Complementary and Alternative Therapies: Distinctions without a difference or validly diverse world-views ?

Geoff Heath
Geoffheath@aol.com

'Almost one-third of newly referred hospital outpatients are suffering symptoms that cannot be explained by any recognised medical condition or disease'. (Times Higher Education Supplement, 14 November 2003).

I shall be posting the original seminar paper as well as the following Reflections paper on the Bowland Press website on which there is a discussion box. If you want to engage in discussion then the website provides an opportunity.

www.bowlandpress.com/phorum or www.bowlandpress.com and follow the clicks to discussion box.

This paper will be sent out to Alternative and Complementary Health Research Network (ACHRN) members prior to the 28 November session. I hope that members have the time to read it in preparation for the session. I shall not deliver it as a lecture, but copies of it will be available on 28 November. For the session I shall provide a typed list of what I consider to be some key issues/questions which will help to focus our discussion. (See pp 8-9 below). I shall also provide two reports from 'The Independent' on alternative therapies one of which (29/11/2000) has a matrix entitled: 'The Good, The Questionable and The Beyond The Pale'. The other being Jane Feinmann's report (10/11 2003) entitled: 'Here comes the science bit'. I will provide multiple copies of a book review from the London Review of Books (23 October 2003) and also of the report in the THES (14/11/2003) from which the opening quotation is taken.

There are two book reviews in the London Review of Books (8 January 2004 pp 21-22) each of which is relevant to issues raised in the seminar and also to complementary and alternative therapies generally.

Lucire Y 2003 Constructing RSI: Belief and Desire. New South Wales.

Moerman D 2002 Meaning, Medicine and the 'Placebo Effect'. Cambridge

The book by Jutte *et al* (2001) is an excellent source for issues of importation and validity.

If it's not too off-putting, this session could be seen as a follow up to the Epistemological Audit Trail (EAT) which I sent out about 18 months ago. What I was trying to do in that EAT was to provide an opportunity for some very detailed reflection on *what kinds of knowing are implicit in your espoused therapeutic theory.*

As members of the group know I am not a practitioner in any of the dis-ease therapies, and therefore some of the following discussion may suffer from my ignorance. My background is in counselling and human relations with a long term interest in philosophy. I have also studied Christian theology. So, in addition to raising questions I am also in the learning mode.

One of the Aims of that previous (EAT) session was:

To enable the exploration of the sources of validity of foundational terms and concepts which are used in the theory of your chosen form of therapy.

We didn't actually address that aim in the previous session.

The Aims of this session are:

1 *To attempt to elucidate differences between Complementary and Alternative.*

2 *To refer, briefly, to some issues of culture and taxonomy.*

3 *To continue the exploration of the sources of validity of foundational terms and concepts which are used in the theory of your chosen form of therapy.*

4 *To consider notions of 'validity' and to explore whether validity for one form of therapy might apply to others.*

Introduction

My sense is that there are implicit, unclear but presumably important differences between 'Complementary' and 'Alternative' which could usefully be explored. I think that not to do so perpetuates confusion in practitioners' minds as well as the minds of public and of potential statutory regulation bodies. I also notice that in the government document (NHS: Modernising Regulation in the Health Professions: Consultative Document, August 2001) the term 'Supplementary' is used. It is possible, of course, that the confusion is in my mind only. In which case I am simply trying to clarify my own confusion. The title of this paper states my confusion. It is also possible that some therapeutic practitioners in the ACHRN group may resist the use of either Complementary and/or Alternative.

Taxonomy: Chinese and otherwise

I was amused, as was Foucault, when I read the Chinese taxonomy below. It reminded me of the immense variety of ways in which cultures make meaning of the world. My own assumption is that there is no meaning in the world itself, and therefore the only sources of meaning are those which cultures construct. Hence, from my point of view, therapies and their associated meanings are located in cultures.

In my previous session I not only focused on epistemological issues but also on meta-narratives. These will still be unavoidably hovering around, but on this occasion I shall try to focus on differences and similarities between C and A therapies. One way of introducing this issue is to ask:

What taxonomies of health/ dis-ease do the different therapies adopt ?

To re-phrase this: how do the different therapies *order* their notions of the body/mind dis-ease and related symptomatology ? How does a particular therapy explicitly relate to this 'ordering' process ?

A Chinese taxonomy.

Quotation from: Foucault (1974) 'The Order of Things'.

> This book first arose out of a passage in Borges, out of the laughter that shattered, as I read the passage, all the familiar landmarks of my thought – **our** thought, the thought that bears the stamp of our age and our geography – breaking up all the ordered surfaces and the planes with which we are accustomed to tame the wild profusion of existing things, and continuing long afterwards to disturb and threaten with collapse our age-old distinction between the same and the other. This passage quotes a *'certain Chinese encyclopaedia' in which it is written that 'animals are divided into: (a) belonging to the Emperor, (b) embalmed, (c) tame, (d) sucking pigs, (e) sirens, (f) fabulous, (g) stray dogs, (h) included in the present classification, (i) frenzied, (j) innumerable, (k) drawn with a very fine camel hair brush, (l) et cetera, (m) having just broken the water pitcher, (n) that from a long way off look like flies'*. In the wonderment of this taxonomy, the thing we apprehend in one great leap, the thing that, by means of the fable, is demonstrated as the exotic charm of another system of thought, is the limitation of our own, the stark impossibility of thinking **that**. (Preface, p xv). (emphasis in original).

I smile every time I read that taxonomy.

A Western Taxonomy

The more usual Western approach to taxonomy, to the ways in which we 'chunk' our forms of knowledge, are as follows (my version is based on Hirst and Peters).

Kinds of knowledge:

1 The scientific exploration of the hard world of 'things', living and otherwise. The world 'out there' as it appears to us and of which we necessarily have to take account.

2 Language and symbols, including mathematics, and what they might mean and to what they might refer – if anything.

3 The social world of relations, politics, groups, organisations, institutions.

4 The ethical world of moral decisions, justice, the law.

5 The existential world of meaning, being, life and death. Religious/spiritual/secular meanings of life language. Notions of origins and destinies. This includes the humanities.

6 The medical/health world of illness, suffering, symptoms, disease and therapy.

7 The world of aesthetics.

8 The inner world of sensations, feelings, thoughts, ideas, fantasies, needs, motivations.

9 The (philosophical) world of problems about which we puzzle: mind/body, inner/outer, epistemology, scepticism, doubt, consciousness, identity, self and so on.

Obviously these categories of knowledge merge, overlap and permeate each other in the business of living.

We could, of course, spend some time discussing this 'Western' taxonomy and general issues arising from our different ways of ordering things, but perhaps not now except by implication in the following response which I sent to Linda.

Complementary and Alternative

In my email thanking Linda for her thought-provoking presentation last time I made the following points which I have since amplified. They relate to my tentative views on ways in which C and A therapies might order their understanding of symptoms, dis-ease and health.

1 Models of Complementary Therapies Related (?) to the Hegemony of the Western Bio- medical model.

It is evident that in 'our' society (Western, Enlightenment/Modernist-dominated etc) the predominant way of ordering and constructing knowledge is considered to be intrinsically *hierarchical* as well as being located in aspects of a Western taxonomy. There are many consequences which follow from this. One is that the official accumulation of valid knowledge (bio-medical for example) is only allowed to take place within 'regulated' settings. Along with the accumulation of officially accredited/valid knowledge goes *formally accredited power and authority.* Thus knowledge on the one hand and power and authority on the other go 'hand in hand' in the hierarchical model. Hegemony rules !! Michel Foucault has provided important and challenging critiques of ways

in which knowledge and power interact. (See Moss (1998) for overview of Foucault's work). Therapists in this model are 'authorised' to tell people what they do not know and what they are deemed to need to know. (By 'telling' I also include acting on people's bodies and minds in 'secret' ways based on the knowledge of the specialist). Therapists are authorised to make treatment interventions. There are strong notions of 'truth seeking' in this model.

I have assumed that 'Complementary' implies that there are basic assumptions made about the ways in which knowledge about disease/unease symptoms and potential cures is accumulated. Namely: 'complementary' is allied in a complementary way with the bio-medical 'Modernist' approach. Allied, that is, to the traditional ways in which 'Western' post-Enlightenment scientific knowledge is sought/discovered and validated by carefully designed empirical methods. Complementary therapies 'complement' the bio-medical model. Or at least it seems to me that that is the implied use of the term. This in spite of some resistance to the hegemony of the bio-medical model which I have noted in the ACHRN group. I assume that there is a distinction between 'hegemony' (bad) and 'empirical methodology' (good).

These issues are explored to some extent in the paradoxical conclusions of Jane Feinmann's report in 'The Independent' (10 November 2003) headed: *'Here comes the science bit. Scientific trials have repeatedly shown that homeopathy doesn't work. Yet patients swear it does'.* Her report quotes the outcome research (N = 5,729) conducted by Dr David Spence at the Bristol Homeopathic Hospital. This research suggests that about 70% of people benefit from good homeopathic treatment ie treatment provided by homeopaths who are also qualified doctors. In the same 'Independent' report Peter Fisher, research director at the Royal London Hospital and homeopath to the Queen, says that science will eventually explain how homeopathy works: *'I believe that science will show that there is an effect from the homeopathic remedy and that there is also an effect from the nutritional advice and reassurance provided by the homeopathic practitioner. There may also, however, be a synergy between the two, which creates an effect greater that the sum of the two different parts of the consultation. When that explanation is available, it will convince people that, while there is a place for placebo-controlled trials in homeopathy, it's not the whole story'.* I find it interesting that he 'believes' in homeopathy and assumes that in future science '*will show that there is an effect from the homeopathic remedy'* . In the meantime, presumably, he practises on the basis of his beliefs. I conclude, among other things, that homeopathy is a Complementary therapy for two reasons: it is a form of medical treatment and I assume that attempts are made to progress understanding by empirical research. I do not know whether homeopaths' self definition is C or A.

The paradox is that whereas we may not know scientifically how something works, some people's experience is of the effectiveness of the treatment. I suppose that that is a paradox of much treatment which goes on even in the

bio-medical model. A clear knowledge base is not always consonant with effectiveness nor is treatment which is in ignorance of causality necessarily ineffective. This could be construed as a charter for a thousand flowers to bloom – irrespective of regulation or rigour - which causes me concern.

In a very different culture I assume that Complementary therapies would be allied and Complementary to the relevant dominant therapeutic model in that culture.

I notice from their respective websites that the following are all considered to be Complementary: Osteopathy, Shiatsu, Reflexology, Acupuncture. I was surprised that the last three were so considered and it reinforced for me that I no longer have any clear idea as to what constitutes a significant difference between the terms C and A.

2 Models of Alternative Therapies

What I had not realised is that in what Linda was calling a 'vitalist' model – in which it seems to be assumed that we all have access to the necessary means for our own care and healing – there is a *distributive or democratic approach* to knowledge and therefore to the authority to exercise the necessary power of 'vital' knowledge. Therapists in this model are helping others to know what they already know. We are in a sense, in this model, *self-therapists*. The BBC programme on Chakra (6 November 2003) seemed to confirm this view of self healing. The Chakra website did not seem to claim that Chakra is Complementary so I assume that it could be deemed to be Alternative.

Some other therapies seem to merge into religious belief systems and I therefore wonder about their validity as therapies. Anthroposophy would seem to be an example. Their website indicates that the medicinal use of extracts of the mistletoe plant are being explored for the treatment of cancer within what they call: 'the anthroposophical medicine theory' . Thus a belief system is transmuting into medicinal treatment. I do not understand the reasoning behind this transmutation. In the Philosophical Background section in their website, in which a report of an Anthroposphical medical conference (June 1999) is given, it is stated:

> Anthroposophical medicine requires physicians to quest knowledge with the realization that what is accessible to the senses cannot fully describe a patient. The physician must be aware of the additional spirit and psyche of the person. . . . Furthermore, Dr Karnow addressed cancer as an example of physical process overcoming the domain in which the soul should be ruling.

I can see how this form of therapy could properly be termed 'Alternative' because it adopts a very different view of physical illness in relation to spiritual sources of healing. Presumably the patient would need to adopt this particular existential view of body and spirit if the therapy was to be

considered to be valid for that patient. Otherwise, the patient's existential position would be in direct conflict with the existential and therefore therapeutic assumptions made by the therapist.

I suggest that 'Alternative' implies (or ought to imply) significantly different views of people and their health/dis-eases and of the ways in which therapeutic and other knowledge about people might accrue. It seems to imply, to me, that it is essentially different from Complementary. I think that 'Alternative' therapies are more mythological, philosophical and possibly spiritual. Some seem to adopt a body/spirit dualism. Those who emphasise 'holistic' approaches seem to ground their basic theoretical assumptions not so much in researched evidence as in the historical and cultural and world-view origins of the validity of the key concepts. What we call the 'East' is a major source of such therapies. They seem to adopt views about the 'meaning of life' and models of human embodiment in universalistic cosmo- ideological understandings. They seem to be existential. They tend to be spiritual/mythical/mystical/holistic/guru based theories. They seem to adopt views of the body and being which differ significantly from the 'Western' view. Nothing intrinsically wrong with that of course, but it reinforces for me the cultural origins of therapies. I keep saying 'seem' because I am not clear about these issues.

It occurs to me that these 'vitalist' approaches could be termed 'existential therapies' because they relate to and derive from meanings of life and mystical approaches to the body rather than from researched evidence. Their existential nature does not necessarily imply that they do not 'work' but it makes the reasons for effectiveness difficult to identify. Perhaps *belief* replaces *researched causal relationships* as the basis of vitalist/existential therapies. It therefore occurs to me to ask: Do the beneficial effects of Alternative therapies depend significantly on the clients' *belief* in both the underlying world view and in their asserted effectiveness ? Does their effectiveness then depend on the persuasiveness of the therapist and the degree of trust given by the client ? The placebo effect comes to mind, but not to be dismissed. The Report by the House of Lords Science and Technology Committee (2000) stated: 'The placebo effect is not just an imagined experience but can positively improve biological measures of health'.

I assume that the more vulnerable some people are, ie suffering undesirable symptoms and in distress, the more likely they are to trust therapists whether or not their trust is well founded. We, generally, have a propensity to believe, and this propensity is increased when we are in need.

I am not sure whether 'vitalist' might be a general term to cover the whole range of 'alternatives'. Holistic, naturopathic, spiritual, sagacious, mystical, existential also seem to be 'alternatives'. But I also note references to Alternative '*medicines*' as well as 'therapies' and I therefore wonder about this.

I am not aware of the methodology (ies) by which these therapies accumulate 'valid' therapeutic/medicinal knowledge. Hence my ignorance to which I referred at the beginning. I wonder whether the statistically variable effectiveness is related to the vagaries of 'believing'.

There also seems to me to be quite strong intuitionist/traditional assumptions of truth/enlightenment attainment in some of these Alternative therapies. 'We know things others do not know'. Almost a case of therapeutic truth by revelation or truth by deep intuition. Thus beliefs play a crucial, perhaps central, part in these therapies. Such beliefs/truths, as evidenced on the respective websites, seem to be assumed to be of *universal validity.* In currently used terminology some of the eastern therapies are pre-Modern in the sense that they were developed before the Modern, Western scientific methodologies came to be invented and used as major ways of exploring the world and ourselves.

Some of my confusions.

Are Alternative models predominantly more *intuitionist* than Complementary models ? I am, of course, aware that intuitions/ beliefs are also around in research methodologies and notions of causality and empiricism.

Those approaches which practitioners call Complementary seem generally (I think but it's not clear to me) to espouse the hierarchical/Modernist/empirical model, whereas those who seem generally to want to call themselves 'Alternative' seem to ally themselves to the 'vitalist' (or existential) approach. This leaves me uncertain as to whether either Complementary or Alternative therapies have, or even attempt to have, a *unifying, coherent and explicit therapeutic theoretical framework.* Perhaps members of the group will have views on this 'coherence' issue.

Incidentally, although not trivially, I wonder what 'world view' clients are assumed to be buying into when they choose different C and A therapies ? I also wonder if these 'world views' are made explicit to potential clients ? Does one have to become a 'believer' in the world view of a therapy in order to benefit from the therapy ? See my reference to Anthroposophy above. I appreciate that 'world views' are usually deeply embedded in cultures and consciousness, but I do think that they are major sources of our definitions of ourselves and of the world in which we live. Hence they are relevant to issues of what we think or hope will be therapeutic. These questions raise very complex issues for me based on the ethical implications of offering therapeutic interventions in people's lives. (See Habermas (2003) for an interesting discussion about the ethics of therapeutic and other genetic interventions which also has a general relevance to ethical implications of intervening in other people's lives).

This 'world view' issue also reinforced for me the ethical necessity of trying to be clear about the bases of therapies which are practised on the public, some of which I term

'imported' therapies with their implicit – or even explicit - importation of world views of meaning. This leads me to another issue:

I suggest that when non-Western therapies are 'imported' into the West they are inevitably dislocated from their original cultural context and world views. They become 'commodified' into a Western capitalist culture. These imported therapies are then 'sold' on the 'market' of therapies available in the capitalist consumer culture. There seems to me to be a supermarket approach to therapies – they are on sale and customers/consumers buy them.

At least eight questions occur to me arising from the discussion above and which could be the focus for discussion in the session:

1 *How (in)appropriate are attempts to transport therapies, and therefore meanings, from one culture to another as if they were universally applicable as saleable commodities ?*

2 *If it can be assumed that therapies arise in and are validated by the norms, beliefs and world views of the cultures in which they are indigenous, what forms of validation are possible when therapies are imported into other and very different cultures with different norms and different modes of validation ?*

3 *How do* you *try to ensure informed client choice/consent in relation to the therapy which you practise ?*

4 *Is it consumer demand and perhaps gullibility which,* de facto*, establishes 'validity'* ? *Does 'validity' of therapeutic knowledge matter ? And to whom ?* Perhaps 'publicity' is more effective than 'epistemological validation'.

5 *Should the mere fact that it is permissible to practise any form of therapy be deemed to make such practice of any form of therapy acceptable ?*

6 *Is there any attempt to provide/define an underlying framework of coherent theoretical assumptions among Alternative therapies on the one hand and Complementary therapies on the other ? Or are basic assumptions just 'made up'? That is, are basic assumptions merely a set of beliefs ?*

7 *How would* you *distinguish between C and A therapies – if at all ?*

8 *Given the common sense meaning of the term 'alternative' do Alternative therapies aspire to provide a comprehensive alternative to the range of bio-medical – and even Complementary - therapies ?*

If distinctions between C and A *cannot* be validly made, then I suggest that the terms 'Complementary' and 'Alternative' might be merely semantic confusions. Distinctions

without a difference. They may merely represent the prejudices of interest groups and should be dropped in favour of one or the other. 'Supplementary' might either be a constructive compromise term or a confusing collation.

If C and A are *validly* different, then I would like the grounds of their difference to be clear and justified. In other words: what are the differing epistemological bases of C and A therapies ? Or are their differences based, not on epistemological considerations but on world view/philosophical differences ?

I note the vast number of both Complementary and Alternative therapies – 157,000 references on the internet. In the field of counselling and psychotherapy *alone* Karasu in 1983 identified about 480 'theories' of counselling and psychotherapy. My mind boggles as to possible criteria for *valid and researched differences.* (See Prochaska and Norcross 1994). I suggest that this plethora of 'theories' indicates a mere whimsicality of theoretical construction which is in the practitioners', but not necessarily the public, interest. Novelty replaces validity – discuss !! Or perhaps novelty itself becomes a form of validity. Therapy as a fashion or life-style statement. A very post-modern approach !

I repeat that from my point of view, neither longevity nor novelty bestow validity.

In the ACHRN research presentations which I have attended over the past three years I have noticed that the majority have been researching the *effectiveness* of a particular therapy. I cannot recall any of the presentations in which research has been carried out on *the validity of the fundamental constructs* used in the particular therapy. As I indicated above, I accept that outcomes are important as a necessary condition, but they do not constitute for me the only criterion of validity. The validity of the theoretical therapy constructs seems to have been assumed rather than challenged. I do not recall any critical intra or inter-therapy dialogue. It is this challenge which I attempted in the Epistemological Audit Trail. I am still on the trail of validity !! I feel the 'holy grail' coming on.

It occurs to me to wonder two more things:

Do C and A (and even Supplementary) therapies work in *therapeutic co-operation* with bio-medical practitioners on the assumption that no single model has all the 'truth' about illness and health ? In other words, is there a conscious and committed *multi-therapy approach* in response the complexity of human health and suffering ? This seemed to be the model which the Chakra practitioner was adopting in the BBC programme, although I suspect that this was probably only for purposes of research for the programme. I don't think that such co-operation was normal practice. Is there *co-operative richness* in the diversity of therapies ? Or is this diversity indicative of *mere confusion allied to conflict* ?

On the other hand, do all or some of the C and A theories make the assumption that they have all, or enough, of the therapeutic 'truth' to be able to practise validly in isolation from the bio-medical – and indeed any other – therapeutic model ? Is there conflict and competition rather than co-operation ?

All this is leading me to think that each of these terms – Complementary and Alternative - comes from very different, but deeply implicit, taxonomies of knowledge about people. Different taxonomies of the meaning of health and symptoms of dis-ease and of the nature of human be-ing. If this is the case:

Which therapies are 'complementary' ? Why ?

Which therapies are 'alternative'? Why ?

What influences might responses to these questions have on any therapy which seeks Statutory Regulation ?

Should there be an obligation on all therapies practised on the public to undergo the rigour of statutory regulation ? If not, why not ?

Ancient Greek and Chinese approaches to science and medicine

By sheer coincidence at the time when I was preparing a later draft of this paper I was reading a book review in the London Review of Books (23 October 2003 pp 24-25). The review was of the book by Lloyd and Sivin: 'The Way and The Word: Science and Medicine in Early China and Greece'. (2003).

I shall bring photocopies of this review to the session on 28 November because I think that it is not only fascinating and but also relevant to the C and A debate which I am discussing in this paper – particularly given the different cultural origins of Complementary and Alternative therapies.

In the meantime I provide some quotations from the LRB review. These quotations are in the context of different approaches to medicine and science by ancient Chinese and Greeks.

> The Chinese were collaborative, the Greeks competitive; in China agreement was sought out or else assumed to exist, in Greece rivalry flourished and was promoted; the Chinese contemplated, the Greeks reasoned. Greek thought is marked by 'strident adversariality' and 'rationalistic aggressiveness'. The turbulent Greeks had to make their way in the 'competitive hurly-burly of the Hellenic world', whereas in gentle China an intellectual's concern 'was first and foremost persuading a ruler or his surrogates to want their advice'. . . . In China there was no raucous market place . The Chinese were generally writing for the Emperor. Hence they 'did not feel the need for incontrovertibility – the driving force in Greek investigations. Rather 'what corresponds in China to the Greek authority of demonstration was **the authority of sagely origin'** so that 'scientific pursuits in China did not aim at stepwise approximations to an objective reality but at a **recovery of what the archaic sages already knew'**. (p 24). (My emphasis).

These brief quotations perhaps give the flavour of the alleged differences between Greek (conflict and rational) and Chinese (co-operation and contemplation) in their approach to science and medicine. They seem to correspond in some respects to the 'hierarchical' (Complementary) and 'vitalist' (Alternative) models to which I referred above which is why I have made the quotations and why I shall provide copies of the review. When I read this review I thought that I had begun to understand why I have been having some difficulties with the 'non-Western' therapies. Of course, I also have difficulties with 'Western' therapies.

These ('vitalist'/holistic/Alternative) are not, it seems, derived from anything like the Western (Greek) tradition of knowledge being approximations to an objective reality. The 'vitalist' approaches appear to be derived from the *'recovery of what the archaic sages already knew'*. The assumption seems to be that there is *an essential human nature* which can be 'out of balance' in ways which produce 'dis-ease'. I can now see why the 'vitalists' seem to believe that we are our own healers if only we knew enough about ourselves. *We produce our own healing because of the essential universality of human nature.* Thus, from this perspective, Alternative therapies are transportable to other cultures because they represent the *essence of all human nature*. In which case I wonder, as I do with the many religions and their associated orthodoxies, why there are so many Alternative therapies. Is not a multiplicity of Alternative therapies, each based on 'universalistic' assumptions, oxymoronic ? Or have I missed something ?

Perhaps these historical references also explain, at least in part, why Complementary therapists seem (generally) to adopt the multiple – and sometimes conflictual - 'specialist' approach in which therapy is 'done' to 'patients'. But they too are by no means immune to assumptions of exclusive and excluding validity. Historical issues are explored in considerable and informative detail in the book by Jutte *et al* (2001).

Now, if all this is the case, or anywhere near the case, then I suggest that the 'vitalist' exponents should be up front about the different epistemological and indeed cultural presuppositions which they are making, rather than assuming that they are competing in the same arena as the Western (hierarchical) models of knowledge accumulation and therapeutic practice. A complex set of issues.

I note that many of the C and A websites contain confident statements of the *essential* and *universal* validity of their understandings of human health, disease and therapy. They are, to me, obviously displaying wares for sale in glowing consumer-friendly terms. I would like to see more scepticism and humility. But scepticism and humility do not shift products from shelves.

I realise that I am using emotive and possibly inaccurate language. I stand to be corrected.

You may also think that I am making an excessively polarised dichotomy between C and A where none exists. I may be off the wall on all of this – in which case you will doubtless let me know at the seminar in November !!

Questions and X may mark the spot

I now pose some questions in relation to your chosen therapeutic theory and in relation to therapies generally. You might like to ponder your answers in preparation for the session.

1 How would you explain/justify your therapeutic theory to a serious but properly sceptical enquirer ? Would your explanation include something about the different cultural origins (if relevant) of the therapy ?

2 What provides you with the confidence to embrace and practise this therapy?

3 What, if anything, do you consider would be capable of challenging or undermining your confidence ? In other words, what might constitute valid criticism of your therapeutic theory and practice ?

4 Should it be axiomatic for therapists to accept the validity of all other therapeutic theories ? In other words, is inter-therapy criticism out of bounds ?

5 What are the criteria for a therapy being acceptable for practice on the public ? Have these ever been published? I discount confident assertions made on websites.

6 Should we be content to let a thousand flowers bloom – some of which 'we' decide are therapeutic flowers ? How do 'we' decide which 'flowers' have therapeutic qualities ? For what symptoms should the therapy be applied – and by whom ? Who has the power of decision as to the validity of a therapy ?

I ask this last set of questions because I sense that some therapies of which I have learned in the seminars seem to assume that we all potentially know the necessary knowledge about ourselves and that the therapist simply needs to release this knowledge. In this case therapy is a form of education or enlightenment.

Where would you place an X indicating your view of your therapy on the following continuum?

Beliefs/myths . . . . . Researched evidence
Existential frameworks of meaning rational. empirical
spiritual belief system
vitalist

Why did you put the X in that place ?

Where would you put an X on the following continuum in relation to your own chosen therapy ?

Complementary . . . . . Alternative

Why did you put the X in that place ?

Did you have any dithering about where to put it ? If so, why ?

You might like to make a brief statement to the group as to where you put your two X marks.

You may decide that it is not relevant to put an X anywhere, in which case if you resist the notion that the therapy which you practise is either Complementary or Alternative, how would you label your therapy and why ?

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Geoff Heath
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Geoffheath@aol.com

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Geoff Heath
Geoffheath@aol.com

Reflections on the Alternative and Complementary Health Research Network seminar: 28 November 2003. Manchester.

I found the session very stimulating and I appreciated the responses to my paper and the questions and issues which it addressed in what I construed as an open discussion. There were some issues which I personally found particularly important and on which I have done some further reflection. Whilst doing this reflection a whole range of additional questions arose which, if you are interested in them, I have appended below. (pp 28-31).

The seminar time was very short in which to deal with the magnitude of the issues, but at least we had a go !! As I said in my paper – I was on a leaning curve.

The three main issues which I shall address are those of *validity*, the *importation* of therapies from different cultures and *political* dimensions of the use of the terms Complementary and Alternative.

Validity.

I had expected to be challenged on some aspects of validity and this was indeed the case. I tried to correct the inference that I was assuming that the *only* valid way of assessing the effectiveness of C and A therapies is by the adoption of Western scientific methods. This is, of course, a hugely complicated issue or rather a set of related issues. I am familiar with some of the scientific methodologies adopted by western science and, incidentally, used by other cultures when they want to explore similar problems and to find solutions which work in practice.

My reference to the Cetina's (1999) book: *'Epistemic Cultures: How the sciences make knowledge'* is actually more relevant to the issue of validity than I realised when I made quick reference to it in the discussion. In this book Karin Knorr Cetina discusses her research project in which she explored what the blurb calls *'two of the most important and intriguing epistemic cultures of our day. Those in high energy physics and molecular biology'.*

I will not bother to provide a summary of the main themes of the book, but I strongly recommend it as a source of informed and researched discussion on how two internationally recognised laboratories go about their work in producing scientific knowledge. They ask different kinds of questions, they develop different methodologies, they use different technologies and they produce very different kinds of knowledge. In other words they are different epistemic cultures. I simply assert that I think that the book

has useful things to say, particularly in her general discussion, about issues of validity which I touched on in my paper and which were raised in the discussion. What the cultures have in common is methodological rigour and willingness to change theories and understanding in response to evidence.

Thagard's (1999) book deals in a critical way with issues about the scientific approaches to disease as does Gillett's (2004) article.

My view is that C and A therapies do themselves and the public a serious disservice if issues of validity and methodologies of validity are not addressed. I do not see this as merely a 'western' question. I think it is a fundamental question – even an ethical question. However, I do not equate 'validity' with 'certainty'. If you want to do any further reading on epistemological matters (which are, of course, related to validity) then the following are relevant: Gunew (1990), Tanesini (1999), Pickstone (2000), Lederman and Bartsch (2001), Harding and Hintikka (2003). All these books, with the exception of Pickstone, have the advantage of being written from feminist perspectives. I say 'advantage' because epistemology is necessarily imbued with perspectives and it is necessary to recognise that explicitly. A journal which is multi-disciplinary and very relevant is: 'The Journal of Consciousness Studies'. I find this journal interesting not least because of the wide range of research methodologies and their respective results which are discussed. Both the issues and the methodologies addressed in the journal are, I consider, broadly relevant to C and A matters.

A recent issue of the journal (Journal of Consciousness Studies, Vol. 10, No. 12 (2003) pp 3-23) contains an opening article titled: 'Inhabiting Conscious Experience: Engaged Objectivity in the First-Person Study of Consciousness' by Petranker. It is relevant to note that he comes from a Buddhist perspective. I quote:

> The scientific method has its roots in the conviction that our immediate experience is unreliable, that the way things seem to us is often incomplete, distorted or simply false. In response, science has developed methods and procedures intended to make empirical data as trustworthy – as objective – as possible. But it has also, and perhaps more fundamentally, committed itself to relying on theories and hypotheses that make sense of the data, even at the expense of immediate experience. Michael Polanyi (1962, pp 3-4) makes this distinction clear: 'Copernicus gave preference to man's delight in abstract theory, at the price of rejecting the evidence of our senses . . . It becomes legitimate to regard the Copernican system as more objective than the Ptolemaic only if we accept this very shift in the nature of intellectual satisfaction as the criterion of greater objectivity. This would imply that we would rely increasingly on theoretical guidance for the interpretation of our experience, and would correspondingly reduce the status of our raw impressions to that of dubious and possibly misleading appearances'.

There are a number of issues in this quotation which I could discuss further. For example the deeply complex relationships between the experience of perception and ways in which careful theorising can upset, deconstruct and re-frame those initial perceptions. Indeed the notion that perception itself is a theoretical act. But, for the sake of brevity, I merely repeat a point which I made in the seminar discussion: I do not think that we can

arrive at ultimate and certain knowledge. All our knowledge is probabilistic. But that does not mean that some modes of enquiry are not demonstrably more effective than others in arriving at practical knowledge, at knowledge which is more probable and reliable than not. I have found Richard Rorty's work particularly helpful in the notion of pragmatic knowledge. (Rorty (1989) for example and Brandom (2000) for a critical discussion of Rorty's work. Also Malachowski 2002).

A final quotation from Petranker's article (2003 p 12):

> In determining whether a given approach to knowledge can arrive at 'respectability', the following criteria seem relevant, if not exhaustive: it must be precise in its approach, rigorous in its procedure and honest in its reporting; as a discipline it must proceed with integrity.

Gillett (2004) provides an interesting and relevant discussion in which he compares and contrasts the scientific framework of orthodox medicine with the holistic and individual approaches of alternative medicine. His discussion also includes epistemological issues similar to those which I have raised both in the original seminar paper and in the epistemological audit trail. The following quotation picks up social and cultural issues to which my seminar paper referred:

> . . problems also arise at the macro level – between communities and researchers trying to understand patterns of disease in a given context and its legislative or political setting. Experiments cannot be done, although the results of certain experiments may be useful in deciding what should be done. Reflection on the particular case (be it societal or an individual patient case) is indispensable and needs to be informed by critical thinking about the body as whole, culture, value, social structure and individual narrative. . . Unconstrained relativism and self-authentication in ways that are not continuous with the Hippocratic tradition are equally destructive in the methods to alleviate real human suffering. The tests we should apply are therefore intrinsic to the values inherent in the health care enterprise as a techne or craft informed by specialist knowledge. The researchers need to be self-critical, sensitive, caring, systematic, and open to the multiple subjective realities that constitute any clinical situation. To encompass this diverse set of virtues we might need our research teams to include people who are conversant with the many discourses likely to illuminate health care situations and not just the highly abstract discourse of contemporary biomedical orthodoxy. (p 735).

In this quotation Gillett is picking up, *inter alia,* a theme to which I referred in the original seminar paper, namely: Do C and A (and even Supplementary) therapies work in *therapeutic co-operation* with bio-medical practitioners on the assumption that no single model has all the 'truth' about illness and health ? In other words, is there a conscious and committed *multi-therapy approach* in response the complexity of human health and suffering ? Does (should) a multi-therapy approach respond to the 'multiple subjective realities that constitute any clinical situation' ?

I also appreciate his critical reference to 'unconstrained relativism and self-authentication'. I focus on some of these issues on pp 22-23 below).

(See also list of questions on pp 28-31 below).

This quotation and the previous one from Petranker's article summarise what I was trying to say about 'validity'. They also have something to say about my continuing insistence that the theoretical constructs of any particular therapy ought to be subjected to constant critique, and that an important aspect of that critique is rigorous and intentionally critical research. It is not good enough, from my point of view, that the basic tenets of any therapy are taken for granted and assumed to be inherently valid – no matter how prestigious their source and no matter how long and 'impressive' their provenance.

In the section of the seminar discussion on validity I took the point that 'outcomes' are important. But, for me, reported beneficial outcomes are a *necessary* but not *sufficient* justification for C and A therapies or for any other therapies for that matter. In addition to outcomes I think that there should be critically scrutinised understanding of cause and effect and the possible relation of these to the particular theory and its practice. I would want to say that merely to rely on outcomes as a source of validity raises some serious 'outcomes' kind of questions. For example: over what timescale are outcomes assessed ? It is well known that some non-beneficial outcomes result from medication which in the short term seems to have only beneficial outcomes. Another question: how is it determined that the outcomes are as reported by the patient ? Are outcomes measures developed which seek to complement the outcomes reported by patients ? There may be hidden outcomes which are even operating in the short term let alone the longer term and which may or may not be beneficial. In what ways are contrary outcomes assessed and taken into consideration ? Are beneficial outcomes from one case, or a group of people, optimistically generalised to future patients ? If so, why ?

So, even though I took the point about an 'outcomes' model having some sort of validity, presumably the very notion of the validity of an outcomes model should be subjected to rigorous research and critical theoretical scrutiny over time.

A current example of this is in relation to HRT. Only comprehensive on-going research as to all (or all assessable and observed) outcomes can result in deeper and more beneficial knowledge being constructed in relation to HRT. Herbal or vegetable extract alternatives may have what appear to be short term benefit outcomes, but only long term and rigorous investigation can produce increasingly valid, in the sense of reliable, knowledge. I emphasise my view on the probabilistic nature of knowledge.

The more I've thought about outcomes the more questions occur to me, so I shall take some space to pose some more questions.

What kinds of issues and assumptions lie behind 'outcomes research' ?

Presumably, outcomes research makes the assumption that there are some cause and effect relationships between the therapy and the outcome. In other words, the extent of

confidence about the validity of the therapy must, at some level, relate to cause and effect.

I assume that this assumption about cause and effect is not a singularly or exclusively Western scientific artefact but must be endemic in all cultures and all therapies. It seems to me to make no logical sense to make any other assumption. Why do something if it is not assumed that it will have a causal relationship to some effect ? I therefore wonder about the validity of the criticism about my use of the term 'valid' as being a merely Western issue. I think that it is a question of human agency in its most general sense. Namely: how does my behaviour affect the world and other people ? Conversely, how does the world and other people's behaviour affect me ?

I propose that cause and effect assumptions are endemic for us as organisms *vis-à-vis* our environment. Checking out the validity of these assumptions is quite another matter.

This leads me to another issue implied in cause and effect and therefore to outcomes. Whilst I suspect that ultimate and total understanding of causes and effects are likely to be beyond the human mind which is, after all, part of the nature of the things which are being investigated, I nevertheless think that there should be rigorous scrutiny of what might be causing what, particularly in cases where other people's health and well being are at stake. If there is a lack of such rigour, then it seems to me that mystical and perhaps superstitious versions of cause and effect might all too easily be projected into therapeutic interventions. It seems likely, to me, that in pre-Modern societies mystical and superstitious causes were almost inevitably assumed. Even in Modern societies mysticism and superstition are still around. Thus, mis-attribution of causes of outcomes is an ever present possibility.

Gillett (2004 p 732) observes:

> The need for systematic observation looks likely to be a *sine qua non* for reflective surgical practice in which careful observations of clinical practice are accumulated over time until conclusions can be drawn as to which methods are effective and which are not.

Issues of cause and effect should not (cannot) be wished away. Celia Green (2003) provides a detailed multi-disciplinary analysis of causes in her: 'The Lost Cause: An analysis of causation'. Further reading on current thinking about mind, consciousness and how we make constructions of the external world can be found in Crane (2003). I mention this because mental processes are endemic in constructions of theories about anything – thus including theories of therapy.

All this relates to my concerns about validity. If the term 'validity' is unhelpful to some, although I am not entirely clear as to why the notion of validity is a problem *per se*, then I would ask: What kinds of evidence 'justify' your acceptance of the theory and practice of your therapy ? What 'reasons' do you adopt and propose for the practice of your therapy ? Is it 'reasonable' to ask you: why do you think that your therapy is only sometimes effective ? What 'persuades' you to practise your therapy and to advocate its benefits ? How do you present the foundation concepts of the therapy when you

are putting on training sessions for intending therapists ? How do you deal with any of their sceptical questions about the validity of the foundation concepts and assumptions of the therapy ? Are you entirely oblivious to questions about 'cause and effect' ? What do you mean by 'outcomes' and over what time-span and in how comprehensive a way do you assess outcomes ?

Or to put all this in language which I have used in the group discussions (sometimes *sotto voce*): Why do you believe in your therapy ?

I realise, of course, that this list of questions, and the list on pp 22-23 below, could usefully be posed to all who practise therapies on the public, and therefore including 'orthodox' therapies.

In this context of validity, I was interested that in response to the following question which I posed to the group (see original paper pp 8-9):

Should the mere fact that it is permissible to practise any form of therapy be deemed to make such practice of any form of therapy acceptable?

One group member said: 'I don't know'. Another said: 'Yes'. I didn't hear anyone say: 'No'. The two responses suggest, perhaps, that issues of validity do not figure as significant in the minds of the two respondents. The 'Yes' response seems to indicate that a thousand – and more – flowers can bloom and any can be deemed to be therapeutic by mere validatory fiat. This causes me some concerns. Of course, we did not have time to explore these responses in any further detail due to lack of time. Nor was there time to elicit any other responses.

As I stated in the session, from my point of view neither *longevity* nor *novelty* of therapies bestows *validity.* I still have a sneaking sense that for some therapies the fact that they have been around for a long time, some of which are from Eastern sources, seems to be used as a form of validity. Validity by tradition and longevity and by being 'not western'. If my sense is anywhere near correct, then I choose to worry about this.

In current parlance, many if not most of the Eastern therapies, and some of the western therapies, originated in what is called the pre-Modern period. That is the period which, in the West, preceded the Enlightenment (16^{th} – mid 18^{th} centuries in the Western calendar). This pre-Modern 'period' was obviously not coherent or integrated either in time or geographically. What was perhaps common to belief systems and therapies which arose during this pre-Modern period was that there were no ways of engaging in rigorous validation of the therapy. As Gillett (2004) observes:

> Some of the theories were predicated far more on myth and theological commitment than on systematic observation and reflection. (p 731).

For example, in the currently used Anglican Book of Common Prayer (1662 version) there is still a prayer for the sick in which it is stated that the sick person should be sure that the sickness is a visitation from God and related to sin, and that confession and

absolution are required for healing. Anointing with oil and exorcisms are also advocated among some sects. Some Christians still practise a form of this therapy with the laying on of hands and the instruction to the demon to depart in the name of Jesus. This is used, in some sects, for a wide range of diseases and conditions. And of course in a few cases it may 'work'. Its occasional effectiveness might be due to the intensity of belief of the 'patient/sinner' and/or the belief of the spiritual healer. Or healing may be coincidental. It is possible that there is a God who is doing the very selective healing. It is certainly an 'alternative' therapy derived from a deeply theological world view and derived from the idea that sin – contravening God's law – is the origin of illness.

The point I am making is that to simply inherit or import therapies which arose not only in other cultures but from pre-Modern times suggests to me that more evidence-based, empirical and rigorously tested processes should be adopted before these therapies are practised on the public in a largely secular, and plural, and significantly empirical West. But a West in which some believe in spiritual forces and spiritual healing, and some believe that God is the source of both sickness and healing. A plural west indeed. But from my point of view plurality should not provide *carte blanche* for any and all therapies to be *practised on the public*. Private therapeutic practice among a consenting group of adult believers is another matter.

I can now sense, as some in the group observed, that I am coming from a Western scientific point of view. There may be truth in this, but I think that I am coming from that point of view not for its own sake, but because this (or rather these) approaches to science in general and disease understanding and therapy in particular seems to me (in my ignorance) to be a major source of discovery and understanding which human beings have at their disposal . There may well be other non-Western methodologies which are rigorous, relevant and effective – that is good news, and if so then these methodologies should be made explicit and subjected to rigorous and open critique. But it would be foolish, I think, to ignore good investigative research practices which we have developed during what is known as the Modernist period in the West. I repeat the Petranker (2003 p 12) quotation:

> In determining whether a given approach to knowledge can arrive at 'respectability', the following criteria seem relevant, if not exhaustive: it must be precise in its approach, rigorous in its procedure and honest in its reporting; as a discipline it must proceed with integrity.

I also think at least two more things picking up the use of the term 'holistic' in the group:

1 Modern work on therapeutic genetics is aiming towards a sort of holistic approach in seeking the genetic identification of each individual's disease pattern so that therapies can be precisely designed for the individual. Even this version of holism could, unfortunately, exclude the 'person' from the treatment. Thus the 'person' could still end up being treated as a third person object.

2 Assertions by some 'holistic' practitioners that they are dealing with the whole person may need to be challenged as rhetoric when the 'holistic' approach does not include any knowledge of human anatomy, physiology, neurobiology, psychopharmacology, epidemiology, symptomatology and so on. In other words I suggest that holism is rhetoric if the holistic therapy is practised in isolation from a knowledgeable, informed and co-operative multi-therapy base and context.

Just as some (much) Western medicine can be criticised for its reductionist approach in which people are viewed as things to be treated so, I think, it is also possible to criticise some holistic approaches which actually only have very limited knowledge of the human body, but assume that by treating the person as 'spiritual' then that is, *de facto,* a proper, i.e. comprehensive, version of holism. That is not necessarily so. There are various versions of reductionism. There are also various rhetorics of holism. For a philosophical and psychological discussion of consciousness, identity and persons which informs notions of holism see Tye (2003).

From my point of view as a person who may require treatment in the future, I would like to be in a position in which the information available to me prior to consent is more rather than less. I want to be allowed – indeed encouraged – to be an informed and empowered participant in acceding to a form of treatment. This principle would apply to whatever the form of treatment contemplated. The notion of an empowering dialogue in which subjectivity is crucial has been considerably assisted by my reading of Gillett's article.

Having said all that, I am trying not to be merely 'Western' in my urging of rigorously elicited evidence – but I am certainly asking for forms of evidence from whatever research methodology is employed to explore the causes of effects within a critical approach to therapeutic theoretical constructs. If we are ignorant of causes, how can we be confident of the relationship between the therapeutic intervention and any improvement ? I appreciate that notions of confidence are necessarily a statistical probability. However, if we merely 'make up' causes, then I think we do the public a disservice.

I pose some 'worry' questions which seem important from my point of view :

1 What methods of enquiry are relevant, rigorous and reliable in relation to the foundation concepts used about the body/mind/spirit in your therapeutic theory and its practice. ?

2 What criteria might you propose for concluding that evidence was convincing ? What actions might you take in the event of evidence which was unconvincing in relation to your therapy ?

3 *What processes of rigorous critical reflexivity on the practice of the theory are used by practitioners of your therapy ? In what forums do these critically reflexive processes go on ?*

4 *Is there evidence that the theoretical constructs of the wide range of C and A therapies undergo constant revision in response to research evidence ?*

5 *Is there a tendency for the knowledge base, and therefore the practice, of your form of therapy to remain rather static and traditional ? If so, why is this ? If so, is this a satisfactory position ?*

6 *Another way of putting this is to ask: Is there a sort of ' plateau effect' in terms of the accumulation of knowledge in your therapy ?*

7 *Are there the equivalent of research chairs and research teams/projects in your therapy in order to challenge and develop the forms of knowledge which are relevant to your therapy ? If not, why not ? It is evident to me that in the broad and varied fields of bio-medical practice research is the norm and there are cutting edge research staff and laboratories.*

8 *Are there the equivalents of consultancy posts in your therapy occupied by those with extensive experience and backed up by research in the therapy and to whom other practitioners can both refer and even defer ?*

9 *Why are there so many C and A therapies ? Who checks out their validity and how is this done ? My website trail (not exhaustive) for the seminar paper indicated 50.*

10 *Is it the case that each therapy assumes that it is sufficiently valid, in isolation, to be effective in the areas of competence which have been 'decided' ?*

11 *If, as I suspect, there are 'common factors' at work across therapies, what is the justification for the perpetuation of the considerable number of therapies – apart that is from prejudice, the need to be different and the need to make a living ? I imagine that work has been done on this 'common factors' issue.*

12 *Who decides on the conditions which are deemed treatable by C and A therapies? How are these decisions made ? How are the boundaries of relevance of a therapy extended or reduced ? Who makes these crucially important decisions ?*

13 *In what respects do C and A therapies take into consideration the research which goes on in related (complementary ??) areas? For example: psychology, neurobiology, psychopharmacology, immunology, CT scanning, PET scanning, fMRI, consciousness studies, philosophy of mind etc etc.*

14 Do C and A therapies operate on the implicit/explicit assumptions of body - mind/spirit duality which are evidenced in much Western bio-medical work – and indeed in the dominant Western world view? What version of dualism does your therapy assume – and why ?

15 Do holistic approaches assume a unitary embodiment approach which attempts to subvert dualistic assumptions ? What cosmo-ideological and psycho-somatic assumptions do or might these holistic models assume ?

16 As you would expect I remain interested in the question: What do you believe and why do you believe it?

Importation

I had stated in the seminar paper my view that therapies are embedded in cultures and I therefore raised the issue of whether a therapy could be simply imported by one culture from another on the assumption that its basic therapeutic component was so demonstrably (?) universally applicable (and 'true' in the sense of universally valid) that the essentials of the theory and practice were valid *independently of the culture in which it was spawned*. I made the point in my seminar paper about the commodification of therapies in western consumer driven societies. I posed the question of whether 'patients' would need to 'buy into' the world view of the culture in which the therapies were spawned.

Some members of the group were of the view that it was not necessary for patients to adopt the world view of the 'sponsoring' culture and that the therapy was valid in its own right. On the other hand someone expressed the view that the therapist would (probably?) adopt the world view of the original cultural proponents of the therapy. I assume, however, that a western therapist would adopt a westernised version of the 'eastern' therapy world view and the related view of the body/mind/spirit. In the discussion I referred to a disjunction between the world view assumptions made by the therapist and those made by the patient. This is once again complicated, but there seems to be an assumption that the effectiveness of the therapy is somehow independent of the beliefs (world view) of the patient. There seems to be an assumption that the therapy can be 'done' to people in what I might call, with great trepidation, a culture-free way. Or perhaps western patients who receive eastern therapy 'simply' bring to the therapy their own beliefs and needs and the therapy either works or not in spite of, or because of, these beliefs/needs. I can feel complexity coming on again !!! The word 'simply' *must* be the wrong word.

I did not challenge this issue too much in the short time available in the session, but I do have some problems with it. The assumption of an essential essence of the therapy which can be imported because it is assumed to be trans-culturally valid once again raises, for me, the issue of validity and of the origins of such validity. I made clear my total ignorance of the ways in which another culture, say China, validated its 'traditional' pre-Modern range of therapies. But I also made the point that notions of validation and the epistemological norms which might be adopted/assumed in a therapy-creating culture are

not necessarily the norms adopted by the receiving culture. This still raises for me the issue of the existential/cultural context in which therapies arise and in which they are predominantly practised.

I don't know whether there has been any work on trans-cultural issues in relation to C and A therapies, but quite a lot of work has been done in the area of counselling and psychotherapy. For example: Pedersen (1997).

It so happens that as I was reading the THES (28 November 2003 pp 20- 21) the day after the seminar I came across a discussion by an American academic, Professor Paul B Courtright professor of religion at Emory University, Atlanta, in which he states the extreme distress which he has been caused by his published views of some Hindu iconic figures in which he explores a possible sexual level of meaning. He has not only received hate mail but also death threats. Obviously the people who sent him the hate mail also felt distressed. His book on the matter has since been banned in India. This is in some way related to the 'importation' issue to which I was referring in the seminar paper. I quote from his THES article:

> Hindu communities forming new identities away from India sometimes feel under siege by how their sacred traditions are turned into commodities for the insatiable consumer markets of a global economy.

It would take more time and effort than I have to elaborate this statement in ways which could be directly related to the issue of the 'importation' of therapies from other cultures, but I think that you will see that there is an implicit link with what I alluded to as the importation of therapies into a consumer society which has a super-market approach rather than an existential/cultural/world view approach to these imported therapies. In so far as therapies are functions of cultures – at least in some respects – then therapies are embedded in meanings. I am positing a wonderment about the validity of therapies isolated from their existential and cultural meanings.

In summary, it is my view that these two issues of *validity* and *importation* are of such inter-dependent importance that the group might decide to spend a whole session on them. Perhaps different members could be invited to present different perspectives on the issues, thus enabling a richly perspectival discussion. I do not think that the issues should be avoided. Again, due to my ignorance, it may be that they have already been rigorously addressed. In which case you might like to suggest some further reading for me.

Political language

The issue of the differences, if any, between C and A only came into sharp focus towards the end of the session. I was amused to hear it said that the two terms Complementary and Alternative are *political terms* which are used *differentially to different audiences.* Foucault would be smiling. My own amusement was, in part, that I had spent ages on that section of my paper trying to tease out differences. You may recall that I had sought to differentiate between 'hierarchical' approaches and 'vitalist' approaches. And I

thought that I was on to something !!! My assumption had been that if there are two terms used then there are different meanings for each of the terms – but I note the first part of the title of my paper. I had not expected to be informed that the two terms are 'merely' (my word) political terms. Ah well. *C'est la vie.*

However, I have to say that I do not think that this political response is good enough !!

I forgot to mention that when I became a Quality Adviser for the University of Derby – following the advent of the dreaded Quality Assurance Agency – I was confronted with the use of the phrase: *fit for purpose*. Among other things the university team of quality advisers had the task of ensuring that courses – old and new – were fit for purpose. Not easy. But I came to quite like the phrase.

I had intended to pose these questions for the seminar group. They all relate to the issue of validity.

1 *Are the various C and A therapies fit for their purpose ? What criteria as to fitness are adopted ?*

2 *Who decides what their purpose is ? How is this decision process effected ?*

3 *How might it be decided that the therapy is* not *fit for purpose ?*

4 *Who decides whether the therapists are fit for purpose ? How is this decision process effected ?*

In constructing those questions it had never occurred to me that the 'purpose' of the two terms C and A was simply political !! In which case I wish to challenge the 'fitness' of these terms for this political purpose. It seems to me that a potential regulatory body would inevitably, and rightly, seek for clarifications and justifications as to the differences. That's why I included the notion of 'Supplementary' from the Government paper of 2001. I really do think that terminology matters – not least to the public who assume (I have not researched this !!) that different words have different meanings. For these purposes – I am the public. You may decide to ignore a focus group consisting of only one person ie me.

I still think that my efforts to distinguish between the terms Complementary and Alternative had some merit – but then I would wouldn't I ?

I propose that the only valid statement of 'fitness for purpose' is fitness for the benefit of clients. No other aim, covert or overt, should be allowed to take precedence over the needs of the client. No prejudice against orthodox medicine, no personal history of being rejected by orthodox practitioners, no assumption of the singular and exclusive validity of one's own preferred therapy, no arrogant belief that one has access to the truth – none of these should weaken the commitment to the benefit of the client. If political

considerations take precedence and replace fitness for purpose, then people become pawns in a game of politics – and there's more than enough of that about.

Now, it may be that the speed at which this issue was dealt with at the end of the session did not do justice either to my own needs for clarification of the terms nor to the views of the members of the group about these terms. I would appreciate further discussion some time, not least because I sense confusion. I still cannot answer the question posed in the title of my original paper !!

The above are the main issues with which I was left.

Finally, three questions which are as neutral as I can make them – to avoid Western bias !

1 If your particular therapy is the answer what was the question/problem ?

2 Why are you practising your therapy ?

3 What might encourage you to discontinue your practice ?

I always find it useful to reflect after complicated sessions – and this was one such complicated session which resulted in my reflection. In this case I decided to send you my reflections. I hope you find these relevant. Thanks for a lively time – I felt a bit knackered !

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I have been pondering some more questions. These are based in part on the work which I did as Chief Executive Officer of a small, national counselling organisation which was in the early stages of pursuing statutory regulation. I have a copy of those organisational regulations if anyone is interested. They are much more carefully constructed than the list of questions below.

Competence, complaints, referral, regulation, supervision, contract and informed consent.

1 What are the *areas of competence* of the various C and A therapies and therapists? ie for what conditions do the extensive range of therapies validly apply ?

How are these areas of competence determined, and by whom, in relation to your particular therapy ?

Who monitors the effective operation of these boundaries of competence ? In other words: who regulates the proper application of these boundaries of competence as practised by the different C and A therapists ?

Who monitors the effective performance of this regulation of therapists ?

How do these areas of competence interact/interface with other therapies – bio-medical as well as C and A ?

Are C and A therapists required to undertake recognised continual professional development – and if so, is this monitored ? If not, why not ?

2 What is, typically, the formal medical training of C and A therapists in order that patients' medical conditions outside the area of competence of the C and A therapists can be recognised ?

If there is no formal medical training for C and A therapists how do they recognise medical conditions for which they have neither training nor competence ? What sources of support and information are available for C and A therapists in this aspect of their work ?

If there is no formal medical training then it seems inevitable that C and A therapists will be unable to recognise symptoms outside the area of their particular therapy. There is also the possibility of symptom mis-attribution. The likely result of this is that there is no knowledge-based information which would enable them to recognise symptoms for which referral would be essential or at least desirable. This is obviously a 'boundaries of competence' issue but it is also an issue relating to the careful recognition of symptoms for which the therapist is not trained and is therefore not able to provide appropriate intervention. This whole area raises issues about 'duty of care'.

3 What are the typical referral policies and procedures of C and A therapists ?

Has any research been undertaken to evaluate the existence and effectiveness of any referral procedures ?

Do C and A therapists have any noticeable resistance to issues of referral ? If so, why and what is being done about this resistance ?

Duty of care issues are again present.

4 Do C and A therapists accept full responsibility for mis-diagnosis and mis-treatment ? If so, how is this responsibility exercised ? If not, why not ?

What complaints procedures typically obtain for patients of C and A therapists ?

Are there clearly established and formal procedures for making complaints ? What happens in the event that (1) a complaint is rejected ? (2) a complaint is upheld ?

Are formal tribunals in existence to adjudicate these issues ? If so, are patients fully informed of these ? If not, why not ?

Are copies of the complaints procedure given to clients when they agree to engage in therapy ?

5 What would/might happen in the event that, say, a homeopathic remedy caused considerable suffering to a patient ?

How would that patient (1) gain immediate further advice and treatment ? (2) make a complaint ? (3) be referred with full case notes to a registered medical practitioner ?

If it is not the practice of C and A therapists to refer to a registered medical practitioner what assumptions are being made about the validity of (1) the particular C and A therapy, (2) the areas of competence of the therapist ? (3) the perceived relevance on the part of C and A practitioners of registered medical practitioners ?

6 If a C and A therapy includes medication then how is the effectiveness of this medication determined ? Who researches this issue of effectiveness ?
I ask these two questions for a number of obvious reasons but also because I notice on the Anthroposophy website that what started as a philosophy of life and education is now researching the effectiveness of mistletoe for treatment of cancer. This is another version of the 'fitness for purpose' issue. It is both an issue of *effectiveness* and of *ethics.*

7 Are there consultant/specialist/supervision processes in place which enable, and perhaps require, the *therapist* to seek further and more experienced advice ?

Are there consultant/specialist systems in place in the wide variety of C and A therapies which allow *patients* to seek a formal second opinion ?

Are all C and A therapists obliged to engage in formal supervision of their practice ? To whom is a supervision report made ? What actions are taken on this report ? Who monitors these actions ?

If C and A therapists are not obliged to engage in formal supervision of their practice, why is this ? How does this impinge on issues of credibility and competence ?

8 Who determines the ethical policies and practices of C and A therapists ? Or, in other words used previously: Who regulates the practice of C and A therapists ?

Are clients given copies of the Ethical Codes of Practice within which the therapist practices along with the names and addresses of those who are responsible for the registration of the therapist so that ethical complaints can be made ?

9 Are there *formal forms of contract* signed by the therapist and the client in C and A therapies ? In other words, how is consent registered in ways which would stand up to any external scrutiny in the event of a complaint ?

What do these forms of contract indicate about: the nature of the therapy, the costs of therapy, the likely time scale of the therapy, the possible outcomes of the therapy – beneficial and otherwise ?

10 What printed information is made available by C and A therapists to enable informed consent for potential clients ?

11 Are therapists obliged to take out public liability insurance ? If not, why not ?

Some of the above issues have been very effectively addressed by the British Association for Counselling and Psychotherapy. This is available on their website.

5 January 2004