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‘GETTING ON WITH LIFE’: THE EXPERIENCES OF OLDER PEOPLE USING COMPLEMENTARY HEALTH CARE

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Abstract

Surprisingly few studies have explored the use of complementary medicine amongst older persons and existent research is typically restricted to those who can afford private treatment. The aim of the current qualitative study was therefore to explore the experiences of older people using subsidised complementary health care. Semi-structured interviews were conducted with 17 regular attendees of a single centre offering low cost complementary health care to the over 60's. The sample was randomly drawn from the patient register and included patients from mixed social and ethnic backgrounds. Transcripts was analysed using Interpretative Phenomenological Analysis (IPA). The core theme underlying participants' accounts related to the desire to *'get on with life'* and maintain physical and social functioning within the constraints imposed by chronic conditions. Consequently, the *physiological effects* of treatment were highly valued, particularly reductions in pain and improved mobility. *Psychological effects* operated at a more subtle level, influencing perceptions of health and well-being. The empowering nature of treatment enabled participants to regain *a sense of control* over their health, which reduced anxiety and facilitated 'normal' functioning. The *whole package care* was perceived as an important source of support and reassurance in contrast to the impersonal experiences of orthodox medicine. Complementary health care was therefore perceived as an important adjunct to orthodox medicine, particularly in terms of its impact on everyday functioning and well-being. Implications for the quality of life of older people with complex health needs and limited access to private complementary health care are discussed.

Key words: older people, qualitative, complementary medicine, quality of life, chronic illness

Introduction

There has been a well-documented increase in the reported use of complementary and alternative medicine (CAM) in the UK and elsewhere (Astin, 1998; Eisenberg et al., 1998; Thomas, Nicholl, & Coleman, 2001a). Depending on the breadth of definition, estimates suggest that between 10% and 30% of the population use CAM each year in the UK (Ernst & White, 2000; Thomas et al., 2001a), spending in excess of 1.6 billion pounds (Ernst & White, 2000). In the US, consultations with complementary practitioners are estimated to be higher than those within orthodox medicine (Eisenberg, Kessler, & Foster, 1993), with around 40% of Americans using CAM each year (Astin, 1998; Eisenberg et al., 1998). However, there are very few studies that have explored the use of CAM in older persons. This omission is surprising in light of our increasingly aging society and the high incidence of multiple chronicity in the older population. Notwithstanding the substantial cost of providing health care to this age group, the complex health care needs of older patients make it difficult to provide a comprehensive care package which incorporates physical, social and emotional well-being (Adams, Gatchel, & Gentry, 2001). It has therefore been suggested that CAM can provide an important adjunct to orthodox medicine (OM) in enhancing quality of life in the aging population in addition to reducing healthcare costs (Dossey, 1997; Willison & Andrews, 2004).

The popularity of CAM for managing chronic complaints (Astin, 1998) suggests that older people would be high users of complementary health care. However, since 90% of CAM is privately-funded (Thomas et al., 2001a), access to CAM may be more restricted for older retired people, even those from relatively affluent backgrounds (Andrews, 2002; Fulder & Munro, 1985). Despite issues of access and affordability, surveys in several countries indicate wide usage of CAM amongst the older population (Dello Buono, Urciuoli, Marietta, Padoani, & De Leo, 2001; Eisenberg et al., 1993; Foster, Phillips, Hamel, & Eisenberg, 2000; Thomas et al., 2001a). Two British surveys found CAM use (of practitioners) in the over 65's to be rather lower than that in other age groups but still significant at around 10% (Ernst & White, 2000; Thomas et al., 2001a). Using a broader definition, surveys in the US suggest that between 30-40% of older people use CAM, only marginally lower than overall population use (Astin, 1998; Astin, Pelletier, Marie, & Haskell, 2000). Furthermore, it is suggested that elderly use of CAM is likely to increase in the next decade as

current users of CAM in the 'baby boom' generation move into their 60's (Wellman, Kelner, & Wigdor, 2001).

Gerontological research indicates that older people are concerned with well-being, prevention of illness and quality of life (Dossey, 1997), issues given particular focus within complementary health care. Indeed, one small-scale Canadian study with older people found that the key reasons given for using CAM were to improve quality of life and maintain health and fitness in addition to providing pain relief (Williamson, Fletcher, & Dawson, 2003). In a much larger US survey with older people enrolled in a healthcare plan (N=728), users of CAM were more likely to engage in self-care activities and the majority reported benefits from using CAM although there were no observed changes in health status since enrolling in the plan (Astin et al., 2000). A survey in the UK found that 54% of over 65's considered CAM to be effective, particularly for psychological and muscular problems (MINTEL, 1997). However, whilst such research suggests rather unsurprisingly that older people using CAM report that is effective, we know very little about older people's subjective experiences of using complementary therapies. Indeed, Willison and Andrews (2004) criticise the lack of critical gerontological perspectives within CAM research and the lack of attention to cultural determinants of CAM use.

In one of the few qualitative studies in this area, Andrews (2002) interviewed 20 older users of CAM in southern England as part of a larger survey. He found that older people were highly satisfied with CAM treatments, reporting significant benefits to both their physical and mental health. Additionally they felt empowered by such treatment. Similarly, in a wider study of health beliefs in older persons, (Conway & Hockey, 1998) found that participants who reported using homeopathy contrasted the empowering experience of CAM with their paternalistic and patronising experiences of orthodox medicine. Certainly, there is considerable evidence to suggest that dissatisfaction with orthodox medicine and/or ineffective treatment is a key reason for using CAM in all age groups (Kelner & Wellman, 2001; Wellman et al., 2001). (Kelner & Wellman, 2001) compared older users of CAM and orthodox medicine, looking specifically at the therapeutic relationship. They found that users of CAM valued the egalitarian nature of the therapeutic relationship, which was strongly related to the participatory and in-depth nature of case-taking and treatment.

Additionally, consistent with the afore mentioned qualitative studies, older users of CAM expected to take an active role in their health care and preferred to take personal responsibility for maintaining their health through exercise and diet. Together these studies challenge traditional views of the elderly as passive recipients of health care and suggest that the opportunity to actively engage in health care decisions has an adaptive and valued function.

Like younger users of CAM, older users reflect a particular demographic profile in that they are more likely to be female, well-educated and middle class (Andrews, 2002; Astin et al., 2000; Cherniack, Senzel, & Pan, 2001; Dello Buono et al., 2001; Thomas et al., 2001a). The samples of most empirical studies have therefore been predominately middle-class so we know little about CAM use in more diverse populations. Indeed, there is a paucity of research into cultural influences and CAM use among different social and ethnic groups. A US study found high usage of CAM among older people from three ethnic groups (asian, hispanic & white non-hispanic) with differences in choice of therapies suggestive of modality preferences that reflect both cultural familiarity and belief salience (Najm, Reinsch, Hoehler, & Tobis, 2003). A study of rural older people also found ethnic differences in CAM use (Arcury, Quandt, Bell, & Vitolins, 2002). African and Native Americans made greater use of home and folk remedies than European Americans, although the traditional values of rural communities meant that the use of CAM practitioners (with the exception of chiropractors) was low in all ethnic groups. Other US based studies have found few ethnic differences in terms of CAM use (Astin, 1998; Cherniack et al., 2001).

A review of the literature indicates that there is a lack of research into the experiences of CAM use among older persons, and particularly among older people of mixed ethnic and social backgrounds. Further research is clearly needed to elucidate the meaning of complementary health care for older people and understand how treatment impacts on physical and mental health and wellbeing. Using a qualitative approach, the current study explores the experiences of older people who have access to subsidised complementary health care in a socially and ethnically diverse area in the UK. Qualitative methods are particularly suitable to enable participants to elaborate their own particular story of treatment use and discuss their individual experiences of using complementary health care. Such input is increasingly recognized as essential

to service development (Dancy, 2003). The aim of the current study was therefore to explore the perceived treatment effects and experiences of older people using subsidised complementary health care.

Methods

Context

The Hoxton Health Group (HHG) was set up in 1987 in order to provide complementary health care for the over 60's in an economically deprived area of north London. It offers a range of six therapies (acupuncture, aromatherapy, herbal medicine, homeopathy, shiatsu and osteopathy) for a small monthly fee. Additionally, the centre offers a range of weekly exercise and relaxation classes. The centre only offers complementary health care, although patients are usually referred to the centre by their GP. Over 350 patients are registered with HHG and most visit the centre on a regular basis, usually once or twice monthly, to deal with chronic complaints. Almost a third of patients are from minority ethnic backgrounds. The HHG is charity funded and does not receive NHS funding although it is located in an NHS hospital.

Sample

Twenty-three patients were randomly selected from the patient register. One patient was excluded due to a recent bereavement, one declined to participate (stating that she had too many hospital appointments) and four (two males, two females) could not make any of the available interview dates. Seventeen users of the service were therefore interviewed (72% response rate). Thirteen participants were female, and six were from ethnic minority groups. Ages ranged from 63-84 years (mean = 70.1 years). Participants had used between 1 and 5 of the therapies offered by the centre and had been registered for between 1 and 15 years. All of the participants had chronic complaints (often multiple), most commonly osteoarthritis. Although provision had been made for a translator if necessary to ensure equal access to all registered patients, all of the participants spoke fluent English. In the reporting of the results, pseudonyms are used and details of participants' main condition and current therapy used are reported where appropriate.

Interviews/Procedure

Participants were recruited via an information letter outlining the objectives of the study. Semi-structured interviews were conducted in a private room at the centre or in participants' homes according to participant preference. The majority were conducted in the former. An interview schedule was developed to provide a structure to the interview whilst allowing the flexibility to respond to issues deemed important to individual participants. The interview schedule was developed from a discussion with the centre manager and practitioners at the centre, a preliminary review of the literature and the investigators' prior experience of research in the area of complementary medicine. It was based around the following key areas: personal and health history, CAM treatment experiences/effects, general experiences of CAM and OM, and attitudes towards CAM.

Following a verbal explanation of the project, all participants signed a consent form to indicate their willingness to participate in the study. They were given the opportunity to withdraw from the study at any point, whether during or after the interview, although all participants completed the study. Interviews were audio-taped and transcribed verbatim. They lasted between 30 and 90 minutes, with most lasting around 45 minutes. Participants received a £10 voucher to thank them for their participation.

Analysis

Each transcript was analysed using *Interpretative Phenomenological Analysis* (IPA) to compile a list of themes that reflected the samples' experiences (Smith, Jarman, & Osborn, 1999). IPA aims to access the "insiders perspective" on their social world in order to reveal how an individual tries to make sense of their experiences. The initial analysis involved repeated readings of each transcript and the recording of initial observations and preliminary interpretations. The second stage involved the identification of emerging themes for each participant, which were coded with key words or phrases that reflected the meaning of the individual's accounts. Each transcript underwent the same analytic process, from which a list of master themes was compiled with extracts from each of the participants. In order to ensure the themes remained grounded in the data, the transcripts were re-read and marginal themes excluded. Finally, higher order 'super-ordinate' themes were identified which represented participants' perceptions and experiences, both in terms of thematic

prevalence (across participants) and thematic salience for individuals. To ensure 'intersubjectivity' (Reason & Rowan, 1981) several transcripts were analysed by an independent researcher to facilitate discussion of the rationale underlying the themes and the hierarchical structuring of the subordinate themes. Additionally, notes were made of observations and reflections immediately after each interview and during the analytic process.

Results

The majority of participants suffered from chronic degenerative complaints for which orthodox medicine offered limited effective treatment and CAM was perceived as providing highly beneficial adjunct care. The core of participants' experiences of complementary health care were organised around ***'Getting on with life'.*** The importance of keeping active and being 'able to do your normal things' was central to participants' sense of independence and well-being.

> [I] don't expect to live forever mind you, but you like to know if you're going to live, at least do something with it, not just sit there as if you're gone if you know what I mean! (Peter, 66yrs; shiatsu for spondylitis)

> I'm alright, I can walk, I do all my housework…I just get on and forget about the pain, I don't make pain my problem. (Janice, 76 yrs; osteopathy for osteoarthritis)

Maintenance of activity and social participation were crucial to participants and there was a strong sense of continuing *despite* the difficulties created by painful conditions. Indeed, there was a sense of being stronger than the disease and 'not giving in' since this was perceived as instigating a downward spiral of further disability. Factors that restricted 'normal' functioning such as pain and impaired mobility were therefore met with considerable concern and anxiety since they posed a direct challenge to the individual's sense of self. The loss of the self as a functioning individual was associated with periods of poor health and depression.

> It was just getting to me because I was always an active person, and I was just sitting there staring at the walls or the TV, hopping into the kitchen and getting

> things to eat, I was putting on weight and I was just painful, painful and depressed I think because I couldn't go out. (Susana, 65yrs; osteopathy, multiple chronicity)

The challenges posed by illness on notions of self were further evidenced by the way in which most participants contextualised their health through social and personal comparisons. In many cases, there were evident incongruencies between participants' perceptions of themselves and their actual physical state ('I shouldn't be like this', James). Both upward and downward social comparisons were made with known others and with ideas about average capabilities of one's peer group. Frequent reference was made to past and possible selves, relating to the loss of previous capabilities, as well as projections about possible negative selves that had apparently been averted by using complementary medicine.

> I can still get about. When you see people in wheelchairs and sticks, I don't have any of those problems, touch wood, so I would say on the whole I can't complain. (Penny, 66yrs; aromatherapy for osteoarthritis)

> I would definitely have been in a wheelchair if it hadn't been for the acupuncture and then coming on to here. (George, 84 yrs; acupuncture for osteoarthritis)

Using complementary health care was therefore viewed within the context of the broad goal of keeping active and maintaining everyday activities, and treatment success was primarily evaluated in terms of its impact on physical functioning. Several subordinate themes emerged from the data relating to the quality of care and the experience of the treatment process itself.

Whole package care

The holistic nature of care provided by the centre was alluded to by all participants. Interestingly, the package of care was perceived as much broader than simply the treatment itself, but was rather represented by the overall ethos of the centre and as such encompassed the therapists, management, patients and even the physical locality of the centre.

> I think it's somewhere to go where I get treatment that I find valuable, and people who listen and time spent, and the confidence I feel in it, I feel safe here, comfortable. I know that if I couldn't come or something they'd be concerned and they'd look out for me, which is very comforting. (Rosemary, 80 yrs; osteopathy for osteoarthritis)

> I think that everyone there has the same ethos, they're there to help…**it's that little extra step that makes the difference** (author's emphasis). (Barbara, 73 yrs; aromatherapy for osteoarthritis)

The highly *personalised care* provided by the centre was greatly valued by all participants and frequently contrasted with the impersonal experiences of orthodox medicine.

> It is two separate entities…[in OM] they have too many people to be taking care of so they cannot give the right care they should give to everybody because they have a very limited time for individuals…you can't compare the two. (Sarah, 63 yrs; osteopathy for osteoarthritis)

The 'personal touch' related not only to the well documented individualised nature of CAM treatment, but more broadly at the overall care package, which was seen to make the entire process of seeking care a positive one, from arranging an appointment to visiting the centre and receiving treatment. Of course, such a personalised approach is facilitated by regular contact between the patient and health centre.

> They look after <u>you</u> like their own personal problem, they take your problem like their own problem and they are looking for ways to get you better. (Sarah)

The intimate and caring nature of the environment in which 'we all get on well with one another' (Jane) was seen as providing an important supportive resource for patients. Additionally, the provision of advice and information about health, lifestyle, and social issues often had a significant impact on quality of life by increasing health

awareness and access to other services as well as encouraging positive action such as exercise.

Not only did participants feel 'cared for' but they also derived considerable *reassurance* from the knowledge that help was readily available when necessary since additional appointments could be made at short-notice. This was particularly salient for these older people who often had to cope with unpredictable bouts of pain and impaired functioning. Knowing that their suffering could be alleviated was an important 'anxiety buffer' which enabled participants to cope in the short-term. Confidence in the treatment and its effectiveness in addressing physical and psychosocial needs was crucial to this sense of reassurance. Additionally, this confidence was frequently situated specifically within the therapeutic package, in that participants' placed their trust in the professionalism of the centre and its recruitment of well-qualified therapists.

> They'll find an appointment for me within a day or two [when in severe pain]…so that relieves a lot off your mind, it helps a lot that you can do these sorts of things. (George)

> I have confidence in here whereas I wouldn't necessarily have confidence in going somewhere else. (Brenda, 67 yrs; aromatherapy for stress)

Relationships with both the practitioner and other members of the centre were valued for their therapeutic and social functions. Participants discussed the importance of discussing feelings and concerns within a supportive and non-judgemental environment. Whilst this applied to both complementary and orthodox approaches, it was recognised that the opportunities for the talking component of therapy were more limited within orthodox medicine where "doctors have not got the time for these sorts of things now" (Cath). Although valued, the therapeutic relationship was perceived as a central facet of treatment only by participants with specific emotional issues.

> I found the treatment helpful but to be perfectly honest what I also found was a terrific relief in being able to tell somebody. Because, as I say, it was

> something I was keeping very closely to myself and I had a sympathetic ear and if I shed a few tears nobody seemed to mind. (Barbara)

The supportive network of social relationships developed through the centre were perceived as an additional by-product of the overall package of care, particularly by those with limited social opportunities.

> You can have a chat and what have you, so it's a good thing for senior citizens to come and have a chat and what have you. (Bob, 72 yrs, shiatsu for osteoarthritis)

Treatment impact

Since participants' overall goal was to maintain 'normal' functioning, perceived *physiological effects* were most salient to their accounts of treatment experiences and outcomes. Additionally experiences of complementary health care were inevitably considered within the context of the broader illness experience, which included a recognition that allopathic medicine offered little hope in terms of treatment for chronic complaints such as osteoarthritis – 'there's nothing they can give you for it really' (Cath). Thus, participants were realistic in their treatment expectations, typically looking to ameliorate rather than cure their conditions. Treatment was therefore evaluated in terms of its impact on *symptoms* (particularly pain), *mobility* and *relaxation*. All participants had experienced a relief of symptoms through using CAM, and several had permanent improvement of either their main condition or a secondary complaint. Coping with pain was a concern voiced by the majority of participants, having a substantial impact on functioning and sleep, in addition to having psychological consequences – 'interfering with me mentally' (Susana). Treatment both reduced pain levels, at least in the short-term, and enabled participants to manage their pain more effectively, which had profound effects on mental and physical functioning.

> "I thought "where did the pain go?", I thought "I'm good", like a human being. ., I can start doing all the things I've never had the chance of doing." (Josephine, 65yrs, acupuncture for osteoarthritis)

Similarly, although improvements in mobility were generally temporary, they enabled a short-term return to pre-illness functioning which enabled participation in everyday activities as well as a sense of being 'free' from the physical limitations of debilitating conditions.

> It used to take me about 40 minutes to walk, 50 minutes, slowly, slowly, slowly. When I had my treatment I used to go home in 15 minutes, (laughs) you can move about then…it won't stay like that, what a pity. (Fatma,67 yrs; osteopathy for osteoarthritis)

> As soon as I go for the treatment I feel free… (Sarah)

Although less dramatic than symptom alleviation and improvements in mobility, relaxation was valued for its inherently positive effects as well as for its impact on pain relief and stress reduction. Thus, the relaxing nature of treatments made participants more aware of the relationship between mental and physical states and facilitated coping with the physical consequences of their condition.

> I used to feel so relaxed it was untrue…I felt really young. (Sian, 67yrs: herbal medicine for colitis)

> I think its been very beneficial because apparently unbeknown to me, the stress I was obviously feeling was manifesting itself in knots in my shoulders and the two young ladies have been massaging me, they both said the same thing, that these knots need breaking down which is what they've been doing, and its been very good indeed, and it does make you feel more relaxed when you've been there as well I think. (Brenda)

Whilst participants primarily emphasised the impact of treatment on their physical complaints, the *psychological effects* of treatment were recognised as playing a role in the healing process and contributing to overall well being. Although given less emphasis, the discourses relating to 'peace of mind' were remarkably similar across participants reflecting a sense of 'feeling good' within oneself, together with an enhanced sense of enjoyment of life. It appears that this 'feel good' aspect of

treatment bridges the gap between individuals' perception and actual experience of self, if for a limited time.

> I feel better after the treatment…it's my inside feelings. I'm happy, I'm free in my body. (Janice)

Whilst these post-treatment effects were often short-lived, longer term effects tended to manifest as a change in perspective, such as adopting a more positive attitude towards one's health and wider opportunities. Thus it was such mental shifts within the course of treatment that led to improvements in perceptions of well-being and engagement.

> "I think I'm more positive about my health…I take every day as a bonus." (Rosemary)

> Don't think I'm silly but I begin to enjoy life, music as well, I enjoy music now and I couldn't stand it before. I used to be very annoyed, always like you've got something in your stomach, it's going to explode. (Fatma – closing comments)

Gaining a sense of control

Dealing with chronic, often degenerative illness raised several issues of control for participants. On the one hand, many participants felt that orthodox medicine offered little personal control either in terms of involvement or choice. In contrast, CAM offered *empowerment* through encouraging participants to participate in their health through lifestyle changes and by providing a safe environment in which patients felt confident to ask questions and address their health concerns - 'they help you to live a better life' (Susana).

> She tells me how to how to do a bit of exercises indoors, how to help yourself (…) You don't want somebody to keep giving you orders. (Fatma)

The potential to make decisions (even choosing to stop treatment) and the empowering nature of adequate explanation were particularly salient for those with

negative experiences of orthodox medicine (one third of participants). Several participants discussed incidences in which they had either not been fully informed about their condition or their treatment requests had been ignored, resulting in a loss of confidence in allopathic medicine. For example, Fatma discussed how she felt when she discovered that she had suffered a mild stroke over fifteen years previously:

> That's why I'm annoyed with the doctor, apparently 1988 I had a mild stroke and he never told me and I never knew nothing about it until last year the other doctor told me. That's why they put me on aspirins to thin the blood. He should have told me shouldn't he?

In another case, George described how he was 'too frightened to go to the doctor's' after previously receiving a treatment against his request. Although relatively rare, such cases highlight the disempowering effects of poor communication and inadequate explanation, with serious implications for subsequent dealings with the health care system.

In contrast, participants' discourses regarding complementary health care demonstrated a sense of ownership over both the treatment process and the centre itself – 'we're all friendly, we all get on well with one another' (Jane). In discussing funding difficulties, another participant identifies strongly with the centre, viewing it as a shared concern: 'there's always that over *our* heads, how much longer' (Penny). Although such engagement may be centre-specific, it does reveal the powerful potential of encouraging patients to participate in their treatment and become involved in the running of health services.

Additionally, treatment was perceived as providing a crucial sense of *control over pain and symptoms.* This had a significant impact on the core theme of 'getting on with life' since the unpredictability and uncontrollability of symptoms was linked with reductions in activities (such as leaving the house), as well as heightened anxiety. The sense of control that arose as a result of successful treatment was therefore important in alleviating participants' fear and anxieties, which in turn facilitated a return to 'normal' functioning.

> "You're dead scared in case you can't move…I've got no fear now of it seizing up, that was my main fear…" (Peter, 66yrs: shiatsu for spondylitis)

Beliefs about treatment

All participants strongly advocated the use of complementary health care, irrespective of prior beliefs and experience. The temporal effects of treatment were a primary means of *evaluating effectiveness*, whereby most participants noted how the positive physical effects of treatment experienced following treatment gradually reduced over time.

> It helps with the pain, definitely helps with the pain. I suppose it does help you to move more because when it's coming up to the month, I find that I'm getting a bit stiffer so obviously it does… (Penny)

Whilst several participants described their initial scepticism of CAM, confidence and faith in the treatment developed for all participants through continued use of CAM, from both personal experiences and observations of treatment effects on others. Such beliefs were also recognised as playing a role in the treatment process of both complementary and orthodox medicine - if you don't have confidence in the doctor you never get better (Fatma).

> …before I had the massages I was very dubious, I thought 'I'm not into this', but since I've been having the massages I definitely think it's very good, very beneficial. (Brenda)

The value attributed to treatments was evident in patients' discourses of being 'grateful' and 'lucky' to be in receipt of such a service. Although virtually all participants felt that they would benefit from more frequent consultations, there was a strong sense of being 'grateful for what you can have…' (Penny). A consequence of this powerful belief in the treatment was a distal fear related to the possibility of losing access to complementary health care at some future point. Indeed, treatment affordability was a key issue, with few participants able to finance private CAM treatments on their limited incomes.

> I wouldn't do without the treatment if I can have it. If I not to have the treatment then I think I would try to cope and try to do some of what I see they do to me, you know, try to help myself. (Janice)

> You can afford to come here, if not a lot of people won't be able to go outside to do it, because pensioners' money is really, really hard… (Susana)

As a result, participants felt that complementary health care should be more widely available for pensioners who could not afford to seek private care.

> But I would like it more often to see if it, you know it progress more, but they can't do it, the money's not there to pay the people and that's why the government should put the money in these things, because it saves a lot of people from clogging up the hospital beds and they don't realise that… (Susan)

A contrast was drawn between the *holistic & natural* approach of CAM compared with the *reductionist & chemical* approach of orthodox medicine. This was closely related to participants' causal explanations of illness and the importance placed on treating the underlying cause of illness through readjustment of the body.

> The whole, holistic idea that your body is being treated, the whole body is being treated as well, and the mind and the (…) you know, that is what I like about it and also not having chemicals… I don't really like chemical medicines, I know I have to take them but I would like to be totally un-chemical! (Rosemary)

Participants attempted to control their medication usage and avoid 'overdoing it' reflecting a wider concern with long-term medication use and dependency. Despite the fact that CAM was repeatedly described as more harmonious with the body, several participants applied similar means of control to their use of CAM, such as stopping treatment when feeling better in order to allow 'the body to try to get back to normal' (Jane). Although perceived as 'two separate entities', both orthodox and complementary medicines were seen as necessary for the maintenance of health;

whilst the gentler methods and effects of CAM might be preferred, the necessity of allopathic medication in managing pain and symptoms was readily acknowledged. Additionally, in several cases CAM was seen to augment orthodox medicine, particularly through supporting recovery from operations.

> …the recovery from the hip operations was absolutely fantastic, I used to come here and they used the needles and things and I think myself, if I hadn't have been coming here for the acupuncture I would have been like a lot of people 'hip operations are no good'. (George)

Discussion

Access to complementary health care was highly valued by the older people in this study both in terms of the physical benefits received from treatment and the overall package of care provided by a highly personalised service. Despite coming from a range of social and cultural backgrounds, the way in which treatment was evaluated was remarkably congruent across participants and related to wider concerns about getting older and coping with ill health. The primary focus was 'getting on with life' and maintaining physical and social functioning within the constraints imposed by chronic conditions. Consequently the effects of treatment most valued were those that improved mobility and reduced pain; however, the more subtle psychological effects on well being were equally apparent and interacted with physical outcomes, particularly with regard to pain.

Although the current study focused on the meaning of complementary health care, the core theme of 'getting on with life' is concordant with broader research looking at people's beliefs about health and illness. For example**,** (Herzlich, 1973) classic study of health beliefs found that the ability to participate in everyday life was a crucial component of health whilst illness was defined by inactivity. Looking specifically at the meaning of health for older people, (Bryant, Corbett, & Kutner, 2001) found that the ability 'to go and do things' was central to older participants' conceptualisations of health, which they contrast with the biomedical view of activity as a *consequence* of good health. Similarly in the current study, treatment was perceived within the overall context of health enablement; CAM facilitated everyday functioning in several ways and thereby had both direct and indirect effects on health and wellbeing. Firstly,

CAM had a positive impact on physical functioning and mobility, key dimensions of quality life in older people (Farquhar, 1995). Secondly, treatment contributed to a more positive psychological profile by reducing anxiety and encouraging a more optimistic outlook. Thirdly, participants felt empowered by CAM since it encouraged a more active and participatory role in their health (Andrews, 2002; Conway & Hockey, 1998). Additionally, the holistic nature of the treatment resulted in attention to psychosocial issues that might impede everyday living (e.g. independent bathing) but which were not necessarily directly related to health.

The significance of this underlying theme can be viewed within the wider context of the individual's construal of the self. Maintenance of the self was central to older people's perceptions of quality of life, and was directly challenged by the experience of aging and illness. (Charmaz, 1983) has discussed the 'loss of self' resulting from chronic illness, which may be particularly challenging for older people facing a gradual deterioration of health. Indeed, (Borglin, Edberg, & Hallberg, 2005) focused on the meaning of quality of life in older people and found that the ability to adjust with a preserved self-image provided coherence and meaning to participants' lives. They also found that 'participating in life' was an important contributor to a satisfied body and mind, linking closely with perceptions of independence. In the current study, participants evaluated their health with reference to social comparisons and contrasts with 'possible selves' (Markus & Nurius, 1986). Treatment was therefore appraised in terms of its perceived impact on past selves (comparisons with pre-treatment self) and on future possible selves (particularly the self without treatment). In several cases, there was reference to regaining a sense of freedom, suggesting a temporary release from the 'illness self' and return to an essential core self. Participants' accounts of treatment were therefore linked in a wider illness narrative which included past health history and experiences, as well as aspirations about the future such as maintaining energy and mobility.

Complementary healthcare played a significant role in the way older people coped with the consequences of ill-health, particularly in dealing with health-related anxiety. Several previous studies have similarly noted the 'expanded effects of care' arising from CAM use in the general population (Cartwright & Torr, 2005; Cassidy, 1998; Paterson & Britten, 2003). The impact of chronic illness on mental functioning was

particularly salient in participants' accounts, ranging from the psychological challenges of chronic pain to the uncertainty posed by the unpredictability of symptom flare-ups. In addition to helping participants to feel in more control of their condition, CAM appeared to boost older people's psychological resilience through both physical (relaxation and symptom relief) and emotional pathways (reassurance and psychosocial support). Previous research has highlighted the role of attitudinal factors in health outcomes amongst the elderly (Bryant et al., 2001) and CAM appears to offer one means of fostering a positive attitude towards one's health (Andrews, 2002). (Rowe & Kahn, 1998) suggest that active engagement with life is an essential feature of 'successful aging'; the current findings suggest that one way in which CAM supports this process is by expanding the coping resources that older people have to deal with the inevitable strains of ill-health and aging.

Whilst older people primarily focused on the impact of treatment on their health, the total therapeutic experience was also key to an understanding of their experiences of CAM. The powerful role of the practitioner-patient relationship and of individualised care has been oft cited (Kelner & Wellman, 2001; Luff & Thomas, 2000; Vincent & Furnham, 1996), but the present study found that this was situated within the wider environs of the health centre and the ethos of care. The holistic and patient-focused nature of the care resulted in patients who were strongly loyal and committed to the centre and their treatments. Similarly, Andrews (2003) identified a connection between the structural and experiential dimensions of the CAM environment, whilst (Williams, 1998) has suggested that a strong sense of place has the potential to enhance the healing process. It is perhaps not surprising then, that older people felt empowered by their engagement with both the treatment process and this wider facilitative environment. The empowering nature of complementary health care is frequently contrasted with the paternalistic style of orthodox medicine, which offers limited choices to older patients with chronic conditions (Andrews, 2002, 2003; Conway & Hockey, 1998). A third of participants reported negative experiences with orthodox medicine, largely relating to quality of care and limited treatment effectiveness. However, an equal number reported positive experiences, and use of CAM was certainly not a form of 'resistance practice' (Conway & Hockey, 1998), but rather an additional and much valued resource to help manage illness and enhance day-to-day quality of life.

Participants in the current study did not reflect the 'typical' CAM user profile, particularly in terms of socioeconomic status, and were not necessarily 'smart consumers' (Kelner & Wellman, 1997) in that they did not have the financial resources to 'shop around' for treatments. However, almost half had some prior experience of CAM, with some having used CAM for the first time more than 50 years previously. This long-term use has been reported elsewhere (Andrews, 2002) suggesting that many older people are familiar with actively engaging in their healthcare in contrast to perceptions of older people as passive and uncritical (Greene, Adelman, Friedman, & Charon, 1994). Interestingly, despite the relatively recent upsurgence in the popularity of CAM, pathways to care in previous eras were broadly similar, namely recommendation and lack of success using conventional means. Cultural background was a major influence on prior use, with herbal approaches particularly favoured by Black Caribbean participants, consistent with traditional cultural practices. In contrast, other participants had no prior experience or knowledge of CAM with some reporting an initial scepticism that was subsequently quelled by positive treatment experiences. Despite such diversity in terms of background, previous experience, and attitudes, participants' experiences of complementary health care were remarkably congruent.

However, the majority stated that they would be unable to afford private treatment and all felt that complementary health care should be a more widely available adjunct to orthodox medicine for older people. Indeed the financial constraints to CAM use have been highlighted in a number of studies (Andrews, 2002), which raises issues regarding resource allocation and access to treatment that enhances independence and quality of life. The cost of providing such care must therefore be evaluated against any benefits to quality of life and functioning in this vulnerable group. Most participants in the present study had tried a range of treatments, not all of which were successful, and physiological effects were often temporary. Nevertheless, all were convinced of the importance of CAM to their overall health care. Clearly further research is necessary to evaluate the impact of different CAM modalities on specific complaints in the elderly population. To date there are very few studies that have evaluated the cost-effectiveness of CAM for treating older people (See (Willison & Andrews, 2004) and such cost-utility analyses are problematic when considering suitable outcome measures to reflect the treatment experiences of older people.

The potential methodological limitations of the study should be acknowledged. Whilst the sample was representative of the study population (in terms of gender, ethnicity and distribution of therapies currently being used), the study was conducted at a single centre thus generalisation beyond this sample is limited. However, the sample was chosen explicitly for its unique access to complementary therapies; the study therefore aimed to provide a representation of elderly users' experience of such a health care package. Whilst the specific attributes of this service may be centre-specific, the study reveals the aspects of care and treatment that are valued by older patients from a wide spectrum of social and ethnic backgrounds and which are therefore applicable to other health care settings. Indeed many of the findings are congruent with broader research into the factors associated with healthy aging (Borglin et al., 2005; Bryant et al., 2001; Rowe & Kahn, 1998).

Reflecting more generally on the methodological approach adopted in the study, qualitative research provides participants with a voice and is therefore a potentially empowering form of methodology for those who feel marginalized from wider society. Additionally, it is inclusive in the sense that it enables those without reading or writing competencies to verbalise their personal experiences within the context of their wider life history. Although several participants in the current study expressed initial reservations about engaging in a formal research project, they appeared to enjoy the opportunity to relate their personal health stories, with several reflecting on the lack of value the elderly were attributed by wider society. Indeed this is consistent with previous findings which suggest that older people perceive that their skills and perspectives are neither appreciated or utilised within society (Conway & Hockey, 1998). In light of the high incidence of chronic illness and high utilisation of health services amongst the elderly, it is particularly important that the perspectives and experiences of older people from all ethnic and social groups are elicited using appropriate methodologies.

Research has consistently shown independence, mobility and active engagement with life to be important criteria for wellness in older people (Borglin et al., 2005; Bryant et al., 2001; Rowe & Kahn, 1998; Willison & Andrews, 2004). Chronic disease cannot be cured but treatment can minimise the impact of disease on functioning and

quality of life. Orthodox medicine is increasingly recognising the importance of tailored collaborative care and patient participation for managing chronic illness (Hunkeler et al., 2006; Von Korff, Glasgow, & Sharpe, 2002) and CAM may be an additional tool in the effective management of chronic illness in older people with complex health needs. In addition to alleviating symptoms and facilitating mobility, the current study supports findings in the wider literature that use of CAM benefits older people's perceptions of quality of life and encourages greater engagement with their health through empowerment.

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