

# Becoming a complementary health practitioner: The construction of alternative medical knowledge

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## Abstract

Complementary and alternative medicine (CAM) has become widely popular in many countries, yet little is known about the actual training of CAM practitioners. This article employs ethnographic research methods to closely examine the meaning-making processes used in such training at a complementary and alternative medical college. It delineates how CAM practitioners in training, specialising in naturopathy, make sense of alternative medical knowledge and transform it into medical truth. The study indicates that the core of CAM training rests on overturning the biomedical epistemological hierarchy between the objectification of disease and the experience of illness through extended intersubjective sharing by instructors and students. This study therefore adds to the extensive CAM literature by carefully examining the way naturopathic knowledge is inculcated during practitioner training. The emerging insight is that introspection and the search for authenticity, a central narrative of modernity, have become powerful resources in CAM's construction of alternative medical truth.

## Keywords

ethnography, experiencing illness and narratives, profession and professionalisation, complementary and alternative medicine, chronic illness and disability

## Introduction

Complementary and alternative medicine (CAM) has become strikingly popular in many countries where the conventional biomedical system is very successful and well-funded. One such case is Israel. Despite the hegemonic status of the biomedical model in the

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country since the 1940s, an unprecedented number of Israelis – approximately one-third of the country's entire population – have sought complementary and alternative medical solutions over the last three decades (Shuval and Averbuch, 2012).<sup>1</sup>

The remarkable rise of CAM in Israel and elsewhere in the West has been characterised as a 'bottom-up' change stemming from the public's growing interest in these types of treatment (Shuval and Averbuch, 2012; Shuval et al., 2002). According to this approach, the rise of CAM is primarily due to the large number of individuals who have found its methods to be helpful in their daily lives, but despite this, there have been few studies that detail the 'lived experience' (Kleinman, 1988, 2006) of those who turn to CAM by ethnographically exploring the intersections that lead them to favour it over conventional medicine. Rather than examining such personal experiences, extant sociological studies have concentrated on economic forces, institutional constraints and social needs, as well as epistemic relations and negotiations over professional jurisdictions in clinical settings (Baer, 2001; Broom and Tovey, 2008; Keshet, 2009, 2013; Mizrachi et al., 2005; Ruggie, 2004; Saks, 2003). In contrast, the present article focuses on the lived experiences of CAM adherents and further endeavours to explain how these lived experiences are translated into meaningful knowledge among CAM practitioners training in a college setting.

Although the fields of sociology and anthropology have seen considerable interest taken in the training of mainstream therapeutic professionals since the foundational studies conducted in the 1950s (Began, 2001; Becker, 1961; Luhrmann, 2000; Shuval, 1980; Wendland, 2010), there have been very few immersive ethnographic studies that have looked at the training of CAM practitioners.<sup>2</sup> The educational lens should not be neglected in the case of CAM; studies that have observed the professionalisation process of doctors within the conventional biomedical paradigm have been extremely productive at both analysing biomedical epistemology and practice, and understanding the way scientific thought has become central to the Western-modern experience (Anspach, 1988).

The current study attempts to fill these gaps in the literature by investigating the CAM professionalisation process via an ethnographic research method, examining the daily processes through which one prominent CAM method, naturopathy, becomes 'true' and 'real' for individuals training to become CAM practitioners. Such students often become interested in qualifying as a CAM practitioner following their own successful experience with CAM methods as patients.<sup>3</sup> The processes of adopting CAM first as a patient and later as a practitioner is outlined through an exploration of the ways in which modern Westerners internalise and interpret CAM as the 'medical truth' they choose to adopt. It will be further argued that such processes involve more than a mere internalisation of the alternative medical model as a private 'truth'; they also entail the transformation of that 'truth' into 'public' knowledge, studied in a college setting.

## Methods

The data for the present study are based on meticulously recorded notes and recordings from an 18-month participant observation carried out during the period 2014 to 2015. The participant observation was conducted among CAM practitioners in training and their teachers at an Israeli college of complementary and alternative medicine, many of

whose graduates go on to be employed by public health centres, hospitals and private clinics. The choice of this field site made it possible to observe how knowledge is inculcated as part of an alternative medical professional socialisation process. Drawing on other ethnographies of medical education that seek to understand the changes the learning process generates in the subjective experiences of trainee practitioners (Luhmann, 2000; Wendland, 2010), and to abide by the request by school staff for all class attendees to share and participate in activities equally, I actively participated in all classes I attended. In order to maintain an analytic distance, I did not officially register at the college or receive a degree, but nevertheless fully participated in classes as an unregistered student. My attendance as an unregistered student at the college was not remarkable because current and prospective students are encouraged by the college to attend classes for which they are not officially registered. Observations were made in various courses, workshops, conferences, informal college activities and treatment sessions at the college interns' clinic. The study focussed on one specific CAM method – naturopathy, which constitutes one of the most common CAM streams practiced in Israel (Shual and Averbuch, 2012). All of the classes that were observed form part of the college's 4-year academic curriculum in naturopathy.

In accordance with the ethical guidelines in place in Israel, the study protocol was approved by the Department of Sociology and Anthropology at Tel Aviv University. The participants in the study were both college students and faculty members, recruited after an initial meeting with the head of the CAM college, who had obtained unanimous informed consent from faculty members. Following an invitation to speak at a college event, I introduced the study and received informed consent from the students. This short presentation outlined the aim of the study, which was to conduct an ethnography of the college, and most members of the college stated that they were not only willing to partake in the study, but in fact keen to do so. Although the participant observation process was long and immersive, it was always clear that I was not training to become a naturopath. All participants agreed to the observation on a voluntary basis, and their anonymity was preserved: The names given in the manuscript are pseudonyms, having been randomly chosen and allocated at the beginning of the study, based on a list of popular names in Israel at the time. Importantly, the study was conducted at a private college, not a public hospital or clinic, and the 'patients' were all trainee students who were undergoing treatment as part of their training. These treatments were all discussed in class.

The naturopaths' eagerness to participate in the study presented some limitations in the initial months of the fieldwork because many saw my presence as a researcher as an opportunity to try to prove that their method works, in the face of the skepticism regarding CAM methods that has been expressed by numerous Israeli medical institutions (Mizrachi et al., 2005). This being so, following my presentation of the scope of the research, I was approached by quite a few students and teachers who offered to help by sharing their stories of recovery. I initially did not consider these narratives as particularly representative of their lived experiences, but rather as being specifically directed at me as an academic researcher. However, as the fieldwork progressed, I observed that these narratives constantly reappeared in the college setting, and became a powerful meaning-making and didactic tool that should be understood as a major theme in CAM training processes. As they grew more familiar with my presence, the naturopaths

eventually understood that I was not there to prove or disprove CAM's methods, and therefore conversations became less defensive. In the beginning, my presence provoked many remarks about my own lifestyle and health by participants who were concerned about my wellbeing and wanted to offer alternative medical advice. Such interactions were emblematic of the students' socialisation in general; the college setting prompted them to talk frequently about their wellbeing and voluntarily offer each other advice. These conversations helped me to experience and further understand the moral meanings that naturopathy attaches to symptoms of illness and that are discussed in the present article, in particular the ways in which these symptoms represent neglect and even self-harm through the notion of 'toxins'.

In the initial stages of the fieldwork, I sampled a large variety of classes including lectures, workshops and tutorials chosen from among the naturopathy programme's various years of study. The purpose behind this was to develop a general sense of the teaching methods implemented throughout the programme, and identify a particular cohort to follow more closely. In order to become more familiar with the ways in which the training process shapes students' perceptions, feelings and understandings of their professional and everyday lived experiences (Luhmann, 2000), I participated in at least two courses each semester with the same cohort, accompanying one group of trainees throughout their second and third years of study. I chose this cohort since the second and third years of the programme offer the fullest curriculum, and it is at the beginning of their third year that students begin to practice naturopathy under supervision. Moreover, when the study commenced, many of the participants reported that these are the months in which naturopathy students 'really begin to become naturopaths'. The cohort I accompanied was composed of 27 students, with six main teachers. During my fieldwork, I also managed to meet all students and members of staff at the college's naturopathy track; such encounters took place in larger classes or school events (90 people in total).

Most of the time I spent at the college involved part-time participation – 10 to 15 weekly hours throughout the entire period – excluding 4 months in 2015 that were dedicated to full immersion. My part-time participation was mostly observational: I attended classes and became familiar with the students and staff through many informal conversations. The full immersion period, however, contained a significant element of participation. Although not formally registered as a student, I was given permission and even encouraged to actively participate as a student in every college activity alongside the third-year students and at this stage, I concentrated solely on this cohort; my involvement with them ranged from classes to afternoon activities such as fieldtrips, homework preparation, in-class presentations, conferences and even personal and social pastimes such as gardening, cooking, sports and celebrations to which I was invited. These invitations were made possible by the close connections I nurtured with the participants during the first months of fieldwork, as well as the informal atmosphere and intimate discussions that took place at the college. Along with the third-year students, I visited the college's interns' clinic as a patient for the entire period to be treated by fourth-year students and their teachers, and while I did not practice naturopathy on patients, I fully participated in clinical simulations in class.

The participant observation was conducted according to the principles of grounded theory (Charmaz, 1990: 1162) and involved a dialectic between data collection and

theoretical analysis. Field notes were taken during or immediately after each class or college event, and all classes were taped and transcribed. I followed Charmaz's (1990) method for analysing ethnographic data: texts were analysed as narrative wholes, and prominent and recurring themes identified both in each observation and across observations. Line-by-line coding permitted the grounded emergence of key themes. Only the most recurrent themes are presented in this article, and the excerpts chosen represent wider thematic data sets.

## The 'turn away' from biomedicine

Almost all the trainee naturopathic practitioners at the college were also satisfied patients of naturopathy.<sup>4</sup> The findings indicate that their choice to abandon courses of treatment administered by mainstream medicine and accept CAM, along with the alternative medical truth it entails, was usually made at similar biographical junctions of pain and a lack of control. Such a decision was very often linked to a personal life crisis involving chronic illness, an experience that instigated a sense of a loss of autonomy. This aching sense of suffering and lack of control was frequently associated with participants' dissatisfaction with mainstream biomedical explanations for their pain. In the majority of cases, participants related their suffering to their experience of the mainstream biomedical model's failure to explain their misfortunes in a way that provides an underlying moral and teleological cause (see Williams, 1984). In other words, diseases did not 'make sense' to them within the biomedical framework because the simple questions of 'why?' or 'why me?' remained unanswered. The emphasis on personal suffering and the search for a moral reason was a central component within the experience of illness:

I really didn't understand back then why it had happened to me, and when it constantly reappeared, I couldn't stop asking myself: Why? And, how could it be that there was nothing else to do other than to just take another round of antibiotics? It didn't make any sense, and it just drove me crazy that these doctors did not know why this had happened to me, what I did wrong.

(Gal – teacher at the college)

Much of the dissatisfaction with the mainstream biomedical model stemmed from what was perceived to be its superficial, narrow understanding of diseases and their causes:

The celiac disease, which worsened after I gave birth, was what taught me the real lesson. I understood very quickly that doctors simply did not know what to do, that their solutions are narrow: 'Take this and that,' and that's it. They have absolutely no understanding about why things happen in the first place. (Edna – trainee naturopath)

The biomedical model was presented as failing to understand the root cause of diseases, even though it does offer many explanations for the appearance of disease. According to the biomedical model 'all disease is materially generated by specific etiological agents such as bacteria, viruses, parasites, genetic malformations, or internal chemical imbalances' (Berliner, 1984: 30). The body is framed accordingly as an integrated set of

biological, physiological and chemical systems, while the manifestation of disease is customarily explained in terms of the functioning or malfunctioning of its internal systems (Kleinman, 1995; Rosenberg, 2007). Consequently, incidents of malfunctioning are not viewed as a result of personal actions; on the contrary, many diseases are understood to be as random as 'a lightning bolt' (Luhmann, 2007).

This background gives rise to the question: Why do these explanations fail to be perceived as satisfying, and are even regarded as false, in many of the stories told by the students at the CAM college? One possible answer is that in certain situations, the 'biomedical' framework is inadequate since it is unable to offer moral and agentic meaning about the diseases that occur. In this respect, these findings are very much in line with Kleinman's (1995) view of moral meaning within the bio-medical framework: 'Meaning itself is not configured as a central focus or task of medicine. Because it eschews teleology, the very idea of a moral purpose to the illness experience is a biomedical impossibility. That serious illness involves a quest for ultimate meaning is disavowed' (p. 32). Within the biomedical framework, 'the traditional dualistic perspective of body and soul as separate units makes it difficult to understand the existential meaning of illness' (Håkanson et al., 2010: 1124). Correspondingly, the experience of illness, and especially chronic illness, often reduces the sense of self from an active agent to a passive patient.

Kleinman's description, which resonates with the way the participants viewed medicine, refers to the traditional biomedical model, but nevertheless, biomedicine is not monolithic but rather quite philosophically diverse. Following this line of thought, scholars have demonstrated that the bio-medical framework can produce illness narratives that offer both morality and a sense of agency (e.g. Mattingly, 2010). Today's physicians, particularly those who treat chronic illnesses, encourage patients to take responsibility for their health through health behaviours such as diets and exercise, and many recognise the mind's potential impact on the body through the concept of stress (Cooper and Marshall, 2013). However, these forms of agency and mind-body interactions differ from those evidenced in the practice of naturopathy. Whereas mainstream physicians often fail to acknowledge their patients' bodily experiences and reflections of these experiences, thus denying them the experience of autonomy and authority (Warren et al., 2012), naturopathy's emphasis on these bodily experiences fosters a sense of autonomy by encouraging patients to be attentive to their body and together with their practitioner, to search for the causes of their illness in their personal biographical experiences. CAM seeks answers to the question of 'why me' not in population-based epidemiological findings, but rather in the authenticity of subjective experiences.

Many of the CAM patients' personal narratives regarding the treatment administered to them by conventional medicine practitioners demonstrate that the latter neutralised their patients' ability to arrive at an explanation that generated feelings of responsibility and control over their situation; in other words, the doctors' responses served to nullify their patients' sense of agency. The centrality of agency within the human experience has been emphasised by multiple anthropological works. Individuals in Western societies experience themselves as living in intentional, moral and meaningful worlds (Good, 1994; Kleinman, 1995, 2006; Kirmayer, 1992) and are accustomed to feel a high measure of agency over their life course (Asad, 2011). As a result, illness presents a significant challenge to one's agency, sense of control and value in the world. As Warren et al.

(2012) have shown, ‘health care providers’ practices are often accompanied by subtle but significant messages that contradict the tenets of empowerment: medical practitioners reinforce professional dominance through both covert and overt methods’ (p. 324). A similar dissatisfaction was expressed in many of the narratives of both the students and teachers at the college. This dissatisfaction was articulated through their assertions of having been ‘robbed’ of their ability to actively contribute to the understanding of the cause of and possible cure for their illnesses:

The doctors never tried to ask me what else was going on in my life at the time. And they did not try and see what I thought might make my situation better. (Edna – trainee naturopath)

In addition to this loss of agency and control, the participants also described a sense of passivity forced upon them by the explanations offered by conventional medicine. In their past experiences with mainstream clinicians, the CAM students’ diseases were almost always depicted as active entities, while the suffering person was framed as passive. In Gal’s account, the clearest manifestations of this were phrases that stated that an infection ‘constantly reappeared’, while Edna’s celiac disease was said to have ‘worsened’ after she gave birth. Expressions such as ‘genetics didn’t leave me much of a choice’, ‘the infection wouldn’t let go’, and ‘the disease attacked me’ were very common in the participants’ descriptions of how they experienced illnesses before they turned to naturopathy. Chronic illnesses such as that described by Edna were frequently portrayed as something that ‘just happens’ to the body suddenly and unexpectedly, without explanation or prior warning. These narratives frame diseases as autonomous entities, as forms of an ‘it’ that takes away control and limits patients’ ability to act appropriately and efficiently. In the many stories I encountered, this experience of passivity and loss of control, of ‘being acted upon’ (Scarry, 1985: 16), played a major role in the ultimate feeling of despair that led patients to ‘find something else on their own’. It appears that the lowest point in each narrative concerns this inability to frame illness as having an agentic meaning.

## **Toxins and detoxification: Making new sense of illness in CAM training**

Diseases perceived to be chronic, such as the celiac disease that intensified in the case of Edna, are one of the most common factors among people who choose an alternative model of care. This choice is initially made as patients, and via their studies at college, their narratives of healing later become naturopaths’ main narrative as they go on to become naturopathic practitioners. In these narratives, suffering is resolved by a revelation described as an act of ‘true listening to one’s body’. Rejecting the biomedical ‘authoritative knowledge’ that denied them the feeling of control (Warren et al., 2012: 324), naturopaths instead turn to seek medical knowledge by authentic introspection by means of a therapeutic process called ‘detoxification’.

According to naturopathy, the appearance of any pain or illness is perceived to be not the result of an unknown or arbitrary cause, but rather as stemming from the suffering self that has accumulated toxins – a self that can be shaped, controlled and ‘detoxed’. In

other words, diseases are no longer framed as an unfortunate event that ‘just happens’, but rather as a deliberate consequence of what the individual brings upon herself by choice:

First of all, give your patients a detox. Most diseases occur when too many toxins accumulate in the body, and we suppress their ability to exit with medication or an incorrect lifestyle. (Dorit – lecturer)

Detoxification is one of the main practices of the naturopathic treatment method. It is a dieting period that begins with abstention from many of the ingredients and foods that might produce toxicity.<sup>5</sup> The strict diet is usually followed by a process of ‘elimination’. Following their naturopath’s instructions, the patient gradually adds various food products to her daily menu and at the same time, is responsible for monitoring the bodily changes caused by each new component through attentive introspection. The detoxification diet is intended to create a sense of responsibility for and control of the patient’s illness, as her own subjective introspection becomes a primary source for diagnosis and treatment. As stated in a presentation slide shown in one of the introductory courses at the college, ‘The detoxification process aims both to cleanse the body and assist patients in understanding what is good for them and what is toxic for them’. Most of the naturopathic treatments observed in this study began with a diet of this nature, with a duration ranging from several days to a few weeks.<sup>6</sup> The process of detoxification demands the patient’s active participation in identifying the causes of her physical condition and paving a path towards the cure. It calls for authentic introspection, which entails an examination of both bodily sensations and personal experiences, and thus echoes the ways authenticity is theorised by deriving knowledge from a search for ‘the inner voice’ (Taylor, 1991: 26). In the same vein, the training process at the college involves constant introspection on the part of the students. In this framework, the students – most of whom are disappointed with conventional medicine – learn to replace the passivity they experienced with regard to their medical condition with a sense of personal control and responsibility. Phrases that express passivity quickly vanish, to be replaced by words that convey activity and agency, the most prominent of which are ‘toxins’ and ‘detoxification’. The accumulation of toxins in the body is perceived as a direct result of the individual’s actions and life choices:

Anything can lead to the accumulation of toxins; toxic nutrition, residence in a toxic environment, lack of movement, conventional medication, and also stress. In short, every person and their own toxicity. (Ron – naturopathy student)

By emphasising the active role of the individual, these two key concepts of the naturopathic philosophy and treatment method are used to consolidate the ‘truth’ of CAM knowledge and to frame it as the antithesis of the objective biomedical approach. As such, the terms ‘toxin’ and ‘detox’, as well as their derivatives, surfaced in many contexts at the college, in classes about other subjects and therapeutic methods as well as during lunch-break discussions and social gatherings. Detoxification constituted a common and routine practice; the naturopathy students and their teachers frequently underwent



detoxification therapies as an integral part of both the lessons and the treatments at the interns' clinic, but also at their own initiative. During these detoxification periods, the students were encouraged to view the negative feelings and sensations that surfaced throughout the process as evidence of self-inflicted bodily damage. In other words, by observing their bodily sensations and noting their subjective interpretations, they soon learned to reframe their negative physical sensations away from a perception that something had gone wrong with the treatment itself, but rather as possessing moral meaning and indicating the presence of toxins. Just as for other CAM methods such as reflexology and acupuncture, it is the transformation of bodily feelings 'from unintelligible symptoms to meaningful bodily reactions' (Pedersen et al., 2016: 50) that enables CAM knowledge to become truthful and trustworthy for individuals. In the case of naturopathy, this transformation rests on a certain attitude towards the existence of toxins, which gives agentic meaning to pain.

Many of my insights into this acquired reframing of negative subjective feelings as proof of the existence of toxins were formulated following a conversation with Shirley, a first-year student at the college. The encounter with Shirley took place on an especially hot day in April 2014 that came at the very beginning of the fieldwork. Shirley – a woman in her late fifties – was breathing heavily and wiping her forehead with a handkerchief. She explained: 'It's my first detox and I've been sweating so much'. Naturally, my first impression was that Shirley's symptoms were an indication that the treatment had gone wrong, and I suggested that she return and report her condition to her naturopath. To that, Shirley responded:

What are you talking about? When I complained about it to my naturopath, she told me that this was happening because there were so many toxins in my body that were now painfully leaving. In short, this is my body's payback for the years of abuse I put it through.

Shirley's words show that according to the CAM method, negative experiences perceived to be 'subjective' such as pain, sweating or discomfort are thought to prove that the body has suffered neglect and is reacting to the detoxification process, and to reveal an agentic, purposeful cause to the illness. The participants' main conception of naturopathy was that:

If there's an illness, it must be because many toxins have accumulated inside the patient's body. And if there are toxins, there is also someone who has let them in. (Dorit – lecturer)

It should be noted that the adoption of the 'toxins' model does not mean that naturopaths entirely reject existing biomedical terms such as 'genetics', 'bacteria' and 'infections'; rather, they reframe and charge them with new meaning, one that allows for agency:

Many patients who come to me with high cholesterol say that it's genetic [. . .]. And they say this as if it somehow exempts them from any action regarding the situation. But genetics can also be influenced – a lot. I always make sure to explain to them that genetics is just the potential, and whether or not it's truly realized is in their hands. (Adi – lecturer)

The idea that suffering and healing lie ‘in the hands of the individual’, and that the patient plays an active role in her life management, is central in both the training period for the naturopathic profession and in the practice itself. In discussions of unsuccessful treatment at the CAM college, the immediate cause is identified as a result of the patient’s own doing; if the patient’s condition does not improve, it must be because she has chosen not to manage her condition properly. Similar to the notion that the patient is the source of healing, the teachers’ and budding practitioners’ subjective experiences become the primary source of knowledge in the naturopathic training process and in future practice.

## **The primacy of subjective knowledge in CAM**

In the CAM college, subjectivity and subjective evidence, rather than objective quantifiable evidence and the biomedical ‘clinical gaze’, were considered to be the most appropriate tools for endowing knowledge and its truth value. Within the ongoing meaning-making process, CAM’s competing knowledge becomes ‘true’ through practices of introspection, as in the case of the ‘elimination diet’. A good example of this alternative epistemology can be seen in a conversation I had with Danny, a trainee naturopath, about whether soybeans should be included in his patient’s diet. Danny explained the role of his patient’s subjective experiences during the ‘elimination’ part of the dieting process:

On the one hand, there are thousands of scientific studies that talk about how soy helps treat and prevent cancer. But for every one of these studies, there are many other ones that show that soy might cause cancer. Furthermore, every one of us is so different, and only common sense can teach us that you simply can’t say that the same remedy is good for everyone. [. . .] the ‘average’ of millions of experiences with soy can certainly tell us nothing.

When asked about the role of the naturopath in this process, Danny replied:

It’s not up to me to reach this understanding. You must understand: we are not therapists or doctors; we are at best advisors, assisting the person in discovering what’s good for him or her.

This excerpt reveals the underlying assumptions of the ‘detoxification diet’. As stated previously, trainees treated by naturopathy as a part of their studies are asked to become active by observing their bodily sensations, applying the guidance of their lecturers and identifying ‘what is toxic for them’ through a process of ‘elimination’. The experiences generated by this trial-and-error process come to be regarded by the naturopaths in training as a necessary part of the interpretation of their sensations. These include sweating, various types of aching and changes in bowel movements. In this type of medical culture, explanations perceived as universal and external, such as those offered by conventional science, are usually seen as unsatisfactory or even false; trainees are socialised to internalise the position that ideas become truthful only after they have been felt personally. Suffering individuals are ultimately regarded as the only people able to identify ‘what is good for them’, and not the trained observer or the external measuring instrument. Interestingly, this emphasis on the role of the individual in maintaining her health joins a broader phenomenon within contemporary biomedicine and neoliberal policy approaches,

whereby patients are increasingly regarded as responsible for their own health. This trend is captured by the proliferation of terms such as ‘self-care’ and patient ‘empowerment’ (Clarke and Bennett, 2013; Fries, 2008; Ziguras, 2004). However, when adopted by biomedicine, these approaches still maintain the authoritative position of the physician as the primary source of expertise (Warren et al., 2012). In naturopathy, however, individual subjectivity is inextricably tied to individual responsibility for health; if information crucial to healing can only be acquired through individual introspection, then healing can only take place if the individual in question takes action and accepts responsibility.

By rejecting his status as a ‘healer’, Danny further demonstrates how he helps patients to regain their sense of control by listening to them and empowering them to explore their experiences. This form of recognition can, as Sointu (2013) has argued, be regarded as an essential component of CAM’s ability to develop intersubjective interactions with the patients’ individuality, which is where biomedicine often falls short. However, my participant observation has indicated that the therapeutic sense of agency and control is gained not only because naturopathy encourages practitioners to take the time to listen carefully to patients (in many mainstream medical systems, physicians simply lack the time to engage in lengthy conversations with patients), but also by emphasising the patient’s authentic introspection as the source of knowledge, and the toxicity framework that renders patients responsible for their situation.

Another important aspect of the CAM method that emerges from Danny’s emphasis on his patient’s self-discovery is the principle of ‘authenticity’. The truth about one’s body is ‘discovered’ through a detox process that is framed as ‘looking within’, which is considered a mode of authenticity (Taylor, 1991). As such, a stark contrast is created between the standard biomedical discourse and knowledge that is bound to inner subjectivity – a personal, authentic experience. Consequently, authenticity – widely recognised as a central narrative of modernity – subverts the authority of scientific truth.

I observed this subversion to take place in the classroom through the teaching of introspection, and to play a role in the process of knowledge validation and transmission; it was intrinsically a major didactic tool of the naturopathic classroom teaching I witnessed. As stated previously, one of the predominant means of the production of naturopathic knowledge by the teachers involved sharing their personal-subjective experiences of illness and recovery, which emphasised the active part of the individual and the body:

A detox is first and foremost an opportunity to let your body teach you a lesson. We no longer know how to listen to our bodies, whereas in the detox, we simply allow it to scream out to us until we hear. [Clutches her stomach in agony, and loudly passes gas]. Did you hear that? I’m now in the midst of the spring detox, and excuse me for bluntly sharing this with you, but my body is producing horrible reactions during this detox, and it’s difficult. But I’m thankful to it for cleansing itself so forcefully; it’s teaching me that all last winter, I was too stressed out, I didn’t invest in it enough. (Dorit – lecturer)

Subjective experience appears to become a way for teachers to transmit knowledge. A part of the lecturers’ authority seems to originate in their ability to embody the very same therapeutic knowledge they wish to offer:

I will tell you my personal story of how I successfully underwent a detox, so you will know that this is not just theory. (Gal – lecturer)

Gal's statement is emblematic of the way in which personal experience is seen to be an imperative part of the ability to transmit knowledge in naturopathic training.

## Conclusion

This study has sought to contribute to a relatively neglected area of the scholarly effort to understand the growing success of complementary and alternative medicine as a social phenomenon. The vast literature on CAM reveals scanty discussion of the process of becoming a CAM practitioner, while the 'lived experiences' (Kleinman, 1988, 2006) of those who turn to CAM and the intersections that lead them to favour it over conventional medicine have also received insufficient attention. The present article fills this research gap by closely examining the process by which alternative medical knowledge has staked a claim in the minds of trainee CAM practitioners who undergo CAM treatments as patients in the course of their studies. According to critics of biomedicine (Kleinman, 1995), the issue of subjectivity has been unjustly overlooked or discarded in the mainstream biomedical discourse. It is against this background that this ethnographic study draws attention to ways in which subjectivity has come to be viewed as a powerful source of alternative medical knowledge and meaning-making, both in CAM treatments and in the training of CAM practitioners.

Three major stages have been identified in this process. The first involves severe disappointment with the conventional medical system, a disappointment that comes about as a result of an individual's inability to frame her illness as possessing an agentive meaning within the biomedical system. The second is the process whereby the meanings generated by CAM knowledge yield narratives that enable patients to reframe their illness, at the same time as reinstating their sense of autonomy, moral agency and self-worth. The study establishes that the paradigm represented by the naturopathic notions of 'toxins' and 'detoxification' creates a sense of patients' responsibility and control over illness. The third stage takes place in the classroom and naturopathic therapy sessions, when subjectivity becomes a means of transmitting knowledge; teachers convey their own experiences to their students and patients, and the students themselves learn to regard their personal experiences as the primary measure of truth. The teaching process provokes an overarching understanding that subjectivity yields truthful knowledge, and forms the basis of students' ability to treat and be treated. Therefore, unlike the 'authoritative knowledge' (Warren et al., 2012: 324), produced in biomedicine, in the CAM framework, answers and knowledge lie in the authenticity of subjective experience, rather than objective, population-based epidemiological studies.

The empirical findings of this research point to the broader cultural repertoire whereby people seek 'truth' in the context of modernity. The objective, evidence-based model offered by biomedicine can be considered as only one of the various trajectories available for knowledge acquisition and validation. Another powerful and growing modernist notion is the assertion that 'truth' is acquired by means of 'authenticity' requiring introspection, implying that a unique 'truth' lies within each person (Taylor, 1991). While the

biomedical objectification of disease necessitates a reliance on external scientific evidence and the patient's release from comprehensive moral responsibility for her condition, CAM's revival of subjectivity reinstates the patient's authentic experience as the ultimate source of knowledge, restoring a sense of moral agency.

This article argues that through its emphasis on authenticity and agency, the naturopathic method subscribes to a modernist notion of the self. The philosopher Taylor (2011) has described the notion of authenticity and the 'lived experience' it entails as a transition from a pre-modern human experience – which he labels the 'porous self' – to a modern perception of the self, which he terms the 'buffered self' – a self-maintained distance, control and disengagement from anything that occurs beyond a person's own consciousness (p. 39). Modern Westerners, writes Taylor, perceive themselves as autonomous subjects who define themselves from within, and not based on some sort of exterior cosmic order. Taylor calls this ideal 'authenticity', an ideal that compels the individual to discover her unique path – the truth that lies within her (Taylor, 1991). Those who uphold the notion of the 'buffered self' view their highest life goals as resulting from their interior motivations, and consider that the definitive meaning of external experiences is rooted in their internal reactions to them (Taylor, 1991, 2011). Such people strongly desire to live an authentic life, whose realisation they deem to require control of both the self and their chosen path, and as a result, if they believe that they possess the ability to define their experiences from within, they alone will be responsible for their feelings and life experiences.

By shifting the direction of inquiry from the passive, diseased body to observing the outcome of the subjective introspection of its 'owner', CAM transforms the patient into an active moral agent who is granted control of her medical condition, life course and fate. CAM's agentive discourse proliferates against the backdrop of contemporary neoliberal approaches to health and illness (Clarke and Bennett, 2013; Fries, 2008; Illouz, 2008). When adopted in biomedicine, these approaches put more responsibility on patients when dealing with their medical conditions, but still maintain a hierarchy between patients and medical practitioners in relation to knowledge production and disease interpretation (Warren et al., 2012). Naturopathy's alternative epistemological approach, in which authentic introspection is considered the primary way to achieve good health, presents an even more comprehensively neoliberal model than contemporary biomedical approaches. Against this background, the present work has shown how authenticity can subvert the authority of scientific truth, and in a context in which neoliberal approaches to health and illness are becoming ever more dominant, naturopathy's concern with authenticity and agency – two quintessentially modern concerns – has enabled it to flourish, without necessitating a complete rupture with modernity.

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## Notes

1. This segment is very large, compared to other Western countries such as the US (Frenkel and Gamus, 2015).
2. With the exception of a few studies such as Gale (2011) and Givati (2015), most of the studies that deal with the ways CAM knowledge is constructed and communicated and with the CAM professionalisation process are not based on long-term, immersive observations of the daily training processes. These studies focus on the relations between CAM's professionalisation and its legal and epistemological status, as well as on its authority in the healthcare market (Baer, 2010; Baer et al., 1998; Barnes, 2003; Boon et al., 2004; Cant and Sharma, 1996; Fadlon, 2004; Saks, 2003; Welsh et al., 2004).
3. Naturopathy is a common CAM method that originated in mid-19th century Germany and spread to the US and the UK in the early 20th century (Whorton, 2002). It arrived in Israel, the location of the present study, in the mid-20th century, and has become increasingly prominent in the last two decades (Cohen, 2012). It should be stressed that while naturopathy does not represent the entire field covered by CAM, it is nevertheless relevant to certain other CAM specialisations.
4. It is worth noting that biographical patterns that grant a right to heal to people who are first able to cope with their own hardships characterise the initiation processes of healers and shamans in many cultures (Bilu, 2009; Kirmayer, 2003). Studies of CAM practitioners also reveal that many CAM practitioners were originally successful CAM patients (Sointu, 2006).
5. It mostly involves a vegan diet, and entails a general abstention from processed food products, sugars and sprayed foods. In most cases, the diet is initially limited to a very small number of food products; for example, only rice and mung beans, or only smoothies made of certain fruit and vegetables.
6. In addition to the dramatic nutritional changes, 'detoxification' is usually accompanied by a range of therapeutic practices that aim to supplement and enhance the process of removing 'toxins' from the body and soul. These practices include mild daily exercise, meditation, therapeutic touch treatments, increased rest, saunas and the infrequent (but not unusual) use of enemas.

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