

**The Validity of
Complementary and
Alternative Therapies
A Critical Approach**

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The validity of complementary and alternative therapies: a critical approach. *

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. . . we should also learn from post-modern commentators the need to engage with the subjectivity of the oppressed, the silenced, the disempowered, and the marginalized when designing health care programmes at a societal level and regimes of therapy for individuals. There are insights here which do not fit a traditional positivist model but which are essential to the understanding of suffering and the significance of the interventions by which we try to modify it. (Gillett, 2004 p 737)

In determining whether a given approach to knowledge can arrive at 'respectability', the following criteria seem relevant, if not exhaustive: it must be precise in its approach, rigorous in its procedure and honest in its reporting; as a discipline it must proceed with integrity. (Petranker, 2003 p 12).

Reality as multi-interactive harmony. An individual thing or an individual class of things always has two aspects: the *yin*, which pertains to its stationary state of existence (its given nature) and its receptivity to the outside world, and the *yang* which pertains to its dynamic state in developing its propensities in interaction with the outside world. . . . In the case of human beings in particular these two aspects of existence must be cultivated in order to enhance and realize human potentiality. (Chung-Ying Cheng in Deutsch and Bontekoe, 1999 p 187).

Abstract

It is impossible to establish the validity of anything by means of certain knowledge. The bottom line of all our knowledge is that we believe in it with varying degrees of confidence arising from varying forms of evidence. Intensity of believing should not be confused with certainty in the validity of the belief. This means that religious beliefs and secular ideologies alike raise acute problems for attempts to validate them.

In this paper five forms of validity are explored: cultural, experimental, experiential, regulatory and by what I am calling 'fiat'. The first four have much to be said for them, as long as what is said is carefully qualified and critically circumscribed. Adopting careful qualification leads to some limited form of validity. Therapeutic validity by fiat – by declaration – seems to me to provide minimal status in terms of validity. This is because it is based primarily upon the intensity of belief in the therapy coupled with minimal or no researched evidence of effectiveness. Such minimal validity, I argue, does not justify the therapies which fall into this category being practised on the public. I am not satisfied with therapeutic validity being based on unevidenced beliefs.

The paper starts with a general exploration of the problem of human knowing. Although a sceptical stance is adopted, this does not, or need not, result in stultifying inability to act or practise. It does mean that therapeutic intervention should always be self-critical, reflective and open to challenge. It should be porous to other world views which include a rich variety of meanings for life including the meanings which we attach to our sufferings and our anxieties – and of course to our therapies.

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Introduction.

Am I ill ? Who says I'm ill ? Why am I ill ? What causes my illness ? Who knows about my illness ? Who owns my illness ? Who has the ability to cure my illness ? What does my illness mean ? How can I avoid becoming ill ? Do I need my illness ? Where did I come from ? Who am I ? What happens when I die ?

These are universal and profound human questions posed by any person who has language within which to frame them. One major issue underlying these questions is the question of *validity*. Am I suffering from a 'valid' illness ? Is the therapeutic treatment which I am being offered 'valid' for me ? If you are involved in any form of therapeutic intervention, then you should not be able to avoid questions such as: Are your therapeutic understandings, your therapeutic meanings and your treatments valid ? I would like to think that anyone who offers any form of therapy to the public is engaged in an ongoing and critical dialogue within their own therapy groups and with other therapeutic groups in relation to those questions. They are questions about validity.

I shall start with the Latin etymology of 'validity'. *validus* – strong, healthy. *valere* – to be strong and healthy. *valeo* – I am strong, well. It was a Roman greeting to say: *valet*: be healthy, be well. Those are the interesting origins of our current words: valid and validity.

John Cornwell (2004) starts the Introduction of his edited book: 'Explanations: styles of explanation in science' with the following observation:

Nowhere, perhaps, are different sorts of explanations more crucial and significant in their consequences for everyday lives than in courts of law, where witnesses, defendants, lawyers, judges, and juries attempt to disentangle versions of the how and the why with attendant evidence and argument. (p xi).

He could equally well have said that nowhere are different sorts of explanations more crucial and significant in their consequences than when it comes to why I am ill and who has the power, the skill, the knowledge to cure me. Questions of 'why?' and 'how?' are crucial to the meanings which we seek to invent for our living and for our suffering. They are life and death questions. The questions 'why?' and 'how?' applied to causes and cures are questions of validity.

Philosophical considerations

No one owns the truth and everyone has the right to be understood. Milan Kundera: 'The Art of the Novel'. Quoted in Rorty (1989).

The arrogance of virtuous certainty masks the egotism of power. It is the opposite of American pragmatism, which always understands that knowledge is contingent, tentative

and imperfect. Sidney Blumenthal is his article: 'This is the new gulag' in 'The Guardian' 6 May 2004.

For the mind of man is far from the nature of a clear and equal glass, wherein the beams of things should reflect according to their true incidence; nay, it is rather like an enchanted glass, full of superstition and imposture, if it be not delivered and reduced. (Francis Bacon, quoted by Shermer 2004 p 27)

Discussion of C and A therapies and also of biomedical therapies is bedevilled by a basic mistake which is frequently made. A mistake and an assumption so deeply embedded in our ways of thinking that it is often not even noticed. It is the mistake of thinking that any form of human knowledge can be certain, secure, true for all people and true for all time. In philosophical jargon: fideism is confused with epistemology. All that we are actually capable of doing is *believing* things with varying degrees of confidence based on evidence of varying kinds. This is, *inter alia*, because our minds are embodied and are therefore intrinsically part of that reality which we are seeking to understand. There is no Archimedean standpoint outside the human embodied mind from which we gain access to the truth and to know that we have arrived at the TRUTH.

It could even be said that the flawed essence of the Modernist project is the *pursuit of certain truth* and the power over others and the world which this certain truth would ensure. Much of the post-Enlightenment knowledge-seeking in the West has this dual purpose: *certainty and power*. Thus scientific knowledge becomes the basis for special authority and status in the West. Those who lack this scientific knowledge base are deemed to have little authority, spurious authority or no authority. Knowledge and authority are closely linked and knowledge is frequently gendered, hence power and authority are gendered. (See Kathryn Addelson's chapter: 'The Man of Professional Wisdom' in Harding and Hintikka 2003). The traditional biomedical culture has not escaped this 'certainty – power' seduction – indeed it has become locked into it. (See Saks 2003 and Gillett 2004). But it is not alone. Wilson (1998 p 5), the originator of socio-biology, makes this bold assertion:

When we have unified enough certain knowledge, we will understand who we are and why we are here.

Amongst other things Wilson is assuming the existence of a mind which can transcend reality and adopt the mythical Archimedean vantage point from which to know the TRUTH. Wilson seems not to realise that his is a metaphysical assumption and that there is no way of submitting it to a scientific test. Hoist with one's own petard comes to mind. (See Heath 2002).

But whilst there are serious problems around the conjunction of knowledge, power, status and authority it remains the case, which I am arguing, that if C and A therapies are to have any form of valid authority they need to establish the bases of their knowledge. C and A practitioners cannot, or should not, avoid the 'authority – validity' issue. Neither can they avoid the 'power/knowledge' problem. (See Petersen and Bunton (eds) 1997: 'Foucault, Health and Medicine').

So at the beginning of this paper I will make my own philosophical position clear:

No human knowledge is ever secure, static and certain, therefore dialogue is always a possibility - indeed a necessity - if progress is to be made and knowledge extended.

There is no method by which the human mind can access complete and secure knowledge. In the context of this paper, this means that there is always space for dialogue. It is only the dogmatic who avoid dialogue. You can't have a dialogue with dogma. Dogma is a monologue. The necessary uncertainty of knowledge should create potential for discussion, exploration and change.

It follows that no one group or person ever has a monopoly of knowledge or a monopoly on the methodologies of knowledge construction.

Our certainties are our deceivers. There is no solution to the problem of living, there are meanings to be invented.

I want to pose some basic questions which seem to me to cover broad issues of validity and which also address epistemological problems. I cannot answer these questions, but my paper is an approach to the problems of validity which they raise. Just because a question cannot be definitively answered does not invalidate the significance of the question.

I think that my two basic questions are:

Do the different world views and terminologies of the diverse therapies validly extend our views of embodied reality in co-operative and potentially integrated ways?

Or do they represent competing, excluding and conflictual views of the insoluble embodied reality of human be-ing ?

An unavoidable human problem which permeates all our attempts at understanding, and therefore includes attempts at understanding causes and cures of suffering, relates to the following four questions:

What is the nature of our knowing ?

How do we know what we think we know ?

What kinds of confidence can we have in our various forms of knowledge ?

What are the criteria for our confidence ?

These are, of course, the epistemological problems which have bedevilled human thought since questions of truth and validity began to be written down and pondered. They

cannot, or should not, be avoided in considering the validity of C and A therapies – or any other conceivable therapies for that matter. Like it or not, epistemology permeates issues of validity. Also permeating issues of validity is the social construction of socially validated knowledge. (Sociological, psychological and philosophical discussions of these issues are found in: Searle 1995, Pinker 2002 and Crane 2003).

In other words, in the context of the diversity of therapies:

- 1 Are they *constructively complementary* in that they all contribute to our knowledge of one truth ? A Modernist way of posing the question.
- 2 Are they *radically alternative* in that their basic assumptions about the world and of ourselves in the world are incompatible ? In this case, how can their essential validity be tested ? An epistemological way of posing the question.
- 3 Are they *multi-perspectival and constructivist* approaches to reality all of which are valid because reality is capable of being perceived in a wide range of ways ? A post-modernist way of posing the question.
- 4 Is our level of knowledge about the world, health, well-being, illness, treatment, cure so shallow that *de facto* we adopt a *pick and mix* approach to therapies ? A pragmatic or serendipitous way of posing the question.

When I was a member of a group of university quality advisers we were charged with the task of ensuring that courses presented for validation were, in the memorable term: '*fit for purpose*'. In other words: Is this course of study valid ? In order to test this question there were complicated and lengthy validation procedures in place. The outcome was a course which was deemed to be valid – validated by peer scrutiny and by external and independent scrutiny. There was, of course, the possibility that the course was deemed to be invalid. Courses could actually be closed as invalid.

Are C and A therapies 'fit for purpose' ?

The wide range of therapies which are included under the broad umbrella of complementary and alternative therapies makes it very difficult, perhaps impossible, to say useful things about validity which apply across the board. This therapeutic spectrum seems to be defined by its diversity rather than its similarity. At least Newton's famous spectrum produced and arose from white light ! There is no homogeneity in these therapies. One print-out from the internet resulted in 50 different C and A therapies. There are vastly differing philosophies, world views and meanings of life implicit and explicit in the different therapies. There are also very different notions of what constitutes health, the classifications of disease, of symptoms and of treatment, for example in the Traditional Chinese model of healing, of which more later. Different health and disease taxonomies produce different therapeutic approaches. This diversity could be seen as

properly reflecting the complexity of the human condition. It could be seen simply as mere confusion. There is a level of difficulty verging on the impossible to answer the question: are all these therapies fit for their various purposes – are they all valid? Are the therapies *themselves* healthy and strong and well?

It's even difficult to be clear as to what their purposes are, that is, what diseases/distresses they are *specifically designed* to address? Who decided on these purposes? What criteria were adopted to agree on these purposes and the fitness of these therapies to effect these purposes? What are the proposed 'boundaries of effectiveness' of this wide and disparate range of therapies?

A final difficulty: Is the fitness for purpose of all these therapies monitored and kept under constant researched review? Who decides on the criteria for establishing and monitoring validity? Who does this monitoring and where are the results published?

Some therapies are explicitly spiritual and even religious. Some have central concepts/terms which seem mystical rather than arising from a carefully constructed and theorised empirical research programme. Some assert that they are 'holistic' but which seem to ignore knowledge of human physiology which are central to the bio-medical approaches. I sometimes sense that 'holistic' is rhetoric. Some therapies are 'imported' from other cultures such as India and China but practitioners seem to assume that the essential therapeutic treatment is culture free, transcends any particular culture and is universally valid. The assumption here seems to be that embodied human beings and their ailments are universal givens. Some therapies are proud of their recent post-Enlightenment origin – the bio-medical approaches for example. While others are proud of their provenance in centuries and even millennia past. Some seem to elevate gurus to an iconic status, whereas others seem to rely on the apparent validity of tradition and longevity. Some even assert the hegemony of particular research methodologies as a means to truth.

A very few are formally regulated. Those which are regulated have the benefit of what I shall later refer to as the validity of legitimacy. The vast majority are practised by anyone who wants to practise. For example, anyone can set themselves up as a counsellor or psychotherapist without any training and without even needing to belong to an organisation which provides basic accreditation and an ethical framework for behaviour and practice. The practice of Chinese medicine in Britain is largely unregulated and does not need any qualifications. 'People can open anything – nobody will check their qualifications. Nobody will check their product standards'. (Dr Liu in 'The Guardian' report 25 March 2004). For those who are gullible and who are suffering there are many opportunities to exercise their gullibility in the search for remedy. For those whose needs have not been met by bio-medical treatments there is a plethora of alternatives available. Perhaps the greater the perceived need the greater the risks of choosing in the unknown.

All these therapies are based on a variety of meta-narratives the main features of which are implicit rather than explicit in terms of public understanding. Meta-narratives or world views provide diverse and broad definitions of the nature of human being and therefore include the aspiration to human well-being. The causes of the symptoms which

are presented by the western patient are likely to come within the purview of the dominant bio-medical meta-narrative because that's the one which many people have absorbed. Patients from within different meta-narratives will present different symptoms and expect different forms of treatment. What kinds of symptoms do people present when they confront therapies from different cultures ? What kinds of language do people use when trying to describe their symptoms to therapists who adopt a non-western world view ? Which narratives do they use in order to present their symptoms, their hopes and their fears ?

'What shall I tell my GP about myself ? Why hasn't she given me a prescription ? The other GP gave me one. I've always taken tablets before'.

'What shall I talk about to my psychotherapist ? What does a psychotherapist do apart from listen ? My friends listen to me, why do I have to pay to be listened to ? '

'What does a homeopath want to know about me? How do these treatments work ? Is this medication like that which the GP gives me? '

'What does she mean by *chakra* and how do these apply to me? It seems strange. I've never heard of it before'.

'Do I have to believe in *yin* and *yang* in order to benefit from this therapy ?'

'What is wrong with me and how shall I know when I am better ? I just want to feel better. I'm fed up with feeling poorly. I'll try anything once'.

And a question from a sophisticated patient: 'Does my therapist assume a position of cell pathology and allopathy or am I to be treated holistically and spiritually ? What happens if I am an atheist? Am I excluded from this therapy on the grounds of my belief system?'

In more general terms: Which narrative do I use to frame and phrase my suffering ? However on earth do I choose from among the plethora of therapies ?

The sample of questions above all indicate the existence of implicit meta-narratives as well as deep confusions. They are all implicitly metaphysical questions as well as expressions of individual distress. One way of putting this complex problem is: How do patients decide which kind of language to use when trying to explain their symptoms to their therapist ? Which cultural milieu are they inhabiting when they speak to a therapist? Which meta-narrative are they inhabiting ?

Meta-narratives are broad, over-arching world views which include notions of the origins of life and of its meaning. These meta-narratives define human existence but are frequently so deeply implicit that their basic concepts are accepted as 'common sense'. It is from 'within' these meta-narratives that we try to construct the narratives of our individual lives and their possible meaning.

Not only do meta-narratives often prescribe what counts as a valid outcome in terms of therapy, they also prescribe what count as valid questions to pose. From the sample above, it's obvious that some people do not even know what questions to pose. Some of the questions indicate that the patient realises that there are different world views (meta-narratives) operating, but does not know how to engage with these different world views. Strange, 'imported' therapies may make it difficult for the person to create a meaningful narrative of illness let alone of therapy. The sense of strangeness arises because an alien meta-narrative is suspected but not articulated. Different meta-narratives/world views will contain different concepts of the meaning of life, health, well-being, illness, treatment, cure.

As I said, my latest count of C and A therapies on the internet indicated 50 such C and A therapies and I suspect that this is not the definitive list. In some areas therapies seem to proliferate exponentially. Karasu's research in 1983 discovered 480 theories and approaches to counselling and psychotherapy. (Prochaska and Norcross 1994). Any attempt at testing the validity of these would tax the ingenuity and stamina of the most committed researcher seeking a 5* RAE outcome !

Given the number and variety of these therapies, and difficult though it is to attempt a general critique of validity, I shall raise some issues which are generally applicable in the hope that if the cap fits then it may, or even should, be worn.

A final introductory philosophical and existential thought. I could argue that one of the defining features of human beings is their considerable propensity to believe in things. The greater our anxiety and the deeper our needs the greater our gullibility in terms of what we can come to believe and hope is for our good. However, the strength of a belief is no guarantee as to its validity. Nor should a therapy rely on the gullibility of people for its propagation.

Eight principles which I think are important.

1 Gillett (2004)

Reflection on the particular case (be it a societal or an individual patient case) is indispensable and needs to be informed by critical thinking about the body as a whole, culture, value, social structure, and individual narrative. (p 735).

2 *The researchers need to be self critical, sensitive, caring, systematic, and open to the multiple subjective realities that constitute any clinical situation. (p 735).*

3 Petranker (2003)

In determining whether a given approach to knowledge can arrive at 'respectability', the following criteria seem relevant, if not exhaustive: it must be precise in its approach, rigorous in its procedure and honest in its reporting; as a discipline it must proceed with integrity. (p 12).

4 Critical reflexivity should replace any tendencies to an over committed belief in exclusive and excluding mono-theoretical therapeutic theories. These can only ever be very partial and highly restricted views of the human being who is presenting as a patient in the hope of treatment for a disease or even the hope of salvation from unspecified anxieties and guilts about be-ing. The salvation sought might be religious or secular.

5 The validity of any therapy can only be enhanced by a commitment to an interdisciplinary and integrative approach to human suffering and angst. This is because there is rarely any simple read-off between symptoms and causes and cures. Conversely any single approach to the complexities of dis-ease and illness is bound to be deficient.

6 Just because the bio-medical model is hegemonic does not mean to say that its multiple methodologies are not valid in terms of their effectiveness.

7 There is no single, discoverable solution to the human condition. There are diverse meanings and different ways of coping. There is no single, all embracing truth to be discovered.

8 Any insidious tendencies to shift from 'believing' to 'certain knowledge' should be strongly resisted.

I shall now explore five forms of validity and briefly discuss some strengths and weaknesses of each. From my point of view it is unavoidable that notions of cause and effect will permeate the discussion. (For current discussion of issues of various models of *explanation* see Cornwell (ed) 2004. For a current discussion of issues around *causality, consciousness and reductionism* see Journal of Consciousness Studies Vol. 11. No. 2 2004).

- 1 Cultural sources of validity – e.g religious and other forms of meta-narratives, world views and ideologies.
- 2 Experimental or researched sources of evidence and validity.
- 3 Experiential validity based on responses of patients and anecdotal evidence.

- 4 Validity by the legitimacy conferred by state regulation.
- 5 Validity by fiat – attempts to establish validity by mere assertion or proclamation.

There will inevitably be some overlap and interlinking among all five because they do not constitute free-standing categories. In particular the cultural category permeates all the others.

1 Cultural sources of validity

Metaphysical commitments are an integral part of scientific activity. . . . Metaphysical commitments are beliefs about the nature of living and non-living things of our world and about their relations with us and with each other. (Addelson in Harding and Hintikka (eds) 2003 p 167).

Some of the (early Greek) theories were predicated far more on mythological and theological commitment than on systematic observation and reflection. (Gillett 2004 p 731).

. . . health, illness and healing can, at least to a certain extent, be considered as socio-cultural constructions'. (Gijswijt-Hofstra in Jütte 2001 p 37).

I shall take most of the space in this paper to explore cultural issues in relation to C and A therapies on the basis that it is culture which creates our sense of who we are, what kind of world we live in, what kinds of questions it is valid to ask and what constitutes valid answers to these questions.

The body can be understood as a metaphor of our views of ourselves in the world. Our cultures give us these metaphors. Therefore at least in part our notions of illnesses and cures derive from our cultures. We experience these notions and meanings in our bodies.

Different cultures have embedded within them significantly different views about human nature, about the world, about human bodies, about how to be in the world. Cultures tend to invent juxtapositions of body and world. Cultures are about being an agent in the world. Cultures provide us with ways of be-ing in the world. We are not born with ideas of how to be in the world. We learn this through culture.

Those therapies which are located in a spiritual view of the cosmos tend to see bodies as the locations of conflict between spiritual forces or as locations of cosmic balance/imbalance. Notions of spiritual conflict carry heavy overtones of morality and sin. Notions of balance/imbalance do not necessarily carry moral overtones but purport to be statements as to how *things* are and how *we* can become what we are.

In traditional Christian thought the body is the location of the conflict between God and evil, even God and the Devil. Being a body in the world is, or ought, to be a body given over to God's will. Being a body in the world is a profoundly moral project. Illness is therefore seen as being caused by sin and evil. Either sin on the part of the individual or sin as resulting from the Fall as described in Genesis or both. According to that story we are fallen, flawed and failed. Our travails can be traced back to that original sin.

A major strand of Chinese thought developed notions of *yin* and *yang* which are dynamic polarities. *Yin* and *yang* are poles which play out in the cosmos, in the world, in society and of course in the body. The point of it all is to find a balance. Illness, in this model, is a lack of balance. Being out of balance with the cosmic forces of *yin* and *yang*.

From a very different point of view during the Enlightenment and in what came to be called Modernism, the body was still a location of conflict but not a spiritual conflict of good and evil, not cosmic conflict of balance between cosmic forces, but a conflict between germs and the body's immune system. The Modernist body is no longer a spiritual, metaphysical realm and battle ground, but is an individual person trying to survive toxic, bacterial and viral invasion. Thus the predominant form of intervention in this Modernist model of the body is that of allopathy. There is a battle to be fought, and the body is still the location of that battle. However, the means of carrying out the battle have significantly changed.

I'm not an anthropologist, but my sense is that many cultures have conflict models of body and world/cosmos. Thus, illnesses and suffering are seen as the result of various forms of conflict and/or imbalance.

At the risk of simplistic polarisation I suggest that on the one hand the spiritual/cosmic notions of the body as the location of the conflict of spiritual forces is at the mythological/religious/metaphysical end of a continuum. The Modernist notion of the body as biological and the location of invasions by other forms of bodies (viruses etc) is at the empirical end of continuum.

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

It might be interesting to ponder where you consider your own version of therapy appears on this continuum – and why. What are some consequences of the position of your therapy ?

The spiritualization of the body and illness seems to me to arise from and perpetuate complex belief systems (some of which are pre-Modern) which are intrinsically incapable of rigorous researched testing. That does not necessarily imply that believing in these origins of illness and cure is irrelevant or invalid. It means, I think, that they are beyond

scientific or other forms of testability. I suggest that they cannot be validated by researchable, empirical means. They are believed to be the case. It follows, for me, that their therapeutic validity lies in the credibility, the justification, of the beliefs. On what basis might I trust certain beliefs? Can I believe in God and in spiritual explanations of suffering and healing? I am a humanist. (Heath 2003). Can I believe in *yin* and *yang* cosmic, social and personal balance? I find those notions difficult but not inherently invalid. If I am unable to believe these things, then how can the therapies which derive from them be valid for me and other non-believers? Believability creates its own problems of validity. These issues are referred to in the quotations from Addelson and Gillett at the start of this section.

Those approaches to illness which assume that the body is being attacked by viruses and various forms of cell pathology, neurological deficiencies etc can, to an extent, be tested and possibly cured by carefully constructed research. But reductionism or restricted biomedicalism *per se* seem to exclude whole swathes of meaning and believing from attempts at interpreting illness and of effecting cures. Neither biomedicalism nor scientism as 'belief positions' can provide total meaning frames for human being. (Vattimo 1999. Rose and Rose (eds) 2000. Heath 2002).

In a sense the irony of this was summed up by Edzard Ernst in the opening sentence of his column in 'The Guardian' 18 May 2004:

If it helps me I don't need science to show that it works.

The rest of his article criticises that position.

The following quotations high-light the cultural dimensions of suffering and therapies – and therefore the multiple meanings of sufferings.

Coping with illness is one of the tasks with which people are confronted time and again. However, what people consider to be illness is variable and subject to change. This also applies to the definition of health and the boundaries between health and illness, the experience and interpretation of health and illness, and what people actually do in order to keep healthy or restore their own health and other people's health. In other words, health, illness and healing can, at least to a certain extent, be considered as socio-cultural constructions. (Gijswijt-Hofstra in Jütte 2001 p 37).

By focussing on the 'Severn sorts of Pulses which indicate danger of Death' in a Chinese treatise translated in the mid eighteenth century and on the emotions in anticipation of death expressed there, (this paper) highlights problems which any researcher interested in understanding other 'life worlds' and world views is bound to encounter. As is well known, the conceptions and experiences of body and nature, self and other, and life and death in unconventional medicine differ from those in the dominating models of contemporary biomedical sciences; and it is precisely the altered conception of self which these medicines offer that provides the basis for successful therapy. (Hsu in Jütte 2001 p 193).

The cultural milieu of the therapy is, it seems reasonable for me to assume, likely to be a factor in its effectiveness because that milieu creates the beliefs which we hold about ourselves, how we ought to live and what might be wrong when we are suffering. Culturally induced beliefs are factors both in the causes of the symptoms, the meaning of symptoms and in the assumed effectiveness of the culturally validated therapy.

Cultures create our ways of being in the world and our ways of thinking about ourselves and the world. Cultural assumptions are so deeply embedded in our thought processes that, until we develop ways of reflecting on them, they seem to be simply unnoticed common sense. Cultures give us our sense of the obvious, the given, the taken for granted. Cultures create the major ways in which individuals construct the meanings and narratives for their lives. These meanings include meanings of illness, sources of illness and the validity of cures. Some notions of cures are very culture specific but these notions of cures may, for various reasons, be imported from other cultures. When this takes place it does so without the general cultural supports and meanings in the receiving culture which are available in the sponsoring culture.

Cultures not only validate the kinds of questions which are deemed to be valid to pose, they also validate the kinds of answers which are deemed to be appropriate responses to those questions. What kinds of questions should/could be posed to imported therapies ?

Given the cultural milieu of therapies and the belief systems which sponsor and support them, there is, therefore, an issue for me around the 'importation' of therapies. That is therapies which are indigenous in other cultures and which, for various reasons, have been 'imported' into the western culture. The deeply cultural components of therapies are clear on the various websites which I have examined. Even when a therapy arises in an indigenous western cultural setting it may emphasise aspects of the variety of beliefs in that culture which are not accepted by all, and therefore the issue of beliefs and culture is still a problem. Homeopathy is an example of a therapy arising in a western culture but which is still marginalized by many 'orthodox' practitioners. (See Jütte 2001 and Dinges (ed) 2002).

So a number of questions arise for me:

- 1 Do therapies which are imported from other cultures rely on the acceptance by potential clients of the alien, or at least unusual, cultural beliefs for their effectiveness?
- 2 Does it matter that only the therapist practitioner might actually believe in the world view and effectiveness of the therapy ? In other words, are the therapeutic benefits available *in spite of* the fact that the patient might neither understand nor believe in the basic belief assumptions of the therapy ?
- 3 What forms of validation are these imported therapies subjected to in order to provide convincing evidence of their effectiveness *outside the cultures in which they were sponsored* ? Or, is their effectiveness entirely, mainly or in part

dependent on the adoption by patients of the cultural beliefs of their sponsoring culture ?

- 4 What forms of researched evidence are there for concepts of the body, suffering and therapy which are imported from other cultures ?

I listened, as I always do, to the BBC Radio 4 Melvyn Bragg programme: '*In our time*' on 29 April this year. I had known that tea was imported from China and that china was imported from China. Both of these items took root in Britain and became so endemic to our culture that tea became our national drink. China ware became a major product of the Potteries where I was born. One of the reasons why tea and china ware took on was because they were fashionable and became fashion statements. They had an exotic Eastern quality about them which became a status symbol for the wealthy which then 'percolated' down to the lower orders. Can there be a similar, but more complex process in relation to Chinese therapies ? Can they become westernised ? Indeed, should they become westernised ? (See Sagli in Jütte 2001).

Different cultures validate different belief systems and these systems include deep assumptions about the meaning of human life, the goals for human living and notions of human welfare and dis-ease. As a general statement: validity means different things in different cultural contexts.

So, one source of validation in this cultural section is validation by the provenance of a long and 'exotic' tradition. Various therapies have been endemic in that culture for ages, and their traditional provenance seems to provide them with validity. One of many problems which occurs to me in the model of cultural and traditional validation of a therapy is this: Given the weight of the tradition and the inertial affects of the tradition, how do therapies which rely for cultural and traditional validation of their effectiveness make any progress in terms of developing understanding of the causes of disease and the causes of cures ? Tradition and custom can be forms of stasis. Therapies can be stuck in the concrete of tradition.

I do not know for myself what the validity of acupuncture, Tai Chi, Qigong, Shiatsu might mean for me. For example, how do I make sense of meridians ? Nor do I know what methods have been used and are used to validate these therapies. I am not saying that they are not valid. I am saying that I do not know how they have been validated. I am also saying that I do not know the basis on which I might come to believe in them. Would I have to believe in these ideas in order to benefit from the therapy ?

Cultures are meta-narratives which are broad, over-arching world views which include notions of the origins of life and of its meaning. These meta-narratives define human existence but are frequently so deeply implicit that their basic concepts are accepted as 'common sense'. In the context of therapy, not only do meta-narratives often prescribe what counts as a valid cause of suffering and of a valid therapeutic outcome, but they also prescribe what count as valid therapeutic questions to pose.

A basic assumption of human beings in western thought is that we are essentially individuals and that we are responsible for what we do. Illness is largely seen as an individual problem to be tackled on an individual basis. If I am suffering individually then I need to be cured individually. It's my body which is suffering and it's my body which needs to be cured. I am aware of socio-epidemiological approaches, but the main western emphasis is on the individual. Chinese tradition is very different.

The classical Chinese tradition begins from the assumption that human being . . . is how one behaves within the context of the human community rather than some essential endowment that resides within one as a potential to be actualised. (Ames in Deutsch and Bontekoe 1999, p 149). . . . the Chinese tradition has been largely persuaded by a Confucian-based relational and hence social definition of person rather than by any notion of discrete individuality. (p. 152).

Nature is seen as the source of the goodness within human beings . . . and following one's nature is the way both to understand and fulfil heaven's plan. (Ivanhoe in Deutsch and Bontekoe p. 156).

These networks of natural resonances provide normative standards according to which one must organize and accommodate one's activity. To follow them meant to go with the natural flow of things; the result was enhanced ease and efficacy. Failing to accord with these patterns, processes and forces meant one's action would cut against the grain and fight the running tide of nature, with corresponding negative results. (Ivanhoe in Deutsch and Bontekoe p.159).

The doctrines which are gathered together under the rubric of 'Classical Confucianism' . . . do present a coherent picture of the good life for human beings. That life is altogether a social one. The Confucian Way of Humankind requires each of us to live properly the relational roles that define us as persons. . . . Collectively, the roles we live define us as persons and the way we live them give us our dignity, meaning, and satisfaction in life. Both within the family, and in the larger society beyond it, custom, tradition and ritual serve as the binding force of our relationships. . . The importance of rituals for the early Confucians must be underscored. (Rosemont in Deutsch and Bontekoe pp 177-178).

Reality as multi-interactive harmony. An individual thing or an individual class of things always has two aspects: the *yin*, which pertains to its stationary state of existence (its given nature) and its receptivity to the outside world, and the *yang* which pertains to its dynamic state in developing its propensities in interaction with the outside world. . . . In the case of human beings in particular these two aspects of existence must be cultivated in order to enhance and realize human potentiality. (Chung-Ying Cheng in Deutsch and Bontekoe p 187).

'Knowing' in classical China is not grounded in a cosmological knowing-what as was the knowledge of the ancient Greeks. The Greeks asked the question, 'What kinds of things are there ?' and responded by providing a sense of the *physis* of things – the 'stuff' of which the world is made. (hence our physics) For the Chinese the question was and is, 'How is life to be lived ?'. 'How may I realize the Way ?'. . . Truth, then, is not attached to propositions but to persons. . . Rather than speak of truth and falsity, the Chinese

concern themselves with questions of genuineness and hypocrisy – terms which apply to the presence or absence of acts of integrity rather than the adequacy of propositions. (Hall in Deutsch and Bontekoe p. 218).

Traditional acupuncturists, for instance, are concerned to balance the opposing forces of yin and yang that circulate through the meridians in linking mind, body and spirit. (Saks 2003 p 115).

There is the Confucian emphasis on tradition, ritual and customs. The meaning of life is that of conforming to the way, living with the natural flow, cultivating the *yin* and *yang* of existence. Life's task is not seeking the truth about the nature of things, it's a sense of integrity and quality of living socially in the community. The validity of everything about life is in the balance of *yin* and *yang*. This metaphysical assumption is posited as a self evident truth. An acupuncture website states:

Modern Western medicine cannot explain how acupuncture works. Traditional acupuncture is based on ancient Chinese theories of the flow of Qi (Energy) and Xue (Blood) through distinct meridians or pathways that cover the body somewhat like the nerves and blood vessels do. According to ancient theory, acupuncture allows Qi to flow to areas where it is Deficient and away from where it is in Excess. In this way acupuncture regulates and restores the harmonious energy balance of the body.

In a vastly different set of metaphysical assumptions – those of the pre-Modern Christian culture of the England of the Book of Common Prayer of 1662 - it was assumed that all health and well-being came from God the author and giver of life. In this Book of Common Prayer there is a prayer offered by the priest when visiting the sick.

Wherefore, whatsoever your sickness is, know you certainly that it is God's visitation. And for what cause this sickness is sent unto you; whether it be to try your patience for the example of others . . . or else it be sent unto you to correct and amend in you whatsoever doth offend the eyes of your heavenly Father, know you certainly that if you truly repent of your sins and bear your sickness patiently, trusting in God's mercy, for His Son Jesus Christ's sake submitting yourself wholly unto his will, it shall turn to your profit, and help you forward in the right way that leadeth unto everlasting life.

Healing could be effected by the priest who was the channel of God's healing power. The assumption was that health and well being were God's prerogative, that sin resulted in illness, that the priest's relationship with God as mediator of God's healing powers was divinely validated, and that cures could only be effected by God's forgiveness and intervention. These beliefs were stated as if they were facts – and presumably to the sick person they were the only valid 'facts' available. And, of course, the 'facts' were validated by God. It required the tectonic shifts of the Enlightenment to challenge the authority of God's validation of 'facts'.

This is a Christian version of the notion of imbalance – spiritual imbalance which appears in other pre-Modern notions of disease, treatment and cure.

A brief reference to shamanism in part because there is a shamanic practitioner not far from Nottingham.

First and foremost, avoiding death is not the purpose for the practice of medicine in the shamanic traditions. Our Western mistrust of these systems often comes from the observation that shamanic healing may not have resulted in an extension to life. Healing, for the shaman, is a spiritual affair. Disease is considered to have origins in, and gains its meaning from, the spirit world. The purpose of life, itself, is to be indoctrinated and initiated into the visionary regions of the spirit, and to maintain oneself in concert with all things on earth and in the sky. To lose one's soul is the gravest occurrence of all, since it would eliminate any meaning from life, now and for ever. Thus, the purpose of much shamanic healing is primarily to nurture and preserve the soul, and to protect it from eternal wandering. (Achterberg 1985 p 17).

These three sources of both illness and healing are located in social (Confucianism) and spiritual (the Christianity of the Book of Common Prayer and shamanism) dimensions which, it is assumed, exist independently of my believing in them, but which nevertheless are believed to be the sources of my illness and the sources of any cures which might be induced to come my way.

The existence of various cultural notions of the origins, causes and cures of illness raises yet another extremely difficult but pertinent question: How are 'benefits' understood in your therapy? For example, are the therapeutic benefits of your therapy primarily spiritual and deemed to be for the benefit of one's eternal soul? Or are they, more modestly benefits for the body and for the here and now and the mortal?

The crucial point I am making is that the kind of culture within which knowledge is produced creates a *knowledge context*. So it would seem that the culture and context in which knowledge is produced influences its perceived status as knowledge. This issue of culture and context is also related to the authority of the people who produce the knowledge and who live and have their being in that culture and context. When there is a confluence of high status of the person and high status of the culture, the knowledge thus produced may be deemed to have high status and may be considered, indeed assumed, to be important. Cultural, social and religious status are sources of validity. Fuchs (2001) explores some current problems with any assumptions that human knowledge can be essentially true and therefore necessarily valid for all people for all time and presents a sociological theory of culture. In other words he explores cultures of knowledge.

In the context of the sciences, there is also the significant issue of whether the knowledge produced has any practical application. People tend to take such pragmatic knowledge seriously. Such knowledge is believed but not only believed. Unfortunately such knowledge might even come to be believed as being *true*. True for all time and true for all people. Thus, some forms of knowledge become valid and validated by the status of the people who produce it, the status of the culture in which it is produced and the benefits which accrue to a wide range of people. We who are surrounded by technology which we do not understand, and which some of us indeed can barely utilise, are the beneficiaries of these cultures of knowledge production. High status people who exist in

high status knowledge contexts give the appearance of speaking and acting with authority. Thus we have the Government's Chief Scientist appearing on television to offer reassurance or warning as the case may be. A problem arises when different scientists appear and provide differing views on the same subject.

Cetina's book (1999) *Epistemic Cultures: How the sciences make knowledge* discusses the cultural aspects of the two world famous laboratories and the differing ways in which their respective cultures produce highly valued and valid knowledge. She has written the first ethnographic study of the work of the CERN high energy physics laboratory in Switzerland, and two internationally famous micro-biology laboratories in Heidelberg and Göttingen. The knowledge which these laboratories produce is very different in form, content and application. What the knowledges share is that they gain high respect from the relevant scientific communities and have impacts on our own daily lives via the high tech toys which we use such as PCs and CD players, and via medical therapies.

On the other hand, and in stark contrast, religion provides an example of a culture in which there is a confluence of status and knowledge but which is not based on experimental methodologies. The Pope, for example, is garbed in exotic clothes. Even to call them 'clothes' seems to be demeaning, 'attire' might seem better – certainly not 'gear'. He speaks from an exalted position and is surrounded by other highly garbed people, but whose garb is less grand than that of the Pope himself. He also relies on the deeply assumed validity of the tradition and the history of the church and of the Bible itself. All this is designed to give enhanced status and authority to whatever the Pope says. The ultimate role model for aspiring gurus! If I stood in the local marketplace and said exactly what the Pope had said I would stand every chance of being ignored. It's not that I would have no clothes – like the proverbial emperor - but that I would have the wrong clothes, would be in the wrong context, would not be able to create an impression of being an authority and would not be part of a visible tradition and ritual. Perceived status has a marked effect on the perception of the validity of the knowledge which one is seeking to purvey. And status is related to the culture in which one operates. Hence the significance of the legitimacy of regulation as form of validation. (See section 4 below on legitimate sources of validity – e.g. statutory regulation below).

The massive differences between the knowledge which is produced by the Pope, and religious, cosmic and metaphysical beliefs systems generally and the knowledge which is produced by the two scientific laboratories studied by Cetina and the other varieties of scientific validity arise from the various notions of validity. Scientific knowledge is valid because it is the result of carefully conducted and criticised experiments, the outcomes of which are always being challenged and scrutinised. The knowledge produced by the Pope may be couched in language which sounds as if it is firm knowledge, but is actually a series of belief statements under the guise of facts of life and facts of meaning. Scientific knowledge is empirical. Religious knowledge is creedal. Scientific knowledge is always changing. Religious, cosmo-ideological and metaphysical knowledge tends to be reiterated and static.

In an aside which seems important to me, I think that one of the benefits of C and A therapies, whether indigenous or imported, is that they offer a meta-narrative challenge to the hegemony of bio-medical orthodoxy. However, I also suggest that the challenge is only valid to the extent to which C and A therapies are able to offer reasons, justifications and forms of articulated and appropriately researched validation if they are to be taken seriously. Mere repetition of the traditional and believed central concepts is not enough. Whatever else may or may not be the case, complexity is where the human condition is at.

But what is wrong with messy richness, so long as we can construct an equally rich texture of satisfying explanation? (Stephen Jay Gould: 'More things in Heaven' in Rose and Rose (eds) 2000 p 91).

If your therapy is the 'answer' what was the question?

2 Experimental or researched validity.

In determining whether a given approach to knowledge can arrive at 'respectability', the following criteria seem relevant, if not exhaustive: it must be precise in its approach, rigorous in its procedure and honest in its reporting; as a discipline it must proceed with integrity. (Petranker, 2003 p 12).

In a recent paper Harry Frankfurt describes human beings as 'generally hard to pin down, difficult to sort out, and just about impossible to sum up'. (Buss and Overton 2002 p xi).

At a very abstract level, organizing is an attempt to convert uncertainty into routines. There are many sources of uncertainty, both internal and external. (Fuchs 2001 p 229).

The use of complementary and alternative therapies is rapidly increasing in the United States. . . Along with the increasing popularity of CAM, there is the need to generate scientific studies that examine the efficacy and safety of various CAM therapies. (Zick and Benn in 'Alternative Therapies in Health and Medicine', May/June 2004 p 50).

Report in 'The Independent' 6 April 2004.

The biggest myths of modern medicine were challenged in a new guide for patients launched on 5 April 2004 that sets out the best treatment for 60 of the commonest medical conditions. Instead of claiming miracles, the guide admits that often the best treatment is no treatment. Devised by the British Medical Journal (BMJ) it is based on evidence from thousands of research studies and is being made available through the NHS Direct website, the advice service for patients.

In this therapeutic culture of research as a source of validity, clinical practice is ideally located in a theoretical framework which consists of defining and internally coherent concepts which are capable of being *disproved*. If there are no conceivable conditions under which the concepts of the theory can be disproved it suggests that the therapy is based more on myth, theology and belief rather than on researched evidence. These

fundamental concepts should provide reasons, justifications and explanations for the therapeutic practice. Careful, coherent and critical reasoning is a form of validity

Such research is focussed on the following kinds of questions: What are the key theoretical concepts which are being assumed and tested? What is the statistical reliability of the practice of this therapy? At what statistical level of confidence does it become in the public's interest for this therapy to be offered as helpful? What are the assumed causes of the symptoms? What are the assumed causes of any improvement in the symptoms arising from therapeutic intervention? In other words: How does this treatment cause the beneficial outcomes? How might understanding of the causes be developed in order to improve diagnosis, treatment and outcomes?

In the briefest form, it matters whether the following questions can be answered at least in part: 'What is happening during this therapy?' and 'Why is it happening?' 'Is what is happening likely to be more than less beneficial?'

In a term used by Lipton (in Cornwell 2004 pp 1-21) in his discussion of the significance of causality in scientific explanation: What is the *Best Explanation* of these symptoms and of the presumed causal benefits of this therapeutic intervention?

Jütte (2001 p 17) poses the issue in stark terms:

Only recently the Pharmaceutical Commission of the German Medical Association issued a clear statement, arguing that those therapies labelled as complementary are based on personal belief and subjectivity and that because 'two completely different paradigms' exist, one subjectifying, the other objectifying, and 'ecumenical union' is out of the question.

That position assumes incompatibility between conventional and unconventional. This raises extremely difficult questions in relation to comparisons of respective validity.

I appreciate at least two important problems in this area of comparison:

- 1 Comparison might presume the *essential validity* of the dominant paradigm and therefore validity can only be established within the criteria established by the dominant paradigm.
- 2 Comparison might be necessarily impossible if the C and A therapies adopt a range of non-orthodox and subjective paradigms of origins of illness and types of therapy, as well as to notions of cause and effect. This range of alternative paradigms may not only make comparison with the benefits of the orthodox paradigm impossible, it may also make comparison *between different C and A therapies* impossible because they too adopt different illness/therapy paradigms amongst themselves. As Sacks (2003) comments: 'Some of the more holistic alternative practices, therefore, are potentially in conflict with the orthodox biomedical approach that aims directly to suppress or

eliminate illness through the use of drugs, surgery and other mechanistic methods'. (p 116).

All this seems like trying to solve impossible riddles. However, difficult though it might be, it seems that it is impossible to explore validity without some form of comparative approach. The difficulties of comparison are perhaps summed up in the three problems posed in the introduction to the English edition of Michel Foucault's (1974): 'The Order of Things – An Archaeology of The Human Sciences' these are:

The problem of change. The problem of causality. The problem of the subject.
I think all three are crucial to issues of validity.

I now discuss some issues related to experimental or researched validity.

In this research model of validity any therapeutic intervention should be the result of experimental research which has demonstrated that the intervention is statistically reliable. Reliable that is in terms of benefit. Reliable, but noting detrimental effects as a necessary aspect of this research. Such experimental research will necessarily include third person objective research in which the 'patient' is viewed as an embodied recipient of treatment and outcomes will be meticulously noted. But there is always the experiential, subjective dimension of the 'patient' as person, and therefore qualitative research is needed in order to incorporate the necessary 'multiple subjectivities' to which Gillett refers (2004 p 735). Any reliability arising from such multiple research methodologies relates to statistical levels of confidence and therefore to statistical validity. This form of validity, as all others, is the validity of probability. Validity is embedded in uncertainty. It seems obvious to me that some of the research methodologies which have been developed by Western sciences are very potent methods of trying to explore validity and to increase the chances of probability. I also propose that if it is assumed that Western scientific methods are not appropriate, then the reasons for this assumption should be articulated and the alternative research methodologies clarified, justified, adopted and subjected to continual review and modification. Validity comes in various guises, but the guises should not become disguises.

A criticism of western empirical research could be that it is attempting to cure the 'wrong' problem. If the 'cure of souls' is the primary problem and the primary problem, or if achieving a balance of *yin* and *yang* is the primary aim, then western bio-medicine is possibly irrelevant and its cures could be deemed to be invalid.

This form of statistical validity helps to create a sense of credibility for therapist as well as confidence for the client. A sense of credibility helps to avoid collusion and defensiveness.

A deep problem of the results of any such research are issues of the uncertainty of generalisability. Is this relatively reliable therapy relevant (valid) for this particular person? There is no certainty in the answer to this question.

Another deep assumption of this model of validity is that symptoms have causes and cures are causes which result in desirable effects in terms of outcomes. Thus symptoms and treatment and cures and outcomes are all (at least in theory) linked and can, at least within limits of the assumption, be understood. This deep assumption about cause and effect is often couched in terms of ‘outcomes research’. From a philosophical point of view the notion of cause and effect is extremely difficult to explore. In quantum mechanics and within the indeterminacy principle of Heisenberg, cause and effect are turning out to be bafflingly elusive. Multiple and parallel universes are now coming into our way of thinking. (See Smolin 2000). It doesn’t augur well for a single simple theory of therapy – alternative or orthodox.

It is also as well to note that cause and effect are not assumptions limited to western thought alone. Any notion of symptoms which require treatment assumes a cause and effect process, although notions of what causes a symptom and what causes a therapeutic effect may differ significantly both between theories and between cultures and world views. These differences relate to models of understanding the world, society, the individual, and respective goal and meaning of living itself. Cause and effect are profoundly problematic because we develop beliefs about them which either cannot be tested or which are extremely difficult to test.

Thagard’s (1999) book: ‘How Scientists Explain Diseases’ is a stimulating study of the multifarious ways of the application of scientific methodologies which attempt to test a range of diseases. It raises issues as to the causes of diseases and the possible causes (sources) of cures for disease. He draws on Goldman’s (1992 p. 195) notion of *veritism* and Thagard re-frames this as follows:

- 1 The *reliability* of a practice is measured by the ratio of results to the total number of results and errors fostered by the practice.
- 2 The *power* of a practice is measured by its ability to help cognizers find results that answer the questions that interest them.
- 3 The *fecundity* of a practice is its ability to lead to large numbers of results for *many* practitioners.
- 4 The *speed* of a practice is how quickly it leads to results.
- 5 The *efficiency* of a practice is how well it limits the cost of getting results.

(Thagard 1999 p 172).

A possible weakness of this form of validation is that its dominant methodologies may exclude methodologies which are relevant but which are not given credence. A particular methodology may become dominant and excluding. However, from my point of view, methodologies which are relevant but which are excluded by the various ‘western’

methodologies need to be explicit and subject to normal and rigorous processes of critique. Even for these I think that Thagard's model is useful.

But, I assert, some model of testing validity must be adopted. Hsu (in Jütte 2001 p 201): '... core issues of unconventional medicine are often insufficiently researched and not well understood'.

Research hypotheses are, after all, couched in culturally constructed forms of language.

If it is the case that the language in which our view of the world is couched actually *defines* the world for us, as proposed by Wittgenstein (see McGinn, 1999), then the differing languages of C and A therapies and the languages of conventional therapies define people's notions of what their illness might be and what might constitute a cure. In some senses then, issues of validity in terms of therapies becomes an issue of the *validity of the languages* of these therapies. Furthermore, the languages of the therapies contain implied epistemologies – theories of our knowing. Thus differing languages imply differing epistemologies which in turn imply different methodologies by which to test the validity of the epistemologies. Put in rather more straightforward terms: the ways in which we come to know what we know depends on the *language* we use to frame our knowledge and the *methods* by which we gain our knowledge. There is no direct way of accessing any reality. Nor does language directly correspond to reality. One consequence of this is that not only is it important to pose good research questions, but also to recognise that the very language within which the questions are posed will have implications for the ways in which the research is carried out and the kinds of 'answers' which will be produced.

Hsu (in Jütte 2001 p 212): 'The concepts we use when speaking about and in other ways acting with regard to the body, both reflect and construct our understanding of the body'.

In this context I now quote some issues raised in the article in 'The Guardian', 25 March 2004.

Traditional Chinese medicines should be classified as drugs and not sold as health foods. Dr Zudong Liu: '... there's a very serious risk because you are dealing with medically functional products. Any medically functional product will have some instance of toxicity'.

Professor Robert Hider, head of biomedical sciences at King's College, London said: 'They need to be properly controlled and administered through licensed pharmacies'.

He was the academic leader of a fact-finding mission to China and Singapore in October 2003. He said that he and his colleagues were impressed with the lengths to which practitioners in Chinese medicine were going to underpin their work with science by carrying out properly controlled clinical trials. There were also efforts to classify and standardise different medicines. Practitioners were also highly qualified requiring five

year degrees. By contrast, the practice of traditional Chinese medicine in Britain is largely unregulated and does not need any qualifications.

Dr Liu: 'People can open anything - nobody will check their qualifications, nobody will check their product standards' adding that the British government must draw up clear rules to govern the sale of traditional medicines and that regulation would also help raise the confidence in potential patients.

Professor Hider's team came back with potential leads for drugs to treat Alzheimer's disease and anti-bacterial compounds for cancer. In some respects this could be seen as a process whereby different cultures, using different approaches and world-views, produce valid therapies because of the rigour of the research and investigative procedures. Thus research methodologies are crucially important.

In the context of Chinese practice I can't resist including the following quotation from Hsu (Jütte 2001 p 213):

Before I proceed, let me recount an episode which will bring to life the kind of problems with which I am concerned. The event I wish to relate took place in China at an international acupuncture training centre. Two persons, a European physician in China to learn acupuncture, and his teacher, a traditional Chinese medical doctor, were engaged in a heated discussion about the importance of the spleen. The western physician had just learned in the acupuncture class that traditional Chinese medicine regards the function of the spleen as crucial. He protested against this view since he knew many patients who had lived happily for many years after their spleens had been removed. The Chinese doctor replied that : 'The spleen in Chinese medicine is different from the spleen in Western medicine. If you want to learn Chinese medicine, you will have to forget what you have learned before'. With this comment, he regarded the discussion as finished and left.

Something of an Anglo-Chinese stand-off !

My assumption is that all therapeutic theory and practice should be located within a properly resourced and independent research culture in which both theory and practice can be challenged and in which careful attempts are made for outcomes (and therefore causes and effects) to be replicated. Research, both empirical and experiential, is a crucial aspect of validity. Are there laboratories which explore the vast range of C and A therapies ? What are the cultures of knowledge production , knowledge acquisition and knowledge challenge in C and A therapies ? Not only 'what' are these cultures, but 'where' are they ? How is knowledge in C and A therapies produced ? How is knowledge and practice in C and A therapies challenged and changed ? I suspect that in some C and A therapies, and indeed in orthodox practice, there is a tendency to inherit an approach and then practise it on the assumption that it will benefit some people some of the time. If there is no research of any form to backup the practice of a therapy, then I presume that its practitioners depend on the beliefs of the patients that the therapy will have curative effects. Such theories, I assume, depend to a maximal extent on the placebo effect.

I make some brief points which I think are important, some of which arise from Thagard quoted above.

There should be no serious counter-indications to the therapeutic practice. If there are, this ought to raise urgent questions about the validity of the therapy. Therapists should have ways of tackling issues of counter-indication, rather than seeking to avoid them by escape into vague and rhetorical terms such as 'holism' or 'spiritual' – or by blaming the patient.

There should also be explicit notions of time scale within which to assess the effectiveness of the therapy. Prolonged treatment suggests that the therapist's need for remuneration is outweighing the validity of the therapy.

There should be some degree of consistency and coherence with the theory and practice of similar therapies. That is, different therapies should not be in direct theoretical competition with each other unless there are clearly articulated theoretical grounds for such conflict. These grounds should be reviewed from time to time to ensure that mere prejudice is not creating collusion with one's own treasured beliefs. This issue of consistency is also a source of validity. However, it could be a source of collusion between therapists who do not wish to expose themselves to the rigours of scrutiny by themselves. Carefully expressed reasons for inter-therapy conflict or inter-therapy similarity are sources of a form of validity.

The therapeutic theory should be located in a broader, and explicit, meta-narrative of human illness, dis-ease and health and well being. This broader meta-narrative should allow the development of a taxonomy of causes of disease/distress, symptoms and a taxonomy of curative interventions. This notion of 'meta-narrative' is complex and, *inter alia*, draws on the idea that our sense of being is culturally located, and therefore our sense of dis-ease, health and therapy are also culturally informed. It also raises issues about the particular culture which spawned or sponsored the therapy. Do therapies survive their transfer from one culture to another? How can the effectiveness of such therapy transfer be effected? Complex issues but, I assert, relevant to the issue of validity.

There is yet another complicated issue related to validity: Do the central terms of the therapy and its practice seem *valid to the clients* who are the recipients of the therapy? At least one area of complexity here is the issue of whether or not a client 'needs' to adopt the world view of the culture which originally sponsored the therapy in order for the therapy to be effective for *that* client in *this* culture. There are obvious examples: Chinese and Indian therapies being transported into a Western culture. If it is simply assumed that therapies can be transported from one culture to another in their clinical aspects, then the deep assumption being made is that the particular therapeutic concepts and practices and their application to this person in this culture are universally applicable. This in turn is based on an assumption that there are universal and essential features of the human condition – including illness, health and treatment - which transcend cultures and world views.

To rephrase this slightly: There are assumptions as to cultural independence and autonomy of the therapeutic effectiveness. The tenets and practices of the therapy are culture free. This assumption, I assert, needs to be carefully articulated by proponents of the therapy and challenge to this view be openly and willingly invited. It is a crucial issue of validity. Meta-narratives permeate our very being, and awareness of them should be included in the assumptions/assertions of validity in all forms of therapy, complementary, alternative and orthodox.

I suspect that one of the sources of conflict between C and A therapies on the one hand and orthodox bio-medical therapies on the other arises from a clash of meta-narratives which are deeply embedded in sets of cultural assumptions but which are not necessarily articulated. World views are not easy to articulate or even become aware of. During the seminar which I gave to the ACHRN in Manchester on 28 November 2003, I posed the question of whether 'patients' would need to 'buy into' the world view of the culture in which the therapies were spawned.

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

Putting this with utmost brevity and with validity issues brimming over: Do you assume that the therapy which you practice is somehow culture free ?

And I repeat the question which I consider to be crucial: If your therapy is the answer, what was the question ?

3 **Experiential validity based on responses of patients and anecdotal evidence.**

The researchers need to be self critical, sensitive, caring, systematic, and open to the multiple **subjective realities** that constitute any clinical situation. (Gillett 2004 p 735 my emphasis).

If it helps me I don't need science to show that it works. . . But what if the treatment in question was tested in a clinical trial and was shown to be completely ineffective ? In such cases, there can be a glaring gap between a patient's positive experience and the negative view of science, and in any discussion about complementary medicine it is essential to understand why this gap so often emerges. (Extended version of the quotation from Ernst Edzard 'The Guardian' 18 May 2004).

An acupuncture website contribution included these comments:

District Court for the Southern District of Texas, July 1980: The courts states that it is a fundamental human right to receive acupuncture treatment. 'Acupuncture has been practiced for 2,000 to 5,000 years. It is no more experimental as a mode of medical treatment than is the Chinese language as a mode of communication. What is experimental is not acupuncture, but Westerners' understanding of it and their ability to utilize it properly . . . when administered by a skilled practitioner for certain types of diseases and dysfunction , it is both a safe and effective form of medical treatment.

The experience that my illness has been cured or my condition improved is one thing and I would not wish to minimise the obvious significance of that. However, the answer to the question: 'What was the cause of the cure?' is still a relevant question which needs to be addressed by researchers and practioners. It is the important distinction between knowing *that* some thing has occurred and understanding *why* it has occurred.

Is my body the location of cosmic, metaphysical, spiritual forces which I need to get in touch with and recognise before I can sort out the causes of my illness and possible cures? Or is my body mine and mine alone, and are the causes and cures to do with the neuro-psycho-biochemistry of my body ? I may feel that I have been cured, but those two questions ought to be hovering around any successful therapist's mind – orthodox or not.

These issues are explored to some extent in the paradoxical conclusions of Jane Feinmann's report in 'The Independent' (10 November 2003) headed: '*Here comes the science bit. Scientific trials have repeatedly shown that homeopathy doesn't work. Yet patients swear it does*'. Her report quotes the outcome research (N = 5,729) conducted by Dr David Spence at the Bristol Homeopathic Hospital. This research suggests that about 70% of people benefit from good homeopathic treatment ie treatment provided by homeopaths who are also qualified doctors. In the same 'Independent' report Peter Fisher, research director at the Royal London Hospital and homeopath to the Queen, says that science will eventually explain how homeopathy works: '*I believe that science will show that there is an effect from the homeopathic remedy and that there is also an effect from the nutritional advice and reassurance provided by the homeopathic practitioner. There may also, however, be a synergy between the two, which creates an*

effect greater than the sum of the two different parts of the consultation. When that explanation is available, it will convince people that, while there is a place for placebo-controlled trials in homeopathy, it's not the whole story'.

I find it interesting that he 'believes' in homeopathy and assumes that in future science 'will show that there is an effect from the homeopathic remedy'. In the meantime, presumably, he practises on the basis of his beliefs. I conclude, among other things, that homeopathy is a Complementary therapy for two reasons: it is a form of medical treatment and I assume that attempts are made to progress understanding by empirical research.

The paradox is that whereas we may not know scientifically how something works, some people's experience is of the effectiveness of the treatment. I suppose that that is a paradox of much treatment which goes on even in the bio-medical model. A clear knowledge base is not always consonant with effectiveness nor is treatment which is in ignorance of causality necessarily ineffective. This could be construed as a charter for a thousand flowers to bloom – irrespective of regulation or rigour - which causes me concern even though there are reports from clients that the outcomes were beneficial.

But, for me, reported beneficial outcomes are a *necessary* but not *sufficient* justification for C and A therapies or for any other therapies for that matter. In addition to outcomes I think that there should be critically scrutinised understanding of cause and effect and the possible relation of these to the particular theory and its practice. I would want to say that merely to rely on reported outcomes as a source of validity raises some serious 'outcomes' kind of questions. For example: with what degree of confidence can the report of benefit be directly related to the treatment rather than to the numerous other events which were taking place in the patient's life? Over what timescale are outcomes assessed? It is well known that some non-beneficial outcomes result from medication which in the short term seems to have only beneficial outcomes. Another question: How is it determined that the outcomes are as reported by the patient? Are additional outcome measures developed which seek to supplement the outcomes reported by patients? There may be hidden outcomes which are even operating in the short term let alone the longer term and which may or may not be beneficial. In what ways are contrary outcomes assessed and taken into consideration? Are beneficial outcomes from one case, or a group of people, optimistically generalised to future patients? If so, why?

So, even though I take the point about an 'outcomes' model having some sort of validity, presumably the very notion of the validity of an outcomes model itself should be subjected to rigorous research and critical theoretical scrutiny over time. In other words: outcomes as reported by patients do not in themselves, provide valid justification for the therapy. Researched causes and epidemiological studies are necessary supplements to reported outcomes.

A current example of this is in relation to HRT. Only comprehensive on-going research as to all (or all assessable and observed) outcomes can result in deeper and more beneficial knowledge being constructed in relation to HRT. Herbal or vegetable extract

alternatives may have what appear to be short term benefit outcomes, but only long term and rigorous investigation can produce increasingly valid, in the sense of reliable, knowledge. Reports on HRT are constantly appearing the press as more research on outcomes is carried out. This 'ongoing research' issue should apply to any and all therapies. This constant research is needed because of the probabilistic, and uncertain, nature of knowledge.

A question which focuses on this issue: What kinds of epistemological and methodological issues and assumptions lie behind 'outcomes research' ?

Presumably, outcomes research makes the assumption that there are some cause and effect relationships between the therapy and the outcome. In other words, the extent of confidence about the validity of the therapy must, at some level, relate to cause and effect. This can only be explored by research – not the reiteration of traditional beliefs or reported expressions of individual benefit.

I assume that this assumption about cause and effect is not a singularly or exclusively Western scientific artefact but must be endemic in all cultures and all therapies. It seems to me to make no logical sense to make any other assumption. Why do something if it is not assumed that it will have a causal relationship to some effect ? Notions of 'validity' are not merely a western, Modernist preoccupation. I think that validity is a question of human agency in its most general sense. Namely: how does my behaviour affect the world and other people ? Conversely, how does the world and other people's behaviour affect me ? How can I draw valid inferences about relationships between action and outcome ?

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

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

Gillett (2004 p 732) observes:

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

‘careful observations over time’ are the basis of more rather than fewer inferences about validity.

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

All this relates to my concerns about validity. If the term ‘validity’ is unhelpful to some, although I am not entirely clear as to why the notion of validity is a problem *per se*, then I would ask: What kinds of evidence ‘justify’ your acceptance of the theory and practice of your therapy ? What ‘reasons’ do you adopt and propose for the practice of your therapy ? Is it ‘reasonable’ to ask you: why do you think that your therapy is only sometimes effective ? What ‘persuades’ you to practise your therapy and to advocate its benefits ? How do you present the foundation concepts of the therapy when you are putting on training sessions for intending therapists ? How do you deal with any of the trainees’ sceptical questions about the validity of the foundation concepts and assumptions of the therapy ? How seriously do you take issues ‘cause and effect’ in relation to your therapy ? What do you mean by ‘outcomes’ and over what time-span and in how comprehensive a way do you assess outcomes ?

Or to put all this with extreme simplicity: Why do you believe in your therapy ?

4 Legitimate sources of validity – e.g. statutory regulation.

Should alternative practitioners generally seek the legally enshrined professional regulatory frameworks possessed by orthodox health professionals ? (Saks 2003 p 155).

‘What then is the definition of . . . conventional medicine ? According to O’Connor . . . *this term refers to the officially sanctioned medical system of modern western societies which: enjoys the approval, co-operation, and protection of the country’s legal system and other supporting social institutions: government licensing and regulatory boards, third party payment systems, preferred access to federal and private research moneys, high prestige and social status and their concomitant benefits, including professional associations with substantial lobbying power and professional associations with influential reputations for authority.*’ . . . Nonconventional medicine can therefore be defined as referring to a heterogeneous set of therapeutical practices that are offered as ‘alternative’ to conventional medicine.’ (Jütte 2001 pp 14-15).

The public needs protection from untested alternative remedies and rogue practitioners of complementary medicine, but no one is providing it a House of Lords committee said. (Report by the Health Editor of 'The Independent' 29 November 2000).

Legislation and formally validated training and education are criteria used to establish and define professional groups who are thereby authorised to practise. Thus the state has a crucial role in both authorisation and validation. Licensing and regulation includes powers of limitation, subordination, inclusion, assimilation and, of course, exclusion. The power of certain groups to organise themselves and to gain state support is a key factor in determining whether a treatment is 'orthodox' or 'unorthodox'. These issues are not decided by epistemological accuracy but by social constructions. (See Jütte 2001, Saks 2003 for detailed discussion).

The seven questions posed by Saks (2003 pp 155-156) draw attention to issues relating to the greater or lesser extent of legitimacy of C and A therapies.

Saks' book explores historical and current aspects of these questions. They are general questions on relationships between Orthodox and C and A therapies. Complicated though they are, I suggest that they need to be addressed as they are integral to a wide range of issues which surround illness, distress, dis-ease and the various forms of therapy intended to be curative or palliative. The questions also imply issues relating to conceptual and pragmatic distinctions between 'orthodox', 'complementary' and 'alternative' and they provide opportunities for these issues to be addressed. Gillett's (2004) article addresses some facets of these questions as do the edited books by Jütte (2001) and Dinges (2002).

But first the probing questions posed by Saks.

- 1 Should specific alternative therapies be applied in mainstream health contexts, in completely separate settings, or as part of a new integrated service based on holistic health centres ?
- 2 Should physicians be the gatekeepers for the alternative therapies or should orthodox and alternative practitioners operate as co-equals, working alongside each other?
- 3 Should alternative practitioners generally seek the legally enshrined professional regulatory frameworks possessed by orthodox health professionals ?
- 4 Should all fields of unorthodox practice be at least minimally based on the establishment of codes of ethics and lengthy education programmes , even if they do not gain formal exclusionary closure ?
- 5 Should shared learning with conventional practitioners be encouraged, in order to enhance future collaboration, and if so at what level ?

- 6 How, moreover, should the development of an evidence base be supported for alternative therapies – by the private sector, the state, or both, as is the case with orthodox medicine ?
- 7 And who should pay for the therapies concerned – the consumer at the point of access, the insurance plans, or the state ? (Saks 2003 pp 155-156).

I add a question of my own:

- 8 Should the mere fact that it is, by default, permissible to practise any form of unregulated therapy on the public be deemed to make such practice of any form of therapy acceptable ?

I simply suggest that all these questions should be creating the agenda at various levels: within a specific therapy practitioner groups, between such groups, between C and A therapists and orthodox practitioners.

Validity by formal legitimation and regulation is an issue which neither will go away - nor should it go away. We are firmly back with issues of ‘duty of care’ and the best interests of patients.

Just to be clear: I am not assuming that the mere fact of legal status of a therapy necessarily implies that the therapy is essentially valid. What I am assuming and hoping is that the rigorous and public process of testing the validity of a therapy, which includes processes which are accountable and transparent, are necessary ingredients in attempting to protect the public and to increase the public’s more rather than less justifiable confidence in a particular therapy or group of therapies.

5 Validation by fiat and by grandiose claims. Validation by declaration.

The chasm between knowing and believing cannot be bridged by thought.
(Habermas 2003 p 10).

Use this information at your own risk. No guarantee is made towards validity. Chakra therapy website.

You are likely to sense my western bias coming out in this section – if you have not noticed it before !

Just as in religious faith systems and indeed any other form of a mere declaration of truthfulness and validity my normal level of scepticism becomes somewhat extreme. So I pose what for me are crucial questions which, I contend, ought to be unavoidable questions. What are the criteria for C and A therapies being acceptable for practice on the public ? Have these ever been published ? Are these criteria based on reasoned

argument, experimental evidence or mere assertion of validity by the practitioners ? I am very sceptical of the confident assertions which I have read on various dedicated websites.

When I entered 'Chakra therapy' in the search engine I was confronted with 'Healing properties of Gemstones applied to Chakras'. In the Disclaimer it stated:

Use this information at your own risk. No guarantee is made towards validity.

The Qigong website opens by declaring: *This ancient Chinese 'practice' can take away stress, pain and sickness from your body at speeds that will amaze anyone – leaving you with more energy.*

The Qigong website declares that the therapy is relevant for:

General pain, migraine, sinus, allergies, spinal problems, weight control, hearing or sight problems, female or male organ problems, kidney and liver dysfunction, strokes, glandular dysfunction, anxiety, diabetes problems, gall or kidney stones, heart disease, heart attacks, circulation problems, depression, cancers, lung problems, digestion problems, autoimmune system problems, bone marrow problems, mental disorders, comas, stress.

There is a belief in the seven chakras which the website states as being 'fields of light connecting mind, body and soul. Our life force energy comes from God flowing in us in clockwise fashion'. One website contributor discusses the evolution of ages of the chakra corresponding to the stages of development of human civilization. I gather that Chakra therapy is mainly concerned with bodily, psychological, relational and spiritual well-being.

The journal 'Alternative Therapies in Health and Medicine' (May/June 2004 p 34) states the following on 'Healing Touch' in an article by Cook, Guerrerio and Slater:

The North American Nursing Diagnosis Association (NANDA) identifies Energy Field Disturbance as ' a disruption in the flow of energy surrounding a person's being that results in a disharmony of the body, mind, and/or spirit'. One approach to treating energy imbalances is Healing Touch (HT) which consists of non-invasive techniques using the hands to clear, energize, and balance human energy fields. These energy fields are complex overlapping energy patterns that penetrate and surround the human body. Although research has not documented the actual mechanisms through which HT exerts its effects, HT is grounded on the principle that all healing primarily involves the individual's own ability to heal. Because HT facilitates self-healing it supports allopathic approaches to health care.

It seems clear to me that these therapies proclaim their validity on their own say so, by declaration – by fiat. I have a sense, which may be quite incorrect, that some therapies are not subjected to rigorous research methodologies in order to explore the causes of alleged effects, but the therapies are believed in with intensity and thereby escape research into

the underlying possible causes for their alleged effectiveness. Strong belief transmutes into confident knowledge.

Putting this in the form of questions: Is more research necessary in order to test the validity of the therapy which you practise ? Or is what you believe about your therapy incapable of being researched because the causes are spiritual, metaphysical, theological? Do you practise your therapy because you merely believe in it?

In this context of validity, I was interested that in response to the following question which I posed to a group of C and A practitioners at a seminar I was leading:

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

One group member said: 'I don't know'. Another said: 'Yes'. I didn't hear anyone say: 'No'. The two responses suggest, perhaps, that issues of validity do not figure as significant in the minds of the two respondents. The 'Yes' response seems to indicate that a thousand – and more – flowers can bloom and any can be deemed to be therapeutic by mere validatory fiat. This causes me some concerns. We did not have time to explore these responses in any further detail due to lack of time.

If it helps me I don't need science to show that it works. . . Like Ernst, I am not persuaded.

Neither am I persuaded by therapy whose therapy seems to rely totally on the placebo effect and which lacks any additional evidence of reasons for effectiveness.

I would want to challenge the basis of the validity by declaration of a therapy on the grounds that mere belief is not a sufficient condition for practising a therapy on other people. Belief may be necessary in the process of healing, but it is not sufficient.

How does one begin to test the comparative validity of competing therapies which are based solely on their self-declaration of validity ?

Putting this in familiar terms: Holistic approaches – as frequently used – seem to want to distance themselves from the reductionism of biomedical approaches. Holism, at least in rhetoric, seems to presume to deal with the 'whole' person. However, some holistic concepts of wholeness frequently seem to involve religious and spiritual notions which are believed to be at work in the functioning of the human body and human experience. Testing the validity of such spiritual and religious notions is a problem which is insoluble, and therefore untestable. So we are left with the assertion of validity based on the strength of beliefs and convictions. I am opposed to the practice of therapies offered to the public which are validated by fiat – by the mere declaration of their validity.

From my point of view the least valid form of credibility is that in which the practitioners assert the validity of their therapy and defensively resist rigorous external and

academic/research and regulatory scrutiny. This form of asserted validity feels to me like the propagation of a belief system in which mystery is deemed to be credible, but only to the coterie of convinced believers. Some forms of psychotherapy and counselling training which I have been involved with exemplify this form of mystery in the guise of validity. Recall that Karasu discovered 480 forms of ‘valid’ counselling and psychotherapy theories being practised on the public in his research in 1983. Such riches seem to me to betoken confusion pretending to be valid.

And finally . . .

I shall end by recalling and juxtaposing ideas from the three opening quotations and one other which I included:

There are insights here (post-modern commentators) which do not fit a traditional positivist model but which are essential to the understanding of suffering and the significance of the interventions by which we try to modify it. (Gillett 2004 p 737)

In a recent paper Harry Frankfurt describes human beings as ‘generally hard to pin down, difficult to sort out, and just about impossible to sum up’. (Buss and Overton 2002 p xi).

In determining whether a given approach to knowledge can arrive at ‘respectability’, the following criteria seem relevant, if not exhaustive: it must be precise in its approach, rigorous in its procedure and honest in its reporting; as a discipline it must proceed with integrity. (Petranker, 2003 p 12).

In the case of human beings in particular (the yin and yang) of existence must be cultivated in order to enhance and realize human potentiality. (Chung-Ying Cheng in Deutsch and Bontekoe, 1999 p 187).

I think that those four quotations just about sum up the differences between those who think that there are no final answers, those who think that any temporary answers should be the result of careful and rigorous research processes and those who think that they have basically got it all sorted and know how to realize human potential.

And given the etymology of ‘valid’ which I stated at the beginning, I pose a final question:

How healthy is your therapy ?

© Geoff Heath
28 June 2004.

For further seminar papers on issues related to C and A therapies and epistemology as well as an attempt to distinguish between ‘complementary’ and ‘alternative’ see:

www.bowlandpress.com

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