Complementary and Alternative Medicine (CAM) as a Toolkit for Secular Health-Care

The De-differentiation of Religion and Medicine

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ABSTRACT

Complementary and Alternative Medicine (CAM) plays a crucial role in many contemporary societies. While biomedicine observes the social differentiation between medicine and religion, holistic healing systems integrate the two. After clarifying important terms, this article begins with a brief sketch of research on these topics. Referring to Ann Swidler's concept of the "tool kit," it suggests an explanation for the attractiveness of CAM to both patients and practitioners. Drawing on relevant studies and data from the author's qualitative study of palliative care, it argues that the attraction of CAM lies in its function as a tool kit that is not differentiated into medicine and religion but is characterized internally by being a loosely coupled field that offers a resource for self-empowerment.

1 INTRODUCTION

The use of complementary and alternative medicine (CAM) by the general population in many countries, such as the United States, the United Kingdom, Japan, and Switzerland, is substantial.[1] Indeed, CAM therapies are

1 Surveys suggest that the use of CAM increased in the United States (Eisenberg et al. 1998) until around 2000 and that it has been more or less steady in several

practiced within the conventional health-care systems of modern western countries, as well as outside them. Referring to the United States, Kaptchuk and Eisenberg state that

> "[...] substantial portions of the medical system have begun to seek reconciliation with alternative medicine. Managed care, insurance carriers, hospital providers, major academic medical centers, and individual MDs are increasingly receptive to developing new 'integrative' models of health care [...]" (2001: 193).

Similarly, Frisk (2013: 388) notes the "increasingly blurred borders between the medical mainstream and complementary and alternative therapies" in Sweden, while Wahlberg points out how "various CAM therapies come to be mainstreamed into national health delivery..." (2007: 2310) in the UK. The situation is similar in Switzerland, where a growing incorporation of CAM into both the academic educational system and public health care can be seen.[2] This "reconciliation" seems astonishing, given the in many respects successful struggle of biomedicine against what it sees as "heterodox" healing systems and actors. The evolution of modern biomedicine or so-called

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countries since then (Hunt et al. 2010: 1501). For further information, cp. Harris and Rees 2000, Yamashita et al. 2002, Wolf et al. 2006, Harris et al. 2012, Becker et al. 2010. One has to bear in mind that there is no uniform way to define CAM and operationalize its use. While some studies include, for example, prayer or dietary supplements, others do not (Hunt et al. 2010: 1501). Therefore, it is difficult to give accurate quantitative data about the popularity of CAM.

2 In 2009, 67 percent of Swiss voters supported a constitutional article on CAM (Federal constitution Art. 118a BV (new): "The Federal government and cantons shall ensure that, within the scope of their jurisdiction, complementary medicine is taken into consideration." Since at least 2012 CAM has slowly been integrated into the Swiss public health sector (https://www.bag.admin.ch/bag/de/home/themen/strategien-politik/nationale-gesundheitspolitik/stand-umsetzung-des-neuen-verfassungsartikels-zur-komplementaermedizin.html?_organization=317, 13 June 2017). Cp. also Martin and Debons 2015. On CAM's institutional integration into the Swiss academic educational system, cp., for instance, www.ikom.unibe.ch, May 18, 2017; www.iki.usz.ch, May 18, 2017; https://www.hes-so.ch/de/bachelor-osteopathie-3381.html, May 18, 2018; for Germany, cp., for example, Spielberg 2007.

conventional medicine during the nineteenth century, which was closely entangled with the development of public health-care systems, is linked not only to the struggle of "orthodoxy" against "heterodoxy,"[3] but also to the social process described as "differentiation" (cp. Luhmann 1984, 1995; Parsons 2001), including that between medicine as physical healing and religion as focusing on the metaphysical and transcendent aspects. As many healing practices and concepts belonging to CAM include such aspects, it is astonishing to see CAM becoming more and more established in institutionalized secular medical contexts. As I will argue below, I interpret this development as an indication of de-differentiation.

My aim in this article is to suggest an explanation for why, among other possible reasons, CAM is attractive in certain medical contexts by looking at the situation in Switzerland. In asking this question, I use Ann Swidler's concept of the "tool kit" (1986), outlining three specific traits that are consistent with many CAM therapies.[4] Before doing so, I will clarify the relevant terms and give a very brief introduction to the historical background of modern medicine and the process of social differentiation in Europe.

The theses presented in this article are backed up by empirical data derived from a Swiss research project on "Alternative Religion at the End of Life," as well as by related studies by other authors. We conducted this project with Rafael Walthert, Mirjam Mezger[5] and Barbara Zeugin in six health-care institutions in the German-speaking part of Switzerland from 2013 to 2016.[6] We carried out qualitative research in different kinds of hospital, a hospice and a nursing home for the elderly. Two of these institutions had a specific ideological background based in anthroposophy, but the others had none apart from the fact that they practiced biomedicine. In all six case studies, we carried out participant observation and conducted guided interviews with nurses (28), doctors (11), therapists (17), chaplains (11), and in most

3 Cp., for example, Wahlberg 2007.

4 As this suggestion stems from a social-scientific position and reflects the non-normative perspective of the Study of Religion, the potential medical effects of CAM will not be discussed in this article.

5 Cp. Mezger 2018.

6 This project was conducted with the financial support of the Swiss National Foundation. Further information on this project and further results can be found at http://p3.snf.ch/project-139280.

cases with the patients (18) and other staff and volunteers as well. We analyzed the data based on the analytical background of grounded theory. The coding procedure was supported by Atlas ti.

2 A MINEFIELD OF TERMS

Kaptchuk and Eisenberg (2001: 189) called the taxonomy of contemporary unconventional healing practices a "linguistic minefield". Further minefields are the taxonomies of "conventional healing practices," "religion," and "spirituality." The use of these taxonomies is influenced by power struggles over legitimation and is profoundly linked to value judgements.

According to Ernst, the umbrella term "complementary and alternative medicine" (CAM) "refers to a diverse array of treatment modalities and diagnostic techniques that are not presently considered part of conventional/mainstream medicine and emphasize a holistic approach towards health care" (2008: 2). Kelner and Wellman[7] explain that the "concept of CAM" covers

> "[…] a diverse set of healing practices, which do not normally fit under the scientific medical umbrella. Instead, these practices emphasize the uniqueness of each individual, integration of body, mind and spirit, the flow of energy as a source of healing, and disease as having dimensions beyond the purely biological. The life force is very commonly seen as a crucial element of the healing process and strong emphasis is placed on the environment, the subjective experience of patients, the healing power of nature, and health as a positive state of being." (2000: 5)

CAM therefore unites very different healing practices and hence inevitably leads to unjustifiable generalizations.[8] However, in this context, the term

7 Kelner and Wellman are referring here to the perspectives of Howard S. Berliner and J. Warren Salmon, as well as Michael Goldstein.

8 On the terminology here, cp. Koch 2015; Ernst 2008:2–3. Similarly used terms are "heterodox medicine" and "holistic medicine."

"biomedicine" refers to the more or less consistent medical system that is restricted to the principles and academic knowledge of the natural sciences.[9]

I use the term "religion" as an etic term, including concepts and practices that practitioners may not refer to as "religion" but as "spirituality." This usage is similar to that of Wouter J. Hanegraaff (2000), who also uses religion as an umbrella term, but differentiates between "a religion" (institutionalized) and "a spirituality" (individual), both of them being "religion". Adapting Geertz, Hanegraaff defines "religion" as

> "[…] any symbolic system which influences human action by providing possibilities for ritually maintaining contact between the everyday world and a more general meta-empirical framework of meaning" (2000: 295).

This perspective is compatible with Luhmann's notion of religion, who states that "communication is always […] religious when it observes immanence from the point of view of transcendence […]" (2002: 77).[10] In this sense, semantics can be called "religious" if something that is perceived as "immanent" is framed by something that is perceived as "transcendent" (Luhmann 1989: 313–316).

For various reasons I do not follow the emic distinction between "religion" and "spirituality," which is often used in a highly normative way: religion is seen as something institutionalized, which may be superficial, dogmatic, exclusive, and intolerant, or even dangerous and aggressive, while spirituality is seen as experience-based, private, "universal," and "wholesome".[11] These normative associations are often the reason why the respective terms are used or rejected by particular agents.[12] I wish to avoid the normativity of these distinctions by using "religion" as an umbrella term. This

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9 Other authors prefer terms such as "conventional," "allopathic," "orthodox," "Western," or "modern" medicine in this context.

10 English translation in Laermans/Verschraegen 2001: 15.

11 Cp. Sinclair et al. 2006: 475.

12 The right of religious freedom makes the label "religion" attractive to specific actors, while the aim of becoming integrated into secular systems, as for instance into secular schools or secular hospitals, can cause its rejection and replacement with the label "spirituality."

also allows me to take the continuity between phenomena labeled "religious" or "spiritual" into account.

Assuming a modern, Western, and Christian environment, in this paper, "alternative religion" is understood as a relative concept referring to a pool of practices and concepts that are not commonly seen as forming part of the traditional canon of Christianity in its institutionalized forms. Although they may even be more popular than traditional practices and concepts,[13] in the West they are seen as "alternative". This pool has no strict boundaries, and the respective practices and concepts—such as, for example, belief in reincarnation or meditation practices—can also be found in conventional religious communities, for instance in churches. There is a huge overlap with tendencies often called "Esotericism" (Frisk 2013: 373) or "New Age," which may themselves be influential. Referring to Hanegraaff, Steven J. Sutcliffe (2014) has referred to this field of religion as "New Age sensu lato", that is, as a field that "remain[s] analytically elusive despite [its] increased visibility in many societies" and that tends to "blur the boundaries between expressions of 'religion' and 'culture"' (2014: 42).

In the case of health care, this blurring refers to the boundaries between expressions of religion, medicine, and therapy. Since the first publication of *New Age Religion and Western Culture*, this "wider New Age movement" has diffused into the wider cultural and social environment of modern "secular" societies and therefore yielded a "fluid New Age".[14]

It is important to realize that there is no unified "movement" or entity that contains unifying concepts. Nevertheless, what could be called a "fluid New Age" and be seen as part of this "alternative religion" may be delineated by the field's emphasis on emotions and subjective experiences, combined with an "individualistic orientation and a weak tendency to organization and holistic function" (Knoblauch 2008: 142).[15] Typical markers of "alternative religion" are the self-identity of being an alternative to something else (Sutcliffe 2004: 467, 479), hence the conceptualization of the self as being different from the kind of religion that is seen as traditional and conservative. This is frequently combined with a sense of belonging to the future, with a

13 Cp. Partridge 2005.

14 Cp. Lüddeckens/Walthert 2010: 9–17.

15 Even if there is organization in this field, the self-perception is often in non-conformity therewith.

sense of having outgrown the old "narrow-minded" religions and of belonging to some kind of growing movement that is different from the predominant materialism. The narrative of the autonomy of the individual is crucial. The individual him- or herself is the guiding principle for the acceptance of authority and for decisions about orthodoxy and orthopraxy. One's own authentic experiences are the normative reference,[16] and communicating choices as individual ones is important. Paul Heelas (2002: 362) in particular called attention to the focus on life in the sense of one's own "true inner life". Quite often it is the life and the focus on the body of the individual in the here and now and the aim of the progress of the individual—her or his transformation into a higher spiritual and mental level (Frisk 2013: 373)—that counts more than the prospect of an afterlife. As we shall see later, these aspects of alternative religion play a crucial role in the context of CAM.

3 THE EVOLUTION OF MODERN ACADEMIC MEDICINE AND SOCIAL DIFFERENTIATION

Three linked developments are important to consider with regard to the evolution of biomedicine as a differentiated social subsystem in the Global North.[17] These developments were responsible for the medical and social success of biomedicine while at the same time giving rise to ongoing criticism.

First, the "clinical gaze" (Foucault 1973), decisive for the evolution of biomedicine, went along with a social differentiation between physician and patient. Within the modern institution of the hospital, patients were no longer

16 Heelas and Woodhead choose to use the term "spirituality" and describe the same phenomenon by calling it a "subjective turn" (2005: 2–5). The emphasis on the individual is in accordance with Callum Brown's observation (2006) of the narrative of individual self-fulfillment and personal freedom that has arisen since the 1960s.

17 The developments described in what follows reflect the medical history of European and subsequently North American societies. However, similar (at least to a certain extent) developments in the direction of the establishment of biomedicine took place in other parts of the world, as exemplified in this volume by case studies in Tanzania (W. Bruchhausen), India (N. Rageth), and Japan (M. Schrimpf).

in a feudal patron-client relationship but had become "objects" for the physician to work on. Moreover, the "transition from Bedside Medicine through Hospital Medicine to Laboratory Medicine was accompanied by a shift in cosmological form away from a person orientated towards an object orientated cosmology" (Jewson 1976: 225).[18] Medicine was no longer "person-oriented," with the physician perceiving the patient as a "holistic" person, but disease-oriented: patients were seen as separate from their social positions, relationships, and social traits, and were only viewed from the aspect of a disease (cp. Vogd 2007; Schoene 1980).

"The modification in professional self-understanding from a healer whose duty is to preserve the patient as a creature of God in a more or less artistic way to a scientist whose duty is to understand illness in a rational way, also changed the attitude towards patients which, in the age of science, seems almost indifferent, at least from today's standpoint." (Atzeni/von Groddeck 2015: 31)

(Bio)medicine became confined to the empirical level, often being perceived as fragmentary and mechanistic. Patients became bodies, and bodies were seen as matter. Atzeni and von Groddeck (2015: 30) analyzed doctors' autobiographies and summarized them with reference to the generation "who started their careers around the middle of the nineteenth century," as well as emphasizing the "scientific aspect of medicine" in their professional self-understanding:

> "Doctors save bodies, not souls. This self-understanding is connected with the belief that the human body is the sum of a person (biological reductionism). Through methodical examination, which Foucault describes as the 'medical gaze' on the body (Foucault, [1976] 1994), the doctor deduces symptoms, illnesses, and causes by applying scientific methods." (Atzeni/von Groddeck 2015: 30)

Hence, patients might experience themselves as being reduced to a diagnosis—a person as a patient seems to be nothing more than his or her illness.[19]

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18 On the development from patient-centered to physician-centered medicine, cp. Lachmund/Stollberg 1995.

19 "From the late 1960s onwards, the image of the heroic, paternalistic doctor disintegrates" (Atzeni/von Groddeck 2015: 33). Concepts and norms of the

Secondly, as the developing biomedicine based itself on scientific methods, it distanced itself from religion and even excluded it. A corresponding development can be observed in modern academic psychology, where "transcendence was structurally excluded and the physical determinism of the 1880s was adopted as an academic theory" (Koch 2015: 436).

The approach to the body as matter and thus the exclusion of any metaphysical, non-empirical aspects led to knowledge that claimed to be scientific because it was based on and restricted to the body as an empirical entity.[20]

Medicalization[21] linked to rationalization (cp. Turner 2008; Ballard/Elston 2005) is compatible with secularization (cp. Bull 1990), of which it forms a part: for example, many "conditions have become transformed from sin to crime to sickness" (Conrad 1992: 213). Deviant social behavior, such as homosexual practices or epileptic seizures, and bodily dysfunctions like infertility, formerly understood in a religious framework, became medicalized and were redefined as medical:

> "Disapproved behavior is more and more coming to be given the meaning of illness requiring treatment rather than of crime requiring punishment, victimization requiring compensation, or sin requiring patience and grace." (Freidson 1988: 248)

"autonomous patient" and the "informed patient" became relevant and led to a change in the general attitude towards patients.

20 It was common in the struggle for medical legitimization to declare one's own kind of medicine to be "scientific" instead of "religious". Therefore, one argument put forward by a medical editor in 1876, an advocate for medicine relying on clinical empiricism as opposed to medicine relying on laboratory experimentation, was, for example: "The practitioner, at the bedside of his patient does not care to indulge in medical metaphysics. [...] In his attempts to solve mysteries, known only to the Infinite, the modern speculator makes bold assertions, not guaranteed by a single fact, and with an audacity unparalleled, will no doubt shortly give the medicinal effects of religion on the human soul, describing the essence of the vital spark, its chemical constituents, and a number of newly discovered elements contained therein." (cited in Cunningham/Williams 2002: 132).

21 Medicalization is a "sociological concept, that essentially refers to the process by which social life comes to be seen through a medical framework" (Howarth 2007: 119).

Thirdly, the evolution of "medicine" as a distinct social and academic system was accompanied by increasingly successful attempts at the subordination and exclusion of practitioners who did not belong to the same academic system and did not share the same "scientific" rationale.[22] While there has always been medical pluralism in the form of different kinds of healers, during the nineteenth century many new healing systems emerged, leading even more strongly to the formation of an "orthodox professional identity" and a "rigid ideology of orthodoxy" (Warner 1998: 5), as well as vice versa (Starr 1982: 95).[23] This antagonism divided biomedicine from medical concepts and treatments that did not restrict themselves to the academic knowledge of the natural sciences and did not necessarily exclude religion. With the "profession of medicine" (Freidson 1988), the profession of medical doctors defined by a certain academic education, and the evolution of specialized professional institutions, (bio)medicine became an "official social order" (Freidson 1988: 303). According to Freidson, "[...] it cannot fail that their [practicing professions'] conceptions will be different from that of the man on the street […]" (1988: 303). This alienation of professional conceptions from the conceptions of patients is strongly interrelated with the "clinical gaze" described above.

The result of these three linked developments was the differentiation between medicine as biomedicine, inseparably linked to the natural sciences[24] and focused on immanent physical illness, on the one hand, and religion,

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22 However, this was not a straightforward development without any setbacks. In the pre-war period in the USA, for example, "the power and prestige of the regular profession were declining" (Warner 1998: 6). Nevertheless, in this period many boundary structures evolved: the American Medical Association (AMA, founded 1847), for example, had as one of its goals to "draw the line of demarcation between those who are of the profession and those who are not" (cited in Warner 1998: 9).

23 The opposition was to medically exclusive "systems" that were "rationalist" instead of "empiricist" in orientation, as especially homeopathy was said to be (Warner 2003: 347).

24 This link does not hint at the de-differentiation between medicine and science, but, in the language of systems theory, to its "subsidiarity" (Schützeichel 2011: 86). Medical praxis, the practice of dealing with patients, should first of all be aimed at their health, not at the acquisition of new scientific knowledge.

concerned with transcendent matters, on the other.[25] Sociological differentiation theory (cp. Parsons 2001; Luhmann 1984, 1995) assumes that there are functionally differentiated systems in modern societies. These systems have different functions for society and operate with different codes. As Schützeichel (2011) observes, in modernity we move within the framework of different *Sinnwelten*, such as art, science, religion, or medicine. According to Schützeichel, we usually know in what kind of framework or Sinnwelt we are and "which rules apply, where the boundaries of these rules are, and therefore where the boundaries of these areas are" (2011: 73, my translation). Medicine in the shape of biomedicine is just one such "area" in the sense of a functionally differentiated subsystem of society (Luhmann 1983, 1990: 183–187; Pelikan 2007, 2009: 42–43), and religion is another (cp. Luhmann 2002).[26]

While "(bio)medicine" operates with the code "sane/insane", "religion" operates with the code "transcendent/immanent," its function being to reduce contingency or eliminate it, at least temporarily. Luhmann assumed that religion will not be part of other functionally differentiated systems in modern societies. Correspondingly, we observe the "separating out of welfare [including medical care] as a distinct area of activity […] central to the process of secularization in European societies […]" (Davie 2013: 225). This separation went along with professionalized agents and the creation of an autonomous sphere with institutions organized by scientific instead of religious logics, norms, and structures. According to Casanova, "differentiation and emancipation of the secular spheres from religious institutions and norms

25 Starr mentions the different moral and religious as well as naturalistic American responses to the cholera epidemics of the nineteenth century: "During a second epidemic in 1849, clerical attacks on science were common, but religious authority no longer figured prominently in response to a third cholera epidemic in 1866. By then, public health methods and organizations were assuming more effective authority." (1982: 36)

26 As Peter Beyer pointed out, under modern circumstances religion, as a functionally systemic form, acquired "essential symptoms of such systematization": "convergent centres of religious authority, expressly religious organizations (many with global extent or at least more than local range), articulated religious programmes elaborating clear religious binary codes, and the effective (self-)observation of these institutions explicitly as religion" (1997: 222).

remains a modern structural trend" (1994: 212). Religion is still present in medical institutions, especially in the field of dying and death, but medical and religious care have been separated: medical staff are responsible for the body, while chaplains are responsible for the soul. According to the World Health Organization, "spirituality" (not "religion"!)[27] should be an integral part of palliative care, and many manuals of various palliative care units demand that medical staff provide spiritual as well as medical support. But these agents are not expected to do both at the same time within the same interaction. All this fits into the framework of social "differentiation," where different social subsystems are responsible for physical health on the one hand and religious well-being on the other. The process of medicalization and the exclusive focus on physical health in biomedical contexts are more sophisticated with regard to psychiatry and psychosomatic medicine. Psychiatrists might feel responsible for the religious well-being of their patients in so far as they may discuss feelings of religious guilt or the fear of hell, but conventional psychiatrists will discuss these matters within a psychiatric framework: their focus is on the health status of their patients, not their transcendent salvation.

27 "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." (http://www.who.int/cancer/palliative-/definition/en/, June 14, 2018).

4 THE CAM TOOL KIT

In the following, I will suggest explanations for why, in a modern differentiated society, processes take place that may be understood as part of a de-differentiation of medicine and religion. In particular, I will focus on the question of why CAM is attractive in certain medical contexts. This question was inspired by the observation in our case studies that many nurses, therapists, and patients in biomedical institutions used practices that belong to the field of CAM, such as aromatherapy, aura-healing, polarity, breath therapy etc.

I will argue that CAM is attractive because it does not differentiate between medicine and religion, because internally it is a "loosely coupled field" in the sense of Weick (1976), and because it offers a resource for self-empowerment. The first trait, I argue further, is especially important and relevant for the other traits. Therefore, I will concentrate on it more broadly. These arguments have been developed on the basis of various case studies of alternative medicine in Europe and the US, in combination with theoretical reflections on contemporary religiosity and religion. They are substantiated by observations and interview data from our own research project.

4.1 CAM as an Undifferentiated Tool Kit

Grace Davie and Terhi Utriainen have already used the term "de-differentiation" with regard to processes in the field of health care in Britain and Finland respectively. Davie (2013: 233) called European developments, especially in Britain, "de-differentiation," where religious agents—the churches among others—are meant to provide a system of welfare, while the state retreats at least partly. Utriainen observed "de-differentiation" with regard to "spiritual care," which she distinguished from Christian pastoral care. She refers to the entering of "spiritual care" in secular institutions and the language of care "becoming increasingly indeterminate and boundless" (Utriainen 2010: 446). She further suggests that "spiritual care is becoming part of the language and, perhaps increasingly, part of the practice of care, [which] will be understandable when it is seen in its historical context and conceptualized as de-differentation" (Utriainen 2010: 447). While Davie and Utriainen discussed the de-differentiation of medicine and religion without referring to CAM, Buss and Schöps see the recognition of naturopathy as an

example of de-differentiation phenomena. However, they do not explicitly discuss this topic with regard to religion (Buss and Schöps 1979: 327). Schlieter suggests to see Kabat-Zinn's MBSR in clinical settings as an example of "dedifferentiation in biomedicine" and argues that "we may describe 'dedifferentiation' more precisely as a process in which two independent systems interact in a shared interface [...]" (2017: 457). It is one argument of this article that the CAM tool kit is used because it is undifferentiated with regard to medicine and religion.

I suggest using the concept of de-differentiation not only where we find the same actors practicing medicine and religion, but also where practices are intended to have religious as well as medical effects and aims at the same time. In other words, I suggest using the concept of de-differentiation where communication deals simultaneously with the differentiation between sane/insane and transcendent/immanent (Luhmann 1989: 313–316). In the cases described in this paper, therefore, (immanent) medical situations and practices are observed under the perspective of transcendence.

Thus, the CAM tool kit does not reproduce the social differentiation between medicine and religion that took place with regard to biomedicine. As I will show below, its strength lies in opposing the developments sketched out above.

The advocates of the unorthodox healing systems of the nineteenth century distanced themselves from what they called "allopathy" or later "Schulmedizin" (Jütte 1996: 23–35). While the German pathologist Rudolph Virchow, for example, used the label "medical science" for the kind of medicine that was mainly taught in the universities and stressed the orientation toward the natural sciences, opponents put "nature" in opposition to the "natural sciences." Accordingly, they blamed allopathy for not being oriented towards nature and even for working against nature and against patients' bodies by means of its barbaric practices. To contrast the measures associated with "heroic medicine," they claimed that their own therapies and remedies were smooth, "natural," and in harmony with nature. Catherine Albanese quotes part of the motto of two Thomsonian editors:

> "No poisoning, bleeding, blistering, or physicing—no secret nostrums—the unity of disease, it being an obstruction to the free operation of the laws of vitality—the use of those remedies only, that act in harmony with nature's laws." (1986: 492–493)

These healing systems, later summarized under the term "CAM," did not accept the "clinical gaze" and did not want to reduce the patient as a person to an object with a very specific illness related to specific aspects of her or his body.[28] Many CAM practices and concepts claim to be "holistic" and to deal with the person as a unity of "body, mind and soul/spirit".

While biomedicine differentiated itself from religion, CAM, at least in its holistic branches, integrated medicine with religion simultaneously.

4.1.1 CAM and Alternative Religion

The integration of religion took place through the reception of alternative religion that did not follow the process of becoming a functionally differentiated subsystem of society.[29] In modern societies we witness religion expressing itself not only in a functional system and in social movements, as Beyer outlines, but in "non-systemic forms" as well (Beyer 1997: 223). These "non-systemic forms" are an "alternative for religion and its carriers […] to avoid functionally specific systemization, to avoid extensive organization, orthodoxifications, and self-presentation as religion" (Beyer 1997: 223).

New healing systems of the nineteenth century, such as homeopathy, Thomsonianism, osteopathy, and hydropathy, were influenced by the

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28 Sered and Agigian call this a "holistic illness narrative" and explain that, while the "discursive expansion of illness intrinsic to the *holism* of holistic healing may be no less valid than conventional understandings of breast cancer," there are "hidden costs to the holistic illness narrative, just as there are hidden costs to the conventional medical narrative" (2008: 617).

29 Apparently, there is a striking parallel and link between "alternative/unorthodox" and "conventional/orthodox" systems in the medical and religious fields. For example, William H. Holcombe (1804–1870), a North American adherent of Swedenborgianism and a prominent homoeopathic physician, saw a strong coherence between his religious and medical convictions and his opposition to "allopathy" and orthodox theology: "Today when speaking rather bitterly of Roman Catholic mummeries, my mind following a familiar undercurrent of thought, I misnamed it Allopathic mummeries. The Old and New Medicine. Indeed, I am a Homeopath simply in primary view because I was previously a new Churchman" (Holcombe as cited in Warner 1998: 8).

alternative religions of their time: Swedenborgianism, mesmerism, spiritism, transcendentalism, and magnetism. Accordingly, mind and body, material matter and spirit, nature and divine energy, were seen as intermingled and in correspondence with each other (Albanese 1986). Albanese described these conceptions, which "deified nature and made it into religion" and where "nature became a symbolic and salvific center, encircled by a cluster of related therapeutic beliefs, behaviors, and values," by using the term "nature religion" and linking it to the experiences of industrialization and urbanization (1986: 489).

Beyer mentions as examples of contemporary "non-systemic forms" New Age movements, Western neo-paganism and Pentecostalism. All three of them are examples of religious expressions that show medical and therapeutic aspects as well. Alternative religion, with its "holistic" self-understanding, is deliberately capable of combining religious and medical practices and "avails itself of a range of bodily techniques, particularly healing techniques, meditation, yoga, Ayurveda [...]" (Knoblauch 2008: 144). Beyer explains that in the case of New Age, its eschewing "convergent systematization" means risking "the 'invisibility' of religion" (Beyer 1997: 223).[30] Correspondingly, writing of the 1970s, John Gordon Melton observed that "the New Age Movement and the holistic health movement merged to the extent that it is difficult, if not impossible, for an observer to draw the line between them" (1990: xix–xx).

The common semantics and conceptions of CAM and alternative religion still involve, for example, "energy," "the 'correspondence' of the physical realm with higher metaphysical realms, enabling lawful patterns of interaction among them" (Fuller 1989: 8), an "inner transcendent self" or subtle bodies (cp. Johnston 2010).[31] Some authors therefore see CAM as a gateway to alternative religion (e.g. Knoblauch 2008: 144; Andritzky 1997). According to Koch, "[...] 'spiritualization' in the sense of the adoption in society of elements linked to religion can […] be observed in the sector of alternative medicine" (2015: 437). She observes further that, for example, "[...] an

30 "All three of these [various religious manifestations like Western neo-paganism, New Age movements, and ironically enough, Pentecostalism] eschew convergent systematization in principle, if not actually in practice. This direction, however, risks precisely the 'invisibility' of religion [...]" (Beyer 1997: 223).

31 For a primary source, cp. Dale 2014.

increasing number of 'Ayurvedas' have appeared since the 1990s, which often expressly describe themselves as spiritual or use religious concepts (cosmological and anthropological concepts of happiness)" (Koch 2015: 437).

All this indicates that alternative religion and CAM go hand in hand in many cases. Aromatherapy, for example, is often perceived as a complementary therapy, with its "etheric qualities" as therapeutics for the body, mind, and spirit that improve well-being physically, mentally, and emotionally, as well as "spiritually." These effects are sometimes attributed to their influence on the limbic system. If a therapist wants to support a patient to connect with his or her "higher self" through an application of bergamot oil or to attract spiritual beings through the application of basil oil, there are obviously religious aspects involved. In our case studies, neroli, lavender, and rose (damascena and bulgarian) oil have been prominent. Beyond their physical and psychological effects, like "relaxing" and "calming," they are seen as "harmonizing," "protecting," "enveloping," "purifying," and supporting transitions, all of them being effects that belong to a wider spiritual concept. Rose oil especially is seen as supporting transitions. One nurse explained her usage of aromatherapy after being asked about any "spiritual practices":

"[...] because it [aromatherapy] is something that supports and comforts you. [...] For instance, especially slightly heavier scents like rose oil or lavender, um, (2) they help (.) people *say*, I don't know if and how this is scientifically proven (.) But people say that it, that it helps for restlessness, stress, anxiety, (.) that it also helps, specifically rose for, um, like letting go, or for, for, for transitions (.) um, like from life to death or vice versa (.). Into life, like at births, one uses that too." (Regina, nurse, 9.12. 2013)[32]

32 Original wording: "will's halt au öppis isch, wo (5) wo eim irgendwo Halt und Trost git. [...] Zum Bispiel ähm (2) Aso gad so chli schwäri Düft wie, wie Rosääl oder oder Lavendel, ähm (2) die würked (.) me SAIT's, ich weiss halt nöd, wie das würklich wüsseschaftlich irgendwie belait isch (.) Aber me sait, dass es, dass es aim, s hilft, gäge inneri Unrueh, gege Aspannig, gege Angst (.), dass au hilft, gad insbesondere jetzt halt Rosä äh zum wie chönne loslah, oder so für für für Übergäng quasi (.) ähm aso ebe vom Läbe in Tod, oder au umgekehrt (.) I's Läbe, aso bi Geburte brucht me das au". This interview was conducted by Mirjam Mezger.

These practices (including communicated concepts) quite often go beyond the regulated practices suggested by the institutional manuals of secular health-care institutions.

Given the undifferentiated character of CAM, the question about the ways in which the use of CAM is made attractive is raised. What are the goals of using CAM in biomedical contexts?

In our case studies, nurses, therapists etc. often rely on CAM when they encounter limits with regard to the tools they are officially trained in. This is the case when nurses experience situations where they "cannot do anything more for the dying patient," and a medical system restricted to biomedicine can no longer work with its own references and logic of healing the physical body. This experience is irritating, as medical staff see themselves as professionals "helping" patients and having an empathic relationship with them. Therefore, they resort to CAM to develop strategies in order to keep in tune with their habitus, to be of help to their dying patients, and to maintain or enforce interaction with them:

"We, the nurses, would like to have complementary medicine tools sometimes, so that you are able to do something. Healing isn't possible anymore [at the palliative care unit], but at least to be able to do something—one has to be careful, whether one is doing it for the patient or for oneself.[33]" (Andrea, nurse, 17.6.2015)

The CAM tool kit involves "symbols, stories, rituals and world-views" (Swidler 1986: 273), practices and concepts that go beyond the framework of the natural sciences. When nothing else can be done for the healing of the body, support for emotional, metaphysical, and transcendent needs is an attractive strategy of action. CAM allows medical staff to rationalize their actions and the ends they are pursuing with them beyond the boundaries of biomedicine, framing them further as "supportive."[34] At the same time, this tool kit allows them to remain within the framework of "healing" and

33 Field note, Dorothea Lüddeckens.

34 CAM also enables actors in the religious field, such as chaplains, to deal with precarious situations by targeting non-empirical as well as bodily levels. Thus, we found carers who rationalized their practices with alternative religious concepts and used CAM, as well as ecclesiastical ministers who completed complementary medical training.

"caring." The use of Aromtherapy by Regina mentioned above is an example of this: the aroma of rose oil is used to support the transition from life to death, the capacity of the patients to "let go", an aim for which no biomedical tools are available.

4.1.2 Religion as a Coping Strategy

CAM also offers a tool kit for agents who are generally interested in creating scopes of action that exceed the limits of their professions as defined and delimited by the differentiated subsystem we call "medicine". They attract actors in the medical field who do not want to restrict themselves to medical practices that focus only on the physical body but want to use religion, or rather "spirituality," as part of coping strategies. This again seems to be especially the case with palliative care, which today is strongly influenced by Cecily Saunders, a British Anglican social worker, nurse, and later physician, and Elisabeth Kübler-Ross, a Swiss-American psychiatrist. One reason for their continuing, international influence is that they combine conventional health care with so-called "spiritual care". As long as there is hope for healing, the physical body is at the center of attention in secular hospitals. Social relationships, psychological aspects, and above all religion are only seen as supporting factors in the physical healing process. However, in institutions and hospital units specialized in palliative care, just the opposite can be observed. The treatment of the body, in the sense of getting "symptoms under control," is seen as the condition for a process in which much more importance is attached to the idea of "a good death," which involves mental and "spiritual" engagement with dying and death, including "acceptance," "peacefulness," and "the decision to 'let go'".[35]

"There seems to be a corresponding interest on the part of the patients, as several studies hint at a 'value shift towards self-transcendent values in palliative care patients, possibly reflecting coping processes which take place in the face of a terminal illness'" (Fegg et al. 2005: 158).

CAM, in connection with "fluid New Age", often meets patients' need to understand their illnesses in broader contexts. It also allows them to discuss

35 Cp. Demjén et al. 2016; Semino et al. 2014.

themselves and their bodies. Patients can understand their sick bodies and their own "spirituality" as an integral part of their own selves. According to our case studies, the tool of breath therapy, for example, may enable patients to connect with suppressed, difficult emotions with the goal of "letting them go". This in turn may be seen as a path to their "higher inner self". In the words of one patient,

"[...] last but not least my illness alerted me, to tell me, hey, do something, in your second life" (Elsbeth, patient, 8.6.2015).[36]

According to one therapist, falling ill is often seen as a task or a "'chance' to have to learn something that maybe I haven't learned in my last lives" (Mara, eurythmy therapist, 11.5.2015).[37] In a similar way, illness is perceived as a "path" or task for personal "development": "There is some reason for getting that [illness], however. And whether to develop myself, to, perhaps, become aware, this is who I am" (Manuela, nurse, 22.5.2015).[38]

Physical experiences in the context of treatments can be connected to the goal of spiritual development. This allows patients, especially when faced with their imminent death, to act, to do something for themselves, even without any opportunities to do anything actively to improve their bodily conditions. In this context, one therapist explained:

"Often it happens during the therapy that people [experience] a mini-enlightenment. [...] and from that something evolves." (Mara, eurythmy therapist, 11.5.2015)[39]

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36 Original wording: "Und nöd z letscht (.) hät mich d Chrankhet wieder emal druf ufegstosse, [Ja] mir z säge, hey, mach doch öppis [Ja] (-) mit dinere zweite Biographie." This interview quote and the following ones stem from interviews conducted by Barbara Zeugin.

37 Original wording: "Ich glaube [...] eine gewisse Krankheit (-) kann [...] sagen, dass ich jetzt was LERnen muss, was ich die letzten Leben vielleicht noch nicht gelernt habe."

38 Original wording: "Es hät ir (.) glich irgend en Grund, dass mer das überchunt. [...] Und segs (.) zum en Entwickligsschritt mache, zum (.) villich bewusst werde, das bin ICH."

39 Original wording: "Oftmals passierts in der Therapie, (1) dass die Leute (-) ne Mini kleine Erleuchtung. [...] Und daraus entwickelt sich dann was."

Many CAM treatments simultaneously have medical and religious aims or offer at least the opportunity for the treatments to be used for both purposes at the same time. Therefore, against the backdrop of the process of differentiation outlined above, the increasing incidence of CAM treatments and CAM practitioners in secular medical institutions may be seen as signs of a process of de-differentiation (Tiryakian 1985, 1992; Buss/Schöps 1979: 324). De-differentiation might be seen as "processes in which previously separate roles or organizations are fused to deal with a broader set of problems." (Rueschemeyer 1977: 8). However, a "'de-differentiated role' does not return to the structurally prior level of development characterized by lack of specialization" (Lipman-Blumen as cited in Tiryakian 1985: 121). The role of the nurse or therapist may become de-differentiated in serving medical and religious aims at the same time without a loss of medical specialization.

These phenomena appear mainly at the margins of the biomedical healthcare system in cases of palliative care, maternity wards, psychosomatic medicine, psychiatry, and preventive medicine. Yet it is often at the margins that new developments occur and this trend has already reached cancer treatment units in particular. Beyond institutional implementation, in our studies, nurses and therapists, as well as in some cases medical doctors, use CAM and explain their dealings with patients by referring to alternative religious concepts, such as extra-sensory perception. This presence of CAM in secular medical institutions, going along with religious semantics, concepts, and norms, hints at processes of de-differentiation.

4.2 An Internally Loosely Coupled Field

The field of alternative medicines and therapies and of alternative religion is decentralized and has so far been institutionalized only weakly. In being characterized by weak and non-committal internal connections between different agents, it can be called a loosely coupled field in the sense of Weick (1976). In contrast, in strongly institutionalized fields such as academic medicine or academic theology, the connections between agents, institutions etc. are much closer and more determined. This means first that training programs are comparatively open, with low-threshold access: one does not need a special level of educational attainment to be admitted to Reiki training, for example.

Secondly, being a loosely coupled field allows a semantic vagueness and a high level of sensitivity to the environment. Semantic vagueness[40] is highly compatible with the diverse professional self-perceptions and world views of the medical staff. The diversity and flexibility of the available concepts and practices enable selective reception with high degrees of accuracy and flexibility to form varying configurations to fit the respective actors and their situational needs, as there are no authorities who can regulate access or the application of concepts and practices.

Thirdly, this adaptability also applies to the relationship of alternative religiosity to medicine and established religion: selectively, theological and especially medical and scientific schemes are integrated into alternative religiosities and their therapeutic practices. Accordingly, we observe a "reflexive curing" culture (Koch 2015: 437) that corresponds to the popularization of the discourse in ritual studies (cp. Lüddeckens 2004) and "reflexive ritualization" (cp. Stausberg 2004). In the case of the latter, elements of anthropological theories of ritual are integrated into popular discourses about ritual (re)inventions. In the case of CAM, for instance, biomedical research, concepts, semantics, and symbols are partly integrated**,** or else references are made to science like quantum theory. CAM concepts involve, for example, nerve tracts, references to the chemical ingredients of remedies, biomedical diagnostics etc.[41] These flexible and selective connections allow actors to frame CAM as "compatible" with and "complementary" to their own biomedical professionalization.

4.3 A Resource for Self-Empowerment

In 1988, in his afterword to his study of 1970, in which he writes about the changed position of the patient since then, Freidson noted that "well-educated middle-class women of childbearing age have become more inclined to challenge medical authority and to insist on playing a more active role in their own treatment" (1988: 388). In fact, surveys show that the idea of having more autonomy is one of the crucial motives for patients turning to

40 Typical examples of this semantic vagueness are terms like "energy", "nature," and "holistic".

41 One example in the Japanese context is *kanpō* medicine, Harasawa S., Miyoshi A., and Miwa (1998).

CAM.[42] Ahlin, who discusses several studies from Europe, Canada, and the USA, concludes that

"[…] most important among these [the appealing positive qualities of alternative therapists] is the sense of responsibility that alternative therapy offers its clients. In contrast to conventional medicine, the client is not a passive receiver of healthcare but a self-governing actor with responsibility regarding his/her health, both today and in the future." (2015: 406)

CAM practices do not necessarily involve patients more actively, and the autonomy of patients in their relationships with their therapists is in fact not necessarily greater than in a biomedical context. However, patients associate the use of CAM with their own control over their own health matters, and this image of CAM is decisive. Bishop, Yardley, and Lewith, in their article *A systematic review of beliefs involved in the use of complementary and alternative medicine*, concluded:

"The evidence suggests that CAM users want to participate in treatment decisions, are likely to have active coping styles and might believe that they can control their health.

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42 One has to take into account the fact that the different studies rely on users of different kinds of CAM and that some of them found different results for different practitioners (e.g. Reiki practitioners may differ from homeopathy users). Moreover, it makes a decisive difference whether one studies people who rely exclusively on CAM or people who combine CAM with biomedical treatments. Astin was able to show that the "desire for control over health matters" (1998: 1551) was one of the independent variables among the significant predictors for relying primarily on alternative forms of health care. Bishop, Yardley, and Lewith suggest that "people who use CAM might be more likely to prefer an active or collaborative role in treatment decisions than non-users" (2007: 852). Similarly, Pawluch outlined that "[...] complementary therapies represented a way to make a statement about the unresponsiveness and oppression of Western medicine. It represented a way to take control of one's health [...]" (2000: 261). In contrast to a study published in 2003 by Lönroth and Ekholm, as reported by Ahlin (2015), the gender aspect is rarely considered. The latter found that 25% of patients, most of them women, had a "wish to take an active part in the healing process," an important factor in the use of CAM (Ahlin 2015: 407).

They value non-toxic, holistic approaches to health and hold 'postmodern belief systems' with viewing themselves as unconventional and spiritual." (2007: 862)

My argument here is that CAM is associated with more autonomy than conventional biomedicine because it is perceibed, at least partly, as separate from the hegemonic health system dominated by biomedicine (which is experienced as depriving patients of their autonomy) and as something the "cultural authorities" do not accept and that is therefore to some extent "subversive." There is a congruence between these heirs of a "medical counter-culture" (cp. Saks 2003) and contemporary spiritualities along the lines of a New Age spirituality (cp. Hanegraaff 2000), the heirs to a "religious counter-culture". The impression that CAM is being increasingly accepted by the mainstream population, and even by the medical authorities, health insurance companies and so on, is even more a confirmation that the "truth" will prevail.

Not only patients, but medical staff too may use CAM as a resource for self-empowerment and a tool for autonomy. As a loosely coupled field, CAM offers actors—in our case health-care providers such as nurses and therapists—more self-determination and autonomy than fields with strong ties do (cp. Granovetter 1973; Weick 1976). The strict regulations in hospitals regarding the practices of nurses are related to the fields of biomedicine and conventional nurseries: they do not include any rules regarding energy medicine or aura healing. There is no constraining authority to control nurses in these fields of CAM as long as they do not offend violently against the general hospital regulations. Therefore, CAM provides a route to "self-empowerment" for actors in the hierarchically organized medical field who see themselves as limited by their professions, as is often the case with nurses and therapists. The threshold for becoming an alternative therapist is considerably lower than the threshold to enter academic medicine. For a nurse seeking a career change, it is much easier to become a "polarity therapist" than to embark on medical studies.[43]

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43 People who follow a de-differentiating course of action publicly and explicitly lose their status in their original field: Cicely Saunders, who is immensely important for "spiritual care" and integrates medical and religious practices and ends, no longer has a strong standing as an academic theologian. Elisabeth Kübler-Ross, originally a doctor, also made de-differentiating moves by conceiving death in a way that is no longer accepted within academic medicine. Her ideas

CAM offers a way to enhance self-esteem and prestige in the eyes of patients and sometimes colleagues as well. As Homi Bhabha observed of agents with less hierarchical power:

"[...] there exist possibilities to reverse the cultural authorities we're facing, to adopt some aspects of it, and dismiss others. This leads to a hybridisation of the symbols of authority and turned into something of its own. Hybridisation to me does not simply mean mixing, but rather a strategic and selective appropriation of meaning, the creation of space for agents whose freedom and equality is threatened."[44] (Bhabha cited in Babka/Posselt 2012: 13)

CAM offers a "selective appropriation of meaning" that one may call a reflexive or hybrid curative culture (cp. Lüddeckens 2013). By integrating the metaphysical or transcendent aspects into medical care, CAM provides agents with the power to claim care beyond what is conventional and physical. The medical system makes this kind of self-empowerment possible, especially in palliative care. Where conventional medical reason has reached its limits, healing is no longer possible, and no more or at least less medical damage seems possible: thus, the field can be opened to alternative practices and interpretations.

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are regarded as esoteric precisely because they integrate the religious and medical perspectives.

44 Original wording: "[...] es [gibt] Möglichkeiten, die auferlegten kulturellen Autoritäten umzudrehen, einiges davon anzunehmen, anderes abzulehnen. Dadurch werden die Symbole der Autorität hybridisiert und etwas Eigenes daraus gemacht. Hybridisierung heißt für mich nicht einfach Vermischen, sondern strategische und selektive Aneignung von Bedeutungen, Raum schaffen für Handelnde, deren Freiheit und Gleichheit gefährdet sind." http://sciencev1.orf.at/science/news/149988, June 21, 2018.

5 CONCLUSION

We are witnessing the growing institutionalization of CAM in secular medical institutions in Switzerland, as in many other European countries. In palliative care units, the CAM tool kit is used when the differentiated "(bio)medicine" sub-system reaches the limits of its inherent logic. In cases where "nothing can be done anymore" with regard to the physical health of patients, medical staff face challenges to their professional habitus as care-givers.

I have argued that CAM is currently successful in European countries because of three characteristics it has. By responding to medical as well as religious or spiritual needs, and also by integrating aspects of alternative religion, CAM allows medical staff to serve not only the bodily but also the emotional, metaphysical, and transcendent needs of their patients. Thus, by using the CAM tool kit, medical staff are able to preserve their habitus as care-givers even at the end of life when nothing or less can be done for the well-being of their patients' physical bodies. As a loosely coupled field, CAM offers low-threshold access to training and application. It also serves as a resource of self-empowerment for patients and medical staff alike in relation to conventional biomedicine and its hierarchical structures.

The relevance of action strategies that refer to the CAM tool kit is growing in secular, biomedicine-oriented institutions in Switzerland. Complementing other cases from England and Scandinavia, I suggest that this increase may be understood as a process of the de-differentiation of medicine and religion in modern, European societies.

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