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Practitioners and patients talk about Chiropractic: a discourse analysis

by

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ABSTRACT

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A DISCOURSE ANALYSIS

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This thesis examines discourses within the chiropractic encounter and describes the
interests and consequences of different discursive strategies. It is organized into three
parts after I have first introduced the background to the study, exploring how our
understandings of pain, health, illness and embodiment are co-constructed and what
interests or motivations might be participant in those constructions. These
understandings are situated within a cultural and historical frame of reference and I
consider how constructs are socially and linguistically co-constituted.

In the first part I use discourse analysis to examine the analytic themes which
emerged in interviews with chiropractors. I describe the employment of rhetorical
devices which establish legitimacy as part of the on-going construction of professional
identity. Talk regarding chiropractic and chronic pain is analysed within a critical
framework that problematises the situating of patients as dis-embodied objects.

In the second part I again use discourse analysis to examine the accounts of chronic
pain patients attending chiropractic clinics. The use of discursive frames in the
construction of self, identity and meaning is explored, and rhetorical devices analysed.

Finally, in the third part, I stand back from the study and focus on issues of
reflexivity in the research, discuss specific implications arising from my analysis and
make suggestions for further work.

CONTENTS

3.0 Chapter Three: The discursive construction of the chiropractic occupational space

4.0 Chapter Four: The construction of patient behaviours as 'normal' vs. 'abnormal'

5.0   Chapter Five: The discursive construction of professional intervention and efficacy

6.0   Chapter Six: Discursive repertoires in patient talk about chiropractic (I) Strategies of resistance to professional authority.

7.0 Chapter Seven: Discursive repertoires in patient talk about chiropractic (II) Strategies to manage blame and accountability.

8.0 Chapter Eight: Reflecting on the research and its implications.

9.0   Chapter Nine: Implications and applications

10.0 Chapter Ten: Conclusions

APPENDICES

ACKNOWLEDGEMENTS

The period of greatest gain in knowledge and experience is the most difficult period in one's life. Through a difficult period you can learn; you can develop inner strength, determination, and courage.

His Holiness the Dalai Lama

The only rule and method I have kept is contained in a text by Char, where the most urgent and restrained definition of truth may also be read: 'I shall take from things the illusion they produce to preserve themselves from us and leave them the part they concede to us'.

<div align="right">Michael Foucault</div>

CHAPTER ONE

Introduction

"We need the power of modern critical theories of how meanings and bodies get made, not in order to deny meaning and bodies, but in order to live in meanings and bodies that have a chance for the future."

Donna Haraway, Situated Knowledges

This thesis focuses on the discursive accounts of twenty patients and practitioners within complementary/alternative medicine (CAM)[1]; specifically within chiropractic health care settings. Against a cultural backdrop whereby chronic pain has become 'an invisible epidemic' (Morris, 1993) there have been a multitude of studies that have sought to understand the lived experience of both chronic pain patients and those that work with them; however despite the increasing popularity of CAM there remains a paucity of work regarding the construction of meaning, identity and negotiated understandings of chronic pain patients and practitioners[2] within non-biomedical settings. The chiropractic encounter is another setting where notions of the body are contested and where meanings of health, illness and pain are co-constructed via discourse. By examining the accounts of patients and clinicians within these settings we may hope to further elucidate our understanding of these concepts within contemporary health care[3].

Background to the study

The original impetus for this work came from the desire to more fully understand the chiropractic encounter; that is to investigate what else was 'going on' in patient-provider encounters beyond the obvious biomechanical manipulations of the neuro-musculoskeletal system. As a student of the mind-body and as a member of the chiropractic community[4] I was all too aware of the limited understanding of the non-biological aspects of modern chiropractic care. At the same time, changes in health care including new legislation (the General Chiropractors Act) and the rise of private health care insurance raised the possibility of chiropractors increasingly taking on the

1

role of primary care practitioners and the responsibilities that are attendant to that. Thus I felt compelled to investigate:

1. To what extent are psychological problems such as depression, anxiety, somatisation and alcohol mis-use present in CAM clinics?
2. Do these problems vary by demographic characteristics?
3. How well are these problems detected by CAM practitioners?
4. How do these practitioners manage such complex cases?
5. What accounts for any observed variation in practitioner detection and management skills?

In order to answer these and other research questions, I reviewed the literature and devised a method based on existing positivist measures of these commonly presenting psychological problems (see Appendix A). True to the spirit of this type of investigation, I decided also to include other CAM practitioners (osteopaths, homeopaths) as a form of 'control group', or at least a point of comparison.

However as the study and my own understanding of the issues progressed, I became increasingly aware that the nature of the enquiry itself required a conceptual and methodological approach far removed from my original positivist-realist attempts. After all, how can something as complex as pain, or distress, or recovery be reduced to a quantitative analysis of answers to a series of closed questions? The journey to CAM is not generally, an accidental one; nor is it without risk. The patients and practitioners who embark upon such a journey have stories to tell; compelling, complex and sometimes contradictory stories that offer much to the listener by way of illuminating this most mysterious and confounding condition, chronic pain. Thus I decided to start over with an entirely different and hopefully more relevant epistemological framework, one which is informed from post-positivist resources, in particular social constructionism and discourse analysis. Returning to my original motivations, I decided to focus wholly on the chiropractic encounter, and to seek to approach my questions about the nature of this encounter by inviting patients and practitioners to give accounts for analysis using a discursive framework.

2

Social science has until recently been dominated by empiricist research informed by objectivist epistemology. Objectivism, which finds its roots in Newtonian physics pursues a research agenda that is principally concerned with hypothesis, measurement, evidence and proof. Such an approach assumes that there is an underlying reality that exists independently of the observer. Research in this vein tends to look for causal relationships; that is, there is a taken-for-granted assumption that causal effects may always be identified; only the degree of difficulty may differ. However, recent paradigmatic changes with regard to the matter of what constitutes good science have allowed for the emergence of alternative views on the nature of knowledge and how it might be achieved. Developments in the philosophy of knowledge have given strength to the rise of discursive or constructionist approaches that take issue with the core assumption underpinning positivism, namely that 'reality' exists independently of the observer, and can be known with objective certainty if the right methods are employed. Constructivism postulates rather that reality cannot be conceived of independently of the observer, and that knowledge is a temporal, culturally shaped construction as opposed to an internalised reflection of reality. This is not to suggest that social constructivists deny reality but rather that reality itself is socially constructed.

Geertz (1980) has characterized this shift in thinking as moving from the mechanistic to the dramaturgical. That is, many observers of social phenomena have subtly moved their focus from the systemic functions that actions may fulfil to the performative. In doing so, the argument is made implicitly that more than one reality, position or truth may exist, and that said truths or knowledges are at best partial, provisional and culturally situated. Therefore, in considering which methodological approach to adopt, it is important to consider the nature of the phenomena we seek to understand. From a constructivist position, approaching psychological processes always entails approaching a form of social or personal construction of these processes. Psychology cannot reach reality in its essence, as objectivism claims, but rather the way in which individuals or communities make sense of their experience. Such constructions of experience are anchored in social, cultural, linguistic, historical, and discursive conventions; arguably, such conventions do not easily lend themselves to objective analysis.

3

Certainly it seems that for this kind of research topic (observing the experience of distress and evaluating the ability of complementary practitioners to detect and cope with those experiences), traditional objectivist methods and instruments appear insufficient. What is being studied is an interpersonal activity, socially constructed, markedly inter-subjective, unique, and conversational. The best methodologies to approach such a complex domain seem to come from disciplines such as anthropology (ethnography), sociology (ethnomethodology), and linguistically informed approaches (critical studies/narrative analysis).

What is more, a critical view of the polarisation of these two discourses suggests that the opposition between the constructivist paradigm associated with qualitative research and the positivist paradigms associated with quantitative research may largely be maintained by misconceptions of what constitutes science. Perhaps a more helpful approach has been articulated by Yardley, who argues persuasively the case for employing 'conscious eclecticism' in the selection of methods and resources in order to be able to construct multi-layered accounts of phenomena (Yardley, 1997: 109). Such an approach understands knowledge as intrinsically linked to intentions and actions, and meaningful only when evaluated in terms of its effects. That is, science is reconceptualised as an essentially human endeavour influenced by human characteristics and thus a rationale and a framework for combining both qualitative and quantitative approaches methods of inquiry is provided. A similarly pragmatic approach is advocated by Bradley:

> it is possible, and highly desirable in the interests of methodological pluralism, to explore assumptions that underlie all research in the context of their usefulness in understanding particular research problems. Active discussion of what we know, in light of how we produced that knowledge, can only extend our understanding... (Bradley, 1993: 448)

Thus in identifying which epistemological framework was most appropriate to the topic, I have taken account of my own construction of health care as a human activity indivisible from the interpersonal relationships within which it occurs. That is to say, research into this lived experience should not be decontextualized from the social, historical, cultural, and political environment. Furthermore, it should look to the centrality of the individual experience and place some considerable emphasis on the

4

role of language, in accordance with the influence it is understood to exert in the construction of meaningful shared knowledge.

Language is a central way by which humans construct meaning from experience. Our discursive practices provide an important means to bridge the gap between inner thoughts and feelings and outer world events/actions. These practices are not passive – on the contrary in creating communicative acts, we engage in a process that is both active and constructive. Several scholars have commented on the 'vital human capacity' (Shore, 1996: 319) to create meaning from experience (Bruner, 1986; Goffman, 1974; Shore, 1996). What is more, the current turn in the social sciences towards examination of language reflects a concern to mediate between the personal and the social. Language offers a way of making experience coherent, of constructing a reality which successfully conjoins objectivity and subjectivity i.e. one focused on observable actions and events, the other on thoughts, feelings and knowledge of those events. Examining communicative accounts from patients and doctors thus may provide insight into important aspects of healing encounters that might otherwise remain hidden.

Accounts from patients and doctors may also help to elucidate how life events are negotiated – in other words how they are made meaningful. As Kleinman reminds us: "Nothing so concentrates experience and clarifies the central conditions of living as serious illness" (Kleinman, 1988: xiii). By attending to the linguistic resources that people make use of, we may be able to discern and understand the ways in which culture influences aspects of our bodily (material) lives. In the dialectic that exists between illness and therapeutic activity we can thus perceive the complex inter-relatedness between situated concepts such as body, self and society. Paying attention to this dialectic – to the meanings of illness - can illuminate and improve the therapeutic process for both patient and healer. Through the examination of illness meanings it may be possible to transcend the dualistic thinking about illness that may hamper therapeutic progress. Privileging illness meanings can thus potentially contribute to the provision of more effective care.

One way in which this can be achieved is to examine the linguistic traditions and resources that individuals make use of in trying to negotiate significant or challenging

5

life experiences. Culturally shared illness idioms represent a common language through which patients and practitioners can communicate their experiences and understandings. Kleinman (1988: 5) observes that: "There are normal ways of being ill (ways that our society regards as appropriate) as well as anomalous ways". It might be worthwhile then to seek to understand how these expectations may vary or otherwise with CAM settings, for practitioners too are of course socialised into a particular collective experience of illness.

> The healer – whether a neurosurgeon or a family doctor, a chiropractor or the latest breed of psychotherapist – interprets the health problem within a particular nomenclature and taxonomy, a disease nosology, that creates a new diagnostic entity, an 'it' – the disease. (Kleinman, 1988: 5)

Yet for patients, the disease or health problem cannot be understood separately from their personal experience of what that means to them. When pathology is privileged at the expense of illness, that experience fails to be recognised as an important or legitimate clinical concern and there is hence a potential for undercare. Discursive approaches, by allowing for the possibility of multiple subjective meanings, may afford a glimpse into this other realm.

To date, analysis of discursive practices has not been a feature of Western medical research, however increasingly health professionals are welcoming an alternative approach which is sometimes more appropriate to certain aspects of clinical experience. Prominent neurologist Oliver Sacks for example, has decried the tendency in biomedical history-taking to prioritise the pathology over the person:

> such [medical] histories...tell us nothing about the individual and his history; they convey nothing of the person, and the experience of the person as he faces and struggles to survive his disease (Sacks, 1987: viii)

This tendency of biomedicine to privilege the body can be traced back to the construction during the 18th century of a discourse which made possible the separation of the anatomical sign and the symptom (Foucault, 1963). This in turn paved the way for what Foucault termed the 'medical gaze' to develop whereby the body could be examined independently of the person's subjective experience. The

6

reverse of course, also became a possibility, whereby symptoms could be judged as real/unreal depending on the presence of biological markers or signs. Thus:

> Symptoms, what the patient said, could provide a guide or a hint or a suspicion of which organ or system might be involved but were only preliminaries; the core task of medicine became not the elucidation of what the patient said but what the doctor saw in the depths of the body (Armstrong, 1984: 738).

Medical science thus has decontextualised disease and illness and translated subjective illness experiences into biological and physical objects, reifying these experiences as mechanical and objective entities. Recently however this has been challenged by authors who have argued for a new awareness of the importance of subjective experiences and meanings in attempting to understand illness experiences. As Sacks has argued, efforts must be made to elicit extended illness narratives, in order to encourage the sharing of richer, more meaningful 'clinical tales':

> ...only then do we have a "who" as well as a "what", a real person, a patient, in relation to disease... (Sacks, 1987: viii).

Certainly there appears to be an increasing interest in recognising the important difference between disease as an objective state of pathology, and illness as a subjective state of experience. Within this context, many theorists are turning to discourse to allow examination of the ways in which language produces and constrains meaning for individuals.

In order to do so we must attend to the accounts that are offered by both patients and doctors within specific healthcare settings to communicate meaning or perspective. These accounts tend to take shape around themes and may communicate a rich variety of personal experience and moral positions. Ultimately, the communicative acts we engage in shape how we understand ourselves and the events in our lives and it is for this reason that they are a compelling subject of investigation. Given the important constitutive power of language then, it seems paramount to be sensitive to discursive practices.

Approaching our topic from a discursive perspective thus allows sophisticated questions to be asked such as: what discursive practices can be observed in patients who take their pain problems to non-biomedical (i.e. non-mainstream) health care practitioners? What does it mean to be a 'complementary' or 'alternative' practitioner and what kinds of actions are compatible with such a positioning?

In this study then, the aim is to generate texts from interviews with patients and practitioners within complementary health care settings to which a discursive lens might be applied, identify discursive practices and attend to the ways in which language does more than just reflect or describe meaning or experience. Within the socio-political context of ongoing inter-professional debate between biomedical and CAM health care providers, a special emphasis will be placed on the analysis of rhetoric. By examining the role language plays in the construction of pain, health and healing discourses and the implications this has for the experience of patients and providers, we may gain a better understanding of the meanings that these constructs hold for the participants.

<u>Cultural and historical context</u>

> The body is a machine, so built up and composed of nerves, muscles, veins, blood and skin, that even though there were no mind in it at all, would not cease to have the same functions – Rene Descartes Trait de l' homme (1634), in Foss (2002: 37).

One feature of social constructivist approaches is that they consider that all knowledge is bound by time and culture and thus our attempts to understand experience must be explicit about both locality and temporality. In seeking to understand more fully the lived experience of patients and doctors within CAM settings, we must first consider questions like:

What is the different status/position of the complementary discipline i.e. what are they 'alternatives' or 'complementary' to?

What ideologies or belief systems are relevant in the delineation of these alternative healing paradigms?

Based on a narrow, precisely defined view of health and illness, the biomedical model has been the dominant paradigm by which western societies have conceptualised health issues. Possessing considerable social and political authority, it provides a style of health care that is individually focused, cure-oriented, and hospital-based. It is recognisable by its core assumption about disease, namely that it represents a state of pathology or deviation from normal biological functioning. Another trademark assumption of the biomedical model is its commitment to the doctrine of specific aetiology, whereby each disease is believed to be caused by a "specific, potentially identifiable agent" (Freund and McGuire, 1991: 227). This reductionist approach to health and healing gained crucial strength from the advent of germ theory, which explained that infection occurred at the individual level through the action of identifiable micro-organisms:

> From the field of infection the doctrine of specific etiology spread rapidly to other areas of medicine; a large variety of well-defined disease states could be produced experimentally by creating in the body specific biochemical or physiological lesions. Microbial agents, disturbances in essential metabolic processes, deficiencies in growth factors or in hormones, and physiological stresses are now regarded as specific causes of disease (Dubos, 1984: 5-6).

From this notion developed the assumption that each disease has specific and distinguishing features, symptoms and processes that are operate independently of historical and cultural contexts. This 'discovery', combined with the belief that the whole could be understood as the sum of its parts provided by Cartesian[5] philosophy, provided medical doctors with a discursive resource by which they could construct and successfully defend a mechanistic and technologically focused approach to health and health care.

Cartesian dualism, which provided the philosophical framework through which mind could be distinguished from body, exerted a profound influenced on the development of biomedicine. It led to a reductionistic focus on issues that were "observable, amenable to measurement and open to accurate technical description" (Moon, 1995: 55). 'Nature', conceptualised as separate and distinct from matters of culture (personhood, society), became understood as the appropriate level at which matters concerning the body should come to be known. Constructed as universal, rational and objectively 'true', the realm of the biological thus became the unquestioned focus

of medical practice and research, an assumption which continues to persist today (Gordon, 1988). In the twentieth century, political, institutional and corporate agendas converged to drive major reforms in biomedical education whereby the emphasis was increasingly placed on the physical sciences, such that medicine essentially began to be viewed as a technical or mechanical task. Medicine, traditionally understood as both a science and an art, became increasingly aligned with the natural sciences, and thus was afforded similar cultural prestige (Gelfand, 1993).

But whilst biomedicine has demonstrably created for itself a position of dominance within the realm of health and health care, this is not necessarily because of its superior therapeutic performance. Rather, it could be argued that the success of biomedicine has been largely due to its ability to defend its position in the health care market by forming alliances with powerful political and social forces, marginalising its competitors and increasing its sphere of influence via a gradual process of medicalisation (Petersen, 1994). Nevertheless, complementary and alternative systems of medicine have continued to survive - indeed even prosper - indicating that the biomedical model is not providing a sufficient or complete answer to modern health care problems.

> We may have won the struggle against a large number of diseases, especially the infectious ones, but instead we are facing other health problems...Anybody who follows the development of medicine will know that progress continues in a large number of fields, but at the same time it is impossible to suppress the suspicion that the major health problems of the day cannot be solved within the conventional framework of ideas (Wulff, Pedersen and Rosenberg, 1990: 10)

Contesting the biomedical model

> Medical practices are simultaneously ideological practices when they justify the social arrangements through which disease, healing and curing are distributed in society and when they justify the social consequences of sickness (Young, 1982: 271).

10

Despite the position and power that biomedicine wields, health it would seem, remains a contested field. Whilst adherence to a model of disease that emphasised specific, measurable criteria provided biomedicine with a clear focus and considerable cultural authority, contemporary approaches now suggest that such a lens is deficient insofar as it neglects the broader social and cultural context in which health occurs (Curtis and Taket, 1996). Furthermore, the assumed 'neutrality' or scientific impartiality or medicine has been challenged by theorists who have pointed out that medical knowledge is socially constructed and thereby subject to bias. That is, like all situated knowledges it is intrinsically partial and perspectival (Freund and McGuire, 1991).

And so, notwithstanding the hegemony enjoyed by biomedicine for the past 150 odd years, complementary and alternative medicine (CAM) has continued to survive and indeed could be considered to be enjoying a surge in popularity. Alternative, complementary or 'other' medicine can be generally defined as those practices used for the purpose of medical intervention, health promotion or disease prevention which lie outside the dominant tradition (Micozzi, 1996: 5). The reasons why other medicines are appealing are many. This has variously been attributed to a decline in confidence in biomedicine (Sharma, 1992), the emergence of an increasingly agentic health consumer, or 'smart consumers' (Doel and Segrott, 2003; Wiles and Rosenberg, 2001), or alternatively as the consequence of increasing collective anxiety (Furedi, 2003). However it is explained though, it would seem that in the wake of this revival CAM is poised to become "a permanent feature of our cultural landscape" (Douglas, 1996: 49). Studies indicate that a significant proportion of consumers in western nations are now subscribing to non-biomedical approaches and an increasing number of biomedical practitioners are incorporating complementary treatments into their practices (Hall and Giles-Corti, 2000).

The World Health Organisation estimates that internationally, the overwhelming majority of people use what would be considered CAM from a Western perspective (WHO, 2002). Whilst much of this use resides in Africa, Asia and Latin America, CAM has been observed to be increasingly relied upon by people in Europe, North America and Australasia for the management of chronic and serious disease (WHO, 2002). CAM does not merely operate on the fringes of Western medicine as perhaps

11

it once did, rather it is increasingly meeting the health needs of people within countries where biomedicine dominates as the principal system of healthcare.

In the UK, it has been estimated that there are c. 70 000 CAM practitioners, represented by c. 170 practitioner associations (Mills and Budd, 2000). There exists considerable diversity within this broad categorisation in terms of organisational size, structure, modality, philosophical underpinning, and relationships with both biomedicine and government. A three-fold typology put forward by the House of Lords (2000) proposes the following strata: the *'principal disciplines'* of acupuncture, chiropractic, herbal medicine, homeopathy and osteopathy; therapies *complementing* orthodox medicine, such as the Alexander Technique, aromatherapy, reflexology, shiatsu and meditation; and *alternative* disciplines, largely separate or contrary to biomedicine and its tenets, such as Ayurvedic medicine, and Chinese herbal medicine.

However, whilst this typology might be an accurate reflection of the current status of the various disciplines, it should be noted that historically, CAM disciplines on the whole were marginalised and rejected by the biomedical community. This gave rise to the parallel and separate provision of CAM health care under a system of self or lay referral, positioning CAM providers as alternative primary care practitioners. The claim to legitimate occupancy of a primary care role is visible throughout CAM professional literature; for example, the General Chiropractic Council's Code of Practice and Standard of Proficiency guidelines state:

> Chiropractic is an independent primary health care profession. In common with other such professions, the law does not attempt to define precisely…the scope of chiropractic. (GCC, 2005)

This positioning by CAM providers as primary care practitioners is of particular interest to health psychologists as the significant association between physical and psychological illness has been demonstrated repeatedly (Kisely and Goldberg, 1996; Verhaak, 1997; Von Korff and Simon, 1996). Patients with chronic somatic conditions have been found to show a high prevalence of psychological disorders (Miranda, Arean and Rickman, 1994). Several studies conducted in biomedical settings have suggested that up to 25% of patients presenting with somatic conditions

12

may also have problems with depression, anxiety, somatisation and alcohol abuse (Tiemans, Ormel & Simon, 1996; Bowers, 1993; Goldberg, 1996). Psychological problems treated at the primary care level have been found to resolve as rapidly as those treated by mental health specialists (Scott & Freeman, 1992; Brown & Schulberg, 1995).

A number of possible explanations have been proffered for the relationship between physical and psychological disorder. In some cases it has been suggested that there may be a direct biological link between a somatic condition and psychological disorder. Examples include Parkinson's disease and multiple sclerosis which, as disorders of the central nervous system, have a demonstrable biological link with specific psychological disorders such as depression (Carlson, 1994). However, such direct links have been shown for a limited number of physical conditions and as such represent only a small proportion of the noted somatic-psychological co-morbidity.

An alternative explanation suggests that psychological problems may arise from the experience of physical pain or disability, whereby the continued experience of pain appears to impact negatively on physical recovery and psychological well-being (Fraser, 1996). Pain is the most ubiquitous of symptoms in primary care settings, and as such is recognised as an extremely important factor in both diagnosis and formulation of treatment plan. The explosion of pain-related disability in recent times, and the increasing tendency for chronic pain patients to use CAM to manage pain, further highlights its importance as a subject of inquiry. It has also been noted that physical disease can be the result of psychological malaise. This may operate in various ways: first, psychological state (e.g. anxiety) may be implicated as the cause of somatic illness as has been observed in several conditions such as gastric ulcer, coronary heart disease, migraine and irritable bowel syndrome (Taylor and Aspinall, 1990). Second, psychological distress may contribute to the onset of somatic illness by the neglect of the self, poor health behaviours, risk-taking and non-compliance to wellness regimes. Indeed evidence does exist for a relationship between psychological distress and elevated rates of cigarette smoking, physical inactivity and hypertension (Hayward, 1995).

Alternatively, the links between organic and psychological aspects of pain may be approached from what has been referred to as a material-discursive perspective (Yardley, 1997). Such an approach attempts to overcome dualist assumptions and suggests rather that the psychosocial and physical aspects of experience may be simultaneously explored by employing a model of embodied experience that seeks to reconcile the two previously sharply delineated realms of body/mind. Embodiment constitutes a concept or paradigm that might overcome body-mind, subject-object divisions in its central understanding of the body as the 'existential ground of culture' (Csordas, 1990:5). Csordas argues that:

> "the body as a methodological figure must itself be nondualistic, i.e., not distinct from or in interaction with an opposed principle of mind" (Csordas, 1990: 8).

Adopting an embodiment perspective reminds us that all our experiences are "both substantial and symbolic" (Yardley,1999: 32). Pain therefore exists not only as a bodily and emotional experience but also serves to fulfil important social and communicative functions:

> "An expression of pain is not a public report of a subjective interpretation of a private physical event. Pain complaints can instead be understood as one verbal element of a changed relationship to the world..." (Yardley, 1999:32)

Traditional debates concerning the links between the organic and psychological aspects of pain are therefore increasingly undermined by the contemporary awareness of the constructed nature of experience, which challenges the classic distinction between mind and body. This theme will be returned to later in this work when pain within CAM settings is further explored from a discursive perspective.

The increasing role of CAM practitioners as primary care health providers is particularly relevant as the majority of psychological problems that come to medical attention are initially flagged up within a primary care setting (Bowers, 1993). It is difficult to place an exact figure on psychological problems in primary care, although some authors have attempted to pull together results from various studies. Sartorius, Ustun, Lecrubier and Wittchen (1996) in their review of the World Health Organisation's (WHO) study found that on overage 25% of primary care attenders had a recognisable mental disorder according to the International Classification of Diseases, 10th edition (ICD-10). This is supported by Craig and Boardman (1997)

14

who also found that mental disorders comprise about 25% of general practice consultations. Bowers (1993) also added that 52% of high frequency attenders showed some form of psychological illness. Verhaak and Tijhuis (1994) similarly estimated that between 22-35% of general practice attenders to have mental health problems, and data from Higgens (1994) review of findings over the past twenty years placed the prevalence of psychological illness in primary care at between 23-29%. These figures are consistently higher than estimates of psychological illness in the community, which range from 8-15%.

The finding that psychological problems are common, disabling and responsive to treatment at this level suggests therefore that the professional self-identity of primary care practitioners might be a worthy subject of investigation. Whilst several studies have sought to examine how biomedical practitioners perceive their role in the management of psychological problems or their understanding of patient experiences from a biopsychosocial perspective, relatively few have looked at this within the context of CAM. Likewise, there exists a plethora of studies that seek to convey the lived experiences of chronic pain patients – however by far the majority of these have focused on patients presenting to biomedical practitioners. Given the exponentially rising use of CAM within the UK, it would seem that this might be an appropriate time and place to examine these issues.

Psychological problems appear to be present in a high proportion of patients in primary health care settings (Goldberg, 1996; WHO, 1995). The WHO study found that approximately 25% of patients presenting to general medical practitioners have well-defined psychological disorders, and a further 9% had sub-threshold conditions. The most common disorders were depression (10%), anxiety-related disorders (8%) and harmful use of alcohol (3%). The difficulties primary care providers encounter in assessing and managing the psychosocial needs of patients have been well-documented in the biomedical sphere (Goldberg & Huxley, 1992). However there is a relative lack of information regarding this within CAM settings.

Recent political changes – the professionalisation of chiropractic in the UK

Chiropractic is a discipline of the scientific healing arts concerned with the pathogenesis, diagnosis, therapeutics and prophylaxis of functional disturbances, pain syndromes and the neurophysiological effects related to static and dynamic disorders of the locomotor systems particularly the spine and pelvis. (European Chiropractic Union. E J Chiropractic, 1990, 38: inner back cover)

Whilst considerable social scientific examination has been directed at the growing demand for CAM, the effect of this burgeoning demand on the provision of CAM has received comparatively less attention. This element is significant because expanded provision is often linked to changes in practice, notably as a part of the complex and transformative process of 'professionalisation', which arguably has the potential to radically alter professional identity and consequently the work of practitioners (Cant and Sharma, 1996).

Sociological analyses have argued that professions make up an interacting system, within which vocations or disciplines compete for control over 'jurisdiction', i.e. the relationship between a given profession and its work (Abbott, 1988). In this model, the key elements of professional life are proposed to be the possession of a body of complex knowledge and the ability to abstract that knowledge. Control over this knowledge and its application is necessary in order to successfully claim a jurisdiction. The impact of external and internal factors means that jurisdictional boundaries are constantly in dispute, encouraging that most fundamental characteristic of professional life, inter-professional competition. Jurisdiction, or the link between a profession and its work, has been stated to be a 'more-or-less exclusive claim' (Abbott, 1998: 34). The jurisdiction of one profession pre-empts that of another because, as an ecological system, every move in the jurisdiction of one profession must affect those of others.

The Weberian notion of social closure has been used and extended by theorists to conceptualise professionalisation as a game of power and control. The term closure was originally used by Weber (1930) to describe the process by which social collectives such as health disciplines attempt to maximise rewards by restricting access to resources and opportunities. Dominant social groups exert whatever power they may have to monopolise opportunities in a 'downwards' or exclusionary process of social and economic closure. These concepts were later developed to include

16

direct references to the social actions of subordinate groups which occur in response to such exclusion. Parkin (1979) called such actions countervailing or usurpationary strategies, and conceptualised these metaphorically as 'upward' responses to the former type of closure.

Whilst exclusionary tactics can take many forms, the possession of knowledge has become a central focus for many theorists as society becomes increasingly information-dependent. Credentialism, or 'the inflated use of educational certificates as a means of monitoring entry to key positions in the division of labour' (Parkin, 1979: 54), is considered by many to be an important tactic used by occupations engaged in professional projects. The common tendency amongst the professions to regulate ever more strictly the entry requirements can be seen as an attempt to control the supply of candidates for the rewards of professional membership, draped in the rhetoric of maintaining competency standards. Dore (1976) referred to this increase in the use of qualifications as the 'diploma disease'.

In contrast to exclusionary tactics, demarcationary strategies are aimed at interoccupational control over claims to jurisdiction between related professions, i.e. those concerned with the regulation of the work of other relevant occupations within a given sphere of labour. Demarcationary tactics are employed by occupations in the struggle to establish and control boundaries within the system of professions. Such manoeuvring was conceptualised by Kreckel (1980) as a 'horizontal' exercise of power, as opposed to the vertical efforts of exclusionary or usurpationary strategies. The notion of occupational imperialism, as described by Larkin (1983), is related to this concept. Larkin (1983) described occupational imperialism as referring to:

> attempts by a number of occupations to mould the division of labour to their own advantage...it involves tactics of 'poaching' skills from others or delegating them to secure income, status and control. (Larkin, 1983: 17)

Thus the fight for occupational space is a two-way struggle, and chiropractic has been no exception, making use of many tried and tested strategies of dual closure. Minimum educational requirements for entry to study chiropractic have steadily increased, and there is a visible expansion of interest in the production of credible

17

research. Undergraduate courses have evolved into 5-year BSc Hons qualifications and several Master programmes have also sprung up.

A defining feature of professions is the need to establish exclusive authority over a particular area of work and the power to delegate related work to subordinate occupations. Several scholars have asserted that the key to achieving professional status depends upon the ability to dominate a particular field. Larson (1979) suggested exactly this when she stated that professionalisation:

> is aimed at monopoly: monopoly of opportunities in a market of services or labour and, inseparably, monopoly of status and work privileges in an occupational hierarchy (Larson, 1979: 609)

Biomedicine of course, has been particularly successful in achieving a near-monopoly in the area of health and illness – however pressure has mounted from many sides for medical doctors to open up the 'business' of healing to a variety of other disciplines. One interesting aspect of this debate is the growing body of evidence suggesting that patient satisfaction, itself in turn dependent upon personal autonomy and choice, is a key factor in rates of recovery. If the ability of each patient to make a free and informed choice about which treatment they will undergo is an important part of resolving their health problem, then any attempt by one health care profession to obtain a monopoly over health care directly contradicts a defining feature of 'professional' conduct, i.e. acting in the interests of the patient.

The formal recognition of the relationship between patient choice and patient health has resulted in an agreement that inter-disciplinary co-operation and communication must be encouraged. The British Medical Association itself has stated that there is a need to pursue an expanded view of health care beyond the dominant medical model (BMA, 1993). Such a position clearly supports the claim of complementary medicine to a legitimate position within the mainstream health system.

Whilst the trend towards professionalisation has long been noted across many occupations, CAM in the UK has only recently embarked upon this lengthy and transformative process as biomedicine gradually has shifted its position from outright rejection/hostility to selective uptake/acceptance. The use of exclusionary strategies

18

not unlike those employed by biomedicine in the mid-19th century to delineate and protect the emerging biomedical profession has recently been observed within CAM. Of particular note is the recourse to claims of specialist knowledge as a source of authority, legitimacy and status. These claims to expert knowledge are typically noted to be protected via the development of extensive and formal socialisation practices, in the form of expanded educational or training schemes, disciplinary procedures, continuing professional development programmes, and rigorous codes of practice (Cant and Sharma, 1996).

Saks (2000: 230) notes that professionalisation often provides "positive benefits to those involved in terms of enhanced income, status and power, as well as the satisfaction of working in a well-regulated profession". However against these benefits must be weighed the inevitable costs, particularly with respect to the individual autonomy of practitioners. Autonomy at the macro level is also arguably diluted via the process, as statutory self-regulation has been noted to be accompanied by an "accommodation to the bio-medical model" (Baer, Tannasi, Tsia, and Wahbeh, 1998: 533). An example of this would be the renewed debate within chiropractic over the use of the term 'subluxation', both within the profession and in external communications.

The 'subluxation' concept was historically, a key concept – arguably it was even the cornerstone of 'chiropractic philosophy'. Chiropractic emerged in the late 1890's as a natural and conservative source of health care, offering an alternative to medication and surgery. The first chiropractic 'adjustment' (spinal manipulation) was administered in 1895, at Davenport, Iowa, USA by Daniel David Palmer (1845-1913), a Canadian practitioner of magnetic healing for ten years. Palmer believed that the cause of disease could be traced to 'subluxations' or maladjustments of the vertebrae which thus interfere with the healthy working of the nervous system. The name for this new theory and practice was provided by a local minister, the Reverend Samuel H. Weed, who combined the Greek words cheiro (hand) and praktos (practice) to produce the modern term 'chiropractic', meaning treatment by hand or manipulation.

The Palmer School of Chiropractic was subsequently established in Davenport in 1897, and taught 'P', 'S' and 'U' (pure, straight and unadulterated) chiropractic. Palmer followers in the United States became known as 'straights', and those who combined chiropractic with any other kind of medical therapies were called 'mixers'. These terms really designated the ends of a continuum rather than two discrete groups of chiropractors, most of whom today fall somewhere between the two poles (Wardwell, 1992). However the old distinction between straights and mixers has in recent times been resurrected and brought to the foreground again, using an updated rhetoric ('evidence-based' chiropractors vs. 'philosophical' chiropractic).

Whilst there is no doubt that chiropractors continue to be treated with scepticism and sometimes outright hostility by many biomedical practitioners and lay-people, it is also true that as a profession, they are currently enjoying a period of growing acceptance and credibility. This is largely thanks to the profession having recently achieved protected status with the passing of the Chiropractic Act, and the establishment of the General Chiropractic Council (GCC). Other signs of a professionalisation process well underway include the establishment of the first university-based undergraduate degree course (in 2000 at the University of Glamorgan), which has now successfully graduated its third cohort of chiropractors. Other universities have been quick to follow suit (Dublin, Surrey, Portsmouth/AECC) and overall we may expect the profession to continue to enjoy a growing acceptability within a culture arguably more open to non-biomedical practitioners than in previous years.

The battle to win this protected status was however, not without its casualties. In order to achieve the status and credibility of an officially approved stand-alone health profession, many ideological compromises (or improvements, depending on your perspective) had to be made. Essentially, the original or core premise of chiropractic, namely that subluxation causes 'dis-ease' has been usurped by the rise of the 'evidence-based' chiropractic. Chiropractors who continue to define what they do as 'the removal of subluxations' are referred to as 'philosophical' – which can be heard as either a compliment or an insult depending on which camp you belong to. The increasing emphasis on evidence-based chiropractic has resulted in a subsequent decrease in time and attention given to the 'philosophy of chiropractic' within the

20

mainstream university-based programmes, a topic which continues to be the source of much debate within the profession. The debates surrounding the rise of evidence-based health care in both biomedical and complementary medicine will be discussed further in Chapter Two.

From biomedical to biopsychosocial

Ironically, it appears that whilst CAM disciplines appear to be increasingly adopting what previously would have been considered a biomedical approach to health and healing, the biomedical discipline itself is moving away from that perspective towards a more 'holistic' view – under the guise of the more rhetorically acceptable name of 'biopsychosocial' medicine. The biopsychosocial model of health is based on a variety of closely related perspectives, focusing (as the name would suggest) on the interactions between biology, individual psychology and social factors (Petersen, 1994: 20). The model, in attempting to broaden the concept of health, is promoted as a more inclusive, holistic perspective. However it is still characterised by an "uncritical faith" in the scientific method for explaining the interactions between the physical, psychological and social realms of life (Petersen, 1994: 21). It is still firmly located within the dominant paradigm of health care where an individual is restored to health by removing the symptomatic factors relating to the dysfunction.

Towards a constructivist understanding of health, illness and pain

In the classic Derridian sense, the task of deconstruction is to 'take apart' or dismantle those concepts which serve as axioms or rules for a period of thought and to demonstrate how concepts are contingent upon historical, political, cultural and linguistic discourses. A deconstructive approach to the chiropractic encounter thus requires a critical understanding not only of the history of medicine/healing but also of the history of cultural experiences of pain and of the cultural meanings of pain, suffering and distress. One of my objectives then, is to explore those contexts – historical, cultural, professional – which operate inter-dependently to co-construct our shared understandings of pain, health and healing.

Examining pain as a cultural construct

> Pain is perfect misery, the worst of evils, and excessive, overturns All
> Patience.
> <div align="right">John Milton, Paradise Lost</div>

Pain, illness and suffering are often conceptualised as private and physical phenomena that are the experienced at the individual level, somehow separate from the social world. However scholars have successfully challenged this view by pointing out that the experience of pain is fundamentally a social one (Morris, 1991). Social anthropologists have long noted examples of cultures whereby illness in the individual body is interpreted as a sign of disease or dysfunction in the wider social body (Turner, 1961, 1969).

Indeed the relationship between pain and culture can be conceptualised as multi-layered and intertwined - of such complexity that it is hard to appreciate or even approach. It is precisely because pain is so complex and so poorly understood that it occupies such an ambiguous position within biomedicine. That is, pain is so rarely accounted for by known physiological pathways and processes that researchers and clinicians are left bemused and stymied in their attempts to apprehend it. The role of psychosocial influencing factors is now widely accepted, and yet this has had little effect in terms of improving clinical guidelines for treatment or achieving positive outcomes in clinical terms. Considerable efforts have gone into understanding the myriad of 'secondary gains' that may be associated with chronic pain, such as sympathy, increased attention, ability to control others, ability to avoid work and so on (Fordyce, 1976; Turk, Meichenbaum, and Genest 1983; Holzman and Turk, 1986). Some researchers have observed that chronic pain can fulfil positive functions such as keeping a family unit together by focusing attention away from other problems or dysfunctions (Minuchin, Rosman and Baker, 1978). Others have pointed out the 'pain games' that can be entered into in order for individuals to gain control over others or escape responsibilities (Menges, 1981). However whilst many pain clinics working from a biopsychosocial model attempt to integrate familial, occupational, emotional and other subjective factors into their treatment approaches, pain remains an intractable problem for many millions of people.

Perhaps this is because pain is inherently unknowable outside of the person suffering it. Indeed Osterweis, Kleinman and Mechanic (1987) concluded that there can be no external or objective means of measuring pain as the experience itself is by definition personal. So pain exists as an inner experience, which language must fail to express adequately. As Scarry says:

> Pain comes unsharably into our midst as at once that which cannot be denied and that which cannot be confirmed (Scarry, 1984: 4)

Thus pain cannot be shared with others, even those closest to the sufferer. One unfortunate consequence of this characteristic of pain, illuminated by Scarry, is that the sufferer can become distrusted by others, who cannot access and therefore cannot appreciate in the same way, his/her pain. This tendency of pain to become of uncertain status to those on the outside can undermine relationships – medical, familial, legal, occupational – causing yet further distress.

As several authors have observed, pain can even cause a rift within the person, whereby the pain is viewed as the result of an unwelcome trauma to the person, an external or 'outer' factor having a profound and unwanted effect on one's inner being (Kleinman, Brodwin, Good and Good, 1992). Pain becomes an 'It' and a foreign invader that is to be expelled, as Scarry puts it:

> ...even though it occurs within oneself, it is at once identified as 'not oneself', 'not me' as something so alien that it must right now be gotten rid of (1985: 52).

It is of little wonder then, that pain remains so inexorably unsolvable within our current health care system. As an experience that is at once material/immaterial, subjective/objective, real/unreal it represents an epistemological conundrum for health care professionals, whose paradigms of health remain firmly entrenched in such dichotomies. Other central assumptions within Western medicine such as the primacy of the individual as the appropriate unit of analysis also serve to problematise pain:

> the experience of chronic pain is fundamentally intersubjective. Chronic pain profoundly affects the lives of the family, intimate friends, co-workers, and

23

even at times the care giver, and such persons in turn shape the experiential world of the sufferer. To regard pain as the experience of the individual, as it is regarded in standard biomedical practice, is so inadequate as to virtually assure inaccurate diagnosis and unsuccessful treatment. (Kleinman et al; 1992: 9)

Thus any comprehensive theory of pain must take into account its status as an experience ultimately indivisible from social and cultural context. As Morris suggests:

Pain...will not be understood solely as a medical problem involving the transmission of nerve impulses but rather as an experience that also engages the deepest and most personal levels of the complex cultural and biological process we call living. (Morris, 1991: 7)

Chronic pain: The 'invisible epidemic'

Almost unknown as a diagnosis in medical writings before the twentieth century, chronic pain now grips so many people in the postmodern era that it is commonly and justifiably described as an epidemic. (Morris, 1991: 108)

Undoubtedly chronic pain has become an epidemic of the modern age. The statistics on chronic pain speak for themselves: figures from epidemiological general population studies in Britain reveal alarming statistics: 46.5% of those surveyed self-report being in pain, of which approximately half is attributed to arthritic complaints (Elliott, Smith, Penny, Smith, & Chambers, 1999). It is estimated that 75–150 million people in the United States have a chronic pain disorder (Elliott et al, 1999; Harstall, 2003), of this an estimated twenty-six million people experience frequent back pain (Edwards, Doleys, Fillingim, and Lowery, 2001).

Chronic pain is often defined quite literally as pain that continues to be experienced for more than three months from the time of its original onset (excluding cancer-related pain). Simply put, chronic pain is pain which has not resolved. This definition makes no assumptions about the causality or the mechanisms behind pain of this sort; it simply defines chronic pain negatively. That is, chronic pain *is not* acute pain, which is alternatively defined as any pain which is of recent onset and

which is expected to be relatively brief in its duration – e.g. pain as the result of a trauma.

Negative definitions always lack specificity; they are inherently ambiguous because they are understood as something that does not quite match with that which *has* been defined. Complex, multifactorial and inscrutable, chronic pain remains elusive to health professionals for it is not characterized by observable criteria or specific, singular causes. Therefore, chronic pain does not sit well within the orthodox medical paradigm, nor does it respond well to orthodox medical treatments. Morris claims that:

> usually chronic pain is called (among other less explicit names)
> 'psychogenic.' Psychogenic means pain created or sustained by the mind.
> Traditional medicine, not surprisingly, does not know what to do with
> psychogenic pain, except to deny that it exists; the term itself is controversial.
> (Morris, 1991: 157).

Arguably, non-biomedical practitioners are equally susceptible to succumbing to this tendency to make a distinction between 'real' pain i.e. pain which can be attributed to an organic cause and 'psychogenic' pain i.e. pain for which no known physiological pathology can be found. However several theorists have taken the stance that a mind-body split of this nature is conceptually inaccurate, empirically unsubstantiated and clinically unhelpful.

Jackson (1992) for example challenges the simplistic thinking of many pain studies which posit "'real pain' as organic, physical pain, whereas unreal is 'all in your head' pain - imaginary, mental, emotional, psychosomatic." (Jackson 1992: 138). Jackson argues that it is impossible to make such a simplified distinction between chronic and acute pain and claims that 'unreal' is actually "a cover term for a set of rather fuzzy and complicated notions" (Good et al, 1992: 138). Her research reminds us that pain is never experienced in a contextual vacuum but rather has meaning to the sufferer which in itself is influenced by a host of personally relevant factors.

Instead it is suggested that pain is a complex subjective phenomenon that can only be directly perceived by the sufferer. Its seemingly random nature threatens the sufferer's sense of identity, creating the desire for meaning to be found (Jackson, 1992). Other authors have therefore sought to offer alternative perspectives to the

widely used International Association for the Study of Pain's definition of pain (an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage [IASP, 1979]). Sheridan, for example asserts:

> Pain is felt in the body, as opposed to the suffering that often accompanies it, and is an anguish in the mind. Chronic pain is seen as extending beyond an acute illness, frequently as a residual of that illness and often without any definite experience of remission. Chronic pain may be experienced continually, or it may wax and wane, as with changes in the patient's activity level and mood. (Sheridan, 1992: 4)

Such a viewpoint is consistent with findings that whilst individuals do not vary greatly in their ability to detect sensation (sensation thresholds appear to be fairly constant), they nevertheless show considerable variability in the level at which they judge a sensation to be painful (pain threshold) and in their ability to withstand pain (pain tolerance) (Melzack and Wall, 1988). Sheridan's account of pain is interesting as it conceives of chronic pain as a bodily phenomenon emanating from an original trauma. It is an attempt to avoid chronic pain being conflated with suffering (and therefore placed in the realm of the psychological); yet in doing so the binary opposition of body and mind is somehow reified. Perhaps it is a testament to the enduring influence of Cartesian thinking that we continue to struggle to find a way to conceptualise pain that can transcend such dualisms. The task of understanding chronic pain must, it seems, remain problematic as long as it is approached using a conceptual framework that perceives the body as separate and opposed to the mind.

Pain, as a subjective state of experience which cannot necessarily be linked with an external or objective cause, thus remains a considerable conceptual and practical challenge:

> The dilemma of pain assessment is easy to state, and extremely difficult to resolve. It is that there is a fundamental divide between the personal, private data available to a patient suffering pain and the objective, public data that are available to external observers who try to understand and respond to the patient's pain. (IASP, 2002)

The problems we have in attempting to articulate about pain have been elegantly explored by Elaine Scarry. Scarry observes that pain is an inner experience and inexplicable to external observers. She writes:

> For the person whose pain it is, it is 'effortlessly' grasped (that is, even with the most heroic effort it cannot not be grasped); while for the person outside the sufferer's body, what is 'effortless' is not grasping it (it is easy to remain wholly unaware of its existence; even with effort, one may remain in doubt about its existence or may retain the astonishing freedom of denying its existence, and, finally, if with the best effort of sustained attention one successfully apprehends it, the aversiveness of the 'it' one apprehends will only be a shadowy fraction of the actual 'it'). (Scarry, 1985: 4)

The impossibility of truly sharing the 'reality' or force of one's pain, leads Scarry to argue that to be in pain is to "have certainty", while for the other person it is so elusive that 'hearing about pain' may exist as the primary model of what it is "to have doubt" (Scarry, 1985: 4). This understanding speaks to the directness and immediacy of the awareness that we have of our own bodies as opposed to the bodies of others. Each of us has a unique relationship with our own particular body, and though others can experience that body, they cannot experience it in the same way. Philosopher Jean-Paul Sartre characterises this distinction as follows:

> Actually, if after grasping 'my' consciousness in its absolute interiority and by a series of reflective acts, I then seek to unite it with a certain living object composed of a nervous system, a brain, glands, digestive, respiratory, and circulatory organs whose very matter is capable of being analyzed chemically into atoms of hydrogen, carbon, nitrogen, phosphorous, etc., then I am going to encounter insurmountable difficulties. But these difficulties all stem from the fact that I try to unite my consciousness not with my body but with the body *of others*. In fact the body which I have just described is not *my* body such as it is *for me*...So far as the physicians have had any experience with my body, it was with my body *in the midst of the world* and as it is for others (Sartre, 1969: 279)

The invisible and ultimately subjective nature of pain is a theme oft-repeated in the contemporary literature surrounding pain:

> A major definitional problem is posed by the subjective nature of pain. Unlike other products of the senses, pain does not necessarily come from or reflect the outside world and this causes many of its problems. (Sheridan, 1992: 3)

Whilst we might be in the presence of a person in physical pain, we cannot actually witness their pain, only their pain behaviour. An outsider cannot imagine themselves into the other's place; each experience is unique and authentically one's own. At the same time, seemingly natural experiences are inevitably inter-twined with cultural realities. Morris claims that:

> Pain is always personal and always cultural...The experience of pain is also
> shaped by such powerful cultural forces as gender, religion, and social class. It
> is reinforced and sometimes created by psychological and emotional states
> such as guilt, fear, anger, grief and depression. (Morris 1991: 20, 25)

Arguably, our inability to grapple with the problem of pain is connected to our cultural heritage of dualism. Morris suggests that this world-view has so permeated our thinking about pain that a reconceptualisation of this fundamental premise is imperative if we are to improve our understanding of this complex phenomenon. That is, so long as we are limited by our Cartesian thinking, we are unable to comprehend the truth of another's particular experience of pain. Morris reminds us that whilst the biomedical view of pain as sensation has proven to be the dominant discourse in recent times, the other rich and complex features of pain are visible if we look to other cultural resources such as literature and art. He argues that the body and mind do not function so separately from each other, but are inextricably bound up together. Morris criticizes the very semantic distinctions between mental and physical pain. He argues:

> ...newspapers and advertisements almost every day contain vivid examples in
> which pain is attributed to serious, if common, afflictions from heartache to
> depression. The familiar German noun *Schmertz* lends itself even to such
> exotic concepts as a deep spirit-crushing ennui or world pain *(Weltscmertz)*.
> Yet somehow, when it comes time to analyze, we reject such unscientific
> usage and assume that nothing counts as pain short of demonstrable tissue
> damage. This absolute dualism of mental and physical pain is a comparatively
> recent idea whose time, as I contend, has long passed. A truly effective
> dialogue between medicine and literature may just succeed in driving a stake
> through its heart. (Morris, 1991: 27)

The relationship of emotion to the experience of physical pain must also be considered. It is precisely because pain is at once physical, emotional, mental and cultural that we cannot marginalise or ignore the role of emotion. Emotions affect the ways in which pain, illness and disability are experienced – and these human events are in turn literally "seething with emotion" (Scheper-Hughes and Lock, 1987). They remind us of the multilevel way in which emotions present themselves as simultaneously physical (heartache, sick to your stomach, gut-wrenching fear etc).

Whilst pain has, most recently tended to be understood primarily as a physiological sensation, albeit one modified by social and psychological processes, the conceptualisation of pain as an emotion actually has a much longer tradition. Pain as

emotion is a construct with a heritage that stretches all the way back to Plato, who understood pain to exist alongside pleasure as the converse side of a dualistic whole. The two concepts here are understood as implicit, that is one cannot be seen to exist without the other. Indeed the pain/pleasure dichotomy certainly would appear to have some resonance, having persisted throughout the ages across a broad range of institutional and other discourses (philosophical, literary, in medical literature).

Another oft-noted association between pain and emotion is the complex and often dialectical relationship that appears to exist between pain, anxiety and depression. Sheridan reminds us that:

> Anxiety, the perceived threat of something unpleasant, heightens pain in both normal and psychiatrically disturbed patients...Extroverts, who are generally less anxious than neurotics, usually report lower degrees of pain...Depression is chronic sadness, often having components of unacknowledged anger, grief, low self-esteem, and helplessness. Depression and physical pain are sometimes thought to be equivalents so that a patient may experience pain as an early symptom of depression. (Sheridan, 1992: 17)

However, as Gail Bendelow points out in her work regarding gender, emotions and pain, there appears to be a stigma attached to emotional or psychological pain, particularly for men (Bendelow, 1993). In her qualitative study, pain that could be attributed to a specific physiological etiology was seen to possess authenticity and legitimacy, although women in the study seemed more at ease with the emotional dimensions of pain. Interestingly, she also found that the more chronic and/or terminal pain was perceived to be, the more negatively it was perceived. Acute or even 'productive' forms of pain (e.g. childbirth) were given much more positive attributes.

Pain then, far from being one-dimensional, is rather a multi-layered subjective experience. Accordingly, care must be taken not to overlook the sufferer as an embodied being:

> Physiologies of illness tell us very little about the suffering of bodily affliction, for they do not explicate the effect of illness within the life-world of the subject. Illness constricts time and space by filling it with the pains and concerns of illness. The future, either short-term or long range, takes on a brittle quality. One finds plans disrupted and possibilities withheld...In illness one discovers one's embodied self as an obstacle in one's own project of encountering and shaping the world. Illness necessarily involves the suffering

29

> of alienation, of being set against one's self in falling prey to possibilities one
> does not own. (Rawlinson, 1986: 43)

The dominant conceptualisation whereby pain is understood as sensation tends to

infer that it is something that exists objectively and can thus be rationally

apprehended and measured using quantifiable, empiricist methods. However pain is

more than just objective sensation, it is a complex lived experience comprising many

other subjective elements which are less easily approached such as emotion, culture

and meaning. Sociological and phenomenological frameworks that have been

developed to study such subjective phenomena as, for example, emotions,

embodiment and meaning, may provide a useful lens through which pain may be

understood more completely. In attempting to take such an approach however, care

must be taken not to reduce pain or the body to a mere social construction, lest the

same mind/body split which is trying to be avoided be further reified. Rather a

material-discursive approach which listens both to the scientific/physiological voice

as well as the sociocultural/psychological would appear to be more useful. The

legacy of Cartesian thinking may be difficult to transcend, but even the proponents of

the most well-accepted model of pain in the late 20th century, Gate Control Theory,

remind us that there is considerable variation when it comes to pain perceptions:

> The word 'pain' represents a category of experiences, signifying a multitude
> of different, unique experiences having different causes, and characterised by
> different qualities varying along a number of sensory, affective and evaluative
> dimensions (Melzack and Wall, 1988: 161)

Bendelow and Williams (1995) suggest that a closer look at CAM may prove useful

in attempting to construct a theory of pain free from the usual mind/body dualisms

that continue to pervade biomedicine and psychology:

> Generally, the Western model can benefit from the philosophies and practices
> of alternative systems of healing as they may offer the potential to transcend
> the Western mind-body dualism in a quest to integrate the physical, emotional
> and existential dimensions of our being. (Bendelow and Williams, 1995: 145)

Furthermore they argue that:

> The elevation of sensation over emotion in traditional medicine and
> psychological approaches results in the lack of attention to subjectivity, which

in turn leads to a limited approach towards sufferers and a neglect of broader cultural and sociological components of pain. In other words, a far more sophisticated model of pain is needed; one which locates individuals within their social and cultural contexts and which allows for the inclusion of feelings and emotions. (Bendelow and Williams, 1995: 146)

For pain is as personal as the search for meaning – essentially unique, non-generalisable from person to person. Indeed, even if one might not be able to choose whether or not we experience pain or suffering, we still retain the ability to assign that experience meaning – we can choose what we believe about pain, our attitudes toward it. For example, pain or suffering may be conceptualised as a task, as a challenge or question that we must answer.

Thus modern health practitioners would do well to avoid perpetuating the dichotomy that Mischler (1984) noted has emerged in orthodox medicine between the medical voice (biomedical, clinical information) and the lifeworld voice (social, contextual information). Whilst these two categories are not conceptualised as being necessarily mutually exclusive, as with many binary categories one is prioritised at the expense of the other; in this case the tendency is for the former to be accepted by health professionals as preferred, and standard whilst the latter is more likely to be considered irrelevant, complicating.

Of course, in attempting to reintroduce the social and the emotional into our theoretical and methodological analyses of pain, the undeniable embodied nature of pain must not be overlooked. One fascinating observation in this area is that in the absence of pain, we live in our bodies almost without awareness of that essential biological fact. That is, so long as all bodily systems are functioning well and we are 'pain-free' in the broadest sense of the term we pay little or no attention to our bodies. Leder (1990) refers to this as bodily "dys-appearance", which is to say that the body whilst ever-present is phenomenologically or experientially absent until events such as injury, disease or death disrupt this normal mode and we are rudely awakened to our corporeality. Experiences such as these force us to become aware of our bodies, and have a profound impact on all levels of our consciousness, from time (slows down) to meaning (things which previously seemed important are no longer so). Leder goes on to make an interesting point – that whilst pain as a phenomenon requires theorising capable of transcending the usual dichotomies of body/mind,

31

objective/subjective, personal/impersonal – the separateness of these categories can in fact be re-imagined and intensified by the very experience of pain itself. Body and mind are 'one' then when we have the privilege to live in our bodies unconsciously; without being constantly reminded of them. Pain, hunger, injury or fatigue to name but a few of the bodily states that can challenge us, can have the curious effect of alienating us from ourselves – our bodies become our foe, a 'thing' that must be attended to, that is perhaps thwarting our attempts to achieve personal goals, even betraying us. The dialectical nature of the relationship between physical, cognitive and emotional experiences is, as Leder points out, the very reason why pain as a concept can be called upon to communicate not only physical suffering but also emotional and spiritual agony (Leder, 1984-5).

Morris points out that our tendency to delegitimize such complicated processes is not only attributed to Cartesian dualism, but to our cultural legacy of Stoicism. Stoic philosophy also conceptualises a radical split between the mind and the body which permeates our beliefs and perceptions today and leads us to see those as suffering from 'unexplained' chronic pain to be malingerers or weak. For, as Morris explains,

> the mind and the will entirely reshape the experience of pain. Stoic writers were fond of describing philosophy as medicine: a practical aid in the affairs of the daily living. Like a medicine, the mind for the Stoic philosopher in effect creates and uncreates the body's pain. The bodily pain of Stoicism, we might say, is paradoxically always in the head because the mind or reason or soul always possess the power -- as well as the duty -- to erase or overcome it. (Morris, 1991: 163)

This powerful cultural belief, that one's mind can influence substantially one's body and that, in fact, the latter is subordinate to the will of the former, plays itself out in our current pain management practices. Thus the chronic pain patient is asked to develop a new attitude towards pain:

> most pain clinics, interdisciplinary centers established in the past twenty years for the comprehensive rehabilitation of those with chronic pain, depend heavily on theories about secondary gain. Because they see pain as a learned behaviour, they believe that it can be unlearned, at least to the extent that a patient can become functional again. (Sheridan, 1992: 14-15)

The Western biomedical model, which deals primarily with the body as separate from one's subjective life, still reigns as the dominant paradigm and thus determines who

might be considered a 'legitimate' sufferer. Under such a model, pain is conceptualised as something which should be definable, surmountable – easily controlled via the application of medical techniques (Scarry, 1994). However the explosion in chronic pain statistics evidences this is simply not the case. Furthermore, it is apparent that phenomenologically, we experience a diverse range of pain experiences. Pain can be felt as depression, anxiety, body aches, or even simply as lethargy. Following a Cartesian binary logic, some of these pain experiences are perceived as 'real' and legitimate by the medical community, while others are seen as motivated by secondary gain or malingering.

Pain as Human Experience

Pain fulfils complex human needs; fulfils complex social, ethical and personal purposes. Morris asserts:

> an understanding of pain requires many kinds of knowledge, but the
> knowledge we most consistently ignore or dismiss...concerns the bond that
> links pain with meaning...it seems we cannot simply suffer pain but almost
> always are compelled to make sense of it (Morris, 1991: 18).

For many people chronic pain causes them to experience great suffering, and yet this suffering which perhaps should be our central concern, is often relegated as insignificant or inconsequential to our primary goal of uncovering the 'truth' about pain. Our cultural tendency also to label and categorise individuals tends to provoke judgments such as: 'real/unreal', 'legitimate'/'illegitimate'. These are not neutral statements but rather are laden with moral implications; it appears that the failure to produce hard evidence of organic or tissue damage lead us to suspect certain accounts of pain. This central point will be explored further at various junctures throughout this thesis. The subjective contingencies and particularities of the self are seen as immaterial to the 'true' causes of pain.

The Meanings of Pain

The versatile and elusive nature of pain can be discerned from the multiplicity of meanings that it can take on. Typically, pain tends to constructed in negative ways as diverse as punishment for sins; as an instrument of force or control (torture, domestic violence); as a manifestation of evil; as a reminder via the restriction of possibilities

33

of our physical vulnerability and ultimate mortality, and so on. However pain can also be imbued with positive meanings – notably in creative discourses (for example childbirth, artistic or spiritual achievements may be inspired of pain experiences), but also as a catalyst for change in positive ways. The very meaning of pain can even be the negation of all meaning. In her seminal treatise on torture, war and pain, Scarry argues that pain under these circumstances can serve to 'unmake' our world, to strip away from the individual any ability to interpret or perceive the world via its sheer intensity (Scarry, 1985).

Perhaps the most easily appreciated aspect of pain is its function as a means of communication between individuals. For clinicians particularly this is the level at which pain is most often encountered, as a signalling device for drawing attention to physiological dysfunction. As Helman (1990) points out, pain is in the first instance 'private data'; that is, in order for us to know whether a person is in pain we are dependent upon that person communicating that to us, either verbally or non-verbally. When that happens the private experience of pain becomes public pain, via the employment of pain behaviours, which are influenced by a complex array of social, cultural and psychological factors. These determine whether private pain will be translated into public pain, the form that this behaviour takes, and where this will take place.

Thus pain can be seen as a form of discourse between individuals, a language, a communication whereby the body as a resource can be managed in a variety of ways to construct a particular version of the self. As a public space, the exterior of the body naturally becomes a focus of our attention. Individuals are actors who can be observed to stage performances using the arena of the body as their natural 'theatre'. Bodies then, are critical to our understanding of these complexities.

The socially constructed body

Pain exists where biology and culture meet, encouraging those interested in understanding pain to consider the role of the social forces in formulating an analysis of pain:

> ...a focus on the emotionally expressive, embodied subject, who is active in
> the context of power and social control, can provide a useful approach for
> studying distressful feelings, society and health. (Freund, 1990: 452)

It is apparent then, that any investigation into the lived experience of patients and
doctors would be incomplete without consideration of one's embodiment. Life
experiences are both enabled and limited by the capacities and senses of our physical
being and hence, embodiment, or the question of how the experience of having a
body is mediated via cultural meanings and actions has arisen as a hot topic across
disciplines in recent years. Sociologists and anthropologists have long considered
issues surrounding the body if arguably in a peripheral manner (Shilling, 1993).
Shilling suggests that the body has been something of an "absent presence"
throughout sociology, that is, whilst the body has recently become a central
theoretical focus it has nonetheless informed the sociological imagination over time.
For example, early theorists such as Durkheim, Marx and Engels considered matters
of embodiment in works which examined bodily actions and the appropriation of
bodies. A more explicit focus on the body subsequently became evident in seminal
works by theorists such as Goffman, Foucault and Bordieau. Shilling argues that this
increasing concern with bodies can be understood within the context of high
modernity:

> in conditions of high modernity, there is a tendency for the body to become
> increasingly central to the modern person's sense of self-identity (Shilling,
> 1993: 1)

Modernity is a difficult concept to define but is generally used in social theory to
refer broadly to the industrialised world – to those modes of life and social
organisation which emerged out of post-feudal Europe and which have become
increasingly global in their impact in the late 20th century (Shilling, 1993). What
Habermas (1983) refers to as the 'project' of modernity came into focus during the
eighteenth century whereby Enlightenment thinkers embarked upon an effort to
develop objective science, universal morality and law. The scientific domination of
nature was pursued as a means to escape scarcity, want and accidental tragedy.
Rational forms of social organisation based on reason and logic were espoused in an
effort to progress away from the irrationalities of myth, religion and superstition.
Modernity then was largely a secular movement that attempted to demystify

knowledge and replace religious faith with scientific certainty. However, theorists of modernity comment that whilst modern life has indeed been accompanied by a gradual secularisation of society, scientific certainty has yet to deliver on its promise. Objectivity and scientific method do not provide us with values to guide our lives; thus we are left with the challenging task of creating our own meaning.

An interesting trend in modern health science is the linking of biology and health to social movements via the construction of biological identities and interest groups around the world. The concept of "biological citizenship" has emerged to describe the range of illness-based movements that have formed around the basis of specific illnesses such as breast cancer, HIV/AIDS, psychiatric illnesses etc (Petryna, 2002). The conditions of possibility for the making of biological citizens are suggested to be those associated with the development of what Ulrich Beck (1992) has termed 'risk society'; itself understood to be contingent upon the conditions of high modernity which Giddens (1991) has argued characterises contemporary Western society. These authors argue that the modern citizen has become increasingly sceptical and distrustful of modern governments and institutionalised dissemination of scientific knowledge. It should be considered then, that the growing fascination with bodies may be attributable to its usefulness in attempting to overcome the epistemological debates which have emerged in the wake of postmodernity (Frank, 1991). The body can at once be understood as material *and* subjective, allowing for re-consideration of age-old debates surrounding realism vs. constructivism. This would also explain why mainstream psychology too has recently taken up the body as a useful theoretical lens through which long-standing issues such as the construction of self, identity and mind/body matters might be examined.

One field or place where an individual may begin the project of defining the self is obviously, the body. In a world without certainty, the body provides a foundation upon which individuals may construct a reliable sense of self. Powerful external frameworks such as religion, or grand political theories have lost their relevance for many and thus the search for meaning has become increasingly privatised; as Shilling says "there is a tendency for people in high modernity to place ever more importance on the body as constitutive of self" (1993: 3). The body has become a means of expressing individual identity; it has also become a locus of control.

36

> If one feels unable to exert influence over an increasingly complex society, at least one can have some effect on the size, shape and appearance of one's own body (Shilling, 1993: 7)

In modern culture it seems there is a tendency for the body to be viewed as a project, which should be worked at as part of developing and presenting the self. Health is increasingly linked to external appearances as the lines become blurred between the two under the explosion of self-care regimes in the form of diet, exercise and fitness practices. The importance of the body to individuals in constructing self-identity has indeed increased so dramatically that a new term 'somatic society' has been coined to describe how the body in modern society has become the principle field of political and cultural activity (Turner, 1992: 162).

However, this increase in attention to the body, and its increasing centrality as a bearer of symbolic value, does not in itself answer modern questions of uncertainty. Indeed it seems that developments in science have in fact led to the paradoxical condition that:

> We now have the means to exert an unprecedented degree of control over our bodies, yet we are also living in an age which has thrown into radical doubt our knowledge of what bodies are and how we should control them (Shilling, 1993: 3).

'Grand narratives' as such have been abandoned and new ways of understanding bodily experience have emerged. This epistemological uncertainty has opened the gates for accounts of embodied human experience to be explored that may help to further elucidate such complex and subjective concepts as 'pain' or 'wellness'. The study of embodiment may provide a useful lens through which we may perceive more clearly sensitive and important issues such as pain, illness and disability. Many authors have proposed theories of embodiment which have attempted to overcome the oppositional thinking which continues to plague contemporary analyses. Merleau-Ponty articulated the beginnings of a material-discursive perspective when he argued that it is not possible to discuss perception without consideration of embodiment, as it is through the body that we apprehend our worldly experiences. Other theorists have

pointed out the dual nature of embodiment, that is, we both *have* bodies, and *are* bodies at the same time (Berger & Luckman, 1967).

Thus pain exists at the juncture of biology and culture, suggesting that theoretical and methodological approaches inspired by considerations of the social may be appropriate to the analysis of pain:

> ...a focus on the sociology of the body inside medical sociology would suggest new, or at least innovative, areas of enquiry, for example, into the complex inter-dependencies between self-image, personal identity, social interaction and body-image; it would also suggest alternatives to behavioural or informational models of pain. (Turner, 1989: 5)

Foucault argues that the body, rather than being a natural phenomenon, is socially and discursively constructed and is therefore a historically variable construct. His central thesis that power relations are constitutive of the social realm, and that they operate significantly through the body has provided fertile ground for debate concerning the relationship between the body, society and power:

> the body is...directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs...there may be a "knowledge" of the body that is not exactly the science of its functioning, and a mastery of its forces, that is more the ability to conquer them: this knowledge and this mastery constitute what might be called the political technology of the body...What apparatuses and institutions operate is, in a sense, a micro-physics of power, whose field of validity is situated in a sense between the great functionings and the bodies themselves with their materiality and their forces (Foucault, 1979: 25-26)

However, whilst the study of embodiment has provided a number of useful insights with regards to the complex juncture of body, self and society it should be noted that the notion of 'body' itself is often left undefined and thus the tendency has existed for 'the body' to be presented as a universal, undifferentiated body (i.e. presumably white, male, heterosexual). Thus while feminists have found Foucault's analysis of the relations between power and the body illuminating, they have also drawn attention to its limitations in failing to consider in what ways disciplinary techniques operate on the female body, specifically. If, as Foucault claims, there is no such thing as a 'natural' body then surely we must consider the ways in which social constructs

38

such as gender may work to co-constitute cultural or shared understandings of bodies[6].

Pain and gender

Any discussion of pain and embodied experience is thus incomplete without consideration of gender. The experience of pain or illness is both intimately personal and reflective of larger social, political, and cultural realities. As such, women's experiences of illness have historically been influenced by medical and social constructions of their bodies and bodily functions. Women's illness narratives reflect not only these external tensions but also internal struggles to define the self in relation to both body and mind.

Our understandings of pain are inextricably bound up with broader cultural considerations, such as gender. Gendered embodiment runs deep in the Western psyche. For example, one consistent Western cultural assumption is that women are emotional whereas men are considered rational. Men are assumed to be rational and individually focussed whilst women by contrast are viewed as emotional i.e. irrational and seeking connection through caring interactions with others (Meyerson, 2000). That is, emotionality is culturally constructed as 'feminine', against rationality being similarly coded as 'masculine' (Lupton, 1998). There is considerable evidence that our cultural assumptions about emotionality are constructed along traditional stereotypes of emotional female versus non-emotional male (Fisher, 1993; Lupton, 1998; Lutz, 1990). The relationship between gender and emotion is complex and difficult to unravel, not least because of the variety of ways in which the concept 'emotion' itself is understood.

Some theorists approach emotions as representative of inner states, albeit ones which may be influenced by cultural factors (Chodorow, 1978). Such works point to the considerable anecdotal/folk evidence of women being more emotional than men, or alternatively of men being less emotionally expressive than women. However discursive and feminist accounts have preferred to highlight the capacity of emotions as agentic – whereby the rhetoric of emotions can be used to 'perform interactional

business' (Locke, 2002). The use of emotional discourse as a means of exerting power has also been addressed within these analyses.

The rhetoric of emotion is suggestive of oppositional assumptions about gender, and therefore of power. Gergen (1999) for example points out that many of the common binaries employed in Western discourses (male/female, strong/weak, culture/nature, rational/emotional) tend to privilege the former over the latter – i.e. masculine over feminine and for this reason, any discussion of emotion necessitates discussion of gender and of social power differences. Lutz (1990) argues that the study of emotional discourse may provide a useful analytical lens through which issues concerning social power may be illuminated. Emotions, when viewed as discursive practices, become ways in which people may be positioned such that they are undermined or marginalised. In this way, the employment of the rational/emotional; male/female dichotomy can be understood as a device to negotiate power at both the individual and group level. Locke (2001) points out that it is this very potential of emotion to be used as a discursive resource to defend traditional sex stereotypes and maintain unequal power relationships that requires theorists to think carefully about how emotionality be constructed.

For example, Fisher (1993) has analysed the concept of emotionality and questions whether women are more emotional than men. She concludes that the widespread notion that women are more emotional tells us more about culturally constructed sex stereotypes than actual emotions. Lupton (1998) suggests that emotion is best conceptualised as a culturally devised discursive device rather than referring to a category of discrete psychological phenomena. Such an approach is epistemologically useful insofar as it enables the theorist to consider what emotionality as a cultural construct accomplishes.

Locke (2002) reminds us that:

> ...discursive psychology proposes that emotion words are culturally coded and used rhetorically and indexically (that is, bound in context) to construct events as problematic or out of the ordinary [Buttny, 1993; Edwards, 1999], and as part of narrative emplotments [Sarbin, 1989], rather than labelling, and derived from, internal states (Locke, 2002: 100).

40

Clearly there is not one uniform feminist view on the body or emotions - however despite the broad range of emphases and understandings they invariably share a deep interest in a return to embodiment. That is to say, feminist theory requires that the body be taken seriously, lest we continue to perpetuate the historical tendency in Western culture to ignore or minimise the body. Feminist approaches to the body also tend to share the discursive view that the body cannot be understood as separate from sociohistorical context. Women's embodied experiences cannot be understood outside of the social and historical context in which they live, nor separately from the shared meanings ascribed to those experiences in a specific cultural or historical context.

The separation between mind and body and its attendant hierarchical ordering of mind over body has undoubtedly cast great influence over Western thinking in a tradition going back to Aristotelian times. Religious and philosophical thinking too has tended to relegate the body to the realm of sin and chaos – an entity to be controlled, denied or transcended. Attempts to transcend the body can be seen as attempts to clearly demarcate between objectivity and subjectivity, self and world (Bordo, 1987). She argues that the philosophical striving to achieve disembodiment via the eschewment of all things constructed as bodily (emotion, nature, subjectivity) in part reflects a 'flight from the feminine' which further underscores the bodily realm (culture, rationality, objectivity) as inherently masculine (Bordo, 1987: 5).

Oppositional constructs such as male/female, culture/nature, reason/emotion, objective/subjective, self/society are implicit within Western thinking about bodies. Feminist theorists have pointed out that these dualisms have tended to be ordered hierarchically, whereby the first term of each pair is given positive connotation and linked to notions of masculinity/men. Thus, in the discourse of progress that emerged out of Enlightenment thinking, women are relegated to a subordinate or diminished position. As 'natural', 'emotional' and 'chaotic' creatures at the mercy of their embodiment (through 'inferior' corporeality – considered lacking as compared to the male body given or held up as the ideal/complete) women are successfully positioned as the 'less-than' Other.

41

Women and their assumed 'emotionality' has been a common theme throughout the ages - for example, hysteria being considered due to the 'wandering womb'. Based on the ancient idea that the female womb was not an organ but rather an animal that lived and roamed around independently within the female body, the 'wandering womb' was held responsible for many aspects of what was considered female nature. This tendency of the womb-beast to indiscriminately move around the female body was understood to cause female capriciousness, her lusty, carnal nature and her unstable emotions. Being derived from the Greek root hyster (womb), hysteria automatically suggests a link between a woman's reproductive biology and illness. However, as Morris notes the womb (hysteria) is here perhaps better understood as a metaphor representing all that mystified (and perhaps frightened) men, thus telling us more perhaps about male physicians in the late 19th century than it does about women.

Hysteria, then, provides a fascinating subject for examining cultural assumptions about gender, emotionality and pain. A widespread affliction in the 19th century, affecting almost exclusively women, hysteria in its original form has all but vanished from the cultural landscape in the 21st century. Morris suggests that closer examination of the genealogy of hysteria may afford useful insight into our understanding of modern pain, insofar as it provides "important evidence that pain is constructed as much by social conditions as by the structure of the nervous system" (Morris, 1991: 104). Referring not to the cause of disease but rather to an incredibly diverse constellation of symptoms, hysteria undoubtedly provided a convenient catch-all diagnosis for the labelling and management (control) of undesirable feminine behaviours. Running as a constant backdrop to hysteria though, was the omnipresent spectre of pain:

> the hysterical patient lived in a world where pain flowed continuously through her body and settled in the most unexpected places. It provided the solid, changeless background against which hysteria played out its more florid and transient symptoms (Morris, 1991: 110)

However the myriad of confusing, varied and transitory symptoms led many physicians to suspect that much of women's pain was in her mind, or even deliberately made up. From here it was but a short step to the term 'hysterical' being

used to refer to false, unreal or imagined illness. The questioning of women's pain at this juncture was at least in part due to changes in biomedical science that saw positivist, organic explanations of pain increasingly take precedence over more traditional views which considered pain an emotion.

Further associations between women and their 'disordered' or 'unruly' bodies continue in contemporary discourses including but not limited to pre-menstrual syndrome, post-natal depression, and menopause. After the long history of discussion regarding women's reproductive systems and mental health discussed above, Premenstrual Dysphoric Disorder (PMDD) has now officially become a medical/psychiatric condition, as evidenced by its inclusion in the DSM-IV (APA, 1994). For many feminist theorists, this event is simply another example of women's normal bodily experiences being medicalised (Caplan, McCurdy-Myers, & Gans 1992; Ussher, 2003). For example, Ussher successfully deconstructs the 'truths' responsible for the reification of PMDD and proposes an alternate conception of PMDD as a "rhetorical accomplishment" (Ussher, 2003: 141). She points out that the construction of PMDD as a psychiatric category paves the way for everyday women's experiences to be labelled as symptoms, and for healthy bodies to be pathologised. Ussher does not suggest that premenstrual experiences do not exist, simply that it is unnecessary for them to be constructed as a psychiatric condition (Ussher, 2003).

Clearly then, women's experiences of illness have historically been influenced by medical and social constructions of their bodies and bodily functions. Women's illness narratives reflect not only these external tensions but also internal struggles to define the self in relation to both body and mind.

Towards a material discourse of bodies in pain

My thesis is that an analysis of patients' and doctors' talk about bodies demonstrates the relevance of the body to experience, at once upholds and challenges Cartesian truths, and reveals an embodied knowledge greater than that which can be accounted for by positivist science alone. CAM discourses in this study demonstrate a non-dualist conception of subjectivity that challenges and at times transcends the traditional Cartesian division of mind and body; yet the legacy of oppositional

thinking can be seen to continue to exert a discernible influence on constructions of self, identity and pain itself. Their discourses centralise the role embodiment plays in the construction of subjectivity, and in doing so suggest an alternate framework for knowing and assessing people's experiences of pain, suffering, health and well-being. That is to say, by imbuing the living body with meaning greater than that accorded by a mechanistic framework, the discourses heard in this study alternately uphold and challenge the dominant biomedical paradigm.

The modernist period out of which biomedicine emerged can be characterised perhaps by its attempts to separate out sensory, emotional and bodily experience in order to isolate and reveal the underlying Truth. Such an approach will perhaps inevitably struggle to embrace complex human experiences such as pain. Biomedicine, with its deeply rooted Western tradition of oppositional thinking has been significantly influenced by such philosophical assumptions. Biomedicine as a social institution may be conceptualised as a site of cultural authority and power, which stems largely from the ways in which is has objectified the patient. By focusing on diseases, the patient is relegated to being an objectified subject, primarily through their examination by institutions that claim the status of science. Foucault postulates a 'will to truth' of institutions that aspire to the status of science. The will to truth is the way in which "knowledge is put to work, valorized, distributed, and in a sense, attributed, in a society" (Foucault, 1981 [1970]: 55). Science should therefore be approached as a regime of knowledge that is embedded and constitutive of the broader cultural context within which it exists. As a regime of knowledge, medicine exercises control of the discourse surrounding health and illness. The control of discourse refers to the ability of institutions, that is, the ideology and behaviour of an aggregate of individuals, to determine the conditions of the application of discourse and impose rules and restrictions on those who use the discourse. The effect of this control of discourse is to limit access to the objects or subjects of that discourse, and to control the proliferation of discourses. Thus as biomedicine developed its hegemonic position within Western society, it worked unconsciously (and sometimes consciously?) to subjugate individuals to biased presuppositions that subsequently have come to be viewed as universal givens. The recent resurgence of non-biomedical disciplines provides a fascinating opportunity to explore to what extent these 'truths' continue to exert power and influence over individuals in postmodern

44

society under what has been referred to as 'conditions of high modernity' (Giddens, 1991).

The work presented here is influenced by post-structuralist (deconstructionist) thinking, in particular its Foucauldian interest in the nexus of power/knowledge in relation to the materiality of the body will be evident. Biomedicine represents a paradigmatic site through which bodies have been constructed as subjectivities. As the dominant paradigm regarding health in the Western world, biomedicine represents a specific field of knowledge, which is in turn constitutive of power relationships. Foucault's relational view of power/knowledge is such that power relationships are seen not to exist without a correlative field of knowledge; neither may a field of knowledge be owned that does not directly imply and constitute power relationships:

> ...deployments of power are directly connected to the body – to bodies, functions, physiological processes, sensations, and pleasures; far from the body having to be effaced, what is needed is to make it visible through an analysis in which the biological and the historical are not consecutive to one another, as in the evolutionism of the first sociologist, but are bound together in an increasingly complex fashion in accordance with the development of modern technologies of power that take life as their objective. Hence I do not envisage a 'history of mentalities' that would take account of bodies only through the manner in which they have been perceived and given meaning and value; but a 'history of bodies' and the manner in which what is most material and most vital in them has been invested. (Foucault, 1976: 151-152)

For Foucault, power is not substantive – it is not "an institution, a structure, or a certain force with which certain people are endowed; it is the name given to a complex strategic relation in a given society" (Gordon, 1980: 236). Thus Foucault's power/knowledge regime is not a comprehensive theory of power and knowledge but rather a framework for discursive analysis. Such a framework has informed this study, which seeks amongst other things to deconstruct taken-for-granted truths within health discourses, and question assumptions within and about biomedicine/CAM. It is also suitable for work such as this which seeks to understand experience within a theoretical framework that recognises all 'truths' or knowledges as partial, situated and embodied.

Whilst this work is heavily influenced by social constructivist viewpoints, it seeks also to be grounded by materialist theories of the body in order to avoid biological experience and agency being marginalised or overlooked. Within social constructivism there can be a tendency to assume that experience can only be understood via discursive practices, and that bodies, as constructions, cannot be agents. However I would argue that bodies are not secondary or contingent to experience, rather, there is no experience without physical bodies. Corporeality is central, although the boundaries and understandings of what constitutes corporeality may be fluid, and permeable. That is, the located and particular lived body is relevant to experience and thus must be moved to centre epistemologically speaking.

This study therefore is concerned with the spoken understandings of health, illness, pain and wellness within non-biomedical settings (specifically, within chiropractic encounters). In attempting to come to grips with such complex concepts, we must first come to an understanding of how embodied individuals interact and co-constitute meaning through the discursive analysis of the talk that surrounds these experiences. The purpose here is not to reveal new 'truths' but simply to try to bring to the literature new data and analysis which hopefully might further illuminate our understandings of these concepts. The chiropractic encounter is an alternative setting where notions of the body are contested and where meanings of health, illness and pain are co-constructed via discourse; both patients and clinicians have sets of statements to share that may differ from those heard before.

Specifically, the aims of this study are to:
1. Generate texts by conducting, audio-recording and transcribing interviews with chiropractic patients and practitioners to which a discursive lens might be applied.
2. Analyse the texts using discursive analytic principles to expose the prevalent themes and discursive frameworks present in the texts.
3. Explore the discourses present in the texts that have an impact on how understandings of pain, health, illness and wellness are constructed and used within the chiropractic setting/environment.
4. Map out some of the discursive resources which are available to speakers as chiropractors or users of chiropractic services i.e. investigate what discursive resources chiropractic patients and practitioners draw on, how those resources

46

came to be culturally available and what effects they have in terms of the kinds of objects, subjects and positions which those resources make available.

5. Uncover the discursive worlds that chiropractic patients and practitioners inhabit and the possible 'ways-of-being' afforded by them i.e. ask the question: what characterises the discursive worlds these participants inhabit and what are the implications of these worlds for possible ways of being? (Willig, 2001:121)

Analysing and presenting those texts generated here, which are textually rich and diverse, has proven to be a challenging task. There are many different ways in which these accounts could be read or interpreted, and structuring the findings in a manner which is conceptually 'tidy' has been particularly tricky. For better or worse, I have chosen to present the accounts loosely along the simple axis whereby those patterns of meaning distilled mostly from provider accounts are presented in the first several chapters, moving towards those provided by patients in the latter half of the thesis. Thus, after a brief discussion of methodological process, I will present the 'findings'[7] from interviews with practitioners. It is not suggested that these findings/analytic themes represent the entirety of shared content within the accounts; I would argue though that they represent perhaps the most salient with regard to the interests and objectives of this particular investigation.

Three over-arching analytic themes from the practitioner accounts thus are considered:

(I)   Construction of chiropractic occupational space

(II)   Construction of patients behaviours as 'normal' vs. 'abnormal'

(III)   The discursive construction of professional intervention and efficacy.

Of course these findings represent but one half of the dialectical relationship which interests us here, namely that between doctors and patients or providers/users of health care services. Thus I subsequently present the findings from the patient narratives, again grouped into analytic themes:

(I)   Discursive repertoires in patient talk about chiropractic (I)
         Strategies of resistance to professional authority

(II)   Discursive repertoires in patient talk about chiropractic (II)
         Strategies to manage blame and accountability

47

However, this should be considered a loose organisational structure, not least because the denotation between 'provider' and 'user', 'practitioner' or 'patient' is in itself problematic. Conceptually, the use of such categories can be critiqued as representing another example of dualistic thinking/speaking that serves to reify the dominant cultural tendency to position people in reductionist and oppositional ways which are neither necessary nor useful. The relational nature of the topics explored in this work mean that to maintain a strict or rigid separation between practitioner and patient accounts would be empirically wrong and conceptually unhelpful. Such categories are also problematic from a practical point of view, insofar as many people occupy both positions experientially over time – with many practitioners for example having come to the discipline through pain or illness experiences. Nevertheless, for the most part, the interviewees approached the questions from the standpoint of either one position or the other, and so for the purposes of this analysis those categories have been retained and acknowledged as meaningful.

Finally, in the remaining chapters I will attempt to step back from the study to reflect on the research and its implications.

CHAPTER TWO

Methodology and Methods

<u>Methodological considerations</u>

The idea that "the way we see things is affected by what we know or what we believe" (Berger, 1972) has become increasingly accepted in the social sciences. This idea represents a shift away from the search for absolute truths towards the recognition of a multiplicity of ways of understanding the world. The growing acceptance of polysemy (the possibility of multiple meanings or multiple interpretations) has led inevitably to scholars recognising that communication transcends simplistic notions of transmitting and receiving straightforward messages, rather, people selectively attend to and interpret information and events they encounter based on prior knowledge and experience.

The de-naturalisation of previously reified objects and concepts is a major legacy of this transition. For many this shift has meant a turn toward interpretive and semiotic approaches to understanding culture (Geertz, 1973; Turner, 1974). Underpinning such approaches is the understanding that "the world does not present itself to us directly" (Worth and Gross, 1981: 134). This aptly describes the theoretical lens that has informed this study, which seeks to understand the myriad ways in which individuals may interpret their experiences either as patients or practitioners of CAM. This approach works to emphasise both the existence of a multiplicity of possible interpretations as well as highlighting the fact that all interpretations are temporal, situated and changeable. Language here is understood not as timeless and stable but a process through which groups continuously and actively create meaning. While the potential for meanings is unlimited, people tend to interpret things in a finite number of ways. Patterns of interpreting, then, appear to be at work – which may in turn reflect the cultural and historical frames of reference that individuals bring with them to each experience. Thus individuals, like institutions, are embedded in their social and historical context, as is reflected in their actions and interpretations.

The accounts presented here act as an entry point to a constructivist analysis of how differently situated individuals within the same multifaceted cultural system use

49

experiences and language to learn, reinforce and enunciate their own meanings and cultural position. The focus on process helps to understand how contemporary actors reconstruct identity and self-positioning in attending to and interpreting social experiences.

The methods employed throughout this study were consistent with the theoretical orientation whereby the constructive nature of language is prioritised and becomes the object of study itself. Broadly speaking then, this study can be viewed as working from an epistemological framework informed by social constructionism and discourse analysis. Of course, within discourse analysis there is great variation in theoretical and methodological nuance. Perhaps therefore it would be useful to make explicit the approach I have employed throughout this work.

<u>What is Discourse Analysis?</u>

The term 'discourse' has increasingly featured across a wide range of academic disciplines, including but not limited to linguistics, sociology, anthropology, critical theory, feminist theory and of course, psychology. Its broad deployment has given rise to a confusing array of theoretical meanings and usages associated with the term; however one useful definition describes discourse as:

> "Linguistic communication seen as a transaction between speaker and hearer, as an interpersonal activity whose form is determined by its social purpose" (Leech and Short, 1997: 3)

This definition alludes to several important features of discourse; in particular its inherently social and relational nature. What is more, it communicates the subtle yet critical understanding that the term 'discourse' (as it understood within this work) is concerned with the effects that words or statements might have, rather than those words or statements themselves (as may be the focus within the context of linguistic study for example). An alternative definition of discourse that has also served to inform this work considers discourse to be:

> "sets of statements that construct objects and an array of subject positions" (Parker, 1994: 245)

Or, "a system of statements which constructs an object" (Parker, 1992: 5)

50

Such an understanding suggests that discourse both constrains and enables what may be said, by whom and when (Parker, 1992), and centralises the essentially institutional nature of discourse. Discourse here is understood to construct certain subject positions that have consequences for subjectivity and experience by way of making available particular ways of seeing (and being-in) the world. Discourses "allow for certain ways of thinking about reality whilst excluding others. In this way they determine who can speak, when, and with what authority, and conversely, who can not" (Cheek, 2000:23). Discourse then, is inextricably linked to the exercise of power, which is in turn considered to be intimately linked to the production and maintenance of specific knowledges and truths.

The simultaneous 'turn to language' across a number of academic disciplines has perhaps inevitably given rise to a number of different types of Discourse Analysis. Discourse Analysis then, refers not to a particular 'method' comprised of rigidly defined procedures but rather to a broad range of approaches to the study of language/meaning-making, all of which are not necessarily similar or compatible. As Potter and Wetherall (1987) note, this has led to considerable debate: 'perhaps the only thing all commentators agree on in this area is that terminological confusions abound' (Potter & Wetherall, 1987:6). Rather than referring to Discourse Analysis as a particular research method then, it is perhaps best characterized as a way of approaching and thinking about a problem; specifically, a manner of questioning the ontological and epistemological assumptions behind a project, problem or subject of investigation. As Harper puts it: 'Discourse Analysis is a process of reading from a position of curiosity, formulating questions about what one is reading and then crafting a coherent written analysis' (Harper: 2006: 3).

What is the main purpose of Discourse Analysis?

The purpose of Discourse Analysis is not to provide definite answers, but to challenge existing assumptions and uncover previously unacknowledged agendas/motivations. As Willig argues, discursive psychology 'does not make claims about the nature of the world, the existence of underlying causal laws or mechanisms, or entities that give rise to psychological phenomena' (Willig, 2001: 103). However, the new perspective provided by discourse analysis can lead to fundamental changes in the practices of an institution, the profession, and society as a whole. Researchers informed by the work of Foucault in particular are concerned with the social and material effects of discourse; nevertheless, no

claims are made to approach or understand the "true nature" of psychological phenomena (Willig, 2001:120). The contribution of postmodern Discourse Analysis thus may be understood as the application of critical thought to social situations to challenge taken-for-granted truths.

What are the main principles/tenets?

Discourse Analysis has developed over time and across a number of academic disciplines, giving rise to a proliferation of varied and diverse theoretical approaches that may contestably fall under its rubric. However two primary concerns may be understood to inform the analytic approach: commitment to the systematic analysis of texts for patterns in the data (shared features of accounts or differences between them); and consideration of the functions, effects and consequences of accounts (Harper: 3). Discourse Analysis is then, essentially *comparative;* i.e. it is interested in the contrast between cases or groups. It is also *contextual*, that is, it is understood that meaning is not made by language alone but by participants within their social, cultural, political and historical context that works to define an activity or situation and its attendant roles and expectations. That is, context itself is a kind of text, to be 'read' from the standpoint of the verbal/written discourse, and all knowledges must thus be understood as situated, perspectival and partial. Finally, discourse analysis is essentially *constructivist* in nature, that is, discourse analysts share an understanding of texts as productive of knowledges and truths, not merely reflective of them (Ballinger and Cheek, 2006). Language is thus not merely descriptive but constitutive; it should therefore not be considered a path to discover underlying entities (such as cognitions) but rather be the object of study itself.

Why did I choose a discursive approach?

With so many well-developed qualitative procedures at first glance appropriate to this research, the path to my decision on a discursive analysis may be worth some explanation. Other methodologies considered included Grounded Theory, and Interpretative Phenomenological Analysis (IPA). Grounded Theory has provided a useful set of procedures for the collection and analysis of rich qualitative data, however it is arguably not best suited to the research aims of this study. First of all, whilst constructionist versions of Grounded Theory have been articulated (Charmaz,

1994), Grounded Theory is ultimately predicated upon the realist assumption that some external reality exists independent of the observer to discover and record, a view challenged by postmodern epistemologies. For example, the central commitment to the development of categories assumes that the concept of categories itself is unproblematic. Perhaps even more salient though is the point that in the examination of complex human phenomena such as pain, we cannot ignore the central role that language plays.

Although similar in many ways methodologically to Grounded Theory, IPA may be differentiated by its focus on investigating underlying social cognitions. IPA is concerned with trying to understand how participants themselves make sense of their experiences. The aim is to explore the participant's view of the world, and the meanings which experiences hold for the participant. IPA is phenomenological in that it wishes to explore an individual's personal perception or account of an event or state as opposed to attempting to produce an objective record of the event or state itself (Smith et al, 1995). At the same time, while trying to get close to the participant's personal world, IPA considers that one cannot do this directly or completely. Access is dependant on the researcher's own conceptions and social cognitions which inevitably come into play when attempting to make sense of another person's world through a process of interpretative action (Smith, 2008). IPA, with its focus on interpretive methods, clearly holds value in the examination of complex and subjective phenomena such as chronic pain and disability. Research into the complete experience using a phenomenological model may highlight more of what is relevant about this experience for the patient and ultimately inform the development of more effective or focused helping interventions. However IPA's assumption that there exist underlying cognitions to be discovered locates this approach firmly within the objectivist/cognitivist camp, which tends to give insufficient attention to the role that language inevitably plays in the co-construction of social realities.

In order to fully understand language as productive rather than merely reflective, talk and texts must surely be centralised. Discourse analysis is such an approach i.e. one that centralises the individual experience and places some considerable emphasis on the role of language, in accordance with the influence it is understood to exert in the construction of meaningful shared knowledge. Specifically, the intimate relationship between power and knowledge is understood to influence what is perceived as natural or normal at any given

53

point in time. These constructed truths have a taken-for-granted reality, and they are often associated with powerful and influential institutions (e.g. biomedicine, psychology). DA influenced by post-modern or post-structural theoretical approaches offers a means of challenging such taken-for-granted aspects of culture, including those that concern health care and health care practices. Chiropractic, whilst striving philosophically to 'march to its own beat' is inevitably influenced by the scientific/biomedical discursive framework. By interrogating discursive frameworks that participate in the maintenance of dominant view of health and illness we may open up new perspectives capable of embracing more diverse and inclusive practices surrounding health and illness.

> "The advantage of discourse analysis is that it reframes the object, and individual's psychology, and allows us to treat it not as truth, but as one 'truth' held in place by language and power" (Parker, 1992: 22).

Key theorists/influences

As pointed out by Ballinger and Cheek (2006), against the backdrop of a diverse range of analytic approaches that may lay claim to the title of discourse analysis, it is important for researchers to 'ground' their work in the particular theoretical context in which their work is situated. One way to achieve this is to identify those theorists whose work has informed the research study; in this case I therefore acknowledge in particular the influence of Foucault and Parker. Foucault's approach to discourse as a system of representation (not as referring to language) constitutes a major theoretical underpinning for this work. Such an approach incorporates a constructionist approach to meaning and representation: that is, physical things and actions exist, but only take on meaning and become objects of knowledge within discourse. That is, since discourse constructs the topic, it defines and produces the objects of our knowledge, and governs the way a topic can be talked about and how it cannot be talked about. As such, this work tends to focus on the discursive resources that people may draw on, and the role of discourse in the construction of objects and subjects, including the 'self' (Parker et al, 1995).

Sampling frame and recruitment procedure

As a novice researcher it was difficult to assess how much time would be needed for transcription and analysis, and I felt I should ensure I didn't 'bite off more than I

could chew'. A small sample size was thus decided upon, in order to allow both patients and practitioners to be interviewed, as well as to allow sufficient time for in-depth analysis of the data to be conducted, and purposive (or criteria) sampling was employed.

Recruitment of clinics/clinicians to the study was facilitated via my own involvement in chiropractic education and research, having occupied a full-time position as a Lecturer in Behavioural Science, first at the Anglo-European College of Chiropractic (a privately owned educational institution in Bournemouth, England) and also having engaged in part-time teaching at the University of Glamorgan (School of Applied Sciences). I also have spent time at the Palmer West Chiropractic College in Palo Alto, California as a visiting researcher, and have taught post-graduate modules in health psychology and behavioural sciences as part of the British Chiropractic Association's Continuing Professional Development programme in the UK. Through these positions I have been privileged to be involved a wide variety of activities such as workshops, meetings, educational committees, social activities and formal teaching situations. It was through these activities that I was able to foster relationships with chiropractors and recruit clinics/clinicians to participate in the study.

The clinics I approached to participate in the study were selected to provide for some diversity in the sample. That is, the majority of chiropractors work in private practice. Many chiropractors comment that the high cost of chiropractic care and its status outside of mainstream medical care (NHS, major insurers etc.) tends to skew patient populations towards well-off (middle class) people. Whether or not this is the case was not a question this study was concerned with, however I was interested to expose discursive frameworks within chiropractic settings, including those surrounding matters of social class and health, and so I chose to include a university clinic (where the cost of care is heavily subsidised) such that discussion surrounding this could be facilitated and also to encourage a perhaps more socio-economically diverse patient population. The clinics selected also provided for a certain geographical diversity, with one being located in a semi-rural small (affluent) village (Ringwood, Hampshire), one in a major town (Bournemouth), and one in a smaller, less affluent town (Pontypridd, South Wales).

Of the ten clinicians interviewed, six were chiropractors wholly engaged in private practice, three were chiropractors engaged in both practising and educational roles (clinical tutors at the University of Glamorgan) and one was a full-time educationalist currently licensed with the GCC; involved in teaching and research but not actively engaged in treating patients. All ten of the chiropractic service users were currently actively participating in chiropractic treatment regimes.

The study population was defined as being limited to chiropractic patients and practitioners over the age of 18. The sample frame consisted of the principals, associates, and patient attendees at the selected chiropractic clinics, which was then refined by screening a flow population against quotas with pre-defined selection criteria. The criteria used for purposive selection of the sample included only demographic characteristics, reflecting the aims of the study, namely to explore the discursive repertoires available to people within chiropractic health care settings.
- Age – to ensure a balanced demographic sample
- Gender – as above
- Employment status - to ensure diversity in the sample

Broad quotas were devised so that a balanced and diverse sample could be achieved across the above demographic criteria:
- Between 8-12 men and women (N = 20)
- A minimum of 3 participants within each of the 18-35, 36-54 and 55+ age groups;
- A minimum of 1 participant within each employment status category (full-time employed, part-time employed, student, full-time parent or retired).

Actual recruitment of patient participants was conducted using a combination of convenience and flow sampling. That is, patients were approached within the selected chiropractic clinic waiting rooms, initially on the basis of whoever happened to be there, but then as more participants were recruited to the study, people were selectively approached who appeared to fit within the quota as described above, and then permission sought to arrange a time and place for a full length interview at a later date.

Unfortunately, records of unsuccessful approaches were not kept, which in hindsight is a flaw that should be corrected in future research.

A total of twenty in-depth semi-structured interviews were conducted. Ten interviewees were currently practising chiropractors, several of whom are also active in chiropractic educational roles, and ten were with users of chiropractic services. These interviews were undertaken after an initial quantitative pilot study. Review of the data from this larger first study (a questionnaire-based survey of patients and practitioners) led me to conclude that the nature of the subject matter would perhaps best be approached using qualitative methods.

Stages and process of interview schedule design

In designing the interview schedule, I adopted a pragmatic approach that entailed thinking first and foremost about what it was that I was hoping to achieve. In other words, what were my aims; what questions could I ask that would best illuminate the broad range of issues that I hoped to explore? Whilst I was conscious of the need to avoid devising a rigid or prescriptive set of questions that could potentially limit data generation, I nevertheless felt it was important to think strategically about the type of questions that I would need in ask in order to generate data that would help to achieve the study aims, and the way in which those questions should be asked i.e. what style, structure and sequence of questions would be most facilitative (Mason, 2002).

In the first instance then, I thought about the 'big picture' in terms of the overall research aims. Then I simply jotted down a long list of questions that immediately sprung to mind or that I felt might prompt discussion/generate data related to these issues or concerns. I then added to the list after going over it with my supervisor, who pointed out some additional questions that I had overlooked. Once I had articulated a number of potentially useful questions, I then worked through them to see if perhaps they could be worded in ways that might help to generate rather than limit the text. Being conscious of the importance of asking open rather than directive or closed questions for example, I attempted to re-phrase certain questions in such a way that participants might be encouraged to speak in a free and unrestricted fashion.

Another concern that I was conscious of was to avoid the use of words or sentence structure that could be leading, or suggestive of a particular viewpoint (Smith et al, 1995). Despite having attempted to do so though, I suspect that many questions were inherently 'leading' in that the participant's awareness of my status as a psychological researcher would have almost certainly influenced or suggested a certain perspective. For example, patient participants may have been prone to thinking that my agenda was to 'prove' a psychological component to their pain. Practitioner participants similarly would likely have assumed other positions behind my questions regarding issues such as 'abnormal illness behaviour' the 'biopsychosocial model' etc. Lastly, I sought to group the questions in a way that 'worked', i.e. so that there was a sensible flow from one to the next; and also in a sequence beginning with the 'easier' questions i.e. less personal or 'tricky' questions to allow (both) participants to ease into the interview and build a sense of trust/rapport before approaching more sensitive issues or topics.

One area of the interview design that in retrospect, could have been further developed, was the construction of key questions in multiple different ways. This would have been helpful in situations where a question phrased in a particular way didn't sit well with the participant, or otherwise failed to facilitate 'good' data. The interview schedule could also have benefited from the inclusion of more probes and prompts, in order to better flesh out particular areas of interest.

The interviews themselves were conducted 'on-site', that is, at the participants place of treatment or work, and lasted from one to three hours. Questions were adapted, depending on whether the interviewees were in private practice or educational environments. Each interview began however with by asking respondents to tell the story of how they came to be involved with chiropractic. Often-times, this led to the generation of a lengthy text, incorporating the respondents own experiences of pain, their family or otherwise introduction to the discipline, and their path to chiropractic. Where such talk was not forthcoming, further prompting was included to encourage discussion of a broad range of topics, including training, educational, practice and treatment experiences. They were also asked to describe their interactions and experiences with biomedical health care over time. Other key questions included asking about their 'philosophy on health', what the term holistic means to them, what

pain means to them, and whether or not they thought chiropractors should practice as primary health care professionals. Many other interesting questions came up during the interviews but these are perhaps best addressed at a later stage. Inevitably, there was some disparity in both depth and breadth of interviews, due to the differing personalities and comfort levels of the interviewees themselves. However all yielded interesting insights, particularly as they 'warmed-up' to the subject matter and relaxed into the experience.

Whilst issues surrounding confidentiality were of importance to the researcher, interestingly they did not appear to be matters of great concern to most of the interviewees. Many possessed well-developed opinions or viewpoints that they were happy to share and see raised in a public domain, particularly with respect to current 'hot topics' such as educational standards, curricula, philosophy of health etc. However in discussing topics such as pain, often interviewees would recount anecdotal stories which might pose a threat to with respect to matters of doctor-patient confidentiality. In order to maintain privacy, names and/or other identifying criteria have either been omitted or changed.

Mode of analysis

As many discourse analysts have been careful to point out, "there is no analytic method" as such that can be applied to this kind of research (Potter and Wetherall, 1987: 169). Parker similarly argues that "Discourse Analysis is not, or should not be, a 'method'" (Parker, 1992: 122). However, in order to assist the analytic process, Parker suggests the application of particular criteria against which texts may be explored. Drawing on this work then, the interview transcripts in this study were treated as texts, and explored using particular questions designed to interrogate the material:

- What concepts are constructed as given, obvious or taken-for-granted? (Gill, 1996; Potter, 1996)
- What objects are referred to? (Parker, 1992)
- What types of person are talked about in this discourse and what kinds of things are they able to say? (Parker, 1992)

59

- What means of describing and defining pain are there?
- What subjectivities do these definitions make possible? (Parker, 1992)
- What oppositions are implied? (Billig *et al.*, 1988)
- What is not said that might have been? (Billig, 1991c; Gill, 1996; Parker, 1992)
- To what problems might these responses be solutions? (Gill, 1996)
- What ideological effects might these have?

Essentially, then, I attempted to read the texts whilst thinking: "why was this said and not that? Why these words, and where do the connotations of the words fit with different ways of talking about the world?" (Parker, 1992: 4) i.e. I sought to attend to the words with a somewhat 'suspicious' eye (Parker, 1992: 124). Analysis, informed by the above-mentioned analytic questions, began during transcription – often as listening to the tapes I would notice discursive features that would 'jump out' at me, without conscious effort on my part. When this happened I would write those thoughts or comments alongside the transcription, noting the line at which the feature had occurred. These early inspirations were sometimes concurrent with other findings from the literature but often were not; and they formed a good starting point for the development of loose categories that would later become analytic themes. Along the way some of these early categories were dropped, others grouped together and elaborated in a process that was both iterative and recursive. This process was extremely lengthy, as thinking through the material made me want to revisit the data time and again – either to check or re-categorise or consider from another analytical perspective. The analytic process continued throughout the work actually, including the writing up stage. At this point, in attempting to articulate thoughts and suggestions, analytic concepts would either be challenged or refined, sharpened.

Data collection, analysis and revision of the interview questions thus occurred in a somewhat circuitous or relational manner, that is, as each interview was completed, new directions for enquiry were thrown up or refinements made. This approach is influenced by the concept of the hermeneutic circle which sees analysis as a circular, continual process of interpretation rather than a method which may be applied to a theoretical concern. As Newman and Holzman argue:

Practice is not our method. Rather, method is what we continuously practice. To us, method is not something applied to something. In our view, it is, to paraphrase Marx, an activity 'for itself' as opposed to 'in itself'. In Vygotsky's language, method is a 'tool and result' as opposed to a 'tool for result' (Newman and Holzman, 1996: p.ix).

Transcription and analysis

Despite having some previous experience of transcription (importantly though, not within the context of a DA study), and also having read the warnings that abound in the literature, I was still taken aback at the length of time that was required to transcribe the data. I had aspired to use a modified version of the notation system devised originally by Gail Jefferson (in Atkinson and Heritage, 1984; Hutchby and Woofitt, 1998). In reality however I found that my original intention to use a Jeffersonian-style became untenable, and I had to greatly simplify my use of the conventions. For example, whilst I had originally hoped to include timings of pauses, I found that this was difficult to do with any consistency or real accuracy; and I encountered similar difficulties recording overlaps. Given this, I felt that the use of number or timings of pauses or overlaps could not justifiably be given as analytic evidence. However, given the nature of the research questions, providing this level of detail was arguably less important than preserving internal consistency.

Preliminary analysis of the material was done by repeated listening to the audiotapes and re-reading of the transcripts in order to become fully immersed in the material. The next stage of analysis consisted of examining the material for recurring discourses, or patterned ways of communicating points of views and meaning. The data were analysed closely for consistencies, inconsistencies, and patterns as variability itself may be illuminating. In order to achieve this, the material was considered from a range of perspectives, such as looking at use of rhetorical devices or strategies, vocabulary choices, emphasis/tone etc. Finally, the material was analysed in terms of identifying emergent patterns of meanings across accounts to produce a comprehensive analysis of the range of ways in which CAM patients and practitioners work discursively to construct and negotiate meaning in complex ways.

As would be expected, 'rich' data were collected, which in turn suggested many areas of analytical interest which will be explored at length in subsequent chapters. The

interview data were treated as texts, in which participants put forward accounts understood not as 'the truth' with regards to people's thoughts, attitudes and beliefs but rather as 'situated truths' that are inextricably linked to the context in which they were elicited. That is to say, it was assumed that the context and process of the research interview inevitably would exert an influencing factor in co-constituting the accounts themselves.

CHAPTER THREE

The discursive construction of the chiropractic occupational space

Introduction

Many social theorists concerned with modern health care have constructed
biomedicine and complementary/alternative medicine as existing in a state of tension,
characterised by political and conceptual competition (Sharma, 1993; Wardwell,
1994; Micozzi, 2001). However it is possible that these two discourses are more
relational than oppositional; that whilst there may exist theoretical tension between
the two models, in practice each may be used as a discursive resource to achieve
specific professional identity work.

In this chapter, I will draw upon accounts provided by chiropractors to show how
they alternately make use of biomedical and complementary discourses to legitimate
their work and construct professional identity. On the one hand their narrative work
is performed in a way that reifies the opposition of these two health paradigms, yet on
the other the biomedical discourse is drawn upon to give authority and credibility to
their work and assist in the construction of a professional identity that works within
the current social and political climate.

In the following analysis, I will discuss several strategies that are used by the
interviewees in constructing a legitimising discourse of chiropractic. First, strategies
of contrast and delineation are discussed, whereby chiropractic is defined as Other
than, separate to and distinct from, biomedicine. Second, the use of rhetorical themes
of collaboration and commonality is examined, whereby accounts are constructed that
serve to position chiropractors rhetorically as professional equals within the modern
health care sphere. This is primarily achieved by characterising the training, practice
and research of chiropractic as similar to that of biomedicine. Finally, I will examine
how the biomedical discourse is utilised as a way of communicating the everyday
work of chiropractors such that their work is legitimated, yet constructed in a manner
that allows for the continued separate status of the discipline i.e. builds a bridge

between the two dialogues without conceding or submitting to biomedical dominance.

In order to do so, I will present extracts from the texts generated during this research study, in particular attending to the personal histories related by individuals that serve to construct meaning. Although they are often focused on the self and its immediate social and historical context, these personal accounts are both constrained by and in turn constrain shared cultural resources. That is, the scope for individual utterances is constrained both by the conceptual schemas and communicative symbols derived from or provided by dominant discourses and by the range of social positions those discourses present for us to occupy. However the relationship is bi-directional, insofar individual speech acts play an undeniable role in the elaboration and maintenance of social discourses. Berger and Luckman speak to the dialectical relationship that exists between identity and social relations:

> identity is formed by social processes. Once crystallized, it is maintained, modified, or even reshaped by social relations...Conversely, the identities produced by the interplay of organism, individual consciousness and social structure react upon the given social structure, maintaining it, modifying it, or even reshaping it" (Berger and Luckman, 1967: 173).

Collective discourses depend upon the elaboration of numerous individual accounts. It is through this process that meanings and understandings may become reified into taken-for-granted truths and thus escape challenge. As a coherent body of talk ('collective wisdom') takes form, self-evident knowledges may be developed that work to construct identities and delineate boundaries between competing social groups.

Using excerpts from the accounts given by providers of chiropractic services, this chapter will explore some of the ways in which discourses are co-constructed in the socially and politically contested arenas of health and health care.

<u>Setting the scene</u>

Many accounts begin with speakers providing lengthy background information that they deem relevant – 'setting the scene' so to speak (Labov, 1972). Attentive discursive analysis of this phenomenon should consider such scene-setting not merely as providing neutral additional information necessary to build context, but rather ask the question: what purpose do these details provide? What interactive business does this rhetorical sequence achieve? In these excerpts, for example, it may be useful to consider why the participant has chosen to begin the story of how they became a chiropractor at a certain point in time.

> *A Level time. I was wanting to be a GP and I went along to see my GP with a bad back, playing football 4 or 5 times a week and without even asking me to lift up my shirt, he said that I had got fibrositis because I don't dry myself well enough after a shower at the end of the game and gave me some painkillers. So I saw my whole life as future captain of England disappearing before me. Dad took me to see a chiropractor, he examined me, treated me, got me better. I was hooked. Applied to do chiropractic college instead of med school.*
> *(MB)*

Beginning a story at one point in time rather than another has the consequence of setting the parameters for what it is to be considered relevant. This in turn has considerable influence over the kind of account that the speaker manages ultimately to accomplish (Riessman, 1993). Inherent in the ascribing of a particular time as 'where it all began' is the implication that other events/conditions pre-dating that particular point in time are less important.

Thus in the above extract, the life event of experiencing back pain that is 'fixed' by a chiropractor is highlighted as the defining or causal event, as opposed to an alternative story which might begin a few years earlier, emphasising psychosocial factors for example, which could equally be considered influential or predisposing factors. This analysis is not designed to suggest that people's accounts are not 'true', or are motivated by conscious desires to create or manage a particular impression –

but simply that it is worth considering why certain factors are chosen for emphasis more than others.

Rhetorical strategies of legitimation/validation (I): Use of Latin/Greek

One advantage of adopting a discursive approach is that it allows us to pose certain questions. For example, how is rhetoric used in the therapeutic encounter as a linguistic resource by both doctors and patients? What kinds of accounts are drawn on to explain different events (e.g. psychological, biological, cultural etc)? It is not my intention here to imply that the factual status of accounts is unimportant but rather that it is perhaps more revealing to consider the effects achieved by these accounts. How are accounts told so that they achieve 'factual' status – and what objectives are being fulfilled in presenting them as factual? Edwards & Potter (1992) have suggested that speakers may successfully construct certain accounts as 'facts',   · particularly when there is some controversy about what constitutes 'the truth'. It seems possible therefore that in a highly ambiguous situation such as one concerning pain or injury, the participants involved might use similar strategies.

One strategy commonly used by both biomedical and complementary practitioners to achieve facticity in their accounts is the use of Latin or Greek-derived terms in order to bestow upon the proposed actions a sense of credibility and historical 'weight'. Indeed, the very name 'chiropractic' was devised from the Greek 'cheir' and 'praktos', meaning 'to do by hand', conveying a sense of formality and educational status to the occupation. Indeed it seems likely that the founder of chiropractic, D.D. Palmer chose to name his new-found profession in such a manner so as to create a sense of authenticity, following the common medical and scientific practice of the time of using Greek and Latin terms.

Similarly we see that key chiropractic concepts are named in a manner consistent with this rhetorical strategy: for example the fundamental chiropractic health concern, namely 'subluxation', is so named from the Latin words meaning "to dislocate" (luxare) and "somewhat or slightly" (sub). A subluxation means a slight dislocation (misalignment) or biomechanical malfunctioning of the vertebrae (Source: www.chiro.org). Despite there being no consensus either internally or externally of the profession with regards to what subluxation actually is, or even indeed as to

whether or not it can even be claimed to exist, we hear repeated reference to it discursively; for example when asked what is a chiropractor, one practitioner responds:

Chiropractors locate and treat spinal subluxations – plain and simple

He elaborates further:

Well, I s'pose my belief about what causes poor health is pretty straight chiro – you know, subluxations of the spine put pressure on the whole system, leading to 'dis-ease'. Having said that, obviously there are loads of other factors as well that are involved, nutrition, genetics, psychological factors. But at the end of the day I work to the philosophy that by removing subluxations, we enable the nervous system to work optimally, providing our bodies with the best possible chance of resisting or preventing disease or injury. (DH)

And another reminisces about her chiropractic education:

Chiropractic philosophy was really central, you know, subluxation, subluxation, subluxation. (AK)

Arguably by holding onto the use of a key word which is known only to those initiated into the profession, the practitioners maintain a sense of 'special' belonging. Exclusivity is also achieved insofar as only those whom have undergone the extensive training and educational process that is required to become a chiropractor would understand and be able to use such terms comfortably.

It is not only when referring to their own philosophies on health that we see the use of complex Latin or Greek derived medical terminology. It is common practice in chiropractic to make use of the biomedical nomenclature when referring to diagnoses and treatment plans, which works to position their work as expert, specialist and scientific through the use of Latin and Greek terms which are often connected in the popular mind to science and scholarship.

67

Rhetorical strategies of legitimation/validation (II): Appeal to history

The use of medical terminology is closely related to another strategy of legitimation, appealing to history. This is a common rhetorical strategy used by members of a group to achieve special or expert status and one which has been well-documented by observers of medicine and other professions. Chiropractic and the other CAM professions are unlikely to be exempt from this tendency, as they are not immune to the competitive occupational struggles that occur as groups jostle for position within a specific or defined sphere of work. Hence it comes as no surprise to note the regular use of this discursive practice in the practitioner accounts:

> *The legislation has been long-overdue, I mean, chiropractic is the third-largest profession in the world, next to medicine and dentistry and its been around for a long time – over a hundred years... (NT)*

In this extract several rhetorical devices are employed to achieve specific professional validity claims: first, chiropractic is validated on the basis of its size *'third largest in the world'*; next, it is positioned alongside the dominant disciplines *'next to medicine and dentistry'*; and finally, credibility is claimed on the basis of longevity *'its been around a long time – over a hundred years...'*

These themes are also evident throughout a variety of chiropractic texts. From the American Chiropractic Association website:

> The roots of chiropractic care can be traced all the way back to the beginning of recorded time. Writings from China and Greece written in 2700 B.C. and 1500 B.C. mention spinal manipulation and the manoeuvering of the lower extremities to ease low back pain. Hippocrates, the Greek physician, who lived from 460 to 357 B.C., also published texts detailing the importance of chiropractic care. In one of his writings he declares, "Get knowledge of the spine, for this is the requisite for many diseases". In the United States, the practice of spinal manipulation began gaining momentum in the late nineteenth century. In 1895, Daniel David Palmer founded the Chiropractic profession in Davenport, Iowa. (ACA, 2007)

The above passage provides a startling example of how past and present can be rhetorically collapsed to achieve a desired outcome; here we see a claim that a 'Great Man' was advocating chiropractic care – approximately 2000 years before the word was even devised! This not so subtle tactic has but one purpose, to align chiropractic

with a well-known and respected historical figure synonymous with education, healing and scientific enquiry.

Similarly we see from the website of the British Chiropractic Association:

> Written records from the ancient Greek and Chinese civilizations, dating back several thousand years, refer to spinal manipulation. The inception of modern chiropractic can be traced back to 1895 when Canadian Daniel David Palmer performed the first chiropractic adjustment and went on to found The Palmer School of Chiropractic in Davenport, Iowa in 1897. (BCA, 2007)

Discursive strategies of contrast/delineation: rhetorical use of the biomedical discourse to legitimate and validate chiropractic

Whilst chiropractors have traditionally sought to differentiate their model of health care as diametrically opposite to that of biomedicine, in practical terms chiropractors demonstrate knowledge of and make use of the discourse of biomedicine. In these legitimising accounts, the medical model is often-times indistinguishable from the chiropractic model. That is, the biomedical model, rather than emerging as a separate entity, is instead drawn upon as a resource through which chiropractors work discursively to construct the validity and credibility of their profession.

One obvious way in which the interviewees were observed to use the discourse of medicine to legitimate their practices is in reference to similarities in educational standards. As one participant stated:

> *I think what was interesting, even at the time of my education, is that my best friend from grammar school went into Med School and we used to swap papers, except we had more exams than they did. So we had them at the end of every term and they had them at the end of the summer term. And there was definite parity right the way through the first two, two and a half years. (MW)*

And from another, relating what his training was like:

69

Definitely primary care (training) is copied from med school and they bolt it
on a lot...they have got a very strong medical approach, a lot of micro-
biology, parasitology, you know, even psychology, things you might not
consider are directly related to chiropractic...In fact nearly all the lecturers
to do with the diagnosis, radiology side were non-chiropractors, so there is
always a slant towards medicine rather than chiropractic, which is a strength
and a weakness at the same time. (VR)

The use of medical language and rhetoric throughout the interviews further serves to underline just how much chiropractors use the biomedical discourse as a legitimating resource in the construction of a valid professional identity. The following excerpts from the same chiropractor could almost be mistaken for being made by a biomedical practitioner:

As a primary contact practitioner in this country under the law, you see
patients without referral; you have obligations in terms of patient safety,
clinical diseases all these things have to be reported to the various agencies.
You have responsibility to the patient to maintain their dignity and privacy
and confidentiality... (perhaps) we're becoming too medical or physiotherapy
orientated now but if we are going to participate in healthcare we have to
adopt these as methods and be evidence-based. (DJ)

Contrast/delineation (I) 'True' work: 'we treat the cause, not the symptom'

An important part of claiming space within the system of work in terms of both defining and defending professional boundaries is to differentiate between competing groups. This can be achieved discursively by highlighting differences and delineating/claiming specific positions and/or moral standpoints. One such claim – authenticity with regards to the core nature of their work - was a feature within the accounts.

AK says:

You know, (it was) just a whole different way of looking at the body, and
learning to treat the underlying cause, not just the symptom. That's the

70

problem with the medics, they just want to mask the pain, whereas we want to remove the underlying structural problem that's causing it in the first place. And then prevent it from happening again, as far as possible.

DH adds:

What you have to remember is that aches and pains are symptoms and the body is telling you there is a problem. Chiropractors treat causes not symptoms. Once we fix the underlying problem or the cause of the pain, the symptoms go away! No pills, no needles, no maybe it will go away. And you know it has to be the real deal, 'cos if it wasn't, we wouldn't still be around! The media, medical doctors whoever can say what they want – the fact is, it works, that's what it comes down to in the end. That's why patients keep coming back, even though it costs them, because at the end of the day we are really fixing their problems, not just giving it a rub, or telling them to rest up and crossing our fingers that it comes right...

The word 'real' here is being used to suggest that one type of work is somehow more authentic than that of the Other. It also subtly introduces the moral dimensions of authenticity, insofar as to be addressing the 'real' causes of disease or illness implies a moral superiority.

Another clinician similarly expresses her conviction that she is practising somehow more authentic work;

The thing that I love about being a chiropractor is that we're really getting to the root of the problems, you know? Not just putting a band-aid onto it, covering it up with Panadol or whatever...how's that gonna help? (Laughs) I'm not saying that we work miracles or anything like that, but at least, I mean, how is a painkiller going to help to actually sort out a problem that is essentially biomechanical in nature? Sure, a certain percentage of cases will sort themselves out, given enough time – but not really you know? The pain might subside a bit but there is still an underlying lesion that is going to destabilise and undermine the body's capacity to function at its best, later on down the line. (NT)

71

And yet another refers to the same theme:

> *I use a lot of Cranio-sacral Therapy, which is a very versatile tool, and*
> *very powerful if you know what you are doing. It's a bit complex, but*
> *essentially it's a technique that allows the patient to confer with their*
> *body's innate wisdom. This allows the true causes of illnesses to*
> *emerge...and helps me to work with the patient to create a treatment plan*
> *that works on a deeper level. What some doctors perhaps don't realise is*
> *that both symptoms and the root causes can be treated...I believe healing*
> *is a subtle process...it can't just be dealt with at a superficial level. (RS)*

The consistency with which this view is put forward is unsurprising if we consider the relationship between authenticity and identity. A claim to a group identity put forward by an individual is subject to that same group accepting or rejecting that claim. This in turn relies upon the group having a core identity that they may refer to in deciding whether or not an individual is truly 'one of them'. Berger and Luckman (1967) suggest that reality is collectively negotiated between actors through daily interaction, that individuals internalize the reality construction particular to that group, which is in turn recreated again once internalized and reinforced through further interactions. To use Cooley's (1902) expression, individuals use the 'looking glass self' to measure themselves against the standards made explicit by the group to which they seek to be a part of.

Bourdieu's (1984) concept of cultural capital further develops this idea, namely that people with a working knowledge of a particular culture (in this case, chiropractic theory of disease causation) employ that knowledge in discourse in order to delineate themselves; to construct both self and group identity. Components of identity or self are drawn from the discursive practices of the group. This idea in turn can be closely linked to the observation that identities may sometimes be competitively constructed. Parkin elaborates on the Weberian concept of social closure to suggest that "social collectivities seek to maximise rewards by restricting access to resources and opportunities to a limited circle of eligibles" (Parkin, 1979).

Contrast/delineation (II) Nice, clean work: 'we don't deal with blood and all that muck'.

Another theme which emerged throughout the clinician accounts was one that characterised chiropractic as 'nice, clean work'. Within this broad category several sub-themes can be detected. One discernible theme is that whereby chiropractic is preferred or chosen by the individual as a way of being able to work within the context of healing but within attractive boundaries of practice, that is, the usual clinical mode of practice is described as being preferable in that the therapeutic modalities do not generally require crossing over into the bodies of patients (i.e. the clinician is not likely to have to deal with messy bodily fluids as part of regular practice).

The following extract demonstrates this discursive theme, where the interviewee talks about how he came to choose chiropractic over physiotherapy...

> *The sort of hospital physios were doing lots of knocking out infection from the lungs and they were sucking out muck from the lungs and they were doing rehab and stretches on amputees and far more blood involved in what they were doing. Lots of sick children, you are dealing with sick patients basically, post amputations or post surgery...not dirty but not clean like someone had just walked into a practice in reasonable health. I did definitely consider it but then I thought no, I would like clean, the cleanliness of chiropractic. (VR)*

Another conveys a similar sentiment:

> *I think one of the attractive things about being a chiropractor for me was, I wanted to, I liked the idea of working with helping people to be healthy but at the same time I wouldn't want to be dealing with the, blood and mess and really sick people – its takes a, you have to be a certain type of person to want to deal with the trauma emergency type surgery and stuff you know? If I wanted that I guess I would've preferred to become a doctor, or even a paramedic or whatever but I didn't want that. (NT)*

Of course, if chiropractic work is to be discursively constructed as 'clean' it is a short step from here to positioning other types of health work as 'dirty'. However this

potential minefield was quickly defused with statements that spoke to the virtue of Other health care work:

> *I mean, don't get me wrong that kind of work is very admirable, someone's got to do it right and I think nurses and doctors, you know if you're working shifts at the hospital and dealing with all kinds of people and patients who are sick, changing dressings and cleaning them up and I mean I take my hat off to them...but there's also a role for us to be looking after the other types of problems that we specialise in that they don't, and to be honest that suits me just fine. (NT)*

Chiropractic was also constructed as 'nice work' by clinicians who emphasised the potential within the discipline to build good relationships with their patients, and sometimes their whole families as well:

> *I love people. I like helping people feel better and watching them do more with more energy as they feel better. I love working with families and seeing them grow and develop healthy bodies and healthy lives (RS)*

The nature of most chiropractic work, since it operates largely outside of mainstream healthcare is such that private practice is the norm. This appears to be considered a plus for most clinicians, who choose to construct this discursively as both a personal privilege and also an advantage that brings tangible clinical benefits:

> *I'm just so grateful to be in a profession where we get to know our patients over time, I'd hate to be working for somebody else or in a hospital or some anonymous place like that where it's 'whose next on the patient list' you know, they're in one minute and you never see them again. Some of my patients I've known now for 15 years, and now I'm getting to see their kids too... it's a nice feeling (RS)*

A common criticism or question with regards to the 'true' efficacy of CAM is that treatment sessions with CAM practitioners tend to be quite lengthy as compared to the typical biomedical encounter. It appears from these interviews that chiropractors agree that they are indeed fortunate to be able to determine/set the length of time that

they spend with patients, since as private practitioners they are essentially in charge of their own schedules.

> *The other thing is that its really important to me to be able to spend time with the patient, fully investigate what's going on with their body, find out what's been happening since I saw them last and suchlike. I feel bad for the medics sometimes, I'm sure there's a lot more that they could give to their patients but I read somewhere that their average consultation time is around 5 minutes or something like that? I mean, there's not much you can achieve in 5 minutes, is there. (NT)*

The hands-on aspect was another feature in the construction of chiropractic as 'nice' work:

> *Most of all, I like the hands-on aspect of my business, knowing that I'm helping people feel better and perform better. I like the fact that I can see obvious results in my work. I get to work on such a wide variety of people – from athletes to kids and seniors. In many cases its people who have suffered an injury and we're working together to get them back to the level of health they had before – if not even better. (RS)*

This theme with regards to variety of care and being able to work across a broad range of conditions was another common feature of 'nice' work:

> *I talk to patients about a wide variety of things including nutrition, exercise and posture. (MW)*

> *I think a lot of people don't understand how educated we are. We are trained to be primary care physicians and we take care of a wide array of physical ailments – not just sore backs. We can diagnose most ailments – and we often refer people to other types of medical care if it's something we can't treat. (SH)*

Collaboration/commonality

A perhaps more explicit and even more unexpected example of how the chiropractors use the medical discourse to legitimate their practice becomes apparent when they speak now not of differences, but rather of collaboration:

> ...I have had some excellent referrals from GP's...and they're definitely listening to us and you see patients coming back with the tests being completed. (VR)

> Well, it certainly helps to build bridges with the medical community. In fact as part of their training our students are required to write regular letters to their patients local GPs, informing them of what they are doing and what they recommending in terms of a treatment plan. They also write follow-up letters to let the GP know when they are making good progress with a patient (or indeed if there is no more they can do for them). Some GP's can be quite hostile initially, but often we find that once they have seen for themselves the success we can have with some of their most difficult, chronic patients, they start to come round. (SH)

In this last extract of text, an educationalist is demonstrating how important she believes fostering inter-disciplinary communication is to the future progress of the chiropractic profession. Several of the accounts suggest that chiropractors do not practice in a sphere separate and distinct from biomedicine; nor do they wish to. On the contrary, many of them believe that a positive relationship with the medical community is vital for the good of both chiropractic as a profession and also for patients, whom may benefit from a truly inter-disciplinary approach to their conditions. Here, a discourse of collaboration is being used to establish chiropractors as similar or equal to medical doctors; certainly as a valid part of the management 'team'. Ironically though, by placing themselves within a dialogue of co-operation, the chiropractors are using rhetoric to achieve status and validation in a way which in turn validates the politically and epistemologically controversial positioning of biomedicine as the 'gold standard'.

Discursive strategies of commonality (I): Evidence-based practice

The success of the 'evidence-based' medicine rhetoric throughout contemporary Western health care in recent times has not been confined to biomedicine. Indeed it seems that CAM professions have also embraced wholeheartedly this concept and incorporated it into their professional lexicon. The extent to which the concept of evidence-based practice has penetrated the chiropractic consciousness seems comprehensive, for almost without exception, the participants in this study made reference to it in some form or another.

Evidence based medicine is a relatively new catchphrase within modern healthcare but one which has captured the popular support of the majority of stakeholders, including clinicians, researchers and patients. The concept was initially derived from the work of Archie Cochrane, who successfully argued that randomised clinical trials (RCTs) represented the highest level of validity. His interest in the rationalisation of healthcare was largely to do with cost-containment, and the Cochrane Collaboration that was set up in 1993 was vested with the task of establishing a database resource that would enable doctors to increase the amount of time spent with patients, by making available to them a means of efficiently evaluating research to support to shape their clinical decision-making.

The Cochrane database thus was established, containing a collection of publications deemed scientifically credible – i.e. that which met their internally devised set of specific criteria, namely that the research be based on the RCT design. These stringent criteria thus exclude a considerable proportion of research which has been conducted using alternative research designs. Whilst this strategy is at first glance appealing with its stated objective of maximising patient outcomes, several authors have voiced concerns over the narrow and arguably exclusionary research selection criteria (Little, 2003; Michelson, 2004). Essentially the evidence-based practice concept works to establish the supremacy of the double-blind, randomized controlled clinical trial over studies of lesser objective status such as cohort, observational, descriptive, or the anecdotal. However as I have argued elsewhere in this study, objectivity itself is highly problematic, particularly within the arenas of health and

77

illness, both uniquely subjective individual experiences. And by privileging the objective, the subjective experience of illness is demoted or even denied altogether.

The evidence-based model has also been criticised for elevating a reductionist form of research that arguably produces one-dimensional, superficial information. Whilst such an approach may be useful for specific problems, such as evaluating the effectiveness of a particular drug therapy, it is hardly going to be sufficient for approaching complex matters such as chronic pain or multi-factorial illness conditions.

Promoting one way of knowing as the 'gold standard' leads inevitably to the findings of such studies becoming treated as 'truths'. That is, evidence based outcomes come to be viewed as the truth, and other forms of knowledge come to be questioned, if not dismissed outright. To borrow a term from Foucault, evidence based medicine represents a *regime of truth* – and institutionalised and regimented version of the truth, which seeks to legitimate and serve a political position of power and authority. This is problematic, as a regime of truth represents the converse of a culture of learning, where multiple ways of knowing are encouraged and instead promulgates a position of hegemony, such that many potentially important forms of knowledge are marginalised.

The identification of political agendas within institutional practices alerts us to another misconception about empirical data, namely that it can be objective. Certainly the quest for knowledge may be desirous to reveal 'Truth', however 'facts' are never independent of their context and therefore the best we may hope to produce from them are 'truths', or received wisdom. Knowledge is constructed within specific historical contexts and reflective of power relationships that are in turn shaped by politics, location, and time. The assumption that empirical data is absolute and unaffected by context is therefore fundamentally flawed and should be challenged.

The assumption that truths derived from the analysis of empirical date are irrefutable and absolute is conceptually flawed, as is the belief that facts are somehow objective. The context in which 'facts' are produced, the audience they are being produced for, and the agendas of those producing them invariably influence their construction. Thus what comes to be accepted as truth is more accurately the current received wisdom, which is shaped and influenced by historical and power relationships and cannot stand apart from these contexts.

The extent to which the movement for evidence-based practice has taken hold within chiropractic can be seen from a glance at some of the professional 'talk'. Here is an exemplary quote, taken from the home page of the most recognised association for chiropractic research, the Foundation for Chiropractic Education and Research (FCER, April; 2007):

> There has been much talk lately about the growing movement towards evidence-based practices in all of healthcare. The need for chiropractors to develop evidence-based practices is becoming an urgent matter. It is a movement that FCER embraces and recognizes as a need for the chiropractic profession to be able to compete in the future. The urgency for evidence-based care does not stop at the individual clinician, but must also flow from the colleges, the researchers, and the various associations and allied organizations within chiropractic.

Certainly evidence-based practice came across in this study as a strong theme, with a largely positive rhetorical tone which arguably conveys a somewhat uncritical acceptance of the concept:

a criticism the profession has now in terms of we're becoming too medical or too physiotherapy orientated but if we're going to participate in healthcare we have to adopt these as methods and its evidence based. (DJ)

These days chiropractic philosophy is not such a major thing, well, it is at some of the universities, especially the American ones like Life and Sherman but here at Glamorgan we try to take a more scientific, an evidence-based approach. (AK)

Here the commitment to an evidence-based approach is used to distinguish between sub-groups of chiropractors (straights vs. mixers), with the implication being conveyed that the evidence-based chiropractors are more advanced, and more credible/scientific.

However whilst evidence based medicine was for the most part in the interviews used discursively to denote a positive professional issue, reservations were also audible:

> *I don't think limiting it (chiropractic) to formal boundaries is a good idea because I'm convinced that we're all looking at tips of icebergs here in terms of the efficacy of chiropractic because the standing of what chiropractic does and how it achieves that isn't fully complete and until such time as that occurs to actually put boundaries on it is a little dangerous (MW)*

> *I think what we need is the scope to be able to use whatever conservative methods we can to treat a broad range of conditions, whilst we wait for the research to catch up with us. I mean, there is a huge amount of anecdotal evidence for the efficacy of types of treatment that has yet to be subjected to randomised clinical trials. If we restrict ourselves to just what has already been studied like that then we wouldn't be able to treat anything except low back pain! And you only have to work in chiropractic to know that there is so much more than we can do than that. (NT)*

Discursive strategies of commonality (II): Reference to scientific credibility (peer-reviewed journals, collaborative research, PhD's)

It appears that chiropractic is in time-honoured fashion using the same strategies that biomedicine has so successfully adopted, namely aligning the discipline with that of objectivist, positivist science in an attempt to gain credibility and acceptance within the broader social and political community. Until recently, chiropractic has not benefited from the same research tradition/culture that biomedicine has, (i) because it does not share political and commercial interests with the powerful pharmaceutical industry that sprung up alongside biomedicine (ii) because of its 'outsider' status – for example, chiropractic has only recently become a part of the university system,

operating its own educational colleges and clinics and (iii) because of these
conditions, there exist relatively few paid positions in chiropractic education and
research – with a resultant majority of chiropractors working in private practice to
support themselves.

However in recent times as part of the professionalisation process these conditions are
beginning to change. In the UK there is now at least one chiropractic degree course
that is offered within the mainstream university system (University of Glamorgan,
BSc in Applied Sciences (Chiropractic), and chiropractic is similarly offered within a
mainstream academic context in Australia (RMIT University). International research
foundations are increasing in size and scope (for example the now well-established
Foundation for Chiropractic Research and Education – FCER) and there appears to be
an increasing awareness within the chiropractic educational community of the value
in participating in the peer-reviewed journal system. Where once rare, the dual
qualified 'D.C./PhD' is becoming more common, and there now exist scholarships
and support systems in place for individuals wishing to take the academic career path
where once there were none.

<u>Positioning of the chiropractor as an expert/the extension of the medical discourse to
apply to complementary practitioners.</u>

Biomedicine is often-times constructed as a 'neutral' science based on a biological
discourse and representing a de-socialised, de-politicised, 'factual' understanding of
health and healing. However this construction can in itself be viewed as simply the
latest in a long line of powerful cultural discourses. As Foucault points out in early in
The Birth of the Clinic:

> The years preceding and immediately following the Revolution saw the birth
> of two great myths with opposing themes and polarities: the myth of a
> nationalised medical profession, organised like a clergy, and invested, at the
> level of man's bodily health, with powers similar to those exercised by clergy
> over men's souls; and the myth of a total disappearance of disease in an
> untroubled, dispassionate society restored to its original state of health.
> (Foucault, 1973: 31-32)

A central idea within this myth is that of the doctor as a special kind of sage, imbued
with a wisdom and expertise that enabled them to see past the surface into the truth of
things. The 'clinical gaze' of which doctors were possessed, could penetrate illusion

and see through to the underlying reality, hidden and therefore unknowable to the layperson. This clinical gaze became a glorified and exaggerated power that enabled the physician to tell patients the source of pain and disease, and how to fix it. This was further fostered by the invention and development of new diagnostic tests and signs.

Chiropractic, whilst on the one hand constructing itself as holistic versus mechanistic, also benefits from the continued belief in this dominant discourse. Thus in de-constructing chiropractic discursive practices we may find the use of the biomedical discourse as a resource to uphold the legitimacy of the expert clinician, in this case, the chiropractor:

> *I think I'm quite...I kind of tell them (patients) what to do in a sense. Like you come in and I'd say right, I've done this, these tests and this is what is going on. Then I would say, I've observed these things and I'd tell them, if I do this, this and this then I should expect results by then so you need to listen to me and do these things...and I can't do my job unless you listen to that and do what I tell you...I don't want to promote dependence at all so like the parent-child thing I don't think is very appropriate, but in order to do my job I have to tell them what's going on because they won't know everything they need to know otherwise. (VR)*

> *...chiropractors are experts, specialists in the diagnosis and treatment of musculo-skeletal disorders and conditions. We have a thorough and up to date knowledge of how the body works, and make use of specialised diagnostic and treatment techniques which have been developed and honed over years. We cannot and should not aspire to curing cancer, but do hope to take an evidence-based approach to the conservative care of (neuro)musculoskeletal conditions and to continue to assist patients in ways which they (medical doctors) cannot, or do not, do. (SH)*

In both of these excerpts we see the chiropractor positioned as expert, and in possession of a unique knowledge of mysterious and difficult conditions.

Thus the discursive practices of chiropractors can be seen to be both complex and contradictory; at once promulgating a separate and distinct professional identity and simultaneously upholding the underlying assumptions and beliefs of the biomedical discourse.

Reduction of the clinical role to the biomechanical/exclusion of psychosocial aspects from chiropractor's clinical remit by reference to the biomedical framework.

One consequence of the Cartesian mind-body dualism that shaped the development of the mechanistic biomedical paradigm in the 19th century was a necessary division of the biological from the social, psychological and cultural. Whilst in recent times this paradigm has been officially usurped by the promotion within educational institutions of the 'biopsychosocial model' of health, many doctors (both biomedical and other) nonetheless appear to retain a strong allegiance to, or affinity for, working strictly in the biological realm.

Few doctors, it seems, will deny the existence of psychosocial, socioeconomic or cultural components to a patient's experience of pain or illness:

> *"You've got people coming through here that have got abusive partners, four or five children, unemployed, heavy smokers. I don't see how they can survive, economically. They are under a lot of stress, all that type of thing..."*
> *(MY)*

and later in the same interview:

> *"(in private practice)...dealing with more marital breakdowns and so on and the stress related to that may be giving rise to more head pain, neck pain and those types of things, you definitely see that...very complex..." (MY)*

In this excerpt we hear a senior clinical tutor and author of several textbooks on chiropractic manipulation technique assert that:

> *30% of people who come with back pain are depressed, you know, chronic back pain and there are issues as soon as you look at the case history form, the person in unemployed or they are divorced or there are other health*

issues...in the clinic at the university, it's a little bit different (than in private

practice) because its attracting a whole different cohort of patients and a lot

of people come in and you can tell that there are some psychosocial issues

and depressive issues and the medications they are on are anti-depressants, or

for pain and emotional control. (DJ)

However, although all the interviewees acknowledged the presence of psychosocial
or cultural factors, they were also quick to assert that this was not an area that they
were felt competent or equipped to deal with. Invariably the chiropractors reverted at
this stage in the interviews to a reductionist approach with respect to the diagnosis
and management of these psychosocial aspects, using discourses that constructed the
possibility that these elements of a patient's experience could be separated from the
physical realm by suggesting that they were best left to the experts (i.e. psychologists)
to deal with. One comments:

there are always the ones where you know there are bigger problems going on

that you aren't necessarily the person to deal with ...so in fact, although I

don't have a psychologist or psychotherapist in my clinic, I have good

relationships with several around Sheffield and refer quite frequently. (MW)

I think you need to be aware of their problems, you definitely need to be

aware of their stressors, how that is affecting their whole life, especially

neuromuscular system but then, say they're very stressed in a relationship or

something, to now get intimately involved and actually advise, well I wouldn't

advise them on what they should do and I don't think that's my job. (VR)

And in the next paragraph:

I think you need to be aware of them holistically and know which parts of

them is yours and then once you have considered that whole other section of

them is beyond your remit, you can send them off to someone else. (VR)

Again, ironically it is exactly on the grounds of this type of reductionism, this
mechanistic approach to health and illness whereby the biological is conceptualised
as being divisible from the psychosocial, that complementary practitioners have often

criticised biomedicine. As the complementary disciplines continue to progress however through a process of professionalisation, we may expect to see further alignment between the two paradigms, as non-biomedical practitioners seek to gain deeper credibility via the limitation and specialisation of their claimed areas of expertise.

Resistance/acceptance to biomedical hegemony

Whilst most chiropractors would appear to accept that biomedicine has its place, the majority of those involved in this study were also at pains to point out that they do not believe chiropractors should be restricted in their clinical remit:

> *Chiropractors treat the whole person not just conditions, so there are lots, all kinds of different problems we can help. Chiropractic treatment is aimed at releasing strains and stresses that have often accumulated in the body over many years, thus improving mobility and the circulation to all parts of the body. The result is often an improvement in many different aspects of health. (RS)*

Discussion

Chiropractors make use of complex and often contradictory rhetorical strategies in order to survive and prosper in that treacherous domain that exists at the boundary of two competing worlds. At times they distance themselves from biomedicine, highlighting theoretical differences in a manner which reifies the polarity which is professed to exist between the two disciplines. Yet at other times they draw upon and make use of dominant biomedical discourses both linguistically (e.g. using medical terminology), epistemologically (e.g. renewed emphasis on 'evidence-based practice') and practically (e.g. wearing white coats) as a means of legitimating their work and constructing a valid occupational identity.

Recent works have argued for an understanding of identity that allows for the construction of a 'self we live by' (Gubrium and Holstein, 1997; Holstein and Gubrium, 2000). The modern chiropractor must construct an identity that allows for successful work at a time when the boundaries between the two discourses,

previously conceptualised as being distinct and competing, can be seen to be converging and interacting with each other. Chiropractors can thus be seen as agentic subjects, who reflect on and substantiate their work principally through the dominant medical discourse, but also with reference to their own chiropractic discursive constructs, in a manner which is relational, complex and contradictory.

The noted recourse to the biomedical framework may also be conceptualised as a last-ditch survival tactic in the face of medical hegemony ("if you can't beat 'em, join 'em"). Against the backdrop of a highly professionalized, tightly regulated and widely accepted biomedical establishment, it can be argued that chiropractic has had little choice but to blur the distinctions between the two disciplines in order to survive at all. However, the texts examined here show little or no evidence of a reluctant co-option into mainstream healthcare; rather we hear the rhetoric of professionalisation being uncritically incorporated into contemporary chiropractic theory and practice.

In this chapter, I have drawn upon accounts provided by chiropractors to show how they alternately make use of biomedical and complementary discourses to legitimate their work and construct professional identity. On the one hand their discursive work is performed in a way that reifies the opposition of these two health paradigms, yet on the other the biomedical discourse is drawn upon to give authority and credibility to their work and assist in the construction of a professional identity that works within the current social and political climate.

I have highlighted several strategies used by the interviewees to construct a legitimising discourse of chiropractic. Strategies of contrast and delineation, collaboration and commonality have been discussed whereby accounts are constructed to position chiropractors rhetorically as professional equals within the modern health care sphere. Biomedical discourse has been seen to be utilised as a way of communicating the daily work of chiropractors such that their work is legitimated, yet constructs a professional identity separate from biomedicine.

CHAPTER FOUR

The construction of patient behaviours as 'normal vs. 'abnormal'

Introduction

In this chapter I will describe how the commonly accepted clinical concept of
Abnormal Illness Behaviour (AIB) is constructed around a cluster of binary
oppositions such that patient's behaviour is viewed as *either* legitimate (functional) *or*
as illegitimate (dysfunctional). The rhetorical strategies used to construct these
oppositions and the different discursive consequences of these oppositions will be
discussed. First I will attempt to locate AIB and chronic pain in its broader cultural
context and discuss the theoretical and analytic framework I have used. From here I
will move on to look at the discursive strategies used by clinicians to structure
patient's behaviour dualistically, and discuss the different effects of that discursive
work.

I will argue that, whilst it is not a formal 'diagnosis' as such, AIB exists as a clinical
concept that has been constructed in a process similar to that which underlies the
development of psychiatric categories, where the assumption is often made that by
observing something and naming it, a material and objective entity exists (Mirowsky
and Ross, 1989). The process by which this occurs and the linguistic and cultural
conditions under which this is made possible will also be explored.

Theoretical and methodological framework

As is the case throughout this work, I have approached this part of the study using a
conceptual framework that is largely informed by a social constructivist perspective,
using a discursive analytic methodology interested in how certain accounts are
constructed, and the consequences of those constructions. I am also interested in
looking at broader institutional and interpersonal 'work' that may be achieved by
those processes. As such, I will be examining the texts provided here by interviewees
to see how those texts may serve to construct objects and subjects in particular ways,

and how differential power relations work to afford particular types of discourses. I will argue that AIB is clustered around key oppositions such as: normal/pathological, self/other, mind/body and moral/immoral in ways that serve to accomplish important institutional and personal work, and that these processes are in turn linked to power. The argument I will develop is that constructing someone as 'abnormal' ultimately serves as a kind of 'get out' clause for clinicians in the sense that the patients behaviour comes to be viewed as anomalous and therefore beyond the remit/responsibilities of usual clinical practice. The constitution of someone as having AIB also serves to remove legitimacy from any complaints that the patient might voice. I will not be analysing definitions of AIB in great depth as the intention here is not to provide an essentialist proposition of what AIB really 'is' but rather to examine how subjects are constructed as exhibiting AIB through language. AIB is a 'taken for granted' category that is widely used by both biomedical and CAM practitioners assumed to be based on the application of explicit and observable objective criteria. In this analysis I seek to challenge those assumptions and ask instead, how is it that a person's behaviour comes to be labelled as 'abnormal'? What reasons do clinicians give for arriving at that 'diagnosis'? How are certain behaviours marked out as anomalous or inappropriate? What moral positions are asserted by this process? And finally, what are the consequences of these processes for both clinicians and patients?

Clinics as social arenas

Perhaps a useful way of approaching this part of the study is to remember that clinics are social arenas, rather than sites of objective mechanical transactions. As a social arena, the key elements are the people who work and manage the clinic, and the people who attend them. In this chapter I consider the process of communication through which people use prior knowledge and experience when interpreting events, conversations and experiences in the social arena of the health clinic. Such an approach provides a useful heuristic lens through which we might examine the ways in which people choose to attend to specific information, and the meanings they construct associated with that process.

This approach draws generally on socio-linguistic theory and the Whorfian notion in particular, which suggests that the language we use has a relationship to that person's culture, thought, behaviour and world-view/influences how we see the world around us (Chandler, 1995). In this part of the research I will argue that the co-constitutive nature of language makes possible different interpretations of illness experiences that are in turn representative of different ways of being in and understanding the world. These notions are presented in the plural to reflect the multiplicity of possibilities that this process represents, and in the present tense as this similarly indicates the temporal and flexible nature of this process, which is always open to change at any time. That is I am interested in the interactional process that is understood to occur between people to co-create particular social realities for particular reasons, within a specific historical-cultural context.

Thus the clinical encounter serves as an entry point for the analysis of how differently situated individuals within the same multifaceted culture interact in ways to learn, refine, reinforce or transform their own personal and cultural understandings. In the following chapters then I will explore the biomedical, chiropractic and lay ways of constructing pain and illness and consider what effect these might have for both patients and practitioners.

First though I must make explicit the central propositions that underlie such an approach. The first is that the different meanings people construct can be usefully apprehended using a process of discursive analysis whereby talk represents a appropriate entry point for psychological research. This proposition has been addressed by other researchers who have developed the use of discursive methods in psychology and argued for more research in this vein (Edwards and Potter, 1992; Potter and Wetherall, 1987; Yardley, 1997). The second assumption within this approach is that speech acts as such have no static or inherent meaning, in that they do not represent a direct and accurate reflection of underlying cognitive or affective states but rather an active and dynamic interactional process whereby multiple meanings are constructed. The objective then is not to reveal the truth, but reveal the many truths that are constituted through discourse.

Finally this approach holds that groups of people with shared experiences and knowledges and who exhibit patterned ways of interpreting information and events are members of interpretive communities (Fish, 1980), or alternatively as discourse communities (Little, Jordens, and Sayers, 2003). Discourse communities may be loosely defined then as groups of people who share common ideologies and ways of talking about and interpreting things. According to this perspective, the existence of patterned interpretations of events and meanings shared by biomedical doctors and chiropractors potentially stem from the shared cultural referents that these various groups bring to the clinical encounter, i.e. whilst theoretically there are unlimited numbers of individuals creating unlimited meanings, practical observation suggests this is not so. Rather, sociologists and anthropologists have found various collectivities and commonalities between individuals belonging to certain groups/similar social contexts and cultures. That is, individuals with similar complexes of prior experience and knowledge often exhibit patterned and shared interpretations and constructions of meaning. This is a central tenet within the study of people as social beings, articulated by one social theorist as such:

> In order to function in the world, people cannot treat each new person, object or event as unique and separate. The only way we can make sense of the world is to see the connections between things, and between present things and things we have experienced before or heard about. These vital connections are learned as we grow up and live in a given culture. (Tannen, 1979: 137)

Thus people who share common prior experience and knowledge of given subjects may be thought of as belonging to an interpretive community (Fish, 1980). Interpretive communities (such as medical doctors, CAM practitioners) are underpinned by shared ideology, which may be defined as 'an interlocking set of ideas and doctrines that form the distinctive perspective of a social group' (Waitzkin, 1989: 221). Essentially, they share culture, or 'interpretative repertoires', which may be understood simply as knowledge about the world (Potter and Wetherall, 1987). This shapes the ways in which they see the world – thus they share not only an awareness of certain facts or objects, but also 'ways of understanding the world, making inferences, and predictions' (Duranti, 1997: 27). As such, knowledge does not just refer to the facts held in an individual's mind, but in the 'tools a person uses, in the environment that allows for certain solutions to become possible, in the joint

activity of several minds and bodies aiming at the same goal, in the institutions that regulate individuals' functions and their interactions' (Duranti, 1997: 31). Different complexes of knowledge, or discourses, thus may account for the different endpoints that biomedical and CAM practitioners come to when encountering the same individual in a clinical context. Anatomically, physiologically, neurologically they are looking at the same thing. But they are bringing to that interaction different ways of seeing, and interpreting the information that they are confronting. If the individual's pain or illness is a mystery, or a puzzle to be solved, and the clinician is the detective (a commonly held metaphor in the healing professions), they are presented with the same clues, but left to fill in the blanks – with explanations that are consistent with their ideology of the interpretive community to which they belong. Individuals are not therefore isolated creators of meaning, but create meaning within the context of interpretive communities, making use of a wide variety of complex and sometimes contradictory discursive practices.

Whilst both the biomedical and lay[8] concept of the body tend to be that of a physical object in a state of health, illness, or disease, social theorists understand the body, health, illness and disease to be sociocultural products (Ettorre, 1998). Social research from many disciplines (notably sociological, anthropological, psychological, literary criticism, feminist theory) have succeeded in demonstrating the social, historical and political origins of medical knowledge, and that biomedicine is not an objective body of knowledge that exists independently of culture. A substantial literature has now succeeded in challenging both theoretically and empirically the biomedical assumption that knowledge can simply be passed on, unchanged, from medical experts to laypeople in the linear and unidirectional fashion characteristic of that model, with its attendant hierarchical and paternalistic tendencies. Such challenges, which reveal the partial and subjective nature of medical knowledge are particularly relevant as so much of the power in the biomedical discourse is derived from the cultural acceptance that it is based on natural truths (Good et al, 1992).

Social constructivist approaches on the other hand, hypothesise that our understandings of the body are influenced by cultural knowledge and experience, and therefore all forms of medical knowledge are socially co-constituted. They note that structures or guides (discourses) for the creation of meaning work to filter and shape

all aspects of the communicative process, from what information is presented, and how, to the reception of that information and its subsequent interpretation. One of the strengths of deconstructivist/discourse analysis is its ability to re-examine the boundaries of categories that are normally take-for-granted as self-evident. One of the weaknesses is that the accounts being examined may only be partial, being only what the speaker is able or willing to articulate. Partiality and subjectivity characterise most social research though in this postmodern age. Bourdieu has argued that this partiality must be addressed. He begins with the understanding that "subjects are not in possession of the meaning of the whole of their behaviour as immediate conscious data" (Bourdieu, 1991: 130). Therefore, he believes, "their actions always encompass more meanings than they know or wish" (Bourdieu, 1991: 131). The theory and method necessary to understand our complex subjects must therefore, involve a way to look at the "externalization of interiority and the internalisation of exteriority" (Bourdieu, 1991: 131). He proposes the notion of habitus as one way of apprehending these complexities. Habitus refers to subjects' accumulated unconsciousness, which are formed by the small perceptions of everyday life, together with the repeated and reinforcing sanctions of an individual's particular universe (Bourdieu, 1991). Whilst his work tends to focus on socio-economic class as the determining factor in the habitus that an individual acquires, arguably this concept is applicable in other ways also e.g. membership of a particular interpretive community.

Other authors have also brought attention to the various ways in which people might interpret the same communicative utterance (Eco, 1979). From this perspective, texts are open messages, the meanings of which are yet to be determined: "the reader as an active principal of interpretation is a part of the picture of the generative process of the text" (Eco, 1979: 4). Eco's theory of intertextuality is integral to the study of meaning as it brings to bear the importance of discursive frameworks and ideologies in the construction of personal and cultural meanings. Used as an analytical lens such a perspective enables the researcher to make connections between actors/creators of accounts and their socio-historical contexts and referents; it also allows (by way of its flexibility with regards to matters of reception and interpretation) for analysis of the ways in which language may be used to construct positions, social realities and achieve specific interactional business.

The discursive construction of Abnormal Illness Behaviour

The problem of abnormal illness behaviour (AIB) is one area in which the self would seem to be particularly relevant. As defined by Mechanic (1962), illness behaviour refers to the way that symptoms are perceived, evaluated, and acted upon by the patient. They are "observable and potentially measurable actions and conduct which express and communicate the individual's own perception of disturbed health" (Mechanic, 1962: 66). Therefore, illness behaviour is neither normal nor abnormal. On the other hand, some illness behaviours appear to be less appropriate, or less adaptive, than others (Pilowsky & Spence, 1975). For example, even after having symptoms explained and a course of treatment suggested, the individual may remain highly concerned about the state of his or her health, may become annoyed at other people's reactions to his or her illness, or even envy those who are healthier. Or, the individual can retain a strong conviction that he or she is ill, even though the findings of physical examinations, laboratory tests, and exploratory surgeries are negative.

Pilowsky thus developed the term 'abnormal illness behaviour' to describe the excessive concern with somatic symptoms and inappropriate treatment seeking observed in patients who apparently are motivated by the fear of disease or by the potential rewards of the sick role (Pilowsky, 1969, 1993, 1994). Patients with abnormal illness behaviour (AIB) are those seen to display behaviour disproportionate to the medical assessment of their objective pathology. Patients with chronic pain are reported to show more frequent abnormal illness behaviour (Pilowsky & Spence, 1975; Colgan et al, 1988). Abnormal illness behaviour is therefore defined as a maladaptive mode of perceiving, evaluating and acting in relation to one's own health (Pilowsky, 1993). Through this theoretical lens, such behaviour is considered a form of somatization and may reflect a close relationship between functional somatic symptoms and psychological distress.

However it is arguable that the very concept of AIB is based on an illness ideology that promotes false dichotomies between normal and abnormal behaviours that locate the problem within the person rather than in the person's interactions with the environment and encounters with socio-cultural values and institutions. This ideology consists not of a set of facts but a set of socially constructed assumptions. Socio-

cultural background may have a significant impact on utilization of medical services and illness behaviour; and such behaviour may differ between cultures and countries. Culture may have a significant impact on beliefs about disease and health, attitudes toward parts of the body, and the value and stigma attached to medical and psychiatric care, which in turn could foster the expression of certain bodily complaints and discourage others.

Deconstructing Abnormal Illness Behaviour

> Not probing or challenging the categories, divisions, and objects that we
> encounter... but rather treating them as 'givens' of the world, is to participate in
> a political act that helps affirm current formulations by never examining how
> they became current and whose interests they serve. (Sampson, 1993: 1223)

In this section I will aim to develop a deconstruction of the concept of Abnormal Illness Behaviour, drawing on the notion of implicit oppositions and using ideas from discursive psychology to aid a fuller understanding of the discourse surrounding AIB. This analysis is deconstructive in the sense that it does not assume that an entity called 'abnormal illness behaviour' exists, rather it seeks to understand how that concept has come about.

First, what do we mean by deconstruction? Parker & Shotter (1990) have noted that there are several different ways in which the term may be applied. For example, it may be used in the Derridian sense to uncover hidden meanings within texts; alternatively the term may be applied to Foucauldian style analyses concerning the historical genealogy of institutional practices. Finally, it may be used to refer to the giving of a voice to the 'other' that is silenced or marginalised within a dominant discourse. Deconstruction is particularly difficult to define as it refers to a process or practice versus a fixed concept based on abstract 'facts'. However it may be understood as a systematic attempt to examine the underlying beliefs that underpin concepts or ideas which are held to be 'natural', 'true' or 'self-evident'. Derrida argued that the task of deconstruction was to take apart those concepts which serve as axioms or rules for a period of thought and to demonstrate how concepts are

94

inextricably linked to historical, political, cultural and linguistic discourses. Thus we 'deconstruct' our taken-for-granted 'truths' by examining how they came to be constructed in the first place:

> A deconstructive analysis cannot therefore purport to arrive at a single, correct understanding of a phenomenon, but instead seeks to question apparent meanings and accepted interpretations and suggest alternative, and perhaps complementary, insights. (Yardley & Beech, 1998: 315)

Abnormal Illness Behaviour can be understood to be constructed around implicit dualities or binary oppositions such as self/society, mind/body and normal/abnormal. Before we attempt to examine the concept of AIB then perhaps it would be wise to further develop these concepts of dualism and opposition to show how the 'abnormal' discourse itself is constructed in two main ways: (i) by being understood as either an individualistic or societal phenomenon; and (ii) as either a legitimate/valid patient or illegitimate malingerer. The rhetorical strategies used to construct these understandings and the different discursive effects of these practices should be considered; however in order to do so the wider cultural context within which AIB as a clinical construct has emerged must be examined.

In this chapter then, I will seek to examine the underlying conditions of possibility that may have contributed to the construction of the concept of AIB. I will then go on to describe how the discourse surrounding AIB is structured dualistically, and examine the rhetorical strategies used to construct and uphold the binary oppositions evident in that discourse. Finally, I will attempt to articulate a positive deconstruction by considering ways in which the boundaries between these oppositions may be dissolved, transforming the subjugated (and dominant) terms.

Oppositional constructs or dualisms permeate Western thinking. Whilst I have already addressed the origins of one profound dualism (mind/body) there are many others relevant to our understanding of bodies, including, but not limited to; male/female, culture/nature, reason/emotion, objective/subjective, self/society. Not only do these linguistically constituted binaries convey inter-related constructs, they exclude other possibilities and tend to privilege one side at the expense of the other (Derrida, 1973). That is to say, hierarchies may be detected within oppositions such

as reason over emotion, male over female, individual over social, even quantitative over qualitative. One way to overcome such oppositions is to attempt to deconstruct them by asking questions that might serve to locate and take apart those concepts. A deconstructivist approach invites a sceptical stance towards the essentialist and hierarchical nature of taken for granted knowledge and instead seeks to question the assumptions which underlie such beliefs.

One important opposition discernable throughout the discourse of AIB is that of normal/pathological. A second, equally important dualism that can be detected is that of mind/body, which has been explored already to some extent earlier in this work. Finally, the opposition concerning self/society should be considered with respect to the construction of understandings such as Abnormal Illness Behaviour. In the remainder of this chapter I will attempt to deconstruct these oppositions and argue that illness behaviour can be read as either 'normal' or 'abnormal' depending on the subject positions that are made available to the patient, and that this process is in turn linked to power.

With its stated focus on 'language in use', discourse analysis places some considerable emphasis on the ways in which discourse is constitutive, that is, the ways in which utterances are in fact, social actions that are 'reality-making'. Discourse is about the production of knowledge through language; knowledge, in turn is inextricably linked to power:

> There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations (Foucault, 1977:27)

That is, specific discourses afford rights to speak and be heard e.g. the medical discourse allows those aligned with that framework to speak as an expert on matters of health, whilst simultaneously precluding alternative ('lay') perspectives. An interesting observation with regards to the construct of 'AIB' is that it is an identity given to an Other as opposed to one chosen for oneself. Constructing someone as exhibiting AIB has a number of effects, including the successful displacement of responsibility away from the primary practitioner. Referring to a person as displaying

AIB enables the practitioner to accept diminished responsibility for their improvement in the sense that their behaviour is regarded as anomalous and inexplicable by 'normal' medical parameters. It also serves to delegitimize the person in a global manner such that their voice becomes irrelevant. Discourse analysis, with its emphasis on the dynamic, fluid nature of language, also allows however for the negotiation of power within that discourse, that is to say it is recognised that participants may challenge the others moral, political or social authority. That is, whilst discursive practices may constrain meaning, it is possible for individuals to resist or refuse any particular discourse.

Implicitly, accounts of AIB are structured by dualism insofar as the behaviour itself is understood in terms of the opposition normal/pathological. The category of AIB itself is assumed to be 'true', a phenomenon which requires explanation however it is equally possible that the behaviour to which it refers can be read in alternative ways, depending on the goals and motivations of the participants, which are in turn influenced by issues of power and identity.

Construction of il/legitimate patients: Rhetorical strategies used in accomplishing in/credibility

How is it then that certain behaviours come to be viewed as legitimate whilst others are not? Judgements about behaviour can be understood as inherently social, insofar as they are made by people in particular social and historical contexts imbued with cultural rules and norms. These rules are of course not separate from the influences of institutional power, and the observer of behaviours in a professional (medical) setting has the power to evaluate the said behaviour and decide upon its legitimacy. This is well understood in the field of psychiatry, where critical appraisals of the diagnostic process have revealed considerable variability and subjectivity (Szasz, 1970). In this study I have been concerned with the rhetorical strategies used by participants to establish themselves or others as either credible or incredible, legitimate or illegitimate and it is to these that I turn my attention now.

A common discursive strategy for defining a behaviour or statement as incredible or implausible is to place it within a broader consensual view of what is or isn't considered true, real or possible. One way to achieve this is to ask others to support

97

or corroborate one's judgement. Thus, the 'abnormality' of another's behaviour is decided by considering the extent to which others agree that it is abnormal. Although this is epistemologically flawed, the potential dangers of this 'diagnosis by consensus' approach here are seen to be overlooked and minimised as the objective here is to confirm and uphold a colleagues' position.

Related to this strategy is the use of a form of 'rhetorical insurance' (Harper, 1996) whereby the clinician defends against an anticipated criticism that they might be overzealous in making psychological judgements. In other words, it is important for clinicians to be seen to be open-minded and having faith in the truth of what their patients are telling them with regard to description of symptoms, pain etc. This may be achieved discursively via the use of statements that convey the speaker to be non-judgemental and fair. By stating that one began in 'good faith', one is protected against any potential objections or complaints.

> *That's why I got into this really, to be able to help people who were hurting or who couldn't do what they should be able to because of trauma or whatever.*
> *(AK)*

This approach is in turn dependent upon a shared assumption between the speaker and audience that there is some kind of understood boundary of normality that we can all agree on that people positioned as exhibiting AIB have somehow crossed.

> *To me abnormal pain behaviour is something that doesn't really correspond with the story that the patient is telling me, either about how the injury happened and the symptoms, or otherwise when the pain is just off the scale compared to what normally people would say. Or if they say that the pain is everywhere, or that it never goes away or whatever. (VR)*

The assumption of commonly agreed parameters of 'normality' is also made apparent via the popular use by clinicians of the concept of 'yellow flags'.

> *...at the uni clinic you know the cost of care is subsidised and so you are seeing a different type of patient and they can be quite hard. You can see all the yellow flags and they have multiple bruises, or they're depressed or*

they're skittish or anxious and not sleeping, just not happy or well, y'know?
And its such an uphill battle for them, to get well because its not just a case of
needing an adjustment, there is just so much that is wrong in a sense with
their lives (MY)

'It's a bit suspect...'

Another common strategy relates to the likelihood of certain claims or statements being true. For example the likelihood of pain being 'always a ten' would be questioned against a backdrop of shared professional agreement that pain is likely to be variable in consistency and intensity.

You can use your experience to say, well this person sitting across from me
they have got a 9 out of 10 on the pain scale yet they look completely
comfortable and it's a bit suspect, you know, I know that person has
exaggerated for whatever reason. Whether they have a distorted central
processing problem or they're malingering or there is some other issue going
on so that becomes the focus because I'm no longer worried about the pain
anymore because that's not the issue, the issue is how they're coping with
that, or not coping with that consciously or unconsciously. Then I can
determine if that's a conscious effort then I know that there is some gain or
there is some other motive. (DB)

A final way in which a patient may be illegitimised is through the use of simple assertion. Several extracts from clinician interviews revealed the use of straightforward statements that are made in an authoritative and unproblematic manner to achieve consensus without debate. The ability to make such assertions is clearly linked to power, insofar as they tend to be made from the point of view of what Edwards and Potter (1992) refer to as a sense of 'category entitlement'. That is, the veracity of a claim is made on the basis that certain people in certain positions know certain things, or have a claim on certain types of knowledge. A chiropractor therefore, may be considered to know more about 'normal' range of motion, neurophysiological processes or musculoskeletal pain than an ordinary person. Having established ownership over a certain area of expertise/knowledge, that person

can then make simple assertions about, for example whether or not something is likely or 'logical'.

> *So if they started, 'I'm really sore' and just from the things you asked them, you haven't touched them yet or anything, from the things they're saying it sounds like something you've seen in patients with the same sort of thing, you roughly know how sore that kind of thing can get. Then if like, they can't even turn their head at all to a side that would then sort of get you thinking a bit. You may think well I've seen people before with this and they can turn their head or like you touch them and literally, or even before you touch them they are really wincing you know... So you know, you can already have an idea if the person is, and there are malingering tests you can do things like you move a toe or whatever and they crick their neck and there is no logical reason why or physical reason why doing that would aggravate something else. (VR)*

This last extract also demonstrates another popular rhetorical strategy, that is, reverting to the ground upon which they feel most qualified/entitled (neurophysiological pathways and processes) in order to make statements about the normality or otherwise of a patients behaviour. These strategies are often used alongside the introduction of powerful anecdotes, or extreme case examples (Edwards and Potter, 1992) which can be used to further illustrate or give credence to that which the clinician is seeking to assert.

Awareness of the limits of 'AIB' as a descriptive category

Some of the interviewees showed a high level of reflexivity with regard to the validity of the concept of AIB:

Interviewer   *So, what about 'abnormal pain behaviour' – is this something that you encounter very often in your clinic?*

Respondent   *Well, that depends on how you define abnormal pain behaviour! I personally think that a lot of patients get given that label by exactly the sort of practitioner that I was just talking about.*

Interviewer   *How do you mean?*

Respondent *Well, abnormal pain behaviour is usually used to describe someone*
      who is either not responding to treatment, or who describes pain that
      doesn't correspond anatomically with what the doctor expects but both
      of these things could actually be the consequence of the doctor's lack
      of ability to comprehend another explanation for the pain in the first
      place. (DH)

Cultural assumptions about effort and personal responsibility

A cultural discourse regarding matters of health promotion, advice and advocacy has become clearly discernible in recent times. Concomitant with changes in perception about the causes of disease were revisions regarding who was ultimately responsible for health and wellbeing. Thus when supernatural explanations of illness and disease reigned supreme, spiritual or religious experts/healers (priests, faith healers, shaman) were regarded as providers of the best chance of healing (laying on of hands, blessing, penance etc). During the Enlightenment period and throughout the modernity project, the causes of disease were seen to lie within the body as a deficient machine – and thus experts in handling that machine (i.e. medical doctors) became elevated in both their status and responsibility for health. However as psychological explanations for health and wellbeing began again to be considered as important contributing or causal factors during the latter stages of the 20th century, an interesting shift appears to have developed whereby the individual is located as the source of both the disease genesis, via poor self-management, and also as having the ultimate responsibility for healing, through making 'appropriate' choices regarding care of the self. Although many social theorists have resisted this discourse by emphasising the impact of social and cultural factors such as socio-economic status, race, environmental hazards, and urbanisation on people's health, the rhetoric of personal carelessness and poor lifestyle choices has remained a powerful force. The persistence of this discursive theme may be attributable at least in part to the impact of broader Western cultural and political values regarding individual rights and responsibilities. It might also be a consequence of political expedience, insofar as it fiscally benefits government health policymakers to blame individuals for their own health or illness[9].

Whilst the early part of the 20th century emphasised collectivist and institutional origins with regards to questions of illness (and therefore achieved better health through large-scale public health reform measures) these explanations have gradually given way to those which point the finger not at structural causes but at agentic 'choices' and behaviours (Leichter, 2003). Where once concerns with dangerous and unhygenic working conditions, long hours and low wages contributing to poverty constituted a driving force behind public health policy reforms throughout the industrialised world, the focus now is not so much on the social and political landscape as on the individual's behaviour within that framework. Negative individualistic and personal characteristics such as 'carelessness', 'ignorance', 'laziness' and 'reckless behaviour' have now it seems taken center stage in the ongoing debate about the etiology of disease and/or illness. The control and near-elimination of infectious disease and the subsequent rise in the relative importance of chronic and 'lifestyle' diseases such as heart disease, liver conditions, lung cancers etc have also undoubtedly been important factors in the shift in discursive emphasis. The idea that irresponsible or avoidable lifestyle 'choices' are the main cause of the nation's ailments has become both widespread and profoundly impactful; audible throughout the texts of many Western opinion-makers and authorities.

Whilst certainly there remain public health advocates for whom environmental, socioeconomic and cultural causes of illness continue to feature as central factors, the belief that the majority of ill health is attributable to poor health choices has dominated recent health talk. Considerable empirical evidence has been constructed linking lifestyle and disease (even though many such studies remain more correlative than causal), with the result that this standpoint has become virtually unassailable. The numerous legislative policy changes and moralistic state-funded media campaigns (e.g. the introduction of mandatory seatbelts, banning the use of mobile phones whilst driving, banning smoking in public places, safe sex campaigns, responsible drinking campaigns etc) is evidence of the powerful hold that this discourse is currently enjoying. Of course as with all discourses, it does not go unchallenged, and so it is that a subtle undertone of backlash can now be discerned. Broadly speaking though, it seems that the rhetoric of personal responsibility is firmly embedded in our cultural discourse regarding matters of health.

However the rhetoric of personal responsibility for health rests upon the assumption that people have the ability to make free and informed decisions. This in turn suggests implicitly that people are responsible only for those actions which they undertake freely and in full possession of relevant information. Conversely then, those actions which are involuntary through either coercion or ignorance should be absolved of responsibility. Free will, it seems, is dependent upon influencing factors that are outside of an individual's direct control – such as their personal circumstances (e.g. socioeconomic status, race, gender, occupation, education) and also the broader social, political and environmental conditions that surround them. Thus, it is argued, some are more 'free' than others. The link between poverty and poor health has been long understood; in 1842 Edwin Chadwick published his 'General Report on the Sanitary Conditions of the Labouring Population of Great Britain':

> The various forms of epidemic, endemic, and other disease caused, or aggravated, or propagated chiefly amongst the labouring classes by atmospheric impurities produced by decomposing animal and vegetable substances, by damp and filth, and close and overcrowded dwellings prevail amongst the population in every part of the kingdom, whether dwelling in separate houses, in rural villages, in small towns, in the larger towns — as they have been found to prevail in the lowest districts of the metropolis. (Chadwick, 1842: 369)

Other more recent surveys of public health have indicated that widespread health inequalities continue to persist (DHSS, 1980). A variety of social factors can be seen to contribute to these observed differences in health chances, including but not limited to: the ability to afford and purchase quality food, access to leisure, engagement in riskier work, access/exposure to health-related knowledge and so on. Thus structural factors, not personal, can be seen to limit the ability of individuals to make health-enhancing choices.

Discussion

In this section, I have illustrated some of the rhetorical strategies used by CAM practitioners to construct certain behaviours as reasonable or legitimate against others which are constructed as illegitimate. The ways in which this is achieved have been examined and it has been argued that the construction of AIB is a flexible, subjective

and discursively negotiated act rather than a statement referring to a judgement made against simple, objective criteria.

I have argued that, whilst it does not exist as a formal diagnostic category, AIB exists as a clinical concept that has been constructed in a process similar to that which underlies the development of psychiatric categories, where the assumption is often made that by observing something and naming it, a material and objective entity exists (Mirowsky and Ross, 1989). AIB has been seen in these accounts to be constructed in a subjective, circular process that serves to reify the concept in a manner akin to that noted in analyses of psychiatric disorders such that articulated by Stoppard in consideration of depression:

> ...reification of the disorder is supported by a process of circular reasoning which begins by considering individual's experiences in isolation from other aspects of their lives. These detached experiences are then reconceptualized as 'symptoms' of an underlying (and unobservable) disorder, one that can be detected only by means of the very experiences on which the initial diagnosis was based. (Stoppard, 1997: 22)

The process by which this occurs, and the linguistic and cultural conditions under which this is made possible, have also been examined. Judgements about behaviour being 'abnormal' have been shown to be not solely based on the observation of discrete, objective criteria but also on a wide range of non-rational factors: assumptions about gender, socio-economic status, education, intelligence, employment status and so on. Thus behaviours are often interpreted according to social and moral norms on the basis of 'common-sense' and taken-for-granted cultural assumptions rather than on the basis of a systematic evaluation of empirical data. However, these statements are often presented as detached clinical judgements. The presence of these non-specific influences suggests that it is possible for clinicians to view people exhibiting the same behaviours but with different personal characteristics in very different ways. Thus the same behaviour might be seen as 'normal' i.e. legitimate/valid for one person of a certain social status but abnormal for someone with a different social status. This is relevant insofar as it suggests that some patients may be afforded a greater degree of trust, resulting in some being taken more seriously than others. As Ingleby points out:

> The more charitably inclined we are to someone, the more likely we will be to
> see their actions as 'making sense'; in this way, judgements about
> intelligibility are inextricably linked to moral attitudes (Ingleby, 1982: 133)

From the data gathered and presented here, it seems likely that at least some of the time CAM practitioners draw rhetorically on cultural notions that are held to be self-evident and which may serve to help clinicians to achieve specific personal or professional objectives.

In this chapter then, I have sought to examine some of the cultural assumptions and narrative expectations about chronic pain patient behaviour and have revealed some of the underlying dualisms that pervade clinicians' appraisals of patients. In doing so I have argued that rationality is not the sole determining factor in judging behaviour as 'abnormal'. Abnormal Illness Behaviour (AIB) has been deconstructed to reveal a cluster of underlying conceptual oppositions that contribute to patient's behaviour being viewed as *either* legitimate (functional) *or* as illegitimate (dysfunctional). Some of the rhetorical strategies used to construct these oppositions have been examined and the different discursive consequences of these practices considered.

CHAPTER FIVE

The discursive construction of professional intervention and efficacy

Introduction

In these passages, the complex and subtle discursive work performed by practitioners to uphold their status as experts in spinal health care, even in instances where the patient does not necessarily respond well to treatment are examined. This analysis looks in detail at how practitioners make sense of non-improvement or poor clinical outcomes as a result of factors external to their clinical expertise and at the effects of these discursive practices. It is informed by the established discursive approach which seeks to consider psychological phenomena as situated discursive accomplishments (Edwards and Potter, 1992). According to this perspective, communicative acts are not understood to reveal underlying cognitive constructs, but rather it is interesting to look at ways in which the accounts themselves are constructed and what social/psychological functions they achieve. Specifically, this analysis concerns itself with the discursive practices employed by practitioners to overcome ideological dilemmas concerning accountability and responsibility within the healing encounter. These tensions can in turn be understood as part of the broader debate concerning the problematic nature of 'expertise' within contemporary Western culture (Bishop & Yardley, 2004). Whilst the biomedical model has traditionally employed paternalistic discourses to position doctors as experts, with a concomitant privilege or authority over non-expert patients, this model has increasingly lost power with the rise of more patient-centred models of care emphasising values such as autonomy, independence, and control. The construction of some as 'experts' is ideologically troublesome within democratic or egalitarian societies, conflicting with commonly held values or ideals concerning individualism, equality and personal autonomy. The context of health problems allows to some degree for these egalitarian values to be temporarily lifted, in that seeking professional help is generally viewed to be responsible or morally correct behaviour. However although this concession of power is to some extent socially sanctioned it does not negate the inherent conflicts that patients and practitioners experience in trying to reconcile oppositional values (passive versus active). At the other end of the spectrum is the

consumerist model of health care, which constructs patients as active agents negotiating care within a broad range of options (including the use of CAM).

However, consumerism in health care can be seen in itself to be problematic, insofar as it assumes patients to be rational actors, neglecting the subjective, embodied and often emotional nature of their experiences (Lupton, 1997). Under this model which emphasises patient rights and capacity for autonomy, the notion of the patient as a calm, rational subject unaffected by emotions is privileged as the ideal and set up in opposition to the 'passive', dependent patient as understood to be typical with the paternalistic model of health care. It seems likely that this representation of an active, calculating self gains strength from its compliance with prevailing cultural values in Western societies that privilege rationality over emotionality, and self-sufficiency over dependency. Such an individual would be expected to critically assess health care options available and be capable of countering or challenging 'expert' wisdom when necessary. However, the healing encounter is a complex, dynamic and subjective event that occurs within an ever-changing interpersonal context replete with tensions and uncertainty. As Lupton points out:

> The privileged representation of the patient as the reflexive, autonomous consumer simply fails to recognize the often unconscious, unarticulated dependence that patients may have on doctors. (Lupton, 1997: 380)

Approaches to understanding the health encounter must therefore acknowledge these subtleties. Certainly the data here suggests that both patients and practitioners can be seen to position self and other in both the 'active' and 'passive' positions depending on the situation and commensurate with the rhetorical outcomes that are trying to be accomplished.

Furthermore it must be considered that in re-positioning patients as active agents, accountability is also shifted toward the patient, resulting in an increased burden of responsibility (Salmon and Hall, 2003). The dilemma for health professionals with regard to the complex problem of constructing oneself as an expert within a society that values democratic or egalitarian ideals has been previously commented on (Billig, Condor, Edwards, Gane, Middleton and Radley, 1988). For complementary and alternative health care practitioners, the balance between patient autonomy and

doctor expertise is perhaps even more delicate, insofar as it must also allow for an epistemological framework that emphasises neither party as ultimately responsible for the return to health, but rather positions the body itself as healer (vis medicatrix naturae). Complementary and alternative practitioners are thus continually required to work discursively to overcome the inherent tensions that come from these ideological clashes concerning expert vs. novice, active vs. passive positions within the healing encounter.

Discourse, treatment and the body

The meanings of treatment regimes, like theories of causation and diagnosis (whether biomedical or complementary) are contested and they demarcate certain subjectivities. The solutions offered to treat chronic pain convey certain assumptions about the nature of pain and communicate a particular view of the body. As discussed earlier in this work, despite the presence of non-biomedical rhetoric throughout CAM, there is considerable overlap in the two discourses with respect to treatment and the body.

Thus throughout these interviews, a discursive theme emerged that was essentially empiricist, objectifying and positivist, whereby pain conditions were viewed as stemming from biomechanical causes within individuals that could be objectively identified and treated independently of social or interpersonal variables. In this work, I am interested to explore how this discourse is constructed and what effects that may have on patients. In order to do so I need to address questions such as: how are treatment regimes used as a discursive resource by doctors to explain events such as clinical outcomes? What kind of accounts are drawn on to explain the effects of certain treatments? What rhetorical strategies or devices are being used and for what purposes?

Once again I have approached this part of the study using a social constructivist conceptual framework, using a discursive analytic methodology that focuses on how certain accounts are constructed, and the consequences of those constructions. An emphasis will be placed upon the institutional and interpersonal objectives that may be accomplished by those discursive processes, and I will be interested to see how

discourses may serve to construct objects and subjects in particular ways, and how power differentials work to afford particular types of discourses. In the following extracts it will be seen that interviewees drew upon a broad range of rhetorical devices to construct many different accounts with regards to treatment and clinical outcomes. The aim in this chapter then will be to outline and briefly describe some of the discursive resources available to speakers within talk about treatment, and what effects they have in terms of the objects and subjects that those resources make available. This will hopefully allow for a reflective analysis surrounding the discursive construction of professional efficacy – although obviously it will not comprehensively cover all the possible perspectives that could emerge around that topic.

Subluxations and toggles: the use of professional jargon and other rhetorical strategies in the therapeutic encounter.

One rhetorical strategy which has been noted in the professionalisation projects of many disciplines is the construction of specific abilities, skills or knowledge as special and unique to members of that group. One way to achieve this is to encode practices in obscure ways, using language or names that have little or no meaning to outsiders of the group. Examples of this in biomedicine are legion, but our interest here is to examine ways in which non-biomedical health professionals similarly use discursive resources to construct professional identity. In the introduction chapter I introduced one example of disciplinary dialect peculiar to chiropractic, the subluxation. Other examples of using obscure or mysterious jargon also appeared regularly throughout the interviews – here one interviewee is talking about the development of his practice techniques over time:

> *I did the basic and the intermediate SOT and I did the basic when I*
> *was in the 4th year at the ACC so I was looking at going more that*
> *way...because the people that I went to work for practised very similar to that,*
> *mostly diversified. They didn't particularly encourage going to into the AK,*
> *SOT aspects of it. I integrated the SOT into the way that I practice but still on*
> *a more mechanical rather than the type of organ side with regards to SOT or*
> *the cranial side...(MY)*

Here a variety of different techniques with indecipherable names that have discipline-specific meaning are mentioned in a casual manner, with the rhetorical effect of constructing chiropractors as being in possession of knowledge of a variety of complicated, diverse and mysterious practices.

Such discursive practices have also been noted in other studies concerning the struggle for chiropractic to maintain its professional identity and autonomy against a backdrop of biomedical hegemony. For example, Dew (2000) notes how the New Zealand Chiropractic Association, in its battle to achieve inclusion within the mainstream health care system in 1978, used 'impenetrable jargon' to help distinguish what they do from others by arguing that chiropractors possess a breadth and depth of knowledge and skill beyond mere manipulation:

> Where is the doctor of medicine or physiotherapist who, when confronted
> with a lumbar intervertebral disc syndrome and contemplating making a
> Chiropractic adjustment in treatment, can evaluate the comparative worths of
> the Cox chiro-manis technique, the sacro-occipital technique, the Gonstead
> disc technique, and the Reinart technique, and proceed accordingly? (NZCA1:
> CIC, in Dew 2000)

Dew notes that the success of the chiropractors in this campaign was in part thanks to their use of rhetorical strategies which served to highlight the esoteric nature of chiropractic, whereby expertise is based on a notion of philosophical understanding rather than the simple mechanics of spinal manipulation. This strategy has been articulated previously by Jamous and Peloille (1970) who argued that invoking a high indeterminacy/technicality ratio can serve to reinforce professional boundaries. Thus where a discipline can successfully argue for both a high level of technical skill (science) and a high level of indeterminate, almost arcane knowledge, it is protected from being reduced to an easily reproducible set of routine techniques. By making use of discipline-specific concepts such as subluxation, which is admitted by chiropractors to be hard to define and imprecise, the esoteric nature of their work is reified, protecting the discipline from interlopers. The following extract evidences this process:

110

Interviewer	*I think I have an idea what subluxation is but as a psychologist I'm not a chiropractor, what would you...*
Practitioner	*I don't know what it is either*
Interviewer	*Yes, that's the problem isn't it.*
Practitioner	*Its something's never been identified, it's a term the professionals use and developed to indicate some form of spinal dysfunction that has many components to it and it was one of those sorts of conditions that tend to bring ill health to people and people can be asymptomatic and have subluxations and so it has a difficulty in trying to understand logically that how does something you haven't identified be so critical in terms of peoples health, overall health and the chiropractor is the only one who can actually identify them. (DJ)*

And in this interesting passage below, one clinician even makes direct reference to this mysterious nature of chiropractic as a defining reason why he became interested in studying and joining the profession:

> *Chiropractic sounded much more interesting and a little bit more risqué about chiropractic than physiotherapy...Osteopathy was a quite strong contender here for a period of time. Definitely osteopathy before I found this stuff on chiropractic. I think it was more interesting because it was more difficult to find stuff on chiropractic therefore it made it a little more intriguing as well and the type of buck that was out there about the nervous system and the innate and the body healing itself so it just sounded more interesting, more exciting. (MY)*

Of course, biomedicine also makes regular use of the same indeterminacy/ technicality ratio to defend its occupational boundaries, provide protection over its area of work and maintain its status and prestige. In fact the jostling for position within the system of health care professions can be viewed as an ongoing discursive struggle, whereby claims are put forward to support a particular worldview using competitive discourses (Potter, 1996). Potter notes the particular use of two types of discourse in this process: reifying (where something abstract is articulated as material

or as an object) and ironising (where statements of 'fact' are questioned in an attempt to return them to their previous status as mere concepts or points of view).

The taking of x-rays by chiropractors, another technical tool or skill, is a matter of controversy between the biomedical and chiropractic communities. A widely debated issue; the arguments for and against provide a useful example of how rhetoric can be used to achieve moralistic and political agendas. That is, social and medical practices interact in ways that are both reinforcing and directive. In the case of using x-ray, the presumed rationalism and objectivity of the medium itself serves to reinforce the desired position of the clinician as an objective expert. X-rays are also typically viewed by both lay and expert people as a means of capturing an accurate image/representation of underlying structures. However arguably, x-ray, like all photography, can in fact be highly selective and subjective, refracting rather than reflecting an object according to the subject position/perspective of the person taking them. Rather than representing an objective reflection of some underlying 'reality', it is more likely that subjective interpretation plays an important role in the reading of x-rays; indeed it has been suggested that x-rays may fulfil a mostly symbolic function within clinical encounters (Radley, 1994).

Chiropractic education incorporates a substantial amount of radiology, radiography, and the majority of chiropractors regularly take and develop their own x-rays of patients in-house (Pederson, 1994). This has been criticised by other health professionals, who claim that this is irresponsible and unethical on two grounds: (i) chiropractors are not certified radiologists or radiographers and (ii) x-ray in itself is health-damaging and so the use should be limited (Ernst, 1998). Further complicating matters is the financial benefit to chiropractors in taking their own x-rays – an additional revenue stream that they would otherwise forgo. However chiropractic has successfully defended its use of x-rays by employing the rhetoric of patient safety. Importantly, chiropractors have modified their original justification for the taking of x-rays, claiming now that x-rays are no longer taken for the purpose of identifying subluxations (which are no longer defined anatomically) but rather for the purpose of screening for contra-indications to chiropractic treatment. By highlighting the importance of screening for disease conditions, chiropractic has achieved important professional work by employing a rhetoric that enables them not only to justify a

certain aspect of their work as being in the patients' best interest (thereby successfully defending, indeed reinforcing a contested occupational boundary) but also enables them to negatively position their competitors (physiotherapists, osteopaths, medical practitioners) who do not always take x-rays before embarking on manipulative treatment programmes.

<u>Treatment plans and preventive/'wellness care' rhetoric</u>

> *You've got a belief that you can help prevent reoccurrences occurring. I do believe that that's something that chiropractic trains to be preventative but then it sort of depends how you practice (MY)*

There has been a notable rise in both the professional and lay literature recently with reference to 'wellness' care, or preventative health care. Preventative dentistry, for example, is now quite fashionable. Certainly there was reference to this type of care during my interviews with chiropractors:

> *Of course it would be nice to practise more wellness care! And I try in my private practice to encourage people to look after themselves with regular chiropractic care so as to prevent really acute situations from happening but realistically most people aren't going to come and see you when they are feeling fine, they're going to be calling you on the weekend when they've cricked their neck and can barely move and are absolutely desperate! (AK) An ideal patient would be somebody that is committed to some type of preventative care and realises their part in that preventative care. (MY)*

However it seems clear that the move towards 'wellness care' is not uncontested. Indeed it has been at the centre of political debates concerning patient dependency, and the ethical/moral issue regarding taking money from patients in the absence of a problem has also been raised. Alternatively referred to as 'maintenance' care, this concept brings with it the implication that the patient should continue to receive the treatment, ad infinitum, in order to prevent recurrence of symptoms or the onset of new symptoms. Of course this challenges the traditional view of treating problems symptomatically via a relatively short and fixed course of treatments. The change in mindset can be morally challenging for some:

113

I know quite a few dentists and doctors now are moving away from (symptomatic care) and going into preventative and I'm just wondering what their ethos is behind their preventative care. What are they really looking for out of preventative care...and I'm just thinking is that what we all want to do, just go for an easy life, people come in without any real problems. (MY)

Talk about preventative or wellness care is an interesting aspect of clinician discourses, as it provides an opportunity to consider how objectivities and subjectivities may be constructed, and the effects that these processes may have on the healing encounter. The extracts presented here suggest that chiropractors often construct the service they provide as essential to maintaining well-being, or preventing dis-ease. One effect of such accounts is that they position regular chiropractic treatment as necessary for health, thereby providing a rationale for the continued use of chiropractic even when people are 'well'. The ethical dilemmas posed by such a position (taking up people's time and money, perhaps unnecessarily, promoting dependence etc.) are neutralised in such accounts by reference back to a rhetoric of the patient's best interests, e.g. regular visits can assist in the early detection of problems; prevention of bigger problems later on.

Drugs don't work

A strong discursive theme within chiropractic (and indeed many of the non-allopathic health disciplines) is that medication cannot 'work' as it only suppresses symptoms rather than addressing the underlying causes of disease/illness. Furthermore, CAM approaches alternatively are discursively constructed by proponents such that interventions can be considered relatively harmless:

Yes, that's the whole point behind what we do, to promote conservative care and avoid unnecessary use of drugs or surgery, which are so dangerous. Every surgery carries risk, so we aim to reduce the risk to patients by helping them to avoid such extreme measures. I mean, that's not to say that allopathic medicine doesn't have its place...(GT)

114

This last extract also shows the related discursive theme that medication does not constitute treatment or therapy as such, but rather is a temporary adjunct that at best should represent a small part of a more comprehensive treatment plan.

> *Not that drugs don't have their place, I just personally don't like them unless it's really necessary, and generally speaking I think medical doctors tend to over-prescribe. I mean, that's the mainstay of their practice isn't it. (SH)*

It would be expected in narratives from CAM practitioners to hear a consistent discursive theme that communicates a lack of faith in medication. Ideologically CAM likes to situate itself oppositionally from that of allopathic medicine and so typically biochemical interventions tend to be represented in less than enthusiastic terms. Chemical pain interventions are often seen as somewhat superficial, crude attempts to mask pain rather than solutions that address the true ('deeper') causes of pain or discomfort. As practitioners of 'natural' medicine, it is perhaps unsurprising to find a consistent anti-drug sentiment whereby drugs are dismissed as not only ineffective, but also dangerous both in terms of possible unintended effects and also insofar as they may encourage a false sense of security for patients that their problems are being solved, potentially leading to a situation whereby patients worsen their conditions by mistakenly thinking they are better due to the quietening down of pain symptomatology.

> *Its like with Cortisone, you know? Athletes hurt themselves and then they are so keen to get back to training, or they have that big comp or whatever so they have their doctor or physio shoot them full of Cortisone. So they feel better, hit the track or whatever and next thing they've really done themselves in. It's just so dangerous...(RS)*

Some practitioners offer an anti-drug account that introduces the notion of patient agency. Here, medication is seen as a way of reinforcing the passive, dependent patient role whereby patients are construed as deficient machinery that requires fixing rather than being able to take an active, participatory role in the recovery process. That is, it is suggested that by offering 'solutions' that are outside of or external to

patients, agency is granted to symptoms which become phenomena unmanageable by natural means. This is seen as both disempowering and unsustainable long-term.

> *You see these chronic patients, and they've become totally dependent on their meds. It's such and such for their pain, and Prozac for their depression and something else for the nausea that they're no doubt getting from all the drugs, and you just think, is this even sensible? How can this be right? (NT)*

Drugs mask pain/pain is your friend

> *The thing people don't understand is that pain is not necessarily a bad thing...you know yes its unpleasant and limiting and so on, but that's for a reason. It's your body telling you that something is wrong and that you need to pay attention and do something about it. But the ethos of painkillers is simply 'kill the pain'! Which is fine so far as an immediate, you know, short term approach but its not addressing the real problem. (SH)*

A common assumption within both orthodox and complementary health paradigms is the pain serves a useful biological purpose, namely to function as an indication that 'normal' biological processes are malfunctioning in some way. Pain then, is a symptom of an underlying pathology and not a condition in its own right. This theme came across repeatedly in the practitioner accounts:

> *People just don't seem to get that pain is not the problem it's just a symptom. Its like, if you have a headache. Don't just reach for the Panadol, ask yourself, why do I have this headache? Is it because I am dehydrated? Or have I cricked my neck? Or maybe I didn't get enough sleep last night. Or I drank too much. Or whatever. And then manage it accordingly. You can still take the Panadol, but don't then just carry on and not do whatever else needs doing...go have a sleep, or see a chiropractor, or drink a glass of water – or all three! But listen to your body, its talking to you. (SH)*

Pain as a messenger communicating some underlying dysfunction or pathology is a key concept then within both biomedical and CAM paradigms. Given this, it is not

difficult to see why orthodox biomedicine (based on a disease model) has struggled to cope both theoretically and practically with chronic musculoskeletal pain, which when investigated from an allopathic perspective appears to have no clear or easily discernible biological origin. Chiropractic however, with its original explanatory model for illness focusing on dysfunction of the spine, has not found this to be so troubling. Pain (and ultimately dis-ease) is understood to be likely resultant from a lesion or 'subluxation' of the spine, which whilst invisible to the naked eye can easily be discerned via the use of specialised and finely honed palpation skills. Thus chronic musculoskeletal pain which by definition does not subside 'naturally' constitutes a state of affairs which confounds biomedical notions of disease and health. However when viewed from a chiropractic perspective (lesion causes dis-ease; remove lesion remove the dis-ease) it is entirely consistent that pain will *not* subside until treated appropriately (i.e. structurally manipulated).

Whilst this appears at first to represent a key difference between the two systems of care for chronic musculoskeletal pain, in fact closer examination in the underlying assumptions of both models reveals other important similarities. Both are in fact based on causal explanations for dis-ease relating to a specific, biological etiology, an explanatory model which can easily lead to a reductionistic, mechanistic approach of 'intervention' rather than the patient-centred or holistic health care that both paradigms purport to aspire to.

Iatrogenesis, side-effects and other rhetorical strategies used to challenge biomedical hegemony: Drugs and surgery are dangerous

Closely related to these discursive themes is the message which communicates that drugs, and surgery, (the hallmarks of biomedicine) are dangerous; that they often do more harm than good.

> *You have to think about what's causing the problem and then do something about it, otherwise what's the point? You're just going to succeed in masking the pain, which is great but then dangerous too because then you go back to doing whatever it is you were doing and cause even more damage. (SH)*

117

The construction by natural health practitioners of biomedicine as dangerous is easily achieved against a broader cultural context whereby statistics concerning iatrogenic illness are legion. The understanding that orthodox doctors represent as much of a threat to health as a help gains much support from the now well-established critiques of the iatrogenic aspects of orthodox medicine that date back decades (Illich, 1975). Of course this rhetoric can be and is used as a discursive resource by both CAM and biomedical practitioners, a point which was made on several occasions when defending the safety of chiropractic:

> *And then in the States in particular in the 80's, early 90's there was a lot of negative press about cervical manipulation and stroke but actually those studies were really flawed, the jury is still out in fact about that and anyway, even if it were true, no-one ever mentioned that the incidence of such an occurrence would be something like 1 in every 3 million adjustments – which is one too many but when you compare it to the fact that one in between 5 and 8 patients who goes into hospital comes out with some sort of iatrogenic illness! (GT)*

Patient safety features in contemporary chiropractic discourse, as is evidenced within the following excerpt from the International Chiropractors Association (ICA) website:

> Chiropractic is safe. Records form insurance and court cases have constantly shown that chiropractic is the safest portal of entry health care available to the public today. Although no healthcare procedures are 100% safe, chiropractic stands on its record of safety and effectiveness unmatched in healthcare...
>
> ...The process of chiropractic adjustment is a safe, efficient procedure which is performed nearly one million times every working day in the United States. There is a singular lack of actuarial data that would justify concluding that chiropractic care is in any way harmful or dangerous. Chiropractic care is non-invasive, therefore, the body's response to chiropractic care is far more predictable than its reactions to drug treatments or surgical procedures. Of the nearly one million adjustments given every day in this country, complications are exceedingly rare. Perhaps the best summary statement on the subject of safety was published in 1979 by the Government of New Zealand which established a special commission to study chiropractic. They found:
>
> "The conspicuous lack of evidence that chiropractors cause harm or allow harm to occur through neglect of medical referral can be taken to mean only

118

one thing: that chiropractors have on the whole an impressive safety record."
(ICA, August, 2007)

Of course the rhetoric concerning 'patient safety' and 'protecting the patient' has a
long history, deriving from what is often referred to as the first rule of medicine:
"First, do no harm". Whilst this phrase is popularly believed to constitute part of the
Hippocratic Oath, it is in fact not so. Scholarly opinion is divided as to who did in
fact originate the popular dictum, however there is evidence of the saying within the
broader Hippocratic corpus *(Epidemics,* Bk. I, Sect. XI): "Declare the past, diagnose
the present, foretell the future; practice these acts. As to diseases, make a habit of two
things — to help, or at least to do no harm." The fiduciary responsibility to always
act in the patients best interests is one of the key themes that underpin the culturally
accepted idea of institutional altruism that is expected of health professionals. It is no
surprise then that this should be evident in doctor discourses, whether biomedical,
complementary or alternative:

> *I can't even bear to think about how many hundreds of thousands of*
> *people have ended up having unnecessary surgery because these so-called*
> *experts can't find the problem, and so they recommend 'exploratory surgery'*
> *or whatever. Or surgery to 'clean up the cartilage' or some other bloody*
> *nonsense. It's a bloody disgrace – and then they're calling us dangerous or*
> *whatever, when we're the ones using conservative means – no drugs, no*
> *surgery, just healing by hand! (GT)*

Not only health professionals and academics are conscious of the 'dark side' to
biomedical treatment; patients too exhibit anxiety and consternation about medical
mis-management:

> *My husband died from the side effects of steroids so I'm quite against taking*
> *medication where I can avoid it. (BR)*

> *It took me about 17 years to find out there was something wrong with my*
> *oesophagus because of the medication they gave me when I had the motorbike*
> *crash and then they said it's full of scar tissue and here, take these pills for*
> *the rest of your life. But all the other doctors used to treat me like you're a*

fraud because they used to think I was having a heart attack and stuff like
that. Yeah, which is caused by your oesophagus cramping. So I've had fun at
the doctors, I avoid them usually. (CR)

Explanations of limited success

In managing situations whereby the body fails to respond to physical therapy in a
manner considered appropriate by the healer, a potential discursive strategy for
practitioners may be to default to the current prevailing wisdom as articulated by
those who occupy the position of 'expert' in matters concerning the mind (vs. body).
As such, CAM and biomedical practitioners can be seen to fall back on rationales
provided by psychologists and psychiatrists, who traditionally have tended to explain
such phenomena in cognitivist terms such as attributions or health beliefs, understood
here to be reflective of underlying inner states or mechanisms. According to such
models, where attributions, beliefs or behaviours are deemed to be dysfunctional or
'abnormal', cognitive-behavioural therapeutic interventions may be appropriate in
order to change the way patients think about their condition and its management.
Negative or dysfunctional illness attributions are likely within this framework to be
understood as contributing to poor outcomes.

A discursive approach to illness attributions would alternatively view such
phenomena not as reflective of stable or enduring underlying mechanisms, but rather
as productive strategies that may be employed to manage blame and apportion
responsibility or accountability (Edwards and Potter, 1992; Potter and Wetherall,
1987). Narration of subjective experiences here is conceptualised as being a situated
activity that seeks to accomplish interactive business (Edwards and Potter, 1992;
Gergen, 1994; Gergen and Gergen, 1986). Such an approach does not concern itself
with pre-conceived theoretical agendas but rather is interested to examine how
narratives may be worked to achieve particular discursive outcomes. Thus talk
concerning matters such as injury causation, development and recovery are seen to be
active social productions whereby identities are constructed and defended (Edwards
and Potter, 1992).

The patient has not been compliant with their treatment regime

Compliance increasingly features in the health literature relating to chronic pain patients and appears to have crossed over into the lexicon of both CAM and biomedical practitioners. Broadly speaking, the term tends to be used to refer to a patient's adherence to a treatment programme or prescribed medical/rehabilitation regime. Several studies have indicated that patient non-compliance is widespread, and the serious ramifications of this with regard to public health have been underscored (DiMatteo and DiNicola, 1982). However some authors have pointed out that social psychological theories of compliance are based on particular assumptions that may in fact limit its applicability to the problem of patients who do not respond as desired to prescribed therapeutic regimes (Kotarba and Siedel, 1984). Kotarba and Siedel set their discussion of the concept of compliance against this definition of chronic pain: "an extended experience of embodied discomfort – quite often associated with neuromuscular pathologies – that fails either to heal naturally or to respond to normal medical intervention" (Kotarba and Siedel, 1984: 1393).

Compliance refers to the adherence of a patient to their prescribed treatment regime (Kotarba and Siedel, 1984). Non-compliance has come to be viewed within both the biomedical and complementary health literature as a serious problem. Generally the concept of non-compliance tends to be used somewhat uncritically to refer to a myriad of behaviours and motivations that are assumed to lie with the patient, thereby placing the loci of responsibility for compliance firmly with the patient.

However these social-psychological notions of compliance have been criticised by some authors who note that they are based on several assumptions that limit its validity as an explanatory model for complex behaviour. Kotarba and Siedel, for example, suggest that social control models have more applicability in explaining lack of adherence to treatment regimes. In their work which focused on pain management seminars and pain clinics, they found other, relatively un-theorised factors such as doctor hostility and suspicion towards chronic pain patients to play a role in the construction of patients as being non-compliant. They argue that chronic pain patients (who by definition fail to respond to treatment in ways deemed acceptable to clinicians) are often cognitively framed as "members of a morally

121

stigmatised, deviant population" (Kotarba and Siedel, 1984: 1395). Their observation, within biomedical pain care settings, was that the chronic pain patient was by definition, a problem patient. This results in the focus of attention moving away from the failure of medicine, or the doctor, to provide a solution to a problem by refocusing attention on the patient as problematic, rather than the pain itself.

This view however that the chronic pain patient is by definition, a problem patient is one worth examining more closely within the context of this study. For in chiropractic, certainly it seems as if this in not usually the case. If chiropractors were to position all chronic patients as problem patients, they would have to be characterising the majority of their daily practice that way:

> *typically I would say patients tend to come to us first with a long-standing,*
> *chronic injury because they have had it for so long and have tried everything*
> *else and nothing has really helped. (SH)*

When asked whether he tends to see more chronic or acute patients, this clinician responds:

> *I think on balance predominately chronic and again I get the impression that*
> *it's particularly because at the time of the patient experiencing their problems*
> *for the first time, chiropractic wasn't on their list of options. (MW)*

And when asked about who would be a 'typical' patient, this chiropractor responds:

> *Oh, that's easy. Someone with back or neck pain, someone who has either*
> *been to see a chiropractor before or has tried everything else and nothings*
> *worked. (DH)*

Thus the chronicity itself is taken-for-granted by chiropractors, and what is more is seen as an opportunity rather than an obstacle to be overcome.

> *Often times they are at the end of the line as well, you know, they've tried*
> *everything else and are sick of being in pain! So they're going to listen to*
> *what you say and prob'ly ask some questions, too. (DH)*

122

Here the fact that the patient is presenting after a long period of illness/pain is being constructed as a positive – the clinician is suggesting that this can be a motivating factor for the patient to get well. Furthermore he is framing the propensity of the chronic patient to ask many questions as a positive too – as an indication of patient agency. The theme of challenge = opportunity can be seen to continue later in the same interview:

Interviewer: *And so, who would be a challenging patient for you?*

Practitioner   *They're all challenging! Hahaha. No, I know what you mean. Um, I suppose someone who seems defeated before you already begin. And you get a lot of those, you know, the ones who are there to see you as a last resort, they kind of don't necessarily have high hopes but are willing to try anything. Those ones are my favourites though! Because they might have been to see 100 people but almost for sure they haven't seen a chiropractor – or not a good one anyway, ha! So I know that I can probably do something for them that will help them, usually right then and there on day one there'll be some kind of improvement, whether its pain relief or just improved range of motion, but anyway you look at it, they're better than they were when they came in and so I love that kind of challenge.*

This is a very interesting passage as not only does it communicate the confidence of this particular clinician in his own skill/abilities but cleverly achieves the reification of chiropractic as a expert, skilled art as well. The comments regarding previous treatment history suggest that had the patient seen a good chiropractor, they would probably already be better – sending a clear message of confidence in the discipline as well as the individual clinician in this case.

This positive tone is audible throughout the various clinician accounts, particularly when talking about chronic patients:

123

*Often these are people who have been rejected by everyone else, they have
nowhere else to go. And sometimes even the smallest improvement can mean
the world to them and then they get a bit more hopeful, and then next thing
you know they are back on the path to wellness again. So I try not to focus on
the negatives I suppose, but rather look for something I can do to help, even if
it's not major and go from there. (DH)*

The issue of compliance can be seen in these interviews to be constructed in various,
sometimes contradictory ways. Non-compliance with the clinicians recommended
treatment plan was sometimes constructed negatively, for example as a lack of
understanding, or as a lack of resources, or even as a lack of drive/moral flaw. Also
discernible in these accounts is the understanding of the treatment plan itself as a
discrete entity rather than as something to be negotiated between doctor and patient.
These rhetorical strategies have the discursive effect of constructing non-compliance
as a characteristic of the patient, rather than of the doctor, or of the relationship
between doctor and patient. This in turn has the effect of placing the responsibility
for compliance (and therefore, it is assumed, for the efficacy of the treatment plan) on
patients rather than doctors, or on the relationship between doctors and patients.

Many different reasons are given for why patients might not comply with or complete
their prescribed treatment plan. One common rationale relates to the private payment
status of chiropractic that is, several chiropractors explained that because of the high
cost of chiropractic care, which is often at personal expense being outside of the
mainstream health care system, patients often 'quit' treatment before they are 100%
resolved, especially if they have already seen good results. Another explanation of
failure to complete a course of treatment is put down to a lack of understanding on the
part of the patient, whereby patients are seen to be limited by their cultural
assumption that symptom relief equals problem solved:

*I don't mind demanding patients it's whether they ...I had one recently
actually, and it just seems to be their sort of, or maybe its my
sensitivity to their not understanding what I am trying to do with
them...(DJ)*

Finally, some non-compliance is explained as being due to general laziness or lack of commitment, due sometimes in part thanks to the success of the treatment thus far. One of the interviewees admits to this behaviour pattern himself, achieving strong rhetorical effect:

I wouldn't say I'm the best patient actually. I go in more for, what's the word like putting out fires kind of approach. I don't necessarily follow through the whole plan, so I'm not a good patient. I get to the point of significant improvement and then I'm happy and push off kind of expression. Which is not very good but that's what I do. (VR)

This is a very effective speech act, insofar as it establishes the clinician as open-minded and accepting of patient (person) foibles. At the same time it confirms the assumption that the 'good' patient is the one who does as they are told, and sees the plan through to the point at which the clinician deems it is appropriate conclusion. Finally, it states as a matter of simple assertion the taken-for-granted notion that there will have been some improvement along the way, reinforcing the effectiveness of chiropractic care generally. Chiropractic then can be seen to be discursively constructed as a 'victim of its own success', a very powerful rhetorical device.

A related discursive strategy which was present in some of the transcripts was that where the lack of positive clinical outcome was explained in terms of insufficient chiropractic care. These accounts achieved a very powerful rhetorical effect insofar as they work to reify a particular therapeutic approach – there is no question that the treatment *could* work – simply that it had not been given the proper chance to work. The implication of course is that given enough time, the desired outcome would undoubtedly be achieved; paradoxically, the lack of response to the prescribed treatment is interpreted as further evidence of its applicability. The efficacy of the therapeutic regime goes without saying, and so is reified in this interesting example of discursive work.

Of course, it is noticeable that all of the above rationales for patient non-compliance are constructed as characteristics internal to the patients themselves, which provides a useful explanatory resource in terms of accounting for instances when clinical

outcomes may be less than satisfactory. However, these accounts also provide for other discursive themes to be constructed – for example, the financial aspect of chiropractic care was often taken up as a positive influence on the healing encounter. Most straightforwardly, this was suggested to be a psychologically motivating factor for people to get well:

People generally come to see us as a last resort because they are desperate and they <u>really</u> want to get well. They aren't going to be dipping into their own pockets unless they are really in pain or really want to get better. (GT)

Another more subtle conviction however was also that the high cost of chiropractic care positively selected towards a different class of patient (well-off, better educated).

Practitioner	*You have to remember as well, we are seeing a different type of patient than most GPs or physios.*
Interviewer	*In what sense?*
Practitioner	*Well, not to be too, I don't know, whatever, but it costs a lot of money to come and see a chiropractor. It's not like it's covered by the NHS. And you normally are talking several sessions, a course of treatment, like I tell my patients, it's not a quick fix. So you are working with a pretty motivated bunch of people, and often times they are at the end of the line as well, you know, they've tried everything else and are sick of being in pain! So they're going to listen to what you say and prob'ly ask some questions, too. Plus, a lot of our patients are quite well educated. As well. (DH)*

A related theme that emerged was that the privileged socio-economic status of their private patients means there are fewer 'stressors' inhibiting their progress – for example in this extract, where a clinician talks about 'complex' patients and relates the differences she perceives between the two clinics she works in:

Well, fortunately it doesn't happen all that often and in my private practice I haven't had that sort of experience but at the uni clinic you know the cost of

126

care is subsidised and so you are seeing a different type of patient and they
can be quite hard...that's something that normally as a chiropractor you are
quite protected from, because normally you are seeing quite privileged, well-
off people. Not to say that having money means you don't have problems, not
at all, and you still see issues with alcohol, or unhappiness but at least they
aren't battling everything, they have good houses, good food, probably go to
the gym, don't smoke so much...(AK)

This point is also underscored by another interviewee who comments that if
chiropractic continues along its path of incorporation within the mainstream health
care system, a material difference in the type of patient receiving chiropractic care
will result:

If the profession at some point moves a little bit further into the system
and becomes more part of the system I think then we will be seeing a lot more
of these chronic, unemployed, depressed, abusive types of individuals because
they have back pain and headaches. (DJ)

Doctor-patient communication

Here a clinician locates the reason for poor outcome within the relationship between
doctor and patient.

if people aren't getting along I tend to discharge them. If not, refer them
on or do something like that so there's not that.. so you're not creating
that angst for yourself. We still have a responsibility as a practitioner that
if, the responsibility is to take care of the patient and if you are
not able to take care of them you should refer them on if they're not
making the progress yet you feel there is benefit in what you're going to
do. Personality clash, well not personality clash maybe a communication
clash...(MY)

...in private practice it is more about that patient is not getting better or their
level of improvement hasn't matched their expectations and they are that

personality where you're starting feeling anxious as well. They are getting, maybe, a little bit agitated and what are you gonna do? But quite easily you can refer them off to who ever. (MY)

Again here the personality of the patient is being constructed as problematic for the clinician, and the discursive theme relating to doctor-patient communication is recurring as a dualistic concept. This was noticeable throughout the clinician interviews, whereby if communication was deemed to be insufficient or lacking it was highlighted as a problem; conversely 'good' communication also was often held up as an explanatory factor for positive clinical outcomes:

The ideal patient is an individual that is somebody who you can communicate with, not someone you hit it off with but someone who you are able to communicate with clearly and you can define the barriers and the boundaries, one that listens, one that asks questions about what they can do for themselves...(DJ)

This last passage also works to construct the notion of the good patient being an agentic one. Later on in the same interview we hear that:

Chiropractors, one of the best things they have actually developed is the patient-doctor relationship. That's really one of the key things that they have actually, without even trying have actually developed the manipulation side, the other skills we've learned, even the guys that talk about subluxations they have good doctor-patient relationship. (DJ)

And again...

I think its communication again, it's actually spending time with the patient and I think we have a luxury of spending between 15 and 20 minutes with a patient, whereas the average GP has about 11 minutes per session, that's the national average, so we're about double that in some regards. I think that has helped people to develop those communication skills and the patients respond to that, they like the thoroughness and the approach. (DJ)

Patients also spoke of the difference they perceived between the biomedical and chiropractic encounter:

> Yeah, more the doctors are sort of like, they treat you as a number, it seems to
> be at the moment. It's like yeah yeah, I've seen a thousand of you today you
> know, here's the medication, see you later but with chiropractors they always
> spend a few minutes finding out what the problem is. (WR)

Some people don't like the hands-on – they're a bit sensitive

Spinal manipulative therapy (SMT), which requires the laying on of hands, has
historically been the mainstay of traditional chiropractic treatment. Although in
recent years chiropractors have embraced a great variety of other therapeutic
modalities, many practitioners continue to refer to the 'hands-on' nature of the
discipline as a key factor in the success of chiropractic over time.

That is, it is a common discursive theme within chiropractic that the hands-on aspect
of chiropractic is a positive point of difference between it and allopathic medicine.
When asked what it was that attracted them to chiropractic over other disciplines,
several interviewees responded along such lines:

> and the fact that it was so hands-on, you know, not sitting behind a desk and
> barely interacting with a person and then writing a prescription. I wanted to
> be able to do what he had done for me, you know, palpate, find the problem
> and then actually do something about it, then and there. (AK)

> What else do I like? I think with me the physical part of it and the speed, you
> know the speed. I don't particularly like drugs, you know some people do, but
> no. I think with the 'hands on' element is good definitely. (VR)

In a similar vein, another clinician remembers what aspect of his chiropractic training
he enjoyed the most:

I really enjoyed all the hands-on stuff, you know, palpation, adjusting, that's
what you're there for really (DH)

This has been theorised within the literature as reflective of the epistemological
differences between biomedicine and CAM, whereby in the former bodies are almost
marginalised as a casualty of pathology. Several critics of biomedicine have
suggested that in its rush to identify and treat the pathology, the physically suffering
body is almost ignored, apart from half-hearted attempts to silence it with sensation-
numbing medications. Within a Cartesian framework, the pain of bodies is
marginalised as a mere symptom of pathology rather than a subjective, meaningful
experience. However in chiropractic and other healing traditions where the dominant
theory of dis-ease is structural/biomechanical (i.e. not philosophically based around
germ theory), the core treatments are 'hands'-on, the physical body is central – not
relegated to secondary status. Rather than being perceived as somehow contingent on
experience it is understood instead that there is no experience without the body;
corporeality is central and thus therapeutic interventions that treat it as such are likely
to have a tangible advantage. The centrality also comes across in statements
regarding the vitalistic capacity of the body ('vis medicatrix naturae'), a common
theme or principle within complementary and alternative health disciplines:

I do subscribe to the theory that the power that made the body is the power
that heals the body, you know the Innate, the Universal Intelligence or
whatever you want to call it...(GT)

However, as with most of the rhetorical devices analysed in this work, it seems that
this discursive resource can be utilised in a binary fashion. Thus we may observe that
the hands-on aspect of spinal manipulative therapy can be constructed alternatively as
a problem or obstacle for some patients:

some people are just more sensitive than others and it sometimes, you
can almost feel it in the room that there's they don't like the 'hands on'
which is another thing, they're a bit sensitive to that (DJ)

Quite a few people that basically seem to get on quite well with but don't like personal touch. People who don't like being touched are really quite...you can adjust them but you really can't do any sort of soft tissue work...Quite a few of those people are basically, I don't know really why its just an emotional thing to human touch or that's just me...you come across some people who basically just freeze as soon as you touch them. That's probably some sort of emotion associated with touch. (MY)

When asked how what he would do under these circumstances, the clinician replied:

Well just do less or more of the stuff that is not as touchy feely. Less touchy feely. (MY)

Thus deciding on what is the best type of treatment appears to be a flexible and pragmatic process rather than wholly rational as is often portrayed by clinicians.

The patient has 'psychological overlay'

What happens then, when the patient fails to respond to the prescribed chiropractic treatment? In a manner strikingly similar to that so often observed in biomedicine, the CAM practitioner finds themselves confounded by a result inconsistent with their held theory and must therefore look to factors outside of that theory to explain the anomalous outcome:

"you can tell that there are some psycho-social issues and depressive issues"
(DJ)

Similar patterns of meaning regarding non-biomechanical explanations for lack of improvement emerge later again in the same interview when the participant suggests:

(we have to) identify people who are disabled, you know, have psychological disability and they're unable to cope with their conditions and all they want is reinforcement that they do have a problem and to massage that a bit. What we should be doing is saying no, you need active treatment, you need to get confident, learn better coping strategies. (DJ)

131

In the following extract, this theme is expanded to encompass being able to almost predict outcome, on the basis on psychosocial factors.

> *30% of people who come with back pain are depressed, you know, chronic back pain and there are issues as soon as you look at the case history form, the person is unemployed or you know if they are divorced or there are lots of health issues in their previous health you know that there is another aspect to this individual. Medications, and that tells you a lot about how they are going to respond if they are actually a patient who will respond to your care, whether they will become chronically dependent upon you and all those sorts of things. (DJ)*

The psychological discourse emphasised the intractability and severity of psychosocial and environmental influences which were assumed to complicate the clinical picture and prevent full or timely recovery. Often these discourses can be seen to effectively locate these problems within the person, although this was sometimes expanded to encompass family or environmental influences as well. Also by referring to the various psychosocial factors assumed to be influential over the person's path to recovery those factors are given agency, constructed as something real and 'out there'.

However others were quick to qualify such statements:

> *I do think people have been jumping or patients are not responding because they've got social factors and now they're putting yellow flags in there as well, they're not responding. Whereas I would still sort of say the biological should not be forgot out of the biopsychosocial factors. (MY)*

Rhetorical prophylaxis

In these accounts we have seen how clinicians employ a variety of discursive resources to account for lack of positive clinical outcome. Chiropractors typically communicate great confidence in their ability to effect positive change in their patient's conditions, both structurally and functionally:

I know that I can probably do something for them that will help them, usually right then and there on day one there'll be some kind of improvement, whether its pain relief or just improved range of motion, but anyway you look at it, they're better than they were when they came in. (DH)

It is interesting to examine these accounts though for strategies that will allow the clinician to communicate 100% faith in the treatment plan, and in their personal ability to execute that plan – yet at the same time provide a form of 'rhetorical innoculation' (Sorenson, 1991) against any potential failure to achieve the desired outcome. Thus in this next statement from the same interview, the clinician goes on to say:

Chronic, acute, I don't mind really 'cause I've always got something to offer them. Or most of the time, anyway! Every once in a while someone is too acute to be able to do much with, that's hard, because you want to be able to just get in there and move things around and make it better but you have to be patient and take things slowly whilst the visceral and muscular side of things settles down. (DH)

In this passage his previous statement 'usually right then and there on day one there'll be some kind of improvement' is qualified by adding 'or most of the time, anyway'. This works to protect the clinician from any future challenge regarding the effectiveness of his treatment i.e. should there not be improvement the clinician has already defended against this by virtue of not having made an absolute statement; the possibility of there being exceptions to the rule has already been pointed out. This nicely achieves other discursive work too; by stating that there are exceptions, the efficacy of chiropractic treatment is taken for granted as the rule – this is a good example then of the kind of reifying discourse that Potter (1996) has talked about. Furthermore, the modifying statement goes on to give an explanation of a specific set of conditions that might preclude good outcome 'every once in a while someone is too acute to be able to do much with'. This statement not only provides a rationale for limited outcome but also manages to place the source of this problem in the patient. This effectively removes blame and responsibility from the practitioner, and

133

also from the treatment itself. Rather the blame is located with the condition itself, which then achieves object status as something 'out there' that is beyond the reach of either patient or practitioner.

Another common strategy to achieve rhetorical innoculation is to highlight the presence of individual differences between patients. This is interesting as with the heavy reliance on the discourse of science (anatomy, physiology, biochemistry etc.) there is usually a tendency to consider all human bodies to be the same. Of course, if this were the case, one treatment or technique would always 'work', and yet clinical outcomes vary widely from person to person. This has been noted as a problem in allopathic medicine, where it is widely recognised that individual responses to medication vary considerably, although less is known about the reasons for that variation. Reference to individual differences between patients can also be understood to achieve similar discursive objectives, insofar as it serves to protect the speaker from potential challenges to the position they have taken; it also works to absolve the speaker from responsibility for the final outcome, by focusing on the patient and thereby shifting any potential blame for poor results away from the clinician. The following passage speaks to this:

> *Generally I like to adjust patients – I'm a fairly 'straight' chiropractor I guess you could say. But obviously not everyone will respond the same to same adjustments, so its important to have other tools in your bag, other techniques like soft tissue, or activator, that might work when they're not responding (NT)*

Rhetoric of balance

Another common rhetorical device displayed throughout the interviews with clinicians was the way in which their responses were often presented using what might be termed a rhetoric of balance, that is, their arguments or comments were often made in ways that positioned the speaker as having considered both (all) sides of the argument, before coming to a conclusion (Billig, 1987). This is a particularly effective discursive strategy insofar as it promotes an understanding of the speaker as a rational, balanced person, who has carefully considered all the evidence before

134

reaching a measured and reasoned final position on a matter. However accounts constructed in this way can, despite their liberal appearances, work to support conservative positions. Thus by suggesting that a liberal, fair and considered approach has been taken, the speaker is insured against potential criticisms of one-sidedness, whilst still maintaining ultimately, a standpoint which continues to uphold the status quo. For example:

> *that's the whole point behind what we do, to promote conservative care and avoid unnecessary use of drugs or surgery, which are so dangerous. Every surgery carries risk, so we aim to reduce the risk to patients by helping them to avoid such extreme measures. I mean, that's not to say that allopathic medicine doesn't have its place, there is room within reason to embrace surgery or anti-biotics or even other systems like acupuncture...(DH)*

By showing two sides to the story, the clinician here strengthens his argument by constructing himself as open-minded and fair. In other words a rhetoric of balance is being employed, insofar as comments are being made in ways that position the speaker as having considered all sides of the argument, before coming to a measured and rational (professional) conclusion. This is a particularly effective discursive strategy insofar as it promotes an understanding of the speaker as having carefully considered all the evidence before reaching a final position on a matter. Thus by suggesting that a liberal, fair and considered approach has been taken, the speaker protects themselves in advance of any possible criticisms of one-sidedness.

Similarly, doctors may make use of biopsychosocial discourses of health care, constructing themselves as modern, holistic, and patient-centered before continuing on to make comments that serve to maintain the primacy of physical pathogenesis (and therefore the continuation of physical treatment regimes/interventions).

> *You can see all the yellow flags and they have multiple bruises, or they're depressed or they're skittish or anxious and not sleeping, just not happy or well, y'know? And its such an uphill battle for them, to get well because its not just a case of needing an adjustment, there is just so much that is wrong in a sense with their lives, whether they are unhappy in their relationships, or*

work, or they have other health complications, maybe issues with alcohol or
drugs, they're overweight, or kind of grey, their skin you know because their
diet is poor, and they don't get any exercise or anything. (AK)

Here, physical therapy/chiropractic adjustment is highlighted as the first treatment to be used, thus establishing its primacy. Supporting this statement is the use of an extreme case example that serves to construct them as subjective and pathological/dysfunctional. This has the rhetorical effect of implicitly constructing the clinician as a thoughtful, liberal professional. Another rhetorical device which may be used to defend against challenges is to incorporate the use of qualifying statements such as 'maybe', 'kind of', 'I think', 'assuming', 'possible' etc. By using qualifications ambiguity is introduced, a useful anticipatory defense strategy as any challenge can be overcome by retreating to the safety of not having made an absolute statement in the first place; also it provides the flexibility to move emphasis onto another part of the proposed explanation or hypothesis.

Multifactorial talk

Similar discursive objectives may be achieved via the use of multifactorial talk, a linguistic resource which may be employed in a similar fashion to narratives of balance to construct an account which appears to be liberal, eclectic and open-minded but can work to protect existing practices and perspectives by deflecting potential criticisms or challenges (Harper, 1999).

> *I was probably a little bit more mechanistic with regards to my understanding*
> *but now I can appreciate the type of more global impact of social economics*
> *on health, psychological aspects of pain perception and disease and the type*
> *of aspects of that on the immune system and more understanding of some of*
> *the type of studies done on placebo aspects of it are quite eye opening and*
> *aspects of pain perception, how can anxiety and stress feed into that. The fact*
> *is that health is just so individual to the person and so multifaceted...(MY)*

The same clinician goes on to elaborate:

...Long time unemployment, low social economic, either unemployed or low
wage. Long history of type of pain, long term disabilities, a lot of people have
signed off for multiple years here. Heavily smoking, drinking you just worry
about the whole type of quality of life for those people. How much is pain a
part of their type of problem is it just a symptom of it or it doesn't matter
whether they're in pain or out of pain. (MY)

Here a number of disparate ideas from a variety of theoretical perspectives are
introduced, combining to produce a multifactorial account. Concepts and
explanations from a variety of epistemologies are brought to the table – biological
(structural/musculoskeletal, neurological, physiological), sociological, psychological
(behavioural, affective and cognitive), and political/environmental. A number of
rhetorical devices are used to produce a flexible and eclectic account that has equally
varied effects. One very powerful effect is that the flexibility introduced here serves
to protect the speaker from challenges to any one part of the explanation. For
example, should physical therapy (adjustment) not work, this can be explained via
reference to the other factors proposed to be influential over the course of
illness/recovery. This effect is observable in the following passage:

> *You know its muscular skeletal profession, your profession, with this kind of*
> *remit using these kind of tools and it does it in this kind of time frame. Its got*
> *the definition, its black and white, it works within very given time frames and*
> *if it isn't there's cool things to consider, the race of the patient, the yellow*
> *flags, the red flags that can link in very well with other medical*
> *professions...(VR)*

Here a hierarchical explanatory approach is evidenced, whereby the
biological/structural cause of illness is emphasised, however psychosocial factors are
drawn upon as maintaining or complicating factors that might impede physical efforts
towards recovery. This would not be possible if a multifactorial model of illness was
not available as a discursive resource, enabling such dilemmas or challenges to be
deflected.

Objectivities, subjectivities

What kinds of objects are being constructed within these accounts? First, there is the underlying illness or cause of dis-ease – in this case the subluxation or biomechanical (spinal) dysfunction. This elusive and undefined object, which can only be apprehended through indirect means, is constructed throughout the narratives as a 'thing' that has agency separate from the person, who is seen to suffer pain and disability as an after-effect of this dysfunction. Thus symptoms are also constructed as objects, 'out there', agentic and needing to be controlled. Finally the notion of instability is constructed, whereby the likelihood of future problems is asserted, to be prevented as much as possible through the close monitoring of biomechanical systems.

Subjects in these accounts are constructed in ways which are both complex and contradictory. Patients are alternately constructed as responsible/irresponsible (compliance), rational/irrational (possessing insight or otherwise with regard to their bodies), agentic/passive (requiring expert help but being positioned as ultimately responsible for their recovery). The professional subject in these narratives is also constructed in ways which appear inconsistent: at once they are held up as experts, but also as limited in what they can achieve given the complexities of health/illness.

Discussion

In these accounts it appears there are a number of diverse, flexible and often contradictory discourses that may be drawn upon to explain the efficacy or otherwise of chiropractic care. The purpose of this analysis is not to debate the 'truth' of these explanations but rather to note that they are called upon to construct particular positions and to achieve specific objectives, and to consider what these might be.

Throughout this part of this thesis I have attempted to identify and analyse several binary oppositions such as normal/pathological, body/mind, legitimate/illegitimate, moral/immoral, that appear to be at work in the texts of practitioners and patients presented here. Not only do these binary oppositions convey inter-related constructs,

it may be argued that one side tends to be privileged at the expense of the other. That is to say, there appears to be a hierarchical tendency within oppositionally based knowledge that favours the former half of each binary pair e.g. privileges reason over emotion, male over female, individual over social.

These oppositions may further be understood to collapse around two conceptual poles; the former being characterised by the positivist, masculine, objectivist science that continues to occupy a hegemonic position within the realm of health care, and the latter representative of the multiplicity of alternatives that are offered to counter, resist or amend this dominant account. This latter collection is more eclectic and idiosyncratic than the former which benefits from its alignment with a well-established, culturally available discourse. Alternatives to this discourse have little in common besides their status as 'Other', that is, this heterogeneous group of oppositional constructs shares little conceptually besides a common lack of power and marginal status.

The talk about illness, treatment and outcomes in these interviews shows that a variety of rhetorical devices are employed that can be understood as epistemologically positioning chiropractic closer to biomedicine than has previously been understood. Biomedicine occupies a hegemonic position within Western health care that appears to be unshakeable, and rather than be dis-empowered by association with subjugated alternatives, chiropractic can be seen to be making use of the same culturally approved rhetoric of science that has successfully supported the biomedical occupational project in its attempts to secure status and power over the jurisdiction of health.

CHAPTER SIX

Discursive repertoires in patient talk about chiropractic (I) Strategies of resistance to professional authority

<u>Introduction</u>

Dominant discourses both constrain and enable the personal construction of meaning. The constraining nature of dominant discourses is of both theoretical and practical interest as this may present a predicament for individuals who find that cultural discourse insufficient to meet their particular needs in defining or coping with their subjective experience. In recent years, considerable attention has been directed to the fact that deficiencies in dominant discourses can prove problematic for individuals (Yardley, 1997; Ingham and Kirkland, 1997, Yardley and Beech, 1998). Other authors have focused on how discursive practices can function as challenges and forms of resistance to dominant discourses (Mishler, 1995). This part of the study reflects on this tension between the powers of dominant discourses and the potential in speech acts for resisting or transcending these discourses. It represents a preliminary exploration of these issues; it is not intended to produce definitive answers, but rather to stimulate further investigation of these and similar themes.

Accounts of personal experience are often presented within the framework of pre-existing master narratives (Mishler, 1995), dominant discourses (Gee, 1992; Gergen, 1995), cultural texts (Denzin, 1992), or 'ways of seeing' (Berger, 1972). Those who share a cultural lens similar to that provided by a dominant discourse typically consider that it provides an accurate reflection of the world ('reality'), rather than a mediated, refracted or interpretive version of that world. This notion in turn derives from the culturally shared idea that words are essentially descriptive, taking their meaning from the objects they are meant to represent. More recent understandings of language, philosophy and knowledge suggest however that the meanings of words are flexible, relational and contextual; that they are continually created and re-created between actors.

Dominant discourses derive from shared cultural knowledge, which has important implications for individuals, whose understandings and experiences are inevitably both constrained and enabled. By restricting the speaker to culturally agreed definitions regarding 'truth', 'reality', and values, dominant discourses can be seen to constrain the personal construction of meaning. At the same time however, dominant discourses may enable the construction of subjective meanings, for example by lending strength to those understandings that uphold or are consonant with their underlying propositions. As the notions and perspectives implicit in dominant discourses are widely accepted as taken-for-granted truths, speech acts consonant with those values are likely to be accepted as further descriptions of 'reality' and as such, no explanation or substantiation for that description is expected. Alternately, where individual's experiences cannot find support from culturally shared texts, they must find creative and idiosyncratic ways to overcome those limitations.

This part of my thesis is thus interested to explore how discursive practices within the context of CAM treatment work to alter the subjectivities of speakers. The accounts that are analysed here suggest that the discursive repetoires available to speakers within CAM settings can affect subjectivities in ways that do not correspond typically with experiences reported within biomedical settings. The patient accounts presented here show how people construct meaning through the deployment of a wide variety of discursive practices A discursive analytic framework will be used, as it provides a rich heuristic device through which talk can be understood as a central means by which people may be constituted as individuals and as social subjects. I will furthermore argue that patients' discursive mediation of their experiences and subsequent on-communication of that meaning serves to facilitate the success of chiropractic and contributes to its survival despite the hegemonic position that biomedicine continues to occupy within the health care system.

This part of the study examines patient experiences within CAM settings (specifically, chiropractic) from a discursive perspective. Accordingly, the findings presented here are not suggested to reveal underlying cognitive constructs, but rather are understood to reveal the ways in which people actively produce social and psychological realities. My objective therefore, is to examine the discursive practices of CAM patients not so that they may be viewed as stable or enduring underlying

141

mechanisms, but rather as productive strategies that may be employed to manage blame and apportion responsibility or accountability (Edwards and Potter, 1992; Potter and Wetherall, 1987). Talk about subjective experiences is thus conceptualised as being a situated activity that seeks to accomplish interactive business (Edwards and Potter, 1992; Gergen, 1994; Gergen and Gergen, 1986). Such an approach does not concern itself with pre-conceived theoretical agendas but rather is interested to examine how language may be used to achieve particular discursive outcomes. Talk concerning matters such as injury causation, development and recovery are therefore seen to be active social productions whereby identities are constructed and defended (Edwards and Potter, 1992). Working from the standpoint that one's experience of self is discursively constructed – that is, one's understanding of self is experienced through the categories available in discourse – the discursive practices of patients here are privileged and the effects that they have are analysed.

Specifically then, this part of the study investigates the construction of identity and agency with regard to existing cultural narratives on the topics of pain, health and illness within the context of complementary medicine. Interviews with CAM patients are analyzed for how they constructed themselves discursively against others, particularly other patients and medical experts (biomedical and complementary). Furthermore, the accounts are examined with regard to the moral positions and identity claims that were constructed. As throughout this study, this is achieved via the use of discursive analysis as a method that may illuminate our understanding of the processes people employ in their attempts to manage the moral ambiguities incumbent with long-term pain, illness and disability (Becker, 1997; Green and Sobo, 2000; Kleinman, 1998). Discourse analysis arguably may allow for a more complex and culturally contextualised interpretation of patients experiences and behaviours, as a deliberate focus on the construction of accounts provides an opportunity to gain insight into ways in which language does more than merely reflect or describe what it seeks to represent and also consider. By seeking to attend to the way language produces and constrains meaning I hope to illuminate how individuals make use of linguistic resources by which social and political 'realities' are produced and reproduced, and that allow for the creative resolution of the difficult moral questions:

> ...our identities as social beings emerge as we construct our own individual experiences as a way to position ourselves in relation to social and cultural expectations (Schiffrin, 1996: 170).

The accounts presented here suggest that the appeal of chiropractic may lie in its consonance with the broader rhetorical strategies through which patients may construct alternatives to the negative or limiting biomedical perspectives. Furthermore, they suggest that the process of seeking out alternative approaches to treatment reflects how patients attempt to construct themselves as 'good' patients. In these ways, chiropractic patients can be seen as making use of a new discursive resource that upholds and sustains a positive or hopeful outlook on their condition whilst simultaneously asserting the soundness of their own moral position. That is, patients engage concepts of agency, prevention, wellness, individualised care and personal authority from chiropractic discourse in ways which uphold the broader discursive frameworks through which they may both construct their personal identities and negotiate complex understanding of their experiences.

The accounts to be discussed here are drawn from interviews conducted with CAM patients (specifically, patients currently attending chiropractic clinics). The conditions that they attending for were the result of accident or injury (i.e. not genetic) and therefore the interviewees have all previously experienced being pain and disability free. As such it could be expected that the dominant discourse concerning the transition to being a patient/disabled person, with its implicit claims and cultural expectations, would form the backdrop against which personal positions were being constructed, positions that could accept, amend, or resist that discourse.

One key element of this discourse is the theme that sickness or wellbeing is the responsibility of individual agents, who are capable of and expected to make active decisions with regard to their personal well-being. This cultural framework which emphasises personal autonomy has contributed to the emergence of an important moral discourse. According to this moral discourse, individuals may either improve or worsen their health chances according to the health 'choices' they make and the type of behaviour they engage in. That is, certain behaviours are held up as good/safe/responsible versus others that are condemned as bad/risky/irresponsible. The emergence of this cultural discourse alongside the widespread acceptance of medical doctors as the appropriate 'experts' with regard to health matters has enabled

that profession to markedly expand its field of influence, validating the medicalisation of a broad range of life experiences.

> Our global village is witness to a sudden and dramatic proliferation in what Foucault termed medical policing, as social institutions and agents increasingly monitor, regulate and subdue individuals in the name of health. (Finerman and Bennett, 1995: 1)

This shift in the locus of responsibility has led to a new, blame focused model of health and illness where the individual is held accountable for the onset, development and outcome of disease or illness (Finerman and Bennett, 1995). This accusatory framework might go some way towards explaining why many patients share accounts that work to position themselves as morally responsible by addressing matters such as their lifestyle, and which convey agency with regard to the therapeutic or recovery process.

Since the traditional biomedical framework demands that patients must comply with specific expectations complicit with their occupation of the sick role, individuals with medical conditions that are resistant to recovery face a special problem, in that they are vulnerable to being identified as 'problem patients' or even 'malingerers'. That is, should the course of illness not conform to 'expert' expectations, the onus may be shifted to the patient to explain why they are not improving in accordance with medical and social norms. The availability of this discourse unfortunately opens the door for questions to be asked concerning the individual's moral or emotional fortitude, particularly in cases where a specific organic diagnosis remains elusive (Jackson, 1992). In these accounts, a variety of discursive practices are employed to handle the moral dilemmas that are presented when long-term illness raises questions of personal credibility. In order to successfully construct themselves as moral agents, patients make use of complex and flexible discursive tactics, that is, both passive and agentic positions are negotiated in order to re-direct responsibility and manage the ideological dilemmas that emerge out of the dominant discourse on chronic pain management.

Since the objective here is to explore the ways in which people engage in discursive practices in flexible and often idiosyncratic ways, rather than to make general statements that are supposed to hold across populations, accounts have been presented

144

that give insight into the processes by which subjectivities and moral positions are co-constituted. The excerpts presented are deliberately selective; no attempt is made to suggest that they should be considered representative or generalisable, although it could be argued that by highlighting 'themes', some claim about generality is being implied; similarly, there may be an implicit suggestion of typicality for, as Yardley argues:

> Nevertheless, some notion of typicality itself still informs the selection of 'interesting' material, which is interesting because it uniquely exemplifies *or* contradicts what it seen as typical (Yardley, 1997: 37) (italics in original)

Research method

As outlined at the beginning of Chapter Two, these accounts were gathered as part of a study that whose purpose was to explore the discursive worlds of patients and practitioners within complementary health care settings. Data collection and analysis unfolded relationally to each other, in accordance with the hermeneutic principle which informs much work of this nature i.e. that it is necessary to consider the whole before it is possible to understand constituent parts, and vice versa. As the primary focus of this study was to examine the discursive practices of the participants, particular attention was paid to the sub-texts concerning the extent to which patients attending complementary health care practitioners (here: chiropractors) accept (or actively resist) the medical/clinical discourse of 'self-care' and 'personal responsibility'.

The study was approved by the School of Psychology Ethics Committee at University of Southampton. Having already completed interviews with ten chiropractors, a further ten people currently attending chiropractic clinics were recruited from private practices in the South West of England and Wales to participate in in-depth interviews concerning their personal experiences. There were 6 women and 4 men, aged between 31 and 60. Practitioners I had interviewed previously offered their clinic waiting rooms to me to approach patients and ask for consent to participate in the study. The nature of the study was outlined in an Information Sheet (See Appendix F). Once consent had been obtained, a date and time for the interview was

145

set, the place of interview being the clinic where they normally attend. The interviews were conducted by the author, audiotaped and later transcribed, using the same conventions as in the practitioner interviews (i.e. an abbreviated form of the Jefferson system, see Appendix B). The main goal in interviewing was to elicit talk about pain experiences and meanings. In this project, as in most interview studies, the question put to the participants identified a given problem area (in this case pain or its associated disability) as a topic requiring discursively constructive work. As might be expected, therefore, the personal accounts of the interviewees were shaped by and located within their understandings of those concepts. This being the case, the interviewees often placed an emphasis on the kind of interpretive exploration and reasoning that has been termed 'evaluative talk'. The tendency to engage in evaluative elaboration was especially pronounced when the interviewees attempted to make sense of their health problems in light of their more general conceptions of pain and disability as a socially situated process. Participants were actively encouraged to provide their own interpretations of their experiences, often being requested to add to and expand upon their reasoning.

The accounts are presented here in a manner that has become well-established, i.e. beginning with the speaker's temporally ordered presentation of events and working from there toward evaluative statements (Labov & Waltzky, 1967; Mishler, 1986). This enables the analyst to consider the reasons why the speaker chose to arrange the events in that way and clarify what those events might 'mean' to the speaker (Riessman, 1993).

From person to patient

> The doctor-patient relationship is characterised more typically by conflict and misunderstanding than by reciprocity and agreement. (Turner, 1987: 49)

Individuals suffering from musculoskeletal pain - whether acute or chronic - often find themselves embarking upon a protracted and circuitous journey seeking diagnosis and resolution of their problem. Typically this will begin with a visit to their general practitioner, from where they may find themselves referred to an orthopaedic specialist. However, en route they may also find themselves visiting a range of medical specialists such as physiotherapists, radiologists, neurologists, oncologists and psychiatrists/psychologists. They may also visit alternative and

146

complementary practitioners as part of this journey, such as acupuncturists, osteopaths, or chiropractors. For many, the search for successful treatment is often lengthy, confusing and disheartening, and only partial alleviation of the symptoms may be achieved. In this study I am interested to listen to patients talk about those experiences, with a particular interest in the rhetorical strategies that they may use to construct accounts that achieve certain objectives.

One important feature of studies such as this one that should be noted is that in asking individuals to speak of experiences, they are required to call upon memories which can best be understood as reconstructive devices. As Garro points out, during such talk memories of past events are brought into alignment with present understandings and the present is also made sense of by reference to the past: both are used to construct proposals about the future (Garro, 1994). This process makes use of available individual and cultural discourses to make sense of information and formulate responses that work for both the individual and the group.

The accounts elicited in this study were quite diverse and also, complex. Many of them spanned several years, and featured highly personal elements, such as the challenges that chronic pain had presented to their family relationships and personal/emotional wellbeing. Some even entered into the existential questioning that had accompanied their journeys, highlighting another under-theorised element of pain. Despite the individual variation between the accounts however, there were also some themes and structures that emerged.

Patient accounts typically began with an attempt to locate the pain experience temporally, by offering some sort of explanation relating to the onset of the condition. In most instances, onset of symptoms was linked specifically to a particular primary cause or event, although this was not always possible. After attempting to address the issue of genesis, most would continue on to describe the process by which they sought answers to the question of diagnosis, and then treatment. This process was neither simple nor straightforward, with many of the participants relating how they often received conflicting diagnoses, or in some cases were simply told that nothing physically wrong could be found (i.e. no disease pathology could be identified). Where individuals had been told that no physical pathology could be found (e.g. x-ray

147

findings were normal), a lack of alternative explanations led to a default assumption being made, namely that the symptoms were primarily psychological. As has been discussed at length throughout the first part of this study, it is likely that this relates back to the difficulties inherent in transcending the dualisms that permeate our Western way of thinking, which sets up mind and body oppositionally.

The quest to understand the genesis of illness is an enterprise that can be understood as an attempt to reconcile one's personal experiences in the aftermath of sometimes profound biographical disruption. Prior to the onset of the illness or pain condition, individuals have a sense of identity and normalcy in their everyday way of being in the world, a sense which can be torn apart during the physical and social breakdown that often accompanies the experience of illness. Charmaz (1983) attested to this in her study of the chronically ill when she concluded that "Chronically ill persons frequently experience a crumbling away of their former self-images without simultaneous development of equally valued new ones" (Charmaz, 1983: 168).

This phenomenological process is often set within a greater context of social and institutional factors that together can act transformatively whereby the person becomes patient. The process of medical diagnosis for example, whereby a person receives a label for their condition, can be seen to work not only to suggest a course of action with regard to treatment, but also to act discursively to propel the individual towards occupying a particular role or position. The process of diagnosis, whether biomedical, complementary or alternative acts to build a framework of assumptions around the patient which are taken-for-granted and tend to construct the clinician as the expert, which may serve to disempower the patient and disenfranchise the person. This recasting of the person as patient constructs them in a new way – as the object of medical/health work. Goffman discussed the difficult balancing act that this kind of 'people work' represents in his work 'Asylums' (1968), where he made the point that the institutional imperatives and professional practices can contribute towards the deconstitution of self, and that the balancing of objectivities/subjectivities, emotions and practicalities, and personal/professional agendas is fraught with complexities. During this process, the person becomes a 'patient', i.e. there is a fundamental shift or transformation of identity. As Herzlich and Pierret argue, this transformation from person to patient means that:

> ...sickness is an individual condition that is conceived in terms of the relationship to medicine and to doctors and also the relationship to social institutions, work, family and friends. The patient's conception of his [sic] illness is also a conception of his relationship to others and to society (Herzlich & Pierret, 1985: 150).

Other authors have noted how medical encounters can serve as an instrument of social control. Foucault in particular has brought attention to the construction during the 18th century of a discourse which made possible the separation of the anatomical sign and the symptom. This in turn paved the way for what he termed the 'medical gaze' to develop whereby the body could be examined independently of the person's subjective experience (Foucault, 1963). Medical science thus served to decontextualise disease and illness and translate subjective illness experiences into biological and physical objects, reifying these experiences as mechanical and objective entities.

How then, do patients handle these assaults on their personhood? What does it mean to them to be constructed as chronic pain patients and what effects does this have for them? How do users of health services construct their experiences such that they achieve important personal 'work' with regard to self, identity and meaning?

Discursive strategies of resistance: Lay vs. professional knowing as superior: 'I know me'.

Discourse analysis, with its emphasis on the dynamic, flexible aspects of language, shares with other poststructuralist research paradigms a notable strength insofar as it allows room for both the constitutive power of discourse and for the ability of people to exercise choice with respect to those discursive practices. That is, whilst discursive practices may constrain meaning, it is possible for individuals to resist or refuse any particular discourse:

> there is always room for resistance. Our study of the ways in which certain discourses reproduce power relations can also promote 'counter-discourses' or alternative arguments for what is usually taken for granted (Foucault, 1977b, in Parker, 1997).

Discourse here is understood to be a multi-faceted social process through which meanings are dynamically accomplished. By engaging in this process a number of

objects and subjectivities may be constructed. Once a particular subjectivity has been accepted as one's own, that person inevitably will filter, process and present information in accordance with that discursive position – however each discursive interaction engenders a number of different and sometimes contradictory perspectives that each individual could adopt. Thus patients can choose between a wide range of possible standpoints, with differing effects.

One option that patients have when faced with being constructed as a novice (versus the clinician's attempt to construct themselves as expert) is simply to reject that representation. An alternative strategy can be employed by the patient that instead emphasises a particular type of lay knowledge, privileging the individual's subjective experience over the rationalist knowledge held by the professional.

In the following passage, for example the patient refers to his chiropractor's recommendation that he participate in some kind of exercise or sport and explains his decision not to comply with this advice:

Interviewer: *Have you been happy with the treatment plan that your doctor has recommended?*

Participant: *Well, mostly, you know I'm coming in twice a week for treatments and that's been great. But he reckons I should be playing sport again but there's no way I'm doing that. That's what got me into this trouble in the first place! And he looks at me like, so? But he's not me and I know my body and I know that if I try to push it, it'll just get worse. OK so I've gained a bit of weight since I got hurt but you know, its not hard to get back into shape, once this problem's been fixed. (MA)*

In this extract, the interviewee asserts that in his particular case, exercise is not only unnecessary but dangerous, despite his doctor's suggestion that it might speed or assist in his recovery. In direct opposition to the expert opinion, he asserts that, in this instance, his lay opinion is superior/correct *("I know my body...it'll just get worse).* The patient remains certain of the correct-ness of his assessment, despite indications that his doctor questions his reasoning *("And he looks at me like, so?").*

The patient's reluctance to accept his doctor's recommendation that he begin an exercise regime may be understood as a logical consequence of the overall understanding that he has negotiated, that of passive recipient of care rather than active participant in the recovery process. He expresses satisfaction with the part of the rehabilitation process that requires receiving expert care *("I'm coming in twice a week for treatments and that's been great")*, but balks at the suggestion that he might benefit from an element of self-care *("there's no way I'm doing that")*. His location of his condition as something outside of his control is evident in his final statement *("once this problem's been fixed")*.

This excerpt may also be read as a defensive reply to the implied criticism that the patients may have inferred from his doctor's comment. By insisting that *(he's not me, I know my body")* he is re-claiming his authority back from his doctor in a manner which suggests that he is the person best-placed to devise a recovery strategy appropriate to his individual needs. This relates back in turn to the rhetoric discussed earlier, whereby the patient was heard to specially emphasise the unique-ness of both (a) his condition and (b) his body and its capabilities. Here the patient is essentially espousing the view that individuals should feel empowered to make decisions regarding self-care that are grounded in their experientially-based understanding of their own needs and circumstances. Contrary to earlier comments that upheld the power of the medical expert, in this passage the patient seems to be emphasising a belief in privileging the perspective of the individual.

He has attempted to reclaim power within the doctor-patient encounter by highlighting his special kind of knowledge, inaccessible to the doctor. This has the effect of re-siting power within the patient, who moves from being the object of knowledge to being subjective knower. This could be interpreted as an attempt to reconfigure the doctor-patient relationship towards one which is more reciprocal in nature.

Agency within the CAM encounter

Patient accounts of their experiences within CAM evidence an ideological dilemma with regard to their positioning as either active or passive (Bishop & Yardley, 2004). In the following analysis, I will attempt to examine the discursive practices employed

by patients to overcome ideological dilemmas concerning accountability and responsibility within the healing encounter. These tensions can in turn be understood as part of the broader debate concerning the problematic nature of 'expertise' within contemporary Western culture. Whilst medicine has traditionally employed paternalistic discourses to position doctors as experts, with a concomitant privilege or authority over non-expert patients, this model has increasingly lost power with the rise of patient-centred models of care emphasising values such as autonomy, independence, and control – a psychological discourse that has been argued to, ultimately, serve the interests of biomedicine (Salmon and Hall, 2003). This presents something of a predicament for patients, who often find themselves faced with a precarious choice to make between active and passive positions, neither of which may be satisfactory for a variety of reasons that will be explored.

The struggle to assert agency can be seen in the following excerpt, when the interviewee is responding to a question asked about whether or not he felt his health practitioner listened to him:

> *Yep. Because I make them as well...if they don't listen to me then I don't really like them because obviously, I mean I've been to doctors before and they don't listen to you and think they know best and so that doesn't impress me because, you know I want at least some say. I know they've done the training but I do know what's going on. (MA)*

The positioning of some as 'experts' is problematic within democratic or egalitarian societies, as it conflicts with other important cultural values such as equality and personal autonomy. The context of health problems allows to some degree for these egalitarian values to be temporarily put aside, in that seeking professional help is normatively viewed to be responsible or morally appropriate behaviour. However the fact that this concession of power is to some degree socially sanctioned does not negate the inherent conflicts that many patients experience in trying to reconcile oppositional values (passive versus active).

Contrasting with the traditional view of the patient as passive recipient of expert care is the consumerist model, which positions patients as active agents negotiating care

within a broad range of options (including the use of CAM). However, consumerism in health care can be seen in itself to be problematic, insofar as it is based on the assumption that patients are rational actors, neglecting the subjective, embodied nature of their experiences (Lupton, 1997). Under this model which emphasises patient rights and capacity for autonomy, the notion of the patient as a disengaged, self-possessed subject unaffected by emotions is privileged as the ideal and set up in opposition to the 'passive', dependent patient as understood to be typical of the paternalistic model of health care. It seems likely that this representation of an active, calculating self gains strength from its compliance with prevailing cultural values in Western societies that privilege rationality over emotionality, and autonomy over dependency. Such an individual would be expected to critically assess the health care options available and be capable of countering or challenging 'expert' wisdom when necessary.

Constructing patients as active agents in managing their disease or illness transforms them from passive sufferer to responsible participant. As Herzlich and Pierret (1987) have pointed out, from here it is not only possible but likely that the patient will also have transferred to them some moral responsibility for getting well. Thus it must also be considered that where patients are constructed as active agents, accountability is also shifted toward the patient, resulting in an increased burden of responsibility (Salmon and Hall, 2003). In CAM settings, the balance between patient autonomy and doctor expertise is perhaps even more delicate, insofar as it must also allow for an epistemological framework that emphasises neither party as ultimately responsible for the return to health but rather positions the body itself as healer. Patients and practitioners are thus continually having to work discursively to overcome the inherent tensions that come from these ideological clashes concerning expert vs. novice, active vs. passive positioning within the healing encounter. The healing encounter is a complex, dynamic and subjective event that occurs within an ever-changing interpersonal context - approaches to understanding the health encounter must therefore acknowledge these subtleties. Certainly the data here suggests that patients can be seen to construct self and other in both the 'active' and 'passive' ways depending on the situation and commensurate with the rhetorical outcomes that are trying to be accomplished. For example, the following interviewee quite clearly prefers to construct herself as a passive recipient of health services:

I want to be fixed, I want to walk out feeling fixed and knowing that if I need to come back it's not going to be an ongoing thing for long periods of time, I'm going to be fixed within a short period of time. (WR)

However the same interviewee has said earlier in the piece that:

I've started using one of those gym balls, doing a core work-out so doing that and stretching. (WR)

This statement clearly implies an understanding of some element of personal responsibility and capability with regards to recovery from the current episode, and perhaps also prevention of future problems. This emphasis on personal and ergonomic/lifestyle contributing factors is further underscored when she is asked what she blames for her ongoing pain condition she answers:

Bad posture and the type of work that I do. (WR)

Patients then, can be seen to construct self and other in both the 'active' and 'passive' ways depending on the situation and the moral/personal outcomes they are trying to achieve. These actions, whilst contradictory, can be understood as pragmatic and constructive if one considers the ideological dilemmas that people with chronic pain or illness inevitably face when attempting to construct personal meanings within discursive frameworks that are at times insufficient to explain or deal with their experiences.

Other studies of patient accounts within biomedical settings have shown how patients may reject traditional attempts to construct them as subordinate within the doctor-patient encounter (Horton-Salway, 2000). In some accounts, patients have described how they experience medical doctors as arrogant, aloof, uncaring or mechanical. In these accounts presented here however, there appeared to be a more subtle consideration of the relationship between patient and provider, with a variety of positions and perspectives being offered at different times to achieve multiple rhetorical effects.

154

<u>Uniqueness/individuality: 'Everyone's different, you know?'</u>

A common rhetorical device that emerged throughout the accounts is the use of a series of reported dialogues between the service users and some Other or Others whose views on pain were presented as quite different. These dialogues may be presented as reconstructions of actual interchanges, or as hypothetical altercations. Typically these reconstructions cast some specific doctor, or doctors in general, as opponents; and as spokespersons for a medical discourse of what is usual or desirable with regard to health, fitness and recovery from injury.

In once such reconstructed dialogue, the patient discusses his perception of himself as a particularly fit and talented person prior to the onset of his pain problems:

> *And I ... was a natural athlete, you know, my record for the 100 meters still stands and I was selected for the Welsh U21 rugby squad when I was just 16...which is very unusual, normally you're not strong enough physically to stand up to those guys until you're at least 18. Everyone was surprised but not me or my dad, after all he was exceptionally quick and strong himself as a young man. We always knew I was going to be a great football player. (JM)*

Here, the patient begins his anecdote by highlighting his special talent (*"my record for the 100 meters still stands"*). He identifies the precociousness of this talent as being a departure from the norm (*"which is very unusual"*), and he introduces his father's commentary (a doctor's) as a credible source of third party endorsement. He then notes that his selection to a top-level training squad was again, unusual (*"everyone was surprised"*), and then quickly introduces his contrasting evaluation of the situation as quite expected (*"but not me"*). He accounts for this alternative appraisal by stating that this success merely confirmed a personal understanding: *"we always knew I was going to be a great football player"*.

In this extract then, the patient can be seen to be attempting to establish his authority regarding his physical condition and experiences against biomedical conceptions of what is normal or expected. Interestingly, concepts of physical norms or standards are themselves not challenged, in fact these reified concepts are upheld in his characterisation of his abilities as unusual. That is, the validity of the medical model

itself is not questioned, rather it is argued that this does not necessarily apply in this specific case.

Not long after relating this dialogue, the same patient presents a reconstruction of a conversation that resembles the 'natural athlete' anecdote both in terms of its structure and what it appears to convey. In this passage, the patient is commenting on his current treatment/pain/most recent surgery:

> *Well, anyway at least I've finally found out why I haven't been able to get*
> *back to normal. The orthopaedic specialist that my doctor referred me to told*
> *me that I have a rare complication/bone spur/whatever that interfered with*
> *the proper healing of the damaged discs, and that surgery might help but it*
> *might not as well, in fact because the damage is in such a tricky place, it could*
> *make it worse. So I'm going to see how much progress I can make using these*
> *other methods and then decide what next. The specialist said it was very*
> *unusual for this type of thing to happen to such a young man, but I figure*
> *since I'm young and fit maybe that will work to my advantage. (JM)*

As in the extract previously discussed, an aspect of his condition is being highlighted as unique and special *("I have a rare condition"),* and it is being stressed that this situation is exceptional. Once again, the medical expert is depicted as confirming both (a) that his condition is unusual and this time, (b) that the patient may have a special chance to get well. The interviewee supports this assertion by referring again to his excellent physical condition *("I'm young and fit").*

At the end of this extract, the patient asserts his own spin on the doctor's comments *("but I figure since I'm young and fit maybe that will work to my advantage").* By ending the account in such a way, the individual communicates to the listener that he does not require the doctor's concurrence, and can remain unshaken in his convictions despite challenge from a representative of the medical viewpoint.

Thus in the dialogues discussed above, it is proposed that this individual's experiences of injury, pain and disability do not conform to the usual course of events anticipated by the dominant medical discourse; moreover, the patient has characterised his self-understanding as constituting a model of his situation that is

more accurate than standard medical expectations. The patient's conviction that his is a special case is logically consistent with the dialogues that he chooses to remember or highlight. His justification of his actions, both past and present, is expounded in the course of remembered and imagined exchanges with doctors and other authority figures.

Potter (1996) has pointed out that one tactic that can be employed in order to bolster the perceived credibility of an account is the introduction of reliable third parties to provide corroborative evidence. Here in Michael's account he uses a device called 'active-voicing' to add power to his story. Active voicing is a strategy whereby speakers introduce other people's voices to underline the 'factual' status of their claims and to protect against sceptical response (Woofitt, 1992). If we return to Excerpt A for a moment:

> *And I ... was a natural athlete, you know, my record for the 100 meters still stands and 1 was selected for the Welsh U21 rugby squad when I was just 16...which is very unusual, normally you're not strong enough physically to stand up to those guys until you're at least 18. Everyone was surprised but not me or my dad, after all he was exceptionally quick and strong himself as a young man. We always knew I was going to be a great football player. (JM)*

By introducing his father's voice here as an 'expert' in the sense that he would presumably know the patient better than others, he is able to construct himself as an exceptionally fit and strong individual and therefore as a 'better' patient than most other (i.e. not 'weak'). In doing so, any potential suggestion of his condition being due to personal weakness (physical or mental) is fended off anticipatorially. As other discursive accounts of illness have revealed, such rhetorical strategies can be used to construct identities in particular ways – for example individuals may be positioned in such as way that certain behaviours (i.e. malingering) are suggested to be unlikely given their character, as evidenced rhetorically (Horton-Salway, 2001). This in turn can be seen to relate to salient cultural (moralistic and political) discourses concerning blame, or responsibility.

Discussion

Dominant discourses both constrain and enable the personal construction of meaning, in a manner which can be problematic in instances when that discourse is insufficient to meet individual needs in defining or coping with their subjective experience. In the context of other debates about the potentially deleterious effects of deficient or inadequate discourses, the subjective experiences of chiropractic patients have been examined. Speech acts can function as challenges and forms of resistance to dominant discourses. This part of the study has reflected on this tension between the powers of dominant discourses and explored the potential in talk for resisting or transcending these discourses. It is intended to be read as a preliminary exploration of these issues; no attempt has been made to assert definitive answers to these questions, but rather its purpose has been to stimulate further investigation of these and similar themes.

The accounts that have been analysed and presented here suggest that the discursive repertoires available to speakers within CAM settings can affect subjectivities in ways that do not correspond typically with experiences reported within biomedical settings. The patient accounts presented here have been used to demonstrate the vital role that language plays in the construction of meaning. Furthermore I have argued that patients' discursive mediation of their experiences and subsequent on-communication of that meaning serves to facilitate the success of chiropractic and contributes to its survival despite the hegemonic position that biomedicine continues to occupy within the health care system.

The analysis presented here has suggested that the appeal of chiropractic may in part be attributable to its consonance with broader cultural themes through which patients may construct alternatives to unhelpful or limiting biomedical perspectives. Furthermore, it has been argued that the process of seeking out alternative approaches to treatment reflects how patients attempt to construct their identities as 'good' patients. In these ways, chiropractic patients can be seen as making use of discursive resources that allow for a positive or hopeful outlook on their condition whilst simultaneously asserting the soundness of their own moral position. That is, patients engaged concepts of agency, prevention, wellness, individualised care and personal authority in ways which at once challenged and upheld dominant discourses.

158

CHAPTER SEVEN

Discursive repertoires in patient talk about chiropractic (II) Strategies to manage blame and accountability

Introduction

Accounts of patients attending CAM also need to be considered within the broader context of available discourses regarding health, illness, pain and disability. The discourse surrounding serious diseases such as cancer have been noted to employ an array of rhetorical devices that work to construct disease as 'an invader, an enemy and an unspeakable evil' (Bishop & Yardley, 2004: 468). These metaphors are no longer confined to discussions of sinister disease processes but rather have been extended out to discourses concerning all manner of issues related to health and illness, including chronic pain (for example the front page of a recent issue [June 4, 2007] of Newsweek was entitled: 'The New War on Pain'). Patients who accept such constructs must also accept their attendant expectations and responsibilities – namely to 'fight' the 'battle' against illness. Thus there is a moral dimension to illness or dysfunction that requires individuals to wage war against their condition via socially approved behaviours e.g. seeking expert help, and complying with treatment regimes. Once again however, this posits an ideological dilemma for individuals who must struggle to balance the contradictory demands placed upon them as members of a society that values personal autonomy, independence, control and self-reliance. In these accounts the ways in which individuals use discursive resources to manage these dilemmas will be analysed. Specifically, this analysis concerns itself with the discursive practices employed by patients to overcome ideological dilemmas concerning accountability and responsibility within the healing encounter. The complex and subtle discursive work performed by patients to construct narratives that manage to reconcile these contradictory demands will be examined within the context of chiropractic care.

In this chapter I intend to analyse the use of conversational idioms in accounts with practitioners and users of chiropractic health services, from the perspective that such forms of talk communicate a socially normative moral requirement rather than reveal

discrete underlying psychological states or cognitive constructs. That is, talk here is considered a form of social action that functions to achieve specific social objectives within its local interactional context. The use of discursive resources to assert a moral position and vindicate the self as a moral agent will be considered, and a close look will be taken at why people say certain things at certain times (rather than focusing on what they say). Finally I will attempt to deconstruct that talk by critically evaluating statements and examining how their construction as taken-for-granted truths works to achieve specific personal issues concerning identity, self and subjectivity.

Discursive strategies: Constructing the 'good' patient

The cultural discourse that has developed in recent years with regard to the moral imperative for patients to actively participate in overcoming illness means that patients responding to an interviewer's questions are doing so as members of a social group where adopting an active, positive mental attitude has become a taken-for-granted responsibility. 'Being positive', despite being a poorly defined construct, has become widely accepted in popular culture as part of being a 'good' person, as well as being a good patient. In their study with cancer patients, Wilkinson and Kitzinger (2000) note that 'thinking positive' has become a commonplace cultural idiom with specific meanings within discourses on health and illness. The notion that one must have a positive mental attitude has become a widespread social norm, and it seems unlikely that this cultural norm would not apply across other illness experiences. Indeed the pressure on patients to display positivity has been noted throughout the literature. However these authors also point out that labels/interpretations such as 'thinking positive' can reflect the theoretical interests and agendas of researchers more than the meanings that speakers actually intended.

The trend towards highlighting the influence of psychological factors in the causation and resolution of health problems is one that has been criticised by social theorists concerned at the onus of responsibility this places upon individuals. Many authors have spoken out against this trend as an example of 'victim-blaming' that provides a convenient excuse for institutions to devolve themselves of responsibility for health care. The political expedience of promoting values such as individualism and self-reliance should also be noted, as such discourse provides a cultural climate in which

160

governments and other social institutions may successfully deflect attention away from other key factors affecting health such as environmental and public health measures.

Talk about health therefore must be analysed within this broader cultural landscape currently dominated by discourses that emphasise personal responsibility and accountability. The widely held notion of health as an individual's personal responsibility is then the social context against which 'positive' comments should be evaluated.

The strong patient: 'What doesn't kill ya...'

> *Yeah, well at first I wasn't very happy about my condition. I guess I kind of assumed, um that it wouldn't be that bad, or it would come right after the surgery or whatever. But it actually it got worse and then it started to affect everything else, and I got, um quite kind of um, depressed in a way. But then I figured there wasn't much point in that, I mean, its not going to make it better is it, cry into your cup of tea, is it? Comes a point you've just got to get on with it. Hah. And as they say, what doesn't kill ya makes ya stronger, right? (AF)*

This extract demonstrates several interesting features of patient talk about illness experience. The protagonist uses the well-known phrase or idiom 'what doesn't kill you, makes you stonger" – a saying which is often thought to be Biblical in origin but actually is an adaptation of a line by Friedrich Nietshce: "was ihn nicht umbringt, macht ihm starker" (Nietsche, 2005 [1908]).

Idioms, proverbs, clichés and commonplace phrases are examples of formulaic expressions that people use to communicate taken-for-granted pieces of cultural knowledge - in a sense they represent a kind of verbal shorthand. A particular type of talk, they possess several features that should be considered by discursive analysts, for whom conversational phenomena are particularly germane. First, idioms tend to be vague, general comments. They are often used in order to summarise and communicate broad ideas - but in a sweeping manner that does not linger on the particulars. The above idiom does exactly that – it conveys a general point about

161

resilience, strength, and good humour but without reference to evidentiary specifics. As a summative statement about how he felt about his chronic illness, it is decidedly vague. As Wilkinson and Kitzinger (2000) comment, this suggests that individuals are simply making use of readily available sayings rather than reflecting on their innermost feelings and then making an authentic response.

It has also been noted in other conversationally based research that talk may be constructed strategically to achieve specific effects (Riessman, 1990).

> Stories, more than other forms of discourse, effectively pull the listener into the teller's point of view. They re-present a slice of life, often by dramatizing and re-enacting a particular interaction, thereby providing 'proof' of how it was...narratives are always edited versions of reality, not objective and impartial descriptions of it... (Riessman, 1990: 1197)

One way to achieve this is to make use of widely-understood conversational conventions that may be used to achieve practical purposes. For example, an idiom that summarises a situation or experience may be used to signal that the speaker is ready to 'wrap it up' and/or pass the conversation over to someone else. By using a well-known phrase their position is summed up in a way which is easily understood by all participants; furthermore the conversation is structured in ways which suit the speaker at that time. The idiom or cliché works as a discursive tool that serves to indicate that the speaker has said all they've got to say for the moment and wishes to draw their turn to a close: returning to the above extract then, it is noteworthy that the phrase "what doesn't kill you..." comes at the end of the passage, suggesting that the interviewee was ready to move on.

Another feature of the use of idioms is that it serves to shift the focus of the conversation away from the personal towards the public or shared domain. As idioms represent a shared, taken-for-granted knowledge, they provide an opportunity for the speaker to re-direct attention from the intimate to the generic and affirm their belonging to a particular sociocultural group. A particular feature of idioms is that they are very durable, very difficult for people to resist or argue with – partly due to their vagueness, which make them difficult for others to refute, but also because to resist them is to make a statement that goes against the group. In conversations where the speaker has made statements that have received little or no positive feedback then, their use can achieve consensus and agreement by redirecting the listener to a shared

cultural norm. In other words, it is possible that rather than reflecting an authentic belief or attitude held within the individual, statements incorporating idioms may simply be an attempt to linguistically build bridges between participants or achieve other interactional work.

What then, might have been the purpose of the above-mentioned phrase? Whilst it's possible that it does actually represent an authentic appraisal of the individual's feelings/attitude towards his condition, from a discursive perspective the question is not whether or not talk reflects internal psychological states but rather why would they choose to communicate this, in these particular ways. What interactional business does this perform? How does it position the speaker and what positions does it make available to other participants?

If taken at face value, this extract also implies that the speaker is almost grateful for the experience. After all, he is now 'stronger' – which is universally understood within this context as a good thing. This brings us to another closely related discursive theme also communicated via the use of idiom – pain or illness experience as a 'blessing in disguise'.

'Blessing in disguise'

The phrase 'a blessing in disguise' is widely used in the English language to denote a good thing that perhaps was not recognised as such at first. It is often used to refer to a problem that has become a benefit, or an instance of bad luck or misfortune that turns out to be positive. But what is a blessing about having an episode of pain or discomfort? It does not seem apparent why anyone would see suffering misfortune of this kind would interpret this in such a positive way. One interviewee gives us a glimpse as to what he means by this when he continues on to say:

> *In a way it's been a blessing in disguise really. I mean, the good thing about all this has been that it has forced me to slow down a bit, have a think about things, get my priorities straight and all that. You've got to listen to your body sometimes, and mine was definitely saying, slow down! Ease up a bit.*
> *(AF)*

163

Thus the 'blessing' as such is in the positive effect that the illness is said to have had on other parts of the patient's life, rather than in the actual event itself. One of the themes notable throughout these accounts was the way in which the illness experience disrupted normal patterns of everyday life and required of the persons involved some degree of re-organisation or restructuring of their daily lives. Other social researchers have noted the biographical disruption that occurs in the context of chronic illness (Bury, 1982; Garro, 1994; Riessman, 1990). In his work detailing the experiences of people with rheumatoid arthritis, Bury suggests that: "...chronic illness, is precisely that kind of experience where the structures of everyday life and the forms of knowledge which underpin them are disrupted." (Bury, 1982: 169). This disruption, he argues, occurs on several levels, for not only are one's taken-for-granted assumptions and behaviours challenged by illness, but also one's explanatory models and understanding of self-concept (Bury, 1982). These themes are further explored in work by other researchers interested in the construction and presentation of self through the creative use of language. Riessman for example, has argued that it is through talk that individuals make sense of disruptive events in their lives, and constitute a version of self that typically serves to sustain their moral character (Riessman, 1990).

Chronic pain conditions in particular represent an ideological challenge for many people, with their complex multi-causal theories of genesis and management. The biopsychosocial model of chronic pain challenges many people's understanding of themselves and can precipitate a crisis of personhood that may be resolved in a myriad of ways. One approach would be to completely deny any psychological involvement whatsoever, in an attempt to firmly locate the problem in the body, which therefore needs to be 'fixed' – thereby placing responsibility with the expert healer and absolving the patient of accountability for recovery. Alternatively, one might take a wholly psychological approach – of course this is not a popular understanding, for obvious reasons given the negative connotations that accompany psychogenic perspectives in our culture (Jackson, 1994). A third approach would be to find some way to accommodate both mind and body – perhaps by reference to culturally available discourses such as 'stress'. When read this way, it makes sense that the individual speaking in the above extract should refer to her pain experiences as a 'blessing in disguise', for she is constructing her experience in accordance with

164

acceptable cultural norms to achieve important psychological work. By interpreting her illness/condition as a sign that she should slow down and re-consider her priorities she re-constructs something that originally was experienced as a negative as something which is ultimately positive in terms of its overall impact on her life. Furthermore, by framing her illness experience in such a way, she provides for herself a 'way of being' for the future that enables her to take a more balanced approach to life and gives her permission to take control by saying 'no' to commitments which may prove stressful or deleterious to her health, which is now understood to be both mental and physical.

What effects does this process of reconstruction have on patients? Garro's work with TMJ sufferers concluded that the individuals in her study ultimately saw themselves as remaining the same person they were before their illness, albeit now with different priorities. However other authors have suggested that the experience of illness often results in a fundamental 'loss of self'.

Loss of self?

It has been suggested that when a person suffers pain or illness, their whole world can be transformed; the experience of pain or disease can undermine our sense of self and personal autonomy (Charmaz, 1983; Leder, 1992). Charmaz argues that the suffering caused by physical pain and the debilitating effects of chronic illness undermine the self and gradually erodes individuals' self-concept against the backdrop of a cultural discourse that emphasises control, independence and recovery:

> The ill individual draws upon past social experiences, cultural meanings and knowledge to engage in a mental dialogue about the meanings of present physical and social existence, specifically, the emergent indications of identity elicited by illness. (Charmaz, 1983: 170).

One of the ways she contends this happens is via the experience of living a restricted life. That is, the constriction that physical pain or disability imposes upon individuals threatens their core sense of freedom, independence and autonomy. When the individual retains the perception that they still exercise choice this effect appears to be moderated; however typically, Charmaz argues, loss of control from life restrictions associated with illness results in losses of self.

165

In these accounts however, illness itself was often constructed as a positive event; some patients also spoke of their treatment experiences in such ways. It seems that whilst the onset and initial part of the therapeutic journey were experienced as negative events, the patient's 'discovery' of chiropractic and subsequent treatment are relayed as positive life events. Several interviewees spoke of the emotional relief that they felt after being given an alternative explanation for their pain that removed the burden of responsibility from them, experienced as implicit in orthodox practitioners' inability to find an organic cause for their pain/discomfort.

Relief

Thus a conceptual split may be perceived here between the originally biomedical journey and the subsequent foray into the non-biomedical world. This may mirror in a practical sense the philosophical transformation observed previously by those participants who described how their experiences of illness and therapeutic journey led to the re-prioritisation of their values and behaviours toward more balanced or holistic lifestyles. For some patients, the immense relief they experienced via their experiences with chiropractors apparently has led to an almost evangelical support of the discipline:

> Dr.( ) has simply changed my life. Changed my life. Before I found him, I
> was stuck in a horrible downward spiral, miserable, going from one so-called
> specialist to another. No-one could tell me what the problem even was, let
> alone what they could do about it. Some of them sent me for psych
> evaluations, told me I was depressed, wanted me to go on Prozac. I was
> about to go in for surgery when a friend suggested I go see Dr.( )...I was so
> desperate I figured why not? As soon as he laid his hands on me, I knew it
> was going to be different, sure enough by the end of that first visit I was
> already so much better! He convinced me to postpone the surgery and after 6
> visits I was a new woman....I tell everyone about chiropractic now, anyone
> who'll listen! I just can't believe how close I was to going under the knife,
> and it wasn't even necessary! (BR)

166

And in the following extract, another interviewee describes how she initially attended a chiropractor for what she believed to be an unrelated health problem, but then achieved miraculous results:

Interviewer: *So tell me how did you come to be a chiropractic patient?*

Respondent: *Um I hurt my neck initially, just falling off a ladder and went to a chiropractor but I also had at the time spastic bowel where you have diarrhoea and in the process of fixing my neck and back they actually solved that problem which actually really made me believe in chiropractic. Yeah, it was amazing because I was like totally blown away, didn't expect that to happen and I'd been told by doctors I'd have it for life, drugs for life so that was cool, and so my whole family went. My husband had asthma, my son had asthma, um so we were all treated as a family by a chiropractor for years. (BR)*

The notable enthusiasm of the 'converted' has over time led to the accusation that chiropractic resembles a 'cult'. This has been a long-standing criticism of the discipline, one which may find its roots in the early days of chiropractic when spiritualism and science were not considered so mutually exclusive. The founder of the discipline, D.D. Palmer, was an avid reader of religious and spiritual texts, and proclaimed that chiropractors had 'a moral and religious duty' to adjust displaced bones so that people may enjoy happy lives (Wardwell 1992: 64). Of course, 100[+] years ago such rhetoric was hardly unusual, however these days complaints about 'preaching the gospel' of chiropractic tend to be reserved for a particular minority of chiropractors who engage in what has become known within the profession as 'practice-building'.

Practice-building seminars (fee-based workshops etc designed to help chiropractors build more financially successful practices through the use of a broad range of sales and marketing tactics) have become wildly controversial within modern chiropractic, with supporters and detractors largely aligning themselves along similar lines as those taken up in the previously discussed debate between 'philosophical' and 'evidence-based' chiropractic (see Introduction). Largely promoted in the USA, practice-building seminars are viewed by many British chiropractors with contempt, who see

167

them as negating their efforts to gain mainstream public support and greater legitimacy within the orthodox health care system. Certainly it seems that the gurus of practice-building do not care to toe the line with respect to restricting themselves to the rhetoric of science and rationalism that is the preferred discourse of the evidence-based chiropractic camp. As Wardwell notes: "sometimes the exhortations of the practice-builders are so emotional and persuasive in their Palmer-like appeals to save the world through chiropractic that they are referred to condescendingly as 'that old-time religion'" (Wardwell, 1992: 271).

Thus chiropractic continues to be characterised by some as resembling a 'cult'; however for many chiropractors this accusation is discursively neutralised as nothing more than 'sour grapes' on the part of physicians who fail to inspire such profound emotion and response in their patients. For these chiropractors, this level of patient enthusiasm is nothing new and indeed can be inferred from other parts of their interviews:

> *People who have been dealing with pain for a while, often they aren't sleeping*
> *that well, you know and pain can make you grumpy and miserable as well so*
> *its no surprise when they get treated and then there's a kind of release, a*
> *physical release of course but also a kind of emotional release too. But*
> *normally people are just really grateful. It's quite touching really, I mean you*
> *know you're just doing your job, really, but they are so grateful to you. I*
> *mean, you should see our house at Christmas. It's just full of chocolates and*
> *wine and scotch and all kinds of homemade presents and cards from patients.*
> *And it's not as if you haven't been paid along the way! I mean, it's your*
> *business, they've already paid for your time, or care or whatever. But they*
> *are just so grateful, and it's really touching. (SH)*

Here chiropractic is discursively constructed as qualitatively different from other health care disciplines, by virtue of the powerful emotions and gratitude that it inspires on a regular basis.

Certainly there is a very personal and transformative tone evident in many of the accounts:

168

Going to see Dr Y literally changed my life...I was so desperate, I had been

dealing with it for so long and no-one could help, useless the lot of them but

as soon as he laid his hands on me I instantly felt better and it was like having

a new lease on life. (BR)

In this excerpt, the patient refers to having a 'new lease on life', conveying a redemptive and transformative message. These utterances, with their references to hands-on healing and the role of chiropractic in giving new life seem to blur the lines between science and religion, medicine and spirituality. The symbolically charged language seems to erode what has perhaps been an artificially created divide between modern, rationalist medicine and traditional, emotive health care. They also seem to express the sense of personal empowerment that comes from having been offered a branch with which one might lift oneself out of the quagmire of dysfunction and disability. What is more, the ability of chiropractic to offer a 'life-line' was talked about positively with regards to the speed with which it was understood to achieve important results.

Speed/immediacy of effect

Returning to the first extracts of this section for a moment, another discursive theme appears: one regarding temporality, or specifically in this case the speed and immediacy with which it is asserted chiropractic therapeutic modalities work. This achieves great rhetorical effect, for it at once positions chiropractic as not only without question efficacious, but also having effect at a greater speed than other approaches. Chiropractic treatment here is spoken of in no uncertain terms not only as one that works, but that works in a tangibly better (i.e. faster) way. This discursive theme was evidenced throughout the practitioner interviews:

I know that I can probably do something for them that will help them,

usually right then and there on day one there'll be some kind of

improvement (DH)

169

Further to this, it is suggested that the ability for chiropractic to have a profound and speedy effect is not limited to physical improvements such as range of motion or reduction of pain sensation:

> *I mean for example, the spiral of depression that you see so much with chronic pain patients, it's amazing to see how quickly that can be broken with just a small physical improvement. (DH)*

However this is clearly not just a practitioner discourse; patients too spoke of the speed with which chiropractic could help them:

> *Initially (its) a little bit daunting because you're not quite sure what a chiropractor does but it's the one thing that I think gives more instant relief than anything else for back pain. (WD)*

In another interview this person describes her experience in seeing chiropractors for assistance in the alleviation of symptoms associated with chronic vertigo:

> *my previous chiropractor died and I had had sort of two months of Stematol to try and settle down the vertigo cos I was going to see him the day he died and he wasn't there of course and because I didn't know where to go, I held off and I had two months of Stematol doing absolutely nothing. I finally tracked down (a new chiropractor) and thought I'd come here and he did one adjustment and (clicks fingers) it was gone! (BR)*

I would argue that these extracts speak to the variety of ways in which patients make meaning of their experiences of illness and recovery. Illness experiences can be spoken of in ways that reveal hybrid subjectivities and multiple interpretive frameworks. Discourse analysis offers a useful heuristic device for producing a more complex and nuanced understanding of illness and treatment experiences within CAM. This examination of patient accounts has shown how patients are able to shift discursive 'frames' strategically according to what particular effects they seek to achieve. For example, a discourse that constructs the clinician as expert may be used to situate the patient in a manner that removes the burden of responsibility for

recovery. Cognitivist models, I conclude, are insufficient insofar as they are unable to capture the fluid and situational character of these multiple discursive strategies and the complex ways in which they may be deployed in negotiating the tricky terrain that is chronic pain/illness.

Passive discursive strategies: invoking the metaphysical Other: 'It's in God's hands'.

At the opposite end of the spectrum with regard to patient agency, was the discursive strategy to defend oneself from responsibility by the placing of faith and power with some sort of metaphysical Other. Thus another discursive strategy that came through in the accounts was the framing of ultimate outcome as being in the realm of the metaphysical. In these accounts, the locus of control lay neither with the doctor or the patient but rather, with God or some other loosely defined 'Higher Power'. However, arguably these utterances that might at first glance be attributed to underlying fatalistic or religious beliefs or attitudes may actually serve other sociolinguistic purposes. Notably, statements of this type were typically made at the end of narratives which had contained lengthy descriptions of the clinical and rehabilitative journey, and/or the breadth of approaches that had been taken to overcome/resolve their condition. It is possible therefore that they were being used to fulfil other discursive functions, such as communicating a sense of resilience, an ability to 'stay tough' i.e. have hope/exhibit positivity despite the lack of progress thus far. In making such statements they position themselves as 'good' patients for having tried 'everything', and yet not giving up. For example, in this passage, so and so says:

> *I've been there done that when it comes to this. Honestly, I have really done the rounds. Nothing's really worked so far, although I must admit I've had better results with Dr.( ) than anyone else so far. I'm happy to keep seeing him, and doing the exercises and everything. There isn't much else I can do, is there?! After that I reckon it's in God's hands. (AF)*

This extract shows many of the same characteristics seen in other passages that make use of idiomatic statements, namely that the phrase is invoked less to communicate an underlying belief in God and more to achieve other rhetorical business. It serves here to underline the individual's hardiness/willingness to carry on with a positive attitude

171

despite the lack of relief thus far. It also works to communicate that they have said all they have to say at that point, signalling to the other participant(s) that it is their turn to speak. The phrase supports culturally approved standards of morality and is sufficiently vague and non-problematic so that it is unlikely to be challenged; it therefore also serves to achieve support for the individual and underscore their membership of a shared interpretive community or culture.

Wellness/wellbeing

> We have an unusual problem here Jane - you want me dead, and I'm less and less concerned for your well-being.
>
> 'Mr. and Mrs. Smith' (2006)

It has been argued in other recent work that a defining feature of the healing sought by users of alternative and complementary health care is that it transcends physiological health to encompass broader goals, specifically, a state of 'well-being' (Sointu, 2006). Whilst it seems feasible that there has been a growing consumer interest in the pursuit of well-being in recent years, statements to this effect are difficult to make as the concept is somewhat loosely defined. Sointu argues however that the negotiation of well-being is an important part of the health that users and practitioners of alternative and complementary health practices seek to produce. In her study with users and practitioners of a variety of alternative and complementary health care systems, well-being was constructed as a sense of harmony or balance that is available to all - illness, disease or disability conditions notwithstanding (Sointu, 2006). Some of the underlying meanings invested in this notion of well-being included the pursuit of fulfilment and (personally authentic) truth, as well as the ability to be able to choose for oneself a person-specific definition of health/well-being that enabled the individual to actively engage in the process of self-actualisation. Well-being then, appears in these accounts to be constructed as an important part of individuals being able to pursue their health in a way which allows for agency, autonomy and personal responsibility. Sointu perceptively notes that whilst alternative and complementary health practices may still be perceived as marginal from a health policy perspective, these desires and capacities are not *culturally* marginal – in fact they are remarkably consistent with strongly held

172

Western cultural values, which may go some way towards explaining the persistence and popularity of non-biomedical health care. Thus, 'the rise of alternative and complementary health practices is aligned with trends that also affect biomedicine' (Sointu, 2006: 339).

In these accounts, well-being did emerge as a theme amongst users of chiropractic services:

> *I think that the ability of my first chiropractor had to actually embrace the wellness of the whole family was really amazing. (BR)*

> *It's just tiring I guess. It affects your whole lifestyle when you, I mean I guess mine's more vertigo than pain but that's huge because it affects your wellness and your everything. (BR)*

In this passage, the notion of well-being arguably is being utilised as a discursive strategy to resist or challenge limiting biomedical definitions of health and illness. By introducing this concept as an important part of her desired outcome, the user is demanding that her practitioner allow room for a more situational and person-specific definition of health to be developed. She is also achieving important moral work insofar as she is framing her quest for health in ways consistent with broader social mores that expect people to try to overcome illness, and fulfil their potential. That is, by discursively employing the concept of wellness, which is taken for granted as a self-evidently positive thing, the interviewee successfully positions herself as a moral agent, whilst simultaneously reinforcing the concept itself as a viable and appropriate rhetoric within the discourse of health care. This is made possible thanks to the notion's congruency with wider social values, specifically those concerning the importance of individual empowerment, agency and self-fulfilment.

Notably, the emotional/spiritual component of well-being that was noted in Sointu's work did not come through the narratives in this study with the same strength or discursive force. Perhaps chiropractic, as one of the more mechanistic complementary health practices, does not allow as much scope as other disciplines for the exploration of the emotional and spiritual aspects of holistic health care.

173

Certainly, there appeared to be considerable practitioner resistance to the presentation of what they considered to be unruly and undesirable emotions within the chiropractic encounter:

> *I don't seem to attract a lot of patients like that, some practitioners do, people end up crying in their office telling them all sorts of information about their lives, their family lives and I don't provide them with the environment to be able to do that, I'm a little more mechanical myself in that regard...But I would say probably over the years I haven't had that sort of patient that is going to be very emotional with me. I think what happens is patients tend to refer patients that are like themselves? And people tend to get sent other emotional people, and some people are really good at being able to handle that. I find it very draining and have always felt it draining...(DJ)*

This is worth considering within the context of contemporary emotion theory which emphasises the performative aspects of emotions, such as that articulated by Sarbin (1986), Harré (1991) and others. Social constructivist approaches conceptualise emotions and emotionality as constituted through the use of particular discursive practices, and which therefore may be analysed 'something like conversations' (Harré and Gillett, 1994: 154). Adopting such a discursive framework allows for the radical reconceptualisation of emotions, insofar as they become understandable as related to the language games, local moral orders, and social functions that serve to make sense of both emotion displays and emotion talk in a given culture or sub-culture (Harré and Gillett, 1994).

Harré summarises this view by defining an emotion as "a bodily enactment of a moral judgement or attitude in accordance with the conventions of local dramatistic codes" (Harré, 1991: 142). As a result then,

> there is no such thing as 'an emotion'. There are only various ways of acting and feeling emotionally, of displaying one's judgements, attitudes and opinions in an appropriate bodily way. (Harré, 1991: 142)

Other social constructionist theories of emotion have similarly emphasised the importance of context, meaning and language in the experience of psychological life

174

(Gergen, 1985). For example, constructivist approaches have questioned the essentialist view of the history of emotion by detailing changes in the way emotions have been described and experienced over time. That is, emotions are historically specific, culturally derived, linguistic phenomena. Constructionism has also questioned the idea that emotions are directly reflective of inner states or feelings, noting that emotions are rule-bound and have regulatory and moral functions (Averill, 1986). This derives from the understanding of discourse as active and constructive; and that one of the many subtle and complex functions that discourse fulfils is the reproduction of existing moral orders. Armon-Jones (1986) argues for example, that judgement about whether an emotion is valid is a social and cultural one. Dominant views of emotions appear, thus, to serve a number of social and cultural purposes.

Stainton Rogers, Stenner, Gleeson and Stainton Rogers (1995) argue that mainstream psychological views of emotions assume the existence of underlying binary oppositions such as mind/body and feeling/thought, and that this reifies the artificial separation of these concepts. They argue that emotions are not static or discrete psychological entities but rather represent ways of being that vary both historically and culturally. They quote Harré's (1986) comments that emotions are better recognised as experiences rather than 'things'. That is, rather than stable or discrete psychological phenomena there are:

> angry people, upsetting scenes, sentimental episodes, grieving families and funerals, anxious parents pacing at midnight and so on. There is a concrete world of contexts and activities. We reify and abstract from that concreteness at our peril (Harré, 1986: 4)

From this perspective, emotions are inseparable from the location or positioning of the participants and these positions are not given but 'negotiated, worked at, resisted at some points, foisted upon others at other points' (Stainton Rogers et al, 1995: 187). For them, an emotion is:

> always a complex assemblage of bodily organization and transformation, bodily experience, thought, judgement, evaluation, perception, all of which takes place in specific cultural locations at particular historical junctures within the context of given social arrangements and practices and in the light of particular personal circumstances. (Stainton Rogers et al, 1995: 188)

175

Eatough and Smith similarly define emotions as 'complex, episodic, dynamic and structured' (Eatough and Smith, 2006: 485). Understandings regarding emotionality within the therapeutic setting then, are likely to be constructed and constrained by the cultural discourses relating to emotions that are available to patients and doctors.

> *say they're very stressed in a relationship or something, to now get intimately involved and actually advise, well I wouldn't advise on what they should do and I don't think that's my job. If they want to volunteer information and want answers the whole time, they bring it into situations where you're not necessarily wanting to go. So they start talking about how horrible someone else is and slagging them off or whatever, its not really my job to defend that person. I don't know if it's my job to shut them up. So you're kind of emotionally drained by the end of it. So you sort of nod, and its probably therapeutic for them to let off steam but at the end of the day its emotionally very tiring (VR)*

Here the scope for emotions to be allowed into the therapeutic encounter is being discursively constructed as something which patients will try but that clinicians can (and should) resist. This aspect of talk within doctor-patient interactions has been noted by other researchers who have highlighted the ways in which doctors shape both the content and form of clinical conversations by asking closed questions that uphold boundaries they are comfortable with i.e. biological or structural, not psychosocial, emotional or lifestyle/'personal' (Campion, Butler and Cox, 1992; Mishler, 1984). In their analysis of general practitioner interviews, Campion et al (1992) showed that patients presented emotional agendas to a far greater extent than doctors addressed those concerns. This tendency for doctors to prefer 'non-emotional' encounters with patients is similarly audible in these accounts with chiropractors, for example, in the following extract a clinician describes his ideal patient:

> *they respond, they ask you questions, they are basically trying to find out as much as they can about what they can do for themselves, they're not needy and they're emotionally stable. (DJ)*

176

Being 'needy' or 'emotional' here is constructed as undesirable patient behaviour and interestingly, this is presented uncritically as a taken-for-granted or self-evident understanding. There is no question asked as to whether or not this is appropriate or 'right' within the broader discursive contexts previously highlighted regarding the role of chiropractors in providing comprehensive primary care, nor their theoretical commitment to providing biopsychosocial care. I would argue that this likely relates back to the narrative theme discussed earlier in this work whereby practitioners made use of the dominant biomedical discourse to construct their clinical role as being strictly or largely biomechanical.

Discussion

In this chapter the ways in which individuals use discursive resources to manage ideological dilemmas that arise within the healing encounter has been analysed. The tension that the dominant yet ambiguous medical discourse presents whereby both passive and agentic positions are encouraged at different times has been considered, and the functions or objectives that this discourse may serve have been examined. The complex and subtle discursive work performed by patients to construct narratives that manage to reconcile these contradictory demands has been examined, within the context of the chiropractic encounter. Particular attention has been paid to the discursive practices employed by patients to overcome the ideological dilemmas that result concerning accountability and responsibility. Specifically, conversational idioms in accounts with practitioners and users of chiropractic health services have been examined, from the perspective that such forms of talk communicate a socially normative moral requirement rather than reveal discrete underlying psychological states or cognitive constructs. That is, talk here has been considered as a form of social action that functions to achieve specific social objectives in a situated and relational manner. The use of discursive resources to assert a moral position and vindicate the self as a moral agent has been considered, and I have attempted to construct an understanding of language that emphasises its functional aspects as opposed to the usual (realist) consideration of talk as a merely descriptive act. Finally, I have attempted to deconstruct that talk by critically evaluating statements and examining how their construction as taken-for-granted truths works to achieve specific personal issues concerning identity, self and subjectivity.

177

CHAPTER SEVEN

CHAPTER EIGHT

Reflecting on the research and its implications

<u>Introduction</u>

In the first two parts of this dissertation I have focused on how webs of meaning are constructed both in the broader sociocultural context and in the specific context of interviews with patients and practitioners within chiropractic settings. In this part I want to 'stand back' from the study and constitute it as an object in order to address some of the issues of reflexivity which have arisen throughout the course of the study. First I will give a brief overview of reflexivity as it relates to discursive analytic and social constructionist work. I will then seek to outline some of the contextual influences which have shaped and informed this account, before moving on to examine the reflexive issues that came into play and have subsequently informed this work. Finally I will attempt to reflect on how the arguments and situated knowledges that have arisen out of this work have themselves been rhetorically constructed. This will then lead on to a discussion of some of the ways in which these observations might be made explicit, in the next chapter concerning implications of the research.

<u>Reflexivity</u>

It is commonly accepted that social researchers need to take a reflexive approach to their work; that is they must critically reflect and evaluate their own assumptions and work. The call to reflexivity is in part due to the increased acceptance that:

> how knowledge is acquired, organised and interpreted is relevant to what the claims are (Altheide and Johnson, 1994: 486)

This in turns reflects the current awareness that social researchers are not separate from the social world that they seek to understand, and that our indivisibility from the same social world we seek to explore necessitates a keen awareness of the limits and challenges one faces in navigating that terrain.

Burr defines reflexivity as a:

> term used by social constructionists to refer to the application of the theory
> back onto itself and its practices. Burr (1995: 185)

Burr (1995) notes that the term 'reflexivity' may be used in a variety of ways, to achieve different purposes. Often, it is used to refer to the way social constructionist theory reconstitutes the role of those they seek to understand, the status of the accounts themselves, and their relationship to the researcher. Reflexivity as a concept may also be utilised to acknowledge that in giving an account, that account is both a description of an event and part of that event. Perhaps most commonly though, it may be used to refer to the fact that social constructionism is itself a social construction and thus the knowledge-making practices of social constructionists must to be considered in a non-trivial way.

Mauthner et al (1998) also provide a useful definition of reflexivity:

> The dynamic self-reflection necessary for researchers to acknowledge and
> engage with their role in, and contribution to, the research processes and
> products. (Mauthner et al, 1998: 736)

As researchers have become increasingly conscious of the socially constructed nature of interviews and data, reflexivity has risen to occupy an essential part of the research process. That is, the ways in which subjectivity influences knowledge constructing processes has become an issue of increasing importance for social scientists. It has become widely recognised for example, that data analysis is not a neutral process but rather is one informed and influenced by the theoretical, epistemological and ontological assumptions of the researcher. Thus data interpretation has come to be viewed as a process through which meanings are made rather than simply 'revealed'. Data analysis, therefore, does not occur in a social or political vacuum but rather can be seen to be the undertaking of a subjective, situated person or persons influenced by interpersonal, emotional, moral and political positions that inevitably manifest in their work.

The construction of knowledge claims is therefore a social activity grounded in its cultural and historical context, and knowledge itself is understood to be at best partial,

imbued with particular assumptions, and reflective of particular perspectives. Knowledge and understanding are therefore now more widely considered to be 'situated knowledges' which are both linguistically constituted and socially, culturally and philosophically informed. Thus,

> as researchers we need to be reflexive about, and articulate, the ontological nature of subjects and subjectivities we are using in our research as well as the epistemological assumptions underpinning our methods of data analysis and knowledge construction (Mauthner and Doucet, 2003: 416)

However it seems clear that to be able to truly 'stand apart' from one's work is a particularly challenging, if not impossible task. That is, there may be boundaries that define how reflexive researchers can be. As Grosz notes:

> the author's intentions, emotions, psyche, and interiority are not only inaccessible to readers, they are likely to be inaccessible to the author herself (Grosz, 1995: 13)

And so we may ask ourselves:

> is there a limit to how reflexive we can be, and how far we can know and understand what shapes our research at the time of conducting it, given that these influences may only become apparent once we have left the research behind and moved on in our personal and academic lives? (Mauthner and Doucet, 2003: 415)

They suggest that, alongside the inclusion of dedicated space and time being allocated within which researchers may be reflexive, it may be necessary to return to the work at a later time in order to apply the benefits of hindsight and emotional detachment. Bola makes the further point that:

> We all have our blind spots – as well as profound political differences. The process of being reflexive, therefore, should not be limited to individual reflection, but should be a collective endeavour, in which we all take some responsibility for the knowledge which is produced. (Bola, 1998: 109).

Scholars therefore must consider reflexivity an ongoing and collaborative commitment in the interests of answering questions concerning the status and validity of knowledge claims. To this end, many authors have pointed out the importance of being reflexive about our social locations and political perspectives that influence not

only our generative processes but also our reception and interpretation of presented knowledge claims. For example, Gill suggests that:

> Discourse analysts should adopt a notion of reflexivity which stresses the need for the analysts to acknowledge their own commitments and to reflect critically upon them. By seeking to explain and justify the basis for their readings or analyses, discourse analysts become accountable for their interpretations and the social and political consequences of these interpretations. (Gill, 1995: 182)

Reflexivity as a conscious undertaking is thus related to theory insofar as theory should be conceived within a reflexive framework whereby the researcher seriously considers the practices and assumptions of the community they investigate *and* that which they themselves belong to with a view to the shared practices, linguistic customs and cultural values inherent in those communities. That is, in considering aspects of health care which are contested within the greater hegemonic arena of biomedical health care provision, care must be taken to deconstruct taken-for-granted truths and understand explanatory categories in terms of subjectivities, power and knowledge (Fox, 1994; Stam, 2000).

Institutional context

> The 'choices' we make in our research with regard to ontological and epistemological positioning, methodological and theoretical perspective, and the adoption of particular research methods are bound up not only with our personal or academic biographies, nor are they motivated exclusively by intellectual concerns. The...institutional contexts in which researchers are embedded also play a key role in shaping these 'decisions'. (Mauthner and Doucet, 2003: 421)

Thus the political and institutional interests of my own discipline (health psychology) and the strategies employed within it with regard to disciplinary boundary maintenance are of central interest in their own right i.e. as well as that of those investigated. That is to say, the discipline of health psychology itself must be considered in its broader political and economic context. Specifically, as researchers within the discipline of health psychology we should be aware of the fact that the discipline to which we belong sits alongside and within the biomedical establishment. As Stam points out, the mission statement of the Health Psychology section (Division 38) of the APA (1996) states:

181

Psychologists are in increasing demand in health and medical settings. The single largest area of placement of psychologists in recent years has been in medical centers. (APA, 1996, in Stam, 2000: 275).

This is due perhaps not in small part to the congruency between the epistemological and methodological frameworks that have informed both medicine and psychology over time; that is, the shared commitment to a realist perspective with its attendant methodologies such as lab-based experiments, randomised controlled trials etc. has led to the two disciplines becoming usual, if sometimes uneasy, bedpartners.

This has both practical and theoretical consequences for health psychology as a discipline. As a major employer there is a clear conflict of interest and disincentive for health psychology as a discipline to challenge or critique biomedicine - but more significantly from a theoretical point of view the challenge for health psychology researchers will be to persist with research that does not appeal to biomedicine with its current focus on 'evidence-based medicine' and the subsequent priority given to empiricist, 'rational' investigations of observable, 'objective' phenomena. That is to say, research that upholds the biomedical fixation on these types of investigation, and which therefore marginalises other types of research (discursive, 'holistic', subjective) is likely to be supported both fiscally in terms of the material allocation of resources (grants, appointments etc) and also rewarded in other non-material ways (for example the greater 'kudos' and 'respect' that researchers working from this 'harder', more 'scientific' perspective may enjoy). Or as Parker (1994) argues:

> The way that social research is contextualized now will also look a little more complex, for the 'context' is, in this account, not an objective background against which the researcher renders an account of the phenomenon in question. Rather the context is the network of forms of subjectivity that place contradictory demands on the research. In social psychological research there is an array of competing interests and agendas that frame the production of proposals; the expectations and demands of 'subjects' or co-researchers; and

the career investments and projected autobiographies that exist in tension in the academic world. (Parker, 1994: 250).

Psychology, with its long-term relationship to medicine both culturally and historically, shares many of its central tenets and assumptions. For example, the tendency is still within psychology (as in biomedicine) to be focused at the level of the individual; the view persists of said individual as a unit that can function 'normally' or 'pathologically'; the assumption that deviations from perceived norms represent a 'malfunction' shares much with the biomedical mechanistic focus on the body rather than the person; the tendency for generalisation from individuals to groups (and the inherent tendency within this to ignore gender, historical/temporal or cultural/ethnicity differences); the philosophical legacies of specific etiology and disease theory (medicalisation and the seemingly endless expansion of psychiatry); and finally, as mentioned previously, the shared adherence to the rationalist 'scientific method' with all of its attendant beliefs and assumptions concerning 'objectivity' and what constitutes 'good' science.

Arguably the relationship between the two disciplines is so close, so inter-twined and inter-related that a change in one is often seen to appear concomitantly in the other. The rise of the biopsychosocial model of health and illness within biomedicine has for example been mirrored by its widespread adoption throughout mainstream psychology, which can be seen to serve less as a theoretical model and more as:

> a useful rhetorical device for the appropriation of a set of topics in health and illness into psychological practice and research (Stam, 2000: 276)

The biopsychosocial model, with its broad remit and vague terminology thus provides health psychology with a golden opportunity to further expand its institutional reach. This in turn relates back to issues of occupational closure and competition within the system of professions, as discussed previously in the chapter regarding the professionalisation of chiropractic/biomedicine. That is, in the same way that different health disciplines (nursing, chiropractic, occupational therapists etc.) compete within the sphere of health care for areas of legitimate dominion, so too does health psychology jostle for position and 'ownership' over an area of occupational work. Clearly there is overlap between health psychology and other providers of health care services in many areas within loosely defined and therefore hotly

183

contested arenas such as family health, chronic pain and illness, 'wellbeing' and so on. A key part of any one discipline's 'success' then in demarcating and defending a position within the system of work is to change and expand its area of understood expertise/relevant influence. As Haraway points out 'scientific stories are not innocent' (Haraway, 1991: 106); they are deeply embedded within the institutional, cultural and historical context in which they occur; and may reflect those objectives and agendas accordingly.

This is not to suggest of course that health psychologists are on an individual basis making competitive moves in a 'self'-motivated fashion, but simply to recognise the structural features of a collective enterprise within its cultural and political context. Transformations concerning the political economy of health care at the macro level have an inevitable effect upon those engaged in the everyday activities of the involved sub-disciplines – and thus we must consider this structural landscape in terms of its possible impact on our theoretical and empirical actions. That is, the best-intentioned actions can sometimes have unintended consequences. For example, the concern with 'norms' and deviation from norms as is necessary for statistical analyses of groups has arguably led to an implicit definition of healthy as referring to those who function according to the said norms. Whilst this may have evolved as an attempt to better understand and be able to facilitate 'good outcomes', it should be understood as equally serving wider social and political functions such as keeping citizens functioning as efficient and unproblematic members of society, in accordance with the goals and norms of the dominant group at the time. Health in this sense is being operationally defined as a functional entity, and this is reflected in its preoccupation with topics such as prevention, coping and ability to perform/fulfil one's social duties and obligations. One unintentional result of this universalism is the tendency for knowledge to be generalised as being independent of the person from whom that knowledge has been derived, and as standing alone from their social and cultural context.

Of course these are not new reflections; authors from a multiplicity of theoretical perspectives (feminist, postmodernist, critical theory) have suggested many alternative approaches to conducting critical research. Not least we have seen a renewed enthusiasm for qualitative methodologies – however it should be

184

remembered that this in itself does not guarantee a reflexive stance to the research has been adopted. As Bradley points out:

> In qualitative research, as in other research traditions, data are collected from the empirical world. Those data then form the basis for conclusions about the empirical world. Any set of data is, in fact, a subset of possible data about any phenomenon, and many of the key issues in data collection across all research traditions address the problems inherent in using a subset as a stand-in for a larger data universe. (Bradley, 1993: 439)

Understandings of and management of bias, particularly researcher bias, is affected by the underlying epistemological assumptions. However the methods employed do not imply that one is more 'objective' than the other:

> Total objectivity is impossible for researchers who are, after all, human beings. The difference between the two research traditions is not that one has and one lacks objectivity. The difference is that naturalistic researchers systematically acknowledge and document their biases rather than striving to rise above them. (Mellon, 1990: 26)

The difference therefore is in the separation or integration of the researcher/subject. However, irrespective of methods employed, what is required is the self-conscious examination of the process of knowledge production itself, and an understanding that as a health researcher one is a 'constituent player engaged in the construction of health and illness' (Stam, 2000:278). As researchers we need to consider our beliefs in 'reality' and how we come to know. Bradley notes that:

> Active discussion of what we know, in light of how we produced that knowledge, can only extend our understanding. (Bradley, 1993: 448)

We therefore need to be open about and cognizant of our ontological and epistemological standpoints and those of existing research so its limits and biases may be revealed.

In reflecting on our standpoints, we must take account of where we are standing – and for what purpose we are acting. In the case of this thesis, the research is being conducted from a particular historical and professional position – whereby the researcher is attempting to communicate in language recognisable and acceptable by other members of a professional group, at a particular point of time. This is part of

the ongoing project whereby members of a group are obliged to continue the work of creating and defending occupational boundaries – a key part of which depends upon the establishment of a specialised knowledge base that is difficult, technical or complex. Recognition of accomplishment or mastery of that knowledge base is a requirement for membership of the group, which is in turn defended with specific, ritualised barriers to entry in order to protect the legitimacy of that particular professional status. Thus the parameters for what is considered appropriate language and even subject/method of inquiry are influenced by membership of, or in this case desired membership of, a defined professional group at a particular point in time and within a specific cultural geography.

In addition to considerations of the institutional group to which the researcher seeks to belong, there are further intrapersonal characteristics to be considered. That is to say, this thesis is the result of work conducted by a research student who brings to that work a specific moral position. For, as Stam (2000) suggests:

> We never leave our moral commitments behind at the breakfast table, they follow us into the consulting room, the meeting room and the classroom. (Stam, 2000: 281)

In this case, the political and moral standpoint of the researcher can be understood to have translated into print; as it is surely impossible for this work to have escaped them – from the conception of the research topic to how it would be approached, to the questions that were asked and how the answers were interpreted.

In attempting to be fully reflexive therefore, one's interpersonal, moral and philosophical beliefs must be considered in addition to those relating to educational and academic affiliation. What personal assumptions, values and beliefs do I then bring with me to this work that might have impacted on and informed the knowledge construction process?

Personal beliefs re pain
In reflecting upon my subjective beliefs and assumptions regarding pain, several personal 'truths' become apparent that surely have had an effect on my work.

1) First of all, it is my personal belief, resultant of both familial and educational factors that pain is our friend, not to be obliterated but rather better to be understood as a communicator of valuable information. The voice of pain is to be heeded, not silenced and attempts to do so are therefore misguided, even dangerous...

2) Pain is always, in one's head, insofar as it is indivisible from the bodymind complex that we are as embodied subjects.

3) Pain is also always, in other people's heads, inasmuch as we are social and cultural creatures always influenced by the broader context in which we exist.

Personal beliefs re CAM

1) CAM represents an important alternative perspective to matters of health and illness.

2) However CAM does not necessarily represent a more holistic approach to health and illness than biomedicine; holism is a practical rather than theoretical orientation.

Personal beliefs/positions vis a vis biomedicine

1) Biomedicine represents a worldview which is at best partial, provisional and perspectival.

2) Traditional biomedical approaches to pain, health and illness are epistemologically impoverished by their philosophical roots.

These interpersonal beliefs and values can be understood best perhaps if placed within the context of the researcher's academic and personal background. Doctoral research is one part of an academic career-building process which occurs against a backdrop of personal and educational events that have inevitably served to shape and influence the researcher's perspective. In my case, I came to this doctoral effort somewhat circuitously after having completed a largely positivistic undergraduate degree in psychology, which was heavily weighted towards behavioural-cognitivist explanations of psychological phenomena. However, I struggled conceptually with what I felt to be the partial and incomplete understanding that such an approach represented when attempting to understand the complex and mysterious nature of human experiences such as illness and pain. In seeking to understand these

187

subjectivities from another perspective, I went on to complete a master's degree programme in sociology and social research, which provided my work with a different set of epistemological and methodological tools that I could then subsequently apply in approaching these topics. Intellectually however, I found myself caught somewhat between the two disciplines, whereby I rejected the limitations of positivistic, experimental psychology but somehow still felt compelled to conform to this model by attempting to relegate myself to the background during the design and practice of psychological research. In exploring the experiences and subjectivities of individuals, I struggled to apply notions of the cultural and social, which influenced, I am sure, in part my design decisions in the early stages of this project.

Doctoral research represents a massive learning curve, and reflection and revision has constituted a major part of that learning. Thankfully the experience of writing the upgrade document and the accompanying oral viva brought with it critical feedback and thought-provoking comments which allowed me to intellectually transcend what I had mistakenly believed to be incompatible disciplinary divisions. This was a pivotal moment for me both personally and intellectually, and had profound effects on this and future research endeavours insofar as it provided me with 'permission' to blend my previous theoretical frameworks, allowing for new ways of conducting research that I believe are more appropriate and ultimately, more illuminating.

Accountability in research

The call to reflexivity can in part be understood as an attempt to encourage authors to be accountable for the knowledge claims that they make. As Mauthner and Doucet put it:

> We would encourage researchers...to be more explicit about the particular epistemological and ontological concepts of subjects that are informing their research practices, their analysis and ultimately their research accounts...we suggest that the particular conceptions employed are less important than the epistemological accountability involved in making these conceptions as transparent as possible for the readers of our research accounts. (Mauthner & Doucet, 2003: 424)

Here the authors are asking researchers to go beyond a mere 'listing' of influences and agendas to achieve a more meaningful level of reflexivity and accountability.

But how is this to be achieved? Other authors have similarly noted that in many cases reflexivity can be seen to simply 'confess' on the part of the author their many interests and/or agendas, without seemingly any other purpose than to absolve the author of the certain epistemological sins (e.g. asserting truths), so that reflexivity can be seen to be acting for all intents and purposes as a kind of 'intellectual insurance':

> current discourse analytic adventures into reflexivity have often served to reinforce, rather than to challenge, the authority of the analyst, and have been used as a vehicle for disavowing explicit commitments, whilst pretending to give voice to other positions (Gill, 1995: 182)

In order to be held accountable for one's work then, it would seem necessary to not only list the influences (personal, academic, institutional, political and so on) that inform and shape one's work, but also to consider what 'voices' or interpretation those influences may have silenced or marginalised throughout the knowledge constructing process.

In the rest of this chapter then, I hope to address in full the many ways in which my role in the research has served to co-construct the accounts as they have been presented. That is, I hope to convey that the findings presented in this work do not represent 'data to be accounted for' but rather joint constructions of knowledge produced interactively between participants and myself as researcher. As such, they represent at best partial and situated knowledges, the limits of which need to be made explicate. Clarity about the many influences on one's work can begin however with making those forces known; to this end it is important that I attempt to outline some of the key interpersonal, intellectual and ideological influences that may be at work in this account.

Discussions of reflexivity typically tend to focus on issues regarding the social location and theoretical perspective of the researcher, as well as the ways in which emotional responses to participants can influence interpretations of accounts, and of course, the need to document the research process. However arguably there are many more subtle factors to be considered, such as the interpersonal and institutional contexts of research, as well as the epistemological and ontological assumptions

inherent in the knowledge constructing processes of data analysis and methods themselves. In this next section, I will attempt to outline some of these challenges, and reflect on how they may have influenced the study overall.

First stages: A note on my focus on chiropractic and the issue of objectivity

Chiropractic is a relatively small profession within the UK, and only one of a plethora of complementary and alternative systems of health care that could have served equally well as an arena for the examination of discourses on health and illness. So why choose chiropractic? The simple and pragmatic answer is, because I could. The majority of people who come into contact with chiropractic do so initially through personal connections of some nature, and I am no exception. My introduction to the profession could hardly have been more personal, nor could it have come at an earlier stage of influence, being born as I was to not one but two practising chiropractors. I consider myself fortunate to be one of the small cohort of people whom have received chiropractic care for their entire lives. This undoubtedly influenced by decision to focus upon chiropractic insofar as I was naturally interested in the discipline, and could also apply leverage to my personal contacts to achieve greater, privileged access to its institutions, archives and members.

On a theoretical level, chiropractic also represents an interesting and often over-looked example of a discipline that has successfully contested the dominant paradigm, overcoming considerable challenges to become a sizeable and reasonably well-entrenched health profession internationally. As Wardwell notes:

> it is the evolution of the profession and its success in changing from very dubious status to the position it holds today that constitutes the central drama of the chiropractic story and demands description (Wardwell, 1992: viii)

Of course, being personally involved in or psychologically close to the subject matter represents a major concern in terms of objectivity and neutrality. However, arguably we are all personally involved with our chosen subjects of investigation – indeed it has even been argued that it is not possible to acquire any meaningful insight into a given topic without such involvement. It is now widely accepted in the social sciences that claims to value-free knowledge are both misguided and dangerous, and

190

that we can hope to achieve impartiality only through vigorous reflexivity and self-awareness.

Issues of reflexivity within the practice of interviewing

This work represented an enormous learning process for me. Discourse analysis is of course a challenging form of research, and can be quite confusing and difficult to get to grips with – particularly for a novice researcher. I began by trying to read a wide range of discursive studies and felt after some time that I had gained a reasonable theoretical understanding of what I had to do. Having said that, when it came down to actually doing the research, I found the experience to be quite different to that which I had anticipated.

One major problem that I encountered throughout this work was a general sense of dissatisfaction/lack of confidence in what I had to say, that led inevitably to a kind of paralysis (both analytically and practically). In order to push through this, I found it necessary in the end to 'ease up' on myself and ask myself a different kind of question: not, 'is this right?' but 'is this good enough, for now?'. Or to paraphrase Billig (1997), 'is this a version with which I am not totally dissatisfied' (Billig, 1997: 54). Nevertheless, whilst I eventually approached a point at which I was reconciled to submit the work as being of some merit, there remain several aspects that could have, in hindsight, been done differently:

Limitations of the approach I took:
(a) Interviews vs. naturally occurring dialogue/texts
Whether semi-structured interviews are appropriate for DA has been a matter of debate (Potter, 1998, 2002; Potter and Hepburn, 2005; Spear, 2002). The decision to use interviews was made on the basis that one of the key aims of this research was to map out some of the discursive resources available to speakers as chiropractors or chiropractic patients. Whilst arguably this could be achieved in part by analysis of naturally occurring resources such as the professional chiropractic literature, I felt that an analysis of more informal forms of dialogue might be more useful, and interviews have been identified as one way of generating this kind of textual data (Gilbert and Mulkay, 1984). Another option would be to videotape naturally

191

occurring conversations about chiropractic, which may be a strategy worth considering for future work.

(b) Directive interview schedule containing many closed questions
Reading through the transcripts also revealed several inadequacies in the study design. For example, in hindsight it is now apparent that the interview schedule I developed contained many closed questions, thus arguably limiting or constraining the data generated. The interview design would therefore have benefited from the inclusion of multiple versions of key questions. This would have helped to avoid situations where a question phrased in a particular way failed to facilitate 'good' data. Similarly, the inclusion of more probes and prompts might have served to achieve better data generation, particularly surrounding key areas of conceptual interest.

Also, despite having an interview schedule to work from, I often asked considerably longer, more convoluted versions of the scripted questions, which sometimes elicited only short answers. Reflection on these and other aspects of my interview style and the manner in which questions should be asked will hopefully result in more expert handling of future work.

(c) Only interviewed people positive about chiropractic:

> Researchers should become more aware of how their own positions and
> interests are imposed at all stages of the research process – from the questions
> they ask to those they ignore, *from whom they study to whom they ignore*,
> from problem formulation to analysis, representation and writing. (Hertz
> 1996:5 in Cheek, 2000) [Emphasis added my own]

One obvious design flaw or oversight on my part was the decision to interview only patients of chiropractors, rather than widening the net to capture the statements of people who might have rejected chiropractic. As Cheek (2000) points out, what or who is absent in research is of as much importance as what (or who) is present. By choosing to interview only patients, I may have inadvertently invited a potential positive bias towards chiropractic, or that negative comments about chiropractic care

192

may be somewhat constrained. Had I chosen to include people from outside of the chiropractic community in the study sample, such discursive features might have appeared more often.

Interview situations are fraught with issues concerning power and position. With one person asking the questions and another answering, there exist self-evident situational and power/control issues that in the interests of reflexivity must be addressed. The dynamics of interviewing have been discussed by many authors who have noted the power imbalances inherent in such situations. It is generally accepted that the researcher inevitably holds some power over the interview process, and that the social dimensions of that power must be addressed. The tendency of interviews to create a number of roles or positions for both participants must also be considered. For example, representing the field of psychology it was clear at times that I was positioned as an 'expert' in matters deemed 'psychological' (e.g. depression linked to chronic pain, abnormal illness behaviour etc.). Any approximation of neutrality within the interviews also appeared to be further compromised by the positioning of me as a health psychologist. Although I attempted to convey both linguistically or tonally a non-judgmental, neutral persona, both patients and practitioners exhibited a sense of unease that they were being 'examined' by a psychologist - a common problem in conducting psychological research that has been noted by many authors.

Social desirability bias

This relates to another important factor that may attenuate the strength of observed phenomena in social research which must not be overlooked, namely, social-desirability bias. This concept refers to the tendency of some individuals to over-report socially desirable personal characteristics and under-report socially undesirable characteristics (Crowne & Marlowe, 1964). Social desirability bias is enhanced in situations where responses are made directly to an interviewer (Tourangeau and Smith, 1996). Since I was known to the interviewees as a psychologist, it is likely that the clinicians will have shaped their responses to be sympathetic to the biopsychosocial perspective. A similar influence may well have also affected the patient interviews; for example, knowing that I was a psychologist they may well

have subconsciously presented their narratives in a manner which emphasises rational, non-emotional factors in order to avoid being 'psychoanalysed'.

Commonality and difference in interviewing

In recent times there appears to have been an increased interest in the literature with regard to the dynamics of difference between the researcher and the researched, particularly within the interview process. Structural anthropological studies have developed binary notions such as 'insider' versus 'outsider' to describe the different positions that researcher and researched may occupy (Hammersley and Atkinson, 1983; Merton, 1972). Similarly, feminist writings about the interview situation have pointed out the problems inherent in interviewing people clearly 'different' from the self (by virtue of sex, race, class, age etc) and have called for more egalitarian research relationships (Oakley, 1981; Smith, 1987; Stanley and Wise 1993).

However recent debate has raised the issue of whether or not such dualistic categories illuminate or obscure the complex and multi-faceted positions that researchers and researched may occupy during the interview process (Song and Parker, 1995). Song and Parker note in their research with Chinese interviewees that perceived commonalities played an equally important role in shaping the interview process. For example, where there was a perceived commonality between researcher and researched (e.g. both were female), this had specific and notable effect on the accounts shared, in terms of the depth and sensitivity of personal and emotional revealed. This suggests that identities within the interview process are not fixed nor can they be conceived in terms of binary oppositions. Instead it may be that interviewers and interviewees can take up *multiple* positions which may shift in complex ways over the course of the interview depending on *both* perceived differences and commonalities.

This issue speaks to the problems inherent in interviews, where, often there exist important social differences between the researcher and the researched. As Song and Parker (amongst others) have noted, when researcher and researched have different social characteristics (including gender, class, age, education, institutional, political affiliation) there are likely to be major implications for *how* people talk to each other

as well as *what* they say. In this research this may be witnessed by rhetorical suggestions that I was viewed as straddling two domains, being identified alternately as representative of biomedicine (as a psychologist) and CAM (via my links to chiropractic both familial and professional). This is likely to have influenced what was said, as well as how it was said, depending on the topics being discussed. At times, practitioners clearly related to me as a fellow health professional – for example when one clinician asked for my confirmation of his appraisal of a patient as 'having psychological overlay'. That the practitioners understood me to be 'one of them' (i.e. part of the chiropractic family) was also apparent from exchanges such as:

> *Interviewer: What would be the most common complaints that you face as a chiropractor?*
>
> *Practitioner: You know the answer to that.*
>
> *Interviewer: I know I do. This isn't for me, this is the psychologist (speaking)*

My educational and professional 'class' I also took for granted, taking certain concepts as given. This was evidenced at the conclusion of one patient interview when the participant confided that they 'don't really know what chronic means, anyway.'

The fact that I chose to tape-record the interviews may have served to further underline power differentials. Several interviewees appeared to be uncomfortable with the presence of the tape recorder, glancing over to it repeatedly or joking as it was being set up (e.g. 'this isn't going to be held against me, is it?' - MW). The tape recorder also provider evidence of the constructed nature of interviews - with MY asking when I was changing over the tapes whether or not the interview was 'going well', and DJ asking me after the interview was concluded and the tape switched off whether it had 'gone ok'.

Another consideration concerning the interview situation concerns which questions are being asked, and how they are being asked. As the interviewer, clearly I had the control over this aspect of the research, which would have exerted some influence

195

over the construction of the accounts. Obviously, the questions I chose to ask reflected my research interests, which in turn are influenced by a host of personal and intellectual factors I have discussed at length already. However, despite being the architect of the interviews, even I was limited by the nature of the topic and setting in terms of the language I could use to access the topics of interest. That is, the nature of the setting being in the realm of health care meant that biomedical language dominated the conversations. This is unsurprising given that the adoption of biomedical terminology has been widespread throughout the professional education of CAM practitioners; similarly the majority of CAM patients typically have had considerable interaction with biomedical health care providers. This tendency for biomedical language and concepts to be introduced is interesting as it speaks to the hegemonic power that dominant discourses exert even when operating 'outside' of institutional or disciplinary boundaries. Institutional language thus can be seen to essentially 'direct' discourse and construct knowledge in specific ways.

My own role in the interviews did not escape this influence either. Either out of habit or for ease of common understanding, the language of medicine permeated my own part of the conversations, for example in questions concerning 'evidence based practice' or 'abnormal illness behaviour'. Whilst given the nature of the investigation this is to be expected, nevertheless it could be argued that I contributed, however innocently, to the continued reification of medical concepts. Using language uncritically overlooks the problematic and contested nature of taken-for-granted concepts such as 'depression', 'chronic', or even 'health'. This is an aspect of the study that I would like to follow-up on with future research, whereby these linguistic categories are themselves deconstructed and examined critically within both biomedical and complementary clinical contexts.

Reflexivity, transcription and analysis

The problems inherent in the process of transcription have been discussed in-depth by several authors who have helpfully brought attention to its constructive nature. That is, research accounts are understood to be jointly constructed by researcher and researched (Mishler, 1986). Data, far from being discrete entities to be discovered, are rather the product of the relationship between interviewer and interviewee, bound by the conditions and contexts (biographical, theoretical, epistemological) in which

196

they were accomplished. The subjective, situated and partial nature of transcription and therefore data has led to the general consensus that texts are negotiated, rather than simply recorded. Transcription then, is not merely the translation of social facts but rather a process impacted upon by researchers assumptions, values, interests and agendas – not to mention by practical problems such as poor audio quality, and procedural issues such as how to transcribe laughter, pauses and subtle variations in tone or emphases.

What is more, in moving from transcription to analysis one encounters ever more problems, not the least of which involves researcher anxiety:

> Making sense of the transcript in terms of the research questions is the most harrowing part of all. The more unstructured it is, the greater the anxiety that it is going to be impossible to analyse rigorously. (Hollway, 1989: 21)

Faced with what seems like too much material to analyse, how does one proceed to work through the data, and on what basis are analytic themes/areas of special interest chosen? Despite best efforts to allow the themes to emerge from the data, there have been powerful arguments from researchers to suggest that conversely, themes are constructed by analysts. Reflecting on one's work and the analytic processes undertaken, one would hope that there would be a defensible rationale behind the selection of themes; however this should not obscure the essential point that analysts nevertheless make choices with regard to what they attend to, and that these choices may constrain, shape and construct accounts as they are finally presented.

The researcher therefore should beware presenting themes as if they are somehow self-evident. For it seems that despite the general consensus that researchers should practice reflexivity during the data analysis process, in reality there is a tendency to present data as if the voices of participants merely 'speak for themselves' – rather than being selectively attended to and presented by an active other, the researcher. In this study I have attempted to remain conscious that it is unlikely, impossible even, for the experiences and perspectives of the participants to be perfectly 'captured', or that my interpretation of those experiences should be considered a direct reflection. Rather I would hope to convey that this study represents at best a partial and positioned account informed and shaped by the researcher's own biases and assumptions that I have attempted to outline in some detail throughout.

197

For example, I have become increasingly conscious of how my biography has affected my choices throughout this work. Specifically, I have become aware of the ways in which my personal and academic background influenced my selection of academic texts, which in turn combined with emotional and political factors to lead me to interpret participant accounts in specific ways. My liberal and feminist leanings, for example, have probably influenced me to subtly prioritise those accounts which challenged mainstream understandings of health and illness. Also, I have never managed to fully relinquish my essentially feminist and sociological perspective concerning structural inequalities and the influence that these have on individual experience, which is likely to have shaped my analysis of accounts throughout this work.

Another issue related to biography that must be addressed is the length of time that has elapsed in completing this work. For personal reasons which have been documented elsewhere, this study was interrupted on two occasions. The first time was after the completion of the upgrade viva from MPhil to PhD candidacy status, at which time I suspended work on the project for a year whilst adjusting to my new status as a mother. Another break occurred later in the piece when I went through considerable personal trauma and upheaval adjusting to my new status as a single mother. Whilst I do not believe that these events negatively affected the overall quality of my research/work, in the interests of reflexivity the impact of the changes in my personal life may be worth considering in terms of possible effects on my analysis and writing up.

A first area of concern with respect to delays in the research process relates to the closeness that the researcher can achieve to the data. It seems likely that the intensity of involvement with the data may be lessened over time – certainly it would seem very difficult to sustain the same level of emotional involvement that one had at the time of study design and data collection. Thus it seems questionable as to whether or not the level of immersion in the data can be comparable to that which could have been achieved had there been no disruptions to the research process. Alternatively though, it could be argued that the inevitable distancing or 'cooling off' from the data that accompanies breaks in the research process may allow the researcher to gain a

different perspective on the data, having the benefit of being able to view the data with a certain level of detachment.

Several authors have noted that data and analysis are constrained by the concepts and ideas that are available to the researcher at the time (Mauthner et al, 1998). That is, insofar as accounts are jointly constructed, they are necessarily shaped and informed by the theoretical and methodological positioning of the researcher at every stage. Obviously as time goes by, one changes both personally and academically, and it is likely that one will also move on in terms of substantive interests as well as theoretical and epistemological standpoint. Some research questions may become more relevant, others may seem to be of less interest than before. For example, my own development of chronic abdominal pain, (now resolved, thankfully) which I attributed to the painful emotional experiences and severe life stressors that I was living with at the time, may have led me to become more interested in the emotional aspects of pain than I previously had been. Also, being advised that I should medicate my unhappiness with a desperate personal situation (rather than change that situation, or remove myself from it) probably did little to improve my attitude towards the medicalisation of women's life experiences. The patriarchal nature of biomedicine and its hegemonic influence across the experiences I have had over the past 7 years (childbirth, motherhood, anxiety etc) undoubtedly shaped my increasing interest in the power structures in health care provision and possibly nudged me even further in the direction of feminist theory and method (although this is harder to state as I definitely had a prior interest in these epistemologies anyway).

The tendency for researchers to selectively attend to themes of interest to them at the time has been noted in other commentaries on conducting discourse research. All point to the myriad of ways in which biographical, historical, philosophical, political and theoretical influences shape and constrain accounts. This surely is why there has been such a strong call within academia to provide absolute transparency in the research process and the role that the researcher in all their subjectivity has played within that process. With this in mind I am conscious that there are many ways in which changes associated with the passing of time over the course of this study may have influenced and shaped this work, some of which I have tried to account for here. Perhaps the most significant challenge that I faced however throughout this work was

maintaining epistemological and methological consistency, which I will seek to address now.

Contradictions in my writing up

An area that I found particularly difficult as a novice discursive researcher was that such an approach requires adopting an entirely new way of looking at and reading texts. Whilst I felt able to do so theoretically, my practical experience was that I struggled to maintain consistency. In writing my analysis, I found that it was almost like I was trying to speak in a new language, only to find myself lapsing into my native tongue without realising that I had done so. In particular I experienced considerable difficulty in maintaining a constructivist perspective (against the backdrop of a lifetime of socialisation into a realist stance). I seemed to struggle against a tendency to imply that speakers were using discursive devices intentionally, and worse, that these devices had something to say about speakers 'beliefs' or 'motivations'. The temptation to interpret texts in such a way, leading to the circular 'discovery' of particular pre-conceived mental constructs has been noted by other authors as a common ontological trap for aspiring discourse analysis researchers (Antaki et al, 2003). Perhaps these challenges and my subsequent analytic confusion goes some way towards explaining why I have at different times throughout the work made inconsistent or even contradictory use of a variety of theoretical concepts. I can only hope that as I continue to develop my skill as a discourse analyst I will become more proficient at averting such analytical mishaps.

Despite these best efforts however, it is still likely that there are many influences and nuances that I have failed to account for. I look forward to the multiple perspectives that other readers may bring to this work and also, look forward to revisiting it myself at a later time when the benefit of hindsight may further change and amend my outlook on the work and the knowledge constructions it represents.

Reflexivity and feeding back to participants

In this study there has essentially been little or no feeding back of the analysis to the participants, either doctors or patients. This is not due to a lack of awareness or willingness on the part of the researcher, but rather due to simple issues regarding the

practicalities of such an endeavour. Having written up the work in a particular style for a specific purpose (i.e. written for an academic audience, in an attempt to satisfy requirements towards attaining a PhD) it is questionable as to whether or not the tone, detail and overall presentation would be suitable for feeding back to the interviewees. In considering whether an abbreviated or modified version should be prepared and circulated back to participants, other questions are raised; for example, how does one decide what to include and what to leave out? To what extent does one 'simplify' the analysis – and does the analysis retain any real meaning anyway if extracted from theory and therefore becomes decontextualised?

Furthermore, one must consider the practicalities of feeding back to participants with regard to demands on their time/efforts. In many cases enough has already been asked of them and one must ask whether or not it is actually placing more of a burden on them. To assume that they would want to read the finished account can also be seen as a little self-important – after all, the work is important to me, but is it really of equal interest to them? Finally, there are also limits to my own resources and therefore to the amount of time/energy that I can expend on following up with individual participants. However in attempting to overcome these practical problems, it seems that there may be ways in which the work can be shared with interviewees such that they are not excluded, yet at the same time not unnecessarily burdened with further participation. For example, it may be that in time I attempt to write up the work in alternative, shortened versions for journal publication. These would be appropriate perhaps for circulation to the study participants, most of whom access and read academic journals or health-related literature regularly.

Reflexivity and the process of writing up

Reflexivity at the stage of writing up requires that the ontological and epistemological assumptions inherent in both one's theoretical approach and methods be closely examined. In the current study, discourse analysis was used to provide a useful framework for examining the ways in which individuals sought to construct meaning and identity within the context of the chiropractic encounter. Discourse analysis then, must be critically examined for the central assumptions it holds that might in turn have shaped the way in which accounts were heard.

One of the central tenets of discourse analysis is its understanding of language as social action, whereby discourse is understood to be constitutive or 'reality-making' (Wetherall, Taylor and Yates, 2001). Utterances are speech acts, that is, they represent social action or an effort on the part of the speaker to construct and communicate a particular perspective that is meaningful to that social actor. This approach enabled the researcher to consider aspects of participant's accounts in a manner yet to prominently feature in the literature concerning doctors and patients within CAM settings, and as such can be seen to form the basis of my claim to make an original and unique contribution to this research domain. However, in my haste to construct *myself* as a professional, in turn derived from my perception of a need to construct an authoritative voice, I may have unwittingly attended to accounts in a manner such that they would add up to provide what might be judged an original and valid contribution to the literature. However, examining the accounts from a discursive analytic perspective also will have meant that those accounts were heard in a particular way, which may in turn have led to alternative aspects being overlooked or downplayed. For example, the tendency of discourse analysis to emphasise the importance of social relationships together with the subtle inference that participants' utterances provide an opportunity to access their experiences may have contributed to a somewhat arrogant tendency on my part to believe that I have somehow 'uncovered' knowledge rather than co-constituting it.

Critique of the social constructivist approach

Throughout this work I have moved increasingly away from a positivist framework and towards one informed by social constructivist understandings. Whilst this shift has arguably benefited the study in many ways, the risks and limitations of the social constructivist perspective must also be considered. Discourse-analytic work, informed by a social constructivist perspective has a strong tendency to relativise claims regarding knowledge about psychological concepts. This relativist position rejects that it is possible to make universal claims about human nature or behaviour, emphasising instead the socio-political and historical context in which events occur. Behaviour is thus relative to the cultural epoch in which it occurs, as is the work or actions of the researcher who is observing, describing or analysing that behaviour. This theoretical position has attendant ramifications for the critical analysis of

phenomena, that is, by relativising claims to truth there is also the risk of removing the possibility for moral, ethical or political analysis, a point which has not been missed by critical and feminist psychologists (Parker, 1997; Burman, 1990; Gill, 1995). Parker (1992) has argued for the resolution of this problem by the adoption of a critical realist position, i.e. one that acknowledges the existence of external realities independent of our perceptions without neglecting the complex social/discursive nature of our interpretations or understandings. Such a position opposes relativism in the sense that it accepts an external reality or world independent of the individual, whilst also acknowledging that in observing and describing that world, we also construct that world. This may represent one way of overcoming the problem inherent in much discursive and deconstructivist work whereby the theoretical underpinnings contributed by social constructivism tend to encourage the total relativising of all positions or assertion.

Final note: are there limits to reflexivity?

In attempting to reflect on the work which has been presented in this thesis, one must consider the question of time frames and 'closeness' to the work. That is, I must ask the question, is it really possible to be fully reflexive at a time when one is so 'bound up' with the work. Being so fully immersed in this particular knowledge-constructing process, and so emotionally invested in its outcomes it seems unlikely that I can be truly and unflinchingly self-critical or self-aware. Perhaps it would be prudent to revisit this work at a later date when I may be able to apply the benefit of distance (both time and emotional) to allow for a more detached, and therefore more complete and searching appraisal. As Maunther and Doucet put it:

> there may be limits to reflexivity, and to the extent to which we can be aware
> of the influences on our research both at the time of conducting it and in the
> years that follow. (Maunther and Doucet, 2003: 425)

Discussion

This work represents a major learning process, the many specifics of which don't necessarily come across in the final written thesis. For example, I think that my skill

in conducting interviews has improved, as has my understanding of the complexities involved in approaching research of this nature. The intellectual growth that has accompanied this journey has also had tangible effects on my everyday being-in-the-world – analysing discourse necessarily changes the way you think about rhetoric in everyday life as well within the academic context, from the way that you listen to or read the media, to the different way that you 'hear' conversations.

In this chapter I have attempted to 'stand back' from this work in order to be able to consider some of the issues of reflexivity which have arisen throughout the course of the study. First I gave a brief overview of reflexivity as it relates to discursive analytic and social constructionist work. I then considered some of the contextual influences which have shaped and informed this work, before finally attempting to reflect on how the arguments and situated knowledges that have arisen out of this work have themselves been rhetorically constructed. It is now my intention to link these discussions with those concerning implications of the research, the focus of the next chapter.

CHAPTER NINE

Implications and applications

Implications and applicability

In the last chapter I sought to reflect on some of the issues regarding limits to this study, as well as some of the influences that I had on the research and how, at the same time the research has influenced me. Now what remains is to look back at the knowledge created here and ask what implications that knowledge might have – for health practitioners (both biomedical and complementary), for users of health services, and finally for other social researchers. In order to do so I propose to focus not just on the outcomes suggested by the accounts themselves but also to examine some of the consequences of the broader themes in the thesis.

First however the notion of applicability itself must be addressed; for the idea that one can extract 'findings' from one particular concept and apply them elsewhere is both conceptually and practically problematic. In this chapter then I will seek to outline some of the problems inherent in the concept of applicability before going on to suggest ways in which those problems might be overcome such that useful implications across relevant fields might be formulated.

Critically evaluating 'applicability': the case of health psychology

The criticism that much research cannot be usefully applied has been levelled at many academic disciplines over time, including health psychology. The debate regarding the relative merits of 'pure' versus 'applied' (theory vs. practice) research is now more than hackneyed and arguably represents a rather unhelpful opposition. I will not go into this in any detail here; suffice to say that I would prefer to support the view put forward by some scholars that a more useful approach might be taken which reflects "the mutuality of science and practice" (Hoshmand and Polkinghorne, 1992: 55). They argue that the debates surrounding theory vs. practice and the applicability of research are based on positivist assumptions, made redundant should we choose

instead to support a constructivist model. Other authors have argued that, from both an ethical and a political point of view, we must apply research:

> ...it is impossible to abstain from involvement since inaction is always a form of action. Thus, we can only ever argue for or against, support or subvert particular practices or causes but we can never disengage ourselves from them (Willig, 1998: 96)

However there are practical as well as epistemological complexities with regard to applying discursive research. For example, with respect to this particular research, what actually *are* the findings? Are they generalisable in any meaningful way such that they *can* be applied? Finally, even if they could be formulated, how would such applications be disseminated out to the relevant audiences?

A straightforward (and some might argue, simplistic) way of overcoming these challenges is to employ an evaluative filter regarding the 'currency' of findings (to borrow a phrase used by Eccleston in a slightly different context, 1997: 699). By this I mean whether specific findings may, if applied, contribute to more helpful understandings and/or better outcomes. That is, how useful or meaningful findings might be when applied outside of the research study itself. Of course this does not address the problem of who should decide the currency of any given notion. However having argued in this thesis for the value in challenging the dualistic basis of the rhetoric employed by users and practitioners of chiropractic health services, I would further suggest that the value of applications (e.g. changes in the education of health professionals) could be judged by the extent to which they question these oppositions as well as their assumptions on which they are based.

In the rest of this chapter I have focused on four audiences for whom some of the implications from this research may have currency. In it I have outlined what I think may be useful for each audiences and highlighted specific aspects of the research which may be considered relevant to their needs.

<u>Practical implications for different interest groups</u>

Implications for the organisation/delivery of biopsychosocial health care

Central to this study is the notion that language does not work to simply describe or reflect reality but that it is constructive and constitutive. Such a view has implications both for the content and process of educating health professionals. Specifically, this research has practical implications for health care education, which has struggled for some time with the matter of how best to reflect and incorporate a patient-centred approach within the training of the next generation of health care professionals. Of course, the structure and delivery of health professionals, both biomedical and complementary, is a specialist topic that is beyond the scope of this thesis however the findings of this study, within the broader context of other discursive work do potentially have some relevance for health educators.

I would argue for example that this study upholds the conclusions of other social researchers who have noted the need for modern health care providers to allow room for the subjectivities and personal meanings that users construct in their quest to render meaningful the otherwise senseless experience of pain or disability, and in order to survive the threat that those experiences represent to their sense of self. This, I believe, is unlikely to be achieved via the teaching of the 'biopsychosocial model' or 'patient-centred health care' as a module or course separate from and alongside courses traditionally dominant in health education (such as anatomy, physiology, pathology etc.). In my experience of teaching courses in behavioural sciences to chiropractic students, and in conversations with biomedical and osteopathic students also, it is clear that these courses are seen as 'soft', 'easy' and largely irrelevant to the 'real' concern which is learning about the physical aspects of disease.

The reasons for this, I would argue, are to be found in the discourse that continues to dominate modern health care. I hope that in this thesis I have conveyed my conviction that there is a need to overcome the unhelpful dualistic thinking that has permeated our culture. Continuing to offer psychology, communication skills, sociology, philosophy etc as separate subjects to be 'tacked onto' the medical curriculum only serves to uphold and reify these binary oppositions that plague modern health care. Perhaps one outcome from this study then that may have currency is that both medical and chiropractic educators consider an alternative strategy whereby patient perspectives and meanings are continuously elicited and incorporated wherever there is discussion of etiology and management of functional

conditions. Given that language is an active and constructive medium there is a need for educators to look more closely at how their students actively construct their knowledge and to use this to lead to better clinical practice. Whilst these are not novel ideas, I would argue that the findings presented here provide support to such an application, which arguably could improve both health education and ultimately, patient care.

Implications for health practitioners

Similarly, I would suggest that there are some practical implications that might be of relevance to health practitioners, both biomedical and complementary. The findings from this and other discursive studies involving patients and practitioners share common ground insofar as they suggest that users of health care services can be constructed as 'experts of the self' and therefore as co-authors of alternative knowledges which demand greater weighting within the health encounter. Furthermore, the users of chiropractic services in this study utilised available discourses as well as tactics of discursive resistance to position themselves accordingly. These strategies can be expected to persist when viewed within the cultural context of increasing consumerism, which in turn continues to support other strongly embedded cultural values such as autonomy, self-actualisation and agency. As such, I would argue that the implications for health practitioners are clear; discourses that serve to disenfranchise the individual, whilst tenable within the professional realm, simply will not 'cut it' any more. Health practitioners would do well therefore to listen to the message that emerged so clearly in these accounts, and give the participants what they want: to be heard. Thus the findings from this study suggest that practitioners should become aware of and actively work to overcome the traditional yet problematic lay/expert opposition. By conceptualising no essential difference or hierarchical relationship between practitioner and patient, power imbalances may be minimised and therapeutic options widened.

The implication here for practitioners is that they will need to be more aware of the perspectival, partial and textual nature of their knowledge, including diagnostic frameworks and therapeutic recommendations. Similarly they will need to recognise and admit to the situated nature of the limited knowledge they have, and be prepared to work with people to construct an understanding of their experiences that does not

cause or contribute towards the 'dis-equilibrium' that has been noted to be a challenge for many patients (Arney and Bergen, 1983).

A final thought regarding implications for health care professionals is that they might consider adopting a more 'hands on' approach to contributing to the social element within the biopsychosocial concept. Chiropractic historically has operated independently of the orthodox health care system. As a result, solo practitioners have understandably busied themselves developing profitable private practices that are not, as commercial enterprises, concerned with addressing structural health care issues such as poverty, housing, employment, education etc. As chiropractic enters the mainstream however, there will be both the opportunity and the demand for them to 'step up' and be actively involved at this level. The links between social/economic factors and health inequalities are undeniable, and therefore any discipline that wishes to employ the rhetoric of working for the patients' best interests will have to actively and visibly participate in these ongoing issues. Involvement of this kind could work either at the practitioner level or at the level of their governing professional bodies.

Implications for chiropractic patients

This research has shown how complex discursive frameworks can be, and also how discourses/tactics can be used to either to constrain or enable different positions and achieve personal objectives. Thus a useful application of this finding or observation would be to work with users of health care services to show them how they can confront and contest discourse, within the context of their own quest for health or well-being. As I have argued elsewhere, there is a pressing need to challenge dominant oppositions like expert/layperson, real/unreal and normal/abnormal, particularly in the realm of patient care. For example, if people were able to discursively construct their experiences as lying on a continuum rather than on one side of a false dichotomy, anxieties they might experience relating to 'threats to self' could be allayed. How, practically, this could be achieved is another question though. One possibility might be through the production of literature written specifically for this audience and disseminated through patient groups and clinics. These could perhaps be designed and co-authored with users, in order to ensure that their perspective is authentically represented, and in order to gain currency with the target audience.

Implications for academic researchers in health psychology

This study suggests that more work needs to be done to analyse the interests and consequences of dominant discourses. Moreover, there is a need for the research agenda to be driven much more by the needs of patients rather than professionals. Discursive approaches can be useful in achieving such objectives by questioning taken-for-granted knowledges and making explicit their constructed nature.

There should be an exploration of other ways to understand people's experience of pain, illness, or discomfort. These new understandings should expressly seek out alternative perspectives to traditional psychological ones that have tended to be based on unhelpful dichotomies such as normal/pathological, mind/body, real/unreal in ways similar to biomedicine. By doing so, a diversity of theoretical options would be created, creating more options for individuals to use in coming to understand their experiences. To outline one very specific instance of how this might then translate into better clinical practice, such an approach would mean for example, that when evaluating patient's pain experiences, an anomalous pain drawing (such as one that locates the pain in the space around the body outline) would not necessarily be taken as 'evidence' of 'AIB' but rather used as a point of exploration, whereby the practitioner is provided with the opportunity to enquire further of the patient what they meant by that drawing. By creating a space for the patient then to communicate their experience 'safe' from the risk of being labelled abnormal or being told that their pain isn't real, any additional anxiety may be alleviated and helpful steps taken to resolve their pain in ways meaningful to that person.

Recommendations for further research

In order to further build on the present study, I would argue that researchers need to develop new languages and new concepts - not so much to find another way of talking about health but, rather to find a way of transforming the concepts and assumptions that limit our understandings. In order to do this there is a need to draw on diverse theoretical and methodological frameworks (e.g. anthropological, sociological, feminist, literary theory, cultural studies) and conduct what is essentially trans-disciplinary research.

In a general sense then, the findings from this study recommend further research that would add to the literature in ways that might privilege alternative perspectives, and thus provide breadth and diversity to the ways in which users/practitioners interact and understand each other. Specifically, I would argue that the findings presented here urge further research into areas that this study revealed to be somewhat under-theorised, including but not limited to:

Accounts of prevention and recovery in CAM/chiropractic

There has understandably been a tendency in the literature to focus on symptomatic patients, and the illness experience. Talk about wellness, prevention and recovery are somewhat less evident. There are notable exceptions, nonetheless I believe that if we are to undermine dualistic understandings of health then we must strive to explore all dimensions of that construct. I would personally be very interested to take further steps in this research direction, and look at talk about prevention and recovery in complementary health care settings, either again with a specific focus on chiropractic or perhaps in a more diverse range of disciplines.

Discursive analysis of CAM/chiropractic in popular culture

Another interesting angle that might add to our understandings of these and related topics would be to look at the discursive constructions of complementary health care, including chiropractic, in popular culture. Although discourse analysis has most often been used in the analysis of interview material or other 'live' accounts such as focus groups, discursive approaches have increasingly been used to examine a wider range of texts including those of popular culture. Such a study would look to draw on a number of different sources from popular culture including cartoons, TV series', newspaper stories, films, novels and so on to explore some of the cultural forces at work in the construction of discourses. A social constructivist analysis of how certain realities, meanings and identities are constituted and contested within cultural texts such as movie scripts or magazine articles might be an interesting and revealing undertaking.

Q-methodological study

Finally I would be interested to explore what a Q-methodological analysis of patients'
and professionals understandings of pain, health or well-being might have to offer.
Q-methodology attempts to facilitate the diversity of expression by offering an array
of propositions related to a given topic (known as a Q-set) sampled from a variety of
texts (e.g. academic, practitioner, user, cultural) to be offered to participants to sort
according to their viewpoint. Having read other work of such design with some
interest (Eccleston et al, 1997) I believe that conducting a similar study specifically
with particular groups of patients and practitioners (e.g. osteopathic, or chiropractic)
would allow for useful elaboration on the findings thus far articulated.

Discussion

In this chapter I have attempted to reflect on the implications of this work for the
different audiences for whom it might be relevant or useful. In order to do so I have
revisited some of the knowledge created in the first seven chapters and asked what the
implications of that knowledge are for health practitioners, health educators, users of
health services, and finally for other social researchers.

In formulating these recommendations I have highlighted specific findings and
evaluated them from the perspective of whether or not they have utility or currency
for those audiences. Finally, both general and specific suggestions for practical
application of key ideas and for future research directions were detailed.

CHAPTER TEN

Conclusions

This research has investigated how patients and practitioners construct meaning and identity discursively within the context of their health and illness experiences. In doing so it has described some of the dominant discourses and institutional practices which influence contemporary health care practice. These discourses at once constrain and enable the construction of meanings for both patients and practitioners. Moreover, the way patients and professionals talk about pain, illness, health and wellbeing is not straightforward but rather appears to create a diverse range of positions and perspectives that work to achieve a multiplicity of personal and professional objectives. These findings are offered not in judgement but simply as an observation; that is, I do not wish to suggest that participants are actively engaging in self-serving strategies to achieve and exert power, but rather that as members of society, influenced by discourse and culture, they necessarily are participant in the constant and evolving process through which realities such as pain, health and illness are discursively constructed.

Thus, for example, patient and practitioner talk regarding the causes of pain is variously cast in ways that construct either agency or passivity depending on conversational context, in order to take up moral positions consonant with notions of self or identity found acceptable to the individual. The same discursive strategies are also used to apportion blame for poor results (and thus absolve the speaker of responsibility) or take credit for positive outcomes.

Users of chiropractic services appear to exemplify the empowered, more knowledgeable health care consumer that has emerged not only in the complementary and alternative health care sphere, but also in the broader realm of health care that biomedicine still dominates. The desire that these accounts reveal for individuals' subjective meanings to be considered, and to be treated as active participants can be understood as an implicit critique of framings that have traditionally constructed users of health care services as passive recipients of expert knowledge.

Chiropractors, whilst working largely outside of the mainstream health care system, have as part of their occupational project internalised many of the tenets and perspectives of biomedicine. Rather than standing ideologically apart from biomedicine as it often assumed, chiropractic appears to sit within the same health paradigm, sharing many characteristics with its presumed opponent; namely a "value system of self-reliance, rugged individualism, pragmatism, empiricism, atomism, privatism, emotional minimalism, and a mechanistic conception of the body and its repair" (Stein, in Baer 1996: 29).

As modern Western health care moves conceptually away from the previously dominant yet artificial dichotomy of mind/body, consumers are increasingly demanding health care experiences that reflect their subjectivity and empowerment as knowledgeable, agentic authors of their own health and well-being. Chiropractic, in its ongoing efforts to achieve acceptance and status within the mainstream health care system will need to ensure that does more than just pay lip service to a more inclusive paradigm; i.e. it will need to be careful to deliver health practices that do not replicate the conceptual and practical errors that biomedicine has fallen foul of historically by adhering to the mechanistic and reductionist principles that serve to create objectified bodies rather than embodied subjects.

Chiropractic, as a major discipline within the realm of alternative and complementary health care, provides a useful (and heretofore under-utilised) platform from which we may consider questions concerning the construction of identity, self and subjectivity within the context of health and illness. Accounts from both users and practitioners of chiropractic have revealed here the use of a range of complex, flexible and sometimes contradictory discursive strategies to construct a multiplicity of subjective meanings from their experiences within that realm of health practice.

Notions concerning causation, treatment and expectations regarding appropriate recovery have been demonstrated in these accounts to rest on a number of unarticulated cultural assumptions. This thesis has attempted to examine those assumptions and to consider the consequences they have for patients and professionals. By focusing on the way patients and practitioners talk, this research has highlighted the importance of language in constructing health and in defining

certain kinds of objects and subjects, in an attempt to reveal language as an active constitutive agent rather than a passive transparent medium.

In this thesis, I have used a wide range of theoretical perspectives to consider these observations and have argued for the development of new ways of thinking and talking that transcend the dualisms inherent in the dominant Western health paradigm. I have argued that the chiropractic encounter is characterised by ambiguity and inconsistency, whereby contradictory discursive resources are drawn upon at different times to achieve specific objectives. This is consistent with the findings of other discursive theorists who have suggested that the construction of identity and meaning is an activity indivisible from cultural context (Shotter and Gergen, 1989), however I am conscious that this is a conclusion that can be interpreted as challenging or 'anti' in some way. The deconstruction of behaviours, words and actions such that underlying and perhaps unintended consequences are revealed is always likely to be experienced by some as unsettling. However, in defense of deconstructive analyses in general and this one in particular, I would remind those for whom these findings are troublesome that such an approach does not imply that discursive 'strategies' are undertaken with a mind to deliberately achieving and wielding power – rather, that power may be considered to underlie and infuse our everyday interactions and understandings in ways which may simply be obscured or overlooked in the absence of close scrutiny or analysis.

Faced with findings that might at first glance de-stabilise or even invalidate some elements of the belief system or ideological framework within which they are embedded, some readers might find offensive these arguments and thus be quick to reject them. That is, both providers and users of health care systems, whether biomedical or complementary, operate within a cultural context and dominant discourse that is essentially realist, and which therefore struggles to assimilate constructivist perspectives on matters they perceive as 'real' objects, such as bodies. To those whose first instinct is to defend their identity and work by returning to the material reality of disease and therapeutic intervention, I would gently remind them that our standpoints are not mutually exclusive; my objective here, far from being that of denying reality, has simply been to note and give voice to the discursive elements that also make up the subjective experience of individuals. Rather than attempting to

make some statement about underlying, discrete realities, I have been interested throughout this investigation to ask what kind of meanings are being created through the creative use of language, and for what purpose.

This analysis has reinforced the findings of other discursive researchers that the healing encounter – from genesis through to diagnosis, therapeutic intervention through to recovery - is co-constructed between patient and doctor in an elaborate, complex and subtle playing out of culturally available discourses which both constrain and enable our understandings of everyday experiences. This emphasis on the socio-cultural and linguistic aspects of experience may be misinterpreted as privileging the discursive at the expense of the material; however I would emphasise here that this is not my intent. Whilst the functional aspects of discourse are a topic worthy of close examination, this should not be at the expense of the material dimension of our Self. As Berger and Luckmann argue, individual experience and meaning exists in a dialectical relationship between the physical and the social; in the circuitous and perpetual interchange between 'having a body', and 'being a body' (Berger and Luckmann, 1966).

The central thesis of this work has been that the discursive practices of patients and practitioners do not work to simply describe or reflect reality but rather serve to co-construct multiple truths in complex and sometimes contradictory ways. I hope that some of those complexities have been illuminated here.

Notes

1   The phrase 'complementary and alternative medicine' and it's attendant
        acronym, 'CAM' has become a commonplace and widely used phrase in the
        social scientific literature. Due to its broad acceptance and useful brevity, I
        too have made use of this phrase throughout this work. However its
        limitations should be noted; namely, that it tends to connote a sense of unity
        between complementary and alternative systems of healing that does not
        necessarily exist; it suggests a perhaps more limited focus and vision (i.e. on
        'medicine') than the disciplines it refers to actually concern themselves with;
        and finally it can be understood to uphold the status of biomedicine as the
        standard against which other disciplines are considered to be complementary
        or alternative to.

2   Use of the terms 'patient' and 'doctor' is also a matter of hot contention.
        Chiropractors refer to themselves as 'D.C.'s, that is, Doctors of Chiropractic
        and commonly are referred to within their clinics as 'Dr.' Medical doctors
        have long fought against this, with varying degrees of success in different
        geographical and historical locales. What is more, the use of the terms
        'doctor' and 'patient' has been critically argued against even within
        biomedicine, where commentators have highlighted the paternalism inherent
        in such terms and issues relating to power that are promulgated via their
        continued use. In order to avoid making the inadvertent suggestion that only
        biomedical health professionals may make use of that title, and at the same
        time introduce equally valid alternatives, I have made use variously and
        interchangeably throughout this work of multiple different terms to refer to
        the participants in this study, including on the one hand doctors, practitioners,
        providers, and health professionals and on the other, patients or occasionally,
        users (of chiropractic services).

3   The concept of 'care' has been critiqued by some authors who have noted the
        paternalistic undertones that tend to accompany its use. For a more in-depth
        analysis of this issue, see Fox (1993).

4   See pages 52-53 and 169-170 for a fuller description of my relationship to
        chiropractic and discussion of how this may have influenced this work.

5   Arguably, there is tension in Descartes' own work about the relationship
        between mind, body and person. However the term 'Cartesian' has become
        widely used to denote the perspective that considers a human being to consist
        of two ontologically separate substances, a mind and a body; it is in this sense
        that this term is used throughout this work.

6   Of course there are other social constructs which also inform our shared
        understandings of bodies such as ethnicity, sexuality, age and so on. However
        the scope of this project prohibits the useful exploration of all these complex
        issues; I have thus limited discussion to that which seem most salient to this
        investigation.

7   Whilst it is customary to refer to the presented outcomes of research as 'findings', it is important to recognize that these outcomes are the result of a two-way co-construction of knowledge, rather than a 'Truth' that has been uncovered. As Mishler reminds researchers: "we do not 'find' stories; we make stories" (1995: 117).

8   The distinction between biomedical or 'expert' and 'lay' perspectives is conceptually problematic. Not only does the separation of these two perspectives work to privilege the expert position at the expense of lay knowledge, upholding unequal power relations, but recent work in this area has furthermore argued that:

>   'lay and expert knowledge cannot adequately be conceptualised as two distinctly different types of knowledge...the boundary between lay and expert knowledge is not fixed and static but fluid and changing. Rather than a schism, there is a continuum of different forms of knowledge(s), reflecting how individuals position themselves in relation to scientific biomedical discourses' (McClean and Shaw, 2005: 730).

9   'Health' vs. 'illness' represents yet another linguistic opposition that is conceptually problematic in ways similar to the false dichotomy suggested by the terms 'normal' vs. 'pathological'. Within this work, the terms health and illness are used not to denote distinct and separate states but rather two ideal-type states of being that co-exist in a relational and fluid manner.

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APPENDIX A

Pilot study questionnaire

Note: Font size has been reduced and layout slightly altered in order to fit the necessary margins for thesis binding.

Are you: Male ☐ Female ☐   Please give your age in years:___

Marital Status: Single ☐   Married ☐   Living with partner   ☐

                  Widowed ☐   Divorced ☐   Separated   ☐

Are you: Employed ☐   Self employed ☐   Unemployed ☐

                  Retired   ☐   Student   ☐

Education achieved: CSE   ☐   GCE 'O'Level ☐   GCE 'A'Level ☐

                  HNC/HND or Degree ☐   Postgraduate Degree   ☐

Please state your occupation or your previous occupation if retired:

---

2. Below are questions about how you feel and how things have been going for you during the past month. For each question please indicate the one answer that comes closest to the way you have been feeling.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you been a nervous person?	☐	☐	☐	☐	☐	☐
Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
Have you felt downhearted and low?	☐	☐	☐	☐	☐	☐
Have you been a happy person?	☐	☐	☐	☐	☐	☐

Is this your very first visit?   Yes ☐   No ☐

If 'No' how many visits have you made?   1-3 ☐ 4-7 ☐ 8-12 ☐ 13-19 ☐ 20 or more ☐

3. Please tick the box or boxes below which best represent the area of your complaint/pain:

Headache   ☐   Neck Pain   ☐   Abdominal   ☐

Leg/foot pain ☐   Shoulder pain ☐   Arm/hand   ☐

Back pain (please specify): Low back ☐   Mid back   ☐   Upper back   ☐

4. Please indicate your level of pain by circling one number on the scale below:

....

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

(no pain)   (worst pain)

5. How long have you had your pain or complaint?

Less than 2 weeks ☐   2-8 weeks ☐   2-3 months ☐

3-6 months   ☐   More than 6 months ☐

6. Do you feel your complaint is getting better?   Yes ☐   No ☐

7. Please detail any medication that you have on prescription:

....
....
....

8. Please answer the following questions on alcohol consumption by ticking the boxes:

	Yes	No
Do you drink any alcoholic drinks?	☐	☐
Have you ever felt that you should cut down on your drinking?	☐	☐
Have people annoyed you by criticising your drinking?	☐	☐
Have you ever felt bad or guilty about drinking?	☐	☐
Have you ever had a drink first thing in the morning to steady your nerves of get rid of a hangover?	☐	☐

9. Below are questions about your physical well-being. Please indicate Yes or No as appropriate.

	Yes	No
Have you ever had trouble breathing?	☐	☐
Have you ever had frequent trouble with menstrual cramps?	☐	☐
Have you ever had burning sensations in your sexual organs, mouth or rectum?	☐	☐
Have you ever had difficulties swallowing or had an uncomfortable lump in your throat that stayed with you for at least an hour?	☐	☐
Have you ever found that you could not remember what you had been doing for hours or days at a time? If yes, did this happen even though you had not been drinking or taking drugs?	☐	☐
Have you ever had trouble with frequent vomiting?	☐	☐
Have you ever had frequent pain in your fingers or toes?	☐	☐

MANY THANKS FOR ANSWERING THE QUESTIONNAIRE

APPENDIX B

Transcription conventions

The transcription notation used is an abbreviated version of that developed by Gail Jefferson (comprehensively discussed in Atkinson and Heritage, 1984: ix-xvi; abbreviated versions available in Hutchby and Woofitt, 1998 and ten Have, 1999).

Pauses: Noticeable pauses are indicated by a full stop in brackets (.). Precise timing of pause lengths were not considered to contribute to this analysis.

Stress/emphasis: sound stress or emphasis is marked by <u>underlining</u>.

Spoken quietly: decreases in amplitude are shown within degree signs e.g. °word°

Spoken loudly: increases in amplitude are shown by using CAPITAL LETTERS

Uncertain transcription: sections of recordings that are unclear are bound by parentheses, indicating the transcriber's ('best guess').

Interupptions: Other interruptions are marked with /

Overlapping talk: Overlapping talk is indicated with [

Other: Extracts are punctuated to facilitate reading.

           Pseudonyms were used in place of all names (including the interviewee's) apart from that of the interviewer.

           Lines are numbered (000 at start of interview)

APPENDIX C

Patient participants

W.A., Female, 31, Student

M.A., Male, 35, Employed

B.R., Female, 55, Employed part-time

H.A., Female, 40, Employed

W.R., Female, 36, Employed

S.G., Male, 48, Employed

W.D., Female, 60, Retired

C.R., Male, 44, Employed

J.M., Male, 32, Employed

A.F., Female, 38, Full time mother

Chiropractor participants

Dr. VR, Male, 38, Lecturer/Clinician

Dr. MY, Male, 42, Lecturer/Clinician

Dr. MW, Male, 56, Lecturer/Clinician

Dr. DJ, Male, 54, Lecturer/Clinician

Dr. AK, Female, 44, Part time in private practise

Dr. GT, Male, 65, Full-time private practise

Dr. DH, Male, 45, Full-time private practise

Dr. NT, Female, 40, Full-time private practise

Dr. RS, Female, 39, Full-time private practise

Dr. SH, Female, 58, Full-time Lecturer

Note: Initials used to identify participants in this study have been coded in order to protect confidentiality in accordance with the Information Sheet and Consent Form (see Appendix F)

INTERVIEW QUESTIONS (Patients)

Note: to be used as a guideline only, that is, to be adapted to suit the individual.

1. So tell me how did you come to be a chiropractic patient?

2. How did your injury/illness first develop?

3. Who did you see initially about it?

4. How did you find that experience?

5. How long did you work with each practitioner before moving on to another treatment approach?

6. Has the injury/condition affected other areas of your life?

7. (If yes, then) Did you find your doctors sympathetic to those difficulties?

8. What other health-related activities do you practice (e.g. exercise, vitamins, dietary supplements, spiritual practices)

9. Are you on medication for any of your health problems?

10. Who or what do you think is to blame for your condition?

11. Do you think the health professionals you have seen really listened to you?

12. Understood you?

13. Describe for me your ideal visit to the doctor/chiropractor.

14. When you visit your doctor/chiropractor, do you feel comfortable or confident to discuss all of your health issues?

15. What areas/aspects of your health do you feel uncomfortable talking about?

16. Have you ever had an emotional response during a visit?

17. What does 'pain' mean to you?

18. Are you ever pain-free?

19. How do you cope with pain?

20. For what type of injuries/conditions would you see a chiropractor?

21. What do you think caused your pain or injury?

22. Do you think there's much difference between seeing a medical doctor and seeing a chiropractor?

23. What are your feelings about chiropractic in general?

24. Is there anything else you would like to say?

APPENDIX E

INTERVIEW QUESTIONS (Clinicians)

Note: these were adapted depending on whether respondents were practising, retired or student chiropractors.

1.   Can you tell me the story of how you came to be involved in chiropractic?

2.   What can you tell me about your training/practice?

3.   Which areas of your training/practice would you say were strongest/most competent?

4.   Can you sum up for me your 'philosophy on health'?

5.   How would you describe your relationship with the medical community?

6.   Has this relationship changed over time?

7.   How would you describe your style of relating to patients?

8.   Can you describe for me your 'average' patient?

8.   Describe for me your ideal patient...

9.   And your most challenging?

10.   Is your daily practise as you expected it to be?

11.   What would you change, if anything?

12.   Would you consider yourself a 'holistic' practitioner?
        (what does this term mean to you)

13. Do your patients ever respond to treatment emotionally? e.g. with laughter, tears, anger?

14. How comfortable are you with this?

15. Do you prefer working with acute or chronic pain patients?

16. Why?

17. How do you measure your patient's experience of pain?

18. 'Pain' is something you interact with everyday. What does 'pain' mean to you?

19. What would you consider to be abnormal pain behaviour?

20. How often would you say you encounter this? (If ever)

21. Would you say you have the resources to manage these patients?

22. Have you noticed/encountered any cultural differences in pain behaviour? e.g. gender, geographical, age...

23. What (if any) other systems of medicine are you interested in/drawn to?

24. (If yes) What is it about this approach that you find interesting?

25. Do you receive chiropractic treatment yourself?

26. Do you visit any other health professionals?

27. In your opinion, should chiropractors be primary health care providers?

28.   If yes, then how would you envisage dealing with social/psychological health problems?

29.   If no, then which areas of health/healing do you think chiropractors should limit themselves to/specialise in?

30.   What motivates you, as a chiropractor? What de-motivates you?

APPENDIX F

Consent Form for Research Participants

Detection and Management of Psychological Morbidity in Complementary Health Care Settings

Information Sheet

I am Tracey Powell, a research student at the University of Southampton. I am requesting your participation in a study regarding your experiences within complementary health care settings. This will involve participating in an interview with myself that should not last longer than three hours. You will be asked to talk about your experiences; our interview will be audiotaped for analysis at a later time. Personal information will not be released to or viewed by anyone other than researchers involved in this project. Results of this study will not include your name or any other identifying characteristics.
Your participation is voluntary and you may withdraw your participation at any time. If you have any questions please ask them now, or contact me on 07736 504410.

Signature: Date:

Name:

Statement of Consent
I _____have read the above information sheet.

I understand that I may withdraw my consent and discontinue participation at any time without penalty or loss of benefit to myself. I understand that data collected as part of this research project will be treated confidentially, and that the published results of this research project will maintain my confidentiality. In signing this consent letter, I am not waiving my legal claims, rights or remedies. A copy of this consent letter will be offered to me.
(Circle Yes or No)
I give consent to participate in the above study.   Yes/No
I give consent to be audiotaped.   Yes/No
I understand that these videotapes/audiotapes will be destroyed after analysis
                                                                          Yes/No

Signature: Date:

Name:

I understand that if I have any questions about my rights as a participant in this research, or if I feel that I have been placed at risk, I can contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023) 8059 3995.

APPENDIX G

Debriefing Statement

Detection and Management of Psychological Morbidity in Complementary Health Care Settings

Debriefing Statement

The aim of this research was to examine the language people use when they are experiencing or managing pain. The types of words and ways in which they are used can give us important clues about people's experiences, and your data will thus help our understanding of the role language plays in the management of pain. Once again results of this study will not include your name or any other identifying characteristics. This research study did not use deception. You may have a copy of this summary if you wish once the project is completed. If you have any further questions, please contact me, Tracey Powell on 07736 504410.

Thank you for participating in this research.

_____

Signature: Date:

Name:

I understand that if I have any questions about my rights as a participant in this research, or if I feel that I have been placed at risk, I can contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023) 8059 3995.