the measles, mumps and rubella (MMR) vaccine, illustrates these processes clearly. In the midst of disputes between experts about whether the vaccine is linked to the development of Crohn's disease and autism,<sup>14</sup> and assurances from the Government and medical professionals that there are no side effects, individual parents must decide whether or not they will have their child vaccinated. Some parents have opted not to have their children vaccinated at all (see Rogers and Pilgrim, 1995, Brownlie and Howson, 2005), but then they may be accused of acting irresponsibly. For example, there are concerns within the medical profession that the low uptake of the MMR vaccine in certain areas is leading to a resurgence of measles, mumps, rubella and associated complications. Other parents, who can afford to, have opted to have the single vaccines as an alternative to the MMR, which is believed to eliminate the risks associated with the combined vaccine. Some parents may have their children immunized with the MMR, but still be anxious about whether they are making the 'right' decision (Brownlie and Howson, 2005). In such situations individuals are required to reflexively assess a range of complex information, from both expert and lay sources, before deciding which course of action to follow, i.e. whether or not to have their child vaccinated. The issues of risk, reflexivity and the status of both expert and non-expert knowledge are not only pertinent to issues associated with health and illness, they are also seen by some commentators, to be characteristics of contemporary late modern society (e.g Beck, 1992; Giddens, 1990; 1991). Therefore before I discuss their relevance to discussions about the use of complementary and alternative therapies, I will explore these theories in more detail.

### **A safer option? Natural healthcare in the age of risk**

Within sociology a number of authors (Douglas, 1992; Giddens, 1991; Beck, 1992) have identified risk<sup>15</sup> as a pervasive feature of contemporary Western societies. It has been

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<sup>14</sup> In 1998, *The Lancet* published a report that established a putative link between the MMR vaccine and the development of Chron's disease and autism (Wakefield et al., 1998).

<sup>15</sup> The term risk is derived from the French word *risqué*, and first appeared in its anglicized form in England in the early 19<sup>th</sup> century (Moore, 1983 cited in Gabe, 1995). Originally used in a neutral way to

argued that individuals living in these societies have moved towards greater awareness of risk and are forced to deal with risks on an everyday basis. Indeed, as Beck (1994:5) writes, 'everyone is caught up in defensive battles of various types, anticipating the hostile substances in one's manner of living and eating'. Whilst there have been numerous accounts provided documenting the nature of risk in contemporary society,<sup>16</sup> it would not be possible for me to review all of this work here. The work of Beck and Giddens has proved particularly influential and has dominated discussions within the field, specifically those dealing with the concepts of 'risk society' and 'reflexive modernization'. For this reason, I will draw chiefly on their work.

Beck has written extensively on the topic of risk (see for example, Beck, 1992, 1994, 1995, 2000a, 2000b; Beck and Beck-Gernsheim, 1995) and has described contemporary society as a *risk society*. Whilst he acknowledges that threats to health and life have always been present in human history, he argues that the nature of risk in late modern Western societies is fundamentally different for several reasons. First, he suggests that risks produced under the conditions of late modernity have increased in magnitude<sup>17</sup> and become globalized: '[I]n the course of the exponentially growing productive forces in the modernization process, hazards and potential threats have been unleashed to an extent previously unknown' (Beck, 1992: 19). In the contemporary era, he argues hazards are

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refer to a wager made by individuals after taking account of the probability of losses and gains (Dake, 1992). Over recent times the concept of risk has become associated with negative outcomes and has become synonymous with danger (Douglas, 1990), or the likelihood of some adverse effect of a hazard (Short, 1984). As Lupton (1999a) points out within everyday language risk now tends to be used to refer almost exclusively to a threat, hazard, danger or harm. Also see Boyne (2003) for discussion of the origins of the concept of risk.

<sup>16</sup> Mary Douglas has also written extensively on the subject of risk (see for example, Douglas, 1985, 1992 and Douglas and Wildavsky, 1982). Douglas was particularly interested in why some dangers are selected as risks while others are not and how risk acts as a symbolic boundary between groups. For her, what was of significance was that groups of people identify different risk attributes and even types of risk as a result of their particular form of social organization and interaction in the wider culture. Another perspective on risk, the governmentality approach maintains that there is no such thing as an objective risk; rather, risks are solely a product of discourses, strategies, practices and institutions around phenomena that turn them into risk (e.g. Castell, 1991). This Foucauldian inspired perspective is particularly interested in the way in which risk operates in relation to the political ethos of advanced liberalism (see Lupton, 1999a for detailed discussion of both perspectives).

<sup>17</sup> As Lupton (1999a) points out in much of Beck's writings he demonstrates a realist approach to risk, arguing that levels of risks have increased. However, this realist perspective is not consistently maintained throughout his work. For example, in some of his writings he adopts a 'weak' version of social constructionism (Lupton, 1999a), arguing that 'it is not clear whether it is the risks that have intensified, or our *view* of them' (Beck, 1992: 55, emphasis in original).



far more apocalyptic than in previous eras, threatening the destruction of all life on earth. According to Beck, because of their scale and magnitude such risks are not easily calculable. Second, modern risks are typically invisible. In the early days of industrialization, risks and hazards were evident to the senses, they could be smelt, touched, tasted or observed with the naked eye (Lupton, 1999a). In contrast many of the major risks today, Beck argues, largely escape perception, as they are 'localised in the sphere of *physical and chemical formulas* (e.g. toxins in foodstuffs or the nuclear threat)' (1992: 21, emphasis in original).<sup>18</sup> These risks exist in scientific knowledge rather than in everyday experience. In this sense individuals are forced to become reliant upon expert knowledge to inform and warn them about risks. The third difference between modern risks and the dangers of the past, is that the former are seen as having their basis in industrial overproduction:

'The risks and hazards of today thus differ in an essential way from the superficially similar ones in the Middle Ages through the global nature of their threat...and through their *modern* causes. They are risks of *modernization*. They are a *wholesale product* of industrialization, and are systematically intensified as it becomes global' (ibid: 21, emphasis in original).

In this sense, for Beck, risk is integrally bound up with the development of modernity (Scott and Freeman, 1995): '*Risk* may be defined as a *systematic way of dealing with hazards and insecurities induced and introduced by modernization itself*' (Beck, 1992: 21, emphasis in original). In pre-modern societies, 'nature', and its dangers, were seen as imposed by external forces, such as acts of Gods or the workings of fate and therefore beyond the control of humans. In contrast, dangers and hazards in late modern societies

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<sup>18</sup> Adams (1995) criticises Beck here for exaggerating the distinction between modern 'risk' and old-fashioned 'danger' or 'hazard'. He argues that risks were no more visible in industrial societies: 'Although human excrement was manifest to the senses in 19<sup>th</sup> century cities, the risks that it posed to health frequently were not. People died of many diseases – typhoid, smallpox, tuberculosis, bubonic plague – caused by microbes invisible to the unaided senses...And without modern packaging and preservatives, foodstuffs contained many, if different, toxins' (ibid: 179-80).

are seen as humanly generated. All of this has led to a new paradigm, that of *risk society*, a new stage of modernity.

Central to Beck's (1992) work on risk is the concept of reflexive modernization. Beck is keen to distinguish this concept of reflexivity from the reflexive monitoring that has always been a part of human activity. Rather, the concept of reflexive modernization, as Beck (1992; 1994) explains it, involves a questioning of the outcomes of modernity in terms of their production of risks. He argues that the focus on risk is a fundamental feature of a society that has come to reflect upon itself. Beck contends that as a result, public debates constantly feature discussion of risks and their effects, while private lives are dominated by concerns about risks. Experts are said to 'dump their contradictions and conflicts at the feet of the individual' (Beck, 1992: 137), leaving the individual to judge for themselves which group of experts to believe in. In reflexive modernization, individuals are no longer willing to accept the truth claims of scientific knowledge, but subject them to criticism (Caplan, 2000). According to Beck individuals have become skeptical about science, because they are aware that science has produced many of the risks. Scientific knowledge about risk is viewed as incomplete and often contradictory, failing to solve the problems it has created. There is a continuing struggle over definitions of risk, particularly between those who produce risk definitions, experts and those who consume them, the lay public. He is critical of experts' positioning of lay people as ignorant, merely requiring more information about risk to respond appropriately. For Beck lay people's apparent 'irrationality' in relation to risk is a highly rational response to the failure of technico-scientific rationality in the face of the growing risks of late modernity. The understandable response of individuals is to become critical of these dangers.

The concept of individualization is also central to Beck's view of risk society and reflexive modernization (Beck, 1992, 1994; Lupton, 1999a). For Beck, individualization refers to the requirement in late modernity that individuals must produce their own biographies, in the absence of fixed, obligatory and traditional norms and certainties and the emergence of new ways of life that are continually subject to change (Beck, 1994).

Beck argues that, the loss of tradition and the dissolution of previously existing social forms such as fixed gender roles and inflexible class positions suggests that people are increasingly engaging with areas of their lives that were previously dictated by tradition and taken for granted norms.<sup>19</sup> Human beings are now faced with a whole range of possible choices. Beck sees individualization as disintegrating ‘the certainties of industrial society as well as the compulsion to find and invent new certainties for oneself and others without them’ (ibid: 14). It is dependent on decision-making as it assumes agency, the ability to shape one’s destiny through self-determination and identification. Beck (1998: 135) refers to this as ‘reflexive biography’. Traditional forms of coping with anxiety and insecurity – families, marriage and male-female roles – are failing, and individuals must turn to themselves, creating new demands for social institutions such as education, counseling, therapy and politics. Individualization, therefore, involves a proliferation of new demands upon people at the same time as choices have become more and more complex and difficult, particularly in relation to such matters as sexual identity, work and family relationships (Beck and Beck-Gernsheim, 1995), and also health. Such planning requires a high and continuing exertion of reflexivity upon the nature and future of one’s life-course.

The increasing choice which individualization brings is not without its problems. For example, Beck and Beck-Gernsheim (1995) reflect on the role of technological innovation in medicine, and how this impacts upon contemporary family life. They argue that technological advancements in diagnostic and genetic testing on the unborn create new parental possibilities, primarily in the realm of health monitoring. However, the very capacity for medical intervention is one that quickly turns into an obligation on parents to use such technologies in order to secure a sound genetic starting point for their offspring. Individualization is thus seen as a paradoxical compulsion, leading people into a much more engaged relationship with science and technology than ever before, and

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<sup>19</sup> The move towards individualization does not mean that social inequalities or structuring of opportunities through such attributes as class, gender or ethnicity have disappeared (Lupton, 1999a). However, Beck (1992) does maintain that in the face of individualization these structures have become less obvious and acknowledged as affecting life chances. Inequalities have, primarily, become viewed as individualized, for example, as ‘psychological dispositions: as personal inadequacies, guilt feelings, anxieties, conflicts and neuroses’ (Beck, 1992: 100).

enforcing a set of obligations and responsibilities that few in society have thought through in terms of broad moral and ethical implications (Elliot, 2002). For Beck and Beck-Gernsheim (1995), individualization is therefore fraught with risk, it is in this sense that they argue that the 'do-it-yourself biography' is also always a 'risk biography' (1996: 24).

There are a number of similarities between the work of Beck and Giddens on risk, reflexive modernization and individualization (Lupton, 1999a, 1999b; Lupton and Tulloch, 2002; Lash and Urry, 1994).<sup>20</sup> Like Beck, Giddens also views late modernity as a 'risk culture', one in which the concept of risk is 'fundamental to the way both lay actors and technical specialists organize the social world' (Giddens, 1991: 3). Further, like Beck, reflexivity is a central concept in Giddens' work on risk.<sup>21</sup> According to Giddens, modern reflexivity, for both individuals and institutions, involves awareness of the contingent nature of expert knowledges and social activity and their susceptibility 'to chronic revision in the light of new information or knowledge' (ibid: 20). The conditions of modernity, the progressive separation of space, place and time and the increasing role played by disembedding mechanisms, all depend upon trust, vested not in individuals but in 'abstract capacities' (Giddens, 1990: 26). People cannot rely on local knowledges, tradition, religious precepts, habit or observation of others' practices to conduct their everyday lives, as they did in pre-modern and early modern times. Rather, they must look principally to experts they do not personally know and are unlikely ever to meet to supply them with guidelines. However, at the same time, modernity is also characterized by doubt about the validity of knowledges, acknowledging that all knowledge is open to

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<sup>20</sup> Nevertheless, there are also a number of differences between their works. For example, Lupton (1999a) suggests that Beck and Giddens differ in the way they represent expert knowledge systems. Whilst for Giddens, reflexivity takes place through expert systems and is reliant upon people's trust in expertise. For Beck, reflexivity is a critique of expertise, based not in trust but distrust in expert systems, particularly in relation to environmental hazards. Giddens places more emphasis on self-reflexivity, whereas Beck places greater emphasis on individuals' reflexive critique of the social. For full discussion of the differences and similarities in Beck and Giddens's work see Beck et al., 1994, Lash and Urry, 1994 and Lupton, 1999a; 1999b.

<sup>21</sup> Nevertheless, as Lupton (1999a) points out Beck and Giddens differ in terms of their interpretation of the relationship that is implied between risk and reflexivity to risk. Beck implies a heightened degree of risk reflexivity is the outcome of a greater number of risks being produced in the late modern era. Giddens sees the relationship as being the other way around. In other words, risks are not greater in late modernity, it is just that they are thought to be greater, because of the nature of subjectivity in general to an approach to life that is far more sensitive to the possibility of risk than in previous eras.

revision. Thus greater knowledge has led in turn to greater uncertainty: 'The fact that experts frequently disagree becomes familiar terrain for almost everyone' (Giddens, 1994: 186). In this sense reliance upon expert systems is characterized by uncertainty. With this awareness of uncertainty in the ranks of experts, it is difficult for members of the public to know which advice to 'believe in'. As a result of the contested nature of expert knowledge, Giddens suggests that the trust and faith invested in experts is being eroded. Lack of trust in expert authority, according to Giddens, is a central theme in the late modern era.<sup>22</sup>

Giddens' writings also closely parallel those of Beck in relation to the processes that Beck calls 'individualization'. According to Giddens (1991), the self is seen as a reflexive project in late modernity, as a problematic rather than a given. At the same time, there is far more emphasis on the malleability of the self and the responsibility that one takes for one's life trajectory. Individuals have greater recourse to expert knowledges in constructing the project of the self. However, as knowledge is being constantly revised in late modernity, the processes of reflexivity are more complicated and uncertain. There are more choices to be made: 'the self, like the broader institutional contexts in which it exist, has to be reflexively made. Yet this task has to be accomplished amid a puzzling diversity of options and possibilities' (ibid: 3). Because traditions have lost their power and there is more 'openness' about how one can live, the concept of lifestyle has become ever more important to selfhood, forcing people to negotiate among a range of options. The reflexive project of self-identity requires 'consideration of risks as filtered through contact with expert knowledge' (ibid: 5).

The work of Beck and Giddens has been subject to considerable criticism. One of the main criticisms of the 'reflexive modernization' thesis is that it is based on broad generalizations of structural and organizational processes that lack grounding in actual processes and experiences of institutional and everyday life. As Williams and Bendelow (1998: 104) note, 'discourses on risk, consumption and the "reflexive" body...continue to be pitched, for the most part, at the level of broad claims and sweeping generalizations

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<sup>22</sup> In contrast to Beck's writings on the risk society the notion of trust is a dominant theme in Giddens' (e.g. 1990; 1991; 1994) work.

with little concern for empirical detail ...'.<sup>23</sup> Indeed, although the speculations of Beck and Giddens are important, neither theorist has considered the diverse ways in which people react to risk and their work requires translation into the context of everyday practices. Their perspectives on risk both adopt a broadly macro-sociological approach (Lupton, 1999a), and they have been criticized for their view of the overly rationalized and individualized human actor and for their tendency to generalize without considering the role played by gender, class, nationality, age and ethnicity in the construction of a variety of different risk knowledges (Lash, 1993; Alexander, 1996, Williams, 2000). As Ellison (1997: 114) notes, there are 'reflexivity winners and losers'. Another criticism of Beck and Giddens' work relates to their assertion that the reflexive critique of science and other expert knowledge systems is a feature solely of late modernity, and was not evident in earlier modernity (Lupton, 1999a). Some commentators have argued that this is not the case, and that Beck and Giddens' representations of modernity are simplistic, not acknowledging the complexity of responses to expert knowledges. For instance, Lash (1993) argues that modernity is by definition reflexive, involving continual monitoring itself, even if through convention rather than through individualization.

Despite these criticisms the work of Beck and Giddens on the nature of risk in contemporary societies has been extremely influential and does have some relevance for discussions about the growth of complementary and alternative therapies. Indeed, Cant and Sharma (1999) have suggested that perhaps we should see the growth of CAM as a dimension of the reflexive nature of modern societies. Within the *new medical pluralism* (Cant and Sharma, 1999), individuals now have a range of options from which to choose when they are ill. Furthermore, as has been demonstrated, empirical research has indicated that CAM users are generally distrustful of Western medicine and often concerned about the 'risks' of biomedical interventions and may, therefore, choose complementary therapies because they offer a safer, more 'natural' alternative. According to Turner (2004: xvi) the tensions between public trust, uninsurable risk and scientific legitimacy have generally undermined confidence in expert systems (Giddens,

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<sup>23</sup> There is now a growing body of empirical research (see for example, Wynne, 1989, 1996; Michael, 1996; Scott et al., 1998; Lupton and Tulloch, 2002), that challenges sociologists who 'tend to make sweeping generalizations about how 'late moderns' respond to risk' (Lupton and Tulloch, 2002: 319).

1990; Beck, 1992) and 'as a result the public has experimented with alternative and less intrusive healing systems'. In this sense, the use of complementary therapies may in part be seen as a response to the contested nature of expert knowledge and an attempt on the part of individuals to regain control over their health in the face of uncertainty.

Furthermore, Giddens's (1991) notion of the reflexive project of the self is also particularly relevant in matters of health. As Nettleton and Gustaffson (2002) note, more and more people are making their own decisions and reflexively assessing complex and often conflicting sources of advice and information on health routines, health interventions and on their experiences of illness. Such activities, it is argued, permeate the psyche, and may impact upon one's notion of self and identity. The reflexive project of the self is carried out amid a profusion of reflexive resources: 'therapy and self-help manuals of all kinds, television programmes and magazine articles' (Giddens, 1991: 30). In Sharma's (1995) study on CAM use in the West Midlands, there was evidence of interviewees who had developed greater confidence in their capacity to choose between therapies: 'I make up my own mind about these things now...Now I feel I am in control of my life' (ibid: 51). At the same time, there exist many substitutes for medical authority for those wishing to adopt a more 'natural' approach to health care. Studies indicate that CAM users draw upon a range of sources for information and advice when deciding whether to use complementary therapies, including self-help books, media sources such as magazines, TV, newspapers and the Internet (as well as friends, family etc).

As an illustration of the processes of reflexivity and 'reskilling' or reappropriation of knowledge, Giddens (1991) himself gives the example of a woman with back pain, the range of options available to her and the way in which she reflexively assesses information from a range of, often conflicting sources, before making her decision. When someone has a back problem, says Giddens, they now have a range of treatment options from which to choose. They might initially go to see their doctor, who may perhaps offer recommendations or help to alleviate the problem altogether. However, it may also be the case that they do not find help and are not satisfied with the treatment

options available, which may include invasive surgical procedures. This individual, Giddens points out, may then choose to inquire further and discover that there are other medical treatments on offer and there are major differences of opinion concerning each of them. Investigating a little more deeply, the patient would discover that there is a range of other treatments for back pain, outside of orthodox medicine, such as those provided by osteopathy, chiropractic, acupuncture, physiotherapy, massage, reflexology, Alexander technique etc. Giddens suggests that at this point the patient may decide to take the matter into her own hands and decide to inform herself about the nature of her complaint and the different therapies available for it, here, she may well consult books about the back. However, Giddens maintains that, deciding which to treatment to opt for, if any, is difficult because she would need to balance off the various claims made by the different approaches. According to Giddens (1991: 141), this is exacerbated by the fact that ‘there is no overarching authority to whom she might turn – a characteristic dilemma of many situations in conditions of high modernity’.

### **Informed consumers of health care**

Within both health and social services, an emphasis on the ‘patient’ or ‘user’ as ‘consumer’<sup>24</sup> with the implied ability to make decisions based on information and experience has emerged (Henderson and Peterson, 2002). The rise of consumerism is regarded as one of the fundamental developments shaping health service delivery within the UK (Nettleton, 1995). The language of consumerism was first applied to users of the UK public health service in the late 1970s and early 1980s (Gabe et al., 2004). However, it was initially criticized on the grounds that the consumption of medical care is very different from the consumption of other goods and services. Indeed, in the mid 1970s Stacey (1976) argued that the idea of patients as consumers was a basic misconception. The social relations of health, Stacey argued, were anathema to such a formulation. Patients simply could not be consumers because they lacked the ability to choose, were deficient in knowledge and power compared with doctors, and could not exercise the

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<sup>24</sup> The term ‘consumer’ has its origins in the world of private business and reflects recognition that producers should take account of the preferences of the purchasers of their goods in order to maximize their profits (Gabe et al., 2004).



right to return or effectively complain about the 'product', so often the hallmarks of consumerism. Nevertheless, despite these concerns consumerism has become a leitmotif of health policy and practice over the past 30 years (Gabe et al., 2004).

Patients are increasingly being treated as consumers who make demands and have needs, which the Health Service must strive to meet. Health policy initiatives over the last two decades appear to endorse a view of service users who are becoming more 'empowered' in their relationships with health professionals (Department of Health, 1989, 1991, NHS Executive, 1996, 1997). This is evident in the setting up of the Department of Health's Expert Patients Taskforce, along with the increase in the amount of research focusing on the concepts of patient-centred care (Kinmonth et al. 1998) and shared clinical decision-making (Charles et. al. 1997, 1999). Consumerism in this context tends to mean the maximization of consumer choice, provision of information, reduced waiting times, encouraging consumers to complain and taking their views into account by conducting surveys to ascertain their levels of satisfaction (Nettleton, 1995). The sociological literature outlines some of the conceptual distinctions, which can be made between the respective roles of 'patient' and the 'consumer' of health care. The patient has been regarded historically as occupying a subject position, with implications of dependency and unquestioning compliance with medical expertise. However, this emphasis on social control and the 'docile' body is felt to be less appropriate when considering the present day 'consumer' of health care services. As Williams and Calnan observe:

'The structure of lay thought and perceptions of modern medicine is complex, subtle and sophisticated, and individuals are not simply passive consumers who are active in the face of modern medicine and technological developments'. (Williams and Calnan, 1996, cited in Hibbert et al, 2002: 47).

At the same time there has been an increase in the availability of information concerning matters of health and illness. Some commentators have suggested that we have entered an 'information society' (Castells, 2000), that provides individuals with the potential to

access an unprecedented amount of medical information (Shilling, 2002). One central medium through which the information society has grown is the Internet (Hardey, 1999; 2001). According to Shilling (2002: 629) the Internet 'allows individuals to traverse boundaries between different knowledges, professions and practices, and constitutes a medium for what has been described as the new medical pluralism'. Hardey (1999) maintains that in such a context users of information, rather than the professional experts, begin to decide what is to be delivered to them. Traditionally, health education is directed and distributed by doctors and educators, but the internet offers a view of health which is 'deprofessionalized and demystified', making the provisional nature of medical knowledge more obvious. Users can access a massive diversity of information and services that appears to promise, for those who can afford it, an unprecedented degree of choice in health care decisions. For Hardey (1999; 2001) the information people can access on the Internet represents a challenge to medical dominance. It increases the potential people have for 'shopping around' for health care, and for second opinions unmediated by their physician. It also means that doctors may be used as secondary, rather than primary, sources of health advice. The Internet provides individuals with numerous avenues through which information about a condition can be gathered, and with unprecedented opportunities for checking diagnoses and prescribed treatments. Users of the Internet may increase their capacity to challenge the opinion of conventional health professionals, and seek help from CAM practitioners (Eysenbach, and Diepgen, 1999; Jahad, 1999; Kiley, 1998; Turner, 1995).

Nevertheless, it is unclear to what extent health care users want to be involved in decision-making about their care. Studies indicate that, while many patients say they would like information about their condition, a much smaller number say they want to participate in treatment decisions, preferring doctors to decide on their behalf (Charles et al., 1997). Lupton (1997) found that patients may want to adopt both 'consumerist' and 'passive patient' roles at various times, depending on the context. Furthermore, as Gabe et al. (2004) note, neither is it clear that doctors are necessarily willing to share information with patients as part of a joint decision-making process. In some cases they may prefer to limit the nature of the information that they share with their patients, as part

of an attempt to maintain their professional dominance. It is questionable whether the informed, pro-active consumer, armed with pages from Internet sites used to challenge their doctor's recommendations is actually that common in practice. Indeed, as Shilling (2002) notes while the internet may *eventually* help to democratize medicine, empirical research does not indicate that greater patient access to knowledge has led to such outcomes. Furthermore, it appears that traditional authorities continue to exert substantial and often decisive control over the organization and delivery of medical services, thus restricting the development of the consumerist patient. According to Lupton (2002) there is a congruence between Giddens' notion of the 'reflexive project of the self' and the 'consumerist' patient. Both are understood as actively calculating, assessing and, if necessary, countering expert knowledge and autonomy with the objective of maximizing the value of services such as health care. Both tend to portray a type of subject that is non-differentiated; for example, there is little discussion of how gender, sexual identity, age, ethnicity, social class and personal biography or life experiences affect the taking up of 'consumerist' or 'reflexive' positions. Further, Lupton argues that 'neither approach tends to take into account the role played by cultural, psychodynamic and affective processes in individuals' everyday life choices, decisions and actions' (2002: 361).

Despite such criticisms there is evidence to suggest that users of complementary therapies can perhaps be viewed as an example of the 'information rich' consumers of health care identified above. Indeed, according to Doel and Segrott (2003b:131) 'debates about why people are attracted to CAM highlight the importance of consumer agency and increasing access to health care information'. Furthermore, empirical studies have revealed that CAM users are often knowledgeable and informed. For instance, Sharma (1995) found that her respondents had informed themselves about the therapy and possible cures for their problem, even though the actual choice of practitioner was made on the basis of advice from members of their social network. Similarly, Lloyd et al (1993) found that after personal recommendation, personal assessment of practitioners after shopping around was the next most frequent means of identifying a therapist and that the majority of participants had accurate and detailed knowledge of the qualifications held by their

practitioners.<sup>25</sup> Wiles and Rosenberg (2001: 221) argue that the increasing use of CAM is being driven by the emergence of 'smart consumers'; people who are well informed about health issues and up-to-date on the latest 'infomessage' from the media'. They rely on personal legitimacy for making their choice, rather than institutional legitimacy. They make individual decisions in which they act as concerned consumers rather than compliant patients (Kelner and Wellman, 1997). This thesis seeks to explore these issues by considering, for example, how far the use of CAM is seen in terms of consumer choice; and whether the rise of complementary and alternative therapies suggests that we have seen the traditional patient of health care also becoming a 'consumer', choosing the services they desire and seeing themselves as active decision-makers (Cant and Sharma, 1999). In particular such issues will be explored in chapter 7, by considering the consumption of complementary and alternative therapies for self-care purposes.

### **Consumer culture, lifestyle and the body**

Within sociology the interest in the process and meaning of consumption<sup>26</sup> has escalated over the last fifteen years. The consumption of goods and services is recognized as a socio-cultural process (Bocock, 1993) that is now regarded as having more impact upon the identity and lifestyle of a person than production (Tomlinson, 1990)<sup>27</sup>. The consumption of commodities has become central to how people define themselves. A number of theorists argue that consumption in postmodernity is largely the consumption of signs, with commodities purchased on the basis of their use as markers or signifiers of meaning (see for example, Baudrillard, 1988; Crook et. al., 1992 and Featherstone, 1991). Such symbolic consumption, it is argued, has become the central activity of identity construction in the postmodern world as traditional identity sources, such as class position have declined (Bauman, 1992a; Giddens, 1991). However, although most authors agree that symbolic consumption is central to the constitution of self-identity,

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<sup>25</sup> However, in contrast to such findings in one study of users of homeopathy (Cant, 1997 cited in Cant and Sharma, 1999), a number of participants had not even asked their practitioner about their qualifications.

<sup>26</sup> Here 'consumption' is used to refer to the purchase and use of goods, leisure activities and services (Jagger, 2000).

<sup>27</sup> Although there is debate surrounding this issue and many commentators continue to argue that consumption behaviours are broadly related to social location (see for example, Bourdieu, 1984; Savage et.al. 1992).

there are differences between writers in terms of how this link can be explained and understood (Jagger, 2000).

For Bourdieu (1984) identities are located in relatively stable and fixed social class positions which determine an individual's or social group's consumption preferences in any social field such as art, sport, diet, home furnishings, music etc. Thus in this view, taste in cultural goods operates as a marker of class identity. In other words, because consumption choices involve discriminatory judgements of taste, they simultaneously render visible to others an individual's or social group's own particular discriminatory capacities. As Bourdieu (1984: 6) writes 'taste classifies, and it classifies the classifier'. To explain the social determinants of taste that characterize a particular class or social group, Bourdieu introduces the notion of 'habitus'. This is defined as a set of unconscious dispositions that organize an individual's capacity to act, to classify and to make sense of social experience. It is manifest in an individual's taken-for-granted assumptions about the appropriateness and validity of his or her taste in cultural goods and practices. The application of this set of classificatory principles as distinctive modes of cultural consumption is thus recognised as a sign of taste or the lack of it. Thus, according to Bourdieu (1984), symbolic consumption is an ideal weapon in strategies of distinction. Cultural goods are deployed to demarcate boundaries between some individuals or social groups and to establish communality with others.

Most researchers examining the consumption of health messages and health products have taken the position that health consumption is related to social location (Bunton and Burrows, 1995; Savage et. al., 1992). Bunton and Burrows (1995) in their analysis of health promotion argue that although health promotion is focused on individual consumption patterns, it has to compete with the influences of social location. They conclude by arguing that social location 'plays a crucial role in the determination of people's tastes and preferences' (Bunton and Burrows, 1995: 221). In their study of differences in culture, consumption and lifestyle amongst the British middle class, Savage et al. (1992) argue that health, lifestyle and consumption are broadly related to social location. Using their framework of economic, cultural and organizations assets to

demarcate different consumer groups, they argue that different groups use different mixes of health behaviour as part of a consumption lifestyle. They identified three distinct lifestyles: 'ascetic'; 'postmodern'; and 'conventional'. The ascetic lifestyle is one largely based upon the consumption of various forms of goods and services associated with health and exercise. Individuals tend to be employed in education, health and welfare. People with high cultural capital but low economic capital who are largely reliant on the state for employment. This category of consumers acts as a 'vanguard for the new healthy lifestyle'. They engage in active health maintenance, avoid health risk behaviours such as alcohol consumption, are drawn towards a culture of 'authenticity' and the 'natural' and maintain an individualistic orientation to health. The group is rich only in cultural capital, and the 'container' for this is the body, a container which must be 'preserved and manicured'. The postmodern lifestyle, by contrast tends to be adopted by those with high incomes in the private sector. It is marked by consumption practices which relate to health and body maintenance and, at the same time, to excess and indulgence, especially with respect to eating and drinking. For this group consumption is not organized into a form of lifestyle marked by any single coherent organizing principle, high levels of indulgence go hand in hand with an emphasis on body maintenance. The third group, which Savage et al. refer to as the 'conventional lifestyle' has very little in the way of 'distinctive' patterns of consumption. Thus, for Savage et al. (1992) health is intrinsically linked to consumption lifestyles but the framework of cultural, economic and organizational assets to which these lifestyles are related indicate that health consumption is linked to social location.

In contrast, rather than seeing identity as rigidly defined in terms of class, postmodern theorists view identity as being dynamic, plural and derived from a multiplicity of sources (see for example, Baudrillard, 1988; Bauman, 1992a). From a postmodern perspective, identities are no longer received automatically through the rituals and social practices of the traditional order, but are constituted through individual marketplace decisions (Jagger, 2000). According to Bauman (1992a) in contemporary society an individual's life trajectory is undetermined, thus self-assembly becomes a key process. The lack of a determined life project generates the need for orientation points in the

assembling of the self. Bauman argues that the pluralism of authority and lack of life trajectory in postmodernity effectively remove binding norms from individuals allowing them to be guided by their own purposes. The autonomy of the agent results in an increase in self-monitoring, self-reflection and self-evaluation. By providing a series of 'expert knowledges', for instance in relation to lifestyle, health, fashion and beauty, consumer culture is understood from a postmodern perspective to have contributed to an increasingly reflexive understanding of the self, an awareness that identity is chosen and constructed (Giddens, 1991; Kellner, 1995). This echoes themes in Giddens' theory of self-identity in late modernity, discussed above, where he suggests that reflexivity is central to the development of identity. In this sense the self in 'late modernity' has become a reflexive project; it is created through a plurality of consumer choices and lifestyles decisions.

For both Bauman (1992a) and Giddens (1991) the body is central to this process. Bauman (ibid: 194) points out that, as the activity of self-assembly has no reference from which it can be evaluated or monitored, the body is 'the only visible aspect of continuity and of the cumulative effects of self-constitutive efforts'. Thus the postmodern individual pays particular attention to everything taken into the body or contacting the skin, as the body is central to the production of 'publicly legible self definitions' (ibid). In consumer culture the self is inextricably bound up with the body. According to Shilling (1993), the body provides the medium through which messages about self-identity are transmitted and is a key site for the marking of difference. Shilling argues that the body may be best conceptualized as an *unfinished* biological and social phenomenon, which is transformed, within changing limits, as a result of its participation in society. From the idea that the body is continually in a state of *unfinishedness*, Shilling develops the notion of the *body as a project*. That is, the body is 'seen as an entity which is in the process of becoming; a project which should be worked at and accomplished as part of an individual's self identity' (ibid: 5). Shilling's (ibid) notion of a body project is based on two propositions. First, that we have the technological knowledge and ability to intervene and substantially alter the body. Second, that growing numbers of people are increasingly aware of the body as an unfinished entity which is shaped partly as a result

of lifestyle choices. Creating and maintaining a healthy and fit body is an example of an increasingly common type of body project (Nettleton, 1995).

The current emphasis on lifestyles in relation to health reflects broader social changes and is seen to be inextricably linked to the rise of consumer culture (Nettleton, 1995). Within contemporary consumer cultures, health has become a pervasive feature of everyday life, identifiable within many sites of consumption, both alongside and interacting with leisure and work (Bunton and Crawshaw, 2002). The 'healthy self' is defined not simply by the absence of illness, but also by an individual's ability to participate fully within communities and consume appropriately (Bunton and Burrows, 1995; Burrows and Nettleton, 1997). Today the concept of health is associated with the consumption of a wide array of goods and services, including 'healthy' foods, health clubs, personal trainers, yoga classes, vitamin supplements, massage treatments, slimming aids, sports clothing etc. Within consumer cultures health status is achieved 'by purchasing the signs of a healthy lifestyle, from low fat spread to fitness club membership' (Bunton and Crawshaw, 2002: 189). Featherstone (1991) argues that the new petite bourgeoisie produce and disseminate cultural imagery and information which aims to expand and legitimate its own particular dispositions and lifestyles. In relation to the legitimation of 'healthy' lifestyles these are disseminated by the medical profession and health promoters, who in this sense may be seen as 'the new cultural intermediaries' (Bourdieu, 1984). In this respect there is a commercialization of health in that people are constructed as health consumers who may consume healthy lifestyles. Central to this is an emphasis on body maintenance.

Health is increasingly conceptualized in terms of body maintenance activities such as exercise, diet and the avoidance of 'unhealthy' products like cigarettes and alcohol (Crawford, 1987). Whilst disciplined body management existed in pre-modern times, in the form of harsh ascetic regimes which would result in higher spiritual ends, such as dietary control and the wearing of hair shirts (Turner, 1984). According to Featherstone (1991), in consumer culture the emphasis of body maintenance is on transforming the outer appearance of the body in pursuit of idealized forms and thus more akin to



hedonism than temperance. Featherstone suggests that this emphasis is a consequence of a conflation between the inner self and the outer body engendered by the importance placed on certain key values, and on health in particular. In commodity culture, body maintenance in the interests of good health merges with the desire to appear attractive, to look good is to feel good (and to be good) and vice versa (Featherstone, 1991). Featherstone (1982) suggests that the term 'body maintenance' indicates the popularity of the machine metaphor for the body. 'Like cars and other consumer goods, bodies require servicing, regular care and attention to preserve maximum efficiency' (Featherstone, 1982: 25). This is linked to preventative medicine, which demands constant vigilance on the part of the individual who has to be persuaded to assume responsibility for his health.

Central to the literature on lifestyles and health is the notion of risk. Health can be promoted and disease can be prevented by the identification and control of risk factors. Certain lifestyle habits are deemed to be more risky than others (Nettleton, 1995). Individuals are encouraged to modify their lifestyles in order to reduce the risk of ill health and disease. For example, so-called lifestyle diseases such as coronary heart disease, diabetes, lung cancer, cirrhosis of the liver etc., have been strongly linked to diet, weight, tobacco and alcohol consumption (Lupton, 1994). The imperative of health (Lupton 1995) encourages individuals to become concerned and reflexive about lifestyle, and invites people to view their lives and bodies as open to transformation and modification (Glassner, 1995). In this way care of the self is constructed as an individual responsibility and the healthy body is increasingly understood as the morally correct and socially acceptable body (Crawford, 1980). The notion of deviancy is extended from the sick person to the '*potentially sick person*' (ibid: 380). As Crawford notes:

'We all become deviants in our everyday lives, when we light up a cigarette, when we consume eggs at breakfast, and when we are unable to express fully our emotions. Persons who act in such a way as to predispose themselves to sickness are now considered actually to be sick' (ibid: 380).

Lupton has argued that 'the dominant theme of lifestyle risk discourse is the responsibility of the individual to avoid risks for the sake of his or her own health as well as the greater good of society' (Lupton, 1993: 429). According to Rimke (2000), such neo-liberal strategies construct the individual with specific relationships to the social world and serve to create the hyper-responsible self who will conform to 'distant' expert discourses. This process is inextricably linked with the governance of populations as 'health becomes idealized as self-governed lifestyle choice' (Bunton and Burrows, 1995: 210). Preventative health discourses promoting the avoidance of risk can be marketed within consumer cultures promoting an ethical disciplined, ascetic bodily regulation, seen for example in practices of healthy eating (Lupton, 1996a). Nevertheless, a number of commentators have stressed the need to exercise caution when talking about the prevalence of such trends. For at the same time there still remain large numbers of people who continue to treat their bodies as vehicles of instant gratification regardless of health considerations (Rojek 2000). Such trends are thought to be most prevalent amongst 'a new body conscious segment of the middle class' (Shilling, 2002) or 'worried well' (Williams, 2000), particularly those segments of the new middle classes anxious for status and distinction (Bourdieu, 1984; Featherstone, 1991).

'Alternative medicine is a *recent* major field of consumption in all those societies that could be considered to be postmodern or late modern' (Rayner and Easthope, 2001: 159), and thus represents an interesting area through which to explore such issues. Complementary medicines can be seen as an example of the 'commercialization of healthy lifestyles' (Featherstone, 1991). Homeopathic remedies, herbal supplements, aromatherapy oils and vitamin supplements are now available for purchase from a wide range of retail outlets, there are an ever increasing number of 'new' and 'exotic' therapeutic treatments available in health spas and beauty clinics, from 'hot stone therapy' to 'Indian head massage'. Such products and services are promoted as part of a 'natural' or 'alternative' lifestyle within the growing number of health and lifestyle magazines (Doel and Segrott, 2003). Both Coward (1989) and Crawford (1980) have linked the use of complementary medicine to the wider shift in expectations about health care, particularly 'healthism', the cultivation of a highly individualistic approach to the

body which emphasizes not just the perfectibility of the body, but the right of the individual to attain such perfect health and the obligation and responsibility of every individual to pursue such perfectibility. According to Coward (1989) alternative medicine is premised on very different ideas about the body and assumes that perfect health is an achievable aim: 'The body has a whole new centrality as a place of work and transformation' (Coward, 1989: 194). This relates to Shilling's (1993) notion of the 'project of the body'. Indeed, Cant and Sharma (1999) suggest that it is possible that the motivations to use complementary and alternative medicine may stem from changes to attitudes held about the body. Certainly, at a time when the body has come to be seen as a 'project' (Giddens, 1991, Shilling, 1993), it is not hard to see the attraction of therapeutic practice that places a great emphasis on a holistic approach to health care and which makes links between physical complaints and the emotional and spiritual levels of a person and indeed offers hope that good health can be achieved and maintained.

## **Conclusion**

In this chapter I have focused on the diverse, yet overlapping, spheres of social scientific literature that are drawn upon throughout this thesis, in order to understand the nature of CAM use in contemporary Western societies. One of these spheres is the growing body of empirical research on CAM use. Whilst, this is a relatively young field of inquiry, there are a growing number of studies considering the reasons why people turn to complementary therapies. However, there is considerable debate surrounding the issue of why people utilize CAM. Broadly speaking, research suggests that individuals are either 'pushed' towards CAMs, through varying levels of dissatisfaction with conventional medicine, or they are 'pulled' towards them because they fit with the own beliefs, values and philosophies. However, as I have demonstrated this literature is under-theorized and tends to skim over more substantive and formal concerns. Indeed, as I have demonstrated, whilst such studies have revealed a great deal about the explanations individuals provide for a particular consultation, this research has been unable to indicate how people make decisions about CAM, in relation to their knowledge and

understandings of them. As a result little is known about whether usage of CAM might be derived from or even bring about broad changes in ideas about health and illness.

This thesis departs from this literature by considering how the increased popularity and use of complementary therapies relates to social change. More specifically, the findings from this study are used to assess the relationship between the usage of CAM and wider social and cultural shifts such as changing attitudes to the body, personal responsibility for health, the role of biomedicine in producing health and questions of risk and trust in relation to experts. As I have demonstrated in this chapter many of the contemporary sociological debates relating to issues such as risk, reflexive modernization, individualization, consumer culture and embodiment are relevant to discussions about complementary therapies. Thus in this chapter I have provided a critical overview of some of the sociological literature that I employ throughout this thesis, and in particular in the analysis of the data, in an attempt to help understand the use of complementary therapies. Nevertheless, throughout this thesis it will become evident that there are certain limitations to such broad theories, when attempting to understand complementary and alternative health practices at an individual level, and often such theories do not correspond with participants' accounts. In this sense, whilst the literature provide useful theoretical tools for understanding CAM use, at the same time this research highlights the limitations of such overarching theorizations in terms of understanding everyday life.

This study also builds on previous studies of CAM use by not only considering the reasons why people initially use complementary therapies, but also the reasons why they return and how their motives change over the course of time. Finally, this study aims to add to our current understandings of complementary and alternative therapies, by also considering the use of complementary therapies for self-help purposes. This will not only add to our understanding of this aspect of CAM use, but also help to explain the ways in which people make decisions about where and when to seek help and advice in relation to health problems. In the next chapter I outline the methods employed in this research and methodological concerns, before moving on to discuss the main body of the research in chapters 5,6 and 7.

## **Methodology**

### **Introduction**

The aim of this chapter is to explain and justify the methodology and choice of methods that have been employed in relation to this research. Specific attention will be given to both the theoretical issues and the practical aspects of the research. I will focus on the overall research process including: the techniques employed in order to gain access to individuals using complementary therapies; the selection of the sample; the process of data collection; ethical issues inherent in the research, and the practical strategies which were undertaken to ensure that the research complied with ethical principles. I also seek to describe the inductive approach I adopted to analyze my data and to explain how and why I used the computer software package Nvivo to facilitate this process. I also discuss the relationship between this analytic process and the ways in which I used current sociological theory to help me to interrogate the data. Finally, I will discuss the process whereby I draw on the data in order to assess the usefulness of existing theoretical accounts.

### **Background**

The aim of this study was to examine the reasons why people turn to complementary and alternative medicines, through an exploration of the sequence of events that leads to the decision to use these therapies. Previous research in this field has revealed a great deal about the type of people who use CAM, and the explanation they provide for a particular consultation. However, such research has been unable to indicate how people make decisions about CAM, in relation to their knowledge and understandings of them. As a result little is known about whether usage of CAM might be derived from or even bring about broad changes in ideas about health and illness. This research sought to explore the

way in which changes in individual's perceptions of health impact on their behaviour. By uncovering the ways in which knowledge of CAM is incorporated into their own understandings of health and the body and the subsequent affect this has on decisions they make about health care. Through a series of semi-structured interviews with CAM users, this research explored their experiences in order to determine their motivations for using them. The questions addressed included: What brings a particular individual to consider using CAM in the first place, and on the basis of what information and advice? How do individuals develop knowledge and understanding of CAM? What affect does usage of CAM have on future health care decisions? The data were then used to assess the relationship between usage of CAM and wider social and cultural shifts such as changing attitudes to the body, personal responsibility for health, the role of biomedicine in producing health and questions of risk and trust in relation to experts. For example, what can an examination of CAM tell us about the role of expert knowledge and professionals in modern societies? How does the issue of risk relate to decision making processes? How far is use of CAM seen in terms of consumer choice?

A number of theoretical assumptions are embodied by this research in relation to the concept of health. This study adopts the principle that people's beliefs about health, illness and disease have their own logic and validity and are worthy of study in their own right (West, 1979; Stacey, 1988). It is understood that conceptualizations of health may be found to vary systematically among social groups. However, it is assumed that different accounts are likely to be variously drawn according to social circumstances and that people's ideas will change over time. In other words, people are less likely to work with unified theories or explanations that transcend time and place and are more likely to have views that adjust according to the concerns of the individual. In this sense, people can be seen to hold a multiplicity of accounts about health and illness, derived from disparate and distinct sources. It is understood that beliefs about health are rooted in wider socio-cultural contexts. Through the study of health beliefs we can come to appreciate the extent to which such ideas, beliefs and practices are socially embedded (Nettleton, 1995). This research adopts an interpretative approach, which seeks to study

everyday life to reveal its underlying assumptions (Turner, 1987). According to Calnan (1987) the value of adopting an interpretive approach is that:

‘[E]mphasis is placed on understanding lay people’s actions in terms of the meaning that they place on these actions. The meaning is itself derived from their own complex body of knowledge and beliefs, which is closely linked with the social context in which they live their daily lives. Thus, rather than treating beliefs about health as idiosyncratic, this approach emphasizes their logic and integrity’ (Calnan, 1987: 8).

This research then adopts a social constructionist epistemology, in the sociological rather than postmodern sense, and seeks to provide an interpretive understanding of the processes of using complementary therapies. Rather than assuming that an objective truth or meaning is somewhere ‘out there’ waiting to be discovered, a constructionist epistemology focuses on how the meanings that social actors employ to understand the world are socially constructed and constantly negotiated throughout the course of everyday life. From this perspective, all meaningful reality is therefore viewed as being contingent on human practices, and is actively constructed in and out of interaction between human beings and their environment (Crotty, 1998). This epistemological position is reflected in the choice of methods used. As this research involves an examination of the meanings and interpretations which people apply to their daily routines qualitative methods were considered most appropriate. Bryman (1988) suggests that:

‘The most fundamental characteristic of qualitative research is its express commitment to viewing events, action, norms, values, etc. from the perspective of the people who are being studied’ (Bryman, 1988: 55).

The justification for my choice of methods and methodology is supported by the theoretical perspective underlying the research. The research seeks to uncover meanings and perceptions on the part of the individuals taking part in the research, viewing these

understandings against the backdrop of people's overall worldview or 'culture' (Crotty, 1998). As qualitative techniques are understood to give prominence to 'understanding the action of participants on the basis of their active experience of the world and the ways in which their actions arise from and reflect back on experience (Burgess, 1984: 3). These particular techniques can be seen to fit the central purposes of this research, which is to focus on an understanding of people's experiences, beliefs and motivations to use CAM.

The approach I took to the interviews was phenomenologically based in that I viewed the interviews as representations of the interviewees' interpretations of their everyday worlds. Moreover, I was concerned with the meanings that they attached to their experience of using complementary medicines. Drawing on Radley and Billig's (1996) work, participant's accounts on health were viewed as more than just their views on health and illness, rather they were viewed as part of the ongoing construction of their identity. By giving detailed accounts of their health and illness, participants disclosed information about the fluid locations they occupy and how these vary according to time and context (Popay and Groves, 2000).

### **Research design**

This research was based on in depth semi-structured interviews with 24 individuals<sup>1</sup> using various types of complementary therapies. The size of the sample was determined partly by time and resources, although, interviewing also ceased at the point of 'saturation', in other words when no new information or themes were emerging from the interviews (Burgess, 1984; Kvale, 1996). The interviews varied in length ranging from 50 minutes to 4 hours 30 minutes, although the average length of interview was 1 hour and 30 minutes. There were more women than men overall (20 women and 4 men), however this balance reflects the wider pattern of CAM use nationally (Thomas et al., 2001). Survey data has indicated that use of CAM is most common among 45-64 year olds (12.9%) and then among people between the ages of 18 and 44 (11.%) (Thomas et

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<sup>1</sup> See Table 3.1 for list of CAM users.



al. 2001). The average age of participants in this study was 47, the youngest participant was 26 and the oldest was 74 years old. Sixteen of the participants were married, 3 lived with their partner, 1 was divorced, 1 widowed and 3 single. Nine of the participants were educated to G.C.S.E/'O' level or equivalent, 3 to 'A' level, 7 were educated to degree level and 4 participants had a postgraduate qualification. The sample included individuals using a range of different complementary therapies including reflexology, aromatherapy, Alexander technique, yoga, herbal remedies, homeopathy, osteopathy, chiropractic, naturopathy, acupuncture, healing, Reiki and shiatsu, as well as a range of herbal supplements and other over-counter-remedies used for self-treatment. Some participants were only using one type of complementary therapy at the time of the interview. However, most were using a range of different complementary health practices. While the respondents were made up of a heterogeneous set of people, it should be recognised that such a sample is not representative. The claims made about CAM use outlined within this thesis are specific to this particular group of CAM users. However, while we cannot generalize from this sample of 24 CAM users, the study does offer a base from which comparisons with users of complementary health practices in other positions and contexts can be explored. Semi-structured interviews were also conducted with 10 CAM practitioners,<sup>2</sup> prior to interviews with users. There were several reasons for conducting interviews with practitioners. First, in order to facilitate access to users of complementary medicines, it was hoped that after learning about the project themselves practitioners would inform their clients about the research. Secondly, to ensure a sample that included users of a range of different types of complementary medicines. Finally, practitioners were interviewed to ascertain the scope of the service, the overall pattern of use and background of users and to determine their own philosophy on health and illness. All interviews were recorded and transcribed verbatim. Interview transcripts were continually analyzed for categories and emerging themes. Data analysis was an ongoing process beginning with the onset of fieldwork, supported by the use of NVIVO.

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<sup>2</sup> See Table 3.2 for list of CAM practitioners.

## Access

Letters were initially sent out to CAM practitioners at three complementary health clinics in the local area (12 practitioners in total). The letter provided an overview of the research along with a request to meet and conduct an interview with each practitioner (see appendix 2 for copy of letter). Two of the complementary health clinics provided a range of therapies including: homeopathy, aromatherapy, acupuncture, osteopathy, reflexology, colon hydrotherapy and hypnotherapy, the third clinic offered chiropractic treatment only. Although responses were slow to begin with, 5 practitioners (1 aromatherapist, 1 chiropractor, 2 homeopaths and an acupuncturist) eventually responded to my letters and agreed to be interviewed. However, in order to include individuals using a wider range of complementary medicines I decided to send a second set of letters out, this time targeting independent practitioners located via the yellow pages (12 CAM practitioners in total). Again I received responses from 5 of these practitioners, 3 reflexologists, a nutritional therapist/yoga teacher and a Bach flower remedies therapist. Despite some obvious omissions such as healing, herbal medicine, Reiki and osteopathy, this selection of complementary therapies includes those therapies that have been shown to attract the most popular support (Sharma, 1992, Fulder, 1996, Cant and Sharma, 1999). Furthermore, it was hoped that many of the individuals consulting with these particular therapists would have also used other types of complementary health practices.

During the interviews with CAM practitioners it was essential to gain their trust and emphasize the importance of the study, so they would encourage their clients to take part. However, this was not a problem for the majority of practitioners as many were very supportive of the research from the outset and agreed to help enlist their clients in the study. For example, one of the first practitioners to respond to my letter, Ann,<sup>3</sup> an aromatherapist, was extremely enthusiastic about the research. She claimed to be 'really interested in this sort of study' and wanted to help as much as possible. Similarly, Julie, a reflexologist, had confessed that initially when she read my letter she thought she would be too busy to get involved. However, she then decided that 'it was important to help

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<sup>3</sup> All names are pseudonyms.

people with such projects' and so decided to contact me. Others expressed similar sentiments and it was evident that many of the practitioners regarded this as an opportunity to promote complementary medicines to a wider audience. In order to convey information about the project to practitioner's clients I produced a leaflet outlining the research and providing contact details for the practitioners to forward on to their clients (see appendix 2 for copy of this leaflet). With the exception of two complementary therapists,<sup>4</sup> all others agreed to pass on leaflets to their clients and those working at clinics offered to leave a pile of them in the reception area.

Using practitioners to gain access to users was thought to be a practical means of finding people to take part in the study. It meant that new interviewees were already aware of the project, and had been assured that the research was worthwhile. It also meant that I was able to find people who were using a range of different kinds of complementary and alternative health practices. However, there were a number of limitations to this approach to gaining access to users. First, it is likely that complementary therapists 'selected' suitable candidates, from amongst their clients, to take part in the research. During interviews several practitioners spoke of how they knew of clients who I should talk to. Individuals who had initially been skeptical about using complementary therapies and had completely changed their views, or individuals who were particularly enthusiastic about using complementary medicines. Secondly, it is possible that clients may have felt pressurized to take part in the study after being asked by their practitioner. Having said that it was still left up to individuals to contact me themselves, which they did of their own free will. Thirdly, one of the main drawbacks of this particular approach was that it would only allow me access to individuals using complementary therapies via a therapist and exclude those individuals who purchase complementary remedies and use them on a self-help basis. It was initially hoped that those consulting practitioners would also be using CAM in this way, and indeed many were. However, I was also keen to speak to individuals who were only using complementary medicines in this way. It was hoped that I could reach such individuals by asking individuals who were consulting with

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<sup>4</sup> One practitioner said she did not want to include her clients because they were very busy and stressed out and would not have the time to speak to me. Another practitioner was concerned that if she asked her clients to take part she may jeopardize the 'special' relationship she has with them.

CAM practitioners if they could recommend anyone. This proved to be successful and a number of participants were recruited who were using CAM for self-treatment. Finally, this method of obtaining access to users of complementary therapies was restrictive and involved a certain amount of 'work' and commitment on the part of practitioners. Once I had given the leaflets to the practitioners there was little I could do except wait for individuals to contact me. In the early stages of the fieldwork responses from practitioner's clients were fairly slow. I had to regularly chase up practitioners to ask if they had spoken to any clients and I felt uncomfortable doing this. Two practitioners were particularly active in 'recruiting' individuals to take part. Ann (aromatherapist) and Marie (reflexologist) went out of their way to find people to take part in the study and by far the largest amount of participants came from them. However, it was unrealistic for me to expect the same kind of response from all practitioners, considering the time and attention they had already given to the project by taking part in the interviews and passing on leaflets to clients. In total 13 participants were recruited via the practitioners, however they only came from 5 out of the initial 10 practitioners. It became evident that if I wanted to generate further participants I needed to devise means of accessing CAM users beyond relying solely on CAM practitioners.

I produced a poster providing an overview of the research and my contact details and placed these in various locations in the local area: 2 community centres offering classes in yoga, meditation and various complementary medicines, a local library and a small health food store. I also handed out leaflets at a yoga class I attended and asked the instructor to hand them out at other classes she ran in the area. Again responses were slow, however, I was eventually contacted by a number of individuals who had either seen the posters or picked up a leaflet from a yoga class. Another method for generating participants was to use the snowball method (Becker, 1963; Burgess, 1982, 1984; Patton, 1990). All interviewees were asked if they knew anyone else who used complementary medicines that they could recommend for an interview. Previous research has shown that individuals are more likely to use complementary medicines if members of their social network are using them (Wellman, 1995). It therefore seemed reasonable to assume that interviewees would know one or two people who also used complementary medicines

and would possibly be willing to be interviewed. However, while it tended to be the case that participants would know of others who were using complementary therapies and initially demonstrated a willingness to help by asking them if they would take part, snowballing was not particularly successful in the early stages of interviewing. My luck changed when I met Alex, who had been using complementary medicines for over twenty years and had been given one of my leaflets by a friend who attended the yoga classes. During her interview Alex said she knew others who were using complementary therapies and within a matter of days of meeting her I was contacted by a further 5 people wanting to be interviewed.

There are a number of disadvantages to using the snowballing technique as a method for generating a sample. First, using the snowball technique takes part of the responsibility away from the researcher in generating the sample. As has been demonstrated snowballing involves a considerable amount of 'work' and commitment from participants. In the case of this study some individuals were more willing to help in this way than others. Another major criticism of using snowballing is that it limits the representativeness of the study, as most of the participants will be know one another, being involved in either friendships or therapeutic networks. Merkens (2004) argues that, because nominations usually take place within a circle of acquaintances, this procedure leads to clustered samples. Nevertheless, the snowball technique can be a convenient and effective way to generate a sample in situations where there is difficulty in getting access to informants.

## **Interviews**

As with all techniques of research there are various limitations to conducting interviews that the researcher needs to be aware of (Bailey, 1994). One of the limitations with interviewing concerns the amount of time required to conduct a number of interviews. Arranging interview locations and times, rescheduling appointments and transcribing the interviews were all extremely time consuming processes. Another criticism of

interviewing concerns the danger of bias creeping into the interview process. Borg (1981) highlights some of the problems that can occur:

‘Eagerness of the respondent to please the interviewer, a vague antagonism that sometimes arises between interviewer and respondent, or the tendency of the interviewer to seek out answers that support his [sic] preconceived notions are but a few of the factors that may contribute to biasing of data obtained for the interview’ (Borg, 1981: 87).

Gavron (1966) was also aware of the dangers of bias whilst conducting interviews with young mothers: ‘It is difficult to see how this can be completely avoided, but awareness of the problem plus constant self control can help’ (Gavron, 1966: 159). As long as the researcher is aware of such criticisms and avoids asking loaded questions, interviews do have the potential of providing detailed and highly illuminating data. The main advantage of the interview is its adaptability. It allows the possibility of adapting to each interviewee, to follow up ideas, probe responses and investigate motives and feelings. The tone of voice, facial expression, hesitation together with other factors that occur during a face-to-face interview can provide information that would be concealed by a written response. As Bell (1989) has noted, questionnaire responses have to be taken at face value, but a response in an interview can be developed and clarified.

There are essentially three different types of interview that can be employed in social research. The structured interview, the semi structured interview and the unstructured interview. Structured interviews would not have been appropriate for this research as having a pre-determined set of questions suggested that I already knew individual’s motives for using complementary medicines. Furthermore, this mode of interviewing allows little flexibility in the way questions are asked or answered (Fontana and Frey, 1998). As Fontana and Frey (1998) point out within structured interviews the interviewer controls the pace of the interview by treating the questionnaire as if it were a theatrical script to be followed in a standardized and straightforward manner. All respondents receive the same set of questions, asked in the same order or sequence, by an interviewer

who has been trained to treat every interview situation in the same way. In contrast, qualitative interviews<sup>5</sup>, what Burgess (1984:102) calls 'conversations with a purpose', are distinguished from survey interviews (structured interviews) in being less structured in their approach and in allowing individuals to expand on their responses to questions (Jones, 1991). These types of interviews are characterized by a relatively informal style, with the appearance of a conversation or discussion, rather than a formal question and answer format. They have either a thematic, topic centred, biographical or narrative approach, whereby the researcher has a range of topics, themes or issues which s/he wishes to cover, rather than a structured list of questions (Mason, 1996). As I wanted to ensure that each interview covered similar topics in order to make comparisons between the interview data, I opted for a semi-structured rather than an unstructured approach. This meant that whilst I used an interview schedule that included a range of topics to be covered, this was flexible and participants were free to talk about the things that they felt were most pertinent. This particular technique also provided the flexibility to modify the order of questions according to the particular context of the conversation, provide explanations and to leave out particular questions that no longer seemed relevant or may have been revealed by previous questions. For the most part, I let participants determine the course the interview took and probed into any comment that seemed significant, using my interview schedule as an *aide-memoiré* (Burgess, 1982) to ensure that similar topics were covered in all interviews, but generally only referring to it at the end of the interview. The majority of my questions were open questions (Robson, 1993) being prefixed by words such as who, where, what, why and when. Asking open as opposed to closed questions provided the necessary scope and depth for generating interesting data.

Previous research on CAM use was influential in the development of interview questions, as was information gleaned from the practitioner interviews. In addition to this a small pilot study was conducted prior to the main body of interviews in order to refine the interview schedule. This involved interviews with four women (all university contacts) who were currently using complementary medicines. Although I adopted a semi-

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<sup>5</sup> The term 'qualitative interviewing' is usually intended to refer to in-depth semi-structure or loosely structured forms of interviewing (Mason, 1996).

structured approach I found it helpful to begin by writing out the interview questions in full. This allowed me to think about the way I might phrase questions in the interview (Jones, 1991). This was then used to produce an open-ended and flexible interview schedule. The interview schedule was divided into topic areas including: defining CAM, i.e. what they understood by the terms complementary and alternative medicine, as well as the differences between complementary medicine and biomedicine; user's history of using complementary medicines, i.e. when they first started using complementary medicines, which therapies they had used, what they used them for, how they obtained knowledge and information about using complementary therapies and patterns of use; attitudes towards biomedicine and the role of doctors in health care; and health and lifestyle, i.e. definitions of health and asking about the sorts of things they do to stay healthy. I tried to leave any sensitive or more complex issues at a later stage in the interview, until rapport and trust had been established (Measor, 1985). The interview schedule inevitably changed over the course of the fieldwork as more users were interviewed and as the earlier interviews started to be analyzed. Themes emerged which were explored in more detail as the interview process progressed. This meant that interview questions changed slightly from one interview to another. During the interviews I had to listen carefully to respondents, retain a critical awareness of what was being said and probe the respondent's answers in order to elicit detailed accounts. During each interview I adopted an attitude of *deliberate naiveté* (Kvale, 1996: 33), asking the subject about his or her view of things which I knew about.

All interviews were recorded and transcribed immediately afterwards. This was a useful process for identifying particular themes relevant for analysis while the interview was still fresh in my mind. There are obvious benefits to recording interviews rather than taking notes during the interview. Not only could I lose valuable data, but also eye contact would be infrequent and the interaction would be affected by the pausing that would inevitably take place in order to write down what the interviewee said (Jones, 1991). Notes are also open to doubts about validity. As Silverman (2001) notes, compared to field notes, recording and transcripts can offer a highly reliable record to which researchers can return as they develop new hypotheses. At the start of each



interview I explicitly asked interviewees' permission to record the interview. No one objected to this process and although some participants were initially anxious about being recorded, all quickly appeared to forget that they were being recorded. As Hermanns (2004) notes it is the duty of the interviewer to accept responsibility for managing the feeling of 'recorder-discomfort', by demonstrating that, irrespective of the fact that a recording is being made, it is possible to speak in a relaxed and open way, with all the imperfections of the spoken language. The interview setting also needs to be taken into account when using recording equipment (Hammersley and Atkinson, 1983). For example, one of the interviews with practitioners was conducted at a local wine bar (this was the interviewee's preference). However, this venue was not entirely suitable for conducting an interview. Not only was there a rather noisy group of people situated at a nearby table, but there was also loud dance music being played. This made it difficult to hear what the interviewee was saying when the tape was played back. I learnt from this mistake and all further interviews were conducted in quiet and private locations. Another issue to contend with when recording interviews is the possibility of recorder malfunctions. I learnt very early on that it was essential to carry a spare battery to all interviews. At the end of one interview with a practitioner I realized that the equipment had failed and I had lost the whole interview. Fortunately, the interviewee was very understanding and agreed to meet and conduct the interview again. By the time I came to do the interviews with users I had mastered the equipment and thankfully nothing like this happened again.

## **Ethical issues**

### *Interview ethics*

The use of qualitative interviews as a data generation method raises a number of general ethical issues, as well as more specific ethical concerns connected to any one particular project (Mason, 2002). The interview process, for example, can be rather daunting for some respondents, and there are a variety of strategies that can be employed to minimize this (Oliver, 2004). There were a number of steps I took to help participants feel at ease,

and to enable them to feel some degree of control over the data collection process. For example, ensuring that the interviews were conducted in a pleasant and relaxing atmosphere, with sufficient privacy. When participants first contacted me about being interviewed they were given the choice of where to be interviewed. The majority opted to carry out the interview in their own home. Several did not express a preference and in such instances I suggested a suitable venue for their approval. A number of interviews were conducted in my department at the university. However, as I shared a room with other postgraduate students I arranged to use the office of a member of staff to ensure complete privacy.

Interviewing in people's homes meant that participants were relaxed and felt more in control. However there were certain disadvantages such as the problem of distractions from children, pets, telephone calls and other members of the household. For example, one interviewee had 17 cats, all of which were present during the interview. Another participant had her two-year-old daughter with her during the interview and at one point she became extremely interested in the recording equipment and started to sing into the microphone, bringing the interview to a complete standstill. During one interview the participant's wife was sitting in for part of the interview. I could sense that he was uncomfortable with this as at times she interrupted him and occasionally contradicted what he was saying. However, she left the room after about 10 minutes and I noticed that he started to open up and speak more freely. Another issue raised by conducting interviews in people's own homes relates to my own personal safety. These were people who I had never met before, despite the fact that many had come to me via their practitioners. As a precautionary measure I made sure that when interviewing in people's homes I notified a friend of my whereabouts and carried my mobile phone with me (Jones, 1991; Lee-Treweek and Linkogle, 2000).

Regardless of the venue, some participants were very nervous at the start of the interview and concerned that they would not be able to answer complicated questions about complementary medicines. One participant claimed that she had been worried about the sorts of questions that I was going to ask and whether she was going to be able to answer

them. According to Kvale (1996: 128) 'the first minutes of an interview are decisive. The subjects will want to have a grasp of the interviewer before they allow themselves to talk freely, exposing their experiences and feelings to a stranger'. At the start of each interview I spent a short amount of time talking with participants about subjects unrelated to the interview itself. This might be as mundane as talking about the weather, or my journey to their house. This procedure was intended to 'break the ice' and create an informal setting in which to conduct the interview. At the beginning of each interview I explained the focus of the study, that it was intended to form the basis of my doctorate thesis, and that there was a possibility that some of the data would be presented at conferences and published in journal articles. I also assured participants that I was interested in their own personal experiences of using complementary medicines rather than to test their knowledge of complementary therapies.

According to Mason (2002) there are ethical implications involved in the process of gaining interviewees' trust, and making the interview feel enjoyable, like a conversation. In such circumstances it is likely that individuals will feel relaxed and be willing to open up and talk about issues that are private. Mason (2002) suggests that the researcher should be aware of what they 'let' their interviewees tell them, and whether they are perhaps revealing things they may feel regret about later. Writing about the process of women interviewing other women, Finch (1984) notes the ease with which women researchers are able to get female interviewees to talk to them and the exploitative potential of this. There are always ethical implications of discussing potentially sensitive, health related topics, in interviews. Some interviewees shared sensitive information with me in relation to their health. For example, when talking about why she started using reflexology one participant told me of an illness she had, that very few people knew about and she preferred to keep secret. I made it clear to her that she did not need to give me any details, however she completely opened up and spoke for quite some time about her experiences:

J: Erm, I suppose there was one [health problem] that I, I thought should could probably help me. Because at that time, I mean I wouldn't, I suppose if I've got a different name in your thing...

LB: Well you don't have to talk about it if you don't want to.

J: No I'll just tell you quickly.

As Burgess (1984: 103) has noted, unlike the structured approach the researcher conducting an unstructured interview can be viewed as 'a friend and a confidant who shows interest, understanding and sympathy in the life of the person' being interviewed. In another incident an interviewee mentioned the fact that she had nearly died from an asthma attack some time ago. I could see that she was clearly distressed even just mentioning it to me so I did not ask any further questions. As Denscombe (2002) notes, questions about personal and possibly embarrassing subjects might have a justifiable place in an investigation, but the researcher would be expected to restrict these to the bare minimum necessary and certainly not include them unless they were absolutely vital. In times of grief or acute anxiety it would be unethical for researchers to intrude on someone's personal life in the pursuit of data.

### *Informed consent*

The principle of informed consent has been embedded in numerous codes of ethics adopted by professional associations in the UK, the USA and elsewhere (Denscombe, 2002). These codes vary slightly but, as Homan (1991) argues, the essence of the formulation is that: all pertinent aspects of what is to occur and what might occur are disclosed to the subject; the subject should be able to comprehend this information; the subject is competent to make a rational and mature judgment; the agreement to participate should be voluntary, and free from coercion and undue influence. All participants in the study were initially provided with an information sheet, which outlined the aims of the research, as well as details relating to the sort of issues they would be

asked to talk about during the interview. I also started each interview by reiterating this information and giving them the opportunity to ask further questions. Participants were assured that if there were any questions that they were uncomfortable with they were not obliged to answer and could end the interview at any point if they so desired.

### *Anonymity and confidentiality*

Participants were ensured confidentiality and anonymity. They were advised that they would not be identifiable, as all names would be changed and that I would be the only person to listen to the recording of the interview, for the purposes of transcription. All names used throughout the thesis are pseudonyms.

Ethical approval for the research project was obtained from the university's ethics committee. This involved submitting details of the proposed research for screening by committee members in order to check that the research was in accordance with ethical principles for research.

### **Data Analysis**

Data analysis was an ongoing process beginning with the onset of fieldwork and supported by the use of the computer software package Nvivo. As Silverman (2000) notes there are certain benefits to computer assisted analysis of qualitative data (CAQDAS). In particular, it is an obvious advantage to the researcher faced with a large amount of word-processed qualitative data, wanting to sort it into categories or coded segments that may then be filed and retrieved easily. This saves time and effort, leaving the data analyst more time to think about the meaning of data, enabling rapid feedback on the results of particular analytic ideas so that new ones can be formulated. However, as Reid (1992) points out the time saving element of CAQDAS really occurs at the later stages of data searching and retrieval. Most programs expect data to have been entered in a word processing package and this task, along with reading and coding large volumes of data, remains one of the major time consuming elements of qualitative data analysis, which computers do not remove. Nevertheless, to have relied on cut and paste techniques

for organizing textual passages into card indexes would have been, restrictive and time consuming (Kelle, 2004). As this research generated large amounts of data, Nvivo was particularly useful for storing and displaying interview transcripts as well as writing memos about the data. Most importantly the Nvivo software allowed for rigorous analysis and helped facilitate the analytic process.

Following Silverman's (2000) advice data analysis began at an early stage in the fieldwork. After each interview I produced a memo document including a summary of key points from the interview such as user's history of using complementary therapies, i.e. what therapies they have used and what for, how they found out about using CAMs etc., attitudes towards doctors and biomedicine more generally, use of over-the-counter remedies, and health and lifestyle factors. Although these were relatively broad categories to begin with this enabled me to familiarize myself with the data and begin to consider how the interview data related to my original research questions. This was also intended as a means of reducing the data to more manageable proportions (Coffey and Atkinson, 1996). After I had conducted several interviews transcripts were imported into Nvivo and then coded into relevant categories. Transcripts were initially coded as a way of organizing the interview data and generating concepts from and with the data. This enabled me to link different segments or instances in the data, bringing together fragments of data to create categories that had some common property or element (Coffey and Atkinson, 1996). Miles and Huberman (1994: 56) suggest that coding constitutes the 'stuff of analysis', allowing one to 'differentiate and combine the data you have retrieved and the reflections you make about this information'. They argue that coding is a process that enables the researcher to identify meaningful data and set the stage for interpreting and drawing conclusions. The process of coding the data involved reading and re-reading transcripts and assigning categories or codes to chunks of interview data, such as words, phrases, sentences or whole paragraphs. Rather than attempting to plan a set of codes before analyzing the data, codes were generated from the actual discourse of my informants. The codes emerged from the data, instead of data emerging from pre-existing codes (Glaser, 1992). Inevitably my codes changed over the

course of time, codes were expanded, changed, or scrapped altogether as ideas developed through repeated interactions with the data (Bryman, 2001).

Once coded the Nvivo software rapidly recovered all the data pertaining to a particular category of code and therefore enabled me to make constant comparisons between new and existing data. Coding and retrieving is the procedure more often associated with coding as an analytic strategy (Coffey and Atkinson, 1996). According to Seidel and Kelle (1995: 55-56), the role of coding within such conceptualizations, is used to undertake three kinds of operations: (a) noticing relevant phenomena; (b) collecting examples of those phenomena, and (c) analyzing those phenomena in order to find commonalities, differences, patterns, and structures. Coffey and Atkinson (1996) stress that because coding inevitably involves the reading and re-reading of data and making selections from the data, it involves interpreting and re-interpreting the data set. As Wolcott (1994) notes, the move from coding to interpretation is a crucial one. Once coding is achieved, the data have to be interrogated (Delamont, 1992) and systematically explored to generate meaning. Transcripts were read and re-read in full. Sections of data pertaining to particular codes were printed off and assembled for reading and exploring. At this stage, Delamont (1992) suggests that one should be looking for patterns, themes, and regularities as well as contrasts, paradoxes, and irregularities. One can then move toward generalizing and theorizing within the data (Coffey and Atkinson, 1996).

One of the themes to emerge from the process of coding the data was participants' reluctance to use, and distrust of, conventional medicines. A few individuals claimed they never used conventional medicines, the majority claimed that they tried to limit their use of them and subsequently only used them as the last resort, a minority of participants said that they did not have a problem with taking conventional medicines at all. For the majority of participants their disuse of conventional medicines appeared to be related to concerns over the safety of pharmaceutical drugs, which were described as chemical, artificial and unnatural and potentially harmful to the body. In contrast, many participants claimed that they preferred to use complementary medicines because they

were more natural and therefore safer. This theme was developed further through the process of writing. As Coffey and Atkinson (1996) argue:

‘Writing and representing is a vital way of thinking about one’s data. Writing makes us think about data in new and different ways. Thinking about how to represent our data also forces us to think about the meanings and understandings, voices, and experiences present in the data. As such, writing actually deepens our level of analytic endeavour. Analytical ideas are developed and tried out in the process of writing and representing’ (Coffey and Atkinson, 1996: 109).

Glaser and Strauss (1967) draw attention to the need to read and to use ‘the literature’ in order to generate ideas and analyses. However, the literature is not used in order to provide ready-made concepts and models. Rather, one can use ideas in the literature in order to develop perspectives on our own data, drawing out comparisons, analogies, and metaphors. Likewise, one can look to other sources for ideas of how to construct our own narratives of social life. In relation to the theme discussed above, the explanations that were offered by the participants appeared to resonate with some of the issues highlighted by contemporary sociological debates around the concept of risk, reflexivity and distrust in expert systems. In particular the work of Beck (1992) and Giddens (1990; 1991) on risk and reflexive modernization was thought to be a useful starting point. However, through further investigation of the data, the process of writing and reading the literature I began to realize that the theories of Beck and Giddens did not wholly relate to what interviewees were saying. It appeared that the discourses of risk inherent in participant’s accounts were far more contradictory and contingent than is allowed for within the writings of Beck and Giddens. These contradictions and contingencies were explored in more detail in relation to the interview data, as well as previous empirical work on risk perceptions (e.g. Macgill, 1989; Ward et al., 2000). All three findings chapters were developed in a similar fashion, that is through the process of coding the data for emergent themes and categories and then developing these through critical engagement with ‘the literature’ to develop my ideas and to theorize about the data.



Where I have used quotations from the interviews in the subsequent chapters, I have selected them for the way in which they illustrate or encapsulate themes that were recurrent. In other words, I have drawn from what is common ground amongst the participants, rather than from the many ways in which they are different.

## **Reflections**

I arrived at the location for my first ever interview with a good degree of apprehension. Would I be able to keep the conversation flowing and remember all the questions I wanted to ask; how much would they want to know about the research; would they mind being recorded; what would I do if they did etc. Following the directions I had been given over the phone I managed to find the health centre with ease. There were no signs on the outside of the building about the complementary health centre and it looked like someone's house, but I entered the building anyway. As I walked in I immediately saw a brass plaque for the complementary health centre. I walked down a small corridor with a number of doors leading off it. The door immediately to my right was open and there was a woman sitting at a computer talking on the phone. Seeing me she said 'Lauren, I'll be with you in a minute'. She asked me to wait in the room opposite, the waiting room. I sat nervously trying to rehearse my questions in my head. Shortly after Ann (aromatherapist) entered the room and formally introduced herself. She then took me down the corridor to her consultation room, where we were going to conduct the interview. We sat down and she immediately proceeded to tell me why she wanted to participate in the study. She also told me that we only had an hour to conduct the interview as she had an appointment she had to go to. I sat there trying to take in what she was saying and also trying to work out at what point I should start the recording equipment off and get out my interview script. The way the interview began, with Ann leading the discussion, set the tone for the whole interview. Ann was very keen to discuss the integration of complementary medicines with orthodox medicine and it was clear that she was pretty involved in talking with GPs and other conventional health professionals to promote this process. Subsequently, I found it hard to take control of the interview and Ann's confidence and passion about her work made it hard for me to

intervene and steer the conversation towards the interview questions. This first interview was very much a learning experience, I realized that there was much more to interviewing than I first had imagined.

When I started the fieldwork I found interviewing extremely hard, the only way I can think to describe it is like trying to pat your head and rub your stomach at the same time. Trying to think about the questions you are going to ask, listening to what they are saying and at the same time trying to encourage them to continue talking. However, as I progressed these skills became more automatic to me. That is not to say that some interviews were not harder than others. Some interviews seemed to flow without much effort and I hardly felt I was conducting an interview – these really were more like ‘conversations with a purpose’. Many individuals seemed to have a sense of what I wanted to know about and just talked, only needing occasional prompting from me. However, in other instances interviewees needed to be constantly asked questions and gave only short answers. At the other end of the scale there were those individuals who gave such detailed answers that it was difficult to know when to intervene, without offending them or seeming like I was not interested in what they were saying.

Overall, the research process was both enjoyable and rewarding, but also frustrating and challenging. One of the most frustrating aspects of carrying out this particular research project was the time it took to recruit participants. Weeks went by when nobody contacted me, I would phone up the practitioners or try and work out other ways to find people to talk to me, all to no avail. In the end, and with a lot of patience, it worked out, thanks to a number of key individuals.

In the following three chapters I will present the main body of findings from the interview data and the central arguments of this thesis. To recap briefly, in chapter 5 I focus on individual’s motivations for using complementary and alternative therapies and how these change over the course of time. In chapter 6 I concentrate on how the issue of risk relates to the decision to use complementary therapies; and in chapter 7 I focus on

the use of CAM for self-care purposes and the implications of this aspect of CAM in relation to the role of expert knowledge and professionals in modern Western societies.

## Becoming a CAM User

### Introduction

As was demonstrated in chapter 3 the question of why individuals turn to complementary and alternative health practices has received a significant amount of attention over recent years. However most research in this field has considered individual's *initial* motivations for using complementary therapies. Only a few studies have considered the reasons why individuals *return* to complementary therapies (Vincent and Furnham, 1996; Sirois and Gick, 2002). According to Vincent and Furnham (1996) studies should separate the reasons for starting to use CAM from reasons for continuing to use it, as these may change over the course of time. More recently, in a study that distinguished between 'new/infrequent users' and 'established users', Sirois and Gick (2002) found reasons for using CAM to differ between the two groups. They conclude that CAM clients need to be understood in more sophisticated ways, rather than being treated simply as a homogeneous group with similar beliefs, motivations and needs. Building on these studies this chapter will not only explore participants' initial motivations for using CAMs, but also the reasons why they remain engaged with such practices and the ways in which their motivations change over the course of time. Drawing on interview data with 24 CAM users in this chapter I will adopt a developmental approach to exploring the process of becoming a CAM user. In order to do so I return to the classic Chicago School theorizations of career and status passage as set out by Becker (1963), Glaser and Strauss (1971) and Goffman (1968). In this chapter I argue that adopting this particular framework allows for a more fluid and dynamic understanding of the nature of CAM use and thus moves away from the more restrictive typologies that force individuals into rigid 'types' (e.g. Sharma, 1995). Four categories of CAM users or stages in the CAM career are identified: 'new users'; 'occasional users'; 'regular users' and 'committed users'. As

individuals progress along the career trajectory their motivations for using complementary therapies undergo significant changes, at the same time they acquire further justifications and rationalizations that reinforce their continued use of complementary therapies. This chapter begins with a brief outline of the literature on status passage and career.

### **Theorizing Status Passage and Career**

The concept of 'status passage' was originally developed by the anthropologist, Arnold van Gennep (1908), who used it to signify the passage of an individual through various stages in a life course (Glaser and Strauss, 1971). The concept was then taken up by sociologists and employed in the study of occupational and organizational mobility, and the process of socialization and career progression (Crawford, 2003). The concept has been adopted mostly by successive generations of academics linked to the University of Chicago (Glaser, 1968a). According to Goffman (1968), status passage, and specifically the consideration of a social career, are concepts that have been most closely linked to studies of individual (and collective) development within a formal organization, and, most frequently, within a rigid occupational structure. However, as Goffman illustrates the concept of career does not necessarily need to be viewed as solely occupational, but can be used to 'refer to any social strand of any person's course through life' (Goffman, 1968: 119). For example, Goffman (1968) himself presented a consideration of the (moral) career of 'mental patients', Glaser (1968b) provided an account of the status progression of medical interns, while Becker (1963) famously charted the careers of marijuana users and dance musicians. More recently the concept has been applied to the study of ice hockey supporters (Crawford, 2003) and football fans (Jones, 2000).

Goffman (1968) developed the concept of the *moral* career through his study of 'mental patients' at St Elizabeth's Hospital in Washington D.C. According to Goffman the moral career of a person:



‘[I]nvolves a standard sequence of changes in his [*sic*] way of conceiving of selves, including, importantly, his [*sic*] own. These half-buried lines of development can be followed by studying his [*sic*] moral experience – that is, happenings which mark a turning point in the way in which the person views the world’ (1968: 141).

For Goffman, the career stages of the ‘mental patient’ typically involve three phases; the pre-patient i.e. those individuals at home under the supervision of their general practitioner; the in-patient, either voluntarily or forcibly hospitalized, and the ex-patient. The career of the ‘mental patient’ is a moral one as it involves a development of an individual’s identity and ‘entails [changes] in the person’s self and his [*sic*] framework of imagery for judging himself [*sic*] and others’ (Goffman, 1968: 119). Through the denial of autonomous control over their activities, the constant invasion of their personal space, institutional uniforms and disregard of personal names, the individual passes from civilian to patient status. The ‘passage from civilian to patient status’, writes Goffman, is marked by the humiliating ‘status degradation ceremonies’, the patient experiences ‘civil death’ as their previous human rights and liberties as citizens are no longer relevant (ibid: 134).

In his influential study, Becker (1953) documented the career stages that are involved in becoming a marijuana user. He showed that people drift into cannabis use for a variety of reasons. Once they begin its use, however, they will – if they persist – follow a particular sequence of stages. Becker called these stages the ‘beginner’, the ‘occasional user’, and the ‘regular user’. As users follow this career sequence, cannabis smoking becomes an ever more important part of their identity. Someone enters the *beginner* stage in the use of cannabis when he or she is offered the opportunity to smoke it in a social situation where others are smoking, where there is a degree of social pressure to conform to group norms, and where the group itself provides a relatively safe and secluded locale away from the immediate possibility of public censure. Becker shows that people who move from the stage of beginner to that of *occasional user* must learn a number of skills and abilities associated with the use of the drug:

'(1) learning to smoke the drug in a way which will produce real effects; (2) learning to recognize the effects and connect them with drug use (learning, in other words, to get high); and (3) learning to enjoy the sensations he perceives. In the course of this process he develops a disposition or motivation to use marihuana which was not and could not have been present when he began use, for it involves and depends on conceptions of the drug which could only grow out of the kind of actual experience detailed above. On completion of this process he is willing and able to use marihuana for pleasure' (Becker, 1953: 242).

Only those who successfully acquire these skills and abilities – the smoking technique, the ability to perceive the effects – will persist as cannabis users. As occasional users, cannabis smokers acquire further justifications and rationalizations for its use, and these reinforce their continued use of the drug. The subculture of the group provides ready-made answers to many of the conventional objections to cannabis use that may be raised in their minds. Users may claim, for example, that cannabis is less dangerous than the alcohol that is tolerated and encouraged by conventional opinion. They are also likely to hold that cannabis smokers are in complete control of when and where they choose to use the drug; that the drug is not in control of them. People do not become regular users if they continue to hold on to the stereotype of addiction or to the idea that they are likely to escalate towards the use of hard drugs. If ideas of addiction, escalation, and mental weakness cannot be neutralized, smokers may revert to occasional use, rather than becoming committed, regular users.<sup>1</sup>

### **The Careers of CAM Users**

The individual process of *becoming* a CAM user can be examined through the analytic concept of the 'career'. It is possible to identify distinctive career patterns and patterns of usage amongst CAM users. Users *typically* follow a particular sequence of stages in the

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<sup>1</sup> See Jackson and Scott (2005) for recent use of Becker's work on 'becoming'.

process of becoming a CAM user. Following Becker (1953) I have called these 'new users'; 'occasional users'; 'regular users' and 'committed users'.<sup>2</sup> As users follow this career sequence CAM use becomes an ever more important part of their identity.<sup>3</sup> In this respect the CAM career can be seen as 'moral' as it represents a 'turning point' in the way in which users view themselves and the world (Goffman, 1968).

Based on findings from a small scale study on CAM use in the West Midlands, Sharma (1995) identifies four distinct groups of complementary medicine users: 'one off users'; 'earnest seekers'; 'stable users' and 'eclectic users'. The first group, 'one off users' represents individuals who discontinue treatment after a limited experimentation. Although in Sharma's study all of the interviewees had used complementary therapies on more than one occasion. The second group of CAM users, 'earnest seekers', are individuals who are desperately seeking a successful remedy to an intractable health problem and will try any number of complementary and alternative therapies until relief is obtained. The next category of users is 'stable users', the most common type, these are individuals who have experienced initial successes with complementary medicine and have developed a fairly regular relationship with a particular practitioner or type of treatment. Finally, 'eclectic users' tend to shop around with a consumerist attitude to specific health problems. As Sharma notes, they are distinguished from the 'earnest seekers' in that, rather than looking for a cure for a single specific problem, they tend to 'shop around' for what they feel is the best form of treatment (orthodox or non-orthodox) for any particular problem.

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<sup>2</sup> It is important to note that these are only illustrative examples of behaviour and attitudes of users within this sample and not a regimented typology of behaviour. It should also be noted that this is a *typical* progression and whilst it is presented in a linear fashion individuals can move both back and forward along the career path. Individuals may regress, leapfrog certain positions or move in and out of this career structure at any time (Crawford, 2003). It is also likely as Crawford (2003) points out that individuals will belong to numerous 'communities', which they will move in and out of several times in their everyday lives, and hence will follow several (often cross-cutting) career paths.

<sup>3</sup> The definition of identity has been subject to extensive debate within sociology. However, in this chapter I adopt Jenkins' (1996: 5) definition and use the term to refer to 'our understanding of who we are and of who other people are, and, reciprocally, other people's understanding of themselves'. Identities are viewed as multiple, diverse and constantly shifting, rather than some static, fixed or innate quality: 'identity can in fact only be understood *as* process. As 'being' or 'becoming'. One's social identity – indeed, one's social identities, for who we are is always singular and plural – is never a final or settled matter' (ibid: 4).



This chapter will build on such research by adopting a developmental approach to the study of CAM use. The theoretical approach I have adopted to understanding the development and patterns of behaviour of CAM users has several advantages over typologies such as Sharma's. First, the use of the term career moves away from restrictive typologies that force individuals into rigid 'types', allowing for a more fluid and dynamic understanding of the nature of an individual's progression through a CAM career. Secondly, it allows for an understanding of how an individual's position within the career and involvement with a particular therapy (or therapies) can change and develop over a life course. Finally, whereas typological and non-career-based continua tend towards characterizing individuals (and allocating a 'type') on the basis of set patterns of behaviour, the concept of a career permits an understanding of how two individuals occupying similar career positions may have differing characteristics and patterns of behaviour (Crawford, 2003). Thus, while *typical* patterns of behaviour can be identified within a CAM career, the temporality and fluidity of these must always be acknowledged. The *typical* sequence of changes in the process of becoming a CAM user and patterns of usage are discussed below.

## New Users

Amongst the participants of this study there were generally two main reasons why individuals initially started to use complementary therapies. The first being that they had a persistent health problem that they had first been to the doctor with and had, in most instances, found the treatment to be unsatisfactory. Either because they found that it was ineffective in providing relief or because the treatment was viewed only as temporary, such as the case of painkillers prescribed for a back problem or sleeping tablets for insomnia. Alternatively, some individuals had been to their doctor and following diagnosis found that there was currently no treatment available for their particular health problem.<sup>4</sup> Many individuals had consulted their doctor on a number of different

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<sup>4</sup> This was particularly the case for individuals with chronic illnesses such as chronic fatigue syndrome (CFS), fibromyalgia and M.E., where treatment options available are often limited. Several participants with such conditions had only been offered antidepressants. All such individuals had reservations about taking antidepressants as they did not feel depressed, or if they did they felt that this was the result of their

occasions in search of relief and taken medications prescribed to them often over a period of weeks or months, prior to consulting a CAM practitioner (see also Sharma, 1995). For example, Amanda, who had been suffering from glandular fever and tonsillitis, had been back to her doctor repeatedly over the course of a year and each time was given antibiotics. She said that at one stage she was returning to the doctor every two weeks for antibiotics and claimed to have had as many as 'nine courses of penicillin in a row'. However, in both instances individuals were prompted to use complementary therapies not simply because of 'failed' treatments from their doctor, but also because they had received a recommendation from another individual, most likely someone from within their immediate social network, i.e. a friend, colleague, family member, who had themselves had some experience of using complementary medicines. For example, Alex said that she had first used homeopathy in her late teens for a skin complaint. She had consulted her doctor on many occasions but the treatment provided was not successful in alleviating the problem. Thus, when a friend suggested she try homeopathy she was willing to 'give it a try':

'The first thing was homeopathy I think, it's a long time ago...I had a skin problem and I'd had it when I lived at home with my parents, and my mother packed me off to the doctors who'd tried all sorts of things that made absolutely no difference whatsoever. So, erm, somebody suggested a homeopath and I thought might as well try, can't make it any worse' (Alex).

Anna's 'story' of how she first started using complementary therapies is almost identical to Alex's. Like Alex, Anna had experienced a particular health problem, this time 'allergies', and had consulted with her doctor. However, having seen a number of different doctors and specialists Anna was also unable to find relief. Despite having had no prior experience of using homeopathy, after hearing how her cousin had been helped by homeopathy, Anna decided to try it out for herself:

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condition and the impact on their life, rather than the other way round. However, some participants had taken them nonetheless, experiencing 'slight improvements' in their condition. Others remained adamant that they would not take them, even though they were the only treatment being offered.

'I think it just started, you know when I had these problems with my allergies I went to the doctor just because my cousin had the same kind of problems and we'd both been to a lot of doctors and specialists and asked what they could do about it and nothing had really worked. And then she went to this homeopath and it worked and so I went and it worked. So, yeah I think it's probably from there that I started thinking about it' (Anna).

Previous research on CAM use suggests that one of the main reasons why individuals consult with CAM practitioners is because they have been dissatisfied with the outcomes of orthodox medicine and have therefore sought help from elsewhere (e.g. Sharma, 1995; Lloyd et al., 1993; McGregor and Peay, 1996). A number of studies also indicate that people usually consult a CAM practitioner for the first time as a consequence of a personal recommendation from a friend or acquaintance (see for example, Sharma, 1995).<sup>5</sup> These findings undoubtedly provide support for such studies. For many of the participants in this study social interaction played a crucial role in introducing individuals to CAM and was also found to facilitate career progression.

The second 'entry route' into CAM mentioned by participants also suggests that individuals are 'introduced' to CAM by other more experienced users. Indeed, many participants claimed that friends, colleagues and members of their family etc, who were using it themselves, had introduced them to the 'idea' complementary medicines. For instance, Suzanne claimed that initially she had not used complementary therapies for any particular health problem. Rather she said she had become interested in complementary therapies through talking with friends who were training to be practitioners themselves:

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<sup>5</sup> It has long been recognized that social networks play an important role in health care decisions. Freidson (1960) developed the concept the 'lay referral network' to describe the process by which a sick individual consults family and friends, which tends to occur at some point between self-treatment and consultation with a professional practitioner. However, as Blaxter and Paterson (1982) discovered in their study of Scottish mothers and daughters, rather than being an extensive network of consultation amongst neighbours, friends and family, individuals are more likely to seek advice from people who are thought to have 'special knowledge'.

'I mean my, I guess when I first started to be interested [in alternative therapies], I suppose my late teens, I don't know probably about eighteen or nineteen. And I had a few friends who were training to be beauty therapists. And a friend of mine was doing as part of her course, she was doing kind of emphasis on reflexology. And so I would revise with her and help her with her revision and all the other bits and pieces. And I got kind of quite interested in it then, you know we would talk about it and look at it and how it worked, you know that sort of thing. And that was the first time that I really started to think about it'. (Suzanne)

Following on from here Suzanne had tried out a number of different therapies, such as aromatherapy oils for the bath and in oil burners and had reflexology. Similarly, John said that he had started to become interested in complementary therapies after attending a yoga class where the instructor was herself a committed user of complementary therapies. During this class and from conversations with the instructor he was introduced to the ideas and philosophies behind many different types of complementary therapies and shortly afterwards started to try out different therapies:

'Well that yoga teacher introduced all sorts of things into the class, and so I became aware of all sorts of things, even though they weren't sort of formerly part of the teaching, they were just sort of there. Plus also I became friendly with the teacher and so we used to meet and chat and talk about all sorts of things. And so out of that really, oh what can I remember, sort of crystals and dowsing and shiatsu and reflexology, there were all sorts...I think there was something about the atmosphere of, of sort of being open minded, of being open minded to different ways of looking at things and even though I don't think that the term well being was ever used, I think that it was all sort of part of that. You know it was sort of this aim of, this aim of just sort of living your life in a sensible way

and being open to all sorts of possibilities and making the most of everything'. (John)

When talking about their first encounters with complementary therapies many individuals claimed they were initially very sceptical about using them. Whilst hearing about other 'success stories' with particular therapies may have served to allay some of these concerns, most felt they were able to try out a particular therapy whilst still maintaining a certain degree of skepticism.

'I had nothing to loose, I just thought I had nothing to loose. I had no idea whether it would work or not, and I thought I'm just game for anything right now so I'll just try it. I didn't know anything about homeopathy, I didn't know anything about the philosophy'. (Laura)

'I was having a lot of trouble with sciatica and I was complaining one day at work about it, and one of my friends she said she'd been going to see someone who did this, I don't know what they're called, it was like skeletal balancing, it was very strange, they tell you to hold your fingers together and then they press certain points and if you can't maintain the pressure on your fingers then there's something wrong. And this girl had done her training and I just felt well there's no harm to lose to just go along'. (Tina)

In this sense it appears that when individuals first start using complementary therapies they place an initial 'side-bet' in favour of using them before proceeding further (Patrick and Bignall, 1987). Originally developed by Becker (1960), the notion of a 'side-bet' refers to an investment of time, money, or other personal resource small enough to be abandoned with no discernible loss to the individual. Indeed, at this early stage in their 'career' individuals have merely taken the decision to consult a practitioner or try out a particular remedy. Having not made any commitment to CAM, if, for whatever reason,

they felt that the treatment had not been 'successful' they may choose not to continue<sup>6</sup> or perhaps consider trying a different type of complementary therapy. Furthermore, the fact that, in the majority of cases, individuals have already consulted with their doctor means that they are not relying solely on the CAM practitioner, having considered all (biomedical) treatment options and hopefully ruling out any potentially serious illnesses. In short they have 'nothing to loose' (except perhaps the money paid for the treatment). As Patrick and Bignall (1987: 211) note at this stage 'given the smallness of this 'stake', individuals can either cut their losses or increase the bet' (Patrick and Bignall, 1987: 211). However, 'if the bet is increased, the individual proceeds with additional side-bets, each small enough to abandon but cumulatively large enough to form a significant investment of individual resources' (ibid: 211). This pattern of gradually increasing one's involvement and escalating one's side-bets is characteristic of the career of the CAM user and can take place over a matter of months or years. In other words, neophyte users begin by trying a CAM for a specific health problem, prompted by a friend, colleague or relative. At this juncture, a 'career contingency' emerges.<sup>7</sup> Individuals may, depending on the 'success' of that treatment, decide to increase their bets and either return for more treatment or start to try out other types of CAM for different health problems, as they do so using complementary therapies becomes an ever more important part of their identity. All participants within this study had progressed beyond this initial phase of CAM use.

### **Occasional Users**

Individuals move from the stage of new to that of occasional user following their initial experiences of using complementary therapies. In most instances when individuals recounted their first experiences of using CAMs they indicated how they had moved from an initial position of scepticism to that of acceptance and a growing belief in the

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<sup>6</sup> Whilst it is undoubtedly the case that some individuals do only ever use CAM on a one off basis, very little is known about this aspect of CAM use. Both in terms of the numbers of people who may be using CAM in this way, as well as their reasons for not continuing the treatment. Certainly, individuals may try out a particular type of CAM and then not return for further treatment, data from this research supports that, however, usually such individuals would then go on to try another type of complementary therapy.

<sup>7</sup> The notion of 'career contingency' was originally used by Becker (1963: 24) to refer to 'those factors on which mobility from one position to another depends'.

effectiveness of CAM treatments. For example, Steve said that when he first tried reflexology he had been very sceptical and could not see how 'massaging your feet could do any good'. However, following a recommendation from his partner, who had been to the practitioner herself and encouraged him to 'have a go', he decided to try it out. Having experienced the treatment for himself his opinions began to change, not only with regard to reflexology, but also to other types of complementary and alternative therapies:

'I think with most of these things, I think most people are the same, you go in very sceptical about the thing and you think 'yeah, yeah', you know. And then you go in and somebody [reflexologist] is sort of rubbing your feet and saying 'you've got a dicky shoulder' and you think 'hang on how does she know that?' And then you start to become a bit more, 'oh well maybe'. And I remember I suffered with eczema at the time and I started going more for reflexology and the eczema disappeared. So it was funny little things, little niggles within yourself all of a sudden disappeared just because I was going to that regularly, you know...And I think having had that encounter with it I think I was a bit more open to the rest of it you know. And then you're, I became, well I'll have a go at anything now, see how it goes and then make my mind up after I've had a treatment or a consultation as to whether it works for you'. (Steve)

The 'results' Steve attributed to the reflexology had convinced him that 'there was something in it' and consequently he became more open to the idea of using complementary therapies. Not only did he start to have reflexology regularly, once every two to three weeks, but he also started to 'experiment' with different CAMs for other health problems, in particular, over-the-counter products such as Echinacea and other herbal remedies for minor ailments such as colds and flu. Like Steve, many individuals indicated that the 'success' of their first CAM experience had prompted them to become more interested. Christine claimed that when she first used homeopathy it had worked like 'magic':

'I had a baby, I had my first baby and I ended up with haemorrhoids. I went to the doctor he sort of, wasn't really able to do very much for that so, this was on the way home from the doctors and I went into the chemist that I knew had homeopathic remedies, and because I'd already read about it, erm, I just began to think oh well maybe I'll give that a try, and I bought the appropriate remedy, popped one in my mouth and by the time I got home they had gone, I could feel them actually shriveling as I walked, magic [laughs]'. (Christine)

After this particular experience Christine started to read more about homeopathy and began using it for an increasing number of health problems, only on a self-help basis to begin with, for both herself and her family. At this stage in their career individuals *typically* start to acquire more information about using CAMs, many individuals claimed that they had wanted to learn more about CAMs and started to use them for an increasing number of health problems, particularly in the case of more minor, 'everyday', ailments, such as headaches, colds, stomach upset, menstrual cramps, indigestion etc.:<sup>8</sup>

'Well, after I started with the homeopathy and realized that you didn't have to rely on medics and started reading about it, well then I started with different stuff and see just does it work...it all came bit by bit, but probably I would say aromatherapy next and the Bach flower remedies, and then as I learnt more and more about it then I started using more stuff myself, like the different kinds of teas for different things, or chewing a clove, you know just different stuff you can do at home'. (Alex)

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<sup>8</sup> I emphasise 'typically' because there were exceptions to this, a few participants had started to use complementary therapies regularly but only for one particular health problem and some had also continued only with the complementary therapy they had originally tried. These individuals were similar to Sharma's 'stable users' and tended to be individuals who were looking for relief from chronic illness. They were generally not interested in trying out any other types of therapies. This group of users will be discussed in more detail in the next section.



For some individuals, such as Alex and Christine, this learning process was fuelled by information and resources obtained through the mass media,<sup>9</sup> such as magazine and newspaper articles and self-help books or 'guides' to using complementary therapies. Individuals often adopt a trial and error approach to testing different therapies to see 'what works' for them. Slowly individuals begin to build up a repertoire of effective remedies and treatments and progress to more regular use.

For other participants the learning process was facilitated by social interaction. Indeed, many individuals claimed that they had learnt about different therapies to use from friends, colleagues or family members who were using them themselves. For example, Tina claimed that at the time she started to develop an interest in complementary therapies many of the people she knew were also using them and shared advice with her about what therapies to use for what:

'Now a girl that I work with she has vertigo as well and she was using oils to try and cure it, to help her. And she also made me one of those things to go around your neck, you know that have the seeds in, the lavender in that you warm up and put around your neck. She made me one of them and said 'if you're feeling peculiar or whatever, put it around your neck, that'll help'. And she made me up some violet oil to use that was supposed to help the vertigo, but I found it made me worse. But it seemed to be at the time that there was a lot of people who I knew were going off and doing training, just because they fancied doing it. And I think at the time there seemed to be a trend of people around me, women, not men, were getting interested through magazines, things they'd seen on the TV...both friends and colleagues. The girl who made me up the collar and gave me the violet oil she does reflexology and I think she does Indian head massage as well. And we have somebody come here [at her work] who does Indian head massage that you can go and visit on a

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<sup>9</sup> There is now an increasing amount of information available on CAMs through the mass media, such as specialist magazines, newspaper columns, TV programmes with features on complementary therapies, self-help books and the Internet.

lunchtime...the girl who does the Indian head massage and the oils, she got me into the Bach's rescue, flower remedies. So it just seemed at the time that there was a lot of people either talking about doing it or going to see somebody or who were actually training to do it themselves'. (Tina)

Similarly, Jane spoke of how she had been introduced to certain remedies through the people she knew:

'I did buy a little book on homeopathy and I did read it. And somebody else worked for the Wildlife Trust who used it, and when she knew that I'd got certain problems she said I should take arnica, or whatever, so I did. So it's the people you mix with isn't it, and talking about things that are apart from mainstream medicine'. (Jane)

Again as individuals learn which therapies work for them they start to increase their use and may even start to make recommendations to others. Several individuals had learnt more about using complementary and alternative therapies in a more formal setting by attending a specific course. For example, individuals had attended courses on Shiatsu, Alexander technique, transcendental meditation, aromatherapy, Reiki, homeopathy and yoga.

The majority of participants in this study had been using complementary therapies for many years,<sup>10</sup> in fact one participant had started using them over 40 years ago. These individuals had moved from being occasional users to either regular or committed users quite some time ago and so it was often difficult for them to reflect back on how this process had occurred. However, for one participant, who had only recently started to use complementary therapies, it is possible to trace the developments of her career as she

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<sup>10</sup> As stated one participant had been using complementary therapies regularly for over 40 years. The remainder of participants had been using complementary therapies for varying lengths of time. Seven participants had started using them over 20 years ago, although not all of these had used them regularly over this period. Eight had starting using them between 10 and 15 years ago, again not all of these individuals had used them regularly during this period. Five individuals had been using them regularly for 5 - 7 years, one for 18 months and one participant had started using reflexology 7 months prior to the interview.

moves from *new* to *occasional* and then progresses towards more *regular* use.<sup>11</sup> For this reason, the remainder of this section will focus on the career trajectory of this particular individual, in order to demonstrate the sequence of stages that occur in the CAM career and how as individuals progress along this career trajectory using complementary therapies becomes an ever more important part of their identity.

Like many individuals Linda first tried complementary therapies after a recommendation from a friend. She had recently had a knee operation and a friend had suggested that she take the homeopathic remedy, arnica, to help with the recovery. After using this particular remedy she started to consider trying complementary therapies for other health problems and purchased a number of self-help books:

‘I’ve got quite a few books on homeopathy and aromatherapy and just well being. I’ve got a good book on just total woman well being and it gives you erm, alternatives for what is it naturopathy, aromatherapy, homeopathy and herbalism, and it gives you the choice of all three and it’s quite good and informative’. (Linda)

In particular Linda was interested in finding a solution to her insomnia. This was a problem that she had suffered with for a number of years. She claimed to have tried *all* the over-the-counter medicines, such as ‘Nytol’ and ‘Sominex’, none of which she said ‘worked’. She had also been to the doctor about the problem and had on occasions been given sleeping tablets, although she said that the doctor did not like to give them to her and she realized that they were only a temporary solution. Thus when she started to develop an interest in complementary therapies she also began to try out various over-the-counter herbal supplements as an alternative to conventional treatments for insomnia. However, she had not been able to find any remedies that had significantly helped the problem.

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<sup>11</sup> Whilst it was possible to trace similar transformations amongst the more ‘inexperienced’ CAM users, Linda’s experiences provide the best example from within this group.

Linda had also recently attended an evening class on aromatherapy and subsequently started using different aromatherapy oils in her bath and for oil burners for relaxation. She also tried using the essential oil lavender as an aid to sleep, with somewhat disastrous results:

‘I have overdosed on it [lavender] as well [laughs]. I actually, when I first started with them I hadn’t realized that you used very little and I ended up using too much in my bath, and then on the bed clothes, and on my pillow, and it had the total adverse effect, I didn’t sleep at all, had bad headaches, kept getting up to go to the toilet, and felt worse off for doing it. Because in moderation the oils are very good, they probably help and they help me relax but I don’t think they actually help me sleep’. (Linda)

Linda had attended the evening class with the friend who had initially introduced her to complementary therapies. This individual had been particularly influential in facilitating both Linda’s induction and her tuition in complementary therapies. As well as encouraging her to try out certain over-the-counter remedies and attend the aromatherapy course, this friend had also suggested that Linda consult the Traditional Chinese medical practitioner that she had been seeing herself, as a possible solution to the insomnia problem. Linda had been seriously considering taking up her friend’s advice, however, the practitioner moved away from the area and she had felt uneasy about going to a practitioner who had not been recommended to her. Linda’s friend had also paid for her to have an aromatherapy massage as a birthday present. Whilst she had tried out many of the aromatherapy oils at home for herself Linda admitted that she would not have gone for the massage unless her friend had prompted her (although she did say she would pay to go again):

‘I don’t know I think it’s like a luxury and I hadn’t thought about actually going and having it, but because it was a gift it was lovely’. (Linda)

After speaking with the therapist who gave her the massage Linda had started to think about going to see a homeopath. She was still having trouble sleeping and the aromatherapist had indicated that she was very tense and might benefit from seeing a homeopath, she even recommended a practitioner for Linda to see in the town where she lives. However, Linda had recently returned to her doctor as she was going through a particularly bad phase of not sleeping and was given some sleeping tablets:

‘But at the moment I’m not getting much sleep at all. I actually got some sleeping tablets from the doctors [laughs], I’ve reverted back [laughs]. I was getting so tired at Easter I actually went to the doctors and I got fourteen tablets this time, got them counted’. (Linda)

The doctor also offered her antidepressants but she said she would ‘rather find an alternative way’. As Linda’s interest in complementary medicines has developed she has started to use an increasing range of different therapies on a more regular basis. However, up until now these have mostly been for the treatment of minor ailments, for ‘anything more serious’ Linda said she would always go to her doctor. Social interaction has played a crucial role in both her induction and tuition in complementary therapies. Whilst it is not possible to know whether Linda will go on to consult with a homeopath or TCM practitioner, it is likely that she will continue to use an increasing range of complementary therapies, thus progressing from *occasional* to more *regular* use:

‘I think the more you, once you start an interest in it, I think it then progresses and you look at, instead of going and buying you know your cough medicine, Benolyn, or whatever, you would look at other ways, like the Olbas Oils and things like that for when you’ve got a cold, rather than take things, you know when you are really sort of decongested, you know just inhale that, have some of that on a tissue. And it’s sort of things like that, that there is other ways rather than taking all these things like flu and cold remedies...But the more I learn about it the more interest I have in it and I think the more sort of things that crop up I will then look to see what

alternative remedy I find...So I think the more I've learnt the more I'm veering off in that direction'. (Linda)

Having moved from new to occasional use individuals *typically* progress on to more regular use of complementary therapies. As Linda's story indicates this process is often facilitated by a number of factors, such as social interaction with other users and CAM practitioners, sharing and receiving ideas about different complementary therapies to use, learning more about complementary therapies through attending courses or reading books, magazines etc, or experimenting with different therapies to see 'what works'. However, a small number of individuals continued to use complementary therapies occasionally for specific health problems. Such as visiting an osteopath when they had back pain or occasionally purchasing over-the-counter remedies such as Echinacea for colds or flu. This may be because such individuals view themselves as generally healthy and therefore do not see the need to use medicines (orthodox or non-orthodox) and so just 'dabble' with CAMs when they feel it appropriate, or when prompted by a more committed user. Nevertheless, that is not to say that such individuals will not progress to regular use at a later stage.

### **Regular Users**

The passage from occasional to regular use for some individuals was facilitated by the occurrence of health problems for which there are limited treatment options. As occasional users, these individuals had used complementary therapies on and off over the years when illness episodes had occurred. For example, Jane had used a number of different types of complementary therapies over a period of twenty years, such as osteopathy for back problems, which she had found very effective but only used when problems arose. She had also used homeopathy on several occasions, although again this had just been in instances where she was looking for a solution to a persistent problem. She had purchased a couple of books on homeopathy but said she had 'never really got into it that far' and only really used it when others recommended specific remedies to her. Nevertheless, some years after these experiences she started having regular reflexology

treatments after being diagnosed with Multiple Sclerosis (M.S.). A friend had been to this particular therapist herself and recommended that she try it out. Jane continued to have reflexology once a month for 10 years, as 'a kind of maintenance regime', until recently when the therapist retired due to illness. She said that she was not really thinking of taking it up again at the moment, but admitted that if the M.S. got worse she might:

'Whether I'll ever pick up on that [reflexology] and start it up again I don't know. At the moment I'm not sort of looking to do that particularly. But perhaps if my health go worse, I mean M.S. can be, you know come in bouts and things, so I might just use it again' (Jane).

Similarly, Janet had had experiences of using many different complementary therapies in the past. Her first experience of using complementary therapies was over 20 years ago, and since then she had used applied kinesiology, osteopathy, chiropractic and acupuncture, at various stages during this period. However, like Jane she had started to use them again more regularly over the past 5 years after being diagnosed with a chronic disease, fibromyalgia. Despite her previous experiences of using complementary therapies she had not initially thought about trying it for her present condition, until she was prompted by a friend to try aromatherapy. She claimed that when she first started to experience symptoms her primary concern had been to find out what was causing the problems and felt that this was best dealt with via conventional medicine. However, once the condition had been diagnosed it became apparent that there was very little treatment available. When a friend offered to pay for her to have an aromatherapy massage for a birthday present she had agreed to go along. However, she said she had initially been very sceptical about aromatherapy, but like many other participants her opinions had changed after having the treatment:

'When I first went I thought this is a treat, I thought this was a joke, how nice I'll get rubbed in some nice smelly oils. I didn't really think it would have any therapeutic benefits, I thought it would be nice but erm. Then

have experienced one I thought I would try that again. And I went just occasionally and then I found that it was getting much better and with her loosening muscles off I could then start to do more movements of my own and I could start doing exercises at home, like rotations of hips and things, with a bit more ease. So I thought a regular visit would be good'. (Janet).

Janet has continued to go for aromatherapy on a regular basis (once a week). However, she admitted that if her friend had not prompted her she would not have tried it. Since seeing the aromatherapist she has also, following the therapist's recommendation, been to see a 'holistic doctor' and was considering going for chiropractic treatment, both to help alleviate the symptoms of the fibromyalgia. Like Sharma's (1995) 'earnest seekers', Janet was desperately seeking a successful remedy for this problem and claimed that she would continue to use complementary and alternative therapies regularly until relief is obtained. Nevertheless, Janet's current position as an 'earnest seeker' is largely determined by the nature of her condition. Whilst, in the past she had used complementary therapies more occasionally, it is possible that through the process of learning about a wide range of different therapies, particularly from the therapist she is currently seeing, Janet will become a more committed user.

In contrast to individuals such as Jane and Janet, a small number of regular users were only interested in using one type of complementary medicine. Like Sharma's (1995) 'stable users' these individuals had, after experiencing initial successes with complementary therapy, developed a fairly regular relationship with a particular practitioner or type of treatment. They were not generally interested in exploring other types of CAM. For example Chloe, who was suffering from M.E., was only using acupuncture on a regular basis. Although she had used acupuncture 7 years ago for a neck and back problem, and despite finding it helpful for that particular problem, she had not used any other complementary therapies until about 2 years ago when she was diagnosed with M.E. After finding out that she had M.E. and that the treatment options available via conventional medicine were limited, Chloe decided to try acupuncture again to see if it would help. She has found that having acupuncture regularly (once a week)



has given her more energy, for example, she claimed that prior to having acupuncture she had not been able to get up off of the sofa all day and now she is able to do a lot more, such as look after her daughter and do household chores.<sup>12</sup> She also said that the insomnia she was experiencing had improved and she was not getting as depressed. She showed some interest in using other types of complementary therapies and has tried Echinacea to help boost her immune system, following a recommendation from her sister-in-law. However, whilst she claimed to be 'open minded' to try things [complementary therapies]', she said that she did not 'go out and about looking for them, only if there's a problem'.

Chloe's point about not going out and looking for complementary therapies is a key difference between regular and committed users. The majority of regular users were using complementary therapies for specific illnesses. However, they were at the same also likely to be using conventional medicines for other conditions, as the following quote from Janet indicates:

'I mean it's not that I don't have time for traditional medicine, because I do have. There are disease conditions that, I mean, they can cope with and nobody else can, that the drugs that they use are the things to use. But they can't do everything and they're not really very good with physical bodies, with locomotion, with limbs and things, they're not too good with them'. (Janet).

Such individuals often adopt a 'pick and mix' approach to health care, choosing the services they see as most appropriate for particular conditions.

### **Committed Users**

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<sup>12</sup> It is common for individuals who suffer from conditions such as M.E. and CFS to experience a rapid loss of much of the life that they had previously taken for granted. In their study of individuals with CFS, Clarke and James (2003) found that many participants described how they were unable to do almost all of the things that they had once done: 'The very basic activities of everyday life – getting up, having a shower, drying hair, making and eating some breakfast – all of these and indeed all the fundamentals of social and even personal life are suddenly difficult if not impossible' (Clarke and James, 2003: 1392).

The difference between regular and committed users does not necessarily relate to the frequency that complementary therapies are used, rather it relates to individual's level of commitment to CAM. Indeed, some regular users, particularly those who were receiving CAM treatment once a week, may be using complementary therapies far more frequently than many committed users. Furthermore, for committed users using complementary therapies is a 'way of life' and has become an important part of their identity. These individuals 'always go for alternatives' in preference to conventional medicine. On the rare occasions where they do use conventional medicines this would only be as the last resort and usually for a diagnosis before deciding on the course of action to follow. *Typically* they will use a wide range of complementary therapies including both practitioner and self-care aspects for a range of different health problems. For example, Laura said she used homeopathy 'all the time', and had been for the past 8 years. As well as taking homeopathic remedies prescribed to her by her homeopath to treat her 'constitutionally', she also uses an array of different remedies for 'day-to-day' ailments, for both herself and her family:

'All the time, all the time. Yes, because I'm under a practitioner, and so are the children. So we're sort of being treated constitutionally, sort of constantly. So initially I went to see my homeopath because I had a migraine, recurrent migraine so she treated me for that. And then now she's treating me for depression so that's an ongoing thing. So whenever the remedy stops working I start going downhill really fast' (Laura)

Laura had initially started reading up about homeopathy and experimenting with different remedies at home and then some years later started to consult with a practitioner. Over the years her use of homeopathy has increased so too has her commitment. She claimed she would now always try and use homeopathy over conventional medicine.

Elaine had only really 'got into' complementary therapies about 7 years ago. However, over the course of this time she had purchased many books on different types of CAM and now uses it whenever possible, in preference to conventional medicine. She had used

a wide range of different complementary therapies including, reflexology, acupuncture, TCM, shiatsu, transcendental meditation, osteopathy, and various over-the-counter products such as Dr Bach's flower remedies and herbal supplements, but was particularly committed to using homeopathy. Whilst interviewing Elaine's husband Paul, also a committed user, he told me that homeopathy had become a 'way of life' for Elaine, in other words she uses it all of the time 'you know I've got this I'll take that straight away'. Whenever she is ill she would always try using complementary and alternative therapies before resorting to conventional medicine:

'I would always look for alternatives, I know Western medicine has it's uses, but for me at the moment yes I'd rather use alternative. As I say I would only go to the doctor to find out what it is, what's causing it, but they don't always know, but then get something alternative for it'.  
(Elaine).

Both Elaine and Laura had progressed on to committed use through a process of learning about complementary therapies and 'experimenting' with different therapies for a range of health problems. The more they had learnt the more they realized that they could use complementary therapies rather than having to resort to conventional medicine. However, for some individuals their progression from regular to committed use had been facilitated by the occurrence of illness and their experiences with conventional medicine. This was the case for two individuals in particular, Steve and Christine. Both were suffering with chronic fatigue syndrome, both had been regular CAM users prior to having this illness and both had become more committed to CAM through the course of their illness and in particular because of their experiences with conventional medicine.

When Christine was diagnosed with chronic fatigue syndrome she had already been a regular CAM user for over 15 years, although up until that time she had mostly used complementary therapies at home for minor ailments and occasionally went to an osteopath when she had a bad back. When she became ill she first went to her doctor to find out what was causing her symptoms, however, after a number of visits she was

repeatedly told that they could find nothing wrong with her.<sup>13</sup> During the interview she recalled one particularly harrowing and ‘humiliating’ experience she had with one doctor:

‘So I finally went back to the doctor and I could sort of barely walk and one of the GPs at our practice, I didn’t see the one that I would have preferred to see, and he was really very brusque and he obviously, M.E. was not a thing, as far as he was concerned and that was how he treated me right from the beginning. Well my husband was with me thank goodness. But it was sort of ‘up on the bench, can you bend this leg? Can you bend your arm? Right nothing wrong with you’. And it was just humiliating and he wasn’t listening to me that was the thing’. (Christine)

Christine claimed that such experiences during the course of her illness had turned her against conventional medicine and pushed her towards complementary therapies even more.<sup>14</sup>

‘[U]p until five years ago I would have said no it wouldn’t have been any different, if I was really worried about a problem I would have gone to the doctors and I would have taken antibiotics or whatever. Now I feel absolutely opposed to it. I even feel that if I were to have cancer or something I wouldn’t want to go to the doctor [laughs], I might change my mind if I actually did get cancer, but that’s how I feel’. (Christine)

Christine later returned to see another doctor and requested to be referred on to a specialist and was subsequently diagnosed with CFS/ME. The only treatment she was offered was antidepressants, which she refused to take, partly she claimed because she had heard (via an ME support group) that taking them could make symptoms worse, but

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<sup>13</sup> Chronic fatigue syndrome is a relatively new disease that is difficult to diagnose. It is also a contested disease immersed in dispute about whether it is a physical or psychiatric reality (Clarke and James, 2003). One participant in Clarke and James’s research on CFS had visited 25 different doctors in the search for a diagnosis.

<sup>14</sup> This supports research that suggests that one of the reasons why individuals turn to CAM is because of the way they have been treated by doctors (see for example, Siahpush, 1998).

also because she 'didn't like the idea of taking chemical concoctions'. It was at this point that Christine decided to return to complementary therapies and during the course of her illness she had tried a considerable number of complementary therapies all in the desperate search for relief from her condition. Following her diagnosis she used homeopathy, Alexander technique, healing, nutritional therapy, aromatherapy, acupuncture and applied kinesiology. Whilst she admitted that she originally started using complementary therapies because she desperately wanted to get well, she claimed that she had become more committed to using them and would now always try complementary therapies before resorting to conventional medicines:

'Because in the past I've always gone to the conventional one first and then to the homeopath or whatever afterwards, but I think I would, my faith is in the alternative first now and the conventional medicine as a last resort'. (Christine).

Amongst the committed users many claimed that they would only use conventional medicines as the absolute last resort and would also try to use complementary therapies were possible. The following examples illustrate the levels of commitment to complementary therapies and also the reluctance to use conventional medicines, amongst this particular group of users. For example, when Alex started to experience what she perceived to be symptoms of rheumatoid arthritis, a condition her brother had suffered from, she went to her doctor. However, after receiving confirmation that it was not rheumatoid arthritis she declined the treatment that she was offered, instead insisting on having complementary therapy. Luckily in Alex's case the doctor was able to refer her to an acupuncturist and after a course of treatment the problem disappeared.

'Oh I did go to the doctors for that actually, that was erm, I got, I was getting in my hands, my brother had rheumatoid arthritis and my hands were all, I couldn't open them up in the mornings and they'd be pins and needles, and the joints were getting swollen and stiff and all that stuff, and my wrists were really bad, and I work on a farm, so it's all physical stuff

so I thought I can't, I'm not going to be able to do my job, badminton and everything. So I did go to see the GP and they offered, I mean stupid things, they wanted to put a splint on my hands and , or I could have an operation where they would put something, cut something or other, cut a tendon or something and I was like no, no, no, whoa. So in the end she [doctor] said 'well would you consider acupuncture?' so I said 'yes I would consider that'. So then they paid for the acupuncture and that sorted it out'. (Alex).

Similarly, when Anna had started to experience regular migraines she had been to her doctor to ask to be referred to a homeopath. She said she had no intention of using conventional medicines, however, as a student she said she could not afford to see a homeopath privately in this country. The doctor told her that it was not possible for her to be referred<sup>15</sup> so she waited until she returned to Belgium and then went to see a homeopath there:

'I've asked them [doctor], you know whether, I used to get headaches quite a lot, sometimes migraines, and I asked them whether I could see a homeopath for it, but that was impossible for that kind of thing. So I thought, okay fine....So when I went back home to Belgium I went to the homeopath there, because it's a lot cheaper, and actually I did get some alternative treatment'. (Anna).

As a committed user of complementary therapies, in particular, Traditional Chinese medicine (TCM) and Shiatsu, when Paul had started to experience symptoms of chronic tiredness he had not even considered going to the doctor. Because of his 'faith' in the benefits of TCM he had chosen to go to a TCM practitioner instead:

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<sup>15</sup> It is certainly possible for general practitioners to refer patients to complementary therapists. As noted in chapter 2 the use of Cam in primary care is becoming more widespread (van Haselen et al., 2004). However, NHS patients have to rely on their GP or other 'gatekeeper' to refer them for complementary therapies.

'Well I went for that [TCM] because it's the most powerful and the most beneficial, as far as I'm concerned...there's no way I would have gone to the doctor, there's no way that I would want whatever you call pep pills, uppers and downers they'd give you'. (Paul)

Perhaps the most convincing example of one user's commitment to the use of complementary therapies comes from Sylvia. When Sylvia had been diagnosed with breast cancer she had been given the option of either having the lump removed and a course of radiation therapy or to have a double mastectomy. Sylvia opted for the double mastectomy because she believed that radiotherapy 'harms the rest of your body'. Following her operation Sylvia proudly told me that she had not needed to take any painkillers. She attributed this to the fact that she had had distance healing and was also taking the homeopathic remedy arnica to 'help with the recovery process'. She claimed that the woman in the bed next to her, who had only had a lumpectomy, was in terrific pain and had needed to take painkillers even though her operation 'was not so severe'.

As individual's progress towards more committed use complementary therapies start to permeate other aspects of their lives. Many claimed that through the process of using complementary and alternative therapies they had made significant changes to their lifestyles.<sup>16</sup> Within most complementary therapies there is a strong emphasis placed on the importance of lifestyle. The call for individuals to pay attention to the healthiness of every aspect of their lives is connected to the belief that health is holistic (Doel and Segrott, 2003). Holism, which rejects the treatment of symptoms in isolation and seeks to understand them in the context of a person's total health profile (Cant and Sharma, 1999), is understood to be one of the core features of complementary therapies (Goldstein, 1999): 'signs or symptoms are not isolated phenomena to be treated. Rather the entire physical, emotional, spiritual, and social makeup of the person must be

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<sup>16</sup> Here the term 'lifestyle' is used to refer to 'patterns of action that differentiate people' (Chaney, 1996:4). The term 'lifestyle' is also employed in relation to consumption and is used to refer to patterns of consumption that become central to how people define themselves. In the context of health the notion of lifestyle is usually used to refer to eating, the use of legal and non-legal drugs, smoking, leisure and sporting activities, sexual activity and aspects of body maintenance (Nettleton, 1995). All of which are deemed important as they are associated with potential risk factors associated with so-called 'lifestyle diseases', such as heart disease, cancer, AIDS etc.

considered' (ibid: 44). Almost every aspect of one's daily practice is drawn into the project of health management. Personal relationships, work-related stress and time management, health-related behaviours such as smoking and alcohol consumption, diet and exercise all have the potential to help or hinder the individual to achieve their optimum state of health. Many described complementary and alternative therapies as part of an 'alternative'<sup>17</sup> or 'natural' lifestyle that *typically* included, eating an organic, 'wholefood' diet and avoiding 'processed' foods, engaging in healthy practices, such as exercise and relaxation techniques (e.g. meditation and yoga) and concern for environmental and animal welfare issues:

'And I suppose that this alternative therapy thing is just part of the whole lifestyle thing, you know with organic foods, and you know using the bike instead of the car, you know and trying to live sustainably, it's all part and parcel of the same thing, they're all kind of running along together'.  
(Alex)

For example, all committed users espoused the virtues of adopting an organic, wholefood diet and the importance of avoiding 'processed' foods, 'ready made meals' or other types of 'convenience' foods.<sup>18</sup> Many also claimed that they read ingredient labels before purchasing foods from the supermarket to check that they did not contain 'artificial' ingredients:<sup>19</sup>

'And sometimes you buy something, maybe you buy a ready made meal or a tin of soup and you take it home and you look at the ingredients and there are all these things that you don't know what they are, or if you

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<sup>17</sup> The notion of an 'alternative' lifestyle can be traced back to Bohemian and Romantic identities of the nineteenth century, as well as to religious and Utopian communities of earlier times. However, the idea of an 'alternative' lifestyle is mostly associated with the 1960s counter culture (Hetherington, 1998).

<sup>18</sup> Previous research has found that users of homeopathy tried to avoid preservatives, colourings and other 'artificial' ingredients in food (Furnham and Forey, 1994).

<sup>19</sup> Reading food labels suggests that individuals are concerned about the 'safety' or 'healthiness' of processed foods. Highly processed foods with 'chemicals', for example, or 'additives' are viewed as suspect. For example, in a recent Australian study of risk perceptions in relation to food, Lupton (2005) also found that many participants read the labels on processed food to check for additives.



know what they are they're just really not necessary in there. Yeah, I'm getting worse and worse at looking at labels [laughs]'. (Anna)

According to Atkinson (1983) contemporary foodstuffs, such as so-called 'convenience' foods are viewed as having been tampered with, adulterated, having had their 'natural' nutrients destroyed, or have been otherwise impaired:

'I wouldn't buy this pre-packed, I never, ever buy convenience foods' (Alex).

'I think you should leave things as natural as possible, try to avoid any processed food, any artificial preservative, flavourings and so on. I think that that's the most important thing' (Anna).

In contrast the category 'natural' carries with it overtones of 'purity', which is also captured in the closely associated notion of 'whole' food (Atkinson, 1983). Many individuals claimed to prefer a 'wholefood' diet; 'fresh and home cooked food', consisting of 'natural' ingredients such as fresh fruit and vegetables and whole grains. Many had also switched to eating mostly organic produce, viewing this as a more healthy option:

'I try to eat organic...Because everything is so sprayed, you know that's why people are getting cancer, because of crop spraying' (Elaine).

'It [eating organic] just seems the most natural way of doing it...I don't think that all the pesticides, or whatever they use are good for us, and we just don't know what they're doing to us'. (Anna)

As discussed in chapter 3, the consumption of goods and services is recognized as a socio-cultural process (Bocock, 1993), that is now regarded as having more impact upon the identity and lifestyle of a person than production (Tomlinson, 1990). The

consumption of commodities has become central to how people define themselves. Indeed, according to Coward (1989) there is an increasing emphasis on symbolic activity and individual lifestyle choices in achieving health and health action has gained importance as a means of self-determination:

‘The notion of being alternative is considerably more than just doing it differently from orthodox medicine. It is also a symbolic activity. It is a profound expression of a new consciousness which individuals have about health and body. This involves a commitment to a new lifestyle, to pursuing a new wellbeing, and to finding ‘natural’ ways of achieving this wellbeing. Above all it is a new consciousness of the importance of the individual in achieving health’ (ibid: 11).

In the sense, the ‘natural’ or ‘alternative’ lifestyle reflects a set of distinctive patterns of consumption that become internalized into a *habitus*.<sup>20</sup>

### **Vocabularies of motive**

The transition that occurs as individuals progress along the CAM trajectory can be explored by considering the different vocabularies of motive provided by new, occasional, regular and committed users. In his well known discussion of vocabularies of motive, C Wright Mills, says motives are explanations given in answer to questions about a person’s activity. The search for ‘real’ motives is mistaken:

‘Rather than fixed elements “in” an individual, motives are the terms with which interpretations of conduct by social actors proceeds. This imputation and avowal of motives by actors are social phenomena to be explained. The differing reasons men [sic] give for their actions are not

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<sup>20</sup> Bourdieu (1984) employed the term ‘habitus’ to show how ways of thinking are absorbed as habits into the body, but are also socially located (Bourdieu, 1977, 1984). ‘Habitus’ is defined as a set of unconscious dispositions that organize an individual’s capacity to act, to classify and to make sense of social experience. It is manifest in an individual’s taken-for-granted assumptions about the appropriateness and validity of his or her taste in cultural goods and practices (Bourdieu, 1984).

themselves without reasons' (Mills, 1963: 439-40, cited in Addelson, 1990: 131).

According to Mills motives should be understood as external products that individuals employ to provide adequate and meaningful descriptions of their behaviour. In this respect such meaningful descriptions are understood as 'accepted justifications for present, future or past programs or acts' (ibid: 907). Indeed some individuals initially found it difficult to account for why they had used complementary therapies and claimed that it was not something they had previously given much thought to. For example, reflecting back at the end of the interview Anna said that being asked about why she used complementary therapies had made her realise things that she had not previously considered:

'When you talk about it [complementary therapies] you realise so many things. Because you think about it a little bit but you don't talk, don't have a discussion with yourself, you just go along with what you think and so it's like you're totally ignorant about all these things that you don't know about'. (Anna)

There were fundamental differences in the vocabularies of motive offered by individuals at different stages of the CAM career trajectory. Previous research exploring individual motivations for using complementary and alternative therapies has identified three main areas of explanation. As discussed in chapter 3, these are dissatisfaction with the medical encounter; dissatisfaction with orthodox medicine; and the emergence of a new 'postmodern' value system (Siahpush, 1998). This research has tended to explore individuals *initial* reasons for using complementary therapies, rather than their reasons for *returning* to complementary therapies. Furthermore, within this literature users of complementary therapies have tended to be treated as a homogeneous group with similar beliefs, motivations and needs (Sirois and Gick, 2002). In contrast to these studies the data from this study suggests that motivations are not static entities, and may undergo significant changes as each individual's unique CAM career unfolds over time. Like

Becker's (1953) marijuana users, as individuals progress along the career trajectory they acquire further rationalizations and justifications for their use and these reinforce their continued use of complementary and alternative therapies. 'Issues once regarded as important may slip down the individual's personal agenda, others once subsidiary, irrelevant or unknown may move upwards' (Beardsworth and Keil, 1992: 271). Individuals also often provide multiple justifications for why they may use complementary therapies at any one time. For example the principle motive could be identified and then subsidiary motives could be cited, motives which usually complement and reinforce the dominant one (Beardsworth and Keil, 1992).

In the early stages of a CAM career vocabularies of motives are very much focused on the need to find relief for a particular health problem. As discussed earlier, the majority of participants had cited 'dissatisfaction' with the outcomes of conventional medicine as their main motivation for initially using complementary therapies. As the following extracts indicate individuals often use complementary therapies as a last resort after 'failed' treatment from orthodox medicine.

'It's probably difficult to give a reason why you try alternative medicine. I think it's when all other avenues are just cut off, when the usual things don't work, things that you expect that'll work just don't help, we always expect that now don't we'. (Chloe)

'I was at the end. I was at the end of my tether with it really' (Amanda).

'Like hypnotherapy, that was for a specific issue and chiropractic and osteopathy. So they were probably the three treatments that I've said, right I've got this problem and conventional things aren't going to sort it out so I need to seek an alternative therapist'. (Suzanne).

As already suggested such findings concur with previous research on individual's motivations for using complementary and alternative therapies (e.g. Sharma, 1995;

McGregor and Peay, 1996). However, as individuals progress on to occasional or regular use, their reasons for continuing with a particular CAM treatment may change. The primary motive of wanting to find a solution to their current health problem remains but secondary motives emerge such as those relating to the effectiveness of the treatments, i.e. whether it works and affective elements of the treatment, such as the feelings of relaxation and enjoyment they experience during the treatment, these factors complement or reinforce the dominant motivation. For example, Chloe was having acupuncture once a week to help with her M.E. Whilst her primary motive for using it is to get better, she continues to have the treatment regularly because of the benefits she gains in the short term and a belief that eventually it will help with her recovery:

‘It works, it really takes the symptoms away, quite dramatically. It doesn’t make me feel one hundred percent better, but I think that the more that I go the better I’ll feel’. (Chloe)

Susan, who was having regular reflexology treatment, initially for ‘menstrual problems’, claimed that having the treatment had completely altered her quality of life. She said she feels much healthier, her skin is better, she has more energy, she sleeps at night, her periods are much better and it has helped to control her pre-menstrual tension. Similarly, Pat, who was suffering with M.S., said that she had really noticed the benefits of the reflexology and that was why she continued to go for weekly treatments:

‘I’ve been going to Marie [reflexologist] since May, but wonderful progress. I know my balance is iffy, but I know it’s a lot better than it was. How can I say? I can stand my balance is okay now, before it was really bad. I feel more confident and that’s great’. (Pat)

Some individuals claimed that they continued to go for regular treatment because they were concerned that if they stopped the symptoms they had previously consulted for would return. For example, Susan claimed that when she had missed a couple of weeks of her reflexology treatments, when she had been on holiday for instance, her menstrual

problems had started to return. Amanda, who was also a regular reflexology user, claimed that she could feel her stress levels rise when she missed a treatment:

‘I feel like erm, because sometimes if I don’t go or I miss a week for whatever reason. Or sometimes if I miss a fortnight you can really tell that you’re feeling that build up, you know you’re starting to feel more and more stressed. I don’t know whether, you know I don’t know how it works’. (Amanda)

A number of participants who had initially started using CAM because of a particular illness had continued with the treatment after the symptoms had disappeared. Many of these individuals continued because of the affective aspects of the treatment, such as the fact that it is a pleasurable and relaxing experience<sup>21</sup> that counteracts the stressfulness of their everyday lives:

‘So even though I haven’t got anything particularly wrong at the minute, I just keep going [for reflexology] because I enjoy it...I find it very relaxing. Because I sit at a desk all day it brings to Marie’s [reflexologist] attention if I’ve got any aches and pains in my neck or back, sometimes I come away from it and I feel like I’ve done, as if I’ve had a good pummeling, and it’s really strange to think that’s she’s been working on my feet. But I think because you’re sitting all day in front of a computer your posture is not very good and she helps to keep you mobile. I mean I try to get exercise but in the winter when the weather’s crap, it’s dark when I’m going to work, it’s dark when I’m coming home from work and I think also if you’ve had a particularly shitty day at work and you’ve had a lot of hassle on the phone from people, it’s just nice to go there, listen to her music, get on the couch and you come away feeling, I come out of there some day and I’m smiling and I’ve got no real reason’. (Tina)

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<sup>21</sup> This only applies to therapies such as aromatherapy, reflexology, hot stone therapy and massage in particular. None of the individuals having treatments such as chiropractic, osteopathy or acupuncture described them as relaxing or particularly pleasurable.

Similarly, Amanda said that having reflexology helps her to relax by 'putting things into perspective':

'I do like the fact that you go and you don't have to worry about anything else for the whole time that you're there and feel really like you're cocooned away from the world in a way, that nothing's, you don't worry. Maybe for the first twenty minutes of the treatment my minds still active and I'm still going through my mind and thinking of all the things I've got to do. But I find that at the end of the hour I've got things sort of crystallized in my mind. Things seem to be ordered in my mind. I often go to sleep. But I think, I'll often go to sleep for the last fifteen minutes or something. But I always wake up at the end of the treatment as soon as she's finished I always wake up. I think that sort of space. Because otherwise you're always sort of, otherwise you're, especially as a teacher you're always beholding to other people all the time...So I think that going there helps me to put it into perspective as well'. (Amanda).

A number of individuals said that they continued to go for CAM treatment because they believed it helped to 'maintain well being' or was part of a 'body maintenance regime'. For example, Jane had been seeing a chiropractor regularly for the past 4 years. She said that in the past she had been to osteopaths when she had experienced problems with her back, but now goes to a chiropractor as part of a 'maintenance regime' to help prevent problems reoccurring. Similarly, Tina claimed that having regular reflexology was beneficial for her general well being and also helped to identify any health problems:

'I just feel it's beneficial for your general well being. To pay Marie [reflexologist] once a fortnight to go and she sort of keeps me maintained as it were, I'd certainly keep going....I think it helps to keep you on a plateau and it also picks up any problems that you may not be aware of. You know she'll say to me 'ow, argh that's your neck', or something, and

she'll work on it. And you think well if I hadn't gone I could have woken up in three or four days time and thought I can't move'. (Tina)

As individuals progress towards more committed use of complementary therapies they experience a shift in their motivations. They acquire further justifications and rationalizations for their use and these reinforce their continued use (Becker, 1953). For example, Alex, a committed user of complementary therapies, claimed that whilst she initially used homeopathy because she had been unable to find relief from conventional medicine for a particular health problem, her motivations for using it were now quite different:

'Well after that [using homeopathy] I thought, and then you start, I suppose awareness was growing generally, I get the Guardian [newspaper] and they constantly have articles, and I read, you know I keep up with current affairs, and I'm quite interested in, like we eat organic food, so we get magazines like the organic way, and all the time stuff like that's coming in and they're questioning the use of chemicals and then you think what about this stuff, like aspirins and stuff like that, you read stuff in the papers, I don't know I was interested and read more and more about it, and the more I read and the more I learnt, the more I spoke to people, I thought, it's just not, conventional medicines' just not good...I mean that isn't what I thought right at the beginning, it was just a well alright I'll give it a go, because with this skin thing nothing else has worked, and like a gradual growing awareness, but now that's where I'm at now, I won't use them'. (Alex)

Like Alex, many committed users claimed that their motivations for using complementary therapies had changed over the course of using them. Amongst this group of users the main motivation given for using complementary therapies was concern over the side effects of Western medicines and a belief that complementary therapies are



safer because they are 'natural'.<sup>22</sup> Indeed, many claimed that they preferred to use complementary therapies because they were not harmful to the body. For example when Anna started to use homeopathy it was because the doctor had been unable to help with her 'allergies'. She now claimed that she preferred to use complementary therapies because they are 'natural' and safe, compared to Western medicines, which she perceives to be chemicals that are harmful to the body:

'I think it's because of what I said before about not knowing what these other things do to your body...I think these man-made, invented things can do a lot more harm [than complementary medicines]'. (Anna)

Such findings provide support for previous studies that suggest that one of the main reasons why individuals use complementary therapies is because they are genuinely concerned about the side effects of drugs and are anxious about taking medication that seems to them to be made of artificial substances and chemicals (Britten, 1996; Cant & Sharma, 1999). In contrast, the apparent harmlessness of alternative medicine and the belief that it is 'natural' is part of the attraction (Sharma, 1996). However, as has been demonstrated this particular motivation does not apply to all 'categories' of CAM users and in this instance has been found to be most prevalent amongst committed users.

## **Conclusion**

The findings that have been presented above reveal the dynamic and multi-dimensional nature of the motivations that propel individuals into CAM use. This is in contrast to the existing literature on CAM use that tends to present motives as static entities and CAM users as a homogeneous group with similar beliefs, motives and needs (Sirois and Gick, 2002). This chapter has provided an alternative approach by suggesting that the vocabularies of motive offered by new, occasional, regular and committed users demonstrates how motives are socially constructed within and through the processes of

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<sup>22</sup> This motivation for using CAM was not only used by committed users. However, for regular users it tended to be given as a secondary or subsidiary motivation, whereas amongst committed users it was the predominant motivational factor for CAM use. These issues will be explored in more detail in the next chapter.

becoming a CAM user. In support of previous research the majority of new users cited 'dissatisfaction' with the outcomes of orthodox medical treatment and personal recommendation from a friend, colleague or family member as their primary motivations for using complementary therapies. However, as individuals progress towards occasional and regular use vocabularies of motive *typically* focus on the effectiveness of the therapy and the affective aspects of the treatment itself. Individuals start to acquire further justifications and rationalizations for using complementary therapies that reinforce their continued use. Committed user's accounts of their motives for using complementary therapies suggested that they used them primarily because of a lack of trust in Western medicines and a belief that complementary therapies are 'safer' because they are 'natural'. This point will be the focus of the next chapter, where individual's perceptions of the risks of conventional and complementary medicines will be explored in detail. In short, this chapter has shown how motivations for using complementary therapies undergo significant changes as each individual's unique CAM career unfolds over time.

This chapter has employed the Chicagoan concept of career in order to highlight the typical transitions that occur in the process of becoming a CAM user. As I have shown it is possible to identify distinctive career patterns amongst users. Following on from their initial experiences of using complementary therapies individuals move from a position of scepticism to that of acceptance and a growing belief in the effectiveness of CAM treatments. At this juncture a career contingency occurs as individuals move from new/occasional use to more regular use of complementary therapies. This process is facilitated by a number of factors such as social interaction with other (more committed) users, by learning more about complementary therapies through books, magazines etc. and 'experimenting' with different treatment to see what works for them. As individuals move towards more committed use CAM use becomes an ever more important part of their identity and using CAM becomes a 'way of life'. These changes should be understood as moral in the respect that the experience of using complementary and alternative therapies has provided a 'turning point' in the way they view themselves and the world (Goffman, 1968).

There are clearly similarities between the 'types' of users in Sharma's (1995) study and the participants in this study in terms of their patterns of using and initial motivations for using CAMs. It is possible to identify 'earnest seekers', 'stable users' and 'eclectic users' from within the sample. However, these categories are not fixed, for example, individuals may be characterized as an 'earnest seeker' at a particular stage in their CAM career trajectory, but then later move on to more to more 'eclectic' use. By adopting a developmental approach to understanding the nature of CAM use I have therefore moved beyond Sharma's typology of users. The concept of career has proved to be a useful conceptual tool, allowing for a more fluid and dynamic understanding of the nature of an individual's progression through a CAM career. Furthermore, it has allowed for an understanding of how an individual's position within the career and involvement with a particular therapy (or therapies) can change and develop over the life course.

## **‘I just don’t want to pump my body full of chemicals’: Risk, embodiment and the consumption of CAM.**

‘They know it’s alternative and they know it’s safe and it’s natural, so. And there is an ethos, isn’t there at the moment, where anything natural is good...So, I think some people come because they want to and they can afford to have a natural product’. (Jackie, homeopath)

‘I think side effects that’s a big issue, that it’s natural and it can’t hurt you. And those are the things that people look for’. (Julie, reflexologist)

### **Introduction**

In chapter 3 I discussed the concept of risk in relation to the consumption of complementary and alternative therapies. Within sociology a number of authors (Douglas, 1992; Giddens, 1991; Beck, 1992) have identified risk as a pervasive feature of contemporary Western societies. The ideas of Beck (1992) and Giddens (1991) have proved particularly influential here.<sup>1</sup> Beck (1992) describes contemporary society as a ‘risk society’ and argues that individuals living in these societies have moved towards greater awareness of risk and are forced to deal with risks on an everyday basis: ‘Everyone is caught up in defensive battles of various types, anticipating the hostile substances in one’s manner of living and eating’ (Beck, 1994: 45). A central tenet of the both Beck and Giddens’ work on risk, is that uncertainty around scientific knowledge is a key element of the contemporary condition (e.g. Beck, 1992; Giddens, 1991). Against

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<sup>1</sup> As discussed in chapter 3, whilst it is widely held that there are a number of similarities between the writings of Beck and Giddens on risk and reflexive modernization (Lupton, 1999a; Lupton, 1999b; Lupton and Tulloch, 2002), there are also fundamental differences in their work. See chapter 3 for further details.

this backdrop, it is argued, individuals are involved in an unsettling 'ever present exercise' (Giddens, 1991: 124) of risk assessment in which risks, as measured by an increasing array of experts, are weighed up and managed at an individual level. The observations of Beck and Giddens on risk and reflexive modernization are particularly relevant to issues of health and illness (see Gabe, 1995; Nettleton, 1995; Turner, 1995; Nettleton and Gustafsson, 2002). People are required to assimilate and evaluate increasing amounts of information, especially about health risks (Bury, 1997). For Giddens (1991) such processes produce a 'contestable culture' in which trust in abstract systems and expertise is frequently threatened. As Gabe et al. (1994) contend this is particularly true in such matters as health risks from the environment, food production, pharmaceutical products and other medical treatments. The increased availability of information and the knowledge of risks may have provided for a more reflexive and questioning consumer.

This chapter takes up some aspects of these theoretical perspectives in relation to the consumption of complementary and alternative medicines. One of the central themes to emerge from the data was reluctance amongst participants to use orthodox medicines,<sup>2</sup> which were associated with potential risks to the health of the body, such as long-term side effects and iatrogenic illness. In contrast, so-called 'natural' remedies or other types of complementary therapies were seen to represent a relatively 'risk free' alternative. In recent times we have witnessed the emergence of an increasing number of iatrogenic diseases caused by pharmaceutical drugs and over-prescription of substances such as antibiotics and antidepressants. At the same time, uncertainties over the 'safety' of certain pharmaceutical drugs are frequently the subject of intense media attention. Recent examples include the publicity given to concerns over the 'safety' of the combined vaccine for measles, mumps and rubella (MMR), whereby despite attempts by the British Government and the medical profession to convince parents that there are no side effects, many parents are still concerned that the vaccine is not completely 'safe' (Rogers and Pilgrim, 1995). Furthermore, at the time of writing this chapter there has

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<sup>2</sup> This includes both prescription (e.g. antidepressants, antibiotics, steroids etc.) and non-prescription, over-the-counter medicines (e.g. analgesics and other painkillers, cold relief medicines, hayfever medicines etc.).

been controversy surrounding the painkiller Vioxx, used for pain relief from arthritis. Originally heralded as a painkilling 'wonder drug'<sup>3</sup>, Vioxx was taken off the market in September 2004 after a clinical trial in America had shown a link to heart attacks. Since then there have been 4,200 claims lodged with courts in America against the drug's producer Merck. On the 19<sup>th</sup> August 2005, a Texas widow was awarded more than \$250 million in compensation, when a court found the company negligent in the death of her husband (*The Sunday Times*, 21 August 2005). In such a context it is perhaps not surprising that, faced with such uncertainties surrounding the safety of Western pharmaceuticals, increasing numbers of individuals are seeking out alternatives. As Cant and Sharma (1996) contend the uncertainties and threats associated with conventional medicine and the belief that CAM is 'safer' as it is 'natural' are factors in the growth of CAM.

Nevertheless, despite the fact that much research on complementary and alternative medicines has shown that individuals are drawn to them because of dissatisfaction with conventional medicines (e.g. Taylor, 1984; Sharma, 1995; Easthope, 1993; Siahpush, 1998) and are concerned about potential side effects of drugs (Verthoef et al., 1998; Wynsong, 1998), the debate concerning motives for using CAM has largely been conducted in the absence of any theoretical input or discussion of the core themes in the sociology of risk.<sup>4</sup> Which, in light of the fact that the concept of risk has become a core theme within the sociology of health and illness (see Williams et al, 2000) seems surprising. Drawing on my interview data this chapter examines how the issue of risk relates to individual's motives for using complementary therapies. In particular I focus on the extent to which individuals' decisions to use complementary medicines are reliant on assessments of the risks and safety of pharmaceutical drugs; and whether complementary therapies are understood by users as providing a solution to the problems associated with orthodox medicines. Furthermore, such issues are also of particular interest in light of recent debates concerning the 'safety' of many complementary and

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<sup>3</sup> The producers of the drug, Merck, believed that Vioxx would revolutionise pain relief, offering the benefits of aspirin without the older drug's risk of stomach ulcers (*The Sunday Times*, 21 August 2005).

<sup>4</sup> I managed to find one exception to this. In a recent Australian study Connor (2004) linked CAM use specifically to notions of risk and risk avoidance. She argues that alternative medicines can be viewed as 'antidotes for the experience of living in a "risk society"' (Connor, 2004: 1).

alternative therapies. Whereby, a number of critics have argued that there are certain 'hidden risks' (Ernst, 2001) associated with using complementary therapies. In this sense it is argued that the assumption that complementary therapies are 'safe' because they are 'natural' is 'naïve at best and dangerous at worst' (Ernst, 2004: 767).

### **Medicine, health and risk**

Whilst research indicates that - certainly in global terms - people are overwhelmingly in favour of medicines (Whyte et al, 2002), at the same time there is evidence of a growing distrust of and aversion to medicines (Gabe and Bury, 1996, Pound et al., 2005). According to Scott and Williams (1992) public knowledge and concern about the risks and limitations of modern medicine has been increasing in the last thirty years, alongside more general questioning of expertise and professionalism. Indeed, scepticism towards medicines in industrialized countries gained momentum in the 1970s<sup>5</sup> when criticism of biomedicine in general grew under the influence of publications such as those of Illich (1974) and Taylor (1978), about doubtful medical practices. Both Illich and Taylor devoted considerable attention to the harmful consequences of prolific prescription of medicines. In 1974, in his book *Medical Nemesis*, Illich gave a damning account of the effects of modern medicine, claiming that the medical establishment 'has become a major threat to health' (Illich, 1974: 918). Doctors were now people who not only cured but also killed.<sup>6</sup> Several publications (Silverman, 1976; Medawar, 1979; Silverman et al., 1982; Melville and Johnson, 1982) not only pointed at the possible iatrogenic effects of medicines but also criticized the commercial character of their production and distribution. Pharmaceutical companies were accused of putting profits before health. Thus, the critical attitude toward medicines as potentially dangerous substances was

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<sup>5</sup> Scepticism towards the value of conventional medicines undoubtedly has a longer history than this. As Scott and Freeman (1995: 159) note: 'Scepticism about the knowledge of specialized elites is not new in historical terms, but it is a new experience for late twentieth century citizens raised on promises of scientific progress and trust in experts'.

<sup>6</sup> Such ideas were also evident, for example, in the women's health movement of the 1970s, where publications such as 'Our Bodies, Ourselves' (Boston Women's Health Book Collective, 1973), taught self-care skills as a means of restoring women's control over their bodies. These issues are discussed in more detail in chapter 7.

reinforced by the argument that pharmaceuticals were made for profit as much as for therapy (Whyte et al., 2002).

According to Worsley (1997) by the 1970s criticism of drug-based therapy was not confined to this or that drug. It gave rise to a general critique of drug-based medicine and of the pharmaceutical industrial. 'Drug disasters' both 'old', such as the Thalidomide tragedy in the early 1960s or the polio vaccination of the 1950s, and 'new', such as the controversy surrounding the MMR vaccine and confusion over possible links between breast cancer and HRT, have served to intensify concern and anxiety over the safety of Western pharmaceuticals (see for example, Rogers and Pilgrim, 1995 and Green et al. 2002). In such a context it is perhaps not surprising that individuals are searching out alternatives. Lupton (1994: 125) contends that:

'In a climate where concerns about iatrogenic disease, the self-serving financial interests of orthodox doctors and the high costs of medical technology have been placed prominently on the agenda for public discussion, alternative therapies appear a refreshing and radical alternative'.

Particularly when such alternatives are said to be 'harmless', 'non-toxic' and not generally associated with negative side effects. Indeed, Fulder (1996: 6) suggests that whilst there are certain risks with all therapies 'they are very small compared with those of conventional medicine' (Fulder, 1996: 6).<sup>7</sup> According to Cant and Sharma (1996) the

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<sup>7</sup> There have been instances where complementary and alternative therapies have been linked to iatrogenic illness and even death. For example in 2003 the government prohibited the sale of the herbal supplement Kava Kava, used for the relief of anxiety and stress, following reports of liver side effects. However, the evidence against the herb was not conclusive and the issue of its safety is currently under review by the Medicines and Healthcare products Regulatory Agency. Nevertheless, this research is not concerned with establishing whether or not CAMs are safe in any objective sense. Rather, I am concerned with the meanings that users themselves attach to the therapies or medicines they use and the affect this has on their healthcare choices. Indeed, some participants did express concern over certain herbal supplements, in particular St John's Wort, following media reports about possible negative effects. However, this was more to do with interactions with other drugs such as the contraceptive pill than a perception that the supplements were harmful or dangerous. For example, one participant had stopped taking St John's Wort after hearing that it could interact negatively with the contraceptive pill. However, she did also say that she had not found it particularly effective in treating her depression.



uncertainties and threats associated with conventional medicine and the belief that CAM is 'safer' as it is 'natural' are factors in the growth of CAM. Harrison (2003: 36) argues that user support for CAMs '...indicates in the clearest possible way that a significant number of people do not like conventional medicine or that it has failed them in particular ways'. Many CAMs pronounce disapproval of the harmful effects of medicine, and in particular the iatrogenic disturbances caused by over medication (Braathen, 1996). Such sentiments can be traced back to the nineteenth-century, when alternative healers castigated conventional medicine for producing the illnesses it claimed to cure (Szerszynski, 2005). Indeed, in the past alternative therapies such as homeopathy were considered a popular choice as they were often seen as a gentler alternative to the heroic therapies of orthodox medicine (Nicholls, 1988).

Nevertheless, concerns about the safety of Western pharmaceuticals are not restricted to those individuals using complementary and alternative medicines. Research indicates that there is widespread caution about taking medicines amongst the population (Pound et al., 2005). Such sentiments are expressed through worries about dependence, tolerance and addiction, the potential harm from taking medicines on a long-term basis and the possibility of medicines masking other symptoms.<sup>8</sup> However, most studies on 'lay' experiences of medicine have been concerned with medicines taken on a long-term basis for chronic illness, and in general have focused on individuals who do not take their medicine as prescribed, rather than those who reject their medicines altogether (Pound et al., 2005).<sup>9</sup> The small amount of research that has considered individual's reasons for rejecting medicines (e.g. Britten, 1996; Dowell and Hudson, 1997; Lumme-Sandt et al., 2000) indicates that one of the main reasons why people do not take their medicines is because of concerns about the medicines themselves (Pound et al., 2005).

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<sup>8</sup> See Pound et al (2005) for a full review of the literature on 'lay' experiences of medicines.

<sup>9</sup> Research focusing on the issue of 'non-compliance' can be traced back over three decades. Early research in this field tended to concentrate on how many people were non-compliant with medicines and their characteristics. However, determining the characteristics of patients who are most likely to be non-compliant has proved to be complex and studies have failed to produce consistent results. Furthermore, the concept of compliance, or non-compliance, where patients are viewed as passively following, or disobeying, medical instruction has been deemed problematic. More recently, the concept of concordance has been adopted to reflect the changing nature of the doctor-patient relationship, where doctor and patient work together to discuss treatment options (Gabe et al, 2004).

In a small scale qualitative study with individuals from 2 general practices in London,<sup>10</sup> Britten (1996) found that whilst many participants had a positive appreciation of the role of their GP, the medicines he/she prescribed and claimed they always complied with what the doctor told them to do. In contrast, other participants, those Britten refers to as 'unorthodox', demonstrated an aversion to medicines. They described medicines as artificial, chemical and unnatural. The fact that they had been made in a factory was in itself a reason to suspect them and many respondents claimed to be reluctant to put something manufactured into their bodies. Some of them stated that they preferred natural products such as alternative remedies. Britten's informants mentioned various mechanisms by which pharmaceuticals cause damage. For example, some claimed that medicine lowered the body's resistance to infection and disease. Another line of criticism concerned the ways synthetic medicines worked and were used. For instance, some objected that pharmaceuticals only fight the symptoms and not the causes and others noted that pharmaceuticals offered uniform treatments that did not consider the specific problems of the individual patient. Resistance to the use of medicines varied amongst this group and the more moderate attitude was the preference for not taking medicines if it could be avoided, particularly in the case of strong or long-term medication.

The 'unorthodox accounts' that Britten collected from this study can be seen to represent a growing weariness and doubt about medicines. As Whyte and her colleagues note, this seems to suggest that many individuals are beginning to have second thoughts about the medicines and other substances that at one stage were 'welcomed as indispensable tools to keep healthy and stay in control of their lives' (Whyte et al., 2002: 75). 'From medicines they turn into poison, from tokens of care into signs of neglect, from helpers into enemies of nature, from comfort into threat' (ibid). As I will demonstrate below such scepticism towards the value of Western pharmaceuticals is particularly pertinent amongst CAM users.

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<sup>10</sup> One was in a socially deprived area and the other was in an affluent suburb.

## Nature, risk and embodiment

According to Coward (1989) 'nature' is the most important concept in the alternative health movement.<sup>11</sup> Individuals are attracted to complementary therapies not only because of dissatisfaction with conventional medicine but also because of the mythology of nature and health that underpins such therapies. Complementary medicines are frequently described as 'natural', and indeed the term 'natural medicine' is often used as a synonym for 'complementary' or 'alternative' medicines. 'Popular' health magazines such as *Natural Health and Well-being*, books such as *The Natural Remedy Bible* (2003) and *Natural Healing for Women* (1994) and organizations such as The Natural Health Foundation, almost invariably signify the presence of complementary or alternative medicines. One of the CAM practitioners I spoke to described herself as a 'natural therapist':

'I would see it as natural health care, there's no intervention...We're trying to achieve balance, physical, spiritual, emotional balance. To induce the body to heal itself...So by using natural methods in the therapies that I practice, which at this point in time are reflexology and aromatherapy, I am hoping that the body will achieve its own way of healing itself and what I'm doing is creating the right circumstances'.

(Marie, aromatherapist/reflexologist)

The assumption here is that complementary therapies such as aromatherapy and reflexology use natural methods, which are non-invasive and work with, rather than

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<sup>11</sup> According to Szerszynski (2005: 73-4), contemporary forms of alternative medicine, with their belief in the healing power of nature, derive their ideas from a complex set of religious and secular tributaries: 'These include eighteenth century Enlightenment notions of reason and nature, and of progressive control over the human condition, and also Romantic notions of nature from which modern society is becoming increasingly alienated'. The notion of a 'natural lifestyle' was also strongly associated with the counter-culture in the 1960s and 70s. Some of the values of those who identified with this 'counter culture' were an antipathy toward high technology and the distrust of conventional bureaucratic institutions, experts, and objectivity. Goldstein (1999) argues that such concerns overlap with those of alternative medicine, in particular its emphasis on the primacy of low tech and 'natural' solutions. The use of invasive techniques – especially those with iatrogenic consequences is anathema to both counter-cultural and alternative perspectives.

against the body to stimulate the body's natural ability to heal itself. Advertisements for complementary medicines often adopt the term 'natural' to promote their products. In an advertisement for Echinaforce, a herbal medicine for upper respiratory tract conditions, a mother and child are shown with the caption: "As soon as anyone gets a sniffle, I reach for Echinaforce. It is the natural, safe and effective remedy for all my family". Beneath in large print it reads 'fight colds and flu naturally'. Within such popular discourses the message is clear 'nature' is something that can be trusted and 'natural remedies' are a safe alternative to conventional drugs. As Coward (1989) argues 'nature' has a powerful symbolic meaning in modern Western societies, related to virtue, morality, cleanliness, purity, renewal, vigour and goodness. Its dominant position within the ideology of complementary therapies is a major attraction for individuals, for '[n]ature by implication is that which is safe, gentle and has inherent properties which will benefit individuals' (Coward, 1989: 19).

A number of studies have shown that users often do regard complementary therapies as a 'natural' and therefore, safer option to orthodox medicines (e.g. Connor 2004; Lloyd et al. 1993; Sharma 1996; Siahpush 1998). For example, in Sharma's (1996) study many participants were genuinely concerned about the side effects of drugs and were anxious about taking medication that they believed to be made of artificial substances and chemicals. In contrast, the apparent harmlessness of alternative medicine and its concentration on natural products was found to be an attraction. In Lloyd et al's (1993) study 31 per cent of their sample claimed to be attracted to alternative therapy because it was seen to be 'drug free' and 'natural'. In a recent Australian study, Connor (2004) claimed that individuals were using 'natural therapies' as strategies for risk avoidance, whereby being 'natural' was taken to signify a 'lack of danger or risk':

'The use of "natural" therapies can be seen as a counterweight to the diffuse forms of disability and malaise that are often associated with environmental pollution and other threats of modern life, in which the manufactured pharmaceuticals prescribed by doctors are sometimes included' (Connor 2004: 5).

Amongst the participants in the present study the perception that complementary therapies/medicines are 'natural' was a common theme and in many cases acted as a significant motive for use. As illustrated by the following extracts, where individuals discuss their motivations for using particular therapies:

'I mean that's why I tried the aromatherapy, because that is very natural, with the oils, and there's also the Bach's flower remedies, they're all in the herbs, they're all sort of the same sort of thing aren't they'. (Linda)

'Again its [homeopathy] something different to drugs and the remedies are herbal remedies and natural remedies so I was interested in trying it'. (Catherine)

'Its [complementary medicine] sort of natural isn't it, its from, I mean I like to be tuned into nature if possible and I feel that its more natural'. (Sylvia)

However, as Calnan and Williams (1992) note, the category 'natural' is far from self-evident and merits further investigation. When participants were asked why they consider complementary therapies to be 'natural' responses were varied. One interviewee said: 'well just like natural for your body...some of these substances are in your body anyway'. Others spoke vaguely about 'natural' meaning flowers, plants and herbs: 'I tend to think its herbs or fruits or leaves'; 'I think of, they're natural remedies...because it's just raspberry leaf and you put hot water on' or 'Dr Bach [flower remedies] is natural isn't it, all the flowers, flower things'. Many individuals classified complementary therapies as 'natural' in contrast to orthodox medicines, which were seen to be 'artificial', 'synthetic', 'chemical' or 'unnatural':

'The kind of medicines that they [orthodox and non-orthodox medicines] consist of different things, I mean one is, how shall I describe it, chemically made, or whatever, not based on natural.' (Anna)

'It's not synthetic drugs. Western medicines are just drugs, they're not natural, they're just not natural, artificially made.' (Elaine)

Within such discourses 'natural' is set up as the polar opposite of 'chemical'. As Coward (1989) notes the distinction between complementary medicines and orthodox medicines is that the former are not 'synthetic', not artificially produced compounds. By interfering with the compounds of plants and minerals they are converted into something with the capacity to do harm, usually presented as 'chemicals', as in the production of aspirin from willow bark or digitalis from the foxglove. Coward argues that this opposition between 'natural' and 'chemical' is an opposition between something 'original' and something transformed by human activity. In other words, "nature' is only ever dangerous or harmful after humans have interfered' (ibid: 23). In this sense, such discourses also indicate an unease about the nature and pace of technological change in general and the perception that some risks are rooted in, rather than addressed by, scientific developments (Beck, 1992).

A substantial number of participants perceived 'chemicals' as harmful. This is clearly articulated in the following quote where John talks about why he tries to avoid 'chemicals'. By making a comparison between growing his own organic vegetables, without the use of pesticides and using complementary therapies rather than conventional drugs:

'I mentioned that we grow quite a lot vegetables, now I mean I, as far as possible, I use no chemical additives, you know I don't use weed killers and I don't use pesticides, I don't use chemical fertilizers and so on, and I feel it's a similar sort of thing with myself, that chemicals that are manufactured are doing something in a different way, erm, which isn't

consistent with the way in which we've evolved, this is my feeling...I mean I suppose it's something to do with concentrations, that when things are produced synthetically they can be in a much more concentrated form. I mean what's the thing, erm, er, aspirins, the constituent of sodium salicylate, or whatever it is, which was discovered by the fact that people chewed the bark of willow trees and so on, and it would be in a certain concentration, you know you chew it from the bark, but as soon as you synthesize it and manufacture it, then you're producing it in a different sort of concentration. I mean it would be most unlikely that you could commit suicide from chewing willow bark. But you can actually commit suicide by taking aspirins. So it's that sort of feel of the difference of something that's naturally there and something that's synthesized'. (John)

Others expressed similar concerns about the potential harm to the body caused by ingesting 'chemicals' in the form of orthodox medicines. Pharmaceuticals were variously described as 'foreign to the body', 'disabling parts of the body', or 'beating the body into submission'. The most extreme embodiment of the view that conventional drugs are harmful came from Paul, who, although happy to take the Chinese herbal medicines prescribed to him by his practitioner, spoke resentfully about the 'poisonous' effects of 'synthetic' drugs:

'And I don't mind that [Chinese medicines] because they're not synthetic drugs, which I loathe the very idea of taking stuff, which is poisonous to your system'. (Paul)

Whilst not all participants were as negative in their descriptions of conventional drugs, many, like Paul, expressed uncertainty about the effects of pharmaceuticals on the body, preferring whenever possible to avoid them. Indeed, according to Schneirov and Geczik (1998), within many complementary and alternative therapies drugs are seen as foreign substances that violate the body's natural harmony:

‘Drugs are considered an artificially created rather than natural substance, something that contaminates the purity of the body, and an expression of the hubris of allopathic medicine in its claim to suspend natural principles’ (Schneirov and Geczik, 1998: 446).

### **Reflecting on the risks of orthodox medicines**

According to Worsley (1997) the increased public interest in complementary therapies is in part a response to public concern over the safety of orthodox medicines: ‘At one level, the growth of alternative medicines may simply reflect patient’s worries about the side-effects of Western pharmaceuticals’ (ibid: 233). Certainly, many of the participants expressed concerns about the long-term side effects and iatrogenic illness associated with orthodox medicines. For example, one interviewee attributed her reluctance to take painkillers for her sciatica directly to concerns about side effects and uncertainty over the long-term effects of such drugs:

‘I mean it’s not a good idea to be taking painkillers. I don’t like to be constantly taking painkillers, because you read, you know brufen they [doctors] gave me can cause ulcers in your stomach and problems with your throat, and aspirin, well you’re only supposed to take that for a limited period of time...So I was trying to get out of going down the painkiller route...I think it’s because of reading articles where people have had long term problems, and me mum ended up with a hiatus hernia and they said it was due to the long term effects of her taking brufen, for her arthritis. So when you see it happening to other people, it’s too easy to take a painkiller...I don’t know how old you are, but the one thing I do remember is this wonder drug that came forward for morning sickness in women...thalidomide. And you always think alright they reckon they’ve tested it on animals, and I’m not a great believer in testing on animals anyway. But when you’re using chemicals all the time it can’t do you any good, over a long period of time, I just don’t think it can’. (Tina)



Tina's views about the safety of painkillers were in part influenced by personal experience, i.e. the example she provides of her mother. However, 'atrocious tales' (Karpf, 1988) reported in the mass media, such as the Thalidomide tragedy, had also served to undermine her trust in modern medicines more generally. As Wynne (1989; 1996) points out members of the public incorporate into their assessment of risk their pre-established knowledge of how the relevant industries and regulatory bodies have tended to deal with risks in the past.

Others were able to cite similar examples of the negative effects of drugs, either for themselves or significant others and the impact this had had on their willingness to take them. When talking about his reluctance 'to put something that's a manufactured drug inside him', Steve gave various examples of things that he had taken in the past that had produced negative effects:

'Because I've got problems with my sinuses as well and I've been going to the ear nose and throat [clinic] and I was given a sort of nasal spray thing and obviously it's full of, what is it cortisones, and with the condition I've got [ME] it just absolutely floored me, it was like phhhew, and I thought is that it, so I stopped taking it, gave it a week and tried it again, floored again, so I thought must be that, so I did it again and you know I was just reacting so strongly to the cortisones, yet I go and get a herbal thing that sort of helps the condition but doesn't do the rest of my body in, you know. So I'm a bit more open to taking something like that than sort of throwing all these, I don't know, chemical sort of drugs you know'. (Steve)

These accounts suggest that personal experience, knowledge of friends or relative's negative experiences of using medicines, or adverse coverage in the mass media impact on individual's perceptions of the safety of orthodox medicines and their willingness to use them (see also Gabe and Bury, 1996; Ward et al, 2000).

In addition to expressing uncertainty about the safety of Western medicines, many participants were also doubtful about the reliability of expert knowledges concerning the side effects associated with pharmaceuticals. For example, in the following extract Anna justifies her scepticism towards conventional medicines in terms of lack of certainty about their long term effects and doubts about whether medicines presented as safe today will remain so in the future:

‘I think it’s because of what I said before about not knowing what these other things do to your body, and I’m sure that even natural things can cause harm if they’re used in the wrong circumstances, but I think these man-made, invented things can do a lot more harm. And even though they think it’s safe at the moment, there’s lots of stories ten years later they find that it has bad effects on whatever’. (Anna)

This is in line with Giddens’ thesis about how modern reflexivity involves awareness of the contingent nature of expert knowledges and social activity and their susceptibility ‘to chronic revision in the light of new information or knowledge’ (1991: 20). According to Giddens greater knowledge has led in turn to greater uncertainty: ‘The fact that experts frequently disagree becomes familiar terrain for almost everyone’ (Giddens, 1994: 186). With this awareness of uncertainty in the ranks of experts, it is difficult for members of the public to know which advice to ‘believe in’. As a consequence, Giddens argues, trust and faith invested in experts are being eroded.

### **Becoming reflexive**

‘I think once they start to use complementary therapies and think about it and what drugs are doing to their bodies, they’re then more likely to try things from the health shop...Yes I do think they try it, a lot of them then prefer not to take drugs if they can possibly help it and they are better for it’. (Julie, reflexologist).

Macgill (1989) argues that people's perceptions and understandings of risk are established over a lifetime of personal experiences as well as their location within social milieux and networks of communication. These include their use of the mass media and conversations with others as well as expert knowledges:

'Social interaction leads to positions being confirmed, adapted and, in some cases, discovered or expressed for the first time. Positions and arguments which are 'successful' get repeated and so both an individual's own rationalities and the cohesion of particular social groups is maintained and, likewise, the rejection or suspicious appraisal of opposing or threatening positions. Prejudices develop. These are not irrational whims that may be ignored by anyone with a serious interest in understanding perceptions or that can be suppressed by an individual. Rather, they are forces which act as filters to people's openness to the world and are a part of their very being. They are simply conditions whereby what people experience or encounter says something to them' (Macgill, 1989: 57).

As was demonstrated in chapter 5 for the majority of participants the 'naturalness' of complementary medicines, and concerns over the safety of orthodox medicines were, in most cases, not the initial motivation for using complementary medicines. For most participants their reasons for initially trying CAM were linked to 'failed' medical treatments or dissatisfaction with the outcome of a specific medical treatment. However, over the course of using complementary therapies many individual's motivations changed, or they developed secondary and subsidiary motivations that reinforced their continued use of them. For example, many individuals claimed that they had become more cautious about using orthodox medicines, beginning to question previously taken for granted assumptions about their safety, since they had started to use complementary therapies. As a consequence they had started to look for more 'natural' modes of healing for an increasing number of health problems. This is most clearly illustrated in the following quote from Linda, who had only been using complementary therapies for the

past 18 months. She describes how she has already started to question the use of 'chemicals' or drugs, something she said she had not thought about previously:

'I've just taken my daughter recently to the doctors, because she gets bothered with hayfever...and I've got her some tablets and I've come back thinking, there must be an alternative complementary therapy that I can get for that, rather than her taking those, because she ends up taking them for most of the summer. Whereas my views are now starting to change, I mean it was a prescription that she's had last year and the year before, but now I'm getting more into it, she's got the tablets and I'm sort of thinking I must read up and find out what she can have as a natural alternative, which would be far better for her, considering that she does take them for a few months in the summer...Before that I would never have thought about it, but now I'm thinking I shouldn't have taken her there, I should look for something else'. (Linda)

This self-reflexive awareness indicates that in the *process of becoming* a CAM user, motives supporting the use of natural remedies in preference to conventional medicines emerge via changes in the symbolic meanings attached to these substances. In Linda's case, she had come to view pharmaceuticals as harmful to the body and had consequently started to search for 'natural' alternatives for an increasing range of health problems. Nevertheless, she did admit that this only applied to the treatment of minor ailments, for more 'serious' problems she would still always consult her doctor. Also, at the time of the interview Linda was herself still taking certain pharmaceutical drugs such as painkillers and occasionally sleeping tablets. However, she did also say that she was now starting to look for 'more natural' alternatives, as they were 'clearly not doing her any good'.

Similarly, Suzanne claimed that since using complementary medicines she had started to become more cautious about using conventional medicines, but would still be willing to use them for certain problems:

'I think I would be more cautious about what exactly it is that I'm taking, why am I taking these, how long would I need to take them for, how do they work. And I think I would be, I'm probably not as accepting now of just, you know, take a pill for it...I would be more worried about taking things than I have been before....I think I would think a bit more carefully'. (Suzanne)

In contrast Alex claimed that she had reached the point where she would not be willing to use any conventional medicines at all. As a long-term user of complementary therapies, Alex reflected back on how her attitudes towards Western medicine had changed since her initial introduction to complementary therapies twenty years earlier. Initially she had been to see a homeopath to help with a skin condition, after the treatment from the doctor had been unsuccessful. Following on from this she had become interested in complementary therapies and started to question the use of conventional medicines. Over the years Alex claimed to have become 'aware' of the risks of using conventional medicines, through 'talking to others' within her social network and through information gained from the media. As a consequence she claimed that she would now only ever use Western pharmaceuticals as the 'absolute last resort'. This included both over-the-counter medicines such as painkillers, antihistamine tablets, antiseptic creams, and in particular prescription medicines such as antibiotics:

'Oh I wouldn't take an antibiotic, no, no, no [laughs]...well I guess I'm very lucky because I've been healthy, but no I wouldn't...No I would, I can't remember if I've ever taken an antibiotic, I suppose I must have done at some time. But no, I'd be very, very reluctant to embark on a course of antibiotics'. (Alex)

Such data indicate that 'rather than remaining static, risk positions are often constantly shifting and changing in response to changes in personal experience, local knowledge networks and expert knowledges' (Lupton, 1999a: 113). Whilst a small number of

participants claimed to have 'always had an aversion to taking medicines', regardless of whether they were using complementary therapies or not, the majority of individuals had not always considered them as posing a threat to their health and their bodies. Many individuals claimed that since starting to use complementary medicines their attitudes had changed and they had come to view orthodox medicine as harmful to their health. For some individuals, such as Alex, this had resulted in a wholesale rejection of Western medicines, others had just become more cautious about using them.

### **Learning to listen to the body**

Within sociological, anthropological and philosophical discussions of human embodiment it is often argued that we tend not to be highly aware of our bodies unless we are in illness or pain, or experiencing hunger, thirst, sexual desire or other pressing bodily needs (Lupton, 1999c). Leder (1990), for example, describes the body as ontologically 'absent' in this state of lack of consciousness. For Leder the body emerges as a problem most acutely when illness and pain disrupt our actions.<sup>12</sup> This 'reappearance' of the body makes us unusually aware of our physical being and prompts us to search for assistance in restoring our functional capacities. However, as Shilling (2002: 626) notes, this conception of the body as latent is problematic, as it excludes 'non-pathological, active orientations to the body'. Certainly, at a time when the body has come to be seen as a 'project' to be regularly monitored, maintained and developed as an integral element of self-identity (Shilling, 1993; Nettleton and Watson, 1998).

Such active orientations towards the body are particularly relevant in the context of complementary and alternative therapies. Indeed, a number of participants described how they had learnt to become more aware of their bodies through the process of using complementary and alternative therapies, and therefore had become more conscious about the food they ate and the medicines they consumed. Some participants pointed to specific triggers, such as illness or pregnancy that had prompted them to become more focused on what they 'put into their bodies'. For example, Lorraine claimed that she had

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<sup>12</sup> Leder (1990) also identifies changes associated with ageing and pregnancy as making us aware of our bodies.

started thinking more about using alternative medicine when she was pregnant and had become more aware of her body: <sup>13</sup>

‘As I said being pregnant was the main thing for me, but until something actually hits you where you think it’s not actually good for me, I’m not actually doing what my body was designed to do and I think when you realize, when you try to put things in proportion of the hormones, and the different chemicals you have in your body, the adrenalin and whatever that you pump round itself. There has to be balance for that if you’re creating a lot of stress your adrenalin levels are up, then sooner or later it can’t continue, you’re going to have to try to balance it out and if your body, I think we’ve lost the art of our bodies telling us that we need to slow down. But being aware of the fact by holistic medicine is something that you can do to actually try to balance out that treadmill of the mundane things. So yeah, I look at things very differently, knowing that there has to be a fair balance’. (Lorraine)

Amanda spoke about how since going for reflexology and being diagnosed with polycystic ovary syndrome she had begun to realize that she needed to take more care of her body in order to maintain good health:

‘I think what I’ve actually come to realize is that you’ve got to treat your body properly otherwise it will revolt against you or whatever...I suppose that the way I see it is, I see your body as a bit like a car or a machine, in that what you put into it is going to make it run sort of properly’. (Amanda)

However, others claimed that they had started to think about their health and their body differently since using CAM:

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<sup>13</sup> According to Lupton (1999c), in pregnancy, the woman’s embodiment is brought even more to the fore. Indeed, Young (1990: 165) argues that the pregnant woman goes into ‘aesthetic mode’; ‘that is, we become aware of ourselves as body and take an interest in its sensations and limitations of their own sake, experiencing them as a fullness rather than a lack’.

'I've learnt to listen more to my body, I think that is something that we've forgotten over the centuries. I think that our ancestors looked far better at their bodies than we do. We expect them to work and we don't really except the signs early enough, think oh that's normal or something. I think that helped because it's far more subtle than with the way symptoms can be seen with conventional screening or diagnosis. I think, yeah, you learn to become more conscious about it and perhaps learn how it works, when you don't know anything about it.' (Helen)

Previous research on CAM use has also found that through the process of using complementary therapies individuals start to become more bodily conscious. For example, in her study of long term users of homeopathy, Cant (cited in Cant and Sharma, 1999) found they had become more aware of their bodies and tended to monitor physical changes more closely, especially recognizing that these may be a sign that they were emotionally unwell. Many CAM therapies encourage individuals to become more committed to their bodies (Coward, 1989), through body maintenance techniques such as diet and exercise. Such increased awareness and concern for the body may in part explain why CAM users pay particular attention to what they put into their bodies, whether that is medicines or food.<sup>14</sup>

### **Consumption of CAM as risk avoidance**

Connor (2004) suggests that individuals use 'natural therapies' as strategies for risk avoidance, whereby being 'natural' is taken to signify a 'lack of danger or risk'. The continual opposition of 'artificial/chemical' and 'natural/unnatural' can be seen as a response to the uncertainty concerning the safety of Western medicines. If individuals can believe that the medicines they consume are 'natural', then they feel better about taking them. In this sense alternative medicines by virtue of their perceived 'naturalness' provide a welcome alternative as they allow individuals to bracket out the uncertainties

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<sup>14</sup> Many participants also paid particular attention to the foods they ate. Preferring to eat 'natural' foods, that did not contain and 'artificial' ingredients such as additives, preservatives etc.



associated with Western medicines and provide a means of coping with the anxieties associated with caring for health and body within the risk society. For example, rather than use conventional medicines Alex uses a range of complementary medicines, mostly on a self help basis for the treatment of minor ailments:

‘Well if I have a tooth ache I would chew a clove, rather than put on bonjela, or I don’t know take a painkiller...or I would use raspberry leaf tea for menstrual cramp...if I had a headache I’d rather take peppermint tea...I’d rather do things like that, or just go and lie down for half an hour’. (Alex)

When she was experiencing pain and discomfort in her elbows, Tina said that she had no intention of having steroid injections. Rather she preferred to use complementary therapies such as aromatherapy:

‘I’m having problems with me elbows...But she [aromatherapist] made me up some oils to use to massage into me elbows and we’ve now got it under control. Because my husband’s had problems with his elbows and he’s ended up having to go and have steroid injections and there was no way I was going to go down that route, because the thought of having injections. And also you can only have so many and then it doesn’t work anymore, so I thought I would rather persevere with complementary medicine as far as I can and view going to the doctors to get injections or tablets as the last, you know, the last option’. (Tina)

Similarly, when talking about her insomnia, Suzanne said that she preferred to use complementary therapies rather than resorting to sleeping pills, which she perceived to be harmful to the body in the long term:

‘And surely it’s better to see somebody, it’s better for me certainly to see somebody like, to listen to the hypnotherapy tape than it is for me to take a

sleeping pill, you know that's got to be better, because it's not putting in another chemical, it's not, it's a natural relaxation, and it's not doing, and I know that I'm not doing my body any harm. Whereas it would be just as easy to take a sleeping pill and say well that's simpler I'll take that. But again it's chemicals into you're body and I just think there's a real overload of that'. (Suzanne)

In fact several participants expressed dismay over people who they knew who were willing to jeopardize their health by using orthodox medicines over more 'natural' alternatives. As the following extracts illustrate:

'We were with some friends having dinner and it turned out that three guys around the table that were in their fifties were all taking some treatment for their prostate. But two of them had gone to their GPs and were having side effects. So I felt really superior and smirked, you know. Erm, and one of them had come off it and said that the side effects, I don't know what they were, but he said that the side effects were, it wasn't doing him any good and the side effects....And I think people are a bit weary you know, of well you don't know what it's [complementary medicine] doing. And I would say 'well it's less likely to do any harm than what you're doing'. (James)

Similarly, Elaine was expressed frustration about one friend who took large amounts of painkillers, but would not even consider using complementary therapies:

'She got addicted to solphadine, and she was taking a hundred solphadine a week. I used to tell her 'apart from the...', well she would take something for the constipation as well, and she did something to her bowels actually, she was lucky to get away with it. She didn't need an operation but she nearly did...I don't know how she didn't kill herself actually. But she would rather do that than take anything else. And she's

so stubborn, some people are like that and you just can't tell them'.

(Elaine)

For the majority of individuals complementary medicines were seen as representing a 'safe' and 'risk free' alternative to conventional medicines. These data, therefore provide support for Connor's (2004) argument that complementary therapies are used as part of a strategy of 'risk avoidance'. Despite attempts by a number of commentators to draw attention to the 'hidden risks' of using complementary medicines (e.g. Ernst, 2001; Mills et al. 2003),<sup>15</sup> on the whole, the majority of participants viewed complementary therapies as 'safe'. In particular many individuals who were using homeopathy, either via a practitioner, or on a self-help basis, described it as totally 'harmless'. Christine, who had been using homeopathy for the treatment of minor ailments for herself and her family for over twenty years, explained that part of the reason why she felt confident to self-prescribe was because she perceived the remedies to be harmless: 'And that's what's good about it [homeopathy] really is that you can't do any harm with it'. Another participant who also used homeopathy for self help was convinced of the safety of the remedies she took:

'Well you know you can't do any harm with it, because it's so, you know it's quite safe, you know a baby could swallow a whole bottle full and it wouldn't do any harm. Try telling that to some people though [laughs]'.

(Elaine)

However, according to Cant and Sharma (1999) consumers may be under some misapprehension if they automatically associate complementary medicines as being safe, as they point out there have been side effects associated with certain alternative medical

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<sup>15</sup> Ernst (2001) maintains that there are certain hidden risks associated with complementary medicines. Firstly, although rare, there have been deaths and other serious complications associated with certain complementary therapies such as acupuncture and chiropractic. Secondly, he argues that there are risks associated with complementary medicines when they are used as a true alternative to seeking conventional treatments for serious medical conditions such as cancer. Thirdly, there are risks linked to the 'invalid diagnostic techniques' used by many therapists, which in turn may result in false-positive and false negative diagnoses. Finally, he highlights the risks caused by individuals relying on self-help books to 'treat' themselves, rather than seeking advice from a trained professional. These themes will be discussed in more detail in the following chapter in relation to self-medication and CAM use.

products. Yet none of the participants had themselves ever experienced any negative effects from taking complementary therapies. In fact many participants appeared surprised that I had even asked about side effects from complementary medicines. The overall consensus amongst participants was that complementary therapies are natural and natural means safe.

The issue of the safety of complementary therapies and possible side effects associated with treatments was also explored in the practitioner interviews. It is interesting to note the ways in which their accounts correspond with those of users. Many of the CAM practitioners interviewed also described the therapies they practiced as non-invasive and harmless compared to conventional medicines.<sup>16</sup> For example, when I asked one of the homeopaths interviewed whether there are any side effects associated with homeopathic remedies, she said that whilst individuals occasionally have negative reactions to the remedies that may be uncomfortable, they are not harmful to them in any way and usually this is part of the process of healing. She also claimed that the lack of side effects associated with homeopathy was a major attraction for many individuals:

'No not side effects. You can get sometimes erm, slight aggravation. Sometimes symptoms appear to be getting worse before they get better. It's actually, in actual fact it's just the symptoms coming out through the center out. So they're healing...but it can be slightly uncomfortable...On the whole you don't get too many of them and they're not harmful and they will go and they will pass. And it has no side effects and people aren't going to be made ill by homeopathy. It only helps, it doesn't hurt, it doesn't hurt at all it only heals. I think that's, I think that's a major appeal

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<sup>16</sup> However, all practitioners interviewed claimed that they did not actively encourage their clients to stop taking conventional medicines. Whilst many claimed that often individuals came to them because they wanted to stop taking medicines from their doctor, they said that they would always encourage their clients to approach this with caution and preferably with the knowledge of their doctor. In instances where individuals had decided to stop their medicines many practitioners claimed that they would help them to do this gradually over a period of months. However, for certain conditions, in particular more serious conditions such as heart conditions and high blood pressure, many claimed that they would not attempt to help patients to come off of their medicines. Interestingly, two practitioners, both of whom had previously been nurses, claimed that they tried to reintroduce their more sceptical clients to the 'benefits' of conventional medicine.

because it hasn't any side effects and they're not having chemicals so they know that they're going to be helped by it and I think that's a major thing'.  
(Jackie: Homeopath)

Nevertheless, some practitioners were quick to point out that whilst on the whole complementary therapies are completely safe, in certain circumstances they could be harmful, particularly in situations where individuals giving the treatment lack sufficient expertise or training. For example, one of the reflexologists interviewed emphasized the safety of reflexology, which she described as 'totally harmless', but at the same time said that therapies such as aromatherapy were more of a concern because inadequate training could potentially be very dangerous, particularly when practitioners are not aware of contraindications with other medicines:

'It's the thing that's very nice about reflexology because even if you're not going to do any good you're not going to do any harm that way, which is brilliant. Whereas aromatherapy you have to know exactly what you're doing and there are a lot of not so well trained aromatherapists out there that frighten me. Dangerous because there are contraindications that those with inadequate training wouldn't know about'. (Julie: Reflexologist)

### **Dependence upon orthodox medicines**

Despite their reluctance to use conventional medicines many participants were not always 'successful' in their attempts to avoid using them. Indeed, for a number of individuals there had been certain situations when they had felt they had no choice but to use them. In such instances complementary therapies were either not deemed a suitable alternative, usually because of the severity of the condition, or individuals had tried to use complementary therapies for their particular health problem but found them to be ineffective in relieving symptoms. For example, when suffering from a severe sore throat Amanda had tried to 'deal with the problem herself' using various alternative remedies recommended from her practitioner. However, in this instance alternative remedies were

not successful in dealing with the problem and so Amanda felt she had no choice but to go to the doctors:

A: In the summer, I'm saying I've not had a cold, but in the summer I had tonsillitis. And erm, I think it was about two weeks before I went to the doctors and I was really adamant that I was going to deal with it myself. And the end I had to have antibiotics.

L: When you say 'deal with it yourself' how would you do that?

A: Yeah so, well I was just drinking lots of orange juice and gargling with tea tree oil as Marie [reflexologist] makes me. And gargling with salt water and having Echinacea and things like that. What else was I having to do, eating organic natural yogurt.

(Amanda)

The nature of the health problem and the ineffectiveness of complementary medicines in treating it were clearly a factor here. When symptoms became unbearable many individuals were likely to turn to orthodox medicines to obtain relief.<sup>17</sup> For example, despite saying that she liked to keep the medication she takes down to a minimum, when Tina developed vertigo the severity of the symptoms meant she had no choice but to take medication from the doctor. So when I asked her why she felt the need to go to the doctors she was understandably quite taken aback:

L: So when you said for the vertigo you had to go to the doctors, was that just because it was unbearable?

T: Have you ever had vertigo?

L: No, I know it sounds like a silly question...

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<sup>17</sup> That is not to say that they will not return to complementary therapies at a later stage.

T: Have you ever been so drunk that when you lie down and the room spins so bad that you want to throw up?

L: Yes, so it's like that is it?

T: Yes that's the best way I can think of to describe what it's like. I mean it came on so suddenly. I came downstairs one morning, walked into the kitchen and tripped over. And I was looking around to see if there was a cat under me feet. I thought strange, didn't think anything more of it. Walked, came into work, was walking along the corridor, tripped up again, and I thought this is a bit weird. So anyway, we were going out, as part of my job, and I was sitting in the back of the car and I thought, I'm going to be sick, and I just had to say 'you're going to have to stop the car' and I was sick, and I was absolutely red hot, I was sweating and somebody said I'd gone this horrendous colour. Anyway, they got me home and I just thought I've got a bug or something, but when I was standing up or turning around everything was moving...And I went to see the doctor and he said it's vertigo...They [doctor] put me on tablets straight away'. (Tina)

The severity of Tina's symptoms meant that she had not even considered using complementary medicines. However, when the medicines prescribed by the doctor did not significantly improve her symptoms she did later turn to complementary and alternative therapies for help, whilst at the same time continuing to take the medications from the doctor.

Elaine was extremely critical of conventional medicines, describing them as 'powerful drugs, which can't be good for your body' and claiming to have 'always had an aversion to taking drugs. I hate having to take drugs, I really, and I can't wait until they've finished and then I think oh'. However, she claimed to have 'given up' trying to avoid using them, as there were certain medicines that she had to use. For example, Elaine had

osteoporosis and had to take a pill once a week: 'Unfortunately I have to take a tablet every week from the doctors for the osteoporosis'. Elaine's concern about the effects these medicines were having on her health had intensified further after she had recently read an article about the long term harm they can cause to the skeleton:

'I read an article that the tablets that I'm taking every week, after you've been taking it for a few years it has a terrible effect on your skeleton, so I'm not happy about taking them, I don't know what kind of effect, it said it weakens your skeleton, so I don't know what to do about that'. (Elaine)

She said that she intended to discuss her concerns with the specialist on her next visit, although she did not hold out much hope:

'It will be such a poor answer, it'll not be worth it, they'll just say 'oh don't be ridiculous'...and 'well don't take them then'.' (Elaine)

So despite her concerns over the long term effects on her health from taking these drugs. Elaine is resigned to the fact that there is very little she can do about it. This suggests that not only are people aware of their dependency on expert knowledges when it comes to disputes about risk. They are also aware of their lack of agency and opportunity, as 'non experts', to challenge expert knowledges, even if the expert knowledges are uncertain or conflicting (Wynne, 1996; Michael, 1996).

It is apparent from these accounts that individuals are aware of their powerlessness and dependency on orthodox medicine, particularly in relation to the treatment of more serious health conditions. As Lupton (1996b) maintains Western medicine at the end of the twentieth century is characterized by a central paradox. On the one hand it is characterized by increasing challenges to its ability to deliver safe, risk free and effective therapies and assailed by criticism for its lack of certainty. On the other hand, people are increasingly dependent on it as therapy. Whilst, many individuals felt they were able to 'successfully' avoid the use of conventional medicines altogether, particularly in the



treatment of minor ailments. For those with more serious health problems, or conditions such as vertigo, which severely interfere with their ability to function on a day-to-day basis, individuals recognised their dependency on the need to use conventional medicines. However, even though they recognized the need to use conventional medicines in certain circumstances, this does not mean they did so willingly. In the following extract, one 'healthy' participant reflects on how his views of Western medicine and use of pharmaceutical drugs may be entirely different if he was to develop a serious health problem:

'I think I've just been healthy...If it was a different world and I'd had an injury that had actually attained itself and that had affected my whole feeling of myself I might be in the doctors every other week, I just don't know....I don't know what I'd be like if I got a very bad dose of flu or something and it left me with some after effects that were leaving me depressed all the time and after that you pick up more illnesses, I've got no idea at all.' (James)

### **Consumption of orthodox medicines**

Beck and Giddens's work on risk has been criticized for adopting an overly rationalistic and individualistic model of the human actor (Lash, 1993; Alexander, 1996; Lupton, 1999a). Concern about risk, from this perspective, is a rational (i.e. cognitive) response to individuals' perceptions of the uncertainties and growing hazards of life in late modernity. However, according to Lash (1993) contradiction and contingency are more characteristic of contemporary reflexive subjectivity than is allowed by Beck and Giddens. People often feel that knowledges about risk, including their own, are so precarious and contingent that they simply do not know what course of action to take. As a result, they may move between different risk positions at different times, sometimes attempting to control risk, at other times preferring a fatalistic approach that simply accepts the possibility of risk without attempting to avoid it. Although many individuals viewed modern medicines as harmful to the body and in many instances tried to avoid

using them, very few participants could say they never used them. Even the most committed users of complementary medicines and advocates of the ideology of 'natural' healthcare, accepted that there were certain situations when they would use pharmaceuticals.

'I do have painkillers in the drawer, but it would have to be...I would have to be really desperate to take a painkiller, but I can't say I never ever have'. (Alex)

However, as I have already indicated, for these individuals this would have to be the very last resort. In contrast, other participants, despite expressing concern over the long-term effects that chemicals could have on the body and claiming to prefer using 'natural' products over pharmaceuticals, were regularly using some medicines. For example, there were instances, both in the past and present, where Tina, (who talked previously about not wanting to take painkillers or having steroid injections because of the associated risks), was taking medicines prescribed by her doctor. Tina was taking antidepressants and despite also having reflexology at the same time, she said she had no intention of coming off of them:

'I wouldn't say I'd flatly refuse to go to the doctor for anything, but I would say I want to keep the medication I take down to a minimum. Having said that I've got to go back to the doctor at the end of October, he will have to drag me kicking and screaming off the anti-depressants, because with that and, I don't know a combination of that and seeing Marie [reflexologist] on a regular basis I feel fine and I've felt better than I have done for a long time...One keeps me mentally sane and the other one keeps me physically fit and, you know keeps me balanced as well.' (Tina)

I asked whether she had ever been concerned about the effects of taking anti-depressants long term. She claimed that despite having read about the problems associated with this particular drug in the media, this had not deterred her from taking it:

'And I'm on one of them that's been in the papers that's causing all sorts of problems for people. But I've been fine and I've spoken to a couple of other people who are taking them and they've said exactly the same thing, that they'll have to drag me kicking and screaming off them.' (Tina)

So despite being aware of the potential risks of taking these particular anti-depressants Tina was prepared to accept these risks because of her dependence on the benefits they provided. Similarly, Linda who spoke earlier about not wanting to 'put chemicals into her body', told me that she took painkillers everyday for headaches, which she attributed to her lack of sleep. Linda felt that once she had sorted out her sleeping problems she would no longer need to take so many painkillers:

'Well I don't want to be on the sleeping tablets long term, I don't think the doctor would give them to me long term anyhow. But it really is, because when I don't sleep I have bad headaches, so then I have loads of Anadin Extras or Ibuprofen or whatever, so really that isn't doing me any good either, because I possibly take far too many of them...and they will damage my kidneys and everything long term....But if I've had a good night's sleep I don't get headaches...So it's really trying to find something that just sort of relaxes me a little bit more where I can get a bit more sleep, then I can stop taking as many chemicals.' (Linda)

Linda also *confessed* to taking sleeping tablets from the doctor, when the herbal supplements she had tried were not working and she was 'really desperate' for sleep:

'When I get really desperate I go to the doctors and get some sleeping tablets...At the moment I'm not getting much sleep at all. I actually got some sleeping tablets from the doctors [laughs], I've reverted back [laughs]. I was getting tired at Easter so I actually went to the doctors and

I got fourteen tablets this time...But I don't want to get reliant on those that's why I'm looking for alternatives.' (Linda)

These examples suggest that whilst individuals may view pharmaceutical drugs as potentially harmful to their health in general, this does not necessarily result in a rejection of all medicines. Rather, many individuals continue to use certain medicines, whilst at the same time trying to limit the use of others and trying to use 'natural' remedies wherever possible. These examples demonstrate that individuals may view medicines as harmful but still continue to use them, particularly if they feel that they 'need' them in order to be able to function in their day-to-day lives.

In contrast, other participants claimed that they had taken certain drugs, mostly in the past, without thinking about the risks, but had later come to view them as harmful and stopped taking them. For example, following her doctor's recommendation Tina had taken hormone replacement therapy (HRT) after experiencing hot flushes. Initially she said she had not questioned whether or not they were safe. However, she stopped taking them after two years following media coverage about possible risks associated with taking them (e.g. increased risk of breast cancer):<sup>18</sup>

'I did have HRT for a while, but again there started to be articles in the paper about long-term effects. Cos I was starting to go through the, I wasn't starting to go through the menopause but I was starting to get hot flushes. But it's taken from horses, and then I thought oh I'm not so keen on this, let's try, let's go without it for a bit and see how we get on, so...Well I felt well and actually kept forgetting to take them as well...and I talked it over with Marie [reflexologist] a few times...I didn't actually say anything to the doctor at the time.' (Tina)

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<sup>18</sup> Research on the use of HRT has demonstrated that despite medical assertions that HRT is good for health, many women are concerned about side effects and unknown risks. In particular they worry about disturbing natural processes and the possible contaminating effects of putting chemicals into their bodies. Thus, they try to avoid taking it except as a last resort, when menopausal symptoms are severe (Hunter et al., 1997; Green et al., 2002).

Tina said that if the symptoms started to return she would now prefer to try complementary medicines such as evening primrose oil or go to a Chinese herbalist rather than use HRT: 'I think I would try different routes before I went back on the HRT'. According to Ward et al (2000) on a normal, everyday level, consumers do not think about the risks of the medicines they are ingesting. However, new information about the risks of particular medicines often prompts them to reflect on the risks of *all* medicines and the expert status of medical knowledge. In Tina's case reading about the potential risks of taking HRT in the newspapers had changed her feelings about how safe it was.

Similarly, Anna claimed that she had been taking the contraceptive pill for years but only recently started to think about the long term effects it could be having on her body:

'I did use to take the pill, but then I stopped taking it...I thought, oh hang on, try to eat healthy and not resort to painkillers to quickly but then still take the pill, which is probably, does lots of things to your body. And I'd never thought about it because I'd been taking it for a while and doctors never talked to me about possible consequences, until here in the university health centre actually. Yeah and I started thinking about it and I thought hang on...because you know my mum died of cancer and it was breast cancer and so I was really worrying about it. And I'd been taking the pill for such a long time and it was like a habit and I'd not really been thinking about it. But then, when my mum as well...So I asked the doctor, I said 'look', you know. So we discussed it and I had been taking it for a long time and she didn't seem very keen for me to continue with it. So she asked me to go away and think about it and I thought yeah I really don't want to take it anymore'. (Anna)

In Anna's case, however, her mother's death from breast cancer had prompted her to think about the long-term risks of taking the contraceptive pill and acted as a trigger for behavioural change. Such examples demonstrate that taking medicines is often a

routinized activity and mostly individuals are not constantly attuned to the 'risks' associated with them. Indeed, protecting individuals from continual uncertainty over every area of their life is the sense of normalcy that comes from bracketing most risks and dangers as remote and of no relevance (Green et al, 2003). Using Goffman's notion of the *Umwelt* (the socially accomplished physical and social environment within which the individual can securely sense safety and danger), Giddens, (1991: 129) suggests that trust, in both individuals and abstract systems, contributes to a 'protective cocoon' which enables most of us, most of the time, to push most risks into the background as unlikely to impinge on our security. Only in 'fateful moments', or when trust breaks down, are we faced with managing the consequences of risk assessment.

### **Children, risk and complementary therapies**

'In our everyday world generalized risks, of the kind Beck (1992) associates with the democratization of risk, are deemed more pernicious when they threaten children's well-being'. (Jackson and Scott, 1999: 86).

Complementary therapies are used frequently for children and the trend appears to be increasing (South and Lim, 2003). In a recent Australian study, South and Lim (2003) found that parents are often attracted to using complementary therapies for a number of reasons, namely, because they are deemed more 'natural'; because they feel that mainstream medicine has somehow failed them, or because they desire more control over their children's health care. Many participants in this study had used complementary therapies for their children,<sup>19</sup> in particular over-the-counter remedies that were seen as a 'gentler' option for the treatment of minor ailments:

'My eldest daughter has been a terrible, terrible sleeper since a baby...and I tried baby massage, went to baby massage classes and used that...and I tried things like chamomile herbs'. (Chloe)

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<sup>19</sup> Only 6 participants had children who were still living at home, however all of these had used some form of complementary therapy for their children. This was mostly on a self-help basis, although 2 of them had also taken their children to practitioners.

'I've used it [homeopathy] on my kids ever since they were babies. Erm, mostly self, you know I did the diagnosing and you know sometimes it worked and sometimes it didn't...And then when the kids were small my son had a lot of ear problems so I started taking him to a homeopath, you know for sort of fuller work. So both by son and my daughter have had it from an early age'. (Christine)

However, many of these individuals claimed that they were slightly more cautious about using complementary therapies, over conventional medicines, for their children than they were for themselves. For example, Lorraine was extremely reluctant to use medicines for herself but when it came to her children she said she would be much more likely to take them to the doctor:

'Before I went to the doctor I'd try to go to the doctors as a last resort erm. I'm confident enough to do that with myself but when it comes to dealing with the children I'm a bit more scared, because I don't know enough about it, I'd always seek medical advice'. (Lorraine)

However, in Lorraine's case she was only using complementary therapies on a self-help basis and indicated that this was the main reason why she did not feel confident about prescribing treatments for her children. She claimed that if she had the opportunity to take them to a CAM practitioner she would be much more willing to use them:

'I've just heard from the hairdresser I use that she's actually having a herbalist lady coming in, a homeopathic advisor. So she's going to be there, and that's actually quite exciting for me to be able to go along and say to somebody that my child is suffering from this rash or whatever, because I would definitely use her, to consult her to see if she could handle it before I put them on antibiotics or any sort of creams that contain something'. (Lorraine)

Similarly, Emily said she had tried various homeopathic remedies out on her daughter when she had been ill, but for anything 'serious' she would always take her to the doctor:

'I've used them on Charlotte [daughter] a couple of times, but I mean its fine it's perfectly safe for children. You can't really do yourself much damage with it....But I think, because this is obviously the way I'm programmed, because erm, I'm still very much if it's serious see a doctor, I would initially give her something homeopathic, erm and if it didn't work, or there wasn't any improvement I would consult a doctor...you're a bit more careful with kids. Because, you know, I don't really want to feel like I'm experimenting on her' (Emily)

Christine claimed that one of the reasons she first got interested in using complementary therapies was because she did not want her children to be 'fed on antibiotics'. However, again when it came to more serious problems she said she would be more likely to take them to the doctor:

'The concern that every time that I took my son to the doctor, you know with the glue ear and everything, it'd be antibiotics and you know I didn't want them to be fed on antibiotics right from when they were small, so just to keep the antibiotics down, some occasions they had to have them...But just use the homeopathy whenever possible. I would still go to the GP for things, probably didn't have the confidence, well you don't with a child you know, you can't know whether it's going to be something really serious, so just treat minor things'. (Christine)

Such data demonstrate a conflict in parents desire to 'do the best' for their children. On the one hand, parents want to protect their children from the harmful effects of Western medicines and so prefer to give them 'natural' products. However, on the other hand they have a responsibility as parents to ensure the well being of their children. Therefore, if they choose not to give their children conventional medicines and the child's condition becomes worse, or turns out to have required medical intervention, they themselves will



be held responsible. According to Beck and Beck-Gernsheim (1995), individualization renders each parent uniquely responsible for their children. Consequently, many parents did not display the same levels of confidence when it came to decisions about their children's health, as they did their own. The following extract, where one participant talks about what happened when she opted not to have her child immunized against whooping cough, indicates how parents are likely to be seen as culpable when they do not adhere to medical advice concerning their children:

'We opted not to have my son immunized against whooping cough. So we had all the other things, but not the whooping cough. And that was because there was some talk at the time about, was there supposedly some connection with brain damage?...And then my son...he developed this terrible cough and that was the year it was supposed to be a terrible whooping cough epidemic...and this horrible, horrible doctor came out took one look at him and said 'yes that's whooping cough'. And of course I felt terrible, erm, he sent the health visitor around in the morning and he [son] was scampering around the floor, you know running around and she said 'are you sure he's got whooping cough?' and I said 'I don't know I'm not the doctor, that's what the doctor said to me' and she said 'oh I don't know'. And she said 'it sounds like croup to me'. Well it was croup. But erm, he [doctor] sent a student...he said, you know it's like you're bad parents and he just stood there shaking his head...So we then rushed out and had him [son] immunized....And this student was saying 'and if you have other children do you think you'll have them vaccinated?' and I said 'oh yes of course, yes'. And she's [daughter] had the whooping cough vaccine'. (Christine).

However, in contrast to some of the other more cautious parents, one participant showed a surprising level of faith in homeopathy and other types of complementary therapies, when it came to both herself and her children. She said she would only take her children to the doctor or give them conventional medicines as the absolute last resort. She had regularly treated all three of her children with homeopathy, both at home and by

taking them to a homeopath. In her view she felt that she was doing the best for her children, and their future health, by not subjecting them to the harmful effects of orthodox medicine:

‘I just think, I had so many drugs when I was a child, I had penicillin and you know I had loads of stuff. And I think partly that’s why I have so many migraines, I’ve just had so many drugs basically. So erm I don’t want to go down that route with them [children], whatever I give them I want it to build them up for the future, rather than erm, er, undermine their sort of overall health. It’s not this week and next week that’s important it’s the next year and the year after that, and you’re undermining someone’s strength by giving them these drugs then eventually you’re going to end up with something really serious you know, chronic’.  
(Laura)

However, Laura’s husband did not share her belief in the effectiveness of homeopathy and at times this created conflict between them, particularly when he felt that she needed to take the children to the doctor. For example, when her daughter had ‘worms’ her husband had wanted to take her to the doctors and get some medicine to treat it, however Laura insisted on treating her daughter herself using herbal remedies:

‘So David [husband] and I had a sort of a bit of a bust up about what we should do about it. He wanted her to go to the quack, the next day and it was Saturday morning emergency surgery and I wanted to wait and order some medicine on Monday, to get some herbal...So I wanted to wait and he didn’t. So I lost...we went on the Saturday morning and took her to the GP and he said ‘oh yes we’ll give her this tablet’, you know worming tablet, and so we gave it to her, and the next day she was absolutely covered in eczema, sort of bright patches of red, raised skin, boiling hot all over, it was an allergic reaction to the tablet obviously...So I said to

David, ok we've tried your way now we'll do it my way. So I sent off for the herbal stuff and it worked'. (Laura)

Such examples again draw attention to the contingent nature of risk positions. Whilst individuals may feel confident about the health choices they make for themselves, when it comes to their children a whole other set of issues come into play. The decisions that parents make when their children are ill are not only influenced by the fact that they are responsible for the care of their children, but also by the fact that they are held responsible for their children's well-being should they come to harm (Jackson and Scott, 1999).

### **Conclusion**

For the 'risk society' perspective, reflexive awareness and concern about risk pervade modern sensibilities, creating new forms of relating to the self and others, including experts and institutions (Lupton, 1999a). Doubt and uncertainty, according to Giddens (1991), are pervasive features of modern life. 'Thinking in terms of risk and risk assessment is a more or less ever-present exercise, of a partly imponderable character' (1991: 123-4). When it comes to the body such concerns are further intensified as many of these risks are seen to 'directly threaten the integrity or health of one's body' (Lupton, 1999a: 124). Giddens himself argues that the body is 'perennially at risk', and must therefore be 'chronically guarded and succoured – in the immediacy of every day-to-day situation as well as in life-planning extending over time and space' (1991: 126). In such a context individuals pay specific attention to what they put into their bodies, whether this be the food they eat or the medicines they consume. Kroker and Kroker (1988) use the term 'panic bodies' to describe the emotions that people feel about their bodies and the threat of penetration by a range of phenomena that are currently deemed to be malign, such as viruses and bacteria, pollutants, food, drugs, other people's bodily fluids. Amongst participant's accounts the view that bodies are contaminated and subject to threat from 'chemicals' was a recurrent theme. A number of theorists have suggested that the reason why individuals have come to pay so much attention to their bodies in

recent times is because they represent a site over which they can exert some control (see for example, Shilling, 1993). Thus, whilst our social, economic and environmental contexts may be characterized by increasing risk and uncertainty, our bodies may be more amenable to management and manipulation:

‘Investing in the body provides people with a means of self expression and a way of potentially feeling good and increasing the control they have over their bodies. If one feels unable to exert control over an increasingly complex society, at least one can have some effect on the size, shape and appearance of one’s body’ (Shilling, 1993: 7).

As Whyte and colleagues (2002: 3) note, medicines ‘are the most personal of material objects, swallowed, inserted into bodies, rubbed on by anxious mothers, used to express care and intimately empower the uncertain individual’. It is perhaps not surprising then that in a society where concern for the body has come to the fore, increasing numbers of individuals have become anxious about taking substances that they believe have the potential to cause harm to their bodies. Over recent years, the intense media attention given to ‘drug disasters’, such as the Thalidomide tragedy and the debates about MMR, have served to intensify uncertainty surrounding the safety of pharmaceutical drugs (Worsley, 1997). Clearly, individual reasons for rejecting or resisting medicines vary, from worries about dependence, tolerance and addiction, to issues relating to identity such as problems of disclosure and stigma. However, amongst the participants in this study the main reasons for rejecting medicines appeared to be concerns and uncertainty surrounding their safety. The majority of participants were particularly anxious about the safety of orthodox medicines, which were seen to represent a threat to the health of the body. Individuals perceived orthodox medicines as ‘risky’, producing negative side effects and iatrogenic illness, resulting in a marked decline in use. These data therefore provide some justification for the Beck (1992) and Giddens (1990; 1991) position, highlighting the emergence of the ‘reflexive consumer’ in late modernity. In contrast, the apparent harmlessness of complementary medicines and their concentration on natural products was seen to provide a significant incentive for using them. If individuals

believe that the medicines they consume are natural, rather than chemical or artificial, they feel better about using them. And as Coward (1989:19) maintains natural therapies are regularly promoted as being 'safe, gentle, kind to the body, and working with the body'. This provides support for Connor's claims that use of complementary medicines can be seen as a strategy for risk avoidance or 'antidote' to living in a risk society (Connor, 2004). The decision to choose 'natural' medicines over conventional medicines enables individuals to 'navigate around a risky world', helping to stabilize self and society in a world understood as permeated with risk and hazard (Szerszynski, 2005:138). The 'natural' emerges and remains as a source of orientation for action and a critical standard against which medical practices can be judged (Schneirov and Geczik, 1998).

Nevertheless, this chapter has also demonstrated that the ways in which individuals make sense of and respond to risks is complex and contingent. First, I have shown that individuals are not always 'successful' in their attempts to avoid the risks of Western medicines. Many individuals were able to cite instances where they felt they had no choice but to take orthodox medicines. This provides support for Lupton's (1994) assertion that modern medicine is characterized by both criticism and scepticism and at the same time dependency upon therapies. Furthermore, this suggests that whilst complementary medicines may be on the increase, biomedicine has not yet lost its hegemonic position (Saks, 2003). Secondly, as Lash (1993) contends, contradiction and contingency are more characteristic of contemporary reflexive subjectivity than Beck and Giddens allow. Despite demonstrating an awareness of the 'risks' of medicines for some individuals this did not necessarily result in their disuse. Finally, this chapter has shown that, rather than remaining static, risk positions change. Over the course of using complementary therapies individuals reassess their views of orthodox medicines and as a consequence many individuals either reduce or eliminate their use of them altogether. Social networks proved important in informing perceptions of risk here. As did information obtained from the mass media and direct personal experiences of the negative effects of modern medicines.

According to Giddens (1991), the questioning of scientific knowledge and expert systems is related to an increase in the knowledgeability of the public. Giddens suggests that individuals are increasingly informed and reflexive, especially as knowledge has become pluralized. In such a context it is likely, Giddens argues, that individuals will attempt to 're-skill', by taking back some control from the 'experts' and by searching for alternatives. The next chapter explores these issues in relation to the consumption of complementary and alternative therapies for self-help purposes an area of CAM use that is often omitted from social scientific studies of CAM.

## **‘I like the control of it’: Self-care practices and complementary therapies**

### **Introduction**

Most of us experience illness at some point in our lives and make certain decisions based on our experiences of illness. For instance, we have ideas about when illness warrants a visit to the pharmacist or when to go and see the doctor. However, orthodox medicine is only one of several healing systems available in modern Western Societies. The increasing availability of complementary and alternative medicines has meant that individuals now have a range of health-seeking options to choose from. As Shilling (2002: 633) writes:

‘The continued increase in complementary/alternative medicine in western [*sic*] economies provides consumers with greater choice, while the diversity and increasing status of many therapists presents a challenge to the medical monopoly enjoyed by orthodox professionals’.

In this sense the consumerist public is presented with the possibility of ‘shopping’ for care and cure (Blaxter, 2004). Individuals may choose whether or not they want to consult with their doctor over a specific health complaint or whether perhaps they would rather try out one of the many alternative healing modalities. A significant, yet often neglected aspect of this growing area of consumer choice is the range of complementary and alternative medicines available for self-treatment. As Saks (2004) notes most CAM practice occurs on a self-help basis. This is indicated by both the expansion of over-the-counter (OTC) remedies available in many supermarkets, health food stores and chemists (Bakx, 1991) and the ever increasing number of books, self help manuals, health magazines and newspaper columns which provide consumers with information on how to

use such products. The House of Lords Select Committee on Science and Technology (2000) estimated the total annual sales of herbal products to be between £93 million (for the retail sector) and up to £240 million per annum (including direct sales, Internet sales and mail order), with signs of continuing strong growth. Data from a report by the market research company Mintel (2003) on CAM, estimated the sale of over-the-counter preparations to be worth £130 million in 2002, having increased by 45% since 1997. Mintel (2003) also predict that these figures will rise sharply over the next few years and the market will be worth almost £200 million by 2008.<sup>1</sup> Therefore, it seems surprising that current CAM research does not reflect this trend. Whilst some commentators have discussed the importance of this area of CAM, (e.g. Bakx, 1991; Coward, 1989; Rayner and Easthope, 2001), to date CAM research has tended to focus almost entirely on practitioner based CAM use. Indeed, in a recent article exploring the relationship between women's health and the use of complementary and alternative medicine, Adams et al., (2003: 157) called for more research relating to this aspect of CAM use:

‘One major area would be research on usage of ‘over-the-counter’ CAM medicaments. This is now a billion dollar industry and yet there is little sociological research into the reasons why women choose certain products rather than others’.

This area of CAM usage is of particular interest, primarily, in relation to Shilling's (2002: 633) suggestion that ‘the commodification of therapies by the direct sale of over-the-counter preparations to consumers, furthermore, enables people to invest in ‘health’ outside of significant contact with health professionals’. Drawing on the interview data in this chapter I focus specifically on the use of complementary and alternative therapies for self-treatment.<sup>2</sup> A significant number of participants in this study used

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<sup>1</sup> These figures only include the consumption of homeopathic remedies, herbal medicines and aromatherapy essential oils, excluding Chinese herbal products, Ayurvedic medicines, natural supplements, vitamins and minerals and Royal Jelly, suggesting, therefore, that consumption of over-the-counter remedies is likely to be even more significant.

<sup>2</sup> By this I refer to the consumption of over-the-counter CAM products such as, herbal supplements, homeopathic remedies, aromatherapy essential oils and other types of ‘natural’ remedies. I do not include vitamin and mineral supplements here, even though a number of participants were using them. The terms self-care, self-medication, self-treatment and self-help are used interchangeably to refer to such practices.



complementary therapies on a self-help basis. Indeed, some participants had only used them in this capacity, having never consulted with a CAM practitioner. In this chapter I will discuss patterns of usage, i.e. which complementary therapies participants use and the sorts of health problems they are used for; how individuals obtain information and develop knowledge about using CAM for self-care and whether such medicaments are used as either an alternative or a supplement to formal health care. I will then discuss the implications of this 'hidden' aspect of CAM use, in relation to the role of expert knowledge and professionals in modern Western societies. It could be argued that the use of complementary therapies for self-care purposes is 'symptomatic' of a more general questioning of expertise and professionalism (Kelleher et al., 1994) and the erosion of authority within the risk-oriented world of late modernity.<sup>3</sup> Giddens (1991) suggests the public is increasingly informed and reflexive, especially as knowledge has become pluralized. In such a context it is likely that individuals will attempt to 're-skill', by taking back some control from the 'experts' and by searching for alternatives. There is evidence that the public have increasingly endeavoured to re-appropriate knowledge for themselves, with many accounts of health knowledge highlighting resistance to the grand narrative of professionally dominated medicine (i.e. Williams and Popay, 1994; Fox, 1991; Monaghan, 1999). In this chapter I consider whether the use of complementary and alternative therapies for self-care purposes constitutes a further dimension of this reflexive nature of modern societies.

### **Self-treatment and medical dominance**

Self-care practices and the idea of individuals taking responsibility for their own health is not new. Indeed, as Dean (1989: 118) emphasizes it is 'the oldest and most widespread of all forms of behaviour that affect the health of individuals'. As late as the eighteenth century most people medicated themselves, or changed their lifestyle when ill, and tended not to seek the help of medical practitioners (Porter, 1992). Medical sociologists have long recognised that self-care and non-conventional modalities constitute the bulk of

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<sup>3</sup> The growth in use of such complementary health practices is also obviously a reflection of the increased availability of over-the-counter CAM products in supermarkets, chemists, health food stores and the Internet, providing greater consumer choice.

health care interventions (see for example, Dean, 1989; Dunnell and Cartwright, 1972; Friedson, 1960; Kleinman, 1980; Levin and Idler, 1981; Zola, 1973). Over twenty-five years ago 'the symptom iceberg' was identified by Hannay (1979), which revealed that the majority of symptoms were self-treated. Use of self-treatment has also been the subject of more recent studies (e.g. Blaxter and Paterson, 1982; Cornwell, 1984; Cunningham-Burley & Irvine, 1987; Reed, 2003; Rogers et al. 1998, Stevenson et al., 2003; Thorogood, 1990). It is clear from such research that individuals deal with their symptoms using a range of options beyond seeking professional care. For example, in a recent study of community health care utilization, Rogers et al., (1999) revealed that the most common response to illness was to self-medicate with products purchased over the counter. The vast majority of efforts to maintain health take place in the home and other private spheres of action, including diet, rest, recreational exercise and relaxation, hygiene, adequate shelter, avoidance of dangerous substances, and prevention of accidents and injuries. Likewise, most health care takes place in the home and is either self-administered or given by members of the family. Virtually all care of minor illnesses occurs outside the formal health care system (Worsley, 1997). Even for health problems that have been treated in the formal system, most of the actual care is done at home: giving medications, tending a person restricted to bed, changing dressings, and monitoring symptoms (Freund & McGuire, 1999). Thus informal care and self-treatment constitute an important, but often hidden aspect of the supply of health care (Rogers et al. 1998).<sup>4</sup>

Medicine has assumed a powerful position within contemporary society (Foucault, 1973). Since Parsons (1951) developed the concept of the 'sick role', the patient has been defined in relation to the more powerful role of the doctor. The literature has provided various accounts of the way medical professionals use their 'social monopoly of expertise and knowledge' (Turner, 1995: 47) to manage encounters and perpetuate their position of power. Proponents of the 'medicalization thesis' viewed medicine as a powerful institution of social control. Within the medicalization thesis, it is argued that medicine

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<sup>4</sup> Data from this study also suggests that self-care practices are used alongside biomedical care, for example some individuals used complementary therapies on a self-help basis after having surgery.

constructs, or redefines, areas of normal life as medical problems (Nettleton, 1995), by claiming expertise about areas of life which had previously not been regarded as medical matters, areas such as ageing, childbirth, alcohol consumption and childhood behaviour (Conrad and Schneider, 1980).<sup>5</sup> Illich (1976), attributed medicalization to the increasing professionalization and bureaucratization of medical institutions associated with industrialization. For Illich, the expansion of modern medicine created a dependence on doctors and took away people's ability to engage in self-care. Zola (1972) too, argued that medicalization is rooted in the development of an increasingly complex technological and bureaucratic system and a reliance on the expert. By transforming: 'pain, illness and death from a personal challenge into a technical problem, medical practice expropriates the potential of people to deal with the human condition in an autonomous way and becomes the source of a new kind of un-health' (Illich, 1974: 918). In other words, the pervasion of and reliance upon 'expert systems' in all areas of social life has led to the 'de-skilling' of those individuals without access to the knowledge and a devaluation of 'lay' and 'local' knowledge (Illich, 1976; Zola, 1972), thus serving to undermine people's autonomy and competence (Williams, 2003). Self-care and care for ones own family and friends thus, become regarded as inferior to that provided by trained health professionals (Nettleton, 1995). Most proponents of the medicalization thesis, advocated the 'empowerment' of patients, encouraging people to 'take back control' over their own health by engaging in preventive health activities, assuming the role of 'consumer' by challenging the decisions and knowledge of doctors in the medical encounter, joining patient advocacy groups and avoiding medicine by seeking out alternative practitioners (Lupton, 1997).

Nevertheless, the claims of the medicalization theorists have been criticized for underestimating people's ability to resist medical ideas and rely on their own knowledge and experiences (Nettleton, 1995).<sup>6</sup> Resistance to medical control is not new. For the

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<sup>5</sup> According to Conrad (1992: 211) medicalization consists of 'defining a problem in medical terms, using medical language to describe the problem, adopting a medical framework to understand a problem, or using medical intervention to "treat" it'.

<sup>6</sup> The medicalization thesis has also been criticized for its rather black-and-white portrayal of Western medicine as largely detracting from rather than improving people's health status. Of doctors as intent on increasing their power over their patients rather than seeking to help them. And of patients as largely

women's movement of the 1970s the medicalization of birth and human reproduction was a key issue, and self-care in their terms expressed a wish for autonomy, self-determination and independence from male medical authorities (Kickbusch, 1989). *'Our Bodies, Ourselves'*, first published in 1972 by the Boston Women's Health Book Collective, was the first of a wide range of texts teaching women self-care skills. More recently, there has been a popular reaction against the process of medicalization, as people increasingly try to take more control over their own health (Nettleton, 1995). Drawing on arguments about modernity as a reflexive social order, 'risk society' and lay re-skilling, Williams and Calnan (1996) suggest that in late modernity there is a far more critical relationship between medicine and the lay populace and that trust in medicine increasingly has to be won and maintained in the face of growing public awareness of the risks as well as the benefits of medicine and the limits of medical expertise. It is in this context that re-skilling or the re-appropriation of knowledge takes place as lay people interpret the information produced by medical experts, both individually and collectively. Examples, include the reaction of the HIV/AIDS movement, where activists have successfully challenged medical control and shaped the nature of AIDS research and funding (see for example, O'Connor, 1995), the growth of self-help groups, seen by some as representing a challenge to modern medicine (Kelleher et al. 1994) and of course the growth of interest in and support for complementary and alternative medicines. Cant and Sharma (1999) contend that the use of alternative medicine requires the user to move from a dependent position as patient to an active one as consumer.<sup>7</sup> Other developments such as the apparent rise of consumerism with individuals rejecting, or being encouraged to reject, passive trust in medical expertise, are seen to represent a challenge to medical dominance (Gabe et al., 2004, see also Kelleher et al., 1994). At the

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helpless, passive and disempowered, their agency crushed beneath the might of the medical profession (see for example Atkinson, 1995). In addition, in their attempts to denounce medicine and to represent doctors as oppressive forces, proponents of the medicalization thesis have been accused of failing to recognize the ways that medicine may contribute to good health, the relief of pain and the recovering from illness, or the fact that many place value on these outcomes (see Lupton, 1997). They have also been criticized for failing to acknowledge the ambivalent nature of the feelings and opinions that many people have in relation to medicine, or the ways that patients willingly participate in medical dominance and may actually seek 'medicalization' (see for example, de Swaan, 1990 and Broom and Woodward, 1996).

<sup>7</sup> However, as discussed in chapter 3, some commentators have suggested that complementary therapies and self-care practices can also be seen as an extension of 'medicalization' (e.g. Crawford, 1980), involving both de-medicalizing and re-medicalizing tendencies (Lowenberg and Davis, 1994).

same time, the increased availability of information relating to matters of health and illness, through outlets such as the Internet, is said to have led to an increase in 'information rich' consumers of health care, with the potential to challenge the authority of their clinicians. According to Hardey (1999; 2001) the information people can access on the Internet represents a challenge to medical dominance. It increases the potential people have for 'shopping around' for health care, and for second opinions unmediated by their physician. It also means that doctors may be used as secondary, rather than primary, sources of health advice. The Internet provides individuals with numerous avenues through which information about a condition can be gathered, and with unprecedented opportunities for checking diagnoses and prescribed treatments.

### **Self-care practices and complementary medicines**

The majority of participants in this study were, either currently using some form of CAM for self-help purposes, or had used it in the past. Of the 24 participants, 21 had, at some point purchased complementary medicines and used them to treat either themselves or a family member. In fact 3 of the participants had only ever used CAM in this capacity, never having consulted with a CAM practitioner. The range of CAM products used by participants for self treatment included homeopathic remedies, herbal supplements, Dr Bach flower remedies, aromatherapy oils and 'traditional' home remedies such as honey and lemon for colds (see Appendix 3: Table 6.1 for full list of CAM products used). However, from the interviews it emerged that the degree to which individuals incorporated such CAM products into their everyday health regimens varied quite considerably. Some individuals only purchased complementary remedies very occasionally. On the whole these individuals did not tend to go out of their way to search out particular CAM products. For example, despite having used a wide range of complementary therapies including chiropractic, hot stone therapy, osteopathy, reflexology and aromatherapy massage, Suzanne used very few complementary medicines for self-treatment:

'I haven't really used things like the Bach flower remedies or anything like that, I've never used those. I do use herbal supplements, you know from time to time, you know things like Echinacea and that type of thing. But I haven't really used those things that much...I'm not very good at sort of keeping up with taking them, so I'm not a very good test to ask if they work because I don't quite stick with it long enough'. (Suzanne)

Similarly, when asked whether she consumed any over-the-counter medications Chloe, who was currently seeing an acupuncturist for M.E., said that although she had tried a few different things such as Echinacea, which her sister-in-law had recommended, on the whole she had not gone searching for things to take for either her present condition or any other ailments she had had:

'I've used arnica before...I've got an aunty who is a homeopath...When I had Rachel [daughter] I ended up having an emergency caesarean and afterwards she bought me this little packet of arnica to take for the healing process. So I'm open minded to try things, I just don't necessarily go out and about looking for them'. (Chloe)

In contrast many other participants regularly used a wide array of different remedies for a range of health problems. For example, Elaine was currently using a vast amount of over-the-counter products on a regular basis, including: herbal supplements, Dr Bach flower remedies, magnet therapy, homeopathic remedies and aromatherapy oils. In the following extract she talks about the different homeopathic remedies she regularly uses:

'If I'm playing in a concert I get a bit, sometimes I get very scared and I come out in these blotches...So I take *argent nit* for that and it's excellent...*Arnica* if you're going on a flight, if you're tired, traveling and things...I've got a delicate stomach so if I'm going to anybody's dinner party...if you take *nux vom* before then you don't have any after effects...*arsen alb* for if you've got food poisoning and diarrhea...I wear

contact lenses and I always get infections in the eyes...And I thought oh I'm going to try this *euphrasia*...Peter's [husband] always sea sick if we go on a sea journey...if you take *cocculus* before you go, and whilst you're on the journey it stops the sea sickness'. (Elaine)

When I asked Steve whether he had ever used over-the-counter remedies, he said that he was currently using them 'all the time'. This included various herbal supplements taken for health problems such as hay fever, sinuses and catarrh, Echinacea, used mostly for treating colds and flu and also to 'boost the immune system', tiger balm and menthol crystals used for when he has a headache and he regularly uses aromatherapy oils for relaxation. In addition to those remedies he has prescribed for himself, Steve also takes a number of supplements prescribed to him by his naturopath and his homeopath for treating chronic fatigue syndrome.

Previous research has demonstrated that self-medication is primarily used for the treatment of minor ailments (e.g. Cornwell, 1984; Helman, 1978; Thorogood 1990). According to Worsley (1997), for minor illnesses people consult their GPs only about one in five times when they feel ill. Recent research has suggested that individuals are more likely to use complementary and alternative medicines for general illnesses such as colds and flu, whilst drawing almost solely on Western medicine for serious illnesses such as diabetes and cancer (Reed, 2003; see also Thorogood, 1990). This corresponds with findings from the 2003 Mintel report on use of complementary medicines. Data from this research revealed that the conditions that alternative remedies are most likely to be used for are those not easily treated by conventional medicine, such as back pain, sleep problems and stress. However, complementary medicines may also be chosen where the conventional option is considered to be too strong or have too many side effects. Complementary medicines are also used in the treatment of minor ailments, such as migraines, coughs, colds and flu and hayfever, as well as being used for preventative measures (Mintel, 2003). Nevertheless, studies on CAM use amongst people with diseases such as cancer and HIV/AIDS have also found high levels of use of over-the-counter products, such as herbal medicines. In Harris et al's (2003) study 42.3% of

cancer patients, reported using over-the-counter diets, remedies or supplements. O'Connor (1995) found that in addition to their conventional medical therapeutics, many people with HIV/AIDS were using a range of herbal and nutritional supplements to help boost the immune system, control infection, help with pain relief and other symptom control, control adverse side effects of conventional medicines as well as for emotional or spiritual well-being and the general enhancement of health. Studies indicate that the majority of individuals who use complementary medicines for such diseases use them in addition to conventional forms of treatment.

In this study complementary medicines were used by participants to treat a wide range of different health problems (see Appendix 3: Table 6.2 for full list). However, on the whole, individuals tended to use them mostly for dealing with minor ailments, such as colds, sinus problems, stomach upsets, menstrual problems, headaches, hayfever etc, and largely as an alternative to more conventional over-the-counter or prescriptive drugs.<sup>8</sup> For example, one participant used a herbal remedy for period pain rather than taking painkillers. Similarly, another participant used a range of different CAM products such as Echinacea, Olbas Oil and vitamin C supplements for treating colds and flu in preference to over the counter drugs such as Lemsip. A number of participants used complementary medicines as a form of preventative medicine. For example, James was taking the herbal supplement, *Saw Palmetto*, used for prostate care:

'It's supposed to, whether it does or not, the prostate swells as you get older...and it's an anti-inflammatory, saw palmetto is an anti-inflammatory, which is supposed to effect, and there have been trials, which suggest that of the alternative medicines even the medical establishment suggests saw palmetto as a reasonable thing to take. So I take that'. (James)

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<sup>8</sup> However, it should be noted that very few individuals had experienced any 'serious' (i.e. life-threatening) diseases. One exception was Sylvia who had had breast cancer and as well as having a double mastectomy had used over-the-counter remedies and spiritual healing to aid her recovery, instead of taking painkillers. Several participants had chronic illnesses and many used over-the-counter remedies to supplement more formal care – such as that provided by a CAM practitioner or their GP.



John said he takes cod liver oil capsules and Bilberry extract every day:

‘I mean I’ve been taking cod liver oil capsules for years, simply because they seem to be generally recommended for keeping your joints mobile. I’ve recently started taking Bilberry extract, because my optician said that it is one of the things that may possibly help with age related macular degeneration, which is one of the things that I’m not suffering from at the moment, but might’. (John)

Other supplements commonly used by participants for preventative care included: Glucosamine Sulphate for joint care, Evening primrose oil, garlic capsules, Echinacea and homeopathic constitutional remedies.

Several researchers have called for an examination of how people obtain information about CAM *before* they visit a CAM practitioner (Cant and Calnan, 1991; Kelner and Wellman, 1997; Sharma, 1995). Networks of family and friends have been shown to be key sources of information (Sharma, 1995), and the importance of mass media has also been noted (House of Lords, 2000). However, very little is known about how individuals obtain information about which complementary medicines to purchase for self care. It is to these issues that I shall now turn.

### **Social networks and the consumption of CAM**

‘Social networks, friends, peers, colleagues, family, all contribute to the decisions about what to buy, what objects mean and how they might be properly deployed’ (Warde, 1994: 892).

Previous research on CAM use has found that the most common reported source of information, and introduction to CAM, is ‘word-of-mouth’ and information provided by relatives, friends, acquaintances and colleagues (Sharma, 1995; Kelner and Wellman, 2001). For example, Wellman (1995) identified the heterogeneity of an individual’s

social network as a reason why certain individuals are more likely to use CAM in the first place. Wellman contends that because those with a more heterogeneous social network are exposed to a wider range of information and ideas, including information about alternative medical care they are more likely to try it. Sharma (1992) found that although respondents had informed themselves about the therapy and possible cures for their problem, the actual choice of practitioner was made on the basis of advice from 'significant others'. Similarly in Australia, Lloyd et al. (1993) found that 64% of their respondents had been to a CAM practitioner following a specific recommendation, compared to only 13% who had found out about their therapist themselves. Although this research focuses on the decision to consult a CAM practitioner, it is also relevant in terms of individual's choice of complementary medicines for self-treatment. It has long been recognised that the decision to seek help is rarely carried out in isolation (see for example Dunnell and Cartwright, 1972; Friedson, 1960; Stimson and Webb, 1975; Zola, 1973). Friedson (1960) referred to the 'lay referral system', a network that provides health solutions and information about when and how to seek medical advice. It is made up of family members, friends, colleagues, etc:

'Indeed, the whole process of seeking help involves a network of potential consultants, from the intimate and informal confines of the nuclear family through successively more select, distant, authoritative laymen, until the 'professional' is reached. This network of consultants, which is part of the structure of the local lay community and which imposes form on the seeking of help, might be called the 'lay referral structure.' Taken together with the cultural understandings involved in the process, we may speak of it as the 'lay referral system.' (Freidson 1960: 377).

Participants' choice of which complementary medicines to use for self-care were often influenced by individuals within their social network. Susan said that she regularly met up with three of her 'close friends', who also used complementary therapies, to discuss different therapies that they had recently tried. She said that this had definitely been a strong factor in influencing her use of complementary medicines over the years and the

likelihood of her trying new ones in the future. When Tina initially started using complementary therapies she said that a lot of her friends and colleagues were also getting into them at the same time and this contributed to her openness to trying them:

‘But it seemed to be at that time that there was a lot of people who I knew, were going off and doing training, just because they fancied doing it. And I think at the time there seemed to be a trend of people around me, women, not men, were getting interested through magazines, things they’d seen on the TV...a combination of both friends and colleagues. The girl who made me up the collar and gave me the violet oil she does reflexology and I think she does Indian head massage as well. And we have somebody come here [where she works] who does Indian head massage that you can go and visit on a lunchtime....And I don’t know, it just seemed that, the girl who does the Indian head massage and the oils, she got me into the Bach’s rescue, flower remedies. So it just seemed at the time there were a lot of people either talking about doing it or going to see somebody or who were actually training to do it themselves’. (Tina)

Many individuals claimed that they had used particular complementary medicines after receiving advice from friends, relatives, work colleagues etc. about what to take. For example, in the following extract Jane talks about some of the occasions when she has received advice about using homeopathic remedies:

‘And I was in a printers in Chester-Le-Street, that was for work, and somebody that worked there was interested in homoeopathy. And I had a very lingering stomach problem, oh three or four weeks I think, it might even have been five weeks. And I mentioned it to her and she said what you want is, can’t remember now which one it was, so I went and bought some, and I actually believed that that sorted it... And somebody else worked for the Wildlife Trust who used it, and when she knew that I’d got certain problems she said I should take arnica, or whatever, so I did...So

it's the people you mix with isn't it, and talking about things that are apart from mainstream medicine'. (Jane)

However, rather than being an extensive network of consultation among work colleagues, family, neighbours and friends, individuals were more likely to seek advice from people who were thought to have 'special knowledge' (Blaxter and Paterson, 1982). Many individuals said that they often discussed their use of complementary medicines with friends, family members etc. However, when it came to specific advice about using complementary medicines for their health problems they were more likely to speak to individuals who were thought to have some particular knowledge of complementary medicines. For example, Paul used a range of different complementary medicines, including homeopathy, herbal supplements and vitamin and minerals. However, he said that rather than finding out for himself which remedies to take, he usually consulted his wife<sup>9</sup> who had 'extensive knowledge' of complementary medicines, homeopathy in particular:

'Elaine [wife] will say 'you need this and you need that' and I'll say 'ok'. But I wouldn't, mmm, sometimes I would know enough to know what I want in the way of homeopathic medicine, but for some reason I wouldn't go forth and do it...vitamin supplements yes, I don't made a decision on that. I'm given a set of pills in the morning and it's just a case of take those'. (Paul)

This also highlights the important role that women play as 'providers' of health care within the family context (Graham, 1985). Similarly, Linda had started taking the homeopathic remedy *arnica* following a knee operation, after a work colleague, who was a committed user of homeopathy, had recommended that she take them:

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<sup>9</sup> Several of the male participants said that they received advice from their wives or partners about which complementary medicines to use. However, none of the women mentioned getting advice from their husbands. According to Adams et al (2003), women, as 'family care givers' are most likely to be the ones purchasing such medicaments for male members of their family as well as for personal use.

L: I had an operation on my knee last year and I took arnica tablets to help with the healing, and I was recommended those.

LB: Was that from a homeopath?

L: No a friend from work. She said that if you take arnica it would help the healing inside, so I've taken those.

(Linda)

Jane said that she often takes people's advice about which complementary medicines to use. However, she said she is more likely to listen to people who 'know what they're talking about':

J: I certainly would listen to people, I had flu in November and we had people coming for the weekend, who still came because they'd both had flu jabs. And I still had a temperature when they arrived on the Friday night. And Catherine who is incredibly into alternative therapies...She's a music friend, rather than through work, and she suggested an infusion of ginger would be a really good thing. So we got some ginger which I think was grated and I went to bed. And that night I just sweated enormously and by the morning I was better...I would certainly, if I got flu again I would certainly use the infusion. So that was just a tip from somebody who we knew.

L: Yeah. So it seems like a lot of the therapies that you've used, you've used through a recommendation from someone.

J: Yeah, yes. I think people who you feel they know what they're talking about.

(Jane)

However, a small minority of participants claimed not to speak to others for advice, or if they did they would listen to the advice but then would weigh it up themselves and always make their own decisions. Such individuals were more confident about their own capability and expressed themselves very independently. These individuals were more likely to carry out their own research into which complementary medicines to use, drawing from a range of information sources such as magazines, newspaper articles, the Internet and self-help books. Blaxter (2004: 78) suggests that such information outlets have now become an extension of the earlier lay referral network: 'Modern health systems have developed this process beyond referral to, or from, family and acquaintances. Information is available in more and more sophisticated forms'. Indeed, according to Valente (2000), the social networks in which self-responsibility for health is situated have increasingly broadened to include national and international dimensions in recent years, through the provision of health information in the mass media, not least via the expanding use of the Internet.

### **Sources of information about CAM**

'The reflexive self is one which relies on a vast array of advice and information provided in a myriad of sources' (Nettleton and Watson, 1998: 6).

For individuals wishing to self-prescribe complementary medicines information may be gleaned from various sources. The 'mass mediation of CAM' (Doel and Segrott, 2003a) has meant that information on complementary medicines is readily available through various global media communication including newspapers, magazines and, more recently, the Internet. Literary sources of information, what Giddens (1991) would term 'guides to living', represent another avenue for those seeking information about particular remedies. Many individuals seemed to expend considerable amounts of time and effort acquiring knowledge and information about different CAM products before incorporating them into their everyday health practices. Many used self-help books on complementary medicine as a source of information about which medicines to use. Over recent years the range of books available on complementary medicines has increased dramatically.

Bookshelves are now filled with titles on complementary and alternative medicines and 'natural healthcare'. Often individuals use such books as guides about what remedies to take for specific health complaints. For example, when Linda has a minor ailment, such as indigestion, sore throat or eczema etc. she uses her books on complementary health care to find the 'natural alternative':

'I've got quite a few books on homeopathy and aromatherapy and just well being. I've got a good book on just total woman wellbeing and it gives you erm, alternatives for what is it neuropathy, aromatherapy, homeopathy and herbalism, and it gives you the choice of all three and it's quite good and informative'. (Linda)

Elaine said she had quite a few books on homeopathy, Chinese medicine and other types of complementary therapies. She refers to these regularly, particularly when she has a specific health problem that she is looking to treat. She also reads such books to further her knowledge of complementary medicines more generally. She claimed to be able to 'sit for hours' reading books on complementary medicines. Alex uses her books as 'reference books for what treats what':

'I've got lots of books now all about herbal remedies and natural remedies, you know all kinds of stuff. I've got a book about teas, different teas'. (Alex)

Whenever Sylvia has a health problem she consults one of her many books on complementary medicines, these included titles such as *The Biochemic Handbook*, Alfred Vogel's *The Nature Doctor*, *Get Well Naturally*, and the *Encyclopedia of Medicinal Plants*.

The media proved to be another popular source of information on complementary medicines amongst participants. It has been suggested that the media create and sustain the demand for CAM, by providing a wealth of information published in popular

magazines and newspapers on diseases and available treatments (Sharma 1995; Doel and Segrott, 2003b). According to Sharma, (1992: 5), 'it is not possible to discuss the way in which people use [complementary medicine] without also discussing their exposure to health information provided by the media'. There are now regular features on complementary medicines in many national newspapers, including *The Guardian*, *The Observer*, *The Times* and *The Daily Mail*. The number of health and lifestyle magazines featuring information on complementary medicines has also increased over recent years. As well as a number of 'natural health' magazines that focus exclusively on complementary medicines (e.g. *Here's Health* and *Positive Health*), there are also a number of publications that cover CAM alongside a much broader set of health related topics (e.g. *Good Health*, *Lifestyle and Beauty*). Furthermore, many women's magazines also now feature articles on complementary medicines. Individuals use such sources to inform them about new CAM products, and to provide information about which remedies to take for specific health problems: 'the *Guardian* or the *Observer* at weekends always have columns about alternative, or natural, whatever you like to call them, so I always read those.' (Alex). As well as consulting her books on self-care, when looking for a particular remedy, Elaine said that she often finds out about a lot the remedies she takes from reading health magazines and the health section in the *Daily Mail* newspaper. For example, when I asked about how she found about one particular CAM product she was using she said: 'I must have read about it in the *Daily Mail*, they have quite good health articles in every week, and I must have read about it there'. Jane said that she has occasionally tried out certain remedies that she has read about in the magazine *Woman's Own*, which has a regular feature on complementary medicines:

L: So how do you find out about what things [complementary medicines] to take? Do you look into it yourself?

J: No it's just sort of what people say really. Well I suppose a bit of reading, and I do, sad person that I am I do read *Woman's Own*, and the articles in there, that's sort of bedtime reading. And there's quite a lot in



*Woman's Own* now about complementary therapies...I would read that.

(Jane)

A small number of participants said that they obtained information about complementary medicines from the Internet. Over recent years there has been a rapid growth in web-based health-related information, including the UK government's NHS Direct Online (Henwood et al., 2003). Numerous websites, interactive forums and email lists now offer information upon and discussion of health care; and consumers use websites to research their own conditions and health care and make decisions surrounding their treatment (Bessell et al., 2002). Information about complementary medicines is also widely available via the Internet. Hardey (1999) suggests that the Internet may act as a conduit to alternative therapy. Individuals can use the Internet to obtain information about how to find practitioners in their local area, learn about different types of complementary medicines, get advice about which remedies to use for particular ailments or to purchase remedies online. However, most participants who said they had used the Internet to obtain information about complementary therapies claimed that it was not their main source for information. For example, Christine claimed to spend hours on the Internet reading about complementary medicines. Although she said she mostly uses self-help books and health magazines for finding out about CAM products, Christine claimed that the Internet is often a good starting point for locating information: 'Now mostly it's the Internet, which I know isn't always the most reliable but it's a quick source of basic information'. Steve claimed that the Internet was one of his main sources of information about different remedies to use:

L: So how do you find out about different complementary medicines?

S: Er, either somebody will say 'I've tried this and this is really good'. Or I'll go and have a look on, on the sort of website, or I'll sort of read up somewhere that this is really good. (Steve)

This supports recent research that suggests that individuals use the Internet to supplement information they have obtained from other sources (Evans, 2005). Indeed, rather than relying on one source for information about complementary medicines, the majority of participants used a combination of different sources: 'Well I think the *Guardian's* health page and things is quite a useful source, friends obviously are, I guess books and leaflets and the Internet I guess' (James). Individuals may learn about a new CAM product after reading a magazine article, however, they may then read up further about that product either in self-help books or on the Internet, or visa versa. James claimed that if he reads about a particular remedy in a newspaper he would always carry out further research using the Internet, or ask others to see if they knew about it:

L: So if you read something in the *Guardian* for example...

J: And I thought it applied?

L: Yes, would you go out and buy it?

J: No I'd probably look into it further. I'd probably check it out and say this is mentioned, who else has heard of this. There's often a reference in there that they might give, you know they refer to some research in the *Guardian* usually, so you can always check that out. I haven't done that recently, as I say it must be at least a year since I've done it.

### **'Lay' knowledge and the re-skilling process**

The way in which some participants actively sought out information about different complementary medicines to incorporate into their health regimens can be seen as part of what Giddens (1990, 1991) has referred to as the re-skilling process. Giddens suggests that the 'lay' public is increasingly informed and reflexive, especially as knowledge has become pluralized. In such a context it is likely that individuals will attempt to 're-skill', by taking back some control from the 'experts' and by searching for alternatives.

Previous research has demonstrated that the lay public have increasingly endeavoured to re-appropriate knowledge for themselves (i.e. Fox, 1991; Monaghan, 1999; Oakley, 1984; Williams & Popay, 1994). In the context of this study this process is clearly demonstrated in the following extract:

‘The Bach flower remedies I use those, but just for myself from reading about them...once I’d discovered homoeopathy and started reading about that and other alternative ways of helping yourself than going to the doctor...and talking to people like Pauline [local health food store owner] in the health food shops...as I learnt more and more about it then I started using more stuff myself, like the different kinds of teas for different things, or chewing a clove, you know just different stuff you can do at home’. (Alex)

According to Giddens (1991) as long as individuals have sufficient resources, i.e. enough time and access to information etc., there is the possibility of a ‘full-blown reskilling in respect of specific decisions or contemplated courses of action’ (Giddens, 1991: 139).<sup>10</sup>

‘Well usually before I take something I would read up about it before I took it. I suppose you could say that some people might be lured in to taking things and not knowing anything about them. But myself I always try to get knowledge about them before I take them’. (Amanda)

Laura had first tried using homeopathy after reading an article in a women’s magazine. She had found homeopathy so effective that she had been motivated to read up further about it: ‘I just started ordering all these books, and reading all these books on homeopathy and erm, started to find out more and more about it’. She then used this

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<sup>10</sup> Giddens’ suggestion that ‘full-blown reskilling’ is possible has been subject to criticism (e.g. Shilling, 2002; Fuller, 2000). As Fuller (2000: 28) notes, ‘knowledge does not empower to the same extent everyone who possesses it’. Clearly, there are differences in terms of individual’s access to information, i.e. not everyone has access to the Internet, can afford to buy expensive books on self-care, or has the time and patience to read about complementary therapies. The limits of the re-skilling process in terms of health and illness will be discussed later in the chapter.

knowledge to treat herself and her family when they were ill. In the following extract she recalls one particular occasion when she used her skills to treat her son:

‘When Harry was a year old he was really poorly, he was losing weight, his skin was all loose on his abdomen, he was sickly looking and very miserable and he didn’t sleep. He was just like not right, I knew he wasn’t right. So I thought I wonder what I can give him. So I started researching all the literature looking at all the constitutional pictures and everything, and eventually I pinned it down to one remedy, which I thought would work for him and it was *burita carb*. And *burita carb* is very good for either the very young or the very old and he had the wrinkled appearance, he had a lot of the characteristics and I thought this is the right one for him. So I sent away, got the remedy and gave it to him. I gave him a 200 to start with and that worked for about two or three weeks and then the symptoms came back. So I knew that when you did that you have to take it up to the next potency, so I gave him a higher potency and he was fantastic for a year, slept at the night, put on weight, he was a transformed baby’. (Laura)

However, a year later when the problem returned, after trying out a few other remedies, Laura finally took her son to a homeopath. She said that she felt she had reached the limits of her own knowledge and ability.

Other individuals had attended ‘classes’ to learn more about complementary medicines and how to use them for themselves at home. For example, John had attended a number of courses on complementary medicines over the years, including: Shiatsu, Alexander Technique, Yoga and was currently attending a class on ‘holistic therapies’. Linda had recently attended evening classes on aromatherapy:

‘I did an aromatherapy course at night class. And I found that very interesting...and one of the reasons for doing it is that my daughter does

athletics and she was often pulling a muscle or a strain, and if there was anything where it was just a twinge I would give it a little massage, with some oils'. (Linda)

Some individuals had taken the re-skilling process a step further and in addition to using their knowledge of complementary medicines to treat themselves they also offered advice to others. For instance, despite not having any formal training in homeopathy Elaine regularly gives advice to friends and family about which remedies to take: 'People often ask me for a remedy and I'll give them it...They'll say 'what can I take for so and so?' and I tell them something and they take it'. This was clearly something that she derived great pleasure from, however she was not interested in training to become a professional homeopath:

'I've never been on a homeopathic course...because it gets very complex. And I don't know whether I'd feel comfortable being a practitioner...I'd rather just give people something on a casual basis, just give them it, and it gives me great pleasure when they say how marvelous it was, but that's enough for me'. (Elaine)

Similarly, Christine also used her knowledge of complementary therapies and in particular homeopathy<sup>11</sup> to give advice to others, but in contrast to Elaine, Christine did express interest in developing her skills further by attending a course organized by her homeopath:

'As soon as I found out about homeopathy I thought, I want to do this, I want to be a homeopath. But I'd already done my degree and I didn't have the money and I thought I can't afford to train as a homeopath...But my homeopath is starting a course, a basic four week course soon, so I'm

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<sup>11</sup> According to Coulter (1984) the homeopathic movement encourages individuals to self-treat certain illnesses and to learn to use some of the homeopathic medicines.

looking forward to going on that and sort of consolidating what I know and learning a bit more'. (Christine)

In Christine's instance her knowledge of complementary medicines was primarily used to provide care for her family:

'I used it on my kids ever since they were babies. Mostly self, you know I did the diagnosing and you know sometimes it worked and sometimes it didn't, I've used it on pets...if anybody's got a sore throat, if anybody says to me in the house 'mum I've got a sore throat' then I say 'take some Echinacea'. And they don't really want to because they say that it tastes horrible'. (Christine)

However, she also said that she enjoys giving advice to other people when they have a particular complaint:

'If I hear that anybody has an illness I would want to find out about it and maybe what caused it and how I could help them, even though I'm not a doctor, but just because I'd want to help that person'. (Christine)

Christine claimed that members of her family had also started to take an interest in prescribing homeopathy and different complementary medicines to others. For example, she said that her daughter seemed to have 'absorbed quite a lot of the stuff naturally' and 'seems to know what to give people' and wanted to train to be an aromatherapist when she left school. Also her husband had started recommending different remedies to work colleagues:<sup>12</sup>

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<sup>12</sup> However, this example was fairly unusual, as most female participants claimed that their husbands were sceptical or even dismissive of complementary therapies. Of the small number of male participants in this study two claimed that they self-prescribed complementary therapies, the other two said that whilst they did use CAM products at home, this was usually because their wives, who were also CAM users, had given them things to take, as in Paul's case discussed above.

'He's [husband] not been to a practitioner no, but he'll treat himself or he'll say what's good for such and such. And he actually prescribes for people at work. Like sometimes somebody's got a problem and he'll come home and say well so and so has got this, this and this going on and I thought, this is a colleague who's child was being sick, and he said I wondered about *arsenicum*, and I said 'well you can try it' [laughs]'.  
(Christine)

Nevertheless, Christine did admit that often the advice she gives to others is not taken up. She was able to site a number of instances where individuals, particularly members of her family, had not followed her recommendations to use complementary medicines, either via a practitioner or by purchasing over the counter remedies:

'In my mother's case, she professes to be quite interested in alternative approaches to dealing with illness, but she hasn't got the confidence to try it out. Also, she would be wary of telling a stranger details about her life, whereas with a conventional medic one tends to deal in symptoms, so she would feel safer with that. There's also the money aspect and, probably most significant, my father's very negative and dismissive attitude towards complementary therapies, he does not agree with giving money to people whom he considers to deal in a load of baloney...My brother had a back problem a few years ago and I suggested that he go to an osteopath. He seems to have inherited my father's views...He was in intense pain for quite a while, signed off work and keyhole surgery and has restricted movement. He's never fully recovered from it and I was a bit miffed at the time that he didn't consider my advice...My sister started to use homeopathy at home for her family after my example...but she only goes so far with such things and she also showed resistance when I suggested osteopathy for a neck problem and is skeptical about the other therapies I've used. She once experience swollen ankles after over-indulging in wine and put it down to liver function. I suggested the herbal remedy milk

thistle as a support for the liver and she was rather hostile about it'.  
(Christine)

### **Individual control and empowerment**

Certainly from looking at such examples it does appear that through the process of re-skilling individuals are able to take back some of the control from experts and 'invest in 'health' outside of significant contact with health professionals' (Shilling, 2002: 363). Indeed, Bakx (1991) has suggested that alternative medicine should be seen as part of a postmodern rejection of authority and an attempt by individuals to reclaim control over their health:

'Self medication and alternative practices are not new...What is different is the extent to which they are practiced and their location within the broader cultural framework of self-determination i.e. [*sic*] reclaiming control over the self and environment' (Bakx, 1991: 30).

Easthope (1993: 293) makes a similar point when discussing CAM, when he notes that:

'People are seeking to regain control over their life-worlds. In healing, this means they are looking for treatment modalities over which they have some say'.

Certainly, previous research has found that individuals are attracted to complementary therapies because they desire more control over the healing process (see for example, Cant and Sharma, 1999; Siahpush, 1998, 1999a). Many of the participants talked about the fact that using complementary medicines for self-treatment gave them a greater sense of control over their health. For example, when I asked Christine why she liked using complementary medicines to treat herself she said:



'Because they're natural, you know they're easily accessible, you know you can have a stock of them in your home, you don't have to mess about getting appointments, you know if you're ill in the middle of the night you can do something about it. And I suppose it's that sense of empowerment, it's within your hands to do something about it'. (Christine)

Others also spoke about the increased autonomy of using complementary medicines for self-treatment. For example, Laura had first started using homeopathy when she was pregnant with her third child. She had wanted to have the baby delivered at home, however, shortly before the birth, during a routine check up, it was discovered that the baby was breach: 'I was so upset, I couldn't have him at home you see...And I was absolutely horrified I said what can I do, she [midwife] said 'well the consultant may try and turn the baby around'. But she said they usually don't stay that way'. On her way back from the hospital Laura had gone into the newsagents and seen a magazine on '*Practical Parenting and Childbirth*', which had a feature article on homeopathy and childbirth. She bought the magazine: 'I thought that looks interesting, so I read it and low and behold there were women having babies at home, breach presentations you name it'. Despite not having any prior knowledge of homeopathy, or knowing anybody who had used it, Laura then sent away for the book that was recommended, read the book and purchased the suitable remedy. Shortly, after taking the remedy she returned to the hospital for another check up and the baby had moved: 'he moved, he took the right position about a week or so later and he never moved again, so that was fine'. Laura's motivation for taking this course of action was that it gave her 'the opportunity to take control, because I felt out of control. I felt that I was in a situation that I couldn't change and I was determined not to be in that situation'. The doctor had taken away the control she had over the situation by not allowing her to have the baby at home as she had wished. She felt it necessary to take action to regain control over the situation and homeopathy had allowed her to do so.

According to Doel and Segrott (2003b: 137) 'the very act of deciding to use CAM is an act of resistance to dominant practices and a form of self-empowerment'. When I asked

Alex why she liked using alternative remedies she said: 'Because they're natural, they're more gentle and they don't have side effects, because I don't have to go and see a GP, I can just use it'. Complementary medicines were often used by individuals in an attempt to either prevent or delay the need to go to the doctor over a particular health problem. For example, Amanda had initially used the herbal supplement St John's Wort in the hope that it would help with her depression: 'I took, what's that natural alternative to antidepressants called?...St John's Wort, I took that for quite a while in the two years leading up to going to the doctor'. Steve claimed that he would usually try to treat himself at home before going to the doctor:

'I think depending on what it was, what the illness was I wouldn't necessarily go to the GP first for a remedy to that particular thing. I would be more, you know like I've complained to, you know every time I've been to the GPs of late, about problems with me chest, now I just go and get over the counter herbal remedies...So I'm sort of tending to do it for myself, instead of saying you know 'it still hasn't cured it', you know'.  
(Steve)

However, many admitted that the degree to which they felt able to take control was very much dependent on the nature of their illness. Graham (1984: 165) suggests that meetings with the doctor 'typically occur at the point where the resources of informal caring have been exhausted'. This implies that the same 'illnesses' or at least the same set of symptoms that were once suitably treated at home shift into the public sphere at the point where 'normal' life cannot be maintained (Blaxter and Paterson, 1982). For example, although Amanda (mentioned above) had tried to treat her depression herself using St John's Wort, it did not significantly alleviate her symptoms. As a consequence she felt that she had no other option but to visit her doctor: 'It had got to a point where I needed to do something. So I'd gone to the doctors' and was given anti-depressants. However, her story does not end here, as after taking the anti-depressants for a few months she decided that they 'were not the solution'. She later stopped taking the anti-depressants, contrary to her doctor's advice, and started seeing a reflexologist.

There are also categories of illness which demand instant medical attention, such as broken limbs and are thus clearly outside the common sense boundaries and yet others which may never require a doctor such as colds or flu (Cornwell, 1984). All participants recognised that there were certain categories of illness that did demand medical attention. Although participant's ideas about what was included in this category varied:

'Obviously if you needed an operation, I mean I needed, I had to have a hysterectomy, and I had awful symptoms, really bad symptoms and I tried treating myself and I thought I've got to go. So I had to go for that'.  
(Elaine)

Similarly, Helen claimed that she would always try and treat herself first using complementary medicines, however, if it was something more serious she would probably go to the doctor:

'I think it would depend on if I got, let's say bronchitis again I wouldn't go to a doctor because he would give me antibiotics that damage more, I would try it first by homeopathy or any other form of alternative treatment. I think if it was an appendicitis or something I probably would go to the doctor [laughs], but erm, I would try as much as possible herbal or natural remedies first before going to the doctor and taking a lot of stuff'. (Helen)

Paul had a very limited view of which types of illness would constitute a visit to the doctor. Indeed when I asked him whether there were any illnesses that would make him go to the doctor, he said: 'broken bones [laughs]'.

Nevertheless whilst individuals did on occasion feel that they had to go to the doctor this did not mean that they passively accepted the doctor's advice or treatment options. Self-medication is also common after individuals have consulted the doctor (Helman, 1978).

Many individuals self-prescribed complementary medicines after having been to the doctor for treatment, particularly when treatment was perceived to be ineffective or undesirable. For example, Christine had first used homeopathy to treat hemorrhoids following a visit to her doctor. She had been unable to find relief from her doctor and so having already read a little bit about homeopathy thought it was worth trying. She said that on her way back from the doctor she went to the chemist purchased the appropriate remedy and took it straight away. She claimed the results were instantaneous. When Sylvia had breast cancer and had to have a double mastectomy as well as having distance healing, she also used a number of complementary medicines to help with her recovery. She claimed that this meant that she did not have to have any further treatment and attributed her lack of pain following her operation to the complementary therapies she had used. As a consequence she claimed that she was able to refuse the painkillers that were offered to her. She also explained how the woman in the bed next to her had needed painkillers, despite only having a lumpectomy:

‘So I took in Vitamin E, to renovate your system, your skin and help with healing, arnica, to help with the pain and the healing, except there was no pain, Dr Bach’s rescue remedy, and what other thing, there was something else, I’ve forgotten. Anyway there were four things that I took in’.

Sylvia also told me that she had written to the surgeon to inform him of the benefits of using complementary therapies for post-operative care.

Many individuals claimed that they would only go to the GP for a diagnosis when they were unsure about a particular illness and then decide for themselves what course of action to follow. Where possible this would then involve searching for complementary medicines to use for themselves. For instance, Elaine claimed that she always tries to self-treat if possible. However, when she does go to the doctor it is usually only to get a diagnosis. Once she has found out what is wrong she almost always treats herself at home using alternative medicines:

'I'd treat myself first...I would go to a doctor really to find out what's wrong, what is it, what's causing it, but they don't always know and then treat it with an alternative therapy and that seems to do'. (Elaine)

Amanda also claimed that for minor complaints she would always self treat, however, for more serious conditions she would usually go to the doctor for a diagnosis before deciding what to do: 'I would go for a diagnosis to a conventional [doctor]'. In this sense medical authority simply exists as one 'authority' among others, part of an indefinite pluralism of expertise (Giddens, 1991).

### **Repositioning of authority and the new 'experts'**

According to Rayner and Easthope (2001) rather than seeing use of alternative medicines as being part a postmodern rejection of authority (Bakx, 1991), consumption of alternative medicine is associated with a 'repositioning of authority'. In other words when obtaining information about complementary medicines individuals rely on different sources, both lay and expert for help and advice, other than their GP. The process of choosing the 'right' remedy to use for a specific health problem often is rather hit and miss. In many instances, particularly in the case of more persistent or chronic health problems, finding the 'correct' treatment involves a trial and error approach, with individuals purchasing a number of different complementary medicines to try out for one particular problem. As the following extract indicates sometimes individuals are lucky and a suitable remedy is found fairly quickly and other times this approach is not so successful:

'Most of the time I tend to sort of look on the shelves to see what they're supposed to do and then I'll sort of look on the web or read up in a book on some of it...And other times it's just sort of a lucky guess, you know 'these sound good I'll have a go with them'...I've bought stuff that I've started taking and thought these aren't doing anything and just sort of left them in the cupboard you know as you do. But then again there's other

things that I've bought that have really worked. You know things like hayfever, I remember buying thinking, you know I'd been taking all these antihistamines and although they stop the hayfever they make you feel really rough, so I found these sort of natural remedies and they worked fine. So it's like 'oh they work keep them for when you get hayfever the next time'. (Steve)

Individuals tend to build up a repertoire of remedies that they have found work for certain illnesses. As Christine says she mostly uses 'the same ones'. However, for some individuals the process of finding a suitable remedy can be lengthy and potentially a very costly exercise. Several individuals claimed that they had a 'store' of different remedies, which they had purchased and having not found them effective hardly ever used. In such instances individuals may feel they need to seek further advice from a health professional. For example, Linda, had been suffering with insomnia for several years and had always either used conventional over-the-counter drugs, or if the problem got 'particularly bad' would go to her GP and get sleeping tablets. More recently she had experimented with a number of different herbal supplements recommended for treating insomnia. In fact she could not even recall how many she had tried and had not 'found the right one yet'. Following a bad spate of insomnia she had recently been back to the GP to get more sleeping tablets. Nevertheless, she did acknowledge that this was only a temporary solution and was now seriously considering seeking further help from a CAM practitioner.

Furthermore, the wealth of information provided in health magazines and other forms of media can often be confusing for individuals wanting to use complementary medicines. For example, the majority of the supplements that Elaine buys are from reading health magazines or books. However, at times she claimed it can be difficult to decipher which advice to follow:

'But I have to stop myself reading the newspaper articles because I think god...I start thinking maybe I should take that as a supplement and this and that, I'm

taking enough, I'm not taking any more...I mean I can't even remember why I took *picnogel*, which is an antioxidant and it's supposed to have the added benefit, this is stupid, of getting rid of thread veins on your face, because it does something to the blood vessels. So I thought oh that's great, but it didn't work, so I thought I'm not going to pay, because they were really expensive, I don't want to become fanatical '. (Elaine)

Bauman (1999, 2001) maintains that with empowerment comes a perilous responsibility. The call for people to make their own choices in life place a large responsibility upon the individual. A potentially limitless responsibility that may be burdensome rather than emancipatory, a form of private anguish rather than social security (Bauman, 1992b, 2001). In matters of health and illness such matters become even more pressing. The series of information pathways to a plethora of products, books and websites offer a partial solution (Doel and Segrott, 2003b). Furthermore, Warde (1994) argues that reliance on social networks may help to allay part of the anxiety that may arise from personal consumption. However, Lupton (2002: 366) argues that dependency is a central feature of the illness experience and the medical encounter and serves to work against the full taking up of a consumer approach: 'Illness, disease, pain, disability and impending death are all highly emotional states, and they all tend to encourage a need on the part of the suffering person for dependency upon another'.

It has been suggested that people may consult their doctor rather than using self-care if they do not feel confident about making self-treatment decisions (Stevenson et al., 2003). However, when making decisions about using complementary medicines many participants sought advice from a range of new expert sources rather than the doctor. For example, several individuals consulted with employees in their local health food stores about which remedies to use:

'No I've only used over the counter advice. Fortunately the one in Durham she's very knowledgeable I think she is a homeopathy, she

studies it quite deeply. So I go in there and say my chest is a bit, I've got a crackly cough or whatever'. (Lorraine)

'I buy the teas there [health food shop], I buy, like my husband had a pulled calf muscle and it wasn't getting any better, so what did I get, Pauline [health food store owner] recommended something for him, it was comfrey and arnica I think, a cream to rub on. So I buy stuff like that from her, I get, oh I get angus castus off her, that's quite good, you know my head goes sometimes when it's my period time, I just can't concentrate and she said try, what is it, evening primrose or something first, that made no difference what so ever, so she said 'have a go with the angus castus it's a bit more expensive but it might do the trick' and it does. So stuff like that...I don't know, it's hard when its part of my life now, it's hard to think of what I do use'. (Alex)

Similarly, when Sylvia had a particularly bad bout of the flu that she was unable to shift using different complementary medicines herself, she consulted her local health food store:

'I took various things for that and nothing seemed to work. So I went to this health food shop in Newcastle...Anyway, one of the assistants said 'take *Floridix*' and I said '*Floridix*, I hadn't heard of that'...it's a tonic, with honey, orange as well and nettle and spinach, so a lot of iron in it. So that help me'. (Sylvia)

Several participants said that they often asked their practitioner about what remedies to buy. For example, when I asked Amanda whether her reflexologist ever recommends any over the counter remedies to her she replied: 'Yes [laughs]. She should get a job selling them really'. She said that if she had a particular health problem she would ask her practitioner: 'a lot of the time I just ask Marie [reflexologist] because she knows a



lot'. Similarly, Tina had started taking the herbal remedy Echinacea following a recommendation from her practitioner:

T: I take Echinacea in the winter...I take it all the time, so it builds your resistance up, but that can work out pricey.

L: Was that something somebody has recommended to you?

T: Julie [practitioner], mmmhmmm. She takes it in the winter, and then there's quite a few of them in the office take it now, I've got them onto it.

(Tina)

Laura claimed that on the occasions when she reaches the limits of her own ability to self-prescribe homeopathic remedies for a particular health problem she would refer back to her homeopath:

'But I've taken remedies for the acute condition of migraine and sometimes it has worked and sometimes it hasn't. And that really is because sometimes I've hit on the right remedy and sometimes I haven't and that's just my lack of knowledge really. But on occasions where I've spoken to my homeopath and said it's like this and she's said take that, you know it's worked'. (Laura)

Steve, who regularly buys over-the-counter-remedies said that often he will check with his CAM practitioner before consuming them. For example, in the following quote he talks about a recent incident when he had bought a homeopathic remedy for himself, only to think afterwards that he should really check with his homeopath before using it:

'It's like I've just bought some sort of homeopathic remedy and then I've thought, 'oh this sounds just what I want from it's supposed to do'...But I haven't taken it until I see Gayle [homeopath] tomorrow. Because I thought this might go against whatever else. Whereas you know that,

from you experience with other things, you know the Echinacea and Garlic are fine with what I'm taking at the minute...Because you know Gayle would say like 'try this and this if you've got a cold or whatever'. But there are times when I'll go there, that's a prime example of where I bought it and went 'oops stop there and I'll just check with the naturopath and the homeopath that it is okay to take'. (Steve)

Although, in Steve's case he claimed that he was more cautious about the sorts of things he took because of his present illness, Chronic Fatigue Syndrome. He was at the time of the interview seeing a number of different practitioners and said he likes to 'keep them all informed' of what he's doing (including his doctor), as he does not want to take anything that might jeopardize his road to recovery. Such findings indicate that, both expert and individual control over health is valued by alternative medicine users. This provides support for the assertion, made by both Bauman (1992a) and Giddens (1991), that postmodernity/late modernity is marked not by a rejection of authority but by a pluralism of authority. The resulting autonomy of the individual gives rise to self-monitoring and self-reflexivity.

### **The 'dangers' of self-prescribing**

As already mentioned, the 'sociology of CAM' (Tovey et al., 2004) has, so far, paid scant attention to use of complementary therapies for self-care. Nevertheless, despite the shortage of social scientific works investigating self-help aspects of CAM use, over recent years there has been an increase in research geared towards establishing the efficacy of particular CAM products, and research emphasizing the potential risks posed by using them. The latter field of inquiry is framed within a discourse of 'safeguarding public health' and is concerned with the 'dangers' associated with the 'incorrect' use of CAM by misinformed consumers. As a result there have been calls for stricter regulations and guidelines for the sale of over-the-counter CAM products<sup>13</sup> and the need

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<sup>13</sup> The regulation of such products has recently been subject to particular attention in relation to the EU traditional herbal medicines directive, which is due to come into force on the 30<sup>th</sup> October 2005, and proposes to restrict the sales of certain CAM products.

to 'educate' the public about the appropriate use of complementary medicines (House of Lords, 2000). Ernst and his colleagues have written a considerable number of articles expounding the 'hidden risks' associated with the self-prescribing of alternative therapies (e.g. Ernst, 2005; Canter and Ernst, 2004; Ernst and Schmidt, 2004; Ernst, 2004; Izzo and Ernst, 2001; Ernst, 2001; Mills et al., 2003). Here, it is argued that the public perception that herbal medicines and other over-the-counter alternative medicines are inherently safe, because they are 'natural', is 'naïve at best and dangerous at worst' (Ernst, 2004: 767). This research identifies a number of 'dangers' to consumers who choose to self-prescribe alternative medicines. First, is the fact that individuals often do not inform their doctors of their use, which is said to pose a 'risk' in terms of interactions with other drugs. Related to this is the concern that individuals may stop taking medicines prescribed by their doctors once they start using OTC remedies (see for example, Canter and Ernst, 2004). Indeed, focusing specifically on the use of complementary and alternative medicines for breast cancer patients, Mills et al (2003: 170-171) argue:

'Several public health concerns arise about the use of NHPs [natural health products]. The potential for drug interactions with chemotherapy might reduce or exacerbate the effectiveness of prescription drugs. The potential for harm increases when large doses of products are used chronically and when NHPs are used simultaneously. Additionally, patients might delay or discontinue orthodox treatment at the advice of a CAM practitioner because the discussion of CAM use with physicians is limited'.

Secondly, there is concern about the wide range of information available for consumers to access on the use of complementary therapies. In particular, the plethora of self-help books and guides on complementary and alternative medicines and the information available about CAMs on the Internet. Following an evaluation of 'lay books' on CAM, Ernst & Armstrong (1998) argue that individuals could suffer real, possibly life-threatening harm if they adhered to the advice issued in such books. In terms of the Internet, there is widespread concern over the 'quality' and variability of information that

may be misleading for consumers (Ernst and Schmidt, 2002). The final objection made by Ernst and his colleagues, concerning the use of complementary medicines for self care, relates to the advice given to consumers in health food shops and other sites where complementary and alternative remedies are sold, as well as concerns over the lack of regulation of such products. For example, following research on the advice health food store employees present to individuals seeking treatment options for breast cancer, Mills et al (2003)<sup>14</sup> draw attention to the heterogeneity of advice provided in such retail outlets. They conclude that 'regulators need to consider regulations to *protect vulnerable patients* from incurring significant costs in their purchasing of natural health food products lacking evidence of benefit and of questionable safety' (ibid: 170, emphasis added). Concern over the availability of such CAM products and inappropriate advice given to consumers purchasing such medicaments was also expressed by one of the practitioners I interviewed:

'I had a client in here the other day who went to Boots, now Boots everyone knows Boots, everybody trust Boots, and she bought some St John's Wort and she was put on the wrong dosage. Now it came about, she said to me, I've been on St John's Wort, she's depressed...and she doesn't want to go onto Prozac, so she said I went and I asked and she'd given me St John's Wort. This woman had put her on 500mg once a day, now I don't know a lot about herbal medicine, but I knew that that was low, so when I went home she could have up to 1500mg a day, so 500mg three times a day, so it's not wonder it wasn't working for her. So you know that was a safe scenario because she was under prescribed rather than over prescribed. But it could have gone the other way...You know

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<sup>14</sup> This study surveyed 34 health food stores in a major Canadian city. Members of the research team were deployed to particular stores and approach a member of staff to ask for advice about suitable treatment options for their mother, who had breast cancer. The participants disclosed information on their mother's condition, use of chemotherapy (Tamoxifen) and physician visits, only if asked. Data gatherers inquired about safety issues and drug interactions with each recommended product. Additionally, they inquired about where the employee had obtained information on the recommended products. They also noted whether the employees referred them on to CAM practitioners or to a physician. 68% of employees did not ask whether the patient took prescription medications, 44% recommended they visit a CAM practitioner. Adverse effects of products were only discussed by 8.8%, potential for drug interactions was discussed by 23.5%. One employee suggested discontinuing Tamoxifen.

you take St John's Wort and you're over prescribed it, it can cause problems, photosensitivity for a start and this kind of thing. So who is regulating the people that are selling these products'. (Ann, aromatherapist)

Whilst it is not my intention to get embroiled in debates about whether or not the use of complementary and alternative therapies for self-help purposes is detrimental to individuals' health, these discourses raise a number of interesting issues in relation to the findings presented in this chapter. Within such discourses individuals who use complementary therapies are portrayed as a misinformed consumers in need of expert guidance. Thus reinforcing the need for medical control and repositioning patients as passive recipients of care. Such arguments suggest that consumers are unable to make 'informed' rational choices about their health. Nevertheless, the claims made by Ernst and his colleagues have not been explored in relation to the experiences of individuals who use these products. Contrary to assertions of Ernst and his colleagues, the findings from this research suggest that rather than being passive recipients, individuals who use such products are pro-active seekers of information, competent in handling information and discerning in their choices, and drawing from a range of information sources, both lay and expert when choosing which products to use. The moves to increase the control and regulation of the sale of CAM products are viewed by users as a threat to consumer freedom, as one participant notes, talking about the proposed EU directive to restrict the sales of CAM products: 'I think it's a bit of an infringement of your civil rights really, to stop you taking things like that. I suppose if people were taking them to excess, but I can't see people, I don't know why, really why they've done it' (Amanda).

## **Conclusion**

In this chapter I have shown that participants used a range of different OTC remedies both as an alternative and a supplement to formal health care. Individuals often used complementary therapies in an attempt to either prevent or delay the need to go to the doctor over a particular health problem. However, many participants admitted that the

degree to which they felt able to take control of their health was very much dependent on the nature of their illness. Whilst individuals were able to use OTC remedies effectively for more 'everyday illnesses' such as colds, flu, upset stomach, headaches etc., for more 'serious' problems individuals would often consult either a CAM practitioner or doctor. However, the data also indicates that whilst all participants recognized that there were certain categories of illness that did warrant medical attention, their ideas about what was included in this category varied. Indeed, those individuals who were particularly sceptical about the value of modern medicine had a very limited notion of what sorts of illnesses warranted a visit to the doctor or A&E department. Always preferring to resort to either self-care or a CAM practitioner. Self-medication of complementary therapies was also common after individuals had consulted with their doctor, as a means of 'safely' dealing with their symptoms. Many individuals claimed that they would go to their doctor for a diagnosis, if they suspected that they had a serious health problem, however, they would then (depending on the diagnosis) self-treat using complementary therapies. In this sense, the use of complementary therapies can be seen as a form of resistance to medical control and a rejection of biomedicine hegemony. Self-care and self-help practices seek to reduce the reliance of individuals on medical practitioners.

In terms of the means through which individuals obtain information about using complementary therapies for self-care, the findings from this study suggest that the key sources of information are similar to those for individuals consulting with CAM practitioners. As I have shown, participants' choice of which complementary therapies to use for self care were often influenced by individuals within their social networks and in particular advice from individuals thought to possess 'special knowledge'. However, information was also obtained from a range of other sources including magazines and newspaper articles that provide information about the use of CAM products, self-help books and the Internet. Indeed, rather than relying on one source for information about complementary medicines, many participants used a combination of different sources. Information about complementary and alternative medicines used by consumers includes both expert and lay sources.

I have also demonstrated that through the process of re-skilling individuals attempt to re-appropriate knowledge and control over their health and their bodies. Over the course of using complementary therapies individuals acquire information and knowledge about different aspects of CAM and build up a repertoire of effective remedies to incorporate into their health regimens. In this sense the use of self-care provides greater autonomy to consumers, by reducing their reliance on medical practitioners. However, in contrast to Giddens' view that a 'full-blown' reskilling is possible, provided individuals have enough time and access to resources, this data suggests that there are certain other restrictions, or limits to the re-skilling process when it comes to matters of health and illness. Indeed, as Lupton (2002) illustrates, dependency upon another is a central feature of the illness experience. In certain situations individuals may need to consult with an expert over a particular health problem, although that might be a CAM practitioner rather than a medical practitioner. This suggests that rather than being a rejection of authority and expert knowledge, there has been a repositioning of authority and an emergence of new experts. Indeed as Rayner and Easthope (2001) argue, while expert control over health has not been rejected, its hegemonic position has.

## Conclusion

### Introduction

This thesis has explored the reasons why individuals turn to complementary and alternative therapies, through an exploration of the sequence of events that leads to the decision to use these therapies. Drawing on empirical research with a group of individual who use these practices, this thesis has explored how individual motivations for using complementary therapies relate to wider social and cultural shifts, addressing key issues relating to risk and trust in relation to experts, to the role of biomedicine in producing health, changing attitudes to the body and personal responsibility for health. Previous research in this field has revealed a great deal about the type of people who use CAM, and the explanations they provide for a particular consultation. However, such research has tended to leave many sociological questions unanswered. Indeed, as Tovey et al. (2004) point out, despite their significance, complementary and alternative therapies have received relatively little theoretical attention. This thesis has sought to build on our understandings of the nature of complementary and alternative therapies, by offering a broader and more theoretically informed account of the use of CAM. In this thesis I have demonstrated that there have been a number of critical changes in late modernity that have altered individual's expectations about health, risk and embodiment and which therefore, help provide an insight into the recent growth of CAM and individual motivations for using complementary therapies. In drawing together and evaluating the aims and findings of this thesis, this chapter will be split into two sections. The first and main body of the chapter will be concerned with the theoretical basis of the study. Here I shall provide a summary of the arguments made in each of the findings chapters and the implications the research has for understanding the nature of CAM usage. The second section will reflect on the research process, address the broader implications and limitations of the research and also focus on the possibilities for future research that have emerged from this study.



## Becoming a CAM user

In chapter 5 I demonstrated how motives for using complementary therapies are not fixed entities and CAM users are not a homogeneous group. Through conducting the interviews and meeting with the various CAM users it became evident that these individuals did not all share the same levels of commitment and reasons for using complementary therapies. Some individuals merely 'dabbled' with complementary therapies, using them when all other options were cut off, whereas for others using complementary therapies was a 'way of life', something that they used all of the time. Individuals also differed in terms of the number of therapies they had used and the length of time they had been using them. For example, some participants had used a vast range of different therapeutic practices, for a number of different health problems over many years, whereas others had used only one or two complementary therapies sporadically over a shorter period of time. Some participants had only ever used complementary therapies via a CAM practitioner, whereas others had mostly experimented with over-the-counter CAM products at home using self-help manuals, others had used a combination of both self-help and practitioner based therapies. Some participants were extremely critical of Western medicines and would attempt to avoid using them at all costs, however, others were much more likely to adopt a 'pick 'n mix' approach, choosing both complementary and orthodox medicines at different times, and for differing health problems. Chapter 5 attempted to capture this diversity amongst the same of CAM users. However, rather than produce a typology of users (Sharma, 1995) that forces individuals into rigid types, I adopted an alternative approach that allowed for a more dynamic and fluid understanding of the nature of CAM usage.

The data revealed that not only did participants have differing motivations for using complementary and alternative therapies, but also that individual motives changed over the course of using CAM. Previous research has tended to treat individual's reasons for using complementary therapies as fixed entities. Furthermore, such research has also focused almost exclusively on individual's *initial* reasons for using CAM, rather than the reasons why they continue to use them. By adopting a developmental approach, drawing on the Chicago school theorizations of status passage and career (e.g. Becker, 1963; Glaser and Strauss, 1971; Goffman, 1968), this

chapter explored individual's initial motivations for using complementary therapies, but also the reasons why they remain engaged with such practices and the ways in which their motivations change over the course of time. The concept of career was originally employed in the study of occupational and organizational mobility and the process of socialization and career progression. However, as Goffman (1968: 119) noted, the concept of career can be used to 'refer to any social strand of any person's course through life'. In this chapter I explored the individual process of *becoming* a CAM user (Becker, 1953), though the analytic concept of the 'career'. I argued that it was possible to identify distinctive career patterns and patterns of usage amongst CAM users. Users *typically* follow a particular sequence of stages in the process of becoming a CAM user. Four categories of users or stages in a CAM career were identified from within my sample: 'new users'; 'occasional users'; 'regular users' and 'committed users'. I demonstrated that as individuals progress along the career trajectory their motivations for using complementary therapies undergo significant changes, at the same time they acquire further justifications and rationalizations that reinforce their continued use of complementary therapies.

The interview data revealed that for the majority of individual their initial motivations for using complementary therapies were similar to those identified from previous research in this field. The majority of participants had first used complementary therapies following 'failed' conventional medical treatments (see also Sharma, 1995). Indeed, many participants had started using complementary therapies after having first been to their doctor for advice and treatment. Many had then, following 'unsatisfactory' results, decided to try a complementary therapy, usually following a prompt from another individual (friend, family member etc.), who was already using CAM. However, in contrast to previous studies this research also found that certain individuals had started to use CAM after being 'introduced' to the ideas and philosophies of different complementary and alternative health practices. These individuals had not initially used complementary therapies because of any particular health problem, but rather had used them for the purposes of relaxation or body maintenance. When individuals first started to use complementary therapies many participants were sceptical about their benefits. Individuals placed an initial 'side-bet' in favour of using them before proceeding further. In other words, they would go along for a consultation with a CAM practitioner or purchase a particular CAM

product, whilst still remaining sceptical about the benefits, feeling that they had 'nothing to lose'. Depending on the 'success' of that treatment they may decide to increase their bets and either return for more treatment or start to try out other types of CAM for different health problems, thus progressing towards more regular use.

After individuals' initial introductions to complementary therapies they progress on to occasional use. Some individuals may move through this stage fairly quickly onto more regular or committed use, to a certain extent this is determined by their health status. However, as they move from occasional to more regular use of complementary therapies, individuals *typically* start to learn more about using complementary therapies and become more open to the idea of using them for different health problems. This learning process was fuelled by information and resources obtained through the mass media, such as magazines, newspaper articles and self-help books or 'guides' to using complementary therapies. And also through social interaction with other more committed users, who share their knowledge of complementary therapies, prompting individuals to try out a range of different treatments.

Whilst a small number of participants continued to use complementary therapies occasionally, only using it when they had a particular health problem that they felt was not 'suitable' for conventional treatment (i.e. back and neck pain), the majority of participants moved on from occasional to either regular or committed use of CAM. In this chapter I argued that regular users were distinguished from committed users, in terms of their levels of commitment to CAM, rather than the frequency with which they used them. Indeed, many regular users were using complementary therapies as often as once a week, in contrast to some committed users who were using CAMs much less frequently. However, regular users were also more likely to continue using conventional medicines for certain health problems. In contrast committed users were shown to be staunchly opposed to the use of conventional medicine and would only use it as 'the absolute last resort'. For committed users complementary therapies had become a 'way of life' and an important part of their identity. These individuals used a wide range of different complementary therapies for a number of different health problems, both via a CAM practitioner and on a self-help basis. Furthermore, I argued that as individuals' progress towards more committed use, complementary

therapies start to permeate other aspects of their lives. For committed users the use of complementary therapies is viewed as being part of a 'natural' or 'alternative' lifestyle. I argued that such 'alternative' or 'natural' lifestyles are reflected in a set of distinctive patterns of consumption (e.g. eating an organic, 'wholefood' diet and avoiding 'processed' foods, engaging in healthy practices, such as exercise and relaxation techniques, concern for environmental and animal welfare issues etc.), which become internalised into a habitus (Bourdieu, 1984). I argued that these changes should be understood as moral in the sense that the experience of using complementary and alternative therapies has provided a 'turning point' in the way they view themselves and the world (Goffman, 1968).

The transition that occurs as individuals' progress along the CAM trajectory was also explored in this chapter, by considering the different vocabularies of motive (Mills, 1963) of new, occasional, regular and committed users. According to Mills (1963) the search for 'real' motives is mistaken. Rather motives should be understood as external products that individuals employ to provide adequate and meaningful descriptions of their behaviour. In this respect such meaningful descriptions are understood as 'accepted justifications for present, future or past programs or acts' (ibid: 907). In this chapter I demonstrated that there were fundamental differences in the vocabularies of motive offered by individuals at different stages of the CAM career trajectory. Indeed, like Becker's (1953) marijuana users, it was argued that as individuals progress along the career trajectory they acquire further rationalizations and justifications that reinforce their continued use of CAMs. Furthermore, the data suggest that individuals also often provided multiple justifications for why they may use complementary therapies at any one time.

In the early stages of the CAM career vocabularies of motive were focused on the need to find relief for a specific health problem, usually following countless 'failed' biomedical treatments. However, as I demonstrated, as individuals' progress towards occasional or regular use their reasons for continuing often change. Secondary motives emerge such as those relating to the effectiveness of the treatment in the short term, such as relief from symptoms and increased energy levels. As well as more affective aspects of the treatment process such as the feelings of relaxation and enjoyment they experience during the treatment. Such factors were found to

complement or reinforce the dominant motivational factor. As individuals progress towards more committed use of complementary therapies they experience a further shift in their motivations. For these individuals, their motives for using complementary therapies were centred around discourses of risk and distrust in biomedicine and medical professionals. Such motivational factors were also evident in other participants' accounts, although they were not the primary motivation influencing their use. In chapter 6 these issues were explored in more detail in the context of sociological debates about risk and trust in experts.

### **Strategies of confidence**

In chapter 6 I explored participant's reasons for rejecting pharmaceutical drugs in favour of more 'natural' modes of healing. The majority of participants in this study were sceptical about the safety of Western medicines and therefore tried to avoid using them where possible.<sup>1</sup> The data indicated that participants viewed Western medicines as posing a threat to the health of the body and associated them with long-term side effects and iatrogenic illness. In contrast, complementary medicines were viewed as providing a 'safer', more 'natural' option. Indeed, amongst the participants the perception that complementary and alternative therapies were 'natural' was a common theme and in many cases acted as a significant motive for use. Coward's (1989) observations concerning the importance of the concept of nature within complementary therapies proved particularly relevant. Coward argues that individuals are attracted to complementary therapies not only because of dissatisfaction with conventional medicine but also because of the mythology of nature and health that underpins such therapies. To be natural, she argues, is automatically seen to be different from, and better than, orthodox medicine. Many individuals classified complementary therapies as 'natural' in contrast to orthodox medicines, which were seen to be 'artificial', 'synthetic', 'chemical' or 'unnatural'.

These findings were explored in the context of debates about risk and reflexive modernization in late modern societies. Drawing on the work of Beck (1992) and

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<sup>1</sup> Although, as I demonstrated the degree of scepticism varied between participants, some individuals rejected conventional medicines and others simply preferred to limit their use of them as much as possible.

Giddens (1991), I focused on how the issue of risk relates to the individuals' motives for using complementary therapies; whether individuals' decisions to use complementary medicines were reliant on assessments of the risks and safety of pharmaceutical drugs; and whether complementary therapies are understood by users as providing a solution to the problems associated with orthodox medicines. As Lupton and Tulloch (2002) note, little empirical research has been conducted that has sought to examine the speculations of Beck and Giddens about 'risk society' (see also Scott et al., 1998; Williams and Bendelow, 1998). In critique of Beck's work Alexander (1996: 134) maintains that: 'Broad tendential speculations are advanced about infrastructural and organizational processes that have little grounding in the actual processes of institutional and everyday life'. Furthermore, previous research on CAM use has demonstrated that many people turn to complementary and alternative therapies because they are dissatisfied with conventional medicines (e.g. Taylor, 1984; Sharma, 1995; Easthope, 1993; Siahpush, 1998) and are concerned about potential side effects of drugs (Verthoef et al., 1998; Wynsong, 1998). However, such research does not consider why it is that CAM users are specifically concerned about such issues. The debate concerning motives for using CAM has largely been conducted in absence of any theoretical input or discussion of the core themes in the sociology of risk. In view of the fact that the concept of risk has become a key issue within the sociology of health and illness (see Williams et al., 2000) this seems surprising. Over recent years there has been increasing uncertainty surrounding the safety of Western pharmaceuticals, the recent controversy surrounding the MMR vaccine demonstrates this clearly. People are now required to assimilate and evaluate increasing amounts of information, especially about health risks (Bury, 1997). For Giddens (1991) such processes produce a 'contestable culture' in which trust in abstract systems and expertise is frequently threatened. In this chapter I situated the use of complementary therapies and the rejection of Western medicines within the context of such debates.

Many participants were doubtful about the reliability of expert knowledges concerning the long-term safety of pharmaceuticals and were aware of the contingent nature of expert knowledges. Here, personal experiences of using conventional medicines, knowledge of friends or relatives' negative experiences of using medicines, or adverse coverage in the mass media influenced individual's perceptions

of the risks of Western medicines. I demonstrated that rather than remaining static, risk positions change over the course of time. Indeed, as Ward et al. (2000) note, the consumption of medicines is usually a routinized activity, and normally consumers do not think about the risks of the medicines they are ingesting. However, new information about the risks of medicines often prompts individuals to reflect on the risks of all medicines and the expert status of medical knowledge. Indeed, through the process of using CAM many individuals had become more reflexive about their use of Western medicines, beginning to question previously taken for granted assumptions about their safety. Whilst a small number of participants claimed to have always been sceptical about conventional medicines, the majority had not always considered them to be harmful. However, many claimed that since they had started to use complementary therapies they had become more cautious about using conventional medicines, and started to perceive them as unnatural and harmful, and had therefore started to increase their use of natural products over conventional drugs. At the same time many participants claimed that they had become more aware of their bodies and started to think more carefully about what they 'put into them'. In support of the arguments presented in chapter 5, this indicates that in the *process of becoming* a CAM user, motives supporting the use of natural remedies in preference to conventional medicines emerge via changes in the symbolic meanings attached to these substances.

Based on findings from a recent Australian study, Connor (2004) suggests that individuals use 'natural therapies' as strategies for risk avoidance, whereby being 'natural' is taken to signify a 'lack of danger or risk'. The findings from this study support Connor's argument. The majority of participants viewed complementary and alternative therapies as a 'safe' and 'risk free' alternative to conventional medicines. The data indicated that if individuals believe that the medicines they consumer are 'natural', rather than 'chemical' or 'artificial' they feel better about using them. In this sense, I argued, that alternative medicines by virtue of their perceived 'naturalness' provide a welcome alternative as they allow individuals to bracket out the uncertainties associated with Western medicines and provide a means of coping with the anxieties associated with caring for health and body within the risk society. This echoes findings from recent research on food and issues of risk and trust, whereby, it is argued that faced with making decisions about what information about

food to trust, individuals tend to fall back on acculturated belief systems, or conceptual 'strategies of confidence' (Sellerberg, 1991), which often involve the use of binary oppositions (Hamilton et al., 1995; Lupton, 1996a, 2005). In relation to decisions about whether to use complementary and alternative therapies, the continual opposition of 'artificial/chemical' and 'natural/unnatural' can be seen as a response to the uncertainty concerning the safety of Western medicines, providing individuals with greater confidence when making decisions about their health.

However, in contrast to users' perceptions concerning the safety of complementary and alternative therapies, over recent years many critics, particularly those from within the medical profession, have tried to draw attention to the so-called 'hidden risk' associated with their use (Ernst, 2001). For example, Ernst (2001) highlights a number of 'risks' associated with the use of complementary therapies, such as instances of iatrogenic illness and even deaths resulting from complementary therapies; the 'dangers' of using complementary therapies as a true alternative to conventional medicine, particularly for serious medical conditions such as cancer; risks linked to 'invalid diagnostic techniques' of CAM therapists; and risks associated with using complementary therapies without informing a medical professional resulting in possible negative interactions with conventional medicines. Previous work on risk perceptions has noted the divergence of opinion between lay and experts in terms of risk. For example, Davison et al. (1991) explored the extent to which lay beliefs about the risk of coronary heart disease both mirror and diverge from expert views. While lay people agreed with health promotion experts that they should accept some responsibility for their health to minimize the risks of heart disease, they differed by referring to the social circumstances surrounding the disease and to more fatalistic ideas when either personalistic or social types of explanation seemed inadequate. According to Wynne (1996), lay actors draw upon their own situated knowledges of the world in constructing risk understandings and responding to experts' pronouncements on risk. As Lupton (1999a: 111) notes, individuals 'often resist or directly challenge experts' judgements on risk'.

For the 'risk society' perspective, reflexive awareness and concern about risk pervade modern sensibilities, creating new forms of relating to the self and others, including experts and institutions (Lupton, 1999a). Doubt and uncertainty, according to



Giddens (1991), are pervasive features of modern life and 'thinking in terms of risk and risk assessment is a more or less ever-present exercise, of a partly imponderable character' (ibid: 123-4). The findings from this study provide some support for Beck and Giddens' assertions concerning the emergence of the 'reflexive consumer' in late modernity. Indeed, as I have demonstrated this group of individuals were particularly anxious about the safety of orthodox medicines, which they believe have the potential to cause harm to their bodies. Furthermore, the combination of uncertainty about technology and declining trust in expert knowledges suggests that concern about the safety of Western pharmaceuticals could be seen as part of a generalized risk anxiety more akin to a 'social state' (Scott et al., 1998: 690). Individuals' risk anxieties about orthodox medicines are one of many anxieties which are linked to the nature of social and technological change, such as concerns about the processing of foodstuffs and 'unnatural' additives and the 'carcinogenic' effects of pesticides:

'I feel as if we're being poisoned by the commercial farming community. Then when you come to hospital with your cancer they focus on the lump, not why it is there, why has this person been poisoned in the food chain, just because they've been spraying toxins on the crops, er, nerve agents or whatever they are...then you go to hospital and you get poisoned by the drugs, and the chemotherapy, well that is the drugs I suppose, and the radiotherapy, double whammy'. (Paul)

Furthermore, such findings correlate with sociological claims that medical orthodoxy is currently being subjected to an external critique and that implicit trust in both the individuals who practice medicine and the underlying system of knowledge may have been weakening (Kelleher et al., 1994).

However, whilst the findings reveal that the 'risk society' thesis was supported in some ways. Other findings, challenged this thesis, for example the data demonstrate that contradiction and contingency are more characteristic of contemporary reflexive subjectivity than Beck and Giddens allow (see also Lash, 1993). Indeed, whilst on the whole individuals tried to restrict their use of Western pharmaceuticals, their 'choice' of complementary therapies was limited in certain situations, particularly in instances involving more serious illness. Indeed, as Lupton (1996) maintains Western medicine

is characterized both by increasing challenges to its ability to deliver safe, risk free and effective therapies on the one hand, and on the other, people are increasingly dependent on it as therapy. Furthermore, certain individuals, whilst still espousing views about the harmful effects of modern medicines, were using certain medicines. In such situations it appeared individuals were prepared to accept the 'risks' of taking medicines, because of their reliance on the benefits from the treatment.

In this chapter I also demonstrated how the use of CAMs for children highlights the contingent and contradictory nature of risk positions. For example, whilst preferring to use complementary therapies for themselves, many participants did not always feel comfortable using them for their children, particularly without consulting an expert (and usually a medical professional). The decisions that parents make when their children are ill are not only influenced by the fact that they are responsible for the care of their children, but also by the fact that they are responsible for their children's well-being should they come to harm (Jackson and Scott, 1999). In this sense, there is a conflict in parent's desire to 'do the best' for their children. On the one hand they want to protect their children from the harmful effects of Western medicines and so prefer to give them 'natural' products. However, on the other hand they have a responsibility as parents to ensure the well-being of their children. This means that if they choose to give their children complementary therapies rather than taking them to the doctor, and the child turns out to have needed medical attention, they themselves will be held culpable (see also Beck and Beck-Gernsheim, 1995). Consequently, parents often do not display the same levels of confidence when it comes to decisions about their children's health, as they do for themselves.

### **Reclaiming control over the self**

In the final findings chapter I focused specifically on the use of complementary therapies for self-help purposes. Here, I refer to the consumption of over-the-counter (OTC) CAM products, such as herbal supplements, homeopathic remedies and aromatherapy essential oils. Indeed, despite evidence to suggest that this is the most popular area of CAM usage, such practices have so far received limited attention within social scientific considerations of complementary and alternative therapies. As a consequence little is known about the sorts of illnesses and health conditions that

individual use such substances for; how individual obtain information and develop knowledge about using complementary therapies for self-care and whether such medicaments are used as an alternative or a supplement to formal health care. In an attempt to bridge this gap in knowledge chapter 7 provided details relating to such issues. The use of complementary therapies for self-care was then explored in relation to the role of expert knowledge and professionals in modern Western societies. Indeed, I argued that such health practices are of particular relevance to these debates as they 'enable consumers to invest in 'health' outside of significant contact with health professionals' (Shilling, 2002: 633).

The majority of participants in this study were either currently using some form of CAM for self-help purposes or had used it in the past. Although the degree to which individuals used such CAM products in their everyday health regimens varied quite considerably,<sup>2</sup> the data from this study suggests that participants used a range of different OTC remedies both as an alternative and a supplement to formal health care. Many individuals used such products in an attempt to either prevent or delay the need to consult a doctor over a particular health problem. However, as indicated in chapter 6 individuals' 'choice' was in certain situations restricted and was very much dependent on the nature of their illness. Indeed, whilst individuals were able to use OTC remedies effectively for more 'everyday illnesses' or minor ailments, for more 'serious' problems individuals would often consult either with a CAM practitioner or more likely a doctor. Nevertheless, many individuals also used OTC remedies *after* they had consulted with their doctor, as a means of 'safely' dealing with their symptoms. Many claimed that they would go to the doctor for a diagnosis, or to rule out any serious health problems. However, depending on the diagnosis, they would then self-treat using complementary therapies. In such situations the doctor is used as a secondary, rather than primary source of health advice (Hardey, 1999, 2001). In chapter 7 I argued that such practices constitute a form of resistance to medical control and a rejection of biomedical hegemony.

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<sup>2</sup> The most 'committed' CAM users used them as an alternative to all over-the-counter pharmaceutical products and would always try to self-treat where possible. However, some other less committed users were more likely to use such products occasionally, such as Echinacea for colds and flu, and usually following a specific recommendation from a more committed CAM user.

A great deal is known about how individuals obtain information about complementary therapies before they visit a complementary therapist (Cant and Calnan, 1991; Kelner and Wellman, 1997; Sharma, 1995). However, very little is known about how individuals obtain information about purchasing OTC CAM products. When consulting with CAM practitioners, previous research has found that networks of family and friends are key sources of information (Sharma, 1995), both in terms of which therapies to use as well as in locating specific therapists (e.g. Lloyd et al., 1993; Sharma, 1995). In terms of participant's choice of which complementary medicines to use for self-care purposes, similar results were found. Many individuals claimed that they had been influenced by individuals within their social network, in terms of advice about specific remedies to try when they had a particular health problem, as well as introducing them to new remedies. However, the data indicated that rather than being an extensive network of consultation among work colleagues, family, neighbours and friends, individuals were more likely to seek advice from people who were thought to have 'special knowledge' (see also Blaxter and Paterson, 1982), and usually individuals who were more experienced users of complementary therapies.

In addition to information obtained through social interaction, individuals also gained knowledge about using complementary therapies from other sources. In particular, the mass media, such as newspaper columns, magazines and to a lesser degree the Internet, as well as literary sources, such as self-help guide books. Many participants used books on complementary therapies as a source of information about which medicines to use, but also to increase their knowledge about complementary therapies in general. As indicated in chapter 5 this is usually something that begins in the early stages in the CAM career and as individuals' progress they become more proficient in their knowledge and build up a repertoire of 'effective' remedies. In chapter 7 I argued that the way in which some participants actively sought out information about different complementary medicines to incorporate into their health regimens can be seen as part of what Giddens (1990; 1991) refers to as the 're-skilling process'. Giddens suggests that the 'lay' public is increasingly informed and reflexive, especially as knowledge has become pluralized. In such a context, he argues, it is likely that individuals will attempt to 're-skill', by taking back some control from the 'experts' and by searching for alternatives. Indeed, in addition to using their

knowledge of complementary therapies to treat themselves, several individuals also regularly offered advice to others.<sup>3</sup> However, whilst the interview data provided some support for Giddens' assertions, in contrast to his view that a 'full-blown' re-skilling process in the context of health and illness. Indeed, a central feature of the illness experience is dependency upon another (Lupton, 2002). Individuals may feel that in certain situations they need to consult with an 'expert' over a particular health problem. Again, this was particularly the case in situations where they were concerned about whether their health problem was more 'serious', or that the symptoms were so severe that they needed immediate medical attention. This suggests that biomedicine has not lost its hegemonic position. Nevertheless, as I have already indicated this does not mean that individuals passively accept their doctor's advice and many participants *returned* to using CAM after they had consulted with their doctor.

It has been suggested that complementary therapies represent a postmodern rejection of authority and an attempt by individuals to reclaim control over their health (Bakx, 1991; Easthope, 1993). Certainly, the data from this study indicate that the use of complementary therapies for self-care purposes provides individuals with a greater sense of control over their health and is also viewed as a means of self-empowerment, enabling individuals to treat themselves how and when they choose. However, as I demonstrated in chapter 7, when obtaining information about complementary and alternative medicines individuals rely on different sources, both lay and expert for help and advice, other than their GP. In this sense, rather than being a postmodern rejection of authority and expert knowledge, these findings support Rayner and Easthope's (2001) assertion that there has been a repositioning of authority and an emergence of new experts (and indeed, new forms of expertise). Indeed, whilst many participants claimed that they did not go to the doctor for help and advice when they were ill, many did suggest that they consulted with their CAM practitioner or individuals working in health food stores when looking for advice about using complementary therapies.

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<sup>3</sup> Although, as I have indicated, the data from this study indicate that this was mostly the case for female participants. However, the small number of male participants is also likely to have produced a bias in this respect.

## Discussion

One of the main aims of the study was to take up the call for a more theoretical approach to the study of complementary and alternative therapies (e.g. Siahpush, 2000; Tovey et al., 2004). The research in particular aimed to contribute to existing literature on complementary therapies, whilst at the same time exploring the relationship between individuals' motivations for using CAM and wider social and cultural shifts that have altered individuals' expectations of health, risk and embodiment. This thesis has demonstrated that there have been a number of critical changes occurring in late modern societies that carry implications for the way that biomedicine is perceived, the role of the public as consumers of health care, and the current popularity of complementary and alternative therapies. For example, this thesis has shown that individuals' motivations for using complementary therapies are influenced by discourses of risk and distrust in biomedicine and the emergence of so-called information risk, bodily conscious consumers of health care (Shilling, 2002). The theme of choice has been pervasive throughout this thesis. The concept of choice features strongly in the writings of individualization theorists such as Beck and Giddens. For Giddens (1991: 80), one of the great challenges to the individual, in late modern societies, is the fact that they are confronted 'with a complex diversity of choices and because it is non-foundational, at the same time offers little help as to which options should be selected'. Individuals are faced with increasing choice and yet at the same time such choice is fraught with uncertainty and anxiety. Beck (1994) argues that, the loss of tradition and the dissolution of previously existing social forms such as fixed gender roles and inflexible class positions suggests that people are increasingly engaging with areas of their lives that were previously dictated by tradition and taken for granted norms. As a consequence, human beings are now faced with a whole range of possible choices. In his work with Beck-Gernsheim, Beck (Beck and Beck-Gernsheim, 1995) has suggested that the processes of individualization have meant that there are greater possibilities for choice in areas of sexual identity, work and family relationships.

Health is increasingly conceptualised in terms of choice, for example there is increasing pressure on individuals to make the 'right' lifestyle choices in relation to 'healthy' and 'unhealthy' behaviours. Should they choose to engage in unhealthy

practices, such as smoking, eating fatty foods or not exercising they themselves may then be blamed when they become ill, for failing to take care of themselves (Greco, 1993). Within health policy there is also an increasing emphasis placed on choice, for example, within the recent Department of Health document '*Choosing Health*' (2004), the focus is on providing people with information about health so they can make 'good choices'. Furthermore, within the current literature on CAM use, complementary therapies are frequently presented in terms of consumer choice, users are conceptualised as active decision makers choosing the services they desire. However, whilst this thesis has undoubtedly provided support for such arguments, it has also demonstrated that there are certain constraints on an individuals' ability to choose between differing health care options. For example, when an individual is faced with an affliction of a potentially serious, life-threatening nature, they may feel they have not option but to return to their doctor for help. This indicates that whilst complementary therapies may be adopted, at least for some users, as a form of resistance to biomedical control, biomedicine has not yet lost its hegemonic position. Furthermore, as Blaxter (2004) illustrates, the new flexibility and reflexive identity does not redress the old inequalities of health. According to Benton and Burrows (1995: 211):

'Although we may well be witnessing the emergence of late modern forms of self-identity it is not a uniform transformation across the population. Some actors have a much greater autonomy to construct their identities than others. Whilst some may be able to pay for cosmetic surgery others have to wait for unacceptably long periods just for routine relief from pain and other obstacles in their daily lives. Whilst some can afford to choose extra virgin olive oil and fresh vegetables, others have to sleep in cardboard boxes on the streets and eat what food they can get'.

Sociological literature has long shown how factors such as social class and gender shape people's health beliefs. Indeed it has been suggested that the use of complementary and alternative medicines is mostly confined to certain segments of the middle class, including the 'worried well', (Crawford, 1980; Williams, 2003), those with the financial resources, time and cultural capital. However, whilst the data from such a small-scale study as this are not equipped to assess such claims, it was

undoubtedly a struggle for some participants involved in this research to allocate both the time and financial resources necessary for specific CAM treatments.

### **Limitations and future research**

The research on which this thesis is based aimed to address gaps within existing research on the use of complementary and alternative therapies. The findings of the study not only address such gaps, but also have implications for future research. In this final section I will discuss the possibilities for future research that have emerged from this study. However, before I discuss these issues in detail, I would like to reflect on the limitations of this research. There are interesting questions that have been generated by this study that inevitably remain unanswered. First, within my sample there was a clear bias in favour of female CAM users. This made it difficult to explore in any detail differences between male and female users. For example, which types of complementary and alternative therapies do men and women use, and are certain types of CAM more popular amongst women than they are amongst men? Are women more likely to rely on social networks when sharing information about using complementary therapies? Indeed, as we saw in chapter 7, female users were more likely to take up complementary therapies for self-care and give advice to others about different types of therapies to use. In contrast, most of the male participants who were using OTC CAM products were doing so following advice and/or prompting from their partner or spouse and on the whole did not generally talk about making recommendations to others. Certainly previous research has indicated that it is mostly women who share information and advice about health issues in this way (Blaxter and Paterson, 1982). However, this situation may be changing as one participant indicated when talking about recent discussions he had with a group of male friends, about prostate treatments:

‘I can’t imagine even five years ago a group of five middle age men sitting around a table talking about their prostate, I cannot imagine it, and these guys are not right on you know, they’re in business, well dealing with business, they’re just not right on, they’re not, they’re, they don’t share their emotions and things, I have other groups of friends who would, but they aren’t. But they are quite happy to, in front of their wives, talking about their penises, it was



amazing, absolutely amazing. And I just think people's attitudes towards health have changed'. (James)

This suggests that in addition to further research focusing specifically on women's CAM consumption (Adams et al. 2003), there is also a need for further research to explore men's use of CAM,<sup>4</sup> and their attitudes and behaviour towards health more generally.

This thesis could also be criticised for providing only a snapshot of CAM consumption patterns, making it difficult to chart trends in individuals' consumption patterns in an accurate manner. Whilst I argued in chapter 5 that individuals' consumption of CAM changes over the course of time, in the interviews I was reliant on individuals' memory and ability to recollect their reasons for using complementary therapies at any one time. For those individuals who had been using complementary therapies for more than 20 years this often proved difficult. A longitudinal study of individual's use of complementary therapies could be employed to help address such issues in more detail. Furthermore, there are undoubtedly problems with having to ask users to talk about their experiences of using CAM retrospectively, as their accounts may be influenced by their subsequent experience of a particular therapy (Cant and Sharma, 1999). This thesis could also be criticised for only focusing on the use of complementary therapies in one part of the United Kingdom. During the final stages of writing this research I moved to the South West of England. It soon became evident, purely on an anecdotal level, that the use of complementary therapies was quite different in this region to the North East of England. For a start, complementary therapies appear to be so much more prevalent in the South West. For instance, just in the small market town where I live there are three complementary health clinics, and posters in health food stores, supermarkets and community centres advertising various complementary and alternative health practices. Furthermore, one of the practitioners I interviewed had experience of practicing both in the North East and the South of England and was able to reflect on the differences between her clients in both areas:

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<sup>4</sup> A small number of studies have focused on male cancer patients' use of CAM (e.g. Boon et al., 2003; Wilkinson, 2002).

D: ...But I've recently moved to Newcastle from Sussex and there's quite a difference...

L: What sort of difference...

D: ...in attitude...

L: What do you mean a difference?

D: Erm, there are people who are more critical of the medical profession and therefore in some cases just say they wouldn't consider going to the GP because...

L: Here or in Sussex?

D: In Sussex yes. They would always use a complementary therapist or take charge of their own health by changing their diet or whatever. Erm, I haven't come across that so much here, they tend to keep on seeing their GP whilst coming to see a therapist...But there is that, and because I haven't seen many people in Newcastle yet I'm not sure how that, whether that's universal.

(Debra, reflexologist)

In this respect comparative research may provide interesting insights into the differences in CAM use between different regions. There is also scope for cross-cultural studies of CAM use. Indeed, whilst research has charted CAM consumption in a large number of countries (including Australia, Canada and the USA), as Adams et al. (2003) point out no work to date has specifically compared CAM use or users from more than one country.

One of the most interesting issues raised by this research was the use of complementary and alternative therapies for self-help purposes. This thesis has demonstrated that the use of CAM for self-treatment is a topic worthy of study in its own right, providing insight into how individuals manage their health problems on an everyday basis. Furthermore, this area of research is of particular relevance in the

context of debates about 'safeguarding the public' from the dangers of self-prescribing, and recent changes in the sale and regulation of CAM products, such as the EU traditional herbal medicines directive. Indeed, further research specifically focusing on this area of CAM usage may help to provide a broader understanding of such practices, in the context of these debates. However, as this study has demonstrated accessing this 'hidden' area of CAM use can prove difficult and future research will require particular methodological approaches, such as the use of health diaries, to provide an insight into such everyday health practices.

Another interesting area for future research to emerge from this study relates to the use of complementary and alternative therapies for children. Indeed, only a small number of participants in this study had children living at home and were currently using complementary therapies for them. However, this area of CAM use is of particular interest, not only because the numbers of children using complementary therapies has increased over recent years (South and Lim, 2003), but also in the context of uncertainty about the safety of particular biomedical interventions, such as the MMR vaccine, whereby parents may increasingly be searching for 'safer' and more 'natural' alternatives. This research domain could explore a number of issues including: How do parents make decisions about whether to take their children for complementary and alternative therapies? Are they mostly users themselves? Are certain CAMs more popular for children than others? How do children, themselves, interpret and understand complementary and alternative medicines?

Finally, this research has revealed the importance of the concept of 'nature' within the complementary and alternative health movement. However, as Coward notes (1989: 15) such understandings of the virtues of 'nature' are not restricted to complementary therapies: 'It is a widespread and prevalent feeling that if it's natural, then it must be good for us'. Indeed, as technological developments continue unabated large numbers of people are becoming interested in finding more 'natural' ways to live (Coward, 1989). For example, over recent years we have witnessed the increase in the availability and consumption of organic foods (Locke, 2002), in vegetarianism (Beardsworth and Kiel, 1992, 1993; Hamilton et al., 1995; Szerszynski, 2005) and in

'green' consumerism (Micheletti, 2003; Szerszynski, 2005),<sup>5</sup> at the same time countless health and beauty products are marketed in terms of their 'natural' properties. Further exploration of the category of 'natural' as a source of understanding is needed in order to explain the relationship between these areas of consumption.

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<sup>5</sup> Douglas (1994: 23) sees vegetarianism, new religions, environmentalism and complementary medicines as part of a general 'option for gentleness' in post-1960s culture.

## Appendix 1: Participants

**Table 3.1 CAM Users**

<b>Name</b>	<b>Therapies used</b>	<b>Occupation</b>	<b>Age</b>
Alex	Various herbal remedies, osteopathy, homeopathy and acupuncture	Part time farmer	45
Anna	Homeopathy, osteopathy, yoga, herbal remedies	Student	30
Laura	Homeopathy, chiropractic, osteopathy, herbal remedies	Store manager	39
Lorraine	Herbal remedies, homeopathy, aromatherapy oils	N/A	37
Emily	Reflexology, reiki, homeopathy	Civil servant	30
Sylvia	Homeopathy, healing, Bach flower remedies, acupuncture	Retired teacher	74
Elaine	Acupuncture, reflexology, homeopathy, osteopathy, shiatsu, Indian head massage, Bach flower remedies, herbal remedies, aromatherapy	Retired probation officer/ teaches piano part-time	56
Pat	Reflexology	Long term sick	49
Susan	Reflexology, herbal remedies, Bach flower remedies	Nursing home manager	43
Steve	Reflexology, osteopathy, acupuncture, naturopathy, homeopathy, reiki, aromatherapy, various herbal supplements	IT manager	46
Paul	Chinese medicine, acupuncture, herbal remedies, shiatsu, reiki, aromatherapy, osteopathy, reflexology, homeopathy	BT engineer	53

James	Homeopathy, various herbal remedies	Lawyer	52
John	Alexander technique, aromatherapy, shiatsu, reflexology, yoga, acupuncture, homeopathy, herbal remedies, healing, reiki	Retired university lecturer	73
Amanda	Reflexology, chiropractic, yoga, iridology, homeopathy, various herbal remedies, aromatherapy oils	Teacher	28
Suzanne	Chiropractic, osteopathy, aromatherapy, hypnotherapy, reiki, hot stone therapy, reflexology and herbal remedies	Marketing manager	37
Tina	Reflexology, herbal remedies, Bach flower remedies	Finance manager	44
Christine	Homeopathy, osteopathy, acupuncture, kinesiology, reiki, spiritual healing, Alexander technique, yoga, herbalism, nutritional therapy, aromatherapy, herbal remedies, Bach flower remedies	Yoga Instructor	46
Mary	Chiropractic, acupuncture, shiatsu, reiki, massage, Indian head massage, osteopathy	Yoga Instructor	56
Chloe	Acupuncture, homeopathy, herbal remedies	Long term sick	32
Catherine	Homeopathy, chiropractic, osteopathy, aromatherapy	Retired/swimming instructor	66
Janet	Osteopathy, kinesiology, chiropractic, aromatherapy, acupuncture, homeopathy, herbal remedies, Bach flower remedies	Retired vet	69
Jane	Homeopathy, reflexology, chiropractic, reiki, healing, osteopathy, herbal remedies	Conservation worker	56
Helen	Hypnotherapy, homeopathy, aromatherapy, naturopathy, cranial osteopathy, Chinese medicine, herbal remedies	Student	26

Linda	Herbal remedies, homeopathy, massage, aromatherapy	Secretary	47
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**Table 3.2 - CAM Practitioners**

<b>Name</b>	<b>Therapy practiced</b>	<b>Other occupation (if any)</b>	<b>Age</b>
Ann	Aromatherapy	Teaches aromatherapy	44
Lisa	Nutritional therapy/Yoga	Personal trainer	36
Ian	Chiropractic	N/A	48
Fiona	Acupuncture	Nurse	34
Gayle	Homeopathy	N/A	58
Marie	Reflexology/aromatherapy	N/A	52
Jackie	Homeopathy	N/A	46
Debra	Reflexology	N/A	49
Julie	Reflexology	Hairdresser/teaches reflexology	59
Sandra	Bach flower remedies	Administrator	54

## **Appendix 2: Flyer and Practitioner Letter**

Copy of the flyer used to recruit my sample:

### **HAVE YOU EVER USED ANY TYPE OF COMPLEMENTARY OR ALTERNATIVE MEDICINES?**

If so, would you be interested in participating in a new study taking place at the University of Durham. Over recent years there has been growing public interest in many forms of complementary and alternative medicines. The aim of this research is to investigate the reasons why increasing numbers of people are now choosing to use them. As part of the research I would like to talk to you about your own experiences of using complementary and alternative medicines. This should take no more than one hour of your time and can be carried out at a venue most convenient for you.

If you are interested in taking part in such a project or have any questions about the study please do not hesitate to contact me.

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Copy of letter sent to practitioners inviting them to take part in the research:

Dear ....

I am writing to you concerning my research at the University of Durham where I am currently undertaking a PhD in sociology, under the supervision of Professor Sue Scott. The aim of this research is to examine the reasons why people turn to complementary and alternative medicines, through an exploration of the sequence of events that leads to the decision to use these therapies.

Over recent years there has been growing public interest in many forms of complementary and alternative medicines. As these forms of health care gain more legitimacy and popularity further research is increasingly important, particularly in relation to the experiences of those using these services. It is to this further development that I want my research to contribute. The research will involve conducting a series of interviews with users of various forms of complementary and alternative medicines. The focus of these interviews will be concerned largely with investigating individual experiences of, and motivation for using, complementary and alternative medicines.

In addition to the interviews with users I would also like to conduct a number of interviews with complementary medical practitioners. This will help to provide me with a better understanding of the context and greater knowledge of the scope of the services, the philosophy of practitioners and the overall pattern of use and background of users. If you are interested in taking part in such a project or have any further questions about the study please contact me at the above address.

Yours sincerely

Lauren Brooks

### Appendix 3: Use of over-the-counter CAM products

Table 6.1 CAM products used for self-treatment

CAM products	Number of participants
Chinese herbal medicine	3
Herbal teas	2
Homeopathic remedies	12
Echinacea	15
Dr Bach flower remedies	7
Herbal supplements <sup>1</sup>	10
Evening Primrose oil	5
Glucosamine Sulphate	3
Aromatherapy oils	9
'Traditional' remedies <sup>2</sup>	7
Propolis Cream	2
Arnica cream	4
Garlic capsules	3
Menthol crystals	1
Tiger Balm	1
Acidophilus	6

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<sup>1</sup> Includes herbal supplements such as St John's Wort, Agnus Castus etc.

<sup>2</sup> Includes remedies such as honey and lemon for colds or chewing cloves for toothache.

**Table 6.2 Conditions for which CAM products were used.**

<b>Health complaint</b>	<b>Number of participants</b>
Colds, flu, sore throat, cough etc.	12
Tonsillitis	1
Headache	2
Migraine	4
Post-operative care	2
Digestive problems	4
Period pain	2
Depression	4
Poly cystic ovary syndrome	1
Toothache	1
Preventive medicine	7
Sinus problems	3
Haemorrhoids	1
Upset stomach	5
Insomnia	4
Injuries (including sports injuries, bruises, cuts, sores etc.)	7
Nappy rash	1
'Boost the immune system'	4
Menopausal symptoms	1
Relaxation	6
Hangover	1
'Nerves', nervousness, feeling anxious or worried	7
Hayfever	1
Pre-menstrual syndrome	2
Eczema	1
Tiredness	1
Travel sickness	2
Breast cancer	1

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