Treat or Treatment: A Qualitative Study Analyzing Patients' Use of Complementary and Alternative Medicine

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Objectives. We analyzed how patients use complementary and alternative medicine (CAM) and examined how patients' perspectives relate to existing, expert-led taxonomies.

Methods. We conducted semistructured interviews with 46 people who used CAM in southern England, then performed a qualitative thematic analysis of the interviews.

Results. CAM appeared to be used in 4 different ways: as treats, and as alternative, complementary, or conventional treatments. Treats were portrayed as personal luxuries, not directed at an identified health need. Systematic differences in the context, anticipated benefits, and implications for financial justification were revealed when nonmedical therapies were viewed and used as alternative, complementary, or conventional treatments. Specific CAM practices were viewed and used in different ways by different participants.

Conclusions. Some participants used CAM practices as a personal luxury, not as a health care technology. This is incongruent with existing expert-led taxonomies. Physicians and researchers need to be aware that patients' views of what constitutes CAM can differ radically from their own. They should choose their terminology carefully to initiate meaningful dialogue with their patients and research participants. (*Am J Public Health.* 2008;98:1700–1705. doi:10.2105/AJPH.2007.110072)

Substantial numbers of patients use practices of complementary and alternative medicine (CAM) such as acupuncture, aromatherapy, and homeopathy in the United Kingdom,[1] Europe,[2,3] North America,[4,5] and Australia.[6] In the United Kingdom, 10% of the population used a practitioner-based CAM therapy in 2000,[1] and CAM practices in general are increasing in popularity and accessibility.[4,7,8] Physicians have a legitimate interest in their patients' use of these therapies, particularly when there are known potential interactions with conventional medicine.[9] However, up to 77% of patients do not disclose their use of CAM therapies to medical practitioners.[10] We present a patient-centered analysis of CAM therapies that offers fresh insight into and explanation for this important phenomenon.

CAM therapies are typically defined in the literature by what they are not: they are "not taught widely at US medical schools or generally available at US hospitals."[11] They are commonly grouped together under the umbrella term *CAM*, a term that indicates the ways in which these therapies are provided, either alongside or instead of conventional (bio)medicine.[12] We use this terminology here not in an attempt to prejudge patients' conceptualizations but as a convenient, common, and widely accepted means of referring to this collection of therapies.

Various expert-led taxonomies for CAM have been suggested.[13–15] A House of Lords report classified them into 3 main categories: professionally organized alternative therapies (e.g., homeopathy), complementary therapies (e.g., aromatherapy), and alternative disciplines (e.g., traditional Chinese medicine).[13] By contrast, the National Centre for Complementary and Alternative Medicine classifies nonmedical therapies into 5 categories: alternative medical systems (e.g., homeopathy), mind-body interventions (e.g., meditation), biologically based therapies (e.g., herbal medicine), manipulative and body-based methods (e.g., chiropractic care), and energy therapies (e.g., crystal and gem therapy).[14]

These categorizations provide a useful organizational framework for understanding differences and similarities between individual therapies. But the extent to which patients' views might overlap with these taxonomies is unclear. Conceptual incongruence between patients' perspectives and those of researchers, providers, and policymakers has been observed.[16] Aspects of patients' conceptualizations and classifications of CAM therapies have been investigated previously, including the concepts of *complementary* and *alternative*,[17,18] the perceived differences between CAM therapies and conventional medicine,[19] perceived similarities and differences between individual CAM therapies,[20] the different psychosocial predictors of primary reliance and adjunctive CAM use,[21] and the conceptual similarities between CAM and physical fitness.[22] However, during an ethnographic study[23] it became apparent that lay people were using and thinking about CAM therapies in ways that have not yet been described or examined. We report on a qualitative analysis based on that study, which systematically examined 4 major ways in which patients use, think about, and conceptualize 5 different CAM therapies.

METHODS

Data Collection

In the context of an ethnographic study, we conducted semistructured interviews with people who used CAM therapies at 2 high street (i.e., main street) clinics located within shops owned by a national pharmacy company that sells a range of health, beauty, and hygiene products. Thus, we were able to investigate the use of these therapies in a setting that was both accessible and provided affordable treatments; understanding CAM use in such settings is likely to become increasingly important for both researchers and providers if the demand for private CAM therapies continues. Interviews were conducted with 46 people (42 women and 4 men) who were attending the clinics for aromatherapy

massage (12 people), herbal medicine (3), homeopathy (8), osteopathy (13), or reflexology (12). Two individuals experienced 2 different therapies and were interviewed twice. Even though we recruited relatively small numbers of people receiving homeopathy and herbal medicine, we reached saturation for our analysis with respect to these therapies; that is, we interviewed sufficient numbers to be able to analyze how patients used them.

Therapists informed their patients about the research (timing was left to the therapists' discretion), and F.L.B. invited them to participate in the study following their appointments. Sampling was purposive, in that we tried to interview CAM users who were likely to have a wide range of different experiences and views. To achieve this diversity, we invited people to take part who were using the therapies in diverse ways (e.g., a single visit or long-term follow-up), on different days (weekdays and weekends), and at different times (from morning through evening). Interviews were audiotaped whenever possible, or if participants preferred, notes were made during and immediately after interviews.

Open-ended questions and prompts were used to explore participants' experiences of CAM therapies. Topics included the participants' choice of therapy, choice of therapist, experiences at the clinic, and perceptions of their therapy. The issue of how participants categorized and defined therapies emerged as important in early interviews, as did the terms *alternative, complementary,* and *conventional.* This issue was explicitly probed in later interviews, in which the following questions were asked: (1) Do you see it [the specific therapy being used by the participant] as a form of health care? (2) What kind of health care do you think it is? (3) Do you think of it as alternative or complementary or conventional, or can you think of a better way to describe it?

Audiotapes were transcribed verbatim and imported with field notes into Atlas.ti version 4.1 (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany), which facilitated data organization, management, and analysis. Pseudonyms were used to protect participants' anonymity.

The interviews were carried out between October 2002 and March 2003 in 2 cities in southern England.

Data Analysis

After data review and immersion in the data by the researchers (i.e., extensive reading and re-reading of the transcripts and repeated listening to recorded interviews), all sections of the interview that explicitly or implicitly described or defined the therapy used by the participant were analyzed at a detailed level, using descriptive, open coding. These codes were then grouped to form themes. Similarities and differences between the themes were examined across participants and therapies.[24] The resulting insights were integrated to develop a conceptual model that summarizes participants' ways of using CAM therapies into 4 categories. Two researchers independently classified half of the coded segments of text into these categories; classifications were consistent for 87% of text segments, and inconsistencies were resolved through negotiation. This process provided a check on the analysis by requiring the researchers to engage in explicit definition, explanation, and discussion of analytic categories and their decisionmaking.

RESULTS

Two major categories of CAM use emerged from the analysis: (1) CAM therapy as a treat, and (2) CAM therapy as a treatment. A treat is defined as an enjoyable luxury, not directed at an identified health need, whereas a treatment is a means of preventing, alleviating, or curing specific health problems. Participants' accounts of using therapies as treatments were grouped into 3 subcategories, conceptualizing therapies as *complementary*, *alternative*, or *conventional* medical treatments (Table 1). Participants did not always talk about a therapy in the same way throughout their interviews; neither was there a simple relation between therapy modality and how a therapy was used. Although homeopathy and herbalism were used exclusively as alternative treatments, there was variation in how people used aromatherapy massage and reflexology, and only osteopathy was viewed as a conventional treatment (Table 2).

Therapies as Treats

Reflexology or aromatherapy massage were categorized as treats when they were described as pleasant experiences used for personal enjoyment rather than any specific problem: "I chose reflexology [because] I'd heard how good it is"; "I personally wouldn't use aromatherapy as a health treatment; no, I use it for being pampered." Margaret came for aromatherapy "just to treat myself really . . . just because I felt like having something to cheer me up today," although she added, "I guess in terms of my all-over health I do feel better for having it because it's a nice experience."

It could be argued that depicting therapy as a treat is consistent with a biomedical view of health. If holistic outcomes, such as relaxation, are seen as important for health, then a therapy that provides relaxation is more likely to be seen as a treatment than a treat. People with a biomedical view of health, however, do not always see therapies as treats. Betty changed from considering reflexology as a treat to regarding it as a potential treatment after realizing that it might offer her physical benefits beyond enjoyment: "I didn't appreciate the treatment basis of it, not until I actually had it. I thought it would just be quite nice and relaxing. I was amazed at how much it helped my feet. . . I'm still going to stay a bit skeptic though." Before she had tried reflexology, she thought it would offer her relaxation, which she suggested is "nice" but does not explicitly relate to her health. It was only when Betty experienced the physical effect of reflexology on her feet, which were a source of discomfort for her, that she considered it might be a treatment.

Carol had regular aromatherapy massages and viewed them as "my luxury," linking her enjoyment and their financial cost: "I enjoy them, they make me feel good . . . I don't smoke. I'd rather spend my money on aromatherapy." Like Betty, Carol explicitly associated what might (by others) be considered to be a holistic health outcome ("feeling good") with enjoyment rather than health per se. The link between paying for a therapy and viewing it as a luxury suggests that therapies might be used as treats when they are seen as nonessential, expensive, and exclusive. The study clinics provided beauty therapies (e.g., manicures) alongside CAM therapies and it was possible to purchase gift vouchers for aromatherapy massage and reflexology, thus encouraging both healthy and sick people to view these therapies as treats. Furthermore,

TABLE 1—Participants' Conceptualizations and Uses of Complementary and Alternative Medicine: Southern England, 2002–2003

	Treat	Alternative Treatment	Complementary Treatment	Conventional Treatment
Use	For recreation or as a gift, in the absence of specific health problems requiring treatment	Primarily in place of conventional medicine, when conventional medicine considered unsuccessful or unsuitable; mainly for specific, chronic complaints	Primarily as supplementary or additional to conventional medicine; mainly for ill-defined or mild symptoms, or aspects of a health condition not remedied by conventional treatment	As technical specialties aligned to conventional medicine (e.g., for specific musculoskeletal problems either unresolved by or unsuitable for conventional medicine)
Anticipated benefits	Enjoyment, pampering, general relaxation	Improvement in and understanding of symptoms and general health; participatory, trusting relationship with therapist	Improvement in physical and emotional state; gentle, enjoyable, and individualized treatment	Explanation and effective treatment of musculoskeletal problem
Rationale	Relaxation not considered intrinsic to health (consistent with biomedical model)	Holistic model: physical and emotional health intrinsically linked; "natural" approaches to treatment	Varying combinations of biomedical and holistic models	Physiological/biomechanical model of musculoskeletal functioning
Financial justification	Personal financial cost accepted, valued as luxury consumable	Most see as a legitimate treatment that should be state funded	Mixed opinions about whether it should be state funded or privately funded	Most see it as a legitimate treatment that could be state funded but may accept personal cost as comparable to payment for other types of circumscribed treatment (e.g., spectacles, prescription)

TABLE 2—Participants' Conceptualizations and Uses of Specific Complementary and Alternative Medicine Therapies: Southern England, 2002–2003

Therapy	Treat	Alternative Treatment	Complementary Treatment	Conventional Treatment
Aromatherapy massage	√	√	√	
Reflexology	√	√	√	
Osteopathy		√	√	√
Homeopathy		√		
Herbalism		√		

our participants willingly accepted personally meeting the financial (i.e., uninsured out-of-pocket) cost of therapies as treats.

Therapies as Treatments

The key difference between recipients seeing and using a therapy as a treatment rather than a treat is that treatments were used to prevent, relieve, or cure a specific, health-related need. Participants were categorized as using therapies as treatments when they described health problems (symptoms or diagnoses) requiring treatment (prevention, relief, or cure) for which they believed the CAM therapy could be effective.

Alternative treatments. Participants were categorized as using therapies as alternative treatments when they described using them for conventionally diagnosed chronic benign illnesses (arthritis, eczema, asthma, headache) that had not been satisfactorily managed by conventional medicine. Alternative treatments were also used for situations perceived as incompatible with conventional medicine. Kay said, "This time, I've got more of a feeling that my body is not functioning properly. You can't go to your [general practitioner] for this. . . . When you have general malaise, homeopathy is better, it is a general, holistic approach."

Participants believed alternative treatments were able to go "further than" simple symptomatic relief, providing them with an understanding of the treatment and the causes of their illness. Michelle saw the herbalist about her migraines because, she said, "maybe I have an allergy or intolerance or something" and hoped that "if I become a bit more healthy then I won't need to take them [herbal remedies] as much" and that the remedies will "readjust the balance." Isabel was using homeopathy for high blood pressure and hoped for both biomedical ("to be cured") and holistic ("to feel better, to be healed") outcomes.

Participants also saw the processes involved in alternative treatments as different from those of conventional medicine, perceiving in alternative treatments a more personal approach with focus on the individual rather than symptoms; a focus on identifying causes or "the root" of a problem; more participatory, involving, and enjoyable consultations; more "natural" or restorative approaches; and a comparative lack of unpleasant side effects.

Some participants contrasted alternative treatments with beauty therapies to emphasize that alternative treatments were indeed

treatments. Vicky said, "I've had facials here with the beauty therapists and they're a bit detached, and that's fine, 'cause it's like buying a product from them. But health is different. It's expertise. It's a trust thing."

Complementary treatments. Use of therapy was classed as complementary treatment when it was seen and used in a manner supplementary to other forms of treatment, usually conventional medicine. Some participants also described some CAM therapies as complementary to "conventional" CAM therapies such as osteopathy and chiropractic care. No single therapy was used consistently in a complementary role. Aromatherapy massage, reflexology, and osteopathy were seen as complementary treatment by some, but not all, participants.

Participants used complementary treatments for both physical and emotional problems including spinal pain, arthritis, tension, stress, and "feeling low." Some participants noted the health-related importance of well-being: "I find that it's [aromatherapy massage] good for you. If it's good for your well-being, it's good for you medically."

Complementary treatment was sometimes used when participants saw their current symptoms as ill-defined or relatively mild. Jill had aromatherapy massage because she "just noticed my shoulders getting all stiff" but went to her chiropractor "whenever I have problems that require my actual chiropractor."

Complementary treatments were also used as a parallel attempt to address a condition or as a means to achieve outcomes that other therapies could not. For example, Heather used aromatherapy alongside chemotherapy "as a way to distract from [being in a lot of pain]." Complementary treatments were described as more enjoyable, more holistic, gentler, and more individualized than conventional treatments.

Some participants argued that complementary treatments should be available on the National Health Service (NHS), drawing on a holistic view of health to establish the importance of well-being to health and illness: "If anxiety and stress underlie a lot of illness it would make sense to have them [complementary treatments] on the NHS." Others felt that people should pay for complementary treatments themselves, seeing well-being as inessential: "For [reflexology] being on the NHS, though, I'd expect it to be wrapped up with research. . . . People have got to be responsible for their own relaxation."

Conventional treatments. Osteopathy was the only CAM therapy that was described as conventional: "I would see it actually as quite conventional in the way that physiotherapy is about concentrating on soft tissues and things like that; osteopathy is to do with the spine." Conventional treatments were used in a way similar to alternative treatments, the only difference being the perceived relation with conventional medicine. Participants talked about having a specific, often musculoskeletal, need for treatment (e.g., for back and neck problems, arthritis) that had not been satisfactorily resolved through conventional medicine and about seeing osteopathy as a technical treatment that is consistent with conventional medicine or even as a medical specialty. (In the United States, osteopaths are fully licensed medical physicians, but this is not the case in the United Kingdom.)

Robby consulted an osteopath about back pain because: "I felt that simply going to the [general practitioner] would have resulted in just getting anti-inflammatory drugs and being sent away for a couple of weeks to see whether or not it got worse. I would rather somebody who had some formal training actually examine the spine and find out whether or not there was an issue or a problem." Robby viewed osteopathy as more able to help his condition than conventional medicine and saw it as a form of specialist conventional treatment.

Some participants felt that their condition did not warrant conventional treatment from a general practitioner but did require attention from an osteopath. Tina "just needed to talk to someone about the pain in my back." The outcomes that participants expected from osteopathy as a conventional treatment were narrow (compared with those of alternative or complementary treatments) and more concerned with physical and functional abilities than overall well-being, such as, "a little less of the nagging dull pain that's become everyday life."

Participants contrasted osteopathy with other CAM therapies to underline their view of osteopathy as a conventional treatment. Alan said, "I have some mixed feelings about alternative medicine, but osteopathy is rooted in real stuff, not the flakey stuff." Zoe perceived osteopathy as more of a treatment than other alternatives: "I've had the odd aromatherapy massage, but I think that more just feels nice, you know, it helps relax you, and I think there's quite a lot more evidence to support osteopathy than some of the other alternatives." Robby explained his view of the value of osteopathy by comparing paying for it with paying for other conventional treatments: "Cost is always a factor, but if it is going to correct a problem which I have got which is affecting how I live my life, then fine. It's like paying for glasses or paying for your prescription; you do it."

DISCUSSION

Participants who used aromatherapy massage and reflexology frequently saw these therapies as treats rather than treatments. When people used CAM as treats, they saw them as personal luxuries that were not directly relevant to a specific health problem. We also distinguished 3 different ways in which our participants viewed and used CAM as treatments and identified systematic differences in the context, anticipated benefits, and implications for financial justification when CAM is used as an alternative, complementary, or conventional treatment.

We have shown how patients' values (for instance, in relation to holistic approaches and outcomes) and their health-related reasons for using a therapy contribute to how they conceptualize that intervention. The relation between participants' use of therapy and the therapy itself was not simple. Homeopathy and herbalism were viewed as alternative treatments by all participants, but participants viewed reflexology, aromatherapy massage, and osteopathy in a variety of ways. It is possible that saturation was not reached for homeopathy and herbal medicine: had we interviewed more participants using these therapies, we might have identified a more diverse set of conceptualizations. However, our finding that homeopathy and herbal medicine are viewed as alternative treatments does resonate with other features of herbal medicine and homeopathy, including the way in which they were marketed at the clinics (as complete and whole systems of health care, in line with some expert taxonomies) and their

availability as over-the-counter health care products, a feature that might facilitate comparisons with conventional medicine.

This study adds a vital patient perspective to current definitions and conceptualizations of CAM therapies, which until now have been largely led by the expert opinions of health care professionals and researchers. Our conceptualization of patients' use of CAM therapies, particularly the use of therapies as treats, does not readily map onto existing taxonomies. In particular, the dichotomy between treat and treatment suggests that for some people, some interventions considered to be CAM by the medical profession do not actually constitute therapies according to their understanding of this term. This has implications for theorizing about CAM use: if we (researchers and care providers) are to improve our understanding of patient decisionmaking in the area of CAM use, we need to broaden our theoretical constructs about what constitutes a treatment so that we can incorporate patients' perspectives.

Our findings reinforce previous observations that patients' conceptualizations of CAM therapies are not the same as those of health care providers or policymakers.[16] This must be taken into account in both research and practice; doing otherwise could lead to inappropriate interpretation of data and clinical "misunderstanding," which may endanger patients.

A patient-centered approach requires clinicians to attend to individual patients' conceptualizations of CAM therapies to communicate effectively about them. Patients do not always disclose their use of CAM therapies to physicians, often because they perceive it to be irrelevant.[10] Our results suggest that this behavior is understandable; if people perceive and use these therapies as treats that are unrelated to a specific health problem, it would be illogical to disclose them, as a personal luxury, to their physician. Furthermore, terminology such as *complementary or alternative medicine* (in a practice or research setting) is unlikely to elicit full disclosure of CAM use.

Our findings also shed light on the disparate views regarding which therapies should be provided in the United Kingdom by the NHS. Patients who view well-being as an adjunct to health are more likely to argue that therapies that improve well-being but do not treat specific symptoms should be privately purchased. Those who take a holistic view of health are more likely to regard CAM therapies as a legitimate treatment that should be state funded.

Both an advantage and a limitation of this study is that we sampled a specific group of patients who may have been overlooked previously. The availability of CAM therapies in various high street settings is an increasingly common, but underresearched, phenomenon. The availability of these therapies is likely to increase their visibility and accessibility, thus, further contributing to their popularity.

One might also expect people of lower socioeconomic status to access CAM in such high street settings; to understand CAM use in the general population, it is essential to broaden our strategies to include all socioeconomic and racial groups in our research.[25]

By focusing on this setting, we have been able to access an important population using common CAM therapies in a common setting that would have been impossible to access through epidemiological sampling methods focused on specific illnesses or conventional environments. However, it is possible that other populations, such as those using different CAM therapies, or those using them through the NHS or in other cultural contexts, may have different approaches to conceptualizing these interventions. It should also be noted that a comparatively small number of men and women using herbalism and homeopathy participated.

Our finding that some people see and use CAM therapies as treats warrants further investigation; quantitative work is now needed to examine how widespread this view is. Future research on use of CAM therapies needs to take into account our findings regarding the different ways that these therapies are viewed and used. ■

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Contributors

All authors devised the study and helped to conceptualize ideas, interpret findings, and review drafts of the article. F.B. was primarily responsible for data collection and analysis and led the writing; G.L. and L.Y. contributed to the analysis and interpretation of the data.

Human Participation Protection

This study was approved by the University of Southampton's School of Psychology ethics committee.

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References

1. Thomas KJ, Coleman P. Use of complementary or alternative medicine in a general population in Great Britain: results from the National Omnibus survey. *J Public Health.* 2004;26:152–157.

2. Nielsen MW, Hansen EH, Rasmussen NK. Use of natural medicines in the Danish population: a national cross-sectional survey. *Ann Pharmacother.* 2005; 39:1534–1538.

3. Nilsson M, Trehn G, Asplund K. Use of complementary and alternative medicine remedies in Sweden: a population-based longitudinal study within the northern Sweden MONICA Project. *J Intern Med.* 2001; 250:225–233.

4. Eisenberg DM, Davis RB, Ettner SL, et al. Trends in alternative medicine use in the United States, 1990–1997. Results of a followup national survey. *JAMA.* 1998;280:1569–1575.

5. Millar WJ. Use of alternative health care practitioners by Canadians. *Can J Public Health.* 1997;88:154–158.

6. MacLennan AH, Wilson DH, Taylor AW. The escalating cost and prevalence of alternative medicine. *Prev Med.* 2002;35:166–173.

7. Ernst E. Prevalence of use of complementary/alternative medicine: a systematic review. *Bull World Health Organ.* 2000;78:252–257.

8. Emslie M, Campbell MK, Walker KA. Changes in public awareness of, attitudes to, and use of complementary therapy in North East Scotland: surveys in 1993 and 1999. *Complement Ther Med.* 2002;10: 148–153.

9. Hu ZP, Yang XX, Ho PCL, et al. Herb-drug interactions: a literature review. *Drugs.* 2005;65:1239–1282.

10. Robinson A, McGrail MR. Disclosure of CAM use to medical practitioners: a review of qualitative and quantitative studies. *Complement Ther Med.* 2004;12:90–98.

11. Eisenberg DM, Kessler RC, Foster C, Norlock FE, Calkins DR, Delbanco TL. Unconventional medicine in the United States: prevalence, costs, and patterns of use. *N Engl J Med.* 1993;328:246–252.

12. Zollman C, Vickers A. ABC of complementary medicine: what is complementary medicine? *BMJ.* 1999;319:693–696.

13. House of Lords. *Complementary and Alternative Medicine.* Select Committee on Science and Technology, 6th Report, Session 1999–2000. London, England: Her Majesty's Stationary Office; 2000.

14. National Center for Complementary and Alternative Medicine. What are the major types of complementary and alternative medicine? Available at: http://nccam nihgov/health/whatiscam. Accessed October 9, 2006.

15. Kaptchuk TJ, Eisenberg DM. Varieties of healing. 2: A taxonomy of unconventional healing practices. *Ann Intern Med.* 2001;135:196–204.

16. Caspi O, Sechrest L, Pitluk HC, Marshall CL, Bell IR, Nichter M. On the definition of complementary, alternative, and integrative medicine: societal megastereotypes vs. the patients' perspectives. *Altern Ther Health Med.* 2003;9:58–62.

17. Low J. Alternative, complementary, or concurrent health care? A critical analysis of the use of the concept of complementary therapy. *Complement Ther Med.* 2001;9:105–110.

18. Caspi O, Koithan M, Criddle MW. Alternative medicine or "alternative" patients: a qualitative study of patient-oriented decision-making processes with respect to complementary and alternative medicine. *Med Decis Making.* 2004;24:64–79.

19. Barrett B, Marchand L, Scheder J, et al. Themes of holism, empowerment, access, and legitimacy define complementary, alternative, and integrative medicine in relation to conventional biomedicine. *J Altern Complement Med.* 2003;9:937–947.

20. Furnham A. How the public classify complementary medicine: a factor analytic study. *Complement Ther Med.* 2000;8:82–87.

21. Astin JA. Why patients use alternative medicine. *JAMA.* 1998;279:1548–1553.

22. Goldstein MS. The culture of fitness and the growth of CAM. In: Kelner M, Wellman B, Pescosolido B, Saks M, eds. *Complementary and Alternative Medicine: Challenge and Change.* Amsterdam, the Netherlands: Harwood Academic Publishers; 2000:27–38.

23. Bishop FL. *Why Do People Return to Complementary Medicine? Understanding the Relationship Between Beliefs, Experiences and Health Care Behaviours* [PhD thesis]. Southampton, England: University of Southampton; 2005.

24. Joffe H, Yardley L. Content and thematic analysis. In: Marks DF, ed. *Research Methods for Clinical and Health Psychology.* London, England: Sage Press; 2004:56–68.

25. Wootton JC, Sparber A. Surveys of complementary and alternative medicine: Part I. General trends and demographic groups. *J Altern Complement Med.* 2001;7:195–208.