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SECTION 1

Profile, demographics and motivations for complementary and alternative medicine use

Introduction

Alongside the recent rise in the popularity of CAM (Complementary and Alternative Medicine) has emerged a body of literature examining the exponential growth of CAM consumption. Opening this initial section of the reader, Andrews and colleagues (Chapter 1) provide a brief overview of the findings and trends from the international consumption literature to date. The chapter focuses on prevalence of use, the profile of users and the drivers/motivations for the growth in CAM consumption. As the chapter suggests, while a wealth of data has been collected and analysed on this broad topic, further study is required to better understand different CAM patient journeys through time and space and the motivations of the increasing number of heterogeneous CAM users. The authors also highlight the need to investigate CAM users in a more sophisticated way, being sensitive to variations in the type of modality used, the nature of use and the type of user.

These issues fit well with Chapter 2, in which Connor provides a rich examination of the perspectives and experiences of those embracing ‘mixed therapy regimens’ in an Australian suburb. This work, drawing on the ethnographic method to explore lay constructions of therapeutic pluralism (using multiple types of therapists and therapies at any one time, or moving in serial fashion from one type of therapy to another), alerts us to the importance of appreciating that health service users may not conceptualize the ‘field’ in terms similar to those of researchers or practitioners. It is telling that the dichotomous model of ‘conventional’ versus ‘complementary’ medicine (or other similar titles) was not universally employed by participants in Connor’s fieldwork to explain their health care experiences or perceptions. In addition to outlining how sufferers are purposeful and pragmatic in their approach to health-seeking behaviour, Connor also explores possible broader sociological explanations (beyond the epidemiological enquiry outlined in Chapter 1) for why people may be seeking out non-biomedical practitioners and constructing mixed therapy regimens.
Closing this section, Sibbritt and Adams (Chapter 3) return to the CAM use/user literature and draw on their work and that of others to explore a number of challenges and opportunities related to secondary data analyses of existing cohort studies and longitudinal databases. As the authors suggest, researchers can utilize the possible resource of secondary data analyses to help advance CAM consumption research, especially with a view to producing longitudinal analyses charting trends in CAM use.
CHAPTER 1

The profile of complementary and alternative medicine users and reasons for complementary and alternative medicine use

GA VIN J. ANDREWS, JON ADAMS, JEREMY SEGROTT AND CHI WAI LUI

Introduction

The use of complementary and alternative medicine (CAM) has become a mainstream health care activity in many countries. The rise in prevalence of CAM use over the past decade reflects an epidemiological transition of disease patterns as well as profound transformations in health beliefs and practices in contemporary societies. As a global health trend, the use of CAM plays an increasingly important role in the management of chronic diseases and the promotion of well-being. The rapid increase in the consumption of CAM has generated much concern and discussion among health providers, policymakers and increasingly researchers. Drawing on a wide body of international research, this chapter provides an introduction to the profile of CAM users as well as the reasons people use CAM.

CAM users

The popularity of CAM has grown exponentially over recent years and CAM is now positioned as a major health care resource in most advanced industrial

societies for both the treatment of illness and the maintenance of well-being (Tovey et al., 2004). Empirical work has identified the use of CAM by a substantial proportion of the general population in a number of countries (Barnes et al., 2004; Adams et al., 2007; Steinsbekk et al., 2007) and analysis suggests that consumers contribute far more financially from their own pocket for CAM than for conventional medicines (MacLennan et al., 2006).

While these and other surveys provide prevalence estimates ranging between 30 and 75 per cent, accurate interpretations and comparisons across surveys are difficult due to variations in CAM definition, question formulation and design rigour (Harris and Rees, 2000). For example, some surveys have reported CAM use over 12-month periods (Adams et al., 2003; Steinsbekk et al., 2007), others lifetime CAM use (Kessler et al., 2001), yet others have begun to produce longitudinal analysis of CAM use over set periods of time (Bair et al., 2002; Sibbritt et al., 2004, Sibbritt et al., 2011). Similarly, whereas some research has reported prevalence rates for consultations with CAM practitioners (Wolsko et al., 2002; Adams et al., 2003), other studies have included the prevalence of such consultations alongside self-prescribed CAM not requiring a practitioner (MacLennan et al., 2006). Geographical variations in CAM definition, as outlined earlier, should also be considered when interpreting such findings (Adams et al., 2004). In addition to prevalence among the general public, work has identified relatively high levels of CAM use among specific patient populations. For example, studies have reported high levels of CAM use among cancer patients (Molassiotis et al., 2005), patients with diabetes (Edge et al., 2002; Yeh et al., 2002) and patients with rheumatism (Rao et al., 1999).

Despite obvious difficulties in comparing prevalence rates across places, populations and cultures, it does appear from the expanding literature that CAM is no longer confined to specific population subsections and minorities, but is a popular treatment choice across society. Nevertheless, much research shows that CAM users are more likely to be female, middle-aged (30–50 years old), have a higher income, have a higher level of education, be in full-time employment and have a poorer health status than non-CAM users. Some work also suggests that CAM users are more likely to reside in non-urban areas than are non-CAM users (Adams et al., 2003). This has prompted some commentators to suggest an urban–rural divide in CAM use. However, further research is required here and at present the use of CAM and its relationship to rural/urban health remains open to conjecture (Adams, 2004).

Research conducted largely in the United States has examined racial/ethnic differences in CAM use, with some revealing a higher level of CAM consumption among non-Hispanic whites relative to minorities (Barnes et al., 2004; Graham et al., 2005; Hsiao et al., 2006). Meanwhile, other work suggests that CAM use is equally prevalent among different racial/ethnic groups (Mackenzie et al., 2003), with different ethnic groups utilizing different CAM modalities, in some cases aligned to cultural traditions (Najm et al., 2003).

As suggested above, the vast majority of CAM consumption data also illustrates that CAM users tend to employ these medicines in conjunction with,
and not as a substitute for, conventional health services (Adams, 2004). This finding suggests that consumers do not perceive CAM as being in direct opposition to conventional services, but are instead employing different types of medicines on a more pragmatic basis (Andrews, 2002). Nevertheless, this does not necessarily mean that consumers fail to perceive differences between the two types of medicines, and it may well be that certain features of CAM (not necessarily predominant in conventional medical care) help understand and explain the increasing popularity of CAM with health care consumers.

**Why do people use CAM?**

Many studies have investigated the reasons people use CAM. Although not always stated in this way, these reasons can be grouped under push factors (from conventional medicine) and pull factors (to CAM). In terms of the former, it is thought that users are effectively pushed towards CAM because they have become dissatisfied with conventional medicine. Various reasons have been given for this, including a lack of confidence in conventional medicine’s ability to treat a range of prevalent chronic conditions effectively (Furnham and Forey, 1994; Furnham *et al*., 1995; Furnham and Kirkcaldy, 1996; McGregor and Peay, 1996), the perceived negative side-effects of drugs and their over-prescribing (Verhoef *et al*., 1998) and a failure to meet the emotional needs of patients through comfort and support (Peters, 1997).

In terms of pull factors, it is thought that users are pulled towards CAM by a range of factors, including the holistic and personalized nature of many treatments, the greater time spent in consultations, the spiritual dimension to care (Vincent and Furnham, 1996), because CAM is more consistent with many people’s personal values and philosophical orientations towards health (Siahpush 1999a, 1999b), because it forms part of a wider identification with an alternative ideology or subculture (Pawluch *et al*., 1994; Fulder, 1996; Kelner and Wellman, 1997a) and ultimately because it is perceived to work where conventional medicine does not.

Of course, push and pull factors are highly interrelated. For example, a desire for more personal control over treatment can be associated with a perception that conventional medicine disempowers patients whereas CAM empowers them. A desire to engage in a more personalized service in CAM, incorporating a closer and more open form of practitioner–patient relationship, contrasts with a perception that conventional medicine is impersonal and remote. A perceived need to seek ‘natural’ solutions to health and illness contrasts with a perception that conventional treatments are invasive and involve an unnecessary iatrogenic toll. Also, a need to find responses in CAM for the increasing range of chronic conditions that affect contemporary populations relates directly to the perception that such conditions are not adequately addressed by the conventional curative model (Millar, 1997; Siahpush, 1998; Bausell *et al*., 2001; Menniti-Ippolito *et al*., 2002).
More generally, an added influence, or pathway, to CAM use may also originate in wider societal change (see Chapter 2 in this collection for further details). Kelner and Wellman (1997b) argue that the increasing use of CAM reflects a greater number of ‘smart consumers’ in western society: more people who are well informed about health-related issues and who prefer to use their own personal informed judgement regarding their health and health care. This, the authors contest, reflects a wider consumer interest in health and body matters in western society and a pervasive moral duty to act and be well (Greco, 1993; Conrad, 1994). It is also argued that the media has a part to play in promoting this consumerist health culture and sustaining the demand for CAM by providing a wealth of information in popular magazines and newspapers on diseases and available treatments (Doel and Segrott, 2003).

Some empirical work has helped explore these issues and has begun to test such hypotheses. However, recent research and commentary suggest that CAM users need to be investigated in a more sophisticated way that is sensitive to variations in the type of modality used, the nature of use (whether prolonged or intermittent and so on) and the type of user (for example across racial/ethnic, gendered or geographical lines) (Andrews, 2002; Siros and Gick, 2002; Adams et al., 2004; Chao et al., 2006; Shmueli and Shuval, 2006). Further empirical research is needed to gain a better understanding of different CAM patient journeys through time and space and the motivations of the increasing number of heterogeneous CAM users.

**Further reading**


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