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**Consumer Value and Value Co-creation  
in  
Complementary and Alternative Medicine (CAM)  
Health Services**

A thesis presented in partial fulfilment of the requirements  
for the degree of

**Doctor of Philosophy in Marketing**

**at Massey University, Albany  
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## **Abstract**

This thesis contributes to an emergent area on consumer value co-creation in a rapidly growing and exciting ‘new’ service market, Complementary and Alternative Medicine (CAM) health services. The market for CAM health services is experiencing strong growth as consumers look for greater value, choice and control in managing their health. Despite the growth in this large health service market there is a paucity of research from a service marketing and consumer behaviour perspective. Yet, understanding what CAM consumers’ value and how they co-create value with CAM health services has important managerial implications. The purpose of this research is to explore what value CAM consumers’ gain and how they co-create value from their consumption experiences with CAM health services.

The research adopts an interpretive approach employing an exploratory case study research strategy, using qualitative methods and an adapted version of the visual elicitation technique ZMET. The research process is semi-longitudinal and is conducted in three phases over a 12 month period. Sixteen CAM consumers with ‘lifestyle’ health complaints who use CAM health services participated in the study.

The findings reveal eight consumer value components including: quality of care, treatment efficiency, physical environment, esteem value, social value, spiritual value, ethics and play. A consumer value model for CAM health services and potentially all health care services is proposed. Significantly this research found that CAM consumers co-create value on three levels according to their: approach to health care, preferred ‘consumer value co-creation relationship styles’ and engagement in ‘consumer value co-creation activities’. Consequently this thesis presents a typology of consumer value co-creation in CAM health services and develops a consumer value co-creation framework that can potentially be used for all health services.

This research contributes to service marketing and consumer behaviour theory by extending the concepts of ‘consumer value’ and ‘value co-creation’ to incorporate findings from the CAM health service sector. The managerial implications of this research could help guide both CAM health care and mainstream medical practices to provide better health services and ultimately improved health outcomes for health care consumers. Future research could implement the unique three phase semi-longitudinal process and visual methods developed in this research, in various health care and service settings.



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# Chapter 1 Introduction

As Galen says, confidence and hope do more than physick – ‘he cures most in whom most are confident’...Faith in the Gods or in the Saints cures one, faith in little pills another, suggestion a third, faith in a plain common doctor a fourth...The cures in the temples of Aesculapius, the miracles of the Saints, the remarkable cures of those noble men, the Jesuit missionaries, in this country, the modern miracles at Lourdes and at St. Anne de Beaupre in Quebec, and the wonder-workings of our latter day saints are often genuine, and must be considered in discussing the foundations of therapeutics. We physicians use the same power every day. If a poor lass, paralysed apparently, helpless, bed-ridden for years, comes to me having worn out in mind, body and estate a devoted family, if she in a few weeks or less by faith in me, and faith alone, takes up her bed and walks, the Saints of old could not have done more (William Olser cited in Bliss, 1999, p. 276)

This quote by William Olser in Bliss’s (1999) book *William Olser: A Life in Medicine*, highlights the importance of the practitioner in the health and wellbeing of the patient. William Olsen, who received his medical degree in 1872, was considered by some historians to be the “greatest doctor in the history of the world” and by others the “great American doctor”. Olsen was revered and renowned for his ‘good-nature’, ‘cheerfulness’, ‘confidence’ and “ability to give the desire to fight to those who had lost courage and hope” (Bliss, 1999, p. 277). It was not just Olsen’s exceptional knowledge and air of authority as a doctor that influenced his patients but his warm and friendly manner coupled with the ability to instil ‘faith’ in his patients. Olsen understood that his role as a practitioner and service provider was more than just treating the symptoms but considering the person as a holistic (mind, body and soul) being.

The above mirrors my own thinking, through my experience as a CAM practitioner, CAM consumer and patient of mainstream medicine, of the important role a practitioner plays in the health, wellbeing and ‘healing’ process of the person. This Ph.D. study has come to fruition because of my own personal conviction that the value gained and value co-created during the service interaction and beyond is critical to a person’s health. I believe that all

health care practitioners and health care providers should act as empowering co-creating service agents.

This Ph.D. study not only fills an academic gap, as will be outlined in the rest of this chapter, but also has personal meaning and significance. When I practiced as a Naturopath I frequently reflected on my own practice with questions such as: What do my clients really need from me? What are my clients' experiences of my practice and treatment? How can I help my clients achieve their health goals? Why do some clients respond well and others do not? As a CAM consumer, my own on-going search for health and wellbeing using various forms of CAM has had both success and failures. Finally, as a consumer researcher, I have assessed both my own behaviour as a CAM consumer and my clients' behaviour, and speculated that CAM health care requires time, commitment and a strong belief in the value of the CAM service. In my own mind, two key questions became apparent and thus gave direction for this research. Firstly, what do CAM consumers' value from their 'experiences' of CAM health services? Secondly, how do CAM consumers and practitioners work together successfully? And so the story begins...<sup>1</sup>

## **1.1 Overview**

This chapter provides an introduction to the thesis by outlining the academic background which drives this study and considers why the topic is important. After which the main purpose of the study is highlighted, the theoretical framework relevant to the research is introduced, and the research objective and research questions are outlined. Subsequently an overview of the methodology and a summary of the contributions of this research are given. Lastly the structure of the thesis is presented.

## **1.2 Background**

Health services are deemed a significant and worthy field to study from a marketing perspective with the potential to make significant contributions to the health care industry (Berry & Bendapudi, 2007). Furthermore, research focusing on consumers' experiences of health services could provide important insights into health care practices that, if

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<sup>1</sup> Please note from this point forward the use of the third person 'this researcher' or 'the author' replaces the use of the first person.

implemented, could ultimately contribute to enhancing peoples' quality of life (Sweeney, Danaher, & McColl-Kennedy, 2015). Notwithstanding the important managerial and societal implications of research on the experiences of health care services, an experiential approach to understanding the "service experience" of a consumer has been highlighted as a critical area to study in service marketing and management academia (Jaakkola, Helkkula, & Aarikka-Stenroos, 2015). Importantly, understanding value creation and enhancing the service experience has been identified as a research priority in service research (Ostrom, Parasuraman, Bowen, Patricio & Vos, 2015). This study examines the concepts of consumer value and value co-creation within a large and growing under-researched service market, CAM health services, contributing further to our understanding of these two concepts within a health service context and from a consumer's perspective<sup>2</sup>.

Researchers show that consumer value and value co-creation in health (Gill, White, & Cameron, 2011; McColl-Kennedy, Vargo, Dagger, Sweeney, & van Kasteren, 2012; Prahalad & Ramaswamy, 2004a; Sweeney et al., 2015; Zainuddin, Previte, & Russell-Bennett, 2013), the search for well-being (Sointu, 2006a; van Wersch, Forshaw, & Cartwright, 2009), and being responsible for your own health (Hughes, 2004) are the new frontiers of health care. The growth in CAM health services epitomizes this with consumers looking for greater choice and control (Bishop, Barlow, Coghlan, Lee, & Lewith, 2011). CAM is a large and growing market both in New Zealand and worldwide. The use of CAM continues to increase particularly in developed nations such as the United States (Barnes, Bloom, & Nahin, 2008), United Kingdom (Thomas, Nicholl, & Coleman, 2001), Australia (Xue, Zhang, Lin, Da Costa, & Story, 2007) and New Zealand. In New Zealand one in five people had visited a complementary or alternative health care worker during a 12 month period in 2006/07 (Ministry of Health, 2008)<sup>3</sup>. Figures reveal that

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<sup>2</sup> Please note the cut-off date for literature was June 2015.

<sup>3</sup> Ministry of Health (2008) statistics do not include osteopaths and chiropractors as complementary and alternative health care workers whereas most overseas statistics include these as CAM therapies. In New Zealand these two therapies are classified under 'other health care workers' alongside the likes of physiotherapists. This would account for the seemingly low statistic in comparison to other developed nations like the U.S. Approximately 10% of the adult population in New Zealand have seen either a chiropractor or an osteopath.

approximately 40% of Australian adults (Xue et al., 2007), 40% of UK adults (Posadzki, Watson, Alotaibi, & Ernst, 2013) and 35% of U.S. adults (Clarke, Black, Stussman, Barnes, & Nahin, 2015) had used some form of CAM health service within a 12 month period.

Consumption within this large and fast growing consumer market, developing outside the well-established public health care sector, raises a range of intriguing questions for service marketing and consumer researchers particularly with respect to the value CAM consumers gain from using CAM health services. Gaps in knowledge within CAM literature exist in the area of consumer behaviour (Vos & Brennan, 2010), particularly in terms of understanding and evaluating CAM consumers' experiences. A gap in the literature is also apparent with regards to the perceived consumer value CAM consumers determine and co-create from their CAM health service experiences. More research is required on 'value' from a consumer's perspective within CAM health services (Rajamma & Pelton, 2010). Future research focusing on the CAM consumer is essential to understanding the CAM phenomenon and its place in modern health care (Adams, 2014; Vos & Brennan, 2010).

Since Berry and Bendapudi's (2007) call for research from a marketing perspective within the complex but important context of health care services, several studies have emerged. One such study by McColl-Kennedy et al. (2012) identifies five health care customer value practice styles, highlighting the significant contribution that marketing academics can make to the field of health care. Studying health care "through the lens of marketing" could provide some valuable insights for health care providers and policy makers (Spence & Ribeaux, 2004). The health care sector also offers an interesting and worthy context in which to study important existing and emerging concepts in marketing and consumer research, such as consumer value and value co-creation.

There has been little research on consumer value within health care per se (Chahal & Kumari, 2011). Yet, "understanding the nature of customer [consumer] value in health care is critical given the diversity of consumer needs, an increase in the number of providers, and resource pressures faced by private and public providers" (Dobele & Lindgreen, 2011, p. 269). Most studies on value in health care have focused on the methods for practitioners to assess what is understood as the patient's value (Liu, Amendah, Chang, & Pei, 2006), the relationship between quality, value and satisfaction (Choi, Cho, Lee, Lee, & Kim,

2004; Moliner, 2009), and the role of ‘health value’, defined as an “individual’s assessment of benefits relative to costs in engaging in preventive health care behaviour” (Jayanti & Burns, 1998, p. 8), and in health behaviour (Lau, Hartman, & Ware, 1986; Rajamma & Pelton, 2010). Research on consumer value and value co-creation in health care is beginning to emerge (See Gill et al., 2011; McColl-Kennedy et al., 2012; Nordgren, 2009; Sweeney et al., 2015; Zainuddin, Russell-Bennett, & Previte, 2011; Zainuddin et al., 2013) but is still in early stages.

A review of the extant literature of CAM and CAM health services in Chapter 2 uncovers why CAM consumers are drawn to CAM health services. In essence CAM consumers are ‘pulled’ towards CAM because of their underlying values, beliefs and philosophical orientation towards health and life. CAM offers consumers a form of health care that is empowering, encourages self-responsibility and has a holistic approach. Studies either conclude or suggest that the reason people use CAM is because of positive therapeutic relationships that are empowering, empathetic, client-centred, encourage self-responsibility, participatory, holistic and supportive (Adler, Wrubel, Hughes, & Beinfield, 2009; Bann, Sirois, & Walsh, 2010; D’Crus & Wilkinson, 2005; Gale, 2008; Long, 2009). However, what is not evident in the literature is once consumers start using CAM health services, what do they value from the experience and how do they co-create value to achieve greater health outcomes?

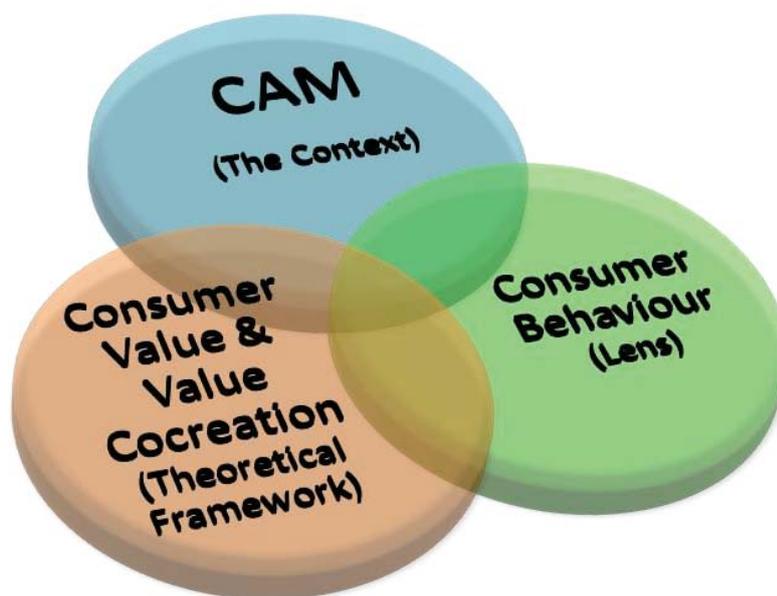
### **1.3 Overall Framework of the Research**

This research uses consumer value and value co-creation theory and concepts as its theoretical framework. The researcher takes the perspective that value (or consumer value) is experiential and contextual, and ultimately determined and co-created by the ‘user’ during the consumption experience epitomising the value-in-use idea (Grönroos, 2008; Vargo & Lusch, 2006, 2008). Consumer value is “at the heart of all marketing activity and therefore clearly deserves the attention of every consumer researcher” (Holbrook, 1999, p. 1). Consumer value is multi-dimensional, consisting of many interrelated components ranging from utilitarian value (instrumental, task-related, rational, functional, cognitive, and a means to an end consumption), and hedonic value (reflecting the entertainment and emotional worth of consuming, which is non-instrumental, experiential, and affective), to

aspects such as social and spiritual value, that form a holistic representation of a complex phenomenon (Holbrook, 1994, 1999; Sánchez-Fernández & Iniesta-Bonillo, 2007; Sheth, Newman, & Gross, 1991).

Figure 1 shows the overall framework of the research including the theoretical framework, context and lens. Consumer value is considered foundational in marketing and consumer behaviour and yet little attention has been given to defining and researching it (Holbrook, 2006a). Likewise the emerging concept of value co-creation, whereby consumers/customers are considered to always be co-creators of value (Vargo & Lusch, 2008), is potentially a fundamental marketing concept that requires more empirical research to substantiate it, particularly from a consumers' perspective (Gummesson, Lusch, and Vargo, 2010).

**Figure 1: Overall Framework of the Research**



CAM health services provide a valuable context in which to study consumer value and value co-creation. CAM health care by nature is considered holistic and multi-dimensional (Fulder, 2005). Therefore CAM health services offers a service context whereby many consumer value components could potentially be experienced, from utilitarian value to spiritual value, enabling theory building of this important yet elusive concept. CAM health services are also a relevant context to study value co-creation, in particular, exploring how

consumers co-create value. Again the nature of CAM health services which advocates self-responsibility and being involved in the health care process provided a worthy context to explore the co-creation of value concept more closely. Furthermore, CAM's popularity and growth alone deem it a worthy service research context in which to study consumer behaviour. Little is known about CAM health services from a service marketing and consumer perspective and is therefore an area that warrants further study using a marketing and consumer behaviour lens (Vos & Brennan, 2010).

#### **1.4 Research Objectives and Questions**

This research has two objectives. The first and primary objective of this research is to study and potentially build on the concepts of consumer value and value co-creation within a health care service context, specifically CAM health services. The second objective is to explore CAM consumers' 'lived experience' of CAM health services in order to understand the CAM phenomenon. Specifically, the study aims to find out what consumer value components individual CAM consumers determine and co-create from their consumption experiences of CAM health services.

The specific research questions for this study include:

1. What do CAM consumers value from their CAM health service consumption experiences?
2. How do CAM consumers co-create value through their consumption experiences of CAM health services?

#### **1.5 Overview of the Methodology**

The research adopts an interpretive approach and employs a semi-longitudinal exploratory 'multiple' case study research strategy, using in-depth interviews and a simplified version of the Zaltman Elicitation Technique (ZMET). To understand the value CAM consumers experience and how they co-create value from their health care services it is deemed appropriate to use a qualitative approach that explores CAM consumers' lived experience. Consumer researchers, such as Schembri and Sandberg (2002, 2011), Thompson (1996), Thompson, Locander and Pollio (1989, 1990), Thompson and Troester (2002), and

Arnould and Thompson (2005) advocate the use of the interpretive approach in consumer research that focuses on the lived experiences of consumers.

The data collection section of this research involves three phases over 12 months. The first phase includes a face-to-face interview with each of the participants which explores the participants' experiences of CAM and where emergent themes on consumer value surface. The second phase involves the participants collecting or taking photographs of images that represent their experiences of CAM. These pictures and images are then discussed in a second interview using five of the ZMET steps including storytelling, missed images, sorting task, most representative image and summary image which enabled greater depth than interviewing alone (Coulter & Zaltman, 1994; Zaltman & Coulter, 1995). The third phase involves an interview that fundamentally aims to explore the process of the participant's CAM health service experience as well as gather feedback on initial analysis from the first two phases.

Sixteen CAM users, 4 men and 12 women, aged between 24 and 77 years old with 'lifestyle' health complaints, and are seeing a CAM practitioner on a regular basis participate in the study. The interviews are digitally audio recorded and transcribed. To ensure trustworthiness of the data all transcripts are member checked. The formal process of data analysis is highly iterative, following the general approach advocated by Miles and Huberman (1994). The transcripts are converted into table format and imported into Microsoft Excel. Excel is a useful tool for organising, analysing and displaying qualitative data (Meyer & Avery, 2009). Data analysis involves thematic analysis and a code-recode procedure to ensure dependability of the data.

## **1.6 Importance and Contributions**

This research makes important contributions to health care practices, marketing and consumer theory, and qualitative methodology, in particular the use of visual techniques to explore consumers' experiences of services. Health care is arguably the most personal and important service a consumer can buy and experience, and consumer researchers have the potential to make significant contributions to this critical and complex field (Berry & Bendapudi, 2007). A positive service experience with health care providers has the potential to contribute to an individual's health outcomes, wellbeing and overall quality of

life (Sweeney et al., 2015). This research has the potential to contribute to both CAM and mainstream health care services by providing insights into what CAM consumers' value from their CAM consumption experiences. This understanding could contribute to improved services of CAM and mainstream medical practices, enabling better client/patient support and potentially contributing to enhanced health outcomes.

Theoretically, this research contributes to consumer research, services marketing and marketing theory by building on the concepts of consumer value and value co-creation to incorporate findings from the CAM health service sector. Specifically, this research addresses and provides an understanding of what consumers' value and how they co-create value through the consumption of CAM health service experiences, advancing knowledge in service experience consumer value and value co-creation. Significantly, this study presents a modified model of consumer value<sup>4</sup> useful for all health care services, and a new framework for understanding the process of consumer value co-creation that can potentially be applied to all service contexts.

Methodologically, this research contributes to qualitative research literature by developing a research process that implements a semi-longitudinal three phase process and uses a visual elicitation technique. This methodology was valuable in terms of uncovering deeper meanings of consumer value and value co-creation enhancing our understanding of these concepts. Additionally, the use of visual techniques to explore consumers' service experiences of health care services has not been widely used. Yet, visual methods could be worthwhile for gaining deeper insight into health service experiences and uncovering unconscious thoughts and feelings not usually found through interview and survey techniques.

## **1.7 Structure of Thesis**

The structure of this thesis generally follows a standard monograph format starting with an introduction chapter, then literature, methodology, findings, discussion and conclusions. There are seven chapters in this thesis. Chapter 1, the introduction, has provided an overview of the research. Chapter 2 presents relevant literature on CAM and CAM health

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<sup>4</sup> The author has published a paper in the Australasian Marketing Journal on consumer value in CAM health care services based on the first phase of this research. See Dodds, Bulmer and Murphy (2014).

services and key literature on consumer value and value co-creation, and ends with the research questions. Due to the complexity of the CAM health service context it was deemed appropriate to present this before literature on value in order to provide the reader with an overview of the CAM health service sector and CAM terminology pertinent to this research. Following this the methodology is outlined in Chapter 3. Chapter 4 and Chapter 5 include the findings. In the spirit of case study analysis Chapter 4 presents each individual case and highlights findings from in-case analyses, and Chapter 5 presents the overall findings from within-case analyses. Chapter 6 discusses the findings in light of the literature, develops and presents new insights and highlights the study's contributions. Lastly, Chapter 7 presents the overall conclusions, including managerial implications, limitations and future research.

# **Chapter 2 Literature Review**

## **2.1 Overview of Literature Review**

There are two main streams of literature that inform this research. The first pertains to the context of this study, CAM health services, and the second to value literature, specifically consumer value and value co-creation. It was considered important and appropriate to first provide an overview of the literature on CAM relevant to this thesis on consumer value and value co-creation in CAM health services. Understanding the context of this research is imperative. CAM is a complex phenomenon that is ill-defined and lacks theoretical grounding. CAM health care is a growing service market that warrants research from a services marketing and consumer behaviour perspective but firstly requires clarification. Secondly, literature on consumer value and value co-creation is discussed. This literature stream begins with an overview of the concept of value from an axiological and economic perspective. It then explores the literature on value in marketing, ending with a typology of consumer value. Thirdly, this section reviews the literature on consumer value and value co-creation within health care services. Lastly, gaps in the literature with respect to consumer value, value co-creation and CAM are exposed and the research questions posed.

## **2.2 Introduction to Literature on CAM**

This section begins by looking at why CAM health services are important to study. It then provides an overview of CAM terminology and discusses the various definitions of CAM. Justification of the definition that was chosen to guide this research is given. A detailed overview of the extant literature on why people use CAM health services is provided. Lastly, literature determining who the CAM consumer is and the CAM market is discussed. It is important to note that this research focused on CAM health services and the interactions and value created between CAM providers and CAM consumers. The

researcher acknowledges the large CAM product and retail market; however, it was not in the scope of this study to address this sector of CAM.

### **2.3 Why Study CAM Health Services?**

CAM is a large and fast growing consumer health care market (Adams, 2014; Barnes et al., 2008; Xue et al., 2007). Adams (2014, p. 1) argues that research addressing “critical questions such as why, when, and how alternative therapies are currently consumed and practiced” is essential to understanding the place CAM has in “contemporary health care”. The majority of CAM research to date has focused on either the efficacy of treatment or the attitudes and integration of CAM from a mainstream medical point of view (Fries, 2008; Lee, Khang, Lee, & Kang, 2002; Poynton, Dowell, Dew, & Egan, 2006; Sewitch, Cepoiu, Rigillo, & Sproule, 2008). A number of studies have attempted to understand the reason behind CAM use (Astin, 1998; Astin, Marie, Pelletier, Hansen, & Haskell, 1998; Bishop, Yardley, & Lewith, 2008; Furnham & Lovett, 2001; Lindeman, 2011; Vincent & Furnham, 1996), some the attitudes and beliefs of users (Furnham, 2007; Furnham & Lovett, 2001; Jeswani & Furnham, 2010), others the decision making processes of CAM consumers (Caspi, Koithan, & Criddle, 2004; Hill-Sakurai, Muller, & Thom, 2008). According to Vos and Brennan (2010) gaps in knowledge within CAM literature exist in the area of consumer behaviour (Vos & Brennan, 2010), particularly in terms of understanding and evaluating CAM consumers’ experiences.

### **2.4 What Exactly is CAM?**

CAM ranges from established and accepted ‘complementary’ therapies such as chiropractors, acupuncture, osteopathy and massage therapy, to more ‘alternative’ therapies such as naturopathy, homeopathy, herbalism, aromatherapy, kinesiology, reiki, and energy healing (Robinson, Chesters, & Cooper, 2009). Each one of these CAM therapies has their own set of therapeutic and healing belief systems and philosophies, making a single definition of CAM problematic (Collyer, 2004; Kaptchuk & Eisenberg, 2005; van Wersch et al., 2009; Willis & White, 2004). However, defining CAM is essential to determine if growing research in the area is to be developed (Wieland, Manheimer, & Berman, 2011). Various attempts to define CAM have been made,

including definitions describing what CAM is not (Eisenberg, Kessler, Foster, Norlock, Calkins, & Delbanco, 1993), positive inclusive definitions of what CAM is (Ernst, Resch, Mills, Hill, Mitchell, Willoughby, & White, 1995), and more extensive operational definitions (Wieland et al., 2011). These are discussed below in more detail. Before discussing definitions of CAM it is important to establish the current terminology that is used.

### 2.4.1 CAM terminology

Complementary and alternative medicine (CAM) is the most commonly used term to describe therapies, medicine and systems of healing that exist largely outside of institutions where conventional health care is taught and provided (Dalen, 1998; Zollman & Vickers, 1999). ‘Complementary’ refers to therapies that are used “together with conventional medicine”, whereas ‘alternative’ refers to therapies that are used “instead of conventional medicine” (Barnes et al., 2008, p. 1). Historically CAM was referred to as “alternative medicine” because these therapies were mostly used as an alternative to conventional health care (Zollman & Vickers, 1999). Latterly the use of the term ‘complementary’ was added when conventional and alternative medicine started being used alongside, to complement, each other (Zollman & Vickers, 1999). The terms used to differentiate CAM from mainstream medicine are listed below (Table 1).

**Table 1: Terms used to characterise mainstream medicine and CAM adapted from Dalen (1998, p.2179)**

Mainstream Medicine	CAM
Conventional	Unconventional
Orthodox	Unorthodox
Regular	Irregular
Scientific	Unscientific/pseudoscience
Evidence based	Not evidence based
Allopathic	Non allopathic
Western	Non Western/Eastern
Modern	Traditional
Reductionist	Holistic
Medical	Natural/Alternative

## **2.5 How is CAM Defined and Classified?**

A common understanding of what CAM encompasses is critical if growing research in the area is to be compared, collaborated on and promoted (Wieland et al., 2011). Various scholars have attempted to define CAM with most concluding that a single definition of CAM is problematic because it includes a diverse range of therapeutic practices, systems of healing and beliefs (Collyer, 2004; Kaptchuk & Eisenberg, 2005; van Wersch et al., 2009; Willis & White, 2004). This section will discuss the various types of definitions and classification systems that have been developed for CAM including an oppositional definition, positive inclusive definitions, an operational definition, classification models and consumer's perspective of CAM classifications. The aim is to establish a suitable definition and classification system to guide this research.

### **2.5.1 What CAM is not - Oppositional definition**

Historically CAM has been defined in terms of its oppositional relationship to mainstream conventional medicine (van Wersch et al., 2009), hence the widely used terms “unconventional, alternative or unorthodox” (Eisenberg et al., 1993). Eisenberg et al. (1993, p. 246) defined “unconventional therapies as medical interventions not taught widely at U.S. medical schools or generally available at U.S. hospitals”. Gevitz (1995) argued that “defining unconventional medicine by ‘what it is’ does not work” (cited in Kaptchuk & Eisenberg, 2005, p. 9). As Willis and White (2004, p. 52) state the term CAM “conceals as much as it reveals”, and is therefore defined by its “ostracism” by orthodox medicine. However, this view of CAM as being distinguished from mainstream medicine is changing. van Wersch et al. (2009) argue that the original definition of unconventional medicine as ‘alternative’ and incompatible with orthodox medicine has now widened due to the recognition that many therapies are considered ‘complementary’ to conventional medicine.

### **2.5.2 What CAM is - Positive inclusive definitions**

Inclusive, positive approaches that describe what CAM is are considered more constructive than a definition that describes what it is not (Ernst et al., 1995). Definitions, in this ‘positive inclusive’ format, have been created by scholars, organisations and Governments

in an attempt to describe what CAM entails and involves. Here are some examples of these types of definitions.

Ernst et al. (1995) put forward the following definition:

Complementary medicine is diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual frameworks of medicine (p. 506).

The World Health Organisation also offers an inclusive approach and defines CAM as:

The sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illnesses (Themeditica, 2009, p. 1).

Many Governments have attempted to define CAM. In New Zealand, for example, the Ministry of Health (2008, p. 299) defines CAM as:

a term used to describe a broad range of healing techniques that encompass all health systems, practices and their accompanying theories and beliefs, other than those in the mainstream health system of New Zealand. Complementary and alternative health care services generally take a holistic approach to health care, including the interactions between physical, spiritual, social and psychological aspects.

The Cochrane Collaboration has perhaps provided the most widely used and comprehensive definition of CAM:

Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities [therapeutic approach], and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and that of the dominant system are not always sharp or fixed (Zollman & Vickers, 1999, p. 319).

The Cochrane Collaboration, established in 1993, is an independent international network that produces and disseminates up-to-date research and information on all areas of health care (Fitzgerald & Howcroft, 1998). The Cochrane Collaboration has an extensive database of systematic reviews of various health care topics and its core work is done by “collaborative review groups whose function is to prepare and maintain systematic reviews on related topics” (Bero & Drummond, 1995, p. 1936). “To meet increasing demand for evidence-based complementary medicine (CM), a CM field, funded by the National Institutes of Health Office of Alternative Medicine, was established within the Cochrane Collaboration in 1996” (Ezzo, Berman, Vickers, & Linde, 1998, p. 1628).

Recently the Cochrane Collaboration has argued that an operational definition as opposed to a theoretical definition of CAM is required for on-going research (Wieland et al., 2011). Wieland et al. (2011) argue that a theoretical definition characterises the fundamental nature of a construct whereas an operational definition tests whether a specific instance is or is not a member of the construct through a series of criteria or tests. This has become important as acceptance for CAM among mainstream medicine practitioners is increasing and the need for an operational definition of CAM to facilitate and harmonise research is required (Wieland et al., 2011). However, even operational definitions are not consistent, especially among Western Governments. In New Zealand, for example, the type of CAM therapies the Ministry of Health (2008) include in their definition are: massage therapy, homoeopathy, naturopathy, acupuncture, traditional Chinese medicine, herbalism, aroma therapy, spiritual healing, Maori traditional ‘Rongoa’ healing, Pacific traditional healing, and other. Interestingly, chiropractors, and osteopaths are classified under ‘other health care workers who also work in the primary health sector’. This is not consistent with definitions of complementary and alternative medicine in the United States and United Kingdom which generally classifies chiropractors and osteopaths under CAM (Miller & Washington, 2011; Vos & Brennan, 2010; Wieland et al., 2011). This difference highlights the need for ‘one’ recognised operational definition and classification system.

### **2.5.3 Cochrane Collaboration's operational definition**

The Cochrane Collaboration's complete operational definition, published and updated online (Wieland et al., 2011) is essentially an alphabetical list of what the Cochrane Complementary Medicine Field classifies as complementary or alternative medicine (includes therapies, herbs and nutritional supplements). An alphabetical list of CAM therapies, included in the definition, can be found in Appendix A.

After an extensive review of the literature Wieland et al. (2011) declared that a group classification system would be superior to an alphabetical system. Hence, Wieland et al. (2011) developed a structure based on the US National Institute of Health's Centre for Complementary and Alternative Medicine (NCCAM) categories. The NCCAM categories include:

- Mind-Body Medicine, which uses a variety of techniques to enhance the mind's capacity to affect bodily function and symptoms.
- Natural Product Based Therapies, which use substances found in nature to promote health.
- Manipulative and Body-Based Practices, which are based on manipulation and/or movement of parts of the body
- Energy Medicine, which involves the use of energy fields, either the unconventional use of electromagnetic fields, or the manipulation of energy fields that purportedly surround and penetrate the human body.
- Whole Medical Systems, which are complete systems of theory and practice outside the conventional allopathic model.

(Wieland et al., 2011, p. 9)

The latest Cochrane Collaboration CAM classifications includes (Wieland et al., 2011):

- Mind-Body Interventions
- Natural Products Based on Therapies
- Manipulative and Body-Based Methods
- Energy Therapies

- Alternative Medical Systems – includes complete systems such as homeopathy and naturopathy

Appendix B contains the fully expanded Cochrane CAM field topic list, which displays the topics and subtopics, plus in brackets the number of research papers that have been reviewed by the Cochrane Collaboration associated with each topic.

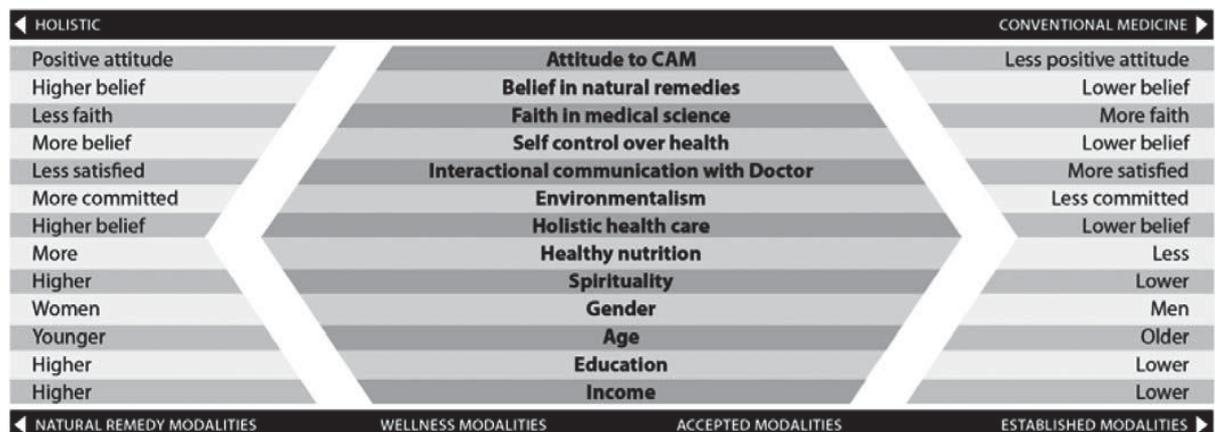
#### **2.5.4 Consumers' perspective of CAM classifications**

Little consideration has been given to what and how the CAM consumer classifies CAM services. The above CAM categories and definitions are all based on what medical experts, both mainstream and CAM, believe constitutes alternative and complementary. If we are to understand the value consumers get from consuming CAM health services and how they co-create value, the CAM user's perspective is an important consideration. One such study has attempted to categorise CAM based on CAM users' perspectives. Robinson et al. (2009) explored whether CAM users view CAM as a unified concept or categorise the different CAM health services. Robinson et al. (2009) found that CAM users did not view CAM as a unified concept, supporting the view that CAM is diverse and difficult to define. In fact, the CAM users they researched chose a CAM health service for themselves according to their beliefs, concerns and characteristics. Based on the users' perspective Robinson et al. (2009, p. 156) divided CAM health services into four categories:

- Natural remedy: includes naturopathy, homeopathy, Chinese medicine, and herbalists
- Wellness: includes aromatherapy, kinesiology, spiritual healing, shiatsu, reiki, reflexology, yoga, and meditation
- Accepted: includes acupuncture, osteopathy, tai chi, and hypnotherapy
- Established: includes chiropractic, massage therapy, prayer, magnet therapy, and Bowen therapy

These lie along a continuum from natural remedy modalities (therapeutic approaches) and holistic health care beliefs at one end to established modalities and a belief in conventional medicine at the other (Figure 2).

**Figure 2: The holistic health care-conventional medicine continuum model (Robinson et al., 2009, p. 159)**



Robinson et al. (2009) argue that this “Holistic Health Care – Conventional medicine” continuum model “enables conventional medicine and scholars of CAM to understand the diversity within CAM use” (p. 161). Importantly, the model goes beyond classifying CAM services it also provides an insight into the attitudes, beliefs, and demographics of CAM consumers and the CAM health services they chose based on these characteristics. Interestingly, CAM health services such as naturopathy, homeopathy, Chinese medicine and herbalists are more likely to be used by CAM consumers who have ‘higher’ beliefs in natural remedies, holistic health, spirituality and environmentalism, and have a positive attitude towards CAM. On the other hand CAM consumers using ‘established’ CAM health services such as chiropractors and massage therapy, have lower beliefs around holistic health, natural remedies and spirituality. According to Robinson et al. (2009) CAM consumers of these ‘established’ CAM services tend towards a more conventional approach to medicine.

### **2.5.5 Classification systems chosen for this research**

Although an oppositional definition is supported by some (for example, Eisenberg, 1993), many believe a positive inclusive definition of ‘what it is’ is actually more helpful (Ernst, 1995). The Cochrane Collaboration’s operational definition and classification system has gone some way to providing a comprehensive field list that enables researchers of CAM to categorise what CAM includes, and create synergy around future research. This researcher

believes an inclusive approach and a comprehensive classification system to define CAM is important for future research on CAM health services. Therefore this research uses the Cochrane Collaboration's classification system for selecting participants for the study, to ensure the results could be compared with international research on CAM, and to give the research credibility. Robinson et al's. (2009) holistic health care-conventional medicine continuum model is also used to help guide the selection of participants to ensure 'popular' CAM health services consumers use are targeted. Although the model is limited to 'popular' CAM services it provides an excellent framework in which to understand CAM users. Like scholars before them, in particular Astin (1998), Robinson et al's. (2009) research shows that CAM services are diverse and are used by people on the basis of their beliefs, characteristics, and health concerns. Understanding why people use CAM health services is critical to understanding what value is gained, and how value is co-created from CAM consumption. It is therefore instructive to now explore the reasons for CAM use.

## **2.6 Underlying Reasons for CAM Use**

The growth and popularity of CAM is an interesting phenomenon considering the controversy over the scientific validity and efficacy of the treatments themselves, and sceptical attitudes towards CAM by mainstream medical practitioners (Berman & Straus, 2004; Hughes, 2008; Thompson & Troester, 2002). Although there are a number of studies on why people use CAM (see Astin, 1998; Astin et al., 1998; Bishop et al., 2008; Furnham & Lovett, 2001; Lindeman, 2011; Vincent & Furnham, 1996) the underlying reasons are still poorly understood (Lindeman, 2011). Lyons and Chamberlain (2006) argue that the question of who benefits from CAM use and how CAM use relates to a CAM consumer's understandings of health and illness is also under researched. To address these questions regarding the underlying reasons why people use CAM and who benefits from CAM use, an extensive review of the extant literature was carried out by the researcher of this study.

A review of the literature revealed six key underlying reasons for CAM use and include: 1) Philosophical orientation and postmodern values; 2) Disenchantment with orthodox medicine and modern health worries (MHW); 3) Empowerment and self-responsibility; 4) Holistic approach; 5) Natural underpinnings; 6) Spiritual, intuitive and paranormal beliefs. A summary of each theme is outlined in Table 2 along with a chronological list of

**Table 2: Summary of literature review on the themes that emerged on key reasons why people use CAM**

Main Reason	Summary	Literature in chronological order	
Philosophical Orientation & Postmodern values	People's attitudes, values and beliefs towards health, health care and life. Postmodern health values include: a preference for 'natural' products, belief in holism, self-responsibility and empowerment.	Goldstein et al. (1988) Coward (1989) Furnham & Kirkcaldy (1996) Kelner & Wellman (1997a) Ray (1997) Astin et al. (1998) Kaptchuk & Eisenberg (1998) Siahpush (1998, 1999a)	Ray & Anderson (2000) Furnham & Lovett (2001) Andrews (2002) O'Callaghan & Jordan (2003) Nichter & Thompson (2006) Bishop et al. (2007) Furnham (2007)
Disenchantment with orthodox medicine and modern health worries (MHW)	Disenchantment with orthodox medicine's philosophy of healing and therapeutic relationships. Modern health worries (MHW) involves people's concerns that their health is impacted by aspects of the modern world, e.g. technology, environmental pollution, pesticides, GMO foods.	Furnham & Smith (1988) Vincent & Furnham (1996) Astin et al. (1998) Siahpush (1999) Barrett et al. (2000) Kelner & Wellman (2001) Sharma (2001)	Andrews (2002) Petrie & Wessley (2002) Bishop et al. (2007) Furnham (2007)
Empowerment & self-responsibility	CAM is 'empowering', where people are encouraged to take responsibility for their own health and gain a sense of control over their health. Active versus passive approach to health	Barrett et al. (2000) Andrews (2002) Hughes (2004) Hutch (2006) Sointu (2006) Gale (2008) Bann et al. (2010)	
Holistic Approach	Treats the whole person in terms of emotional, physical, psychological, spiritual and social factors	Vincent & Furnham (1996) Kaptchuk & Eisenberg (1998) Barrett et al. (2000) Andrews (2002) Hill (2003) Coulter (2004)	Ernst et al. (2005) Fulder (2005) Bishop et al. (2008) van Wersh et al. (2009)
Natural Underpinnings	Basis is from nature and uses natural remedies. Philosophical orientation that believes the body has the natural ability to heal itself.	Coward (1989) Kaptchuk & Eisenberg (1998) Siahpush (1999) Coulter (2004) Nichter & Thompson (2006) Hill-Sakurai et al. (2008)	
Spiritual, Intuitive & Paranormal Beliefs	Sense of connection with oneself, the universe and the divine.	Goldstein et al. (1988) Vincent & Furnham (1996) Astin (1998) Kaptchuk & Eisenberg (1998) Andrews (2002) Hill (2003)	Capsi et al. (2004) Petry & Finkel (2004) Hutch (2006) Bishop et al. (2007) Jeswani & Furnham (2010) Lindeman (2011)

literature that contributes to each category. Although six different themes surfaced in the review of the literature it was a person's 'philosophical orientation' that appeared to be the dominant dimension that influenced CAM use. Postmodern values have also greatly contributed to CAM's increasing popularity. Philosophical orientation and postmodern health values appeared to run through all the other five reasons. However, each reason warrants exploration in its own right therefore a discussion of each theme follows, highlighting the underlying reasons for CAM use.

### **2.6.1 Philosophical orientation & postmodern health values**

A person's philosophical orientation and values towards health (postmodern health values) are considered the main underlying reasons why people use CAM. A discussion of these two aspects follows and concludes that underlying attitudes, beliefs and values towards health and healing are the best predictors of CAM use.

Philosophical orientation refers to a person's beliefs, attitudes and values towards health, health care and life (Astin, 1998). Astin (1998) concluded from his U.S nationwide study that a key reason for CAM use is because it is consistent with a person's philosophical orientation. The majority of CAM users in the U.S choose alternative medicine because it is "more congruent with their own values, beliefs, and philosophical orientations towards health and life" (Astin, 1998, p. 1548). Having a holistic philosophy of health (belief in the view that body, mind, and spirit are related) was predictive of alternative health care use. Even prior to Astin's (1998) study a number of scholars had argued that people who use alternative health care services do so because they subscribe to a distinctive set of beliefs about health, illness and healing, that is often referred to as an alternative treatment ideology (see Coward, 1989; Furnham & Kirkcaldy, 1996; Goldstein, Sutherland, Jaffe, & Wilson, 1988; Kaptchuk & Eisenberg, 1998; Kelner & Wellman, 1997a, 1997b). Kelner and Wellman's (1997b) study found that some CAM users subscribed to 'an alternative ideology' while others chose CAM for more pragmatic reasons such as 'disenchantment with orthodox medicine'. More recent literature concurs with the 'philosophical, ideology and beliefs' argument (Bishop, Yardley, & Lewith, 2007; Furnham & Lovett, 2001; Lindeman, 2011; Nichter & Thompson, 2006). Furnham and Lovett's (2001) study on predicting the use of CAM found that attitudes, beliefs, subjective norms (social

approval/disapproval), perceived control and past behaviour were good predictors of intentions to use CAM. These intentions were significant predictors of actual use.

Studies have suggested that people are “pulled towards” CAM because of an underlying philosophy and “a new set of health beliefs and values in society, entitled the post-modern philosophy” (O’Callaghan, 2003, p. 28). Postmodern values refers to the shift in values that have signified a transition from the late modern era to postmodernism (O’Callaghan, 2003). A number of postmodern health values have been identified and include: rejection of authority, an increase in consumerism, importance of individual responsibility for health, emphasis on nature and natural remedies, anti-science sentiments and a holistic view of health (Siahpush, 1999a). Several studies have found that subscribing to postmodern values of health were significant predictors of attitudes towards and use of CAM (O’Callaghan & Jordan, 2003; Siahpush, 1998, 1999a). O’Callaghan and Jordan (2003) concluded that an emergence of postmodern values of health can partly explain the increased popularity of CAM. Interestingly, Siahpush (1999b) found that CAM users do not reject mainstream medicine and science outright. Many believed there were circumstances when medical science and technology was useful.

These findings suggest that CAM use may reflect a cultural paradigm shift towards health care from an emphasis on curing sickness to creating wellness (Prahalad & Ramaswamy, 2004). In fact Astin et al. (1998) found belonging to the value group ‘cultural creatives’ was a significant predictor of consumer use of CAM as was having higher education. ‘Cultural Creatives’ described by Ray (1997) and Ray and Anderson (2000) are a group of Americans who have a distinct set of values that are argued to be emerging beyond modernism to become what is called ‘Trans-Modern’. Based on 12 years of survey research, 100 focus groups and dozens of interviews, Ray and Anderson’s (2000) study presents a complex portrait of this emerging group. The core values this group hold include: concern for environment and social issues; feminism; love of foreigners and the exotic; altruism and interest in self-actualisation, personal growth and spirituality; belief in authenticity, holism and everything natural, believing that body, mind, and spirit is unified. Cultural Creatives who make up approximately 26% of the U.S population are considered the core market for psychotherapy, alternative health care, and natural foods (Ray, 1997; Ray & Anderson, 2000).

In New Zealand this group could be compared to what Lawson, Todd and Evans (2006) term 'Educated Liberals' who make up 9.4% of the New Zealand population. 'Educated Liberals' are progressive and egalitarian who value equality, social justice and the environment along with "creativity, love and inner harmony" (p. 11). Food choices for this group tend to be healthy and natural with a preference for fresh produce and organic foods. Seventy percent of the Educated Liberals are female between the ages of 35-60 years, highly educated with high household incomes. Interestingly, there has been little growth in this group in New Zealand 2000 (Lawson et al., 2006). Lawson et al. (2006) have observed an overall trend of conservatism and a shift to traditional values, which is opposite to what Ray and Anderson (2000) proclaim is happening in the U.S. Kelner and Wellman (1997b) argue that there is an increasing number of what they term 'smart consumers' who are seeking better health and making informed choices about health care. This 'smart consumerism' is thought to reflect the growing interest in CAM and a wider consumer interest in health and body matters in Western society.

### **2.6.2 Disenchantment and modern health worries**

Despite a growing body of literature that suggests CAM consumers are 'pulled' to CAM because of CAM's health and healing philosophies, there is still debate among scholars about whether some CAM consumers are 'pushed' away from mainstream medicine towards CAM health care due to disenchantment and bad experiences. This section discusses the literature that supports the notion that some CAM consumers have become disenchanted with mainstream medicine and associated aspects, such as the pharmaceutical industry. It also discusses the concept of modern health worries (MHW) which has also had an impact on consumers' choices of health care. The section concludes that there is evidence to suggest that consumers are both 'pushed' and 'pulled' towards CAM.

Disenchantment and bad experiences of mainstream medicine and medical practitioners is considered one reason why people choose alternative medicine (Furnham & Smith, 1988). According to Astin et al. (1998, p. 2303) "the most frequently cited reason for consumer use of CAM is dissatisfaction with the ability of conventional medicine to adequately treat chronic illnesses". Sharma (2001) argues that dissatisfaction with orthodox medicine is not about medicine's failure to 'cure' a disease or even the medical practitioners' competence

but more about the process of healing that today's health consumers are seeking. Bishop et al. (2007) found those with favourable attitudes and strong beliefs about CAM and holistic approaches to health tended to be the most dissatisfied with conventional medicine. Sharma (2001, p. 103-104) provides five key reasons why CAM consumers have become dissatisfied with conventional medicine:

1. The claim that conventional medicine fails to get at the 'root cause' of chronic illness or fails to take a preventative approach, and can therefore only treat the symptoms.
2. The fear of drugs which might become habit forming, or the dislike of side effects of particular drugs.
3. Fear or dislike of forms of treatment which are seen too radical or invasive.
4. Perceived inability of conventional medicine to cope with the social and experiential aspects of illness.
5. Dissatisfaction with the kind of relationship between doctor and patient which interviewees feel that conventional medicine requires and presupposes

Scepticism and disenchantment towards modern medicine and an increase in CAM use has been associated with high levels of what is termed 'modern health worries' (Furnham, 2007). The term 'modern health worries' (MHW), coined by Petrie and Wessely (2002), relates to concerns that personal health is impacted by aspects of the modern world. Such aspects include supposedly toxic interventions (for example, pharmaceutical drugs, vaccines, amalgam fillings, fluoridation of water), environmental pollution, technology (particularly mobile phone use), tainted food (pesticides, genetically modified food) and radiation. Petrie and Wessely (2002) argue that people's suspicion of modernity has created a distrust of 'experts' and "fostered a migration to complementary medicine" (p. 690).

Some studies have found the 'push' factor to be more dominant than the 'pull', in that, people turn to CAM because they are dissatisfied with "various aspects of conventional medicine practice" such as short length of visits, poor interpersonal attitudes and low availability (Shmueli & Shuval, 2006). The poor therapeutic relationship between patient

and practitioner is often cited as a reason for the disenchantment towards mainstream medicine among CAM users (Andrews, 2002; Kelner & Wellman, 2001). CAM consumers tend to be more critical of mainstream medicine (van Wersch et al., 2009) with complaints of disempowerment, paternalistic manners, standardisation of treatment and insufficient consultation time (Barrett et al., 2000; Kelner & Wellman, 2001). Furnham and Smith (1988), for example, found that patients who seek CAM are less likely to feel satisfied from a short ‘GP consultation’ and prefer the longer sessions that CAM practitioners provide. Siahpush (1999b) discovered that it was dissatisfaction with the medical encounter rather than the practitioner’s ability that led to a favourable attitude towards CAM. Some people favour CAM because they think medical practitioners do not listen, allow enough time, give respect, and enable participation in the healing process.

However, as previously discussed in 2.6.1 other studies have found that CAM users are predominantly ‘pulled’ towards CAM due to their belief and underlying philosophy as opposed to ‘pushed’ away from conventional medicine (Furnham & Forey, 1994; Furnham & Kirkcaldy, 1996; Lovgren, Wilde-Larsson, Hok, Levealahti, & Tishelman, 2011). Astin (1998) found in his U.S national study of CAM users that dissatisfaction with orthodox medicine was not necessarily a good predictor of CAM use but that ‘philosophical orientation’ was a better predictor. Siahpush (1998) concluded the same in his Australian study, stating that ‘postmodern values’ were a better indicator of CAM use than dissatisfaction with orthodox medicine. Furnham and Kirkcaldy (1996) had also observed this phenomenon in their German study. They found that:

Clients who select complementary forms of treatment may do so less from disenchantment with, and bad experiences of, orthodox medical techniques rather than from a deep-seated belief in the effectiveness of complementary medicine (Furnham and Kirkcaldy, 1996, p. 49)

It is argued that any disenchantment with orthodox medicine is primarily due to people’s philosophical orientation towards health and beliefs about CAM and modern medicine as opposed to poor health care and bad experiences. Therefore CAM consumers are both ‘pushed’ and ‘pulled’, often simultaneously. Bishop et al. (2007) found people who use CAM “value non-toxic, holistic approaches to health and hold ‘postmodern belief systems’ while viewing themselves as unconventional and spiritual” (p. 862). Vincent and Furnham

(1996) found that CAM consumers do not appear to be ‘in flight of science’ or to have ‘unusual’ views, but have a belief in the efficacy of CAM treatments and value the “willingness of their practitioner to discuss emotional factors, the explanations given for their illnesses [and] the chance to play an active part in their treatments” (p.47). Kelner (2005) argues that the CAM therapeutic relationship is primarily based on ‘partnership in healing’, whereas orthodox relationships are mostly based on ‘trust in expertise’. Barrett et al. (2000) believes that CAM practitioners facilitate rather than direct the healing process and rely on self-empowerment and personal responsibility for health. Modern health care consumers have greater choice and are becoming actively involved in the management of their health care. Therefore many are choosing private health care services such as CAM because not only does it resonate with their underlying philosophies, beliefs and values on health and healing (pulled), it also provides an empowering alternative to mainstream medical care (pushed).

### **2.6.3 Empowerment and self-responsibility**

Empowerment and self-responsibility are themes that emerged in the literature as key determinants of CAM use. These two terms are described and the literature pertaining to these concepts in CAM is discussed.

The attraction of CAM has been attributed to its empowering nature, where people are encouraged to take responsibility for their own health and gain a sense of control (Andrews, 2002; Bann et al., 2010; Barrett et al., 2000; Barrett et al., 2003; Sointu, 2006). CAM consumers are seeking more equitable practitioner-patient relationships and hence patient empowerment is often cited as a reason why great numbers of people are turning to CAM (Gale, 2008). “In the context of CAM treatment, empowerment reflects a type of support that enables and motivates people to take the necessary steps to manage and improve their health in a self-directed manner. Empowerment has been described as being characterised by responsibility and readiness for change” (Bann et al., 2010, p. 746). Personal empowerment is considered important for health and CAM practitioners tend to focus on personal empowerment more than their conventional counterparts (Barrett et al., 2000). Barrett et al. (2003) points to increasing evidence of people desiring to be in control of their health. This desire for self-responsibility reflects changing societal values. CAM

provides an ideal environment to promote empowerment and self-responsibility due to the 'patient-centred' nature of the CAM therapeutic relationship (Gale, 2008).

Sointu (2006, p. 507) argues that CAM health practices "facilitate the recognition of personal, often emotional concerns" that foster a sense of self-worth and empowerment. Sointu (2006) also believes CAM consumers are looking for a sense of wellbeing as opposed to just health. This need for wellbeing expresses a demand to be "recognised as an active, empowered and knowledgeable agent" (Sointu, 2006a, p. 346). Wellbeing "signif[ies] a sense of rediscovered belonging, and even a sense of rediscovered identity as a full person" (Sointu, 2006, p. 506). Wellbeing in this sense is connected to the idea of the self-responsible, empowered 'contemporary self' as Sointu, 2006a, p. 337-338) identifies:

Being a 'choosing, deciding, shaping human being who aspires to be the author of his or her own life, the creator of individual identity' (Beck 2000: 165) is important in contemporary Western societies where '[e]xploring and engaging with the inner-self has become an important constituent of contemporary identity' (Furedi 2004: 17).

Bann et al. (2010) found evidence that aspects of the CAM therapeutic relationship were associated with empowerment, and this was responsible for shaping the healing experience as well as being linked to beneficial health outcomes. An empowering therapeutic relationship between the CAM practitioner and client is recognised as being a key factor in positive treatment outcomes (Bann et al., 2010).

The flip side of CAM's ideology around 'empowerment' and 'self-responsibility' has been the accusation that CAM practitioners are absolving patient care (Miskelly, 2006). CAM has also been criticised as being consumerist, implying good health can be purchased (Miskelly, 2006; Gale, 2008). The idea of paying for health care is associated with 'individualistic' and 'neo-liberal' ideologies that advocate accepting responsibility for health. Accordingly with this responsibility comes self-blame when health goals are not achieved (Miskelly, 2006) and raises questions about the impacts of 'patient burden' (Alder, Wrubel, Hughes, & Beinfield, 2009) and who is responsible for a person's health (Miskelly, 2006).

There is evidence that the growing interest and use of CAM reflects a larger societal and cultural paradigm shift towards a more holistic, spiritual and empowered way of being

(Astin, 1998; Barrett et al., 2003; Ray, 1997). This has also been recognised in marketing literature where discussion of a new consumer has emerged, one that is well-informed and highly empowered (Baker, 2003; Kotler, Kartajaya, & Setiawan, 2010). An overview of the ‘new consumer’ is discussed later in section 2.7.

#### **2.6.4 Holistic approach**

CAM is considered more holistic than mainstream medicine (Fulder, 2005) which is considered relatively more reductionist (Coulter, 2004). Individuals who seek CAM practitioners generally do so knowing they will be regarded holistically in both diagnosis and treatment (Fulder, 2005). The reason many people use CAM is the emphasis on treating the whole person, in that all aspects of the person are taken into account (Vincent and Furnham, 1996). In this context a holistic approach or ‘holism’ is referred to as “treating the whole person in terms of emotional, physical, psychological, spiritual and social factors” (Barrett et al., 2000). Coulter (2004, p. 113) argues that:

Holism postulates that health is related to the balanced integration of the individual in all aspects and levels of being: body, mind, and spirit, including interpersonal relationships and our relationships to the whole of nature and our physical environment. Holism therefore is contradictory to the notion of reductionism since it holds that the whole is different from, and greater than, the sum of the parts.

Despite the apparent allure of holism, Miskelly (2006) believes that CAM largely ignores societal and individual circumstances, for example, ethnicity, social class, gender, economic circumstances, and educational background. Baer (2003) too argues that because CAM is only interested in the individual and ignores society and its institutions it lacks ‘holism’, an aspect it is often praised for. Miskelly (2006) argues that CAM has adopted such a strong neo-liberal and individualist discourse that advocates individual responsibility which often results in people ‘therapy-hopping’. Paradoxically as a consequence a long-term therapeutic relationship based on principles of holism may be prevented. Conventional medicine on the other hand is more collectivist and is therefore more holistic from a societal public health viewpoint. Nevertheless CAM continues to attract people because of its holistic and personalised approach that empowers people to take control of their own health (Andrews, 2002). As discussed previously this is mostly because CAM is consistent with individual personal values and their philosophical

orientation (Astin, 1998; Barrett et al., 2003; Bishop et al., 2007; Kaptchuk & Eisenberg, 1998).

### **2.6.5 Natural underpinnings**

Natural underpinnings is the foundation of many CAM therapies which advocates natural forms of healing, treatment and medicines that work in harmony with the body (van Wersh et al., 2009). Consumers who use CAM are attracted by this natural aspect, hence this theme consistently arose in the literature (Coulter, 2004; Hill-Sakurai et al., 2008; Kaptchuk & Eisenberg, 1998; Nichter & Thompson, 2006). Once again the reason for using CAM can be related to the power of its underlying shared beliefs and cultural assumptions that most CAM therapies are considered natural and/or has its fundamental premise in nature (Kaptchuk & Eisenberg, 1998). Coulter (2004, p 113) in his study of CAM users found that

most of the CAM groups express a preference for natural remedies. This is bound up with a set of philosophical principles which may be expressed as: the body is built on nature's order; it has natural ability to heal itself; that this is therefore reinforced by the use of natural remedies; that it should not be tampered with unnecessarily through the use of drugs or surgery; and that we should look to nature for the cure.

Other studies support this notion of CAM being natural and supporting the body to heal itself (Hill-Sakurai et al., 2008; Nichter & Thompson, 2006). Hill-Sakurai et al. (2008) in their study of menopausal women discovered that “most women who used CAM valued that it was natural” (p. 621). ‘Natural’ from their perspective sometimes meant gentler or safer than orthodox medication. However, many also described natural in relation to obtaining balance in the body and the body’s ability to heal itself. Nichter & Thompson’s (2006) ethnographic study of supplement use found that some CAM users “expressed overt ideological reasons” for using CAM supplements such as being “natural”. These consumers preferred “natural” medicines for their bodies instead of what they perceive as more “toxic” pharmaceuticals. CAM consumers also reported to be making choices that have positive impacts on others such as using herbal remedies believing they are better for the environment (Nichter & Thompson, 2006). Kaptchuk and Eisenberg (1998) argue that a consumer’s use of ‘natural’ treatments or adhering to ‘nature’s’ healing philosophy is an opportunity to save both the self and the world. In the postmodern world ‘nature and

natural remedies' are highly regarded (Siahpush, 1999a) and viewed as gentle, caring, kind, benevolent and safe (Coward, 1989). In contrast, conventional medicine's use of science and technology is increasingly considered harmful and invasive by CAM consumers (Siahpush, 1999a).

### **2.6.6 Spiritual, intuition and paranormal beliefs**

Lastly, having spiritual, intuitive and paranormal beliefs are themes that arose in recent literature about why people use CAM. Scholars have recognised that the CAM phenomenon is mostly about people's beliefs and values, therefore research has been directed towards uncovering exactly what these beliefs are. This section will discuss each of these three beliefs (spirituality, intuition and paranormal) and its relationship to CAM use.

'Unconventional' spiritual beliefs, rather than formal religious beliefs, have been associated with CAM use (Bishop et al., 2007). Studies have shown that many CAM practitioners see spirituality as an essential component to health and healing (Goldstein et al., 1988; Hill, 2003). These CAM practitioners understand the importance of spiritual experiences and spiritual beliefs in health, illness and healing (Goldstein et al., 1988). For them CAM enables people to connect with a 'power' and/or life-supporting cosmic forces, referred to as vital energy or 'vitalism' (Kaptchuk & Eisenberg, 1998).

This vital energy takes myriad forms: homeopathy speaks of a "spiritual vital essence", chiropractic refers to the "innate", and acupuncture is said to involve the flow of "qi". Ayurvedic medicine is based on the power called "prana", and new age healing practices work with "psychic" or "astral" energies (Kaptchuk & Eisenberg, 1998, p.1062).

Not only do some CAM consumers experience this 'vital energy', their search for health can take on "sacred proportions" enabling a person "to discern ultimate meaning and make profound connections with the universe" (Kaptchuk & Eisenberg, 1998, p. 1063). Consumers of CAM are generally thought to be 'pulled' by the spiritual dimension of CAM that is not seen in orthodox medicine (Vincent & Furnham, 1996). Petry and Finkel (2004) found a direct relationship with spirituality and CAM by using an easily administered measure - Spiritual Involvement and Beliefs Scale (SIBS) that was developed for use in a general medical practice by Hatch, Burg, Naberhaus, & Hellmich (1998). The

scale measures two factors of spirituality; core spirituality (connection, meaning, faith, involvement and experience) and spiritual perspective. Petry and Finkel (2004) found that “persons choosing CAM practitioners for their health care possess a measurably higher level of spiritual involvement” (p. 943).

Despite using the SIBS measurement tool in their study to assess the relationship between CAM use and spiritual beliefs, Petry and Finkel (2004) argue that it is difficult to measure ‘spirituality’ because “the very definition of the construct that we measured is an elusive one” (p. 942). Part of the difficulty of researching spirituality is its “lack of grounding in theoretical and empirical literature” (Giacalone & Jurkiewicz, 2003, p. 17), and its elusive meaning (Petry & Finkel, 2004). Definitions of spirituality vary from ‘meaning and purpose in life’ (Eisler & Montuori, 2003; Post, Puchalski, & Larson, 2000), belief in a higher power (Petry & Finkel, 2004), a sense of connection with oneself, other people, nature, a higher power or spiritual force (Dossey, 2003; Hungelmann, Kenkel-Rossi, Klaasen, & Stollenwerk, 1996) to emotional transcendence where feelings of peace, inner harmony, joy, and ecstasy are experienced (Skousgaard, 2006).

Intuitive reasoning, a process that is unconscious, non-verbal, pragmatic, holistic, and relies on personal experiences, was found to be an underlying reason why so many people believe in CAM (Lindeman, 2011). A number of studies have found a link between a person’s intuition and CAM use (Caspi et al., 2004; Hill-Sakurai et al., 2008; Jeswani & Furnham, 2010; Lindeman, 2011). The decision to use a CAM therapy because it “felt right” is often touted by users, especially those that only adhere to CAM (Caspi et al., 2004; Hill-Sakurai et al., 2008). Caspi et al. (2004) found that CAM users based their treatment decisions on “spiritual signs” or an “intuitive feeling” signalling that it was “right for them”. They argue that the “locus of control to a powerful other (God/spirit)” was particularly evident for consumers who only use alternative forms of medicine. However, Hill-Sakurai et al. (2008) associate user’s intuition more with “listening to one’s own body” (p. 621).

Recent studies have shown that paranormal beliefs correlate with users’ belief in CAM (Jeswani & Furnham, 2010; Lindeman, 2011). Those with higher paranormal belief scores were more likely to believe in CAM, in particular the efficacy of CAM. People who

subscribe to supernatural thinking tended to be attracted to CAM therapies whose frameworks are grounded in the ‘supernatural’, such therapies include Acupuncture, which is based on the idea of chi or vital energy and Reiki, a form of energy healing (Jeswani & Furnham, 2010). Lindeman (2011) also found paranormal beliefs to be related to belief in CAM and argues that belief in CAM, thus CAM use, is better explained in consumers with intuitive reasoning and paranormal beliefs than the usual descriptive variables, such as, demographics, self-responsibility, dissatisfaction with conventional medicine and philosophical orientation (world view).

Interestingly, this more ‘spiritual’ connection with CAM would seem to ‘fly in the face’ of the self-empowered and self-responsibility pursuit of health (Hutch, 2006). On the one hand people are attracted to CAM because it promotes self-responsibility and is empowering, yet evidence suggests people are motivated by their ‘spiritual beliefs’, where dependency on ‘spiritual signs’ and ‘intuitive feelings’ are paramount and control is ceded to an ‘other’. This is an interesting phenomenon which warrants further investigation.

### **2.6.7 Summary of reasons for CAM use**

The philosophical orientation, values and beliefs of CAM consumers are the key underlying reasons why they are drawn to CAM. CAM consumers’ personal philosophical orientation towards health recognises the importance of a holistic, natural, empowering and sometimes spiritual approach. CAM and its various forms of therapies and belief systems advocate and reflect this orientation ‘pulling’ consumers towards it. Health care consumers are also ‘pushed’ towards CAM due to disenchantment with mainstream medicine practice and MHW. Therefore CAM consumers are often both ‘pushed’ and ‘pulled’ towards CAM health care. Although there is strong evidence to support why consumers are using CAM little is known about what CAM consumers actually ‘value’ and how that value is co-created throughout the CAM consumption experience with CAM health services. The themes highlighted in this section such as holistic, natural, spiritual, intuitive, empowerment and self-responsibility may potentially be aspects that consumers’ value from their consumption of CAM health services, however, no research has been found to directly support this connection.

## 2.7 The CAM Consumer

In seeking to explore how consumers of CAM engage in co-creating value and what value they gain from consuming CAM, we must first attempt to understand who the CAM consumer is and examine the nature of today's consumer as the key protagonist. As previously discussed it is thought the CAM consumer holds postmodern values particularly towards health and healing (Siahpush, 1998, 1999, 1999a). Does the CAM consumer epitomise the postmodern consumer or what is often referred to as the 'new' consumer?

There has been much discussion and debate about the 'new consumer' in consumer literature: Who are they? Why are they important? How did they emerge? (Baker, 2003; Goldsmith, 2001; Lewis & Bridger, 2000; Prahalad & Ramaswamy, 2004a). Lewis and Bridger (2000) in their book, *The Soul of the New Consumer*, defines the 'new consumer' as individualistic, involved, independent and informed with an over-riding quest for authenticity. Old consumers, who still exist alongside new consumers, are relics from the 'production orientated' economy and described as conformist, uninvolved and uninformed. Unlike the 'new consumer's' drive for authenticity old consumers are motivated by a need for convenience. Although the book is criticised for lacking in empirical research and adding little to consumer research (Goldsmith, 2001), it does provide an interesting account of, if not insight, into the changing profile of the consumer that contemporary marketing scholars are espousing (see Achrol & Kotler, 1999; Baker, 2003; Grönroos, 2008; Gummesson, 2002; Holbrook, 1994; Kotler et al., 2010; Prahalad & Ramaswamy, 2004, 2004a; Skousgaard, 2006; Stuart-Menteth, Wilson & Baker, 2006; Traulsen & Noerreslet, 2004; Vargo & Lusch, 2004; Woodruff, 1997). These consumers are described as more empowered (Kotler et al., 2010) and involved in the products and services they consumer. Kotler, et al. (2010, p. 4) believe "we are witnessing the rise of a values-driven era". They talk of consumers as "whole human beings with minds, hearts, and spirits", who not only want functional and emotional fulfilment but "human spirit fulfilment in the products and services they choose". Baker (2003) in her book *New Consumer Marketing: Managing a Living Demand System* also talks about a new breed of consumer who is well-informed and highly empowered. Baker's (2003) approach is based on a 'value-centric orientation' where value co-creation and value delivery are at the heart of all marketing activity.

Prahalad and Ramaswamy (2004) concur with the changing role of the consumer from isolated to connected, from unaware to informed, from passive to active. The impact of this new consumer role has manifested because of technological advances enabling increased access to information globally, consumer networking and activism, plus providing opportunities for consumers to experiment with and develop products. Prahalad and Ramaswamy (2004) challenge the traditional notion of value and its creation, in that firms create and exchange value with consumers. These authors argue that the future of competition will require firms to co-create value with their consumers and thus will have to engage consumers in the co-creation of value. This engagement will involve personalised interactions that are meaningful and sensitive to an individual consumer. It is the co-creation experience, not the specific offering, which forms the basis of unique value. Prahalad and Ramaswamy (2004a) identified four consumer choice dimensions which they think condition the co-creation experience. First, consumers want freedom to interact with the firm via a variety of ways; second, consumers want to define choices that reflect their desires; third, consumers want to interact and transact quickly, easily, conveniently and safely; and fourth, consumers want their consumption experiences to be fairly priced (i.e. what they are willing to pay for).

The shift from a production-driven economy to a consumer-oriented society was highlighted by Baudrillard (1988). He argued that value is created during the consumption process and not at the point of value exchange as has been argued by economist for centuries. This is especially pertinent in health care where a new consumer is emerging, one that is “information strong, information seeking, non-authoritarian and increasingly demanding” (Traulsen & Noerreslet, 2004, p. 203). Kelner and Wellman (1997b) in their study on health care and consumer choice concluded that many consumers feel free to choose from a range of health care options, from traditional medical care to alternative therapies in the search for better health and personal growth. Kelner and Wellman (1997b, p. 211) concur with the new consumer sentiment in health care.

We are seeing increasing numbers of “smart consumers”; people who are well informed about health issues and up-to-date on the latest “infomessage” from the media. These are consumers who prefer to use their own judgement and the guidance of personal referrals to make health care decisions...Their decisions are individual ones, in which they act as concerned consumers rather than compliant patients

Despite some obvious advantages for the empowered new consumer Rotfeld (2003, p. 7) warns “that in health care, the customer does not always know best”. The informed consumer is not necessarily a good thing. Rotfeld (2003) believes that not all health consumer needs should be satisfied because they are not the medical expert. Pandering to consumers’ new found autonomy may not be in their best interest (Miskelly, 2006). In fact Miskelly (2006) in her study on ‘healing pluralism and responsibility’ found that patients of health care (orthodox, integrative and CAM) wanted to share the responsibility of their health with their health practitioner. Accordingly the orthodox model provides a more secure ‘collectivist’ discourse than does the ‘neoliberal’ and ‘individualist’ ideology of CAM, where taking responsibility for your own health is paramount. In her study, Miskelly (2006, p.249) notes that although “the fostering of individual responsibility for health and wellbeing further enhanced patient perceptions of CAM”, the reality was patients did not necessarily want to take full responsibility for their own health. On the other hand, Long (2009) argues that CAM has the potential to contribute to the area of health promotion because it naturally supports individuals to take control of their own health and fosters behaviour change (Long, 2009).

## **2.8 Summary of CAM Literature**

CAM health services offer an interesting and worthwhile context to study consumer behaviour. Current research in the area has begun to provide evidence that the growth in CAM is primarily due to people’s changing beliefs, values and personal orientation towards health and healing. People are seeking more natural, holistic, and empowering health services, that considers the ‘whole’ person in terms of mind, body and spirit. Although research on CAM is beginning to emerge from a marketing and consumer perspective there are still many gaps particularly in terms of consumers’ experiences, consumers’ perceived value of their experiences and value co-creation between consumers and CAM service providers (Vos & Brennan, 2010). Research now needs to focus on consumers’ experiences of CAM services to determine the value CAM consumers are gaining from using this form of health care and how they co-create value. It is pertinent now to explore the literature on consumer value and value co-creation.

## **2.9 Introduction to Literature on Value**

‘Value’, a simple yet complex word, has had philosophers and scholars debating the meaning of this nebulous and elusive concept since time immemorial. This researcher is no exception as she grappled with the huge literature on ‘value’ and tried to make sense of what she believes is an important concept to not only her thesis topic on consumer value and value co-creation in CAM health services, but to marketing and consumer literature per se. As Babin and James (2010, p. 472) argue “value must be understood to understand marketing”. Many marketing scholars concur about the importance of understanding ‘value’ in marketing (see Grönroos, 2006a; Grönroos, 2008, 2011a; Gummesson, 1995; Vargo & Lusch, 2004; Woodall, 2003; Woodruff & Gardial, 1996) despite it being ill defined and elusive (Vargo, Maglio, & Akaka, 2008; Woodall, 2003).

Before delving into consumer value and value co-creation, the key concepts being used in this thesis, it is important that the broader term ‘value’ be explored. This section begins with an overview of the concept of value from an axiological and economic perspective. It then explores the literature on value, consumer value and value co-creation in marketing. Lastly, literature on consumer value and value co-creation within health care services is considered.

## **2.10 The Concept of Value**

The concept of value has been in contention since the days of Aristotle (Vargo et al., 2008). Part of its elusiveness comes from the multiple meanings and perspectives applied to value concepts in the literature (Grönroos & Raval, 2011; Woodruff & Gardial, 1996). One of the main confusions, in marketing and consumer literature anyway, has been the difference between ‘value’ (singular) and ‘values’ (plural), which many marketing scholars assume are the same concept (Sánchez-Fernández & Iniesta-Bonillo, 2006). Values (plural) pertains to personal values (enduring beliefs, norms, goals, ideals) that a consumer holds (Blackwell, D’Souza, Taghian, Miniard, & Engel, 2007). Classification schemes such as ‘Values and Life Style’ (VALS) (Mitchell, 1983), Rokeach Value Scale (RVS) (Rokeach, 1973, 1976) and ‘List of Values’ (LOV) (Kahle, Sharon, & Homer, 1986) have been developed to measure consumers’ values. The singular ‘value’ on the other hand is concerned with evaluative judgements of products/services and/or consumption

experiences (Holbrook, 1994, 1999), which are often influenced by consumers' personal values (Sánchez-Fernández & Iniesta-Bonillo, 2006). This researcher agrees that much confusion about the concept of value has been due to the misconception of the words 'value' and 'values', however, she also argues that a consumer's 'values' will ultimately influence how a consumer will 'value' a product or service and therefore the two concepts are interrelated. The influence of a consumer's values is particularly relevant to CAM health services, where CAM consumers, as discussed in 2.6.1, have chosen CAM because of their underlying philosophical beliefs and values towards health and healing. Therefore it is assumed that CAM consumers will value their CAM consumption experiences based on their values. This interrelationship is explored further in 2.14.1.

'Value' has its "roots in many disciplines, including psychology, social psychology, economics, marketing, and management" (Woodruff & Gardial, 1996, p. 54). Pitta and Laric (2004, p. 452) agree "value has been approached from an eclectic perspective building on the fields of economics, strategy, organizational behaviour, psychology, social psychology, biology and others. Each field has contributed to knowledge about value." For the purpose of this review 'value' will be discussed from a 'philosophical (axiological)', 'economic', and 'marketing' perspective as the researcher considered these aspects to be important in the development of concepts such as consumer value and value co-creation.

## **2.11 Axiology - Philosophical Theory of Value**

The philosophical theory of value, known as Axiology, is important to understand when studying the concept of value, particularly within a complex service consumption context as CAM health services. Axiology considers 'value' as a broad concept that constitutes all the things considered important to a person, and essentially arises out of our experiences with life. The value of experiencing CAM health services is believed by this researcher to be both broad and deep, from functional value, such as treatment results, through to deeper meaning such as spiritual value. An overview of axiology is now presented.

Axiology is a relatively new discipline and was first coined by Paul Lapie and Eduard von Hartmann in the early 1900s (Hart, 1971; Rämö, 2004). The term axiology, known as the 'Theory of Value', comes from the Greek words "axios" meaning worthy or worth and "logos" meaning science or theory (Britannica, n.d; Hart, 1971). Axiology is a branch of

philosophy that contemplates the nature of value and considers what ‘things’ have value (Arneson, 2009). Often referred to as the ‘science of values’, axiology sits alongside “metaphysics” (inquiry into existence) and “epistemology” (knowledge) and is thus considered one of the three most general philosophical sciences (Bahm, 1993). According to Bahm (1993) all other sciences may sit in one of these three areas – metaphysical, epistemological and/or axiological, with some sciences in all three. Axiology is the most fundamental value science and includes:

aesthetics: the science of beauty, ugliness and fine art; ethics: the science of oughtness, duty, rightness and wrongness; religiology: the science inquiring into the ultimate values of life as a whole; and economics: the science of wealth and [illth] relative to the production, distribution, and consumption of goods (Bahm, 1993, p. 4).

“Subsciences” that deal or involve value in their inquiries, such as the psychological, sociological, historical, anthropological and political sciences would therefore all fall under axiology (Bahm, 1993). Grünberg (2000) argues that in modern society axiology is a term that best designates a general theory of value. In this sense, axiology is broadly concerned with all forms of value including the aesthetic value of beauty, the ethical value of good/bad and right/wrong, and the epistemic value of truth, rationality and justification (Arneson, 2009; Hiles, 2008). Value types including “truth, utility, goodness, beauty, right conduct, and obligation”, with a “direct focus on the purported value of matters such as human life, knowledge, wisdom, freedom, love, justice, self-fulfilment, and well-being” (Hiles, 2008, p. 2) are all covered within axiology.

Although the philosophical study of value “dates back to the 6<sup>th</sup> and 5<sup>th</sup> centuries BCE” (Arneson, 2009, p. 2) axiology attempts to bring the diverse nature of value under a single heading (Hiles, 2008). As Hart (1971) points out,

the problems and issues axiology investigates have been with us from the moment man [woman] began to reflect upon conditions of his [her] life, the structure of reality, the order of nature and man’s [woman’s] place in it ... Inquiry into the claims, truth, and validity of value judgement is a necessity of life itself. The concept of value permeates our life at every step. We prefer one thing to another, we shift our attention from one event to another, we praise one behaviour and condemn another, we like and dislike, and whenever we do it we value. Behind our passions, interests, purposive actions is the belief that they are worthwhile. We

attach to them different degrees of importance or value (Hart, 1971, p. 29).

Historically there has been “intense and diversified thinking on value[s]” (Hart, 1971, p. 30) where aspects such as economic, moral, and aesthetic value have been considered in relative isolation (Britannica, n.d). According to Hiles (2008) the nature of value has had a long and “contentious” history, with Aristotle seeing value as “human interest” and desire, Plato as “essences that are known through intuition”, neo-Kantian philosophers as “objective and universally valid”, and existentialists, such as Nietzsche and Sartre as “constructions” (products of human invention). Hiles (2008, p.2-3) argues that “whatever perspective is taken, it would seem that value is clearly not a property of the thing-in-itself, it cannot be perceived by the senses, and it cannot be measured scientifically, but somehow it arises out of our relationship with things”. Likewise McKnight (1994, p. 466) states “an entity possesses value if it satisfies a need or want of a living organism. This is the prerequisite of all value”.

This researcher agrees with Holbrook (1994, p. 26) who “suspects that axiology has important lessons to teach marketing and consumer researchers concerned with the nature of customer [consumer<sup>5</sup>] value. Yet it is a perspective that has been seriously neglected”. Holbrook (1994, 1999) provides a framework of ‘consumer value’, drawing on axiology (i.e. the theory of value), where he proposes a concept of consumer value that is relevant to consumer behaviour (see later section 2.13.5 for a full discussion of Holbrook’s typology of consumer value). An axiological perspective on value is somewhat different to that held by classical economists, such as Adam Smith, David Ricardo and Karl Marx, who supported the idea that “value” is embedded in ‘things’ (objects, products, goods etc.) and is created in the production process (Woodall, 2003), from which initial marketing theory was born. The economic concept of value is now discussed.

## **2.12 Economic Concept of Value**

A literature review on ‘value’ cannot ignore the influence that economic scholars have had on its meaning and conceptualisation. Arguably the economic perspective of value has

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<sup>5</sup> Holbrook (1994) used the term ‘customer’ value and then in 1999 changed it to ‘consumer’ value in his book entitled “Consumer Value: A framework for analysis and research”.

dictated marketing thinking since its inception. The economic meaning has long permeated the concept of value (Grunberg, 2000), specifically the ideas of value-in-exchange versus value-in-use (Grönroos & Ravald, 2011; Vargo & Lusch, 2004; Woodall, 2003; Woodruff & Gardial, 1996). Aristotle, who is considered by many scholars to be the ‘father of value theory’, unbeknown to himself began the use value and exchange value schools of thought (Gordon, 1964). Aristotle supported use value (the consumer utility approach) more than exchange value (production labour-orientated approach) through his observations that value has the ability to satisfy wants and is gained through the use of the good or service. Gordon (1964) believes the philosopher’s key thinking on use value is expressed in the proposition “the use value of an article or a service derives from its being productive of the individual person’s good” (p. 117). He quotes Aristotle:

Thus (e.g.) the relation of the pleasant to pleasure is like that of the useful to the good; for in each case the one produces the other. If therefore pleasure be a kind of “good,” then also the pleasant will be a kind of “useful”: for clearly it may be taken to be productive of good, seeing that pleasure is good (cited in Gordon, 1964, p. 117).

Other scholars agree that Aristotle created the concept of value-in-use and distinguished it from value-in-exchange (see Kauder, 1953; Younkins, 2005). Despite this a value-in-exchange labour-orientated approach dominated thinking for centuries. Classical economists Adam Smith, David Ricardo and Karl Marx all supported the labour theory of value which held that the value of any good depended upon the amount of labour spent producing it (Pressman, 1999a), and value-in-exchange idea where value is simply “what can be ‘got’ for an item” (Woodall, 2003, p. 3). Essentially “these economists regarded value as being an intrinsic part of commodities” and believed that the sum of the costs of “land, labor, and capital” was what created value (McKnight, 1994, p. 465).

Adam Smith, a pioneer of value theory and “father of economics” (Pressman, 1999b, p. 20), was very familiar with Aristotle’s work and was thought to be influenced by a number of passages in Aristotle’s writings that could be interpreted as meaning that he too thought that cost (in particular labour) was connected with the process of value determination (Gordon, 1964). Kauder (1953) argues that Adam Smith in his support of a labour, rather than a utility theory of value, thwarted the course of value-in-use and led to value being regarded as something that is an intrinsic part of products, goods and services. Vargo,

Maglio and Akaka (2008) attribute the foundations of the traditional goods dominant (G-D) logic to Adam Smith's value-in-exchange ideas. The idea that value is embedded and distributed in tangible goods and provides the basis for an exchange became the focus of not only economic science but also disciplines like marketing that followed economic models.

The Austrian school of economics in the late nineteenth century, led by Carl Menger, questioned the labour oriented and exchange theory of value and argued that "value is a product of a commodity's marginal utility" (McKnight, 1994, p. 466). Menger was one of the first economists to discover the marginal utility theory of value and was an early advocate of a subjective theory of value. Value, Menger argued, is determined by subjective factors (utility or demand) rather than by objective factors (the cost of production or supply). Value from this perspective comes from the satisfaction of human needs where factors of production have value because they satisfy wants and are needed to produce goods that people desire (Pressman, 1999). This concept is synonymous with the value-in-use idea (McKnight, 1994).

In the last decade there has been a resurgence of the value concept in marketing literature initiated by Lusch and Vargo's (2004) inaugural article *Evolving to a new dominant logic for marketing*. Vargo and Lusch (2004) proposed that marketing thinking needed to shift away from the economic goods based model of exchange towards a new marketing perspective where a service-dominant view needs to prevail. They argue that marketing has been dominated by a logic based on the exchange of "goods", where "tangible resources, embedded value, and transactions" (p. 1) have been the focus. Vargo and Lusch (2004) proposed a service-dominant logic (S-D logic) where "value is perceived and determined by the consumer on the basis of "value in use" (p. 7). This idea is not new in marketing with a number of scholars (see Grönroos, 1994; Gummesson, 1998; Holbrook, 1994, 1999; Prahalad & Ramaswamy, 2004, 2004a; Prahalad & Venkat, 2004b; Ravald & Grönroos, 1996; Woodall, 2003; Woodruff, 1997), to name a few, having alluded to this concept previously. However, Vargo and Lusch's (2004) S-D logic has captured marketing scholar's imagination in the literature that these former efforts did not. S-D logic is discussed later in 2.13.2, but first it is imperative to review the concept of value in marketing and show its evolution.

## 2.13 Concept of Value in Marketing

The concept of value in marketing has had a long history with the value-in-exchange idea still dominating the discipline. Marketing textbooks are still espousing the thought that marketing is about ‘exchange’ and exchange is “the process by which some transfer of value occurs between a buyer and a seller” (Solomon, Charbonneau, Marshall, & Stuart, 2012, p. 9). Babin and James (2010) argue that value is an important marketing concept but has “often taken a back seat to more focal concepts such as quality and satisfaction” (p. 472). However, over the past 15 years a number of marketing scholars (see Boksberger & Melsen, 2011; Grönroos, 2008, 2011a; Gummesson, 2008; Holbrook, 1999, 2006a; Prahalad & Ramaswamy, 2004; Prahalad & Venkat, 2004b; Sánchez-Fernández & Iniesta-Bonillo, 2006, 2007; Sánchez-Fernández, Iniesta-Bonillo, & Holbrook, 2009; Vargo & Lusch, 2004, 2006, 2008; Vargo et al., 2008; Woodall, 2003; Woodruff, 1997) have attempted to study ‘value’ with the intention of defining and understanding its role within marketing and consumer behaviour. The concept of value within marketing and consumer research remains “abstract and polysemous” (Gallarza & Gil-Saura, 2006, p. 438) and “nebulous” (Sánchez-Fernández & Iniesta-Bonillo, 2007, p. 428). Value, with its multiple meanings and various terms, is one of the most overused and misused concepts in the social sciences, particularly in marketing and management literature (Khalifa, 2004). Within marketing, terms and concepts such as perceived value (Boksberger & Melsen, 2011; Sánchez-Fernández & Iniesta-Bonillo, 2007; Sweeney & Soutar, 2001; Zeithaml, 1988), customer value (Gallarza, Gil-Saura, & Holbrook, 2011; Holbrook, 1994; Khalifa, 2004; Woodruff, 1997; Woodruff & Gardial, 1996), consumer value (Holbrook, 1999; Sánchez-Fernández & Iniesta-Bonillo, 2006; Sánchez-Fernández et al., 2009), ‘value for the customer’ (Woodall, 2003), value creation (Grönroos, 2011b; Grönroos & Ravald, 2011; Iniesta-Bonillo, Sánchez-Fernandez, & Cervera-Taulet, 2012; Lusch, Vargo, & Wessels, 2008; Sheth & Uslay, 2007), and co-creation of value (Babin & James, 2010; Cova, Dalli, & Zwick, 2011; Fisher & Smith, 2011; Grönroos, 2008, 2011a; Lusch & Vargo, 2011; Payne, Storbacka, & Frow, 2008; Prahalad & Ramaswamy, 2004a; Vargo et al., 2008; Zwick, Bonsu, & Darmody, 2008) have arisen adding to the confusion. Sánchez-Fernández & Iniesta-Bonillo (2006) provide an extensive chronological list of definitions for the concept of consumer value showing how the concept has evolved and

demonstrating the diversity that exists in the literature (Table 3). Definitions by Grönroos (2000, 2008), Woodall (2003), Vargo and Lusch (2004) and Vargo et al. (2008) have been added to the table to provide an extended updated version.

**Table 3: An evolution of illustrative contributions to defining the concept of consumer value (based on Sánchez-Fernández & Iniesta-Bonillo, 2006)**

<b>Authors</b>	<b>Definitions</b>
Holbrook and Corfman (1985); Holbrook (1994, 1999, p.5)	“I define consumer value as an interactive relativistic preference experience” <sup>6</sup>
Zeithaml (1988, p. 14)	‘Perceived value is the consumer’s overall assessment of the utility of a product based on perceptions of what is received and what is given’
Lichtenstein, Netemyer and Burton (1990, p.54)	“We can define value as the ratio of quality to price”
Monroe (1990, p. 51)	“Buyers’ perceptions of value represent a balance between the quality or perceived benefits of the product compared to the perceived sacrifice by the payment of the price”
Dodds et al. (1991, p. 308)	“The cognitive trade-off between perceptions of quality and sacrifice results in perceptions of value”
Liljander and Strandvik (1993, p. 14)	“Perceived value equals perceived benefits/perceived price”
Gale (1994, p. xiv)	“Customer value is market-perceived quality adjusted for the relative price of your product”
Rust and Oliver (1994, p.7)	“Value is some combinations of what is received and what is sacrificed”
Hunt and Morgan (1995, p.6)	“Value refers to the sum total of all benefits that consumers perceive they will receive if they accept the market offering”
Butz and Goodstein (1996, p.63)	Customer value is “the emotional bond established between a customer

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<sup>6</sup> A full definition of Holbrook’s (1994, 1995) concept of consumer value (CV) includes: Interactive – CV involves an interaction between a subject (consumer or customer) and an object (product, service, good, person etc) ; Relativistic – CV is comparative (involving preferences among objects); personal (varying across people); and situational (specific to the context) ; Preferential – CV embodies a preference judgement (favourable disposition, general liking, positive affect etc); Experience – CV resides not in the product purchased, not in the brand chosen, not in the object possessed, but rather in the consumption experience(s) derived there from.

	and a producer after the customer has used a salient product or service produced by that supplier and found the product to provide an added value”
Fornell, Johnson, Anderson, Cha and Bryant (1996, p.9)	Perceived value is “the perceived level of product quality relative to the price paid”
Woodruff and Gardial (1996, p. 54) <sup>7</sup>	Customer value is the customers’ perceptions of what they want to have happen (i.e. the consequences) in a specific use situation, with the help of a product or service offering, in order to accomplish a desired purpose or goal.
Woodruff (1997, p 142)	“Customer value is a customer’s perceived preference for and evaluation of those product attributes, attribute performances, and consequences arising from use that facilitates (or block) achieving the customer’s goals and purposes in use situations”
Sinha and DeSarbo (1998, p.236)	“Value is quality that the consumer can afford”
Sirohi, McLaughlin and Wittink (1998, p.228)	“We define value as ‘what you get for what you pay”
Oliver (1999, p. 45)	“Value is a positive function of what is received and a negative function of what is sacrificed”
Grönroos (2000, pp.24-25)	“Value for customers is created throughout the relationship by the customer, partly in interactions between the customer and the supplier or service provider. The focus is not on products but on the customers’ value-creating processes where value emerges for customers and is perceived by them”.
Lapierre (2000, p. 123)	“Customer-perceived value can, therefore, be defined as the difference between the benefits and the sacrifices (e.g. the total costs, both monetary and non-monetary) perceived by customers, in terms of their expectations, i.e. needs and wants”
McDougall and Levesque (2000, p. 394)	“Broadly defined, perceived value is the results or benefits customers receive in relation to total costs (which include the price paid plus other costs associated with the purchase). In simple terms, value is the difference between perceived benefits and costs”
Oliva (2000, p.56)	“Customer value is the hypothetical price for a supplier’s offering at which a particular customer would be at overall economic breakeven, relative to the best alternative available to the customer for performing the same set of functions”

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<sup>7</sup> Added Woodruff and Gardial (1996) definition of customer value to compare with Woodruff (1997) definition.

Slater and Narver (2000, p. 120)	“Customer value is created when the benefits to the customer associated with a product or a service exceed the offering’s life-cycle costs to the customer”
Kothandaraman and Wilson (2001, p.380)	“Value is the relationship of a firm’s market offering and price weighed by the consumer against its competitor’s market offering and price”
Van der Haar et al. (2001, p.628)	“The customer value concept assess the value a product offers to a customer, taking all its tangible and intangible features into account”
Walter, Ritter and Gemunden (2001, p.366)	“We understand value as the perceived trade-off between multiple benefits and sacrifices gained through a customer relationship by key decision makers in the supplier’s organization”
Afuah (2002, p. 172)	“The value that a customer attaches to the characteristics is a function of the extent to which they contribute to the consumer’s utility or pleasure”
Chen and Dubinsky (2003, p. 326)	“Perceived customer value is “a consumer’s perception of the net benefits gained in exchange for the costs incurred in obtaining the desired benefits”
Woodall (2003, p.21)	Value for the customer (VC) is any demand-side, personal perception of advantage arising out of a customer’s association with an organisation’s offering, and can occur as reduction in sacrifice; presence of benefit (perceived as either attributes or outcomes); the resultant of any weighed combination of sacrifice and benefit (determined and expressed either rationally or intuitively); or an aggregation, over time, of any or all of these.
Vargo and Lusch (2004, p7)	“Value is perceived and determined by the consumer on the basis of “value in use.” Value results from the beneficial application of operant resources sometimes transmitted through operand resources. Firms can only make value propositions.”
Grönroos (2008, p. 303)	“Value for customers means that after they have been assisted by a self-service process (cooking a meal or withdrawing cash from an ATM) or a full-service process (eating out at a restaurant or withdrawing cash over the counter in a bank) they are or feel better off than before”
Vargo, Maglio and Akaka (2008, p.148)	“Value results from the beneficial application of operant resources, which are sometimes transmitted through operand resources or goods, from this view, value is co-created through the combined efforts of firms, employees, customers, stockholders, government agencies, and other entities related to any given exchange, but is always determined by the beneficiary (e.g., customer)”

Recently a number of marketing scholars (in particular Boksberger & Melsen, 2011; Grönroos, 2008; Sánchez-Fernández & Iniesta-Bonillo, 2006, 2007; Vargo et al., 2008; Woodall, 2003) have attempted to unravel the concept of value within a marketing context and provide either extensive reviews of the literature and/or provide a theoretical framework for the concept of value. In an attempt not to ‘reinvent the wheel’ an overview of what these scholars found and/or are conceptualising is outlined below.

This section starts with Woodall’s (2003) conceptualisation of ‘value for the customer’ which attempts to capture a range of associated and existing value concepts into one framework. After which emerging ideas on value such as Vargo and Lusch’s (2004, 2006, 2008) Service-Dominant (S-D) logic ‘co-creation of value’ and the Nordic School’s services marketing scholars Grönroos (2008, 2011a) and Gummesson and Grönroos (2012) concept of ‘value creation’, are discussed and debated. The researcher’s view on the use of S-D logic’s value co-creation as a theoretical lens for this study is then outlined. A review of the literature pertaining to the concept of consumer value is then given, and lastly Holbrook’s (1994, 1999) typology of consumer value and Sánchez-Fernández, Iniesta-Bonillo and Holbrook’s (2009) model are presented and discussed as a potential framework to guide this research.

### **2.13.1 Value for the customer (VC)**

Woodall (2003) was arguably one of the first to propose a conceptual framework for value within marketing that considers all forms of value, for example, value-in-use, value-in-exchange, utilitarian approach, intrinsic value as well as human/personal values. In the search for a ‘value’ framework for this thesis Woodall’s (2003) Value for the Customer (VC) was considered, but rejected due to its complexity and the researcher’s preference for S-D logic and Holbrook’s typology. An overview of Woodall’s VC framework is given for completeness. The VC framework represents the demand-side notions of value (i.e. what is derived by the customer from the supplier). The use of the term VC is considered more meaningful than other terms such as customer value, consumer value, perceived value, and customer perceived value in that it captures the concept of value as something that is “perceived/derived/experienced by a customer” and “explains their connection to a particular good or service” (Woodall, 2003, p. 1). An extensive review of the literature by

Woodall (2003, p. 7-8) found five key value forms which he named 'Marketing VC', 'Sale VC', 'Derived VC', 'Net VC' and 'Rational VC'. Marketing VC is value that is generally "conceived as product attributes", following the idea that value is imbedded in products as a strategic marketing focus (Dodds, 1999). Sale VC is "conceived as reduction in sacrifice, or low price" where price is the key value, following the value-in-exchange idea. Derived VC on the other hand is "conceived as use/experience outcomes", epitomising value-in-use (Holbrook, 1994, 1999; Richins, 1999; Sheth et al., 1991). Net VC is concerned with the balance of benefits and sacrifices and follows a more 'utilitarian' perspective on purchase and consumption (i.e. what benefits does the consumer receive in relation to the sacrifices made) (Zeithaml, 1988). Rational VC is a "form of value that combines the notions of 'exchange value' with 'intrinsic value' and...is essentially utilitarian in nature" (Woodall, 2003, p. 8). Rational VC has an objective perception of a price band that is tolerable, depending on the perceived benefits or attributes of the product the consumer will decide what is 'a fair price'. These five forms serve as the foundation of Woodall's (2003) conceptualisation of value which provides an initial comprehensive overview of the concept of value. Despite this attempt, the concept of value is still in contention today, particularly in light of Vargo and Lusch's (2004, 2006, 2008) emerging marketing theory Service-Dominant (S-D) Logic where value is a central theme and terms such as 'co-creation of value' have taken precedent.

### **2.13.2 S-D Logic perspective on value**

S-D logic as a 'new' emerging theory of marketing provides an interesting perspective on the concept of value, in particular two of its foundational premises, "the customer is always a co-creator of value" and "value is always uniquely and phenomenological determined by the beneficiary" (Vargo & Lusch, 2008, p. 7). This section begins by providing an overview of S-D logic and then focuses on S-D logic's premises of value co-creation and value-in-use. This research wants to explore what value CAM consumers experience and how CAM consumers co-create value through their consumption experiences of CAM health services and therefore S-D logic's foundational premises on value and value co-creation provides a worthwhile lens for this study.

Vargo and Lusch (2004) proposed that marketing thinking needed to shift away from the economic goods based model of exchange towards a new marketing perspective where a service-dominant view needed to prevail. Service(s), they argue, should not be differentiated from goods as a sub discipline but an integral part of marketing per se, be it goods or services (Vargo & Lusch, 2004). They believe that service (as opposed to goods) is the fundamental basis of exchange (Merz, He, & Vargo, 2009) and define services (later changed to the singular service) as “the application of specialised competences (knowledge and skills) through deeds, processes, and performances for the benefit of another entity or the entity itself” (p. 329-330).

Vargo and Lusch (2004, 2006, 2008) have brought to the fore and organised 30 years of service marketing research into one framework and put forward ‘service’ as a new logic for marketing (Grönroos & Ravald, 2011). This is not only timely but a necessary step for the advancement of marketing theory (Lusch & Vargo, 2011). Rust, Kohli, Gummesson & Arnould (2006) claim that many marketing academics agree with the basic premise of S-D logic and the need for a shift in marketing thinking amidst the changing business and social environment. Despite leading marketing academics past efforts to call for a new paradigm shift for marketing relatively little had changed (Achrol & Kotler, 1999; Grönroos, 1994; Gummesson, 2002; Kotler, 1997; Rust, 1998). What Vargo and Lusch (2004) have done is “generate a general theory of the marketing discipline by synthesizing the various schools of thought in the marketing literature” (Theoharakis & Sajtos, 2007, p. 84). This has led to a plethora of reactions from the international academic community (for example Aitken, Ballantyne, Osborne, & Williams, 2006; Brodie, Glynn, & Little, 2006; Brookes, 2007; Grönroos, 2006a, 2006b, 2008, 2011a; Grönroos & Ravald, 2011; Gummesson, 2008; Merz et al., 2009; Peñaloza & Venkatesh, 2006; Rust et al., 2006; Schembri, 2006; Winklhofer, Palmer, & Brodie, 2007; Wright & Russell, 2012) many of whom have provided momentum and ideas for S-D logic’s development (Lusch & Vargo, 2006).

Gummesson et al. (2010) acknowledge that “there are a host of challenges associated with the further growth, development, and implementations of S-D logic” (p. 18), but argue that time is of essence and change in marketing theory is required. Gummesson et al. (2010) call for more empirical studies using various research methods to move S-D logic towards theory development. This research on consumer value and value co-creation in CAM

health services from a CAM consumer's perspective hopes to contribute, at least, to S-D logic's foundational premises on value co-creation and the idea that value is experienced during the consumption process. An overview of these ideas is now discussed.

According to S-D logic, value does not reside in the product (goods, services or experiences) but in the 'service' the product renders. In other words the product itself does not hold value until it is used and/or experienced by the consumer (Vargo & Lusch, 2004, 2006, 2008). Therefore it is only during the use of the product that value emerges (Ledden, Kalafatis, & Mathioudakis, 2011). From this perspective "the firm does not sell goods; it sells a need-satisfying offering" (Finney, Spake, & Finney, 2011, p. 3), and value is not imbedded in products but determined by the consumer during the consumption experience (Vargo et al., 2008). Lusch and Vargo (2006, p. 284) argue that "value can only be created with and determined by the user in the 'consumption' process and through use or what is referred to as 'value-in-use". This idea is one that a number of marketing academics support (Ballantyne & Varey, 2006; Grönroos, 2008, 2011a; Gummesson, 2008; Gummesson & Grönroos, 2012; Holbrook, 2006b; Iniesta-Bonillo et al., 2012; Prahalad & Ramaswamy, 2004, 2004a; Prahalad & Venkat, 2004b; Woodruff, 1997; Woodruff & Gardial, 1996).

The premise that "the customer is always a co-creator of value" implies that the value created in the consumption process is "interactional" and "collaborative" (Vargo & Lusch, 2008, p. 7-8). Lanier and Schau (2007) argue that co-creation implies that consumers have some input into the product or service and therefore can extend, modify or alter its form, meaning and use to benefit themselves and/or to achieve their consumption goals. Consequently this allows the consumer to experience the product or service in creative ways. Interestingly, Grönroos (2011a) argues that S-D logic's foundational premise 'the customer is always a co-creator of value' is misleading because it presupposes that both parties, the firm and the customer, create value. Grönroos (2011) view is that "the customer creates value, and the firm facilitates value creation" (Grönroos, 2011, p. 289).

Value creation is not an all-encompassing process. Consequently, design, development and manufacturing of resources, and back-office processes, are not part of value creation... The total company process that leads to value-in-use for customers is needed to enable value creation, but all parts of it are not part of value creation for the customer. Logically, the

creation of value-in-use by the user and value creation as an all-encompassing process including value-creating activities by both provider (firm) and the user (customer) cannot be included in the same analysis, as is done in the service-dominant logic literature (Grönroos, 2011, pp. 282-283).

Grönroos (2011) argues that the concept of value in marketing is still elusive and attempts to unravel this imprecise concept from the Nordic School's perspective as discussed in the next section.

### **2.13.3 Nordic School view on value**

A discussion on the concept of value, particularly within a service context, cannot ignore the work of Nordic School scholars, in particular Christian Grönroos and Evert Gummesson. Before addressing their work a brief overview of the 'Nordic School' is given to provide context. The designation of the 'Nordic School of Service' as a brand came to fruition in the 1970's by Northern European scholars from Finland and Sweden. The pioneers of the school were Grönroos (Kanken School of Economics in Finland), Gummesson (Stockholm University School of Business in Sweden), and Normann (a Ph.D. who founded the Service Management Group in Sweden). In the early 1980's Edvardsson (founder of the Service Research Centre at Karlstad University in Sweden) joined the 'Nordic School' group. The aim of the group was to bring together scholars and research focused on 'services' due to growth in this economic sector. The 'Nordic School' brand also served to make Nordic service research visible internationally (see Gummesson & Grönroos, 2012).

The 'Nordic School' has for decades raised concerns about the need for a new perspective on marketing that moves away from production-centric goods to service and value creation (Gummesson & Grönroos, 2012). Prior to S-D Logic both Gummesson (1987, 1997) and Grönroos (1994) advocated for a paradigm shift in marketing that recognises the importance of relationships and interactions between the customer and the selling firm, known as 'relationship marketing'. In the late 1970's, through service marketing research, the Nordic School had already begun to consider "a marketing approach geared towards facilitating interactions with customers during their consumption process rather than the exchange itself", hence subscribing to the 'value-in-use' idea (Grönroos, 2006b, p. 3).

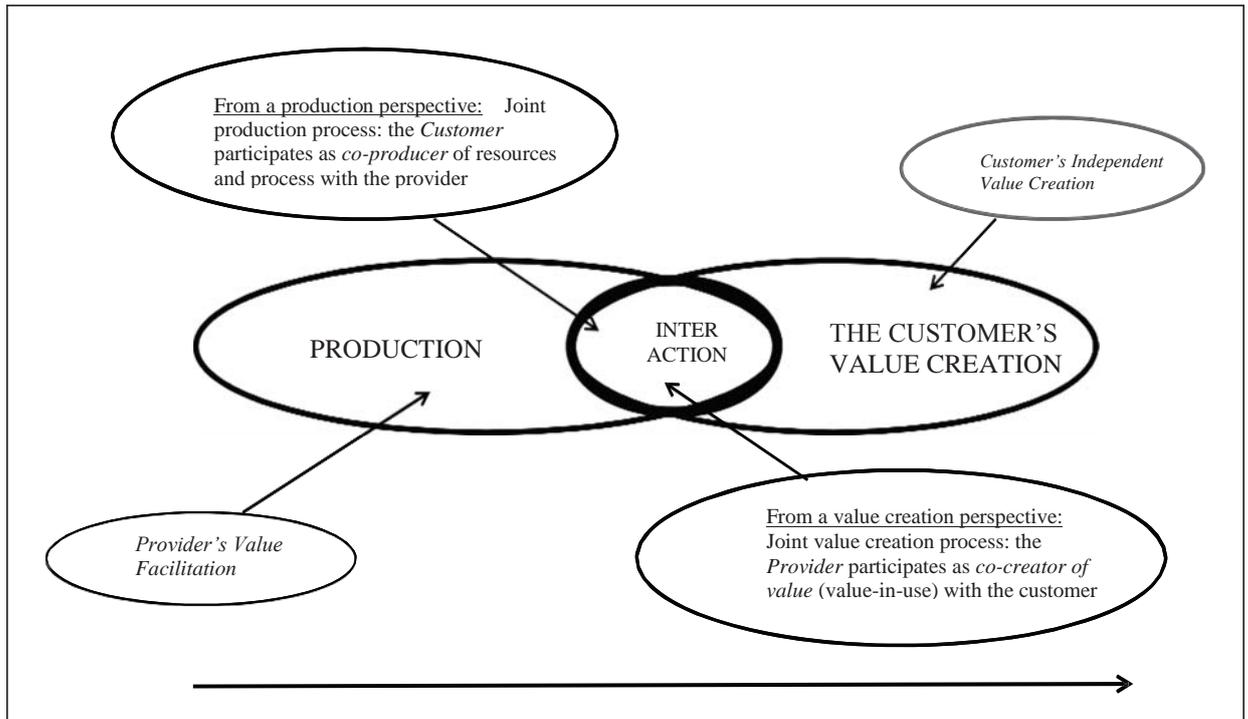
Gummesson (1987) alluded to the co-creation idea, arguing that “the customer is a co-producer” (p. 14) through their relationships and interactions with sellers. However, Vargo and Lusch (2008) believe that ‘co-production’ is distinct from co-creation of value because co-production implies the customer has input into product, which isn’t necessarily always the case.

Ravald and Grönroos (1996) explored the concept of value and argued that value is “an important constituent of relationship marketing” (p. 19). Gummesson (2008) agrees that value is realised during the customers ‘interaction’ with a product. He argues that ‘service’ is created in that consumption process. Therefore “co-creation of service” is a necessity and separating suppliers and customers deprives them of “context and interdependency” (p. 16). Traditional service industries, like health care, acknowledge the customer as co-creator of service in line with S-D logic (Gummesson, 2008). Gummesson (2002, 2008) argues that companies and organisations cannot be either customer-centric (solely customer focused) or supplier-centric, they must be balanced. Suppliers and customers cannot be separated; suppliers create the value proposition without which there will be no value actualisation on the customer side, and customers create value through the use of the product or service.

The Nordic School support a ‘service logic’ for marketing and argue that “services are value-supporting processes” and therefore “service logic means that the firm facilitates processes that support customers’ value creation” (Grönroos, 2006b, p. 7). However, Grönroos (2011a) argues that little is known about “the process of value creation, when it starts, what it includes and when it ends” (p. 282). The concept of value creation from a Nordic School’s perspective “is defined as the customer’s creation of value-in-use”, meaning value is only created during the use of a product (be it a good, service or experience), and is therefore not an all-encompassing process (Grönroos, 2011a, p. 282). Hence, S-D logic’s foundational premise “the customer is always a co-creator of value” is too simplistic for theory development and draws attentions away from the underpinning logic of value-in-use as it implies value creation should be equally shared between customer and the firm (Grönroos, 2011). Grönroos (2008, 2011) argues that firms facilitate value creation and are not necessarily always co-creators of value. “Co-creation of value can take place only if interactions between the firm and the customer occur. If there are not

direct interactions, no value co-creation is possible” (Grönroos, 2011, p. 290). Grönroos (2011) value-in-use creation ideas are summarised in Figure 3. This model provides a useful foundation to consider the process of value creation.

**Figure 3: A value-in-use creation model (Grönroos, 2011, p.291)**



Although there is debate over the terminology ‘value co-creation’ versus ‘value creation’ and its literal meaning, there is one common agreement, that the customer/consumer is involved in creating value through their experience and/or use of the product or service. The debate lies in whether firms co-create value or facilitate value. In a service context, such as health care, this researcher thinks both the customer and the service provider co-create value and therefore prefers this term. She also acknowledges and advocates the idea of ‘service experience co-creation’ that was recently highlighted as an important and key issue in service research and practice (Jaakkola, Helkkula & Aarikka-Stenroos, 2015a; McColl-Kennedy, Cheung, & Ferrier, 2015). However, this study began wanting to further understand the concepts of consumer value and value co-creation in CAM health services and answer the questions: What do CAM consumers’ value from their experience and how do CAM consumers co-create value? The answer for both perhaps lies in understanding

and exploring how CAM consumers experience value. Hence the next two sections provide a comprehensive overview of consumer value.

#### **2.13.4 Consumer value**

This section provides an overview of the literature on consumer value which leads to the following sections on Holbrook's (1994, 1999) Typology of Consumer Value and Sánchez-Fernández et al's. (2009) model of 'consumer perceived value'. Holbrook's typology and Sánchez-Fernández et al's. model are considered as potential theoretical frameworks on consumer value to guide this study on CAM health services.

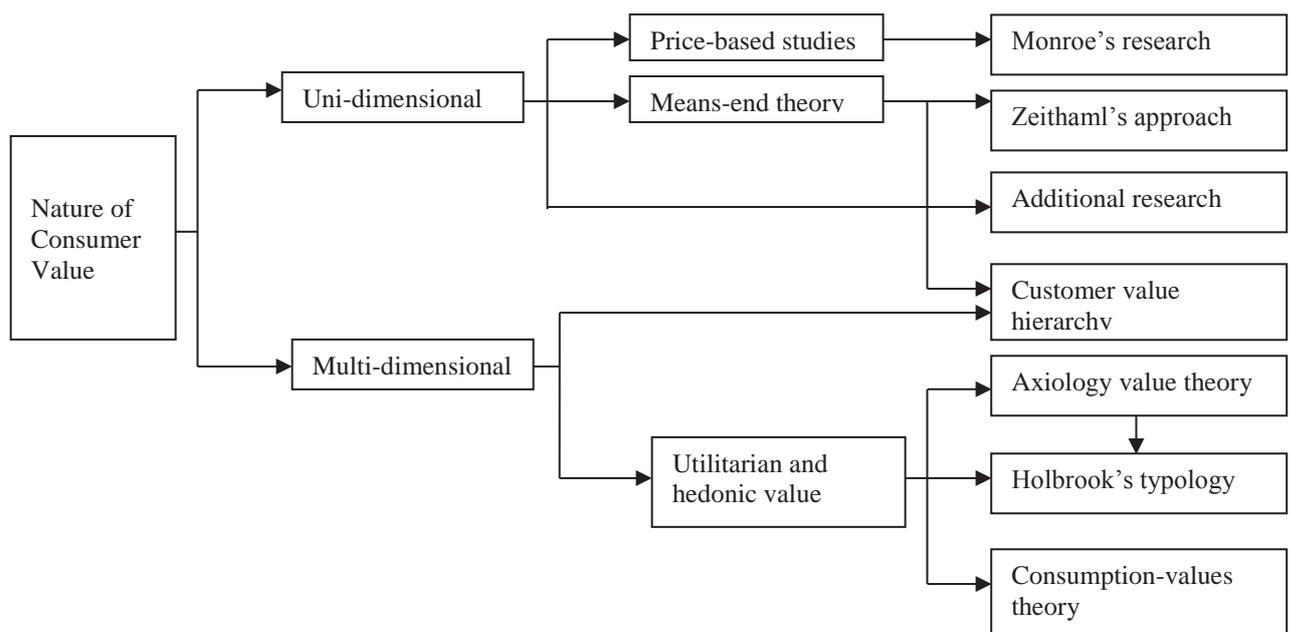
Consumer value is considered the "foundation for all effective marketing activity" yet little attention has been given to defining and researching it (Holbrook, 2006a, p. 715). The concept of consumer value has been of interest to marketing and consumer researchers for the past two decades and reflects the growing interest in the "phenomenon of value creation" (Iniesta-Bonillo et al., 2012; Sánchez-Fernández & Iniesta-Bonillo, 2007). Although Sánchez-Fernández & Iniesta-Bonillo (2006) argue the term 'consumer perceived value' illustrates the meaning of all other terms used to define 'value' in marketing, such as judgement value, shopping value, consumption value, product value, customer value, consumer value and perceived value, this researcher prefers the term 'consumer value' because it reflects both 'real' and 'perceived' value from a consumer's perspective.

Sánchez-Fernández and Iniesta-Bonillo's (2007) widely cited paper *The concept of perceived value: a systematic review of the research* provides an extensive overview of the concept of consumer value. Their study found two key research approaches to the operationalization of value – uni-dimensional and multi-dimensional (Figure 4). A uni-dimensional approach has arisen from a stream of research pertaining to a purely utilitarian perspective of value which is based primarily on economic and cognitive reasoning (Sánchez-Fernández & Iniesta-Bonillo, 2007). "Utilitarian value results when a consumer evaluates a consumption activity as successful in that a desired end result is achieved" (Babin & James, 2010, p. 473). For example, Monroe's (2003) price based view which focuses on the price-quality relationship and Zeithaml's (1988) approach using means-end theory. Perceived consumer value, from a price based approach, is determined primarily by

price-quality perceptions and comes from economic theory and the concept of utility where value is seen as a trade-off between perceptions of quality and price (Sánchez-Fernández & Iniesta-Bonillo, 2007). Whereas a means-end theory approach is mostly concerned with what a consumer can ‘get’ (includes quality as well as emotions, prestige and convenience) for what they ‘give’ (includes money but also aspects such as effort, time, opportunity, and emotions) (Babin & James, 2010; Zeithaml, 1988).

As shown in Figure 4 multi-dimensional approaches, such as Holbrook’s (1994, 1999) typology and Sheth et al’s. (1999) consumption-values theory, consider both utilitarian value (instrumental, task-related, rational, functional, cognitive, and a means to an end consumption) and hedonic value (reflecting the entertainment and emotional worth of consuming, which is non-instrumental, experiential, and affective); and are therefore more holistic and complex, demonstrating that perceived value “consists of several interrelated attributes or dimensions that form a holistic representation of a complex phenomenon” (Sánchez-Fernández & Iniesta-Bonillo, 2007, p. 431). Consumer value in these multi-dimensional approaches tends to refer to the evaluation of an entity (for example, a service, experience or good) by a consumer (Boksberger & Melsen, 2011).

**Figure 4: Research streams on perceived value (Sánchez-Fernández & Iniesta-Bonillo, 2007, p. 430)**



Sánchez-Fernández and Iniesta-Bonillo (2007) agree that both uni-dimensional and multi-dimensional models and perspectives contribute to the study of value. However, they argue that uni-dimensional approaches, although simplistic, “do not reflect the complexity of consumers’ perceptions of value” and “fail to take proper account of the numerous intangible, intrinsic, and emotional factors that form part of the construct” (p. 441). Holbrook’s Typology of Consumer Value (1994, 1999), in their view, offered the most comprehensive approach to the value concept. Holbrook’s (1994, 1999) typology stood out from other models, such as Woodruff and Gardial (1996) ‘customer value hierarchy’ and Sheth et al. (1991) ‘consumption-values theory’ because it covered a wider spectrum of consumer value components including economic, social, hedonic and altruistic value which the other did not (Sánchez-Fernández & Iniesta-Bonillo, 2007; Sánchez-Fernández et al., 2009). However Boksberger and Melsen (2001) argue that although Holbrook’s (1994, 1999) typology is comprehensive it lacks critical reflection in the literature. Ledden et al. (2011) found that Sheth et al. (1991) ‘consumption-values theory’ has strong theoretical grounding across a diverse range of disciplines such as economics, sociology, psychology and consumer behaviour and has more empirical evidence. Although Sheth et al. (1991) have contributed significantly to the study of value their model ignores altruistic value, such as ‘spirituality’ and ethics’ (Sánchez-Fernández & Iniesta-Bonillo, 2007).

Holbrook’s (1994, 1999) typology of consumer value offers a potential theoretical framework to study the CAM consumer. More research is required on ‘value’ from a consumer’s perspective within CAM health services (Rajamma & Pelton, 2010). Holbrook’s framework in particular covers aspects such as spirituality and ethics, which other models do not (Sánchez-Fernández & Iniesta-Bonillo, 2007). This multi-dimensional approach and in particular the inclusion of spiritual value and ethics, fits well with the CAM consumer as per the discussion in sections 2.6 and 2.7.

#### **2.13.5 Typology of consumer value**

Holbrook’s (1999) typology of consumer value, as mentioned earlier, has been hailed by Sánchez-Fernández and Iniesta-Bonillo (2007) as the “most comprehensive approach to the value construct” (p. 441) they have come across. Therefore the typology warrants further discussion. An overview of Holbrook’s typology follows.

Holbrook’s (1994, 1999) “A Typology of Consumer Value” (Table 4) represents eight different types of consumer value – efficiency, excellence, status, esteem, play, aesthetics, ethics and spirituality. These value types are based on three dichotomies 1) Extrinsic versus intrinsic; 2) Self-oriented versus other-oriented; 3) Active versus reactive. Each dimension is briefly outlined below using possible CAM scenarios<sup>8</sup> to illustrate.

**Table 4: 'Typology of Consumer Value' (Holbrook, 1999, p.12)**

		Extrinsic	Intrinsic
Self-oriented	Active	EFFICIENCY (Output/Input ratio, Convenience)	PLAY (Fun)
	Reactive	EXCELLENCE (Quality)	AESTHETICS (Beauty)
Other-oriented	Active	STATUS (Success, Impression Management)	ETHICS (Virtue, Justice, Morality)
	Reactive	ESTEEM (Reputation, Materialism, Possessions)	SPIRITUALITY (Faith, Ecstasy, Sacredness, Magic)

i. Extrinsic versus intrinsic

Extrinsic value refers to a “means-end relationship” where consumption is valued for its functional and utilitarian nature (Holbrook, 1999 p. 10). That is, where a product or service helps consumers accomplish a goal or an objective. In the case of a CAM consumer, an extrinsic value could be the use of an acupuncturist to relieve the severity of a headache. Intrinsic value on the other hand pertains to the consumption experience being “appreciated as an end in itself – for its own sake” (p. 10). A CAM consumer receiving a massage enjoys the pleasure of the therapeutic touch or a consumer undergoing ‘reiki’ (energy healing) might have a magical spiritual moment.

ii. Self-oriented versus other oriented

Holbrook (1999) found that most scholars concerned with the theory of value agree that the dimensions self-oriented versus other-oriented are important elements of value. Self-oriented value is when consumption is primarily for the self (Holbrook, 1999). Being self-oriented is about the effect a product or service has on the individual. For example, a

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<sup>8</sup> The CAM consumption examples and scenarios have been ‘made up’ and are being used for demonstration purposes only as well as illustrating how these dimensions might play out in CAM. No research has been found to support these dimensions from a CAM perspective.

massage alleviates an individual's aches and pains, and a personalised dietary plan helps a person lose weight.

Other-oriented value is when consumption is directed at or for the sake of someone or something else. Being other-orientated is about the effect a product or service or consumption experience has on the other and how they react to it. "Other" in this sense "could range from the more micro level (family, friends, colleagues) to an intermediate level (community, country, world) to the most macro (the Cosmos, Mother nature, the Deity)... The "other" could [also] refer to some inaccessible "inner self" or to some "unconscious" part of the mind with which one seeks to "get in touch" (Holbrook, 1999, p.11). A stressed businessman seeks help from a naturopath for his family's sake. A young woman goes to a spiritual healer to experience being at one with the Universe.

### iii. Active versus reactive

The dimension active versus reactive appears less in the literature than the other two dimensions, however, Holbrook (1999) believes it is an important aspect of consumer value. He defines active value as being "a physical or mental manipulation of some tangible or intangible object" (p. 11). By this he means the consumer either does something to or with a product or service, for example, a consumer takes a liver supplement three times a day for a month, as prescribed by his practitioner (physical manipulation of a tangible object). The value is in the active taking of the supplement. A natural practitioner recommends 'meditation' for stress relief, requiring the active mental manipulation of an intangible object.

According to Holbrook (1999) "consumer value is reactive when it results from apprehending, appreciating, admiring, or otherwise responding to some object" (p. 11). Being reactive is where the product or service produces a reaction or acts upon a consumer. For example, a young woman suffering from pre-menstrual tension feels delighted to be symptom free, after following a course of treatment. A previously over weight man admires himself in his new jeans after being on a weight loss programme for 3 months.

Based on these three dichotomies Holbrook (1999) proposed eight types of value which are summarised below (Boksberger & Melsen, 2011, p. 232):

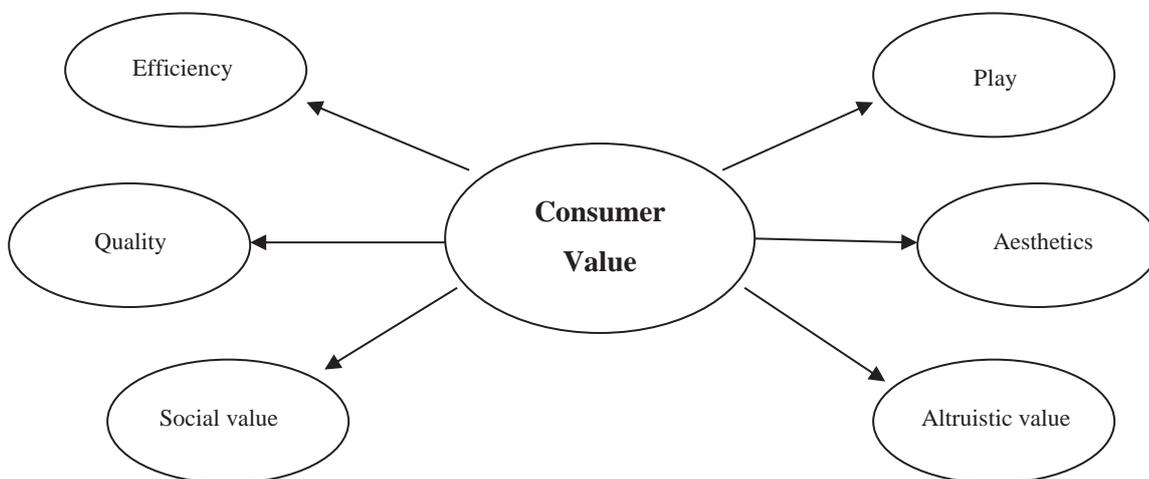
1. Efficiency (output/input ratio or convenience) – The perceived value that results from the active use of a product or consumption experience in pursuit of a self-orientated end.
2. Excellence (quality) – The perceived value associated with a reactive appreciation of some object's or experiences potential ability to serve as an extrinsic means to some personal self-orientated end.
3. Status (success, impression management) – The perceived value of one's own consumption experience as a means to achieve a favourable response from someone else.
4. Esteem (reputation, materialism, possessions) – The perceived value from the reactive contemplation of one's own status as reflected in the opinion of others.
5. Play (fun) – The perceived value of an active self-orientated experience enjoyed for its own sake.
6. Aesthetics (beauty) – The perceived value of an essentially reactive appreciation and as an end itself.
7. Ethics (virtue, justice and morality) – The perceived value from an ethical action favouring others.
8. Spirituality (faith or ecstasy, sacredness or magic) – The perceived value of a devotional experience.

Despite Holbrook's (1999) typology being comprehensive one of its main limitations is its complex nature (Sánchez-Fernández & Iniesta-Bonillo, 2007). The key issue with the Typology of Consumer Value matrix is the conceptual distinction between adjoining cells. For example, the subtle difference between ethical value and spiritual value or esteem and status (Brown, 1999; Sánchez-Fernández & Iniesta-Bonillo, 2007; Sánchez-Fernández et al., 2009; Solomon, 1999). Holbrook (2006) cut his model down to two dimensions (intrinsic vs extrinsic and self-oriented vs other-oriented) instead of three suggesting that his original model was perhaps too bound and complex. Sánchez-Fernández et al. (2009) with Holbrook's input refined Holbrook's original matrix further and proposed a new model for the structure of consumer to address this complexity.

### 2.13.6 Proposed model of consumer value

Sánchez-Fernández et al. (2009) refined Holbrook's matrix by removing the dimensions and creating 6 value types – efficiency, quality, social value, play, aesthetics and altruistic value (Figure 5). The model offers a more simplified version of Holbrook's original and has been tested empirically in a restaurant 'service' setting (Sánchez-Fernández et al., 2009). Each value type as determined by Sánchez-Fernández et al. (2009) will now be discussed.

**Figure 5: Proposed model for the structure of consumer value (Sánchez-Fernández, et al., 2009, p. 99)**



#### ***Efficiency***

Efficiency is the extrinsic value that results from the active use of a product or consumption experience as a means to achieve some self-oriented purpose or goal (Holbrook, 1994, 1999). Within this framework the consumer value efficiency is most often assessed in terms of use-to-exchange, i.e, what the consumers gets for the purchase (Holbrook, 1999). Efficiency is generally measured in terms of a ratio of outputs to inputs (O/I ratio), meaning what results does a consumer gain from their consumption efforts (money spent, time involved, ease of use). Commonly, cost is a key denominator in the efficiency ratio (Sánchez-Fernández et al., 2009). As Gummesson (2008) points out a product or service has no value in itself, if unused the consumer's money is wasted.

Convenience is another example of efficiency, whereby time is the key denominator (Holbrook, 1999). Time efficiency, quick access, availability and ease of use of a product, service or experience are the key concerns.

### **Quality**

The consumer value ‘quality’ relates to Holbrook’s (1999) idea of ‘excellence’ which he defines as “a reactive appreciation of some object’s or experience’s potential ability to serve as an extrinsic means to some personal self-orientated end” (p. 14). Included is the view that ‘quality’, as a consumer value, is inferred from products, services and consumption experiences (Sánchez-Fernández et al., 2009). Quality is connected in this sense to the experience of ‘customer satisfaction’ (Holbrook, 1999). In line with S-D logic, quality as a consumer value is determined by the consumer during their interaction with and use of a product, service and/or experience (Ledden et al., 2011). From this stand point ‘quality’ is only realised during the consumption process. .

### **Social Value**

Social value is a combination of Holbrook’s (1994, 1999) original sub categories ‘status’ and ‘esteem’. Status assumes the idea that people consume products or engage in consumption experiences to project an image or construct a persona that demonstrates success in the eyes of others (Holbrook, 1999). Solomon (1999) argues that ‘status’ is a social construction where consumers are driven or motivated to engage in consumption experiences that support their desired social standing. Solomon (1999) views “status-as-value”

as a multiple stage process of (1) determining the social persona(e) one can or should adopt (status definition); (2) acquiring products or pursuing experiences instrumental to attaining that goal (status seeking); and (3) evaluating the efficacy of that consumption in service of the chosen persona(e) (Status validation) (Holbrook, 1999, p. 16).

Esteem from Holbrook’s (1999) perspective relates to the “reactive counterpart to status” (p. 16). Instead of actively manipulating a product, service or experience to achieve a favourable response from others, esteem is a passive reaction (e.g. appreciation, admiration) of one’s own consumption or lifestyle as a potential means to enhancing their

‘social’ image. Esteem from this point of view can also include “self-esteem”, where the ‘other’ of interest is the ‘inner self’, the value of admiring ones-self (Holbrook, 1999).

Status and esteem were considered the most difficult categories in Holbrook’s first model to separate due to the inter-relationship and similarities between the two (Richins, 1999; Solomon, 1999). Therefore Sánchez-Fernández et al. (2009) combined the two to form social value, which is in line with other previous researchers who define social value as a single category (see Sheth et al., 1991; Sweeney & Soutar, 2001).

### ***Play***

Play is a self-oriented, intrinsic value that is actively sought and experienced and enjoyed for “its own sake” (Holbrook, 1999). In this sense play involves having fun, is intrinsically motivated and is related to people’s need to leisure (Holbrook, 1999; Sánchez-Fernández et al., 2009). Kelly (1990) argues leisure (play) is the perception of freedom, the orientation of intrinsic motivation, and is defined in terms of what is perceived in the experience itself. He concludes that leisure is a ‘lived’ meaningful experience (Kelly, 1990).

Grayson (1999) argues that almost all products and services could be consumed as play. Hence play is a motive in much consumer behaviour (Deighton and Grayson, 1995). Shopping in its own right is considered a leisure experience that incites the multi-sensory and emotive aspects of consumption known as hedonic consumption (Arnold and Reynolds, 2003; Holbrook and Hirshman, 1982). Hedonic consumption is defined as the multisensory, fantasy, and emotive aspects of consumption, which is driven by the ‘fun’ a consumer has in the consumption process (Holbrook & Hirschman, 1982).

Despite a large literature on the concepts of ‘leisure’ and ‘play’ (see Blackshaw, 2010; Gunter, 1987; Iso-Ahola, 1980; Kelly, 1990; Murphy, 1981; Neulinger, 1981) “very little attention has been devoted to the study of play as a type of consumer value” (Sánchez-Fernández et al., 2009, p. 101).

### ***Aesthetics***

Aesthetics is a reactive, intrinsic, self-orientated value where a consumption experience is appreciated for its own sake as an end itself (Holbrook, 1999). Artwork, for example, is admired for its beauty. Wagner (1999) argues ‘aesthetics’ can also be ‘active’ and other-orientated especially fashion and ‘applied art’ (everyday objects such as furniture,

appliances etc). For example, fashion is often appreciated (reactive) and worn (active) for its pleasing appearance not just for the self but often for the admiration of others (other orientated).

Sánchez-Fernández et al. (2009) argue aesthetics as a consumer value is under-researched but potentially exists in many consumption experiences. “Aesthetics constitutes a key aspect of value in consumption experience because individuals are exposed to it on a daily basis – in homes, in retail stores, in public spaces, and especially in such service areas as art, entertainment and other cultural offerings” (Sánchez-Fernández et al., 2009, p. 101). In consumer research there are linkages between the concept of aesthetic value and consumer decision-making, where aspects such as ‘style’, ‘design’ and ‘beauty’ are considered in the purchasing process (Wagner, 1999). In Sánchez-Fernández et al. (2009) study of consumer value using the service context of a vegetarian restaurant, aesthetics was one of the most important value types along with play. Service setting atmospherics such as decor, music, lighting could be important aspects in terms of consumer value and value co-creation (Sánchez-Fernández et al., 2009).

### ***Altruistic value (Spiritual value and ethics)***

The consumer value types spirituality and ethics were the most difficult of Holbrook (1994, 1999) categories to demarcate and therefore were combined under the heading of ‘altruistic value’ (Sánchez-Fernández & Iniesta-Bonillo, 2007; Sánchez-Fernández et al., 2009). “Altruistic value [is] viewed as an other-orientated consumption experience valued intrinsically for its own sake as an end in itself” (Sánchez-Fernández et al., 2009, p. 102). For example, a consumer who attends a yoga class may do so to achieve union with the universe or one’s inner-self (spiritual value), hence the experience is other-orientated (directed at the universe) and valued for its own sake. Other-orientated can include entities such as a divine power, cosmic force, mystical entity or inner being (Holbrook, 1999). Another example could be an individual donating money to child cancer because they are concerned for children’s welfare (ethical value). This is ethical value because it is other-orientated (concern for children) and intrinsically motivated.

Smith (1999) argues the ‘other-orientated’ aspect of ethical value is more often than not also self-orientated because people benefit personally from the act of giving or ‘doing good’. The same can be argued for spiritual value, in that most people seeking spiritual

fulfillment are doing so for their own personal benefit and spiritual development. Therefore it is arguable whether spiritual value and ethics should be categorised together under 'altruistic value'.

It has been recognised that spirituality and ethics have increasingly become important aspects of marketing, consumer behaviour and the consumption experience (Brown, 1999; Holbrook, 1994, 1999; McKee, 2003; Smith, 1999). There is a growing body of literature on 'ethical consumption' alone (see Carrier & Luetchford, 2012; Lewis & Potter, 2011; Turcotte, 2011), reflecting the growing movement of consumers who are concerned about the impact their consuming has on the environment and others (for example industry workers and animals) (Turcotte, 2011). Spirituality's link to consumption too is starting to gather momentum within marketing and consumer behaviour literature (see Brown, 1999; Elliot & DeBerry-Spence, 2010; Holbrook, 2001; Kotler et al., 2010; McKee, 2003; Skousgaard, 2006), in particular the role consumption has on a person's spiritual development, and the expansion and fragmentation of expressed spiritual needs (McKee, 2003). Spiritual value is an an important consumer concept to investigate because increasingly consumers are demanding to be considered, as Kotler, et al. (2010, p. 4) describes "whole human beings with minds, hearts, and spirits", who not only want functional and emotional fulfilment but human spirit fulfilment in the products and services they choose". Skousgaard (2006) attempted to advance the understanding of spirituality as a dynamic consumer value in her meta-analysis of spirituality and the spiritual experience and concluded that "much needs yet to be learned about spiritual motivations for consumption" (p. 294). Despite this growing body of literature very little research has been devoted to spirituality and ethics from a consumer value perspective (Sánchez-Fernández et al., 2009).

### **2.13.7 Summary**

Consumer value and value co-creation are important concepts in marketing and consumer research. Although these concepts have been extensively conceptualised by marketing scholars more empirical evidence is required to test the concepts in a variety of consumption contexts. Sánchez-Fernández and Iniesta-Bonillo (2007) have provided the most comprehensive overview of the concept of 'consumer value' and Sánchez-Fernández

et al.'s. (2009) model of 'consumer perceived value' is perhaps the most useful in terms of providing a framework to study consumer value. The concept of value co-creation has also begun to conceptually take shape via the work of Vargo, Lusch, Grönroos and Gummesson, in particular. This thesis contends that to understand value co-creation from a consumer's perspective you must first understand what and how consumers perceive value. In other words understanding consumer value helps understand value co-creation. The two concepts are intrinsically linked.

## **2.14 Consumer Value and Value Co-creation in Health Services**

Research on consumer value and value co-creation in health care is beginning to emerge (Gill et al., 2011; Hardyman, Daunt, & Kitchener, 2015; McColl-Kennedy et al., 2012; Nordgren, 2009; Sweeney et al., 2015; Zainuddin et al., 2011; Zainuddin et al., 2013; Zhao, Wang, & Fan, 2015). Most studies on value in health care have focused on the methods for practitioners to assess value; what is understood as the patient's value (Liu et al., 2006), the relationship between quality, value and satisfaction (Choi et al., 2004; Moliner, 2009), and the role of 'health value', defined as an "individual's assessment of benefits relative to costs in engaging in preventive health care behaviour" (Jayanti & Burns, 1998, p. 8) in health behaviour (Lau et al., 1986; Rajamma & Pelton, 2010). Health care services have been deemed a significant and worthy field to study from a services marketing perspective with the potential to make significant contributions to the area (Berry & Bendapudi, 2007). This section will firstly examine the literature on consumer value in health care, both mainstream and CAM. Secondly literature on value co-creation in health care will be examined.

### **2.14.1 Consumer value in health care services**

There has been little research on consumer value conducted within the health care context (Chahal & Kumari, 2011), both mainstream and CAM. However, "understanding the nature of customer (consumer) value in health care is critical given the diversity of consumer needs, an increase in the number of providers, and resource pressures faced by private and public providers" (Dobele & Lindgreen, 2011, p. 269). A number of studies in mainstream medical literature have alluded to a relationship between perceived value and relationship quality in health care services (Choi et al., 2004; Moliner, 2009; Wu, Liu, &

Hsu, 2008). Perceived value and 'patient' value have also been linked to consumer loyalty (Caruana & Fenech, 2005; Chahal & Kumari, 2011), satisfaction (Liu et al., 2006), and word of mouth (Dobele & Lindgreen, 2011), based on the quality of the health care experience. The value of patient satisfaction and perceived quality in mainstream medicine has been examined by Liu et al. (2006). The results of Liu et al.'s. (2006) study indicated that the providers' skills and knowledge and their respectful communication with the patients are the most important in terms of patient satisfaction. The level of empathy and attention shown by the provider along with the physical environment were also key factors. Emmerton, Fejzic and Tett (2012) explored consumers' experiences and values in both conventional medicine and CAM and found consumers value: time with their health care practitioners, direct involvement in treatment decisions (shared decision making), whole person approach, and mutual respect.

Consumer perceived value and consumer loyalty in a hospital setting has been investigated by Chahal and Kumari (2011). Data was collected from 515 hospitalised patients and the results suggest that consumer perceived value is a function of six different types of value. These include: acquisition value (refers to a trade-off between benefits and sacrifices when products or services are acquired), transaction value (relates to psychological satisfaction or pleasure or relief gained from services performed), efficiency value (refers to how efficiently and effectively the treatment process is completed), aesthetic value (refers to the visual appeal of the hospital setting), social interaction value (refers to the patient's interaction with friends, family, staff and other patients), and self-gratification value (refers to improvements in personal well-being, relief from stress, alleviation of negative mood, elimination of loneliness, and giving oneself a special treat). Chahal and Kumari's (2011) study arguably is one of the first to consider a variety of value components within a health care setting and demonstrates the importance of considering consumer value as multi-dimensional.

Undoubtedly the practitioner-client and doctor-patient relationship is an important value aspect because the therapeutic relationship has received attention in the CAM and mainstream medical literature (Adams, Price, Tucker, Nguyen & Wilson, 2012; Bann et al., 2010; Bishop et al., 2011; Flocke, Miller & Crabtree, 2002; Theofilou, 2011). The doctor-patient relationship has long been described "as the keystone of care" which leads

to “optimum health outcomes” (Adams et al., 2012, p 127). Flocke et al. (2002) found that doctors with a person focused interaction style were linked to higher reported quality of care by patients. In CAM health services, quality is determined by the client-practitioner relationship (Bann et al., 2010; Bishop et al., 2011; Bishop, Yardley, & Lewith, 2010; D'Crus & Wilkinson, 2005; Emmerton et al., 2012). A number of studies have either concluded or suggested that the reason people use CAM is because of positive therapeutic relationships that are empowering, empathetic, client-centred, encourage self-responsibility, participatory, holistic and supportive (Adler et al., 2009; Bann et al., 2010; D'Crus & Wilkinson, 2005; Gale, 2008; Long, 2009; Thompson & Mark, 2007). The interpersonal dimension of CAM healthcare is particularly important in the early stages of the treatment programme to ensure continuity and compliance (Bishop et al., 2010). Kelner (2005) found that CAM client-practitioner relationships were also pragmatic, “if the practitioners could help them, they would continue to see them; if not, they would move on to try another practitioner or another kind of therapy” (p. 112). Miskelly (2006) claims that CAM consumers ‘therapy hop’ and do not always establish long-term relationships with CAM practitioners. She argues the consumerist approach of CAM is partially responsible for this. However, Kelner (2005) in her study of CAM and Family Physician therapeutic relationships established that both types of practitioners tend to sit in the middle of the therapeutic relationship continuum where shared decision-making is paramount. Hence CAM consumers in Kelner’s (2005) study did not perceive the relationship with their practitioner to have a ‘consumerist’ approach, where decision making is largely in the hands of the ‘consumer’, but a more holistic collaborative approach.

Quality of the consumer-practitioner relationship is potentially an important consumer value in CAM health services. Little is known about the relationship between quality of care and use of complementary and alternative medicine services (Lovgren et al., 2011). Few studies could be found that relate specifically to ‘quality’ and consumer value within a CAM service context. Emmerton et al. (2012) explored consumers’ experiences and values in both conventional medicine and CAM and found consumers value: time with their healthcare practitioners, direct involvement in treatment decisions (shared decision making), whole person approach, and mutual respect (Berger, Braehler & Ernst, 2012; Emmerton et al., 2012). Bishop et al.’s. (2011) study of acupuncture consumers found they “valued the individualistic, holistic care” (p. 7) along with the empowering and inclusive

nature of their practitioner. Lovegren et al. (2011) suggest the relationship between CAM use and quality of care be explored further.

Efficiencies in health care are often evaluated in terms of short waiting times, prompt access and dealing with emergencies and problems efficiently (Liu et al., 2006). Within CAM health services time efficiency is considered important when evaluating the length of time it takes to experience any health benefits. Bishop et al. (2010) found that CAM practitioners who provided a timeframe within which the consumer might expect to experience health benefits positively motivated ongoing consumer use of CAM. Individualised CAM health care and treatments that are tailored to the individual were valued by private sector acupuncture patients (Bishop et al., 2011).

The physical health care setting can influence consumers' perceptions of quality (Fottler, Ford, Roberts, & Ford, 2000; Liu et al., 2006). Bishop et al. (2011) found that acupuncture (CAM) consumers "rarely talked about the physical environment, and focused instead on the value for money and effectiveness of their treatment and their experiences of care, control, and choice" (p. 8). Fottler et al. (2000) argues that "an excellent healing environment will reinforce excellent clinical quality" (p. 91) and healing outcomes. An excellent healing environment includes ambient conditions such as colours on the wall, room temperature, smells and lighting; spatial conditions including layout, crowding, equipment and furnishings; and signs, symbols, and artefacts such as signs, style of decor and personal artefacts. Liu et al. (2006) contend that aspects of the physical environment such as cleanliness and decor of treatment and waiting rooms, layout and perceived quality of equipment are valued by patients in hospital settings.

Various studies have found a correlation between CAM use and socio-economic levels (high income and education) (Barnes et al., 2008; Eisenberg et al., 1993; Ernst, 2000; Kelner & Wellman, 1997a; Ong, Petersen, Bodeker, & Stewart-Brown, 2002; Xue et al., 2007). Although this is mostly attributed to the cost of CAM, it is possible that the consumption of CAM is an important 'status symbol' and/or demonstration of 'esteem' among this group. For example, regular sessions with your massage therapist or osteopath could project a certain image the consumer wishes to create. Bishop et al. (2008) discovered that some CAM consumers use certain therapies, such as aromatherapy massage and reflexology, as a treat rather than a treatment. "The link between paying for a

therapy and viewing it as a luxury suggests that therapies might be used as treats when they are seen as nonessential, expensive, and exclusive” (p.1701).

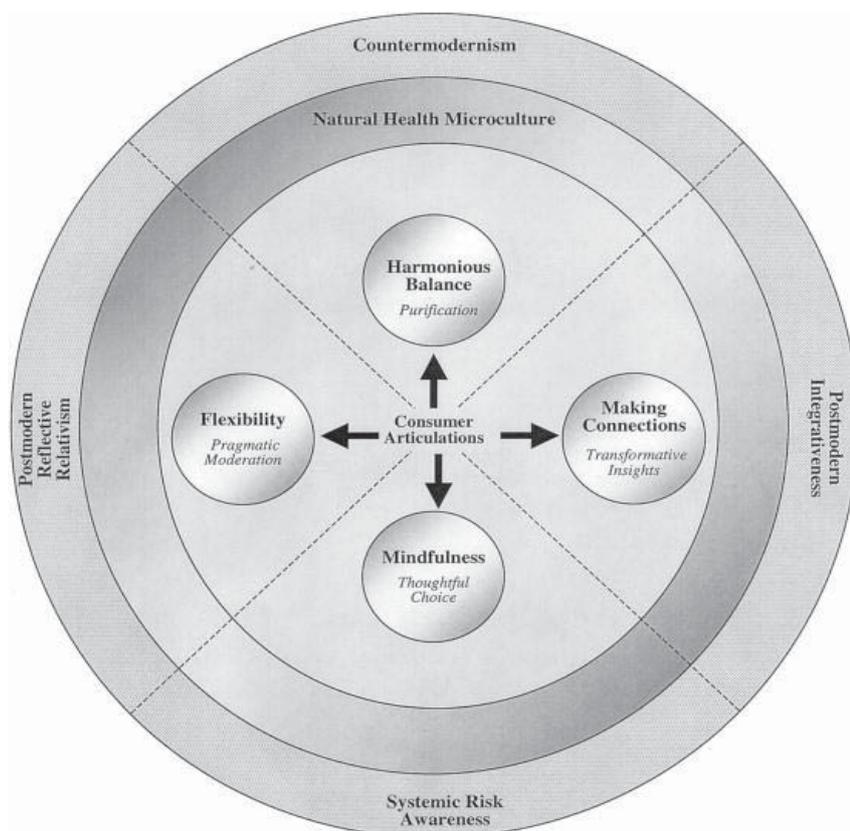
Empowerment and self-responsibility is possibly a key CAM consumer value that potentially sits under ‘social value’, although no specific research exists that links them together. However, Sointu (2006, 2006a) in her research on CAM and wellbeing, argues the healing experiences, sense of wellbeing, empowerment and recognition gained from CAM are connected to feelings of self-worth and legitimacy. CAM consumers value being ‘recognised’ for who they are and their current situation by CAM practitioners (Sointu, 2006). Barrett et al. (2003) points to increasing evidence of people desiring to be in control of their health. This desire for self-responsibility reflects changing societal values. CAM provides an ideal environment to promote empowerment and self-responsibility due to the ‘patient-centred’ nature of the CAM therapeutic relationship (Gale, 2008). As discussed earlier, empowerment and self-responsibility, is a key reason why people use CAM (Barrett et al., 2000; Andrews, 2002; Bann et al., 2010). Although there are inklings of a relationship between social value and CAM consumption further research is required to how it might influence consumers’ perceptions of ‘value’, and the role it has in co-creating value.

‘Spiritual care’ was uncovered as an important value concept driving satisfaction and perceived quality (Liu et al., 2006) in the health care literature. Liu et al. (2006, p.65) argue that “providing spiritual care to satisfy patients’ spiritual needs has become a major issue for health-care providers to consider”. Spiritual care is the health-promoting attendance that affects and acknowledges the spiritual perspective of an individual (Greasley, Chiu, & Gartland, 2001; Taylor, Amenta, & Highfield, 1995). As previously discussed in 2.6.6 spirituality is an essential component to health and healing in CAM health care (Goldstein et al., 1988; Hill, 2003). CAM practitioners understand the importance of spiritual experiences and spiritual beliefs in health, illness and healing (Goldstein et al., 1988). Therefore spiritual value in health care is potentially an important dimension because spirituality and spiritual values and beliefs have been associated with the consumption of CAM health services (Bishop et al., 2007).

Some studies have shown a connection between postmodern values and beliefs, such as spirituality, and the use of CAM (O’Callaghan & Jordan, 2003; Siahpush, 1998, 1999a), as

previously discussed in 2.6.1. Thompson and Troester (2002), in their study on CAM consumers, provide a useful model in terms of understanding and considering the value system that potentially influences what CAM consumers' value and how they co-create value. Thompson and Troester (2002) argue that CAM consumers are part of a natural health microculture which has value systems that have emerged from the fragmentation of postmodern consumer culture. The authors claim that meaning based aspects of consumer value systems are important motivators for consumer behaviour and attitudes towards CAM. Thompson and Troester (2002) developed a 'contextualised model of the natural health value system' (Figure 6). The model highlights "four higher-order postmodern orientations" - harmonious balance, making connections, mindfulness and flexibility, that CAM consumers subscribe to.

**Figure 6: A contextualised model of the natural health value system (Thompson & Troester, 2002, p.556)**

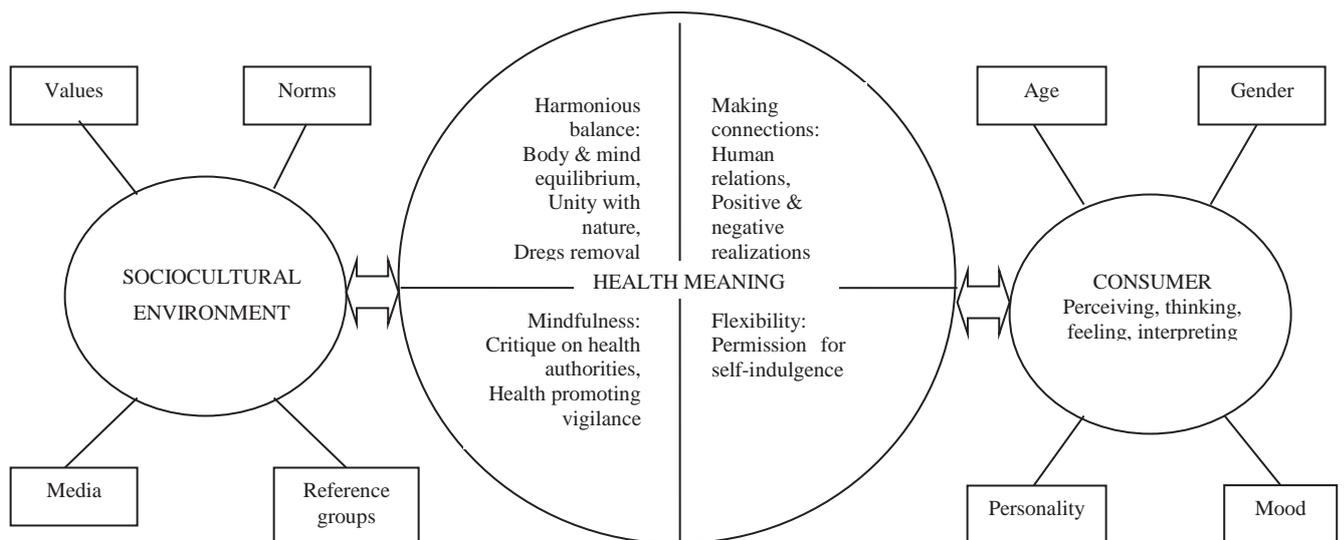


Harmonious balance relates to the natural health consumers' goal of wellbeing, which they believe is achieved through 'purification', and restoring harmony, and having balance in

their life. Health problems were considered a symptom of an underlying disharmony. The value of making connections is about ‘transformational insights’ that consumers have about the complex holistic interconnections that affect their health. Mindfulness relates to self-awareness and making thoughtful choices that do not impact on their well-being. The value of flexibility was about compromise between natural health ideals and the demands of living in a fast convenient orientated consumer culture. Natural health consumers adapted their health values and goals to the constraints of everyday life.

Luomala, Paasovaara & Lehtola (2006, p. 269) expand Thompson and Troester’s (2002) model and offer a tentative conceptual framework for analysing the dynamics of health consumption meanings (Figure 7). Although not empirically tested Luomala et al’s. (2006) model could provide a useful starting-point for research on consumers’ meanings of health in relation to the value they gain from using CAM and how they co-create value through their experiences with CAM health services. This model recognises that the meaning (and arguably ‘value’) consumers attach to health is multi-faceted and influenced by consumers’ sociocultural environment and individual moderators such as age, gender, mood and personality

**Figure 7: A tentative framework model for analyzing health consumption meanings (Luomala et al., 2006, p. 276)**



### 2.14.2 Value co-creation in health care

A number of articles focusing on value co-creation/value creation in health care services have surfaced within the last five years, highlighting the importance of the interactions and engagement between the health consumer/patient and service provider in this context. However, many studies are still conceptual and invite further testing. Hardyman et al. (2015, p. 92) suggest that the “co-creation of value through engagement in health care warrants more detailed exploration,” and highlight the need for more empirical analysis and data on this important area in health care services.

Two notable articles on value co-creation in health care include McColl-Kennedy et al.’s. (2012) paper on *Health care customer value co-creation practice styles* and more recently Sweeney et al.’s. (2015) paper on *Customer effort in value co-creation activities*. McColl-Kennedy et al. (2012) identified five health care customer value practice styles and proposed a health care customer value co-creation practice styles typology which provides a valuable platform for understanding how health care consumers co-create value with their health care providers. McColl-Kennedy et al. (2012) studied 20 cancer patients in two private oncology practices and found that “activities” such as collating information and cerebral activities, “roles” such as assembling and managing a team of health care practitioners, and number of “interactions” with people including family and friends, contributed to customer value co-creation in this health care setting. The five customer value practice styles that McColl-Kennedy et al. (2012) identified included 1) team management (assembling and managing a health care team), 2) insular controlling (controlling health care from a distance), 3) partnering (collaborating and cooperating with Doctors and other health care professionals), 4) pragmatic adapting (adapting to their changed circumstances) and 5) passive compliance (complying with health care providers). Two styles, team management and partnering, were linked with a higher quality of life for the participants.

A number of studies have identified ‘practice styles’ in mainstream medical health care (Adams, et al., 2012; Huygen, Mokkink, Smits, Van Son, Meyboom & Van Eyk, 1992; Flocke et al., 2002). In medical literature the emphasis has been on identifying practice styles and determining the correlation between practice styles and satisfaction with care received. Flocke et al. (2002, p. 835) for example concluded that in community based

medical practices that “the person-focused interaction style” was the “most congruent with patient reported quality of primary care”. Adams et al. (2012) found a cluster of people who value positive long-term relationships with their doctor and identifies a group of variables, including good dialogue, choice and shared decision making, which indicated a positive partnership between doctor and patient. What is not clear is which attributes the health care consumer values and what the nature is of their involvement in the interaction.

Sweeney et al. (2015) builds on work by McColl-Kennedy et al. (2012) by investigating a “hierarchy of activities that reflect customer effort in value co-creation activities” (p. 2). Importantly, this study recognises the importance of value co-creation taking place beyond firm-customer service interactions and demonstrated that health care customers involve themselves in activities outside of the clinic environment that ultimately contributes to their health and well-being. Significantly this research found that the more effort a health care customer puts into value co-creation activities, such as compliance, actively sharing information, connecting with others, the more satisfied they are and ultimately the greater quality of life they experience. Sweeney et al. (2015) recommend that health care professionals facilitate and encourage customers to engage in value co-creating activities. Due to the client-centred and empowering nature of CAM health care it is assumed that many CAM consumers involve themselves and put reasonable effort into value co-creation activities. Therefore exploring this aspect within a CAM health service context could provide further insights into this important finding. As Zhao et al. (2015) argues, understanding the drivers of patient value co-creation activities is imperative because without knowing, health care providers cannot “adopt effective programs, policies, and services to encourage value co-creation activities or achieve the meaningful health care benefits that can accrue from such practices” (p. 73).

Nordgren (2009) studied value creation using discourse analysis, based on analysis of authoritative texts within the areas of value creation and service management. Nordgren (2009) concluded that the health care customer is a ‘value creator’ of their own health and life quality. Value is created throughout the health care experience and the “interaction between the provider and the customer” (p. 124). Nordgren (2009) recommends health care providers encompass value attributes such as experienced health, quality of life, reduced waiting time and accessibility, trust, information, avoidable suffering and avoidable deaths.

The interpersonal interaction and process of service co-creation is considered by Gill et al. (2011) as a key component in the delivery of quality health care. On the premise that service value creation is interactional, irrespective of the type of service the client is always a co-creator of value through their participation in the creation of the service (Gill et al., 2011). Knowledge about co-creation in health care services is limited despite concepts such as patient-centred care, patient involvement and patient participation being widely discussed in health care literature (Elg, Engström, Witell, & Poksinska, 2012). Elg et al. (2012) empirical investigation of 53 patients found that “patients can be active contributors of knowledge and skills in health care service development” (p. 338).

Zainuddin et al. (2011) research on value creation in a well-women’s health service highlighted the need to use an experiential approach to study the concept of value in health care as opposed to an economic approach. Four common components of value, including functional (economic value), social value, emotional value and altruistic value, as espoused by Holbrook (2006a), Sheth et al. (1991) and Sweeney and Soutar (2001) were used as a framework to interpret data from 25 in-depth interviews with women with regard to breast screening. Six themes that represent the four components of value (functional, social, emotional and altruistic) emerged and include: 1) Convenience – representing functional value and relates to practical aspects such as convenient location, service processes (reminder phone calls and letters, accessibility), and useful facilities (parking); 2) Control – representing both functional and emotional value and relating to a sense of control over one’s health; 3) Peace of mind – an emotional response that reduces negative emotions and promotes positive emotions to achieve relief; 4) Behaviour as reinforcement for beliefs – representing emotional value where existing beliefs about health are reinforced positively; 5) Identification of self as an influencer – representing social value where performing desired behaviours (having a breast screen) potentially influences others into performing and maintaining the same behaviours; 6) Benefit of behaviour to others – representing altruistic value where performing health behaviours are for the benefits of others, e.g. family and friends. Zainuddin et al. (2011) state that their research “constitutes the first step towards understanding consumers’ value interpretations during the consumption of health services” (p. 370). This study highlights the usefulness of using an ‘experiential approach’ to consumer value as advocated by Holbrook (1994, 1999) in a health care service setting.

A study by Bishop et al. (2010) has begun to highlight the broad nature of CAM as an experience and provides some insight into what consumers may gain from their consumption experiences. Bishop et al's. (2010) study found consumers described and evaluated their CAM experiences along four dimensions: 1) interpersonal - relationship with the practitioner; 2) physical – sensations experienced during or as a result of treatment, e.g. touch or pain; 3) affective – emotional aspects, e.g. feeling empowered, happy, reassured; 4) cognitive – belief about the treatment and gaining new knowledge. Experiences of these dimensions determined whether the consumer would maintain or stop the specific CAM therapy. Interpersonal relationships with the practitioner were found to be a key factor in the maintenance of CAM (Bishop et al., 2010). This finding highlights the importance of the 'service' element of the CAM experience. According to Vos & Brennan (2010) this is an area within CAM along with consumers' experiences that requires more research.

## **2.15 Summary of Literature and Exposed Gaps**

It is clear from the literature on CAM why consumers are motivated to 'use' CAM health services. An extensive review of the extant literature found six key underlying reasons for CAM use: philosophical orientation and postmodern health values, disenchantment with mainstream medicine, empowerment and self-responsibility, holistic approach, natural underpinnings, and spiritual, intuitive and paranormal beliefs. In essence CAM consumers are 'pulled' towards CAM because of their underlying values, beliefs and philosophical orientation towards health and life. CAM embodies these philosophies and offers these consumers a form of health care that is empowering, encourages self-responsibility and has a holistic, natural and sometimes 'spiritual' approach. However, what is not evident in the extant literature is what do CAM consumer's 'get' when they 'use' CAM health services. Specifically unknown is what CAM consumers' perceptions, evaluations and benefits (value) of their 'experiences' of CAM health services are, and how CAM consumers co-create value throughout their consumption experience of CAM health services.

As discussed in the 'value' literature, 'consumer value' is ultimately determined and 'created' by the 'user' during the consumption experience (Vargo & Lusch, 2006, 2008; Grönroos, 2008, 2011). Consumer value is multi-dimensional consisting of many interrelated dimensions including utilitarian value (instrumental, task-related, rational,

functional, cognitive, and a means to an end consumption) and hedonic value (reflecting the entertainment and emotional worth of consuming, which is non-instrumental, experiential, and affective) that form a holistic representation of a complex phenomenon (Holbrook, 1994, 1999; Sheth et al., 1999; Sánchez-Fernández & Iniesta-Bonillo, 2007). A gap in the literature is apparent with regards to the value CAM consumers determine and co-create from their CAM health service experiences. More research is required on ‘value’ from a consumer’s perspective within CAM health services (Rajamma & Pelton, 2010). Understanding this is critical to understanding the CAM phenomenon and its place in modern health care (Adams, 2014), and in developing a deeper understanding of consumer value and value co-creation in a service setting.

## **2.16 Research Objectives and Questions**

The objectives of this research is to study and extend the concepts of consumer value and value co-creation within a health care service context, specifically CAM health services, and to explore the CAM consumer’s ‘lived experience’ of CAM health services in order to understand the CAM phenomenon.

The specific research questions that this research studies to address the exposed gaps in the literature are:

1. What do CAM consumers value from their CAM health service consumption experiences?
2. How do CAM consumers co-create value through their consumption experiences of CAM health services?

# Chapter 3 Methodology

## 3.1 Introduction

This chapter outlines the strategy, design and methodology that framed the research project. The research adopted an interpretive approach employing an exploratory ‘multiple’ case study research strategy, using qualitative research methods including in-depth interviews and a simplified version of the Zaltman Elicitation Technique (ZMET). The main aim of this research was to explore what value individual CAM consumers gained (or lost) and how they created value from their consumption experiences of CAM health services in order to understand the CAM phenomenon. The research process was semi-longitudinal and was conducted in three phases over a 12 month period. In the first phase 16 CAM consumers were recruited and interviewed about their experiences of CAM health care. The second phase involved 14 of the original 16 participants each participating in a photo/image gathering exercise and a photo-elicitation interview. A final interview with 13 participants was conducted in the third phase primarily to gain feedback on the findings from the first two phases as a form of triangulation. In total 43 interviews were conducted. Throughout the three phases the research was inductive, reflexive and iterative in approach. In this section the research paradigm is described, and an outline and justification of the research strategy, design and methodology given. This is followed by a description of the key stages of the research process, and a summary of data collection and analysis methods. An on-going issue in the literature has been how to assure the quality and validity of interpretive field research. Consideration is given to this issue, as well as ethical issues the researcher needed to address.

## 3.2 Philosophical Paradigm

A philosophical paradigm, the researcher’s worldview, underpins any study. The paradigm plays a critical role, guiding the way in which the researcher conceives the research objectives and approaches the research process; contributing to the research outcomes, and

(to some degree) even determining the nature of results. According to Denzin and Lincoln (2000, p. 19) a paradigm is a combination of (a) the researcher's ontological perspective (what is the nature of reality?), (b) their epistemological views (what is the nature of the relationship between the inquirer and knowledge?), and (c) their methodological premises (how does one gain knowledge of the world?). Crotty (1998) describes four elements of the research process: epistemology, theoretical perspective, methodology and methods. Each element informs the other to create the overall research paradigm.

Creswell (2014) on the other hand prefers the term 'worldview' to describe a researcher's overall philosophical orientation, as does the researcher of this study. The term 'worldview' simply defines the researcher's general orientation and beliefs about the world and nature of the research that they hold. The researcher's 'worldview' will often determine the research approach they predominantly embrace. Fundamentally, the researcher of this study holds that humans are complex, holistic (physical, mental, emotional and spiritual) beings living in and influenced by a socially and culturally constructed world. To understand human behaviour and phenomena requires a holistic and integrative perspective, that is, a perspective that considers the whole person as being interconnected, and not separate, to the world around them. Therefore the underlying worldview of this study is social constructionism and the theoretical perspective interpretative.

Constructionism is defined by Crotty (1998) as a worldview where meaning is not discovered but constructed, where "there is no objective truth waiting for us to discover", but that "truth, or meaning, comes into existence in and out of our engagement with the realities in our world", and argues that "different people construct meaning in different ways" (p. 8-9) to the same phenomenon. Social constructionism on the other hand considers that all meaningful reality is socially constructed as people engage with others in the world they are interpreting (Crotty, 2003), meaning, people view the world through the lens of their own cultural and social perspective. The use of the word social in social constructionism emphasises the social mode of meaning generation (Crotty, 1998). Social constructionists view knowledge as socially constructed through language and interaction (Tracy, 2013). Interpretivism is based on the view that that there is no universal truth. Any understanding must therefore arise from interpretations that are created from within the

researcher's frame of reference. Interpretivism views reality as being an essentially subjective social product that is constructed and interpreted by humans, according to their beliefs and value systems (Crotty, 1998; Esterberg, 2002; Grant & Giddings, 2002).

### **3.2.1 Theoretical perspective of the study**

The theoretical perspective adopted for this research was interpretive. Grant and Giddings (2002, p. 16) describe the interpretive approach as a paradigm that involves "listening to people" and attempts to "understand what it is to be human and what meanings people attach to events of their lives". Interpretivists assume that reality is constructed via the meanings people give through their experiences and "individuals are actively involved in making sense of the world they are experiencing" (Schembri & Sandberg, 2002, p. 195).

An interpretive approach was considered appropriate because the CAM phenomenon is multifaceted and can be viewed differently by different people according to their experiences, knowledge, beliefs, values and social context. To understand the CAM phenomenon from a CAM consumer's perspective the study focused on the 'lived experience' (Thompson et al., 1990; Schembri & Sandberg, 2011) of CAM consumers and explored how CAM consumers constructed meaning about health and wellbeing by focusing on what they value from their CAM health care.

Holbrook and O'Shaughnessy (1988) have argued the need for an interpretive perspective in consumer research for many years, recognising "the need for interpretation in our attempt to explicate the meanings embedded in consumer behaviour" (p. 400). Schembri and Sandberg (2011) acknowledge there has been an increasing acceptance of the interpretive research approach within the marketing field over the past 30 years. Consumer researchers, such as Schembri and Sandberg (2002; 2011), Thompson (1996, 1997), Thompson, Locander and Pollio (1989, 1990), Thompson and Troester (2002), and Arnould and Thompson (2005) not only advocate the use of the interpretive approach in consumer research but espouse the importance of research that focuses on the consumer's 'lived experience'. Schembri and Sandberg (2011, p. 168) explain

our lived experience of the world enables us to make sense of ourselves, other and the things we encounter every day. Hence, within the interpretive research tradition, the human world is never a world in itself but always an experienced world.

The researcher's view is that 'reality' is a moment in time and our interpretation of the world is based on our personal experiences, beliefs and values. She argues that to truly gain insight into human (consumer) behaviour requires not only a deep understanding of personal experiences in a socially and culturally constructed world, but must also acknowledge the individual as a complex holistic being. Understanding consumer value and the CAM phenomenon she contends required a holistic interpretative approach. This research has captured 'moments' in the CAM consumer's 'lived experience' that has given the researcher an understanding into how CAM consumers perceive and create value from CAM health services providing insights into the CAM phenomenon and its place in modern health care.

### **3.2.2 The qualitative research approach**

The methodological dimension of the research paradigm identifies the researcher's philosophy about how knowledge of the world is gained and governs our choice and use of methods (Crotty, 1998). Other authors, including Creswell (2003) view methodology as a philosophical approach, rather than as a dimension of the paradigm. Qualitative methods have traditionally been positioned as sitting in opposition to quantitative methods as a philosophical approach, but the situation today is "less qualitative versus quantitative and more how research practices lie on a continuum between the two" (Cresswell, 2003, p. 4), and depends on the researcher's world view. Interpretive approaches have become equated with a qualitative research approach to data collection, analysis and interpretation (Esterberg, 2002; Grant & Giddings, 2002; Spiggle, 1994).

Qualitative research primarily aims to understand a human or a social problem in its natural context and generalises to theory. As opposed to a quantitative approach which typically uses measurements and statistics to test and validate theory, and to ascertain whether it can be generalised to a population. Van Maanen (1983, p. 9) argues that qualitative research

is at best an umbrella term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency of certain more or less naturally occurring phenomena in the social world.

The aim of qualitative research is to build a rich, holistic picture, and a deep understanding of a phenomenon within a particular context (Miles & Huberman, 1994). Denzin and Lincoln (2000) describe qualitative research as a “situated activity” that places the researcher “in the world”. The qualitative researcher is seen as employing various interpretative practices to help “make the world visible” (Denzin & Lincoln, 2000, p.3). This involves making sense of the phenomena being studied in terms of the meanings that people in the relevant natural settings bring to them. A qualitative approach typically involves the collection and analysis of a range of empirical materials (such as case studies, personal experiences, interviews, artefacts, texts, and interactions) that describe “moments and meanings in people’s lives” (Denzin & Lincoln, 2000, p. 3).

### **3.2.3 Qualitative approach in consumer research**

Denzin (2001) argues that critical qualitative inquiry in consumer research is imperative to understanding today’s consumer and consumption behaviour. Historically, consumer research has been dominated by positivistic quantitative methods which still continue today despite a “revolt” against this dominant paradigm in the 1990’s (see Reid & Brown, 1996; Hirschman, 1989; Brown, 1995, Hirschman & Holbrook, 1992; Brown, 1995). However, the transformations in qualitative research made in this period have remained and scepticism towards qualitative inquiry as ‘soft’ research has diminished (Denzin, 2001; Goulding, 2005). A new respect for qualitative research has emerged as more researchers recognise the contributions it has made to consumer and marketing theory, management implications and policy (Bellenger, Bernhardt, & Goldstucker, 2011).

### **3.2.4 Rationale for use of qualitative approach in this study**

This research adopted a qualitative approach as it was considered an appropriate design to investigate the research problem of what and how CAM consumers perceive and co-create value and to understand further the CAM phenomenon. Of particular importance to this study, qualitative methods have been advocated as the best strategy for exploring a new area, such as CAM, to understand people’s “lived experience” and generate conceptual frameworks (Miles and Huberman, 1994). Qualitative methods are also inherently flexible, and can be varied in the course of the study, according to the nature of emerging findings

(Spiggle, 1994). This is beneficial when little is known about the phenomenon being investigated (Miles and Huberman, 1994).

### **3.3 Case Study Research Method**

This research adopted a case study design, described by Yin (2009) as a ‘holistic multiple-case design’. Qualitative methods, including in-depth interviews and a visual metaphor elicitation technique were the main tools of data collection. This section will outline what case study research is, the use of case study research in consumer behaviour, the case study design for this research as well as justify why case study research is considered appropriate for this study.

#### **3.3.1 What is case study research?**

The case study research method is a way of studying one or a few entities (people, groups, organisations, communities and even countries) in depth providing “holistic” analysis and “thick” descriptions of the phenomenon in question (Gerring, 2007). The case study approach is “an intensive study of a single unit or a small number of units (the cases), for the purpose of understanding a larger class of similar units (a population of cases)” (Gerring, 2007, p. 37). The approach is useful in research of an exploratory nature (Gerring, 2007).

Case study research has been defined by Yin (2009, p. 17) as “an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident.” Woodside (2010, p. 1) argues that Yin’s definition is not broad enough and defines case study research as “an inquiry that focuses on describing, understanding, predicting, and/or controlling the individual (i.e., process, animal, person, household, organization, group, industry, culture, or nationality)”. Radley and Chamberlain (2012, p. 391) attempt to “rescue case study from the bottom of the methodological toolbox”, and argue that the case is something to be explored. Gerring (2007, p. 19) describes the ‘case’ as “a spatially delimited phenomenon (a unit) observed at a single point in time or over some period of time. It comprises the type of phenomenon that an inference attempts to explain.” Case study research provides the researcher with input from the ‘real world’ by providing data from which concepts can

be formed or tried (Gummesson, 2001). This author prefers Yin's (2009) view on the case study because it is clear and comprehensive and outlines key characteristics as summarised below:

- Phenomenon is examined in a natural setting
- Many variables of interest
- Multiple methods of data/evidence are used
- One or few entities (person or group) are examined
- No experimental controls or manipulation are involved
- Benefits from prior theory development to guide data collection and analysis

Case study research is useful in the study of 'why' or 'how' questions (Yin, 2009); and when the researcher is interested in obtaining a wealth of current information concerning the subjects, phenomenon or problem area in a natural setting, using multiple methods of data collection (Gummesson, 2001; Yin, 2009). Case study research provides the researcher with input from the 'real world' by providing data from which concepts can be formed or tried (Gummesson, 2001). Gillham (2000) argues that case study research is about gathering evidence from which "theorizing emerges" (p. 35). Case study research is therefore less about testing theory and more about building theory (Gillham, 2000).

### **3.3.2 Case study research in consumer behaviour research**

Case study research has been used in consumer research to explore and understand the consumption behaviour of consumers, and "used to arrive at specific or general conclusions about certain phenomena, recognizing the multitude of variables, complex interrelations and ambiguities of social life" (Gummesson, 2001, p.34-35). Thompson et al. (1990) and Thompson (1996) advocate the use of in-depth case research when exploring consumers' 'lived' experiences. Thompson et al. (1990) used individual case research to explore the consumption experiences of ten contemporary married women with children. Thompson (1996) explored the consumption experiences of seven professional working mothers. A recent study by Elms and Tinson (2012) used case research to study the grocery consumption experience of one mother with a disability to explore the concept of

consumer vulnerability. Other advocates of in-depth case research in consumer behaviour include Fournier (1998) who explored consumers' relationships with brands using three women from different life situations, and Woodside, Sood and Miller (2008) who studied two consumer's use of brands.

### **3.3.3 Case design**

This research adopted a 'holistic multiple-case design' as described by Yin (2009) and used individuals as the unit of analysis. According to Yin (2009) the holistic approach is useful when the 'global' nature of a case or cases is examined or "the relevant theory underlying the case study is itself of a holistic nature" (p. 50). The context of CAM and the concept of consumer value are both considered holistic and multi-faceted. Hence, a holistic case design approach was considered appropriate. Multiple-case designs have the advantage of providing more compelling evidence and are generally "regarded as being more robust" (Yin, 2009, p. 53). However, a multiple-case study design can often require more resources and time that is beyond the single student or independent researcher. However to obtain variation in the cases (i.e. a variety of CAM therapies) a multiple-case design was necessary.

### **3.3.4 The unit of analysis**

This research was primarily interested in consumers' experiences of CAM health services and the value they gained and co-created from these experiences, therefore, the unit of analysis was individual CAM consumers. Sixteen individuals, 12 women and 4 men, aged 20 years and over with 'lifestyle' health complaints who had just started a treatment programme with a CAM practitioner or were currently seeing a CAM practitioner on a regular basis (for example, a chiropractor) participated in this study. The participants, their involvement in the research, and recruitment procedures are described and outlined in more detail in section 3.5.

As highlighted in 3.3.2 case study research using one or a small number of individual/s is a widely accepted approach in consumer research to study consumers' consumption experiences in-depth (Elms & Tinson, 2012; Fournier, 1998; Woodside et al., 2008; Thompson 1996). Thompson (1996) argues that in-depth research of the consumption

experiences of a few individuals can provide a rich understanding of the social, cultural and psychological dynamics that shape consumer practices and preferences. Ultimately, in-depth case study research can lead to building theory (Eisenhardt, 1989).

### **3.3.5 Rationale for use of case study research**

The use of case study research as the research method for this research is deemed appropriate for four key reasons. Firstly, this research was interested in the CAM phenomenon and using CAM as a ‘real life’ context to study consumer behaviour. Secondly, the research purpose was to explore and understand the experiences and consumption behaviour of CAM consumers, requiring depth and “thick descriptions” (Geertz, 1973). Thirdly, one of the key research questions for this study was a ‘how’ question which is appropriate for case study research. Lastly, and most importantly this research was exploratory in nature and focused on theory building not theory generalisation.

## **3.4 Visual Methods**

As discussed previously in the literature review the process of value co-creation is not well understood and scant research to date can be found that studies how a consumer co-creates value. It is believed that value co-creation is a process, yet no-one knows when it starts, how it develops and when it ends (Grönroos, 2011a). Plus, the terms and concepts of value and value co-creation are still imprecise and would potentially be difficult for a consumer (the participant) to articulate their experiences of value and value co-creation in an interview alone. Therefore, it was deemed appropriate to use a combination of interview and visual elicitation methods to gather data on value and value co-creation in the CAM context.

This research adopted a photo/image-elicitation method using participant-produced photography and image collection as part of its research process. Using the auto-driving technique (Heisley & Levy, 1991) and a simplified version of Zaltman and Coulter’s (1995) ZMET technique participants were asked to collect pictures and/or take photographs of images that most represented what they thought and how they felt about their experiences of CAM prior to attending a second interview. The images were used as

an ‘auto-driver’ in the second interview to elicit metaphors that illuminated deeper meanings of the CAM experience, in particular the value gained and the value co-creation process. Prior to outlining the research process it is pertinent to discuss the underpinnings of visual research, the use of the photo-elicitation method and its relevance to consumer research.

### **3.4.1 Why visual methods?**

The use of visual methods has seen a “global surge” as researchers come to the realisation that considerable knowledge can be gained by adopting image-based methodologies (Prosser & Loxley, 2008). Prosser and Loxley (2008, p. 1) argue that

visual methods can: provide an alternative to the hegemony of a word-and-number based academy; slow down observation and encourage deeper and more effective reflection on all things visual and visualisable; and with it enhance our understanding of sensory embodiment and communication, and hence reflect more fully the diversity of human experiences.

Humans are visual beings that tend to comprehend their visual environment immediately (Belk, 2013), and what we ‘see’ is often a reflection of who we are and what we value (Tian & Belk, 2005). Typically our thoughts occur as images which are then expressed verbally (Zaltman & Coulter, 1995). According to Hodgetts, Chamberlain and Radley (2007, p. 263) “the visual medium is central to how most of us navigate daily life and come to know and interact with our social worlds”. Often our conversations are filled with verbal references to images and icons that give meaning to our lives and express our experiences of the world (Pink, 2007). Visual methods when combined with in-depth interviews “can create exciting new knowledge” through the “meanings that people create when they combine images and words” (Pink, 2007, p.31). Visual images enable research participants to explore and articulate deeper meaning and insights into the phenomenon being studied that cannot be elicited by interviews alone (Harper, 2002; Rose, 2012). Sheridan and Chamberlain (2011) argue there is a growing recognition of the limitations of interviewing, and the use of visual methods has become a popular tool to enhance the interviewing process. Visual images can change the emotional tone of an interview and can “engage the senses more powerfully than conversation alone” (Reavey, 2011, p. 6).

Visual methods can offer researchers' opportunities to gather "appealing and pertinent data" that otherwise would be difficult to obtain (Brace-Govan, 2007, p. 735). New technologies, such as digital cameras, phone cameras, internet images, have made it even easier for researchers to explore experiences using visual methods of inquiry (Butler-Kisber & Poldma, 2010). Technology has been a key factor in the evolution of visual research (Prosser & Loxley, 2008).

### **3.4.2 Visual methods in consumer research**

Visual methods are not new in consumer research. The use of visual methods in consumer research can arguably be traced back to three papers that were presented at the Association of Consumer Research Conference in 1985 (Heisley & Levy, 1991). One of these conference papers by Heisley and Levy introduced the photo-elicitation technique which they referred to as "autodriving". Photo-elicitation is a method where photographs are brought to an interview and discussed (Rose, 2012). The premise being that photographs elicit information, evoke feelings and jog memories that words alone cannot (Harper, 2002). Auto driving is based on projective and visual techniques where participants drive the interview based on visual stimuli of their own consumption behaviour (Heisley & Levy, 1991). Heisley and Levy's conference paper led to a series of articles being published that used photo-elicitation, including their own inaugural paper 'Autodriving: A Photoelicitation Technique' (Heisley & Levy, 1991). Heisley & Levi's research used photo-elicitation to encourage participants to talk about family meal behaviour. Photographs of three families preparing and eating dinner were taken by the researchers and then subsequently used as autodrivings in interviews with the family (Heisley & Levy, 1991). Around this time a number of other renowned consumer researchers began to use visual methods in consumer research. Belk et al. (1988) used photography as a source of field notes in an ethnographic and naturalistic pilot study on consumer behaviour in America, and has continued to use visual methods to study consumers (Belk, 2013; Belk, Ger, & Askegaard, 2003; Belk, Wallendorf, & Sherry, 1989; Tian & Belk, 2005). Holbrook too at this time began using photography to study his own consumption experiences and has continued to use visual methods (For example, Holbrook, 1987; Holbrook, 2006a; Holbrook & Kuwahara, 1998). Wallendorf and Arnould (1991) examined over 2,500 photographs taken of Thanksgiving to understand the rituals around

this occasion. In the early 1990s the Zaltman Metaphor Elicitation Technique (ZMET) was developed providing both marketing academics and practitioners a tool to elicit both conscious and unconscious thoughts about brands, products and advertising using photographs and pictures (Zaltman & Coulter, 1994, 1995). Zaltman and Coulter (1995, p. 38) believe that

pictures typically represent basic concepts and therefore are useful tools for understanding consumers, thoughts, feelings, and behaviours. Pictures, then, can serve as entry points for exploring other consumer concepts and represent a natural and efficient way for consumers to convey higher order constructs (Zaltman & Coulter, 1995, p. 38).

Despite being introduced to consumer research nearly 30 years ago visual methods have recently resurged again having suffered from the ontological objectivist positivism versus humanistic relativism divide (Basil, 2011). Introduced by predominantly humanistic, naturalistic and/or ethnographic orientated consumer researchers there were concerns that visual methods, such as photography, were too subjective and therefore not a valid source of data (Basil, 2011). The resurgence of visual methods, such as photo-elicitation, in marketing and consumer research, demonstrates the power of ‘the visual’ to drive verbal expressions of lived experiences (Rose, 2012). Photo-elicitation, in particular, offers a way of gaining insight into participants’ lives by asking for their interpretation of the visual, leading to a rich source of data (Croghan, Griffin, Hunter, & Phoenix, 2008). The current emphasis on participants being more involved in the research process by taking their own photographs has taken the photo-elicitation method a step further (Belk, 2013). Participant-produced photos not only empowers the participant and provides a greater insight (than the researcher taking the photos) but it also helps bridge the gap between the researcher and the researched (Croghlan et al., 2008; Harper, 2002). An overview of participant-produced photography follows.

### **3.4.3 Participant-produced photography**

Participant-produced photography, where participants are asked to take photographs of particular objects or experiences, has become an increasingly popular method in marketing and consumer research (Belk, 2013; Brace-Govan, 2007; Tian & Belk, 2005). Having participants take the photographs enables participants’ to become involved in the

generation of research data (Belk, 2013; Brace-Govan, 2007; Pink, 2007), which empowers the participant and leads to rich sources of information (Rose, 2012). Brace-Govan (2007) argues that not only can participant produced photos offer a greater level of depth during interviews, but they can also provide a check on the researcher's findings and "act as a simple and efficient memory-prompting device" (p. 738) for the participants.

Zaltman and Coulter (1995) understood the power of photo-elicitation and participant-produced photography in their research on metaphor-based brand and advertising research, arguing that these techniques help uncover important stories that are often latent or hidden. Coulter and Zaltman (1994) argue that one of the core benefits of participant-produced photos is control:

Customer control has a number of benefits. First, customer-generated pictures are especially meaningful because what the eye perceives when it is encoding a sequence of information over time, including the viewing of a static image such as a magazine ad or a point-of-purchase promotion, is guided by existing customer knowledge, beliefs, or expectations. Second, requiring customers to collect the stimuli increases the likelihood of uncovering important, but previously unconsidered customer issues (Coulter and Zaltman, 1994, p. 503).

Since Zaltman and Coulter (1995) introduced the ZMET method, a number of consumer researchers have used the entire ZMET method or parts thereof, specifically participant-produced photography and depth interviews as their key method to gather data. Zaltman's (1997) article 'Rethinking market research: putting people back in', which advocates the use of participant-produced photos, has alone been cited in over 450 articles. The original ZMET method includes the following ten steps 1) Storytelling 2) Missed Issues and Images 3) Sorting task 4) Construct Elicitation 5) Most Representative Image 6) Opposite Image, 7) Sensory Image 8) The Mental Map, 9) The Summary Image and 10) The Vignette (see Zaltman and Coulter, 1995). Many of the studies using the ZMET technique specifically and other visual methods have focused primarily on consumers' perceptions and the meanings they attach to products and brands.

A number of studies have used participant-produced photography to explore consumer experiences. In an earlier study Holbrook and Kuwahara (1998) used photography, the photo essay and stereography as a collective approach to understanding consumption

experiences of the topic “What New York Means to Me”. Advocates of participant-produced photography, Holbrook and Kuwahara argue that photos taken by the participants (as opposed to the researcher) are more powerful in terms of uncovering thoughts, feelings and meanings of consumption experiences. More recently, Cheetham and McEachern (2013) used photo-elicitation, participant-produced photography and autodiving interviews to study consumption experiences and consumption practices among fifteen pet owners. Participants were asked to take photos of their pets in whatever way they wished. The photos were then used in a phenomenological interview to enable the participants to tell stories about themselves, their families and their pets. Cheetham and McEachern found the photo-elicitation technique played a key role in stimulating participants to tell their stories. Johnstone and Todd (2012) studied mothers’ experiences of the retail environment using participant-produced photography and photo-elicitation interview techniques. Five stay-at-home mothers with young children were asked to photograph servicescapes they visited frequently. Use of photos was found to be invaluable because it encouraged participants to think about the places before the interview and were used as a memory tool.

Tian and Belk (2005) used participant-produced photo elicitation to study the meanings of possessions displayed in people’s offices. They asked 20 participants to think about the personal objects or material goods they have in the workplace and to take photographs of 12 objects or possessions that are important to them or that they value. These photos were then used in ‘photo-elicited interviews’ where the participants were asked to talk about the photos. Brace-Govan (2007) asked 10 household shoppers to take photos of anything interesting connected to their shopping and were subsequently interviewed about the photos. Kent and Kirby (2009) used photo-elicitation and an adaption of ZMET to explore store design and retail image.

Very few studies have used visual techniques such as ZMET to study services and service experiences. Lee, McGoldrick, Keeling and Doherty (2003) used a shortened version of the ZMET procedure to understand customers’ behaviour and motivation towards 3G mobile technology in the mobile banking service. Eight participants were recruited, provided information on the 3G mobile phone service and asked to collect at least ten images that indicated what the topic meant to them. Depth interviews were conducted using ZMET procedures including story-telling, missed images, sorting task, construct elicitation, most

representative image, opposite image, sensory images, and summary image. Chen (2008) adopted ZMET to study consumers' family vacation experiences. Twenty participants who had been on a family vacation in the past 12 months were recruited and asked to bring in photos or images that depicted their thoughts and feeling about family vacations. To this authors knowledge no research could be found that used visual techniques to study consumers' experiences of health services.

#### **3.4.4 Visual techniques used in this study**

This research used a simplified adapted version of the ZMET method. The entire ZMET method was considered too complex, time consuming and required experienced ZMET researchers to implement. However, parts of the ZMET method, particularly the use of participant-produced and/or gathered images and the conversation 'story-telling' style interviews were appropriate and within the scope of this research and the researcher's expertise. The shortened version of the ZMET technique provided a more simplified, valid and credible process for the photo/image elicitation component of this research. Having a proven technique to uncover both conscious and unconscious thoughts and feelings was considered essential to understanding value and value co-creation in this research.

In line with Zaltman and Coulter's (1995) philosophy the CAM participants were asked to take a minimum of 12 (maximum of 20) photographs and/or find images (from magazines, internet, newspaper, books etc) that represented or captured what they thought and how they felt about their CAM health care experiences. These photos/images were then discussed using the "auto-driving" technique (Heisley & Levy, 1991) in the second interview using five of the ZMET steps including: Step 1 Storytelling, Step 2 Missed images, Step 3 Sorting task, Step 5 Most representative image and Step 9 Summary image. A brief outline of the shortened ZMET techniques follows.

##### **3.4.4.1 ZMET Technique – shortened version**

The Zaltman Metaphor Elicitation Technique (ZMET) is a qualitative research tool that uses visual and sensory images to help better understand the meaning consumers have of brands, products, services and advertising (Coulter & Zaltman, 1994). Primarily it has been used to elicit "the metaphors, constructs and mental modes that drive customers' thinking

and behaviour” towards brands and products (Coulter & Zaltman, 1994, p. 501). More recently the technique has been used to help understand consumer experiences (Chen, 2008).

Typically the implementation of ZMET involves recruiting 20-25 consumers per project who are given a camera and instructed to take photographs and/or collect pictures of what the topic at hand means to them, e.g., a brand name or product use. Individual interviews using ‘guided conversation’ and focusing primarily on the photos and pictures is scheduled approximately seven to ten days later (Coulter & Zaltman, 1994; Zaltman & Coulter, 1995). The five steps used in this study are described below.

**Step 1. Storytelling** – This step provides participants with an opportunity to tell their stories by describing the content of each photograph or picture. This step is in line with the photo-elicitation ‘auto-driving’ technique as described by Heisley and Levy (1991) where photographs and pictures are used to drive the conversation with the participant. The auto-driving technique enables the participant to respond to stimuli (the image in the photograph or picture) that has been drawn directly from their own life experiences (Heisley & Levy, 1991). In this research participants were asked to describe each picture by asking the participant the following “tell me about this picture”.

**Step 2. Missed Images** – In this step the interviewer asks the participant to describe any aspects or issues for which she or he was unable to photograph or find a picture, and to describe a picture that would represent the issue. Hodgetts, Chamberlain, & Radley (2007) concur that consideration of photographs not taken or pictures not found is an important part of the process. One of the limitations of photo-elicitation is time and access restraining the participant from taking the photographs they want. If not addressed by the researcher important information could be missed. Hodgetts et al. (2007, p. 267) argue “that what could not be photographed is as important as what is photographed” because these “absent” images can provide as much depth and understanding as the photographs themselves. It was anticipated that due to the sensitive nature of the topic of this research that there would be pictures that participants would like to have taken but couldn’t for privacy or access reasons. Therefore, this step was considered an important part of the

research process. Participants were asked if there any images or pictures they would have like to have taken or found but couldn't.

**Step 3. Sorting Task** – In this step the participant is asked to sort his or her pictures into meaningful piles and to provide a label or description for each pile. This step is useful because it helps establish important themes to the participant. This research intended to establish 'value' themes, in terms of what aspects participants valued most from their CAM experiences, and therefore deemed appropriate to include.

**Step 4. Most Representative Image** – Participants in this step are simply asked to choose the image that most represents the topic at hand. In this research participants were asked to choose one image that most represented their CAM experiences in order to establish the most important aspect.

**Step 5. The Summary Image** – In this step the participant creates a summary image or montage using his or her own images. Participants in this research were instructed to complete a summary collage using six of the photos/images during the interview. Participants chose up to six images and then placed them on a A4 piece of paper. These images/pictures were then later created into a collage using Microsoft word by the researcher.

### **3.5 Data Collection Procedures**

#### **3.5.1 Selection of the cases**

Purposive sampling was used to select appropriate individuals for the research. Purposive sampling techniques are commonly associated with qualitative methods (Miles & Huberman, 1994), and used for sampling of information-rich cases (Hardon, Hodgkin, & Fresle, 2004). This research used 'maximum variation sampling' (Hardon et al., 2004; Miles & Huberman, 1994). The 'maximum variation sampling' method "aims to select study units which represent a wide range of variation in dimensions of interest" (Hardon et al., 2004, p. 58). As previously alluded to in the literature section, CAM ranges from established and accepted therapies such as chiropractors, acupuncture, osteopathy and massage therapy, to more 'alternative' therapies such as naturopathy, homeopathy, herbalism, aromatherapy, kinesiology, Reiki, and energy healing (Robinson et al., 2009).

Each one of these CAM therapies has their own set of therapeutic and healing belief systems (Collyer, 2004; Kaptchuk & Eisenberg, 2005; van Wersch et al., 2009; Willis & White, 2004). To capture the ‘essence’ of the value CAM consumers gained and co-created, and to understand the similarities and differences it was important that a variety of CAM therapies be explored.

A sample of both women and men of varying ages were also recruited. Significantly more women than men use CAM health services (Ministry of Health, 2008) which was one reason why a smaller proportion of men participated in the study. The four men had been recruited and subsequently interviewed after the women. Initially this research was only going to focus on women, primarily because women are more likely to use CAM health services. However, after feedback from an esteemed scholar on the initial findings from the women, a recommendation was made to include men in the study. Age was also a consideration hence a variety of ages were also sought. Ages of the participants ranged from 24 to 77 years old with the majority in the 40 and 50 year old bracket.

Three main criteria were established prior to the recruitment of the participants with the aim of recruiting a variety of CAM consumers who were using different CAM health services at the time of the research for chronic lifestyle health issues. The criteria were incorporated in to the promotional material, such as posters and fliers, and information material (discussed in 3.5.2.1), to attract participants who fitted the required profile. Each criteria is now outlined.

1. To attract participants from a wide variety of CAM health services the Cochrane Collaboration group classification system (Wieland et al., 2011), as outlined in section 2.5.3 and appendix B, which classifies CAM into the following categories: Mind-body interventions; natural products based on therapies; manipulative and body-based methods; energy therapies; and alternative medical systems, was used to guide the selection of the cases. Participants that were seeing practitioners/therapists of ‘popular’ therapies as outlined by Robinson et al. (2009, p. 156) and the Ministry of Health (2008) and included the following: Chiropractor, Osteopath, Massage therapist, Homeopath, Naturopath, Acupuncturist, Traditional Chinese Medicine practitioner, Herbalist, Aromatherapist, Reiki, Meditation, and Bowen therapy, was also a consideration in the selection. These CAM health

services were listed on the promotional material and in the participant information sheets.

2. The research was interested in individuals who either had just started a treatment programme and intended continuing with the CAM practitioner they had, or were seeing a practitioner on a regular basis, for example, a massage therapist or a chiropractor. The purpose of this research was to study value co-creation over time and therefore it was deemed necessary for participants to be seeing a practitioner during the time of the research.
3. Individuals with ‘lifestyle’ health issues, for example, stress, weight problems, allergies, back/shoulder/neck pain, headaches, digestive disorders, women’s health issues (menopause, PMS, hormone imbalance), general well-being, was an important criteria for this study. Acute illnesses, potentially life threatening conditions and serious mental health issues such as clinical depression were generally not considered. The reason for excluding life threatening and serious mental illness was for participant and researcher safety. Although the researcher is a qualified naturopath, she is not currently practicing and therefore did not have the appropriate medical or psychology training to deal with potentially problematic cases. Despite this criterion one participant who had previously been diagnosed with lung cancer was chosen because her condition was in remission and she was using CAM at the time of the study as a means to maintain her health. One other participant with long-term depression and anxiety also participated in the study as her condition at the time of the study was not considered serious and she was being managed by a medical doctor. Although the participant had attempted to use CAM in the past for this condition her primary reason for using CAM at the time of the study was for menopause, back/neck issues and general well-being.

Cultural differences amongst consumers in terms of CAM health care consumption was not in the scope of this research, therefore, selecting individuals from different cultural background was not a key recruitment criterion. Individuals seeing a Maori traditional ‘Rongoa’ healer or a Pacific traditional healer were not actively recruited, due to the sensitivity of Maori and Pacifica health issues that the researcher was not qualified to deal with. However, if a participant was seeing or consuming these forms of CAM then advice

from a Maori and/or Pacific advisor respectively would have been sought as required by the University's human ethics policies. This was not required. All of the participants bar one were of European descent. One participant self-identified as Pakistani.

It is important to note that many CAM practitioners offer a variety of treatments that potentially fall into two or three of the Cochrane Collaboration categories, for example, a naturopath (Alternative Medical Systems) may offer nutrition therapy and herbal medicine (Natural Product Based Therapies) and could also be a qualified acupuncturist (Energy Therapies). Also, many of the participants used a variety of CAM therapies often simultaneously as an integrated form of health care or for different ailments. Table 5 summarises the 16 participants highlighting the CAM therapies used, age, and gender. It also shows the phases each participant was involved in and where the interviews were conducted, discussed further in 3.5.4 and below respectively. The therapies in bold indicate the therapies the participants were using at the time of the study.

The interviews took place in various places, at the convenience of the participant, and included participant's homes, university campus library meeting room, community library meeting room, participant's workplace and cafes. Six participants were interviewed at their home which provided the most conducive environment for interviewing. It also gave the opportunity to view the participants in their own surroundings which added to the richness of the data. Three out of the four men chose to be interviewed at their place of work, primarily for convenience and time because they were working full-time. This also gave some insight into the participants in terms of seeing them in a real life context, particularly because all three men had suffered stress due to their work environments which CAM health care was helping them with. Six participants were interviewed in a library meeting room on either the university campus or at a community library. This environment provided a more formal and mutual situation which suited these participants. Four participants were interviewed in local cafes convenient for the participant (mostly phase 2 and 3 interviews). Although this environment was noisy it did create more of a 'meeting a friend for a coffee' relaxed type atmosphere for the research.

**Table 5: Summary of the 16 participants including the research phases involved in**

	<b>Pseudonym</b>	<b>Sex</b>	<b>Age</b>	<b>CAM therapies used</b>	<b>Where interview was conducted</b>	<b>Research phases involved in</b>
1	Lilian	F	46	<b>Osteopath</b> , naturopath	Participant's home	Phase 1, 2 & 3
2	Jenny	F	28	<b>Homeopathy</b> Herbal medicine & supplements	Massey University Campus, meeting room	Phase 1, 2 & 3
3	Margaret	F	46	<b>Chiropractor</b> Massage, bowen therapy	Participant's home	Phase 1, 2 & 3
4	Vivian	F	52	<b>Naturopath, Chiropractor, Energy healing</b> , Holistic GP, spiritual healing, aurosoma	Participant's home	Phase 1, 2 & 3
5	Margo	F	39	<b>Cranial Osteopath, Holistic GP</b> , energy healing, acupuncture, herbal medicine	Participant's home	Phase 1, 2 & 3
6	Olivia	F	24	<b>Naturopath, osteopath, nutritionist</b> , acupuncture, energy healing, herbalist	Massey University campus, library meeting room	Phase 1, 2 & 3
7	Rachel	F	45	<b>Osteopath</b> , naturopath, hypnotist, massage	Participant's home	Phase 1, 2 & 3
8	Mandy	F	26	<b>Massage, Osteopath, Naturopath</b>	Local Café near participant's home	Phase 1
9	Jules	F	31	<b>Holistic Counsellor, Naturopath, TCM, osteopath</b>	Participant's home	Phase 1 & 2
10	Anne	F	60	<b>Acupuncture, Yoga</b>	Community library meeting room	Phase 1, 2 & 3
11	Fiona	F	49	<b>Acupuncture, naturopath, Chiropractor</b>	Community library meeting room City café (phase 2 & 3)	Phase 1, 2 & 3
12	Jane	F	51	<b>Naturopath, Reiki, Bio resonance, Nutritionist</b>	Massey University campus, library meeting room	Phase 1
13	Peter	M	40	<b>Chiropractor, kinesiology massage, acupuncture,</b>	Participant's workplace in a meeting room	Phase 1, 2 & 3
14	Bill	M	77	<b>Reiki, self-hypnosis, Body Harmony</b>	Community library meeting room City café (phase 3 only)	Phase 1, 2 & 3
15	David	M	50	<b>Energy healing, acupuncture, kinesiology</b> , naturopathy, meditation, Chinese medicine, Bowen therapy, aurosoma	Participant's workplace in a meeting room off his classroom	Phase 1, 2 & 3
16	Steven	M	49	<b>Manipulative Therapist, Acupuncture, osteopathy (cranial), Pilates, Ozone therapy, chiropractor</b>	Participant's workplace in their office City café (Phase 2)	Phase 1, 2 & 3

### 3.5.2 Recruitment of research participants

Recruitment of participants was conducted in two ways. Initially participants were sought by advertising in six Auckland based CAM clinics and CAM related businesses. The majority of the women participants were recruited in this manner. Further participants were sought via a convenience sampling, using second hand contacts, to ensure a spread of gender and CAM health care therapies. All the men and some of the women were recruited

this way. To ensure individuals “freely agree[d] to participate in the research” (Esterberg, 2002, p. 45) a self-selection recruiting method was used. Those individuals that were interested in participating were asked to either phone or email the researcher. The researcher did not contact any potential participants without having first been advised of their wish to volunteer.

### **3.5.2.1 Recruitment via CAM clinics/businesses**

Six established CAM clinics and businesses within the Auckland region that offered a range of CAM therapies and health care services were approached either via email or in person. Those contacted by email were sent a Clinic Information Sheet (Appendix C) and permission was gained to advertise for research participants. Poster adverts and fliers asking people to volunteer were placed in the clinics (refer appendix D and E for a sample of the advert and flier). The adverts briefly described the research project and asked interested individuals to email for more information. Twelve women made contact via email asking for further information. The researcher emailed a detailed Participant Information Sheet (Appendix F) and asked each of them to read the information sheet and phone or email back if they were still interested. Ten participants emailed that they were interested and two declined. All ten women were screened over the phone and met the criteria as detailed above.

### **3.5.2.2 Recruitment via second hand contact**

To recruit more participants, in particular men, an email was sent to selected contacts via second-hand personal contacts (i.e. not personal contacts of the researcher but contacts via others) that may know someone that might be interested in participating. All four men and two women were recruited this way. Once again, to ensure participants self-selected and did not feel pressured to participate, people who were interested in finding out more about the study were asked to make contact either by phone or email. In total six men made contact, two of whom declined after receiving the Participant Information Sheet. The two women who made contact agreed to participate and met the criteria.

### **3.5.3 Participant commitment**

Participants were asked to commit to the project for a period of 12 weeks and were offered a \$50 voucher for their time. Each participant was informed that they would be interviewed up to 3 times in a mutually agreed location and asked to take photographs and/or gather images that represented their CAM experiences. It was anticipated that each interview would take approximately 60-90 minutes and the photography/image collection exercise to take approximately 1-2 hours. The estimated time involved was approximately 6-8 hours over a 12 week period. Those that agreed to participate were made aware of this commitment. However, the reality of this was very different with timeframes for individuals ranging from 3 to 12 months as discussed below in 3.5.4.

### **3.5.4 Three phase process interview strategy**

Semi-structured (in-depth) interviews was the main method used to collect data. A semi-structured (in-depth) interview, unlike the structured interview, relies on general topics to be covered as opposed to a list of formal questions (Fontana & Frey, 2008). The goal of a semi-structured interview is “to explore a topic more openly and to allow interviewees to express their opinions and ideas in their own words” (Esterberg, 2002, p. 87). This enables the generation of depth information about lived experiences and their meanings (Denzin & Lincoln, 2005). The rich and vivid material that an interview turns up is one of its most positive features (Gillham, 2000). In-depth interviews are very good for exploring a topic in detail or for constructing theory (Esterberg, 2002). This research was exploratory in nature and intended not only to explore in detail the CAM consumer’s experience but understand how value is created.

As previously outlined each participant (case) in this research was interviewed up to 3 times over a period of approximately 3 to 12 months; some took longer due to the personal circumstances of the participant. The reason for this semi-longitudinal approach was to explore how value emerges over time; this was considered a particularly important aspect in the consumption of health care services where therapeutic relationships and treatment programmes take time. The stance taken in this research is that value is determined by the consumer during the consumption experience (Vargo & Lusch, 2008). It was assumed that the value of CAM health care is built up over the consumption period and beyond. This

included the experience of the CAM consumer at various points in the treatment programme both in clinic and at home, and the relationship that developed with the CAM practitioner (assuming multiple visits). Multiple interviews also allowed for greater depth and the ability of the researcher to create rapport with the individual participants. Researchers who spend more time with participants are more likely to have a greater knowledge and better personal relationship with their interviewee than a one-time encounter where the relationship is more likely to be impersonal (Esterberg, 2002). Fontana and Frey (2008) argue that there is a growing realization that “interviewers are increasingly seen as active participants in an interaction with respondents, and interviews are seen as negotiated accomplishments of both interviewers and respondents that are shaped by the contexts and situations in which they take place” (p. 144).

#### ***3.5.4.1 Triangulation and trustworthiness***

Importantly the three phase process allowed for triangulation whereby the use of multiple methods over multiple time periods enabled deeper understanding and dependability of data (Woodside, 2010). Figure 8 provides an outline of the research process implemented to collect data for this research along with the approximate timeframes. To ensure trustworthiness of the data the majority of the first and second phase interview transcripts were member checked and any changes to the data were made. Member-checking involved the interview transcripts from phase 1 and 2 being sent to each participant via email and then verified at the beginning of each subsequent interview, for example, phase 1 interview transcripts were checked at the beginning of interview 2 and so on. Phase 3 interviews were not member checked because this interview was primarily in itself a form of member checking for phase 1 and 2, therefore it was deemed unnecessary.

**Figure 8: Research process and approximate timeframes**



#### **3.5.4.2 Phase 1: Story-telling interview**

The first phase of this research involved a ‘story-telling’ interview whereby each of the 16 participants had an opportunity to tell their story about his or her experiences of CAM health care. The aim of this interview was to investigate and explore the participant’s experience of CAM where emergent themes on consumer value were expected to surface. The interview began with: “Tell me your story of what has led you to use CAM.” This allowed the participant to express their story in their own words (Esterberg, 2002), enabling the generation of depth information about lived experiences and their meanings (Denzin & Lincoln, 2005). Discussions flowed like a conversation with deeper questions asked such as “tell me about the treatment you are getting” and “what benefits have you experienced?” Probing was implemented to encourage participants to explore an area of

their health care experiences further. The use of ‘probes’ helped clarify and extend the participants response and encouraged participants to say what they think and helped steer them in the right direction (Gillham, 2000). Essentially the ‘interview’ ran like a conversation which was subtly directed by the researcher (Esterberg, 2002). See Appendix G for the interview guide. Each interview took place shortly after recruitment at a time and place convenient to the participant. Interviews ranged from 40 to 90 minutes in length. At the end of each interview participants were given instructions about phase 2 – the photograph/image collection exercise and second interview - including an instruction sheet explaining the process. Refer to Appendix H for the instruction sheet.

#### ***3.5.4.3 Phase 2: Photograph/image collection and image elicitation interview***

Phase 2 of this research was the most complex and time consuming. Fourteen of the original 16 participants completed this phase. Of the two participants that didn’t complete this phase, one participant did not respond to follow-up emails and texts and the other participant pulled out due to ill health and time commitments. Participants were given two weeks to provide a minimum of 12 and a maximum of 20 photographs, pictures and/or images that represented what they thought and felt about their experiences of complementary and alternative medicine. However, this phase took longer than originally anticipated with the majority of participants taking 4-6 weeks to complete this task. One took 8 weeks and another took nearly 12 weeks. The key barrier for completing this phase from the participant’s perspective was time constraints. All of the participants involved in this phase sent the pictures/images through to the researcher via email. On receipt of the pictures and images the researcher arranged a second interview with each participant. These were conducted within 2-3 weeks of receiving the pictures. Interview times in this phase ranged from 30 to 70 minutes with the majority ranging between 35 and 50 minutes. The second phase interview used the simplified ZMET technique, as outlined in section 3.4.4. Refer to Appendix I for a copy of the interview schedule. Prior to the interview the images/pictures were placed in a word document with approximately three images per page and printed. The pictures were individually cut out and taken along to the interview.

The number of images/pictures taken or collected by participants ranged from 9 to 17. Interestingly eight participants provided less than the stated minimum requirement of 12.

These participants commented that finding more than 12 images was difficult and some felt they were beginning to repeat (i.e. finding images that meant the same thing). Of the fourteen participants only three provided their own photographs. One participant was a graphic designer and photographer, one was a teacher of visual arts and the third used a couple of personal photographs he had taken previously. All the other participants found images off the internet primarily using Google Images. Given the choice the majority of participant's preference was to gather images than take their own photographs due to ease and time.

#### **3.5.4.4 Phase 3: Feedback interview**

The third phase of this research involved a final interview with thirteen of the participants with the primary aim of gaining feedback on findings from the previous two phases as well as understanding the process of value co-creation. Refer to Appendix J for the interview guideline. Interviews were scheduled with participants approximately 6-8 weeks after the phase 2 interview. Due to time commitments one participant did not complete the final phase, demonstrating the difficulty of semi-longitudinal research in terms of participant involvement. Participants during this interview were firstly asked to reflect back on their experiences of CAM and recall any key incidents that were significant in their journey. The majority of the interview was devoted to getting participants' feedback on preliminary findings. Please note due to the longitudinal and inductive nature of the research three participants were presented with their individual case analysis (i.e. analysis of their phase 1 and 2 interviews) to give feedback on in the phase 3 interview, because these participants completed phase 1 and 2 early on in the research process. However, later in the research process the researcher decided to present the other ten participants initial cross-case analyses; this was done via a very short power-point presentation (Appendix K). This proved to be more fruitful in terms of gaining feedback on overall findings, enabling the researcher to refine key results.

#### **3.5.5 Researcher reflective writing**

Reflective writing by the qualitative researcher is often incorporated into the research process to provide a data set of the researcher's reflections of the process. Often referred to as "field notes" it is recommended to write detailed notes straight after an interview to

recall aspects such as the setting, appearance of the interviewee, details of the interaction, impressions of how the interview went and any small details about the interview that seem important (Esterberg, 2002). For qualitative researchers, reflective writing not only offers a way to document the researcher's role and thoughts about the process, but also provides an opportunity to triangulate data by the journal itself entered as a data set, and a way to use the journal with participants in the study as a communication tool (Janesick, 1999). The researcher of this study wrote field notes after the first phase interviews. These notes were primarily used to reflect on the interviews and make any necessary changes for subsequent interviews. The researcher also noted any observations about the physical setting, the interviewee, their behaviour, the interaction, first impressions, and generally about the process. The notes recorded also contributed to data and provided another opportunity for triangulation of participant data sets.

### **3.6 Data Analysis Procedures**

Miles and Huberman's (1994) guidelines for analysing case research are well-recognised and were followed in this research. When analysing qualitative case research data it is important to recognise that the data collected reflects participant's reported experiences and the researcher's interpretations (Esterberg, 2002). "The strengths of qualitative data rest very centrally on the competence with which their analysis is carried out" (Miles & Huberman, 1994, p. 10). Methodological rigour in case research arises from careful planning of the study design and procedures, and the selection of appropriate data analysis techniques.

In qualitative research, the data analysis stage is seen as involving three overlapping processes: data reduction; data display; and conclusion drawing and verification (Huberman & Miles, 1998). Miles and Huberman (1994) explain this process: data reduction is the process of systematically reducing the data into categories; summarising, coding and identifying themes; data display requires the organisation of information so that actions can be taken and conclusions drawn; conclusion drawing and verification is when the researcher interprets and draws meaning from the displayed data. In this research, analysis occurred in three phases following the study's data collection process (outlined in detail in 3.6.2). The data collection and analysis process was iterative, enabling flexibility

and the ability to respond to emerging themes that occurred in each phase (Bassett, 2010). Eisenhardt (1989) notes that in interpretive case research, there needs to be an iterative data analysis process involving continuous interplay between data collection and analysis. This enables the researcher to remain flexible and to make adjustments to data collection, improving the prospects of generating quality theory. Data analysis involved thematic analysis and a code-recode procedure.

### **3.6.1 Thematic analysis**

Thematic analysis is concerned with identifying themes and patterns of behaviour (Aronson, 1995). Thematic analysis therefore involves searching for themes that are important to the description of the phenomenon through the process of reading and re-reading the data. It is the formation of patterns within the data where emerging themes become the categories for analysis (Fereday & Muir-Cochrane, 2006). According to Boyatzis (1998, p. 161) a theme is “a pattern in the information that at minimum describes and organises the possible observations and at maximum interprets aspects of the phenomenon.”

Similar to Fereday and Muir-Cochrane (2006) the thematic analysis used in this research incorporated both the data-driven inductive approach of Boyatzis (1998) and the deductive approach using pre-determined codes from the theoretical framework and research questions on consumer value and value co-creation. Throughout the analysis a deductive and inductive approach was used. Miles and Huberman (1994) recommend using an initial set of codes that are related to the conceptual framework and research questions adopted. After this initial deductive approach an inductive approach was primarily used to find emerging patterns of behaviour and themes on consumer value and value co-creation. The coding process was thus two-fold and involved pre-determined codes and the identification of codes within the data that captured emerging patterns of behaviour and themes around consumer value, value co-creation and the consumption experiences of CAM health services.

### 3.6.2 Overview of data analysis

Overall 43 interviews, sixteen from phase 1, fourteen phase 2 and thirteen phase 3, were digitally audio recorded and transcribed. Transcription of the interviews varied for each phase. Phase 1 interviews were transcribed verbatim and included filler words such as ‘ummm’. Phase 2 interviews were also transcribed verbatim but excluded filler words. In phase 2 relevant headings were placed in each transcript to demarcate each ZMET stage. The pictures and images were also inserted into the transcript in the appropriate place. The phase 3 interviews were transcribed semi-verbatim. During this phase the interview involved the researcher explaining the results and getting the participant’s response. Therefore, the researcher’s explanations were only summarised whereas the participant’s responses were transcribed verbatim. Transcriptions of the recorded interviews were completed mostly by the researcher. A paid transcriber was used to help transcribe six phase 1 interviews and three phase 3 interviews.

After the interviews were transcribed the transcriptions were then coded. Please refer to Appendix N for the final list of codes used in the data analysis for all three phases. Phase 1 and phase 2 interview transcripts after initial coding and analysis in Microsoft Word were uploaded into Microsoft Excel for within-case and cross-case analyses. Excel is a useful qualitative analysis tool that “can handle large amounts of data, provide multiple attributes, and allow for a variety of display techniques” (Meyer & Avery, 2009, p. 91). In line with Meyer and Avery’s (2009) process the transcripts were converted into tables in Microsoft Word and then imported into Microsoft Excel.

Once the interview transcripts for phase 1 and 2 were uploaded into Excel and the final codes assigned within-case and cross-case analyses were conducted. Eisenhardt (1989) has noted that “analyzing data is the heart of building theory from case studies, but it is also the most difficult and the least codified part of the process” (p.539). The process of reducing the rich individual stories down into manageable and meaningful codes, without losing the essence of the individual, was difficult. However, the analysis of each individual case and subsequent write up compensated for this. Within-case analysis was an important part of the overall analysis in this research as it not only enabled consumer value and value co-creation themes to be explored and developed further but it also allowed individual

participant stories to be told, and subsequently made it easier to analyse across cases. According to Eisenhardt (1989), within-case analysis can help to accelerate subsequent cross-case comparison. In this research cross-case analyses were used primarily to “deepen understanding and explanation” of the CAM consumers’ experiences and contribute to theory building with the potential to “enhance generalizability” (Miles & Huberman, 1994). The third phase interview as outlined in 3.5.4 was used to determine the process of value co-creation and gain feedback on initial analysis from phase 1 and 2. Therefore the data from phase 3 was collected after an initial analysis and interpretation of phase 1 and 2. A detailed outline of the analysis procedures undertaken in each phase of the research follows.

### **3.6.2.1 Phase 1 data analysis**

Initially the first phase interview transcripts were coded using broad consumer value themes from the literature, including quality, efficiency, aesthetics, social value, play, spiritual value and ethics, plus key value co-creation themes such as practitioner-client relationship and consumer value co-creation activities. After which the transcripts were then re-read and re-coded according to emerging consumer value themes and sub-themes. The codes were kept as semantically close to the terms and concepts they represented, provided a structural relationship to each other, and were considered appropriate for the level of detail and the unit of analysis that they described (such as a sentence, word or other or sub-unit of text) as outlined by Lincoln and Guba (1985). For example, the CAM practitioner was a key theme that emerged under the broad consumer value theme of ‘quality’ and was split into six different codes as follows:

1. P – Practitioner (used for any general reference to the practitioner that did not fit under the following codes)
2. Pk – Practitioner knowledge and expertise
3. Pm – Practitioner manner
4. Ps – Practitioner service
5. Pr – Practitioner relationship (partnership, involvement, collaboration)

## 6. Pt – Practitioner trust, integrity, authenticity

The coding of each transcript was undertaken as soon as possible after each interview, in order to keep an up to date overview of the key themes and issues. As the issues and codes emerged, the interview process evolved accordingly, allowing for focusing in on key ideas, and refining and teasing out of emerging theory as recommended by Eisenhardt (1989). For example, the idea that gaining knowledge, learning and being educated by the CAM practitioner and through the participant's experience of CAM health care emerged in the first few interviews therefore this was explored and probed in subsequent first phase interviews with other participants.

### **3.6.2.2 Phase 2 data analysis**

Data analysis of the phase 2 image-elicitation interview transcripts followed a similar process to phase 1. By this stage many of the consumer value codes had already been formulated and codes for value co-creation were beginning to emerge. However, a code-recode procedure was still implemented and any new themes that emerged were assigned a code. What was different in this phase was the use of the images. Although the images themselves were not going to be analysed and interpreted by the researcher they were integral to this phase. Therefore it was considered important to include the images in the participant interview transcripts. The images were embedded into the transcripts at the appropriate place, i.e., where each picture was discussed in the transcript. During initial analysis and coding of the phase 2 transcripts in Microsoft Word the images were used as a visual cue by the researcher to help with the coding process. However, when the phase 2 transcripts were uploaded to Excel the images were not included, partly due to the difficulty of embedding them in Excel but primarily because it was the participant's interpretation of their images that was imperative not the researcher's. The images were used to elicit metaphors and underlying thoughts and feelings towards the participant's experiences of CAM as outlined in section 3.4. Coulter and Zaltman's (1994) ZMET technique advocates the participant's interpretation of the images and pictures they take and collect as the key to understanding the meaning they attach to brands, products and services, in this case CAM health services.

### **3.6.2.3 Phase 3 data analysis**

Phase 3 data collection was carried out once the analysis of phase 1 and phase 2 data was completed because initial findings were presented to the participant in this phase. In terms of data analysis the transcripts from this phase were read and re-read for new themes particularly with regard to the process of value co-creation. New codes were thus assigned to emergent themes in the data. Simultaneously interview 3 transcripts were also assigned existing codes which aided in refinement of the initial analysis. Further discussion of how the themes emerged and subsequent coding can be found in Chapter 5, the cross-case analysis chapter.

## **3.7 Approaches to Ensuring Quality and Rigour**

Often, qualitative researchers are criticized, mostly by the researchers with a positivist perspective, for not being precise about what they do (Janesick, 1999). Qualitative methods have been described as “soft” research (Grant & Giddings, 2002). This concern arises because data within an interpretivist paradigm is inherently different from the positivist view of data because the data is inseparable from the researcher’s views, the interplay of these views with the views of research participants, and the research context. In other words, the interpretive researcher not only interprets, but may influence data that is gathered (Esterberg, 2002; Grant & Giddings, 2002; Lincoln and Guba, 1985). “This misconception has contributed to the perception that these forms of research, and those that do them, are second rate” (Grant & Giddings, 2002, p. 16).

The issue of quality assurance in conjunction with interpretive and/or qualitative methods is often raised in the literature. This is due, in part, to the fact that the positivist concepts of validity and reliability cannot be readily translated into interpretivist terms. The concept of trustworthiness, rather than reliability, is commonly used in the qualitative research literature, and will now be considered. A number of authors maintain that trustworthiness is necessary order to ensure reliability (or its equivalent) in qualitative research (Golafshani, 2003; Lincoln & Guba, 1985; Seale, 1999). Seale (1999) states that the “trustworthiness of a (qualitative) research report lies at the heart of issues conventionally discussed as validity and reliability” (p. 266). The trustworthiness of qualitative research relates to the value of findings and their authenticity (Denzin & Lincoln, 2005). Lincoln

and Guba (1985, p.300) propose a set of four criteria for addressing trustworthiness: credibility (replacing internal validity), transferability (instead of external validity), dependability (instead of reliability) and confirmability (instead of objectivity). In this study credibility and dependability are considered the most important; these are outlined below with the approach to meeting each.

### **3.7.1 Credibility**

Credibility is related to richness of the information gathered and the analytical abilities of the researcher (Patton, 1990). Techniques for enhancing credibility include using member checks (in which research participants are asked to check interview transcripts and corroborate findings) (Lincoln and Guba, 1985) and making data available for others to analyse (which generally cannot be done during Ph.D. research). Credibility can also be enhanced through several different types of triangulation of data (Esterberg, 2002; Patton, 1990; Woodside, 2010). In this research project, credibility has been gained through member checks as previously discussed, consistent and appropriate interviewing techniques, researcher journal, Ph.D. supervisors critiquing the analysis, feedback from three Ph.D. symposiums, attending research seminars and workshops, and via submitting and publishing an article using data from the first phase of the study (see Dodds, Bulmer, & Murphy, 2014). Credibility was also enhanced through the approval of this research by the Massey University Human Ethics Committee. Due to the nature of this study (studying human participant's health) the research went through a "full ethics application" which involved completing a 12 page document outlining the study in detail.

### **3.7.2 Dependability**

Dependability of research data can be improved through dense description of research methods, stepwise replication, triangulation, and a code-recode procedure (Krefting, 1991). Triangulation and a code-recode procedure were the main methods used to ensure dependability in this research. The three phase process in particular enabled the cross-checking of interpretations which helped to reduce misinterpretation, and identified areas for further exploration (Esterberg, 2002). The use of triangulation also increased the richness of understanding (Janesick, 1999). Each phase of the research provided not only different techniques to gather data but gave a foundation on which the subsequent phases

could build on. The final phase interview in particular provided the greatest opportunity to ensure the data collected and analysis was dependable and trustworthy.

### **3.8 Role of the Researcher**

Interpretive research recognises the role of the researcher as being central to the research process and results (Esterberg, 2002). There is no attempt to “predict” or aim for “objectivity” or “neutrality”, as is the goal of the positivist researcher, rather the researcher acknowledges how their role as an interpreter of a socially constructed world has an impact on data analysis, interpretation and the presentation of findings (Crotty, 1998; Esterberg, 2002).

In this research, it was important during both data collection and data analysis to be aware of any personal interpretative perspectives, and to declare these. The researcher in this study is a qualified non-practicing CAM practitioner with experience in the CAM health service industry. Her knowledge and experience of CAM was beneficial during the data collection and data analysis phases. An understanding of the CAM therapies enabled the interviews to flow more freely resulting in greater depth. Once participants realised the researcher had experience and knowledge of CAM they engaged more with the process and the researcher. Her knowledge of CAM terminology and philosophies was also helpful during data analysis. However, she acknowledges a possible personal bias with data interpretation. Attempts to mitigate this were reduced by having member checks, the third phase feedback interview, having Ph.D. supervisors who are non CAM users, and via feedback gained in presentations of findings in academic seminars.

An extensive literature review was conducted prior to implementing the study which uncovered a range of perspectives and theoretical models that contributed to the knowledge of the researcher. The researcher acknowledges that this prior knowledge may have impacted on how the data was collected, analysed and interpreted, and hence implemented ‘bracketing’ to mitigate the effects of preconceptions that may have tainted the research process (Tufford & Newman, 2012), and to ensure emergent data and subsequent theory arose. An effort to balance the following of possible ‘leads’ from the literature with facilitating emergent findings was made.

### 3.8.1 Approaches to managing ethical issues

Appropriate ethical data collection, analysis and reporting were employed according to Massey University's Human Ethics code of ethical conduct. As previously mentioned the research was approved by the Massey University Human Ethics Committee (MUHEC). Potential ethical issues arising in this research project included: a) informed consent and participant rights, b) confidentiality and anonymity, c) coercion, and d) participant and researcher safety.

#### a) Informed consent and participant rights

Informed consent from participants requires providing participants with all the information they need to make an informed decision before participating (Esterberg, 2002). In this research participants were informed of the time commitments, nature of the research, and depth of sharing required by the participant, particularly the potentially sensitive area of their health. Participants were asked to read the information sheet and sign a consent form (Appendix L) at the beginning of the first phase interview indicating they had read the information sheet and had the details of the study explained to them. Participants' safety and rights were paramount in this research. Although potentially sensitive topics arose, participants were informed that the emphasis of the research was about consumption experiences not health issues per se. The interview questions were kept safe and non-threatening and the participants were given the right to not answer any questions and to pull out of the research at any time.

#### b) Confidentiality and anonymity

Participants were reassured that the researcher and others privy to the information gathered, such as Ph.D. supervisors and professional transcribers, would maintain confidentiality. All hardcopy documents, such as printed transcriptions and signed consent forms were stored in a secure cabinet to ensure that participants' information was kept safe. Digital files, such as digital voice recordings, typed transcriptions, and participant contact details, were kept in computer files that only the researcher could access via a password. The professional transcriber signed a confidentiality agreement (Appendix M). Information identifying the participant was not shared with CAM clinics, CAM therapists

or other participants. Participants were assigned a pseudonym to ensure anonymity. Any data that the participant did not want to be included was removed. During analysis, particularly the cross-case analysis, all attempts were made to ensure all information that identified the participant was removed.

c) Coercion

The importance of enabling potential participants to self-select so that no coercion existed was an important ethical issue in this study that was discussed in the section on recruitment. The use of snowballing (finding participants through other participants) was not deemed appropriate for this study due to the potential sensitive nature of the topic. Hence advertising in clinics and convenience sampling via secondary contacts was used. All effort was made to ensure that potential participants were free to choose to participate. The researcher only made phone contact once a participant had agreed to be involved.

d) Participant and researcher safety

Participants, as discussed previously, would not have been selected if they had possible serious health complaints at the time of the research, for example, cancer, heart disease, severe depression, for both participant and researcher safety. Two participants posed an issue with these criteria, one was in remission from lung cancer and the other was on medication for depression. However, these participants at the time of the study were not suffering from serious health complaints and wanted to be involved in the research, therefore were allowed to participate. As mentioned previously the participant in remission from lung cancer by the second phase of the research ended up having another course of chemotherapy and therefore discontinued with the study.

If any unforeseen health issues arose during the research the participant would have been kindly taken off the research project and/or referred to an appropriate medical practitioner accordingly. In case of any unexpected emotional discomfort or if a person's physical, mental or emotional well-being was considered "at risk" or out of the scope of the researcher, the research would have discontinued and the participant would have been referred, if appropriate, to a relevant medical practitioner. In case of an emergency, e.g. asthma attack, the researcher would have called 111 immediately. To ensure researcher

safety the supervisors were informed of interview times and places; plus the researcher's personal contact information such as home address and home phone number, were not included in any of the information sheets. Instead the researcher provided a University email address and a mobile phone number as contact details.

### **3.8.2 Approaches to managing potential risk of harm**

No physical, psychological or social risk of harm to the participant was anticipated. There was possible minimal discomfort as personal information about their health status was asked in the first phase interview. The participant's emotional, mental, physical and spiritual well-being was discussed in all three interviews. Potential discomfort arising from sensitive topics (e.g. health status, emotional/mental/spiritual wellbeing) was minimised by making it clear that all information is confidential and they are free to stop the interview or pull-out of the research at any time. Informed consent was gained and the participant was fully informed of the research process. The researcher was very conscious of ensuring a safe environment for the participant. Respect for each individual's personal dignity and beliefs were paramount through-out the research project. As a qualified practitioner (3 year Diploma in Naturopathy) the researcher has had extensive training and experience in ethical conduct, in particular the importance of considering client cultural beliefs and values.

Minimal risk to the researcher was anticipated. Possible psychological risk could occur if a participant became emotional during the interviews or became acutely un-well during the research project (e.g. diagnosed with a potentially life-threatening illness, has an asthma attack or heart attack). Possible physical risk could have arisen if a participant had an unknown contagious condition (e.g. virus infection). This did not occur due to participants having been screened prior to selection.

## **3.9 Summary of Methodology**

This research adopted an interpretivist approach and employed a multiple case study research design using qualitative and visual methods. This approach and the methods chosen were appropriate for the research problem and questions, which were exploratory in nature. The unit of analysis was 16 individual CAM consumers, aged 20 years and over

who were either regularly seeing a CAM practitioner or were embarking on a CAM health programme. This section has outlined and justified the research paradigm, methodology, and design. It has justified the choice of a qualitative multiple case design. It has outlined in detail the data gathering procedures and analysis methods. The overall method was highly iterative and reflexive, and depended on a skilled, well-structured interviewing approach, together with the application of a flexible interpretive analytical lens. The large quantity of interview data that was gathered made it an interesting and challenging process. The literature review helped establish themes that were used as preliminary codes at the outset of the analysis phase. These were used with caution to ensure that new themes and issues emerged. A range of issues to do with quality assurance have been outlined and addressed.



# Chapter 4 In-case Analysis

## 4.1 Overview

Individual participant narratives were critical to this research in terms of understanding the value that was experienced from CAM health services. Consumer value is a complex and multi-faceted concept that can mean different things to different people. Studying each individual case provided great insight into not only the CAM phenomenon but how individual consumers assess and process value for themselves. Therefore each case was written up providing an overview of the participant's experiences of CAM health services but primarily focusing on the key consumer value themes that arose from his/her CAM health service experiences. It was deemed appropriate to focus on consumer value in the within case analyses because the analysis of each case was derived from the first phase story-telling interview and the second phase image-elicitation interview, where consumer value themes strongly emerged. Plus, within case analysis of consumer value enabled value co-creation themes to emerge which were then explored further and analysed during cross-case analyses, which incorporated data from phase 3. References were also made to the interview environments which were taken from the researcher's field notes. This was considered important because it is known that the interview environment can impact on the quality of data gathered from the interview. Within each case write-up a table was used to highlight the consumer value components for that participant using illustrative quotes from the transcripts to support. The participant's summary collage formed in the phase two interview, if completed, was also included to support the analysis, provide visual appeal and demonstrate the use of the image elicitation technique. An overview of the participants is presented in Table 6 which details the participants' demographics, health issues they were seeking CAM for and why they were attracted to CAM.

**Table 6: Profile of the 16 participants including why they were attracted to CAM**

No	Pseudonym	Personal Profile	Health issues using CAM for	CAM Therapies Used	Why attracted to CAM
1	Lilian	46 year old homemaker with 3 children aged 6, 8 & 13, married	Back pain, family health	<b>Osteopath</b> , naturopath	Natural, treats the cause
2	Jenny	28 year old homemaker with 3 children aged 7, 5 & 2, married	General family health, minor ailments	<b>Homeopathy</b> Herbal medicine & supplements	Family beliefs about homeopathy - history of family use, holistic, safe, natural, easy to use, treats the cause
3	Margaret	46 year old general manager with 2 teenagers aged 13 & 17; married	Shoulder, back & neck pain, unresolved for 20 years	<b>Chiropractor</b> Massage, osteopathy, Bowen therapy	Last resort as did not want surgery, non-invasive.
4	Vivian	52 year old executive trainer with 1 child aged 12; married	Menopause Back/neck issues Depression & anxiety (long-term)	<b>Naturopath, Chiropractor</b> , Holistic GP, Energy healing, spiritual healing, aurosoma	Has to be a better way (than drugs), disillusionment in mainstream medicine, searching for a cure, curiosity and belief about energy, spirituality & quantum physics, more holistic
5	Margo	38 year old homemaker with 2 children aged 12 & 1	General health & wellbeing, all illnesses, combat environmental toxins, back issues,	<b>Cranial Osteopath, Holistic GP</b> , energy healing, acupuncture, herbal medicine, kinesiology	Natural, helps the body heal itself, holistic, belief that conventional medicine and modern society is harmful to health
6	Olivia	24 year old student living in a defacto relationship	Polycystic ovaries, tight jaw, general health & wellbeing	<b>Naturopath, osteopath</b> , acupuncture, energy healing, herbal medicine, homeopathy	Holistic, natural and makes more sense to treat the body naturally, treats the cause
7	Rachel	45 year old graphic designer with 2 children aged 13 & 11, married	Stress, neck, back shoulder pain, headaches	<b>Osteopath, yoga</b> , naturopath, massage	Failure of conventional medicine, intelligent approach that considers and treats the cause, holistic, makes sense
8	Mandy	26 year old self-employed, living with others	Back injury, weight loss, general health	<b>Massage, Osteopath, Naturopath</b>	Holistic, prevention and wellness orientated
9	Jules	31 year old student, living with others	Women's health, mental health, ankle injury, general health & wellbeing	<b>Holistic Counsellor, Naturopath, TCM, osteopath</b>	Holistic - respected as a whole person, treats the cause, spiritual and intuitive, supportive
10	Anne	60 year old professional, living alone	Cysts, gallstones, general wellbeing, women's health	<b>Acupuncture, Yoga</b>	Holistic, natural, re-discovering deep tradition, offers different dimensions and respects different dimension of a person
11	Fiona	48 year old executive with 1 child, married	Polycystic ovaries, fertility, general wellbeing	<b>Acupuncture, naturopath, chiropractor</b>	Didn't like taking drugs (steroids), no side-effects, gentle, treats the cause
12	Jane	51 year old with one teenager, widowed	Cancer (lung)	<b>Naturopath, Reiki, Bio resonance, Nutritionist</b>	Natural, supportive, had nothing to loose
13	Peter	40 year old professional with 2 children, married	Back pain, piles, shingles, stress, general health	<b>Chiropractor, kinesiology massage, acupuncture</b> ,	Natural, holistic
14	Bill	77 year old retired businessman, married	General health & well-being	<b>Reiki, self-hypnosis, Body Harmony</b>	Holistic
15	David	50 year old teacher, married	Stress, general health and wellbeing, back pain	<b>Energy healing, acupuncture, kinesiology</b> , naturopathy, meditation, Chinese medicine, Bowen therapy, aurosoma	Holistic, search beyond mainstream medicine
16	Steven	49 year old lecturer with 2 teenagers, married	Back pain, headaches	<b>Manipulative Therapist, Acupuncture, osteopathy (cranial), Pilates, Ozone therapy, chiropractor</b>	Holistic, makes sense,

Due to the number of cases and the need to keep the within-case analysis focused on the research questions it was deemed appropriate to place this information in a summary table. Participants have been listed in terms of the order they participated in the first phase interview.

## **4.2 Case 1 - Lilian**

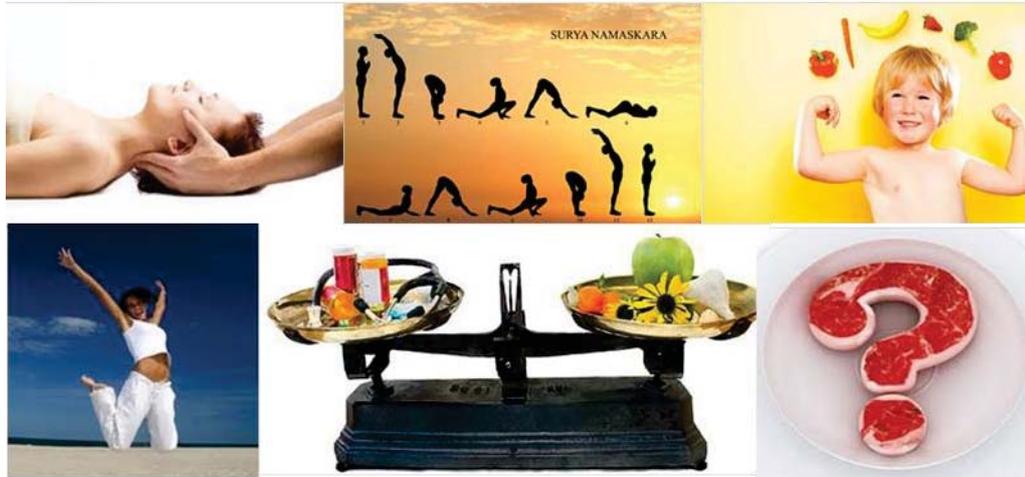
Lilian has “dabbled in and out” of “complementary” medicine for about 10 years whenever “standard medicine isn’t meeting [her] needs”. Her first experience was going to a naturopath for on-going hay fever that wouldn’t clear after taking lots of antihistamines and her doctor saying “that’s the only thing you can do...which sort of didn’t feel quite right”. The naturopath recommended a slight change in diet and gave her “some lotions and potions” and “low and behold the hay fever went away and was away for several years”. Over the years Lilian has continued to see various naturopaths for herself and her family, particularly for one child who is prone to colds. She also sees osteopaths for sore shoulders and back issues, gets the occasional massage for a treat and regularly attends yoga classes. Despite seeking CAM health care Lilian views it all with healthy “scepticism”, saying “I was and still am quite sceptical. I just sort of like things proven and evidence based.” As can be seen in Table 7 Lilian’s priorities when it comes to CAM health care and indeed any form of health care was a level of professionalism and expertise from the practitioner who can withstand being questioned and who can provide satisfactory answers. The scale image in Figure 9 epitomises Lilian’s stance when it comes to health care a “balance between” traditional and alternative medicine with both forms having “merits”.

Fundamentally for Lilian it is important that she understands the treatment, underlying cause and what is being prescribed and why. Therefore Lilian values practitioners, both CAM and mainstream, who can answer her questions in a comprehensive but simple way. One particular Naturopath that Lilian had been seeing while living in Sydney embodied all the aspects that Lilian values from a practitioner.

**Table 7: Lilian's perceived consumer value components with illustrative quotes**

<b>Perceived consumer value components</b>	<b>Illustrative quotes</b>
<b>Knowledge, learning</b>	"I do it with all [doctors and CAM] you know quiz...I would initially quiz, quiz, quiz and be really comfortable", "Lots of information", "I just like to educate myself...I said oh what does that one do and what does that one do [herbs]", "I need to understand until I get why, once I get why, it's much easier for me both to do it and understand what I meant to do"
<b>Practitioner – service, manner, knowledge</b>	"she looked really professional...smartly dressed", "he seemed really professional", "preparedness to answer questions with lots of facts...simply", "I like the fact that she'd done a pharmacy degree", "She had a pharmaceutical background so I quite like that science", "I trusted her", "competence", "Them having confidence that they know, depth of knowledge", "I think she was very genuine", "I've got to really I think trust them and that's about their integrity and their experience"
<b>Quality</b>	"When [CAM]...stands up to testing...I go hallelujah it's leaped those hurdles and is accepted", "If it's so good why don't they, why can they not stand up to that sort of rigour"
<b>Integration</b>	"I checked it all with the GP", "balance between the two traditional versus alternative medicine", "merits of both and I don't see it as an exclusive but as complementary", "evidence that there is some convergence going on", "advice lines up [between mainstream and CAM] not contradiction", "I'd talk to her on the phone which was great",
<b>Treatment results, treatment plan</b>	"hay fever went away and was away for several years...surprising outcome", "well I was getting the results", "short term pain relief...that's a huge thing, really nice to know", "she would type up a prescription and it would say what it was, how much to give, what it was meant to do and some other comments...it was great", "her A4 sheets were hugely important",
<b>Value of money</b>	"It was expensive but I was happy with that...we've got the money", "It just cost so fucking much you know and a good separation between the prescriber and the seller is really important"
<b>Holistic</b>	"whole interconnection of the body...makes sense to me", "holistic in the sense that the body is interrelated" "it's that combination of the meditative, the physical and the energy", "interrelationships", "More holistic nature"
<b>Physical environment</b>	"smart offices...not clinical but a little bit and very warm", "premises do have an impact", "I like to have lots of framed certificates up on the wall", "It was in this cool old building...lovely old wooden place with rugs"
<b>Play/Leisure</b>	"I really want to be able to ski and walk and do stuff", "It's [massage] more of a treat as opposed to treatment"
<b>Esteem -Self-awareness, self-responsibility</b>	"I know I feel energised and good", "bringing awareness to it and what that can do", "I do have an open mind", "it's ultimately my health and my kids health", "insurance policy...trying to keep well"

**Figure 9: Lilian's summary collage**



Well she looked really professional, smart offices, smartly dressed still not clinical but a little bit and very warm...and a big thing was that she was recommended by someone that had a really serious health issue... and also the preparedness to answer questions with lots of facts was great because I would initially quiz, quiz, quiz and be really comfortable. And for me I think a sign of someone that is really competent is their preparedness to answer something simply...I liked the fact that she'd done a pharmacy degree.

Lilian was interviewed at her home located in a wealthy suburb. Interestingly her description of the physical environment she liked for CAM health care, “smart...very warm...lovely old wooden place with rugs”, matched her own home environment. Although money wasn't an issue and she was “happy” to pay she expressed how expensive CAM was and said she often hid the receipts from her husband.

Along with professionalism and expertise Lilian appreciates when CAM and mainstream medicine “converge”, in that advice from both “lines up” and is “not contradicted”. For example, her doctor also advising her to take probiotics (usually a naturopathic treatment) while on antibiotics. Although Lilian continues to seek CAM health care alongside mainstream medicine she still questions some CAM therapies scientific validity and cannot understand “if it's so good why don't they, why can they not stand up to that sort of rigour”, this is represented by the image of a question mark in her summary collage. However, underlying Lilian's motivation to seek CAM health care is CAM's holistic philosophy which “makes sense” because “the body is interrelated” and self-responsibility

in terms of proactively keeping herself and her family well. Ultimately her family's health, particularly her three children, is paramount as is represented in the image of a child in Figure 9. Interestingly, Lilian's summary collage was mostly about the value she gains from the forms of CAM that she now accepts as mainstream, such as massage, osteopathy and yoga which enable her to keep well and feel "energised" as the image of the woman jumping depicts. Leisure participation was also a key motivator to seeking a more preventative type of health care like CAM because she "wants to be able to ski and walk and do stuff."

### 4.3 Case 2 - Jenny

Jenny has primarily used homeopathy for 20 years. The use of homeopathy stems back to family beliefs, in particular, her father who was a strong advocate of homeopathy. Jenny grew up in a household that used homeopathy and a homeopathic family practitioner, who she still consults today. Over the years Jenny has gained a reasonable amount of knowledge about this form of CAM and now self-administers to herself and her family for minor ailments. She consults the family homeopathic practitioner for more complex problems or to get advice.

I have a basic knowledge of homeopathy, for example, colds or flu, if he's [family practitioner] is not available for minor things I can do it and I'm interested so I'm studying more and more... I will go to the practitioner for advice."

Jenny's interviews were held in a meeting room at the University. In the first interview Jenny mostly talked about her experiences of homeopathy in terms of treatments, treatment results and learning about homeopathic remedies and "potencies". This interview was slightly stilted however the second interview using metaphor elicitation enabled more depth and made it easier for Jenny to express herself. What emerged from the second interview was that Jenny valued the interconnection of all the CAM therapies that she uses – homeopathy, herbal remedies, massage, nutritional supplements - along with eating well and seeing an "allopathic" (mainstream) doctor when needed. This is highlighted in Jenny's summary collage with the 'diagram image' placed in the centre. Jenny commented that "there is a connection...they all help...I can't rely on one thing...I have choices". It is necessary to highlight that Jenny would not hesitate to use or take her children to a

mainstream medical doctor for any serious illnesses. This is significant in terms of Jenny valuing an integrated approach to her and her family's health care.

Ten consumer value components emerged for Jenny (Table 8), of note was how much value Jenny placed on the ease of using homeopathic remedies, particularly when administering to her children. Along with this was that she considered homeopathy and herbal medicine to be safe and effective, treating both the cause and the symptoms. Her long term relationship with the family homeopathic practitioner was essential to Jenny understanding and gaining knowledge about homeopathic remedies and thus experiencing positive treatment results. The following quote sums up Jenny's experience with her homeopathic practitioner.

What I have experienced is that he asks you symptoms, even a single symptom, like you have to describe your problem very well because a single symptom can change the medicine. The more he knows about the symptoms and understands the better he gives you medicine that will work...you should be open to him so that you can describe everything happening to you...he's giving you enough time to listen to you.

Proactively gaining knowledge and learning about the different CAM therapies along with getting results were also important. Over the years Jenny has sought and gained enough knowledge to treat herself and her family giving her a sense of control and self-responsibility over her and her family's health. Paramount to her experiences was that CAM health care was "near to nature", "nature based" and a "gift from God". The image on the top right of her summary collage with the homeopathic remedy on a leaf and "the true green medicine" picture represents this. Along with this was the perception of gaining "improved quality of life" and being "happier" when you look after your health and use CAM health care to keep the body "strong".

**Table 8: Jenny's perceived consumer value components with illustrative quotes**

Perceived consumer value components	Illustrative quotes
<b>Practitioner – relationship, manner, knowledge and expertise</b>	“very nice and relaxed, very good when I’m with him”, “friendly”, “listens and asks about every single symptom”, “we have the one family [homeopathic] practitioner and he knows my history”, “gives you enough time to listen to you”, “has expertise”, “open to him”, “I go to the practitioner for advice”
<b>Interconnection, integration</b>	“Different therapies work together”, “I can’t just rely on one thing”, “it’s about having choice”, “There is a connection”, “[Allopathic and homeopathy] they go nicely together”
<b>Knowledge, learning</b>	“I have quite a sense now...I have a lot of books on it [homeopathy]”, “I have quite a bit of knowledge now”, “I’m really interested in how it works”, “I have a little bit of knowledge about potency”, “I do a bit of research”, “I consult my friend or my mother...my father [and]...the family practitioner”, “google it”
<b>Treatment, treatment results</b>	“Homeopathy has really cured things where allopathic fails”, “Relief from symptoms”, “acts fast”, “I saw that it really worked...my beliefs got stronger”, “homeopathic is quite easy to take...for the kids as well”, “really sweet and easy to take and easy to digest”, “more practitioner knows the better he can prescribe”, “relieved his sinus and allergy problem”, “kidney stones just disappeared”, “daughter ...had a urine infection so I used homeopathy and it really worked”
<b>Root cause</b>	“Goes to the root” [of the problem]
<b>Value for money</b>	“It’s really not expensive”
<b>Self-responsibility</b>	“It’s giving you options”, “I’m always prepared for things”, “made a home remedy...for my son’s cough”
<b>Natural</b>	“Homeopathy is near to nature”, “nature based”, “being near to nature it protects you and does not harm you”, “it’s not too processed”, “doesn’t have so much reactions and side effects”
<b>Spiritual</b>	“God has given these things (natural constituents of plants) for curing”, “gift from God”
<b>Wellness, wellbeing, quality of life</b>	“if you go for the natural...you can have improved quality of life and you can be happy”, “Happier”, “more relaxed and easy”, “help the body gain strength and keep strong”

**Figure 10: Jenny’s summary collage**



#### **4.4 Case 3 - Margaret**

Margaret, after years of suffering pain in her shoulder, neck and back and relying on pharmaceutical pain killers for relief decided to seek out a Chiropractor as a last option. Her doctor had suggested she see an orthopaedic surgeon and consider surgery for her shoulder. However, she was not convinced that this was the right course of action having previously sought advice from specialists and physiotherapists who could not give her any definitive answers on what the problem was with her shoulder. Margaret's CAM health service experience was primarily about seeking pain relief and the service provided by the chiropractor was paramount to her continuing treatment and experiencing long-term relief. Eleven consumer value components emerged for Margaret (Table 9).

What impressed Margaret most about the chiropractor was the level of service, in particular, that the chiropractor completed a thorough examination including x-rays and took the time to explain exactly what was going on using the x-rays and a skeleton of a spine to explain, as highlighted in. This depth of explanation about her condition and how the spine worked resonated with Margaret and was the first time she had experienced this with a health care professional. Margaret was empowered by this experience commenting that "it does give you more power to actually understand what's going on". The importance of gaining knowledge and understanding was evident in both interviews and is represented in the image practitioner-client image in her summary collage in Figure 11.

Both interviews were held in Margaret's home where she seemed relaxed and willing to share her experiences. The first interview was mostly about her health history, the chiropractic treatment and practitioner service, whereas in the second interview other components emerged, in particular the sense of freedom and "feeling like a new woman" from being pain free. Although quality of care, treatment efficiencies and treatment results were key components that Margaret valued from her experiences more importantly the treatment results enabled Margaret to get "back in action" and "get on with life". In particular, the treatment enabled her to be more active and participate in leisure activities she couldn't do prior to the treatment. Margaret described this as a "new beginning" giving her a sense of "freedom" physically, mentally and emotionally. The butterfly image represented "a new start, new beginning".

**Table 9: Margaret's perceived consumer value components with illustrative quotes**

<b>Perceived consumer value components</b>	<b>Illustrative quotes</b>
<b>Practitioner – service, manner, knowledge</b>	“chiropractor explained everything”, “good at explaining”, “he discusses the plan and he shows you exactly what the x-rays show and where he needs to do manipulations”, “he’s funny...relaxed, he’s very easy going, he’s easy to talk to, he’s actually quite calming”, “honest”, “he put me at ease straight away”, “his manner is very friendly”, “I was so comfortable with him”, “I was guided by what he said”, “listened to me”, “discuss whether things are working”
<b>Practice - service</b>	“the whole practice is a very comfortable from the time you walk in the door the ladies on reception are lovely”, “both ladies greet me by name and now it’s a big smile when you walk in, it’s very welcoming”, “walking through the door you feel immediately relaxed”
<b>Knowledge, learning</b>	“I need to know what’s what so actually seeing...the plastic spine”, “he’s showing on the x-ray”, “to actually have that shown to you and how they all connect up”, “I’ve got something concrete to go away with”
<b>Treatment, treatment results</b>	“there’s instant relief”, “I can go in with a headache and come out without a headache”, “When I walk out there is no pain and I actually feel good”, “only commitment I have to give is 10 minutes once a month”, “Initial [consultation] is 45 minutes”, “chiropractor puts a plan in place”, “discusses the plan...you agree that’s fine”, “it’s a safety net”
<b>Value for money</b>	“If it wasn’t working then it would be expensive but it is working so I just look at the fact that I’ve got to pay that if I want to be pain free”
<b>Physical environment</b>	“It looked professional”, “It’s got a good car park”, “It’s not like sitting a doctors surgery...its quite pleasant, it’s quite comfortable”, “waiting rooms are nice and bright and airy and very calming”, “it’s a very welcoming place...it doesn’t feel like a health place”
<b>Natural</b>	“I don’t like taking drugs”, “most non-invasive natural way”,
<b>Play - leisure participation</b>	“I can start doing things that I looked at before and gone oh no I can’t do that”, “He [son] can actually go off and play sport and run and do things again”, “I can now run around with the kids...that’s really important”, “I can actually throw a ball...now”, “I can get out and do things, kayaking is something I love to do”, “being able to run and jump and do just what I want”
<b>Spiritual - meaning and purpose</b>	“basically freedom, freedom to do things”, “a new beginning for me to be pain free”, “new start, new beginning”, “coming out feeling like a new woman”, “I felt like I could actually do things and just get on with my life”
<b>Self-responsibility and social self</b>	“I am taking responsibility for my health, for my wellbeing”, “it gives you more power to actually understand”, “it’s important mentally and physically”, “do things with the boys”, “able to do stuff with the family”, “family orientated”

**Figure 11: Margaret's summary collage**



That's also basically freedom, freedom for me is the fact that I can get out and do things umm kayaking is something that I love to do, to get on the water and all these little nooks and crannies that I've seen and I keep saying I'd love to be able to get out on the water and just paddle around all these places that I'd never been able to because I just haven't got the strength in my arms and shoulders to do it whereas now I do, so that just kind of gives me freedom.

Margaret was prepared to commit the time and money to this health care because of her initial positive experience. The level of service maintained throughout her treatment programme, where she continued to build a relationship with her chiropractor and felt welcomed by the reception staff and enjoyed the relaxed yet professional environment.

#### **4.5 Case 4 - Vivian**

Vivian has suffered from long-term depression and anxiety and has been on and off antidepressants for nearly 30 years. Her introduction to “alternative” forms of therapy began when she was hospitalised at 22 years old with an eating disorder after her father died. At the psychiatric hospital she was introduced to various forms of therapy including dance and art therapy. This sparked an interest in looking at alternative ways to cope and manage her mental health. Throughout her history Vivian had always thought “there must be a better way” than being on medication.

Vivian's primary health goal had been to come off anti-depressants permanently and manage her mental health naturally. Over the years Vivian tried various forms of CAM therapy without any degree of success in terms of enabling her to come off anti-depressant medication permanently. Recently, she tried again with a holistic medical doctor, unfortunately without success. Currently she is resigned to living with depression and anxiety and managing it with medication, diet and exercise. Although disappointed that CAM health care has not "cured" her mental health issues she has valued her CAM health care journey which she attributes to her maintaining a good level of health in a holistic way.

So, I'm disappointed I haven't been able to cure it without being on drugs, antidepressants...I do believe there are better ways of doing it that are more natural to the body... if I hadn't have done this I wouldn't have had the education, would I be taking the things I take and doing the things I do in a holistic way, probably not.

Vivian continues to use CAM health services for other issues such as menopause, stress, diet, weight management, general wellbeing and back issues. Not only has Vivian's CAM health care journey been about her physical and mental health but she has also used it for her emotional and spiritual wellbeing. Eleven consumer value components emerged for Vivian (Table 10).

Vivian was interviewed at her home in her conservatory. In the first interview Vivian spoke freely and at length about her health and health care experiences, both CAM and mainstream, and expressed her frustration at not being able to find a "natural" solution for her mental health. She often joked throughout both interviews about being "complicated", and saying "I would like to offer myself clinically...to test my brain", but ultimately feels like "it's a dead-end and it's like shit, dead-end and shit what am I going to do now." Despite this Vivian continues to use and seek CAM health services and values practitioners who are "authentic", competent, show "empathy" and have "integrity". Vivian is a self-employed corporate facilitator and trainer who runs various leadership and communication type courses so has strong views about client relationships and service as is evident in this quote.

I think what you're looking for which I know is my thing in my work is you're looking for authenticity and authenticity is does this person have

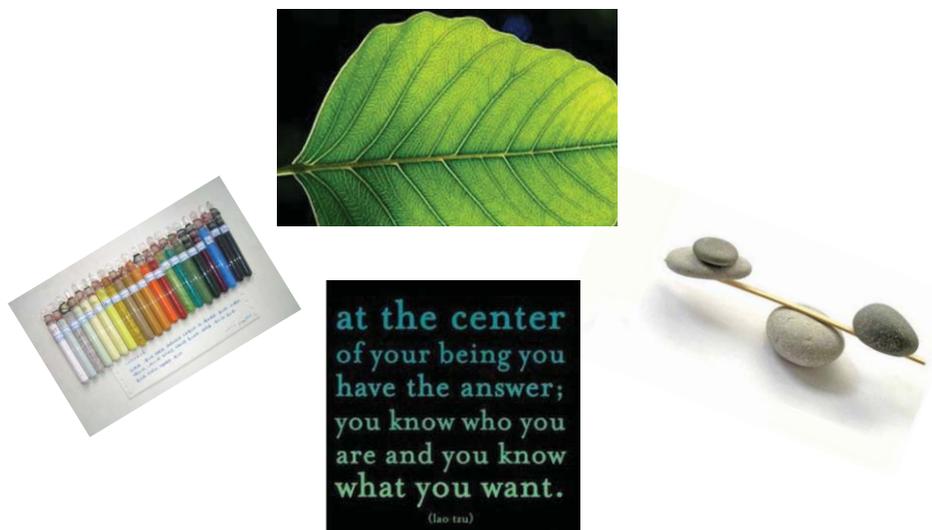
integrity, do they have the competence. If you take credibility, [which] is integrity and competence together that's what we see as credibility and the integrity is you feel they're talking from the heart...they're looking to do the best they can for you... that's real integrity and they have empathy

**Table 10: Vivian's perceived consumer value components with illustrative quotes**

<b>Perceived consumer value components</b>	<b>Illustrative quotes</b>
<b>Practitioner – manner, trust, knowledge, relationship</b>	“he’s got a really good manner”, “She has so much knowledge which she passes on”, “I built up that relationship and trust with her”, “been a long term relationship, he know my problems I don’t have to repeat them but he’s also very thorough”, “you need someone who will listen to your story and be able to bounce off and help you shape it”, “kind and caring”, “trust”, “integrity”, “empathy”, “competence”
<b>Knowledge, learning</b>	“chatting with [naturopaths], understanding a lot more and then I go and read up”, “part of education”, “you get re-educated around what’s good food”, “I was really interested to learn how to do these things”, “all the education”, “By trying all the things I’ve tried and reading I’ve got educated”, “I’ve collected lots of things, knowledge, best practice...what do I need”
<b>Treatment, treatment results</b>	“pulled my back...within 4 weeks it was much better”, “I was having hot flushes...she gave me a prescription...hot flushes stopped which is amazing”, “I haven’t been able to cure it...and live without being on antidepressants”, “I believed that helped because I felt something at the time she was working on me”, “it’s only 15 minutes for a regular check-up”, “you’ve got to have a plan”, “customised”
<b>Self-responsibility</b>	Reminds you...to look after yourself”, “it’s in your own hands”, “there are no quick fixes it’s about having it in your own hands”, “realisation of self-responsibility”, “self-caring”, “It’s up to you”
<b>Self-awareness</b>	“trusting yourself”, “trusting your inner knowing”, “my personality is into curiosity, to explore...better ways of doing it...can I heal this another way”,
<b>Wellness</b>	“Continual taking of supplements and eating well keeps body nutritionally boosted and well”
<b>Natural</b>	“I do believe there are better ways of doing it that are more natural to the body”, “makes common sense”, “my fundamental belief is we are organisms”
<b>Spiritual - holistic</b>	“more holistic”, “holistic way”, “it’s a holistic approach that means you maintain health all over”, “it’s the interconnectedness of everything”
<b>Spiritual – interconnection, energy</b>	“reality is we’re all energy”, “it’s about quantum physics of manifestation and energy”, “I do believe we are all energy”, “connected with spirit”, “she [spiritual healer]connected with spirit, and connected with the earth and then she will have her guides working with you”, “healing power”, “energy healing”,
<b>Spiritual – meaning and purpose</b>	“On the spiritual side, for me, it’s looking for more meaning”, “reminds you to think positively, behave positively”
<b>Spiritual - balance</b>	“For me it’s all about finding balance”, “being aware of being out of balance”, “it’s about balancing, is there a better balance you can create”, “when I came out of those sessions I would feel really rebalanced”

Fundamentally Vivian believes that a holistic natural way is better and this is represented by the leaf image in her summary collage (Figure 12). The leaf also represents the interconnectedness of CAM health care whereby all the different therapies and aspects to good health work together and cannot be separated. Finding balance (mental, emotional, physical & spiritual), represented by the stone image, was also imperative for Vivian and CAM has assisted Vivian in trying to maintain this. At the heart of Vivian’s CAM health service experience is gathering knowledge and tools to enable her to find her own solutions and answers.

**Figure 12: Vivian's summary collage**



## 4.6 Case 5 - Margo

Margo has embraced an ‘alternative’ healthy living lifestyle in a semi-rural environment. Her alternative life-style includes home schooling, eating organic, adhering to a predominately vegan diet, and relying on nutritional and herbal supplements. Margo is very conscious of the “toxic load” modern living has on health and therefore choses to live in a way that reduces this load, including not having a mobile phone or television, and avoiding mainstream medical intervention where possible. Margo was interviewed at home which provided much insight into her “alternative” lifestyle which was visually evident with supplements and herbal tinctures on the bench, organic foods in the kitchen, no television and her home-schooled daughter at home.

Margo has been using CAM health care for many years. She became interested after talking to people about natural therapies and began a journey of self-learning and seeing various CAM practitioners. She primarily uses CAM because it is natural but also for its healing properties and ability to combat toxicity.

Not just that [CAM is] natural but that they are good for you and that they help heal bodies from any illnesses and clearing out toxicity in the body and, you know how modern society makes you toxic and unhealthy and conventional medicine and stuff can make your body toxic and unhealthy and so it helps get rid of the bad effects of the other stuff.

CAM health care has been integrated into Margo's life and she uses it for herself and her family for every ailment and illness as well as a preventative measure to keep well. Mostly Margo will self-administer using herbs and supplements; however she seeks CAM health care practitioners for more complex issues or issues requiring a practitioner, for example, an osteopath for back pain. At the time of the first interview Margo and her family were seeing a cranial osteopath regularly (they all travel to Auckland for a group booking) for various issues including back pain, and a local holistic medical doctor for advice. It appears that these are the only two practitioners that Margo has come to trust. Interestingly, despite a long history of using predominantly CAM health care Margo is very scathing of many CAM practitioners, particularly naturopaths as was vehemently expressed:

All the naturopaths I've been to see I've just got bad things to say about them, they were crap and idiots...they haven't looked at new ways of doing things or they just care about money...some are just clueless about what they are doing.

Margo's strong view about CAM practitioners is possibly because she has gained a great deal of knowledge about natural therapies and medicine over the years and therefore only respects those that she perceives to have exceptional knowledge. Twelve key perceived consumer value aspects of CAM health care arose for Margo and are based primarily on her experiences of the holistic doctor and cranial osteopath. These are listed and summarised in Table 11. However, other general experiences of CAM health care both positive and negative have also contributed to these findings.

An important aspect was gaining knowledge and learning from CAM practitioners. Margo described her experience with her holistic doctor as "it's kind of like having this tutoring

**Table 11: Margo's perceived consumer value components with illustrative quotes**

<b>Perceived consumer value components</b>	<b>Illustrative quotes</b>
<b>Practitioner - manner, knowledge</b>	“what makes her good, her knowledge, herself, her abilities”, “being really knowledgeable at the technical things”, “Being really caring and kind”, “Looked at new things and new ways to do things”, “look at you like an individual”, “passionate about what she’s doing”, “capability”, “very intuitive”
<b>Knowledge, learning</b>	“I’ve learnt about it”, “I just started learning more and more about it [CAM]”, “The more I learnt the more I felt strongly about it”, “I do learn a lot of things from her too because she’s [practitioner] really knowledgeable”, “It’s kind of like having this tutoring during the consultation and I get information about things”.
<b>Quality products</b>	“I only use [quality brand] and the only other things I would use would be natural tinctures or powdered herbs”
<b>Integrated</b>	“eating healthily...healing herbs for your body and body work and meditation for your mind and healing energy for your aura. Your body and everything all together really, there not separate... they all work together to create [good health]”
<b>Treatment, treatment results</b>	“I’ve seen it work”, “I do enjoy when she works on my head”, “gentle and non-manipulative”, “helps with your structural problems but its deeper than that too”, “I usually have phone consults with her because I usually don’t have time”, “I went to see an acupuncturist who was really good for sciatica”, “helps me with my aches and pains in my body, back problems, neck problems”, “taking nutritional supplements...keeps your energy levels up”
<b>Value for money</b>	“I always like people who offer a good deal”, “not just doing it for the money...they’re doing it because they actually want to help people”, “some of them only care about the money and trying to sell you a whole bunch of supplements”
<b>Natural</b>	“natural things are more in line with what we need because we’re natural”, “help heal bodies from any illnesses and clearing out toxicity”, “life force”, “natural oils you get from plants which has unique properties”, not as processed, it’s still in a very natural state”, “flowers are very healing and have healing power”, “close to nature”, “best way to get your medicine, freshly picked medicinal herbs”
<b>Spiritual - holistic</b>	“we’re not separated into segments...we’ve got spirit and a body and a mind”, “holistic approach...holistic mind, body and soul approach”, “it’s holistic healing, healing energy, healing mind, body and soul”
<b>Spiritual – energy, intuitive</b>	“there’s an energetic level to things...we do have energy that goes though out body...healing energy coming out of the hands”, “healing energy”, “just very intuitive lady and she does this amazing intuitive work”, “energy work kind of helps your soul, it helps your body”
<b>Self-responsibility</b>	“I take the information and then I look it up myself”, “I treated it myself”, “I find them myself [supplements]”, “go and do the homework myself”, “I’ve been eating healthy food for so long”
<b>Play - relaxation</b>	“feeling relaxed and blissed out”
<b>Wellness</b>	“keeping yourself healthy and well”

during the consultation and I get information about things”. She stated that “I do learn a lot of things from her because she’s really knowledgeable about a lot of holistic stuff.” Along

with valuing the practitioner’s knowledge Margo also found the practitioner manner to be important, particularly their ability to be intuitive (emotional and spiritually) and treating her like an individual. Money was also a big factor for Margo and this was tied into the practitioner’s approach and philosophy. Margo abhorred practitioners that appeared to be “just trying to make money off you” by charging expensive consultation rates (\$100 for a 1 hour consultation was considered too expensive).

One of the reason’s she valued the holistic doctor is because

she’s really passionate about what she’s doing, she spends hours and hours with people and she really wants to try and help people and she’s not on some kind of ego trip because she’s a GP that you should pay her a ton of money and only gives you half an hour and then says right see you.

**Figure 13: Margo's summary collage**



The key aspect Margo values about CAM is that it is natural, holistic (i.e. considers “spirit, body and mind”) provides healing and helps combat modern day toxins. It was very important to Margo that nutritional and herbal supplements were as near to nature as possible (i.e. little processing), so quality products was also a key factor. An integrative approach to health was paramount as demonstrated in her summary collage. Margo believes that great health comes from “everything working together” including eating well, using CAM therapies, being out in nature, and using quality products.

## 4.7 Case 6 - Olivia

Olivia's first experience with a CAM health practitioner was when her mum took her to see a holistic doctor that had been recommended. Olivia at the time had been suffering from skin problems (including dark hairs around the chin), tiredness, sore throats and generally feeling "run down". She felt this was the first health practitioner who gave answers to what potentially might be causing her health issues. Prior to this Olivia had been to see mainstream medical doctors who she said could never really give her any suitable answers and would prescribe medication that only provided short-term solutions to her health problems. Olivia's initial positive experience got her interested in CAM and put her on a path of learning and searching for alternative health care. Olivia described herself as a person that likes to try things out, is open to new experiences and initially wanted to give everything a go. She had always had a sense that natural medicine must be better and makes more sense because of its holistic and natural approach. Twelve key perceived consumer value components of CAM health care arose for Olivia (Table 12).

The most important consumer value aspects for Olivia were primarily around the practitioner relationship in particular the idea that the relationship with a CAM practitioner was an equal partnership and involved working together, learning from each other and moving forward together.

[It is] the partnership between the practitioner and the client just like the joining of one umm, one can't work without the other; you've both got to be in it... [It's about] the coming together with the practitioner and working together.

Integral to this idea of a 'partnership' was the ability of the practitioner to empower Olivia by educating, providing information and imparting their knowledge enabling her to have and make choices for herself. Learning from CAM practitioners and the holistic approach of CAM has not only contributed to her physical, emotional and spiritual well-being, but has ignited a self-development and spiritual journey where she has begun to consider the meaning of life as well as learning to keep life balance, which is represented by the yin and yang symbol in her summary collage (Figure 14).

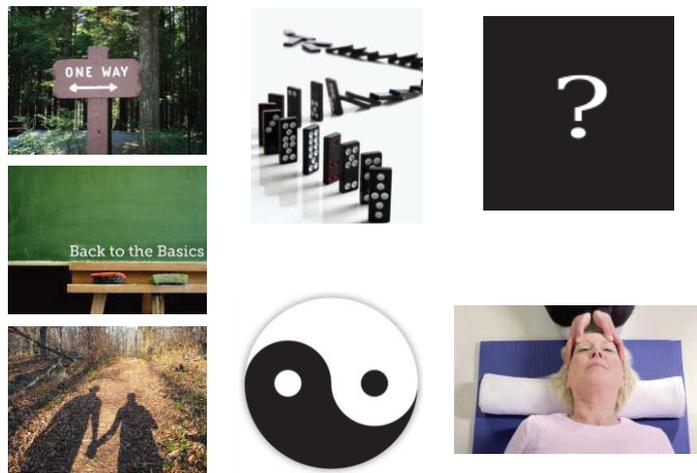
It's [CAM] is a journey...it's turned more into a self-development spiritual sort of stuff through the health and getting better and trying to

get well...I feel practitioners who encourage self-development, encourage you to find yourself and they say ok this is one way but you need to find your way that meets your journey or the way that you heal um they're very good practitioners.

**Table 12: Olivia's perceived consumer value components with illustrative quotes**

<b>Perceived consumer value components</b>	<b>Illustrative quotes</b>
<b>Practitioner - relationship, manner, knowledge</b>	“she wants to educate me”, “she provides me lot of information about my case”, “practitioner has all this knowledge”, “someone that can answer my questions”, “listen to everything you say”, “good at the way they relate to you, talk to you”, “partnership between the practitioner and the client”, “working together...going forward together”, “friendly”
<b>Knowledge, learning</b>	“I started to understand it [CAM] more”, “I get so much information from them [CAM practitioners]”, “lots of education, things to go forward, things I wouldn't know”, “so much knowledge to grasp”, “everything she said was just so valuable”
<b>Treatment, Treatment results</b>	“most of the treatment would be a herbal formula...starting to work”, “food advice”, “hands on work...gentle”, “clicked me back into place and it made me feel better”, “release of tightness”
<b>Holistic, root cause</b>	“they look into the root cause”
<b>Natural</b>	“Going back to the basics”, “we have everything in nature to heal ourselves”, “had this sense like isn't natural medicine better”, “makes sense to use something that was already put here”, “using nature to heal yourself, to get better, nature already has it all”
<b>Self-responsibility, empowering</b>	“it's helping me to help myself”, “making choices”, building self-up so that doesn't have to rely on practitioner”, “I am trying to build myself up so that I don't have to go back”, “I'm quite focused on getting better”, “I'm determined”
<b>Interrelated</b>	“coming together with practitioners working together”, “one might recommend you go to this practitioner”
<b>Balance</b>	“keeping balance and that's what you learn from those practitioners”, “it's about being centred it's about being present and a lot of the practitioners talk about being like that”, “they are trying to centre you”
<b>Spiritual - holistic</b>	“It's a big holistic thing...nature of the natural health”, “had more of a holistic approach”
<b>Spiritual –energy , connection</b>	“after she cleared my energy channels I could actually feel a line of energy running up and down my body”, “I've been with an energy healer...philosophy behind it is that you're releasing the [emotional] baggage”, “acupuncture you get your energy flowing again”, “The more I get into it [CAM] the more I think everything is connected...interrelated...my perception of the world there's a lot more going on at a bigger, higher level”
<b>Self-awareness, meaning and purpose</b>	“when you see health professionals it brings up that big what do I want in life, how do I want to be”, “I find getting into natural therapy I start asking the big life questions”, “I think now it's probably more something like me searching for the purpose to life”, “I'm really into self-development”, “gradual process and knocking down walls”, “it's a way to get on a healing journey”, “I'm reconnecting myself to my original self”, “hope”
<b>Physical environment</b>	“clean, tidy, spacious...something normal looking”, like the idea of people who don't practice from home”, “private”
<b>Leisure</b>	“you're relaxed and you're not doing anything”, “I've had practitioners say to me go for a walk on the beach”

**Figure 14: Olivia's summary collage**



Another key aspect that Olivia values is that CAM practitioners “provide more answers; they look into the root cause” and have assisted in the “gradual process of knocking down walls” to solve health related problems. This is represented by the domino image in Olivia’s summary collage. In Olivia’s case the root causes of her health problems from her experience were often unresolved emotional issues or related to blocked energy channels. This led to a particular interest in energy healing and valuing the healing power and touch of practitioners. In Olivia’s summary collage the three pictures down the left best explain what Olivia valued from seeing a CAM practitioner. The one way image was about making choices regarding her health and life and gaining knowledge and learning from her CAM practitioners enabled her to make better choices. The second image was about how her experiences with CAM health care taught her how to “go back to the basics” in terms of good nutrition, using natural remedies and exercise. The third image represented her “partnership” with the practitioner and “moving forward together”. On the right hand side the bottom image shows the experience with the practitioner – caring, relaxing and healing. Despite embracing CAM health care Olivia still has questions about what is right and what is not, particularly in term of its spiritual aspects. She is wary of “pushy’ practitioners who think their way is the only way. Again, this highlights the importance of the practitioner in terms of their integrity and professionalism.

## 4.8 Case 7 - Rachel

Approximately 17 years ago, at the age 30, Rachel hit a crisis point in her life where she felt stressed, angry, sick, bloated, had constant headaches and was feeling generally unwell. Rachel came to the conclusion that she needed to find an alternative solution because mainstream medicine had not been helpful. Her first experience of CAM health services was with a well-known naturopath and within a week of his treatment, which included dietary changes, herbal medicine and emotional techniques, she “felt fantastic”. Since then Rachel has primarily chosen CAM health care for herself and her family believing it to be “an intelligent approach” because it considers the whole person and looks for the underlying cause. At the time of the research Rachel was seeing an osteopath, a form of CAM health care that she had been doing regularly for over 10 years after a “miraculous turn around” with treating painful headaches and tension. As a self-confessed “stress junkie” Rachel believes the regular osteopathy enables her to maintain balance and function better physically, mentally and emotionally. Rachel is a graphic designer who runs her own business from home and employs two full-time staff. Along with running a full-time business Rachel also manages a family, therefore maintaining balance is a high priority. Table 13 highlights the key areas that Rachel values most from her CAM health care, with a holistic approach and gaining balance the main consumer value aspects.

The first interview was conducted in Rachel’s home during the evening while her family was home. The setting was relaxed and Rachel was animated telling her story about how she came to be using CAM. The second interview was conducted in a café over coffee and although noisy created a casual ‘meeting a friend for a coffee’ type setting. Rachel was the only participant who provided images that were all her own photographs. Rachel is an ardent photographer; hence all of the images, including the images in her summary collage, were from Rachel’s photographic collection. It was evident throughout interview two the personal attachment and meaning that Rachel attributed to each photo, demonstrating the power of participant-produced photo elicitation. The central image of candles in for example was taken in a church while traveling in Spain. This image represented the “state I aspire the most, is that light in me is there, I’m really conscious of my own personal energies... It’s got energy too them...but it’s also incredibly calm and that’s the huge part of the process for me is learning to de-stress, be a lot calmer, be a lot more balanced.”

Essentially this sums up Rachel’s experience of CAM, in that it enables her to be physically, mentally and emotionally strong.

**Table 13: Rachel's perceived consumer value components with illustrative quotes**

Perceived consumer value components	Illustrative quotes
<b>Practitioner - relationship, manner, knowledge</b>	“There’s a huge amount of trust in them [osteopaths]”, “He’s gentle...he’s got a really calm nature”, “abilities of them [osteopaths]”, “Huge amount of relationship that’s attached to the treatment.”, “It’s very much about collaboration...its partnership”
<b>Root cause and holistic</b>	“Intelligent approach...looking at the whole picture...what’s causing the headache”
<b>Balance</b>	“What I’m aiming for is balance”, “learning to de-stress, be a lot calmer, be a lot more balanced”, “It’s [CAM] has made me strive for balance”
<b>Spiritual – energy systems</b>	“My therapist has their own energy that they feed in to me which helps me get my own energy back”, “Healing touch”, “Energy is so important because I’m not me without my energy”
<b>Self-awareness, self-worth</b>	“I’m very self-aware”, “I’m constantly looking after myself”, “It’s what I’m aiming for that cleanness and clarity, “I’m a better person for all this treatment”, “Feel like me again”
<b>Social self</b>	“People would rather that you were energetic...and pleasant to be around...when you’re well you’re so much happier and much nicer to be around and that’s worth something”
<b>Leisure</b>	“I don’t have the ability to do lots of stuff, I can’t dance the salsa if I haven’t got any energy...if I don’t keep well”

Energy systems, gaining energy, and having personal energy was of great significance to Rachel and something she attributes to her general wellbeing.

I find for myself my energies are a huge part of why I try to stay well , because I find if I don’t have my inner who I am energy thing going then I’m back to this murky pool and I don’t like that.

Four of Rachel’s images in her summary collage represented “energy”. The two images showing an energy ball and hands represented the healing touch and flow of energy from the practitioner. The right hand image represents Rachel’s personal energy and how that enables her to be a “happier” and a “better” person. The central image was about inner energy, and a sense of calm and peace within.

**Figure 15: Rachel's summary collage**



#### **4.9 Case 8 - Mandy**

Mandy “had no idea that physio or anything [like CAM] existed” until she injured her shoulder six years ago when she was 20 years old and happened to meet “a guy who was a massage therapist” who gave her a “prod and it felt a lot better”. Almost immediately she went and learnt massage therapy and felt “excited” by the prospect “that you can do something about it”. Prior to this Mandy had lived a reasonably sheltered life having been brought up with “Christian Science”. Mandy said that her parents “very rarely used doctors” and “didn’t really use medicine as a family” relying mostly on “pray and “faith healing.” Learning about massage opened Mandy’s eyes and introduced her to CAM health services such as osteopathy, massage therapy and naturopathy which she continues to use today. Interestingly despite Mandy’s religious upbringing spirituality was not important to her and now she has a fairly pragmatic approach to her health care. When asked if spirituality was important to her she replied

Not really, no. The most important things is that I’m in control and that I know the stuff that I’m doing to get healthy isn’t actually harming me. It’s more of a pragmatic thing; actually I’ve got more faith in the science behind natural medicine than I do with what’s behind modern medicine.

As alluded to in the above quote having a sense of control and self-responsibility, being empowered, and learning were key components that Mandy valued from her CAM

experiences. Integral to this was her relationships with her CAM practitioners who “share information”, provide “practical advice” and give “emotional support.” Ten consumer value components emerged for Mandy (Table 14).

**Table 14: Mandy's perceived consumer value components with illustrative quotes**

Perceived consumer value components	Illustrative quotes
<b>Practitioner - relationship, manner</b>	“CAM works really well for me in that practitioners are keen to share the information and have the time to spend with you”, “she was really informative”, “really knowledgeable and easy to be around”, “she was really good at making me feel comfortable”, “really experienced”, “a huge component of it is emotional support”, “I really appreciate the practical advice”, “very lovely, really caring”,
<b>Empowering</b>	“I really appreciate them giving me empowering information”, “the big benefit it being empowered”, “it puts it in my hands and I appreciate that”
<b>Knowledge, learning</b>	“It was amazing, it was quite educational”, “It was very educational”, “I get the information from them and make up my own mind”,
<b>Treatment, treatment results</b>	“one of my goals was to lose weight...I took on her advice”, “I put my back out...he pretty much put it back in one session and that was a huge relief”, “I’m constantly on herbs...I’m taking herbs for my immune system and nervous system”, “he dropped everything to treat me”
<b>Natural</b>	“it’s natural”
<b>Holistic</b>	“looking at me holistically”
<b>Self-responsibility</b>	“be responsible for your own health”, “I just needed to ground and look after myself”, “it’s in my hands”, “the most important thing is that I’m in control”, “I’m in a place where I know enough to maintain my own health”
<b>Self-awareness, meaning and purpose</b>	“It’s a journey”, “I want to be really strong and live long and be very clear headed and be living my true purpose in life”, “I became a lot more aware of my body”
<b>Play</b>	“I was doing a lot of sewing, a lot of creative work...I don’t feel I can achieve my creative goals when my body isn’t in good order...I have to put a lot of energy into it [health] so I can be in a place I want to be, like being an artist”
<b>Wellbeing</b>	“If I wasn’t doing it [CAM] I would probably be quite sick”

Although Mandy only participated in the first interview, she provided a wealth of information which has given an overall perspective of the key components that she valued. Mandy was interviewed in a local café close to where she lives which provided a mutual and comfortable atmosphere allowing Mandy to share her experiences. One area that began to emerge in the first interview was the idea that CAM health care had assisted in her “journey” and life purpose. Like many other participants Mandy’s first interview focused primarily around her health history, treatments, treatment results and practitioner experiences. However, she did show a reasonable level of self-awareness and this area may have emerged further in the second interview. What is interesting about Mandy is that she has gone from a more ‘alternative’ approach to health due to her family beliefs to a more

‘complementary’ and pragmatic approach. Unfortunately Mandy could not be contacted regarding a second interview where this could have been explored further in subsequent interviews.

#### **4.10 Case 9 - Jules**

Jules was introduced to CAM health care in her teens when her mother took her to see a naturopath for debilitating “period pain” and hormonal issues that were not resolved via mainstream medicine. Not only did this practitioner resolve her health issues to a manageable level, she provided Jules with a supportive and safe environment for her to talk about emotional issues that were also impacting on her health and wellbeing. As a vulnerable teenager struggling with her family and self-identify this practitioner gave Jules a life line. “Without the support of that practitioner I don’t know if I’d still be alive to be honest”. Jules continued to see this practitioner regularly for approximately 2 years. This positive experience started Jules on a “journey” of seeking CAM health care and providing herself with a level of regular care that supports her physical, mental, emotional and spiritual wellbeing. She now rarely goes to a doctor unless she requires antibiotics or is seriously ill – “in general I don’t go to allopathic doctors anymore because I’ve had such bad treatment from so many of them”. Since this initial experience Jules has used a variety of CAM therapies and has been empowered and gained knowledge about how to care for herself on all levels, physically, emotionally and spiritually, which she believes is the aim of CAM health care. Twelve consumer value components arose for Jules with the majority around personal growth, empowerment, spirituality and practitioner approach (Table 15).

At the time of the research Jules was seeing a holistic counsellor who she had been seeing on and off for nearly 8 years and an osteopath for a chronic ankle issue. These two practitioners epitomised for Jules the “integrity”, “trust”, “respect” and “congruence” required for healing to take place and enable her “unfolding” (personal growth). This is highlighted in the following quote.

There’s congruence...you’re always supported to become who you are...The kind of practitioner I’m looking at can support my natural unfolding, my next step , my knowing for myself, my rightness in myself or something like that. I’m not really interested in a practitioner who will

tell me this is a solution to a situation or this is what they think about something.

**Table 15: Jules's perceived consumer value components with illustrative quotes**

<b>Perceived consumer value components</b>	<b>Illustrative quotes</b>
<b>Practitioner - relationship, manner, knowledge</b>	“Part of an empowering relationship is that both people are holding”, “mutual respect or mutual regard”, “moving towards the same place.”, “plugged in and intuitive.”, “very respectful and very consenting”, “authenticity”, “can support my natural unfolding”, “support”, “congruence”, “empathetic”, “supervision for my life”
<b>Empowering</b>	“Feels very, very empowering”, “having our health in our own hands and on our own terms that’s really empowering”, “I feel empowered with knowledge”, “I’m partly looking for that next level of empowerment where I’m able to maintain a level of health myself”, “giving me that sense of empowerment”
<b>Knowledge, learning, education</b>	“It’s around education...education around self-empowerment and how I care for myself going forward”, “knowledge about how to care for myself”, I gradually educated myself...[its] part of the aim of natural therapies to educate people”
<b>Treatment results</b>	“Resolved my pain to manageable level ”,“ effective herbs that only take a few days to get results.”
<b>Self-awareness, self-discovery, ideal self</b>	“reclaiming innocence”, “unfolding” “knowing myself”, “If I’m in my ideal state I’m fit, I’m vital”, “[CAM] health care is about me coming back to my own natural rhythm and my own self hood as an identity thing”
<b>Holistic, root cause</b>	“mind, body and soul”, “seeing the whole person”, “seeing a root of things”
<b>Balance</b>	“Feeling restored”, “internal softness.”, “balance my body”
<b>Spiritual – energy, hope, connection, freedom</b>	“About my vitality”, “hope and light...natural medicine gives me hope”, “grace”, “spiritual healing”, “beliefs and spiritual values...can create significant physical changes”, “appreciation of life or the life force”, “when I use natural medicine I feel part of a global family”, “sense of spiritual freedom from having good health.”, “sense of transcendence”
<b>Spiritual – Meaning of life</b>	“World view of how the world is or how the world functions.”
<b>Natural</b>	“appreciate the bounty and abundance of the earth”, “purity of nature”, “being in harmony with nature”
<b>Political stance</b>	“I’ve got the right to choose”, “Patriarchal paradigms that try to repress the [CAM] industry”, “I do feel quite a strong feminist thread”, “One of the ways I take back from that [patriarchal] paradigm is to engage with female practitioners and a knowledge base that’s come from feminist history”, “World peace”
<b>Leisure</b>	“being strong enough to travel”

Jules was interviewed at her kitchen table in a house that she lives and rents with others. Jules in her interviews came across as an incredibly self-aware and articulate young woman who has strong feminist views about the world. Of importance was that Jules is gay and part of her CAM journey has been about self-discovery and self-identity. Along with

this Jules use of CAM has become a political stance about personal freedom and choice in health care.

Until 5 years ago I didn't realise I was gay and there are probably right now things I don't know about myself and in the future I will know, so that's the kind of journey process and so the clearer the practitioner relationship I have and the more trust that's there I will unfold in my own right way the more I will be able to do that rapidly and smoothly with support in a really healthy way...when I'm using natural health care I'm also taking a political stand and that feels very, very empowering.

The images Jules chose were very powerful representations of not only her CAM health care experiences but her worldview. It was during the image elicitation interview where her political stance and feminist thread became evident, shown in the “plenty sister”, “innocent child” and “lens” images (Figure 16). These were three of other images that represented Jules's political outlook and worldview about having your health in your own hands, being empowered, and having the right to choose. Essential to Jules's CAM experience, shown by the central picture was “vitality” and “spiritual freedom” that comes from having good health.

**Figure 16: Jules's summary collage**



## 4.11 Case 10 - Anne

Anne has been using CAM health care for over 35 years. She started during what she describes as the “big movement” towards living naturally and being “green” at the time. She became a vegan (and still is today), was “part of an organic co-op” and began learning about natural health herself and experimenting with various CAM therapies and “clinicians”. Anne was attracted to CAM because it was natural, holistic and held very deep traditions. “When I entered those circles it was a re-discovering of those old traditions.” Since, Anne has integrated CAM into her life, regularly practices yoga and meditation, and has continued to primarily use CAM health care opting to use mainstream medicine for practical aspects like getting smears and blood tests, recognising the relationship with a CAM practitioner is “different often to a GP”. The following quote sums up the essence of CAM health care for Anne.

They respect all the different dimensions of who we are and they involve me more than allopathic treatment would and I build a relationship with the practitioner over time, I can see the progress and can re-decide where to take it or when to stop it, so the practices involve me more and allow me more choices so I do have a greater sense of success and empowerment which I also think contributes to my emotional wellbeing and also my confidence that I can continue staying well as well instead of having that dependency to a GP where they say this or not take this, I feel more like it's my responsibility to stay well

The above quote highlights some the key aspects that Anne values about CAM, such as empowerment, practitioner relationship, wellbeing and a sense of self. The positive, collaborative and communicative approach of the practitioner was of particular importance, enabling Anne to feel empowered and confident. This empowered and confident self was evident during the interviews where Anne had an air of self-awareness and confidence. The first and second interviews were conducted in a library meeting room, a convenient mutual location requested by Anne. Anne was particularly concerned about her privacy and asked for any personal references to be removed from the transcripts, for example, her nationality and her occupation. Despite this the interviews ran smoothly and a great sense of Anne and her experiences was gathered. Eleven key consumer value components emerged for Anne (Table 16).

**Table 16: Anne's perceived consumer value components with illustrative quotes**

Perceived consumer value components	Illustrative quotes
<b>Practitioner - relationship, manner</b>	"I like to be informed", "Radiates confidence", "positive approach", "collaboration between the practitioner and the patient", "always communication", "always asking for feedback", "I trust the guy", "I build a relationship with the practitioner", "practice involves me more", "being together on this journey and supported", "in tune", "spend time with you"
<b>Knowledge, learning</b>	"I learnt a lot about it...read up about it...informed myself...I experimented"
<b>Empowering</b>	"I feel I can make a greater informed choice for my health and wellbeing and the treatment", "feeling more empowered if I can actually contribute to the healing", "greater sense of success and empowerment"
<b>Treatment</b>	"it [acupuncture] helped me treat my cysts...and also gallbladder stones", "effective and efficient"
<b>Self-awareness, meaning and purpose</b>	"[CAM] can assist me in this process of transformation", "observing your own process", "acceptance", "freedom", "becoming mindful", "deepens your awareness", "helps me on with my spiritual path and life path", "feel close to your calling", "connect to your essence and live with integrity", "I feel so much more energy and capacity to do things", "confidence"
<b>Holistic</b>	"approaches you from a more holistic point of view", "I think for myself that disease is because you're holding on to something...it's a lockage mentally and physically...helps release that blockage", "respect all the different dimensions"
<b>Spiritual – connection</b>	"I certainly feel there is a spiritual dimension to it", "connected to the mother earth and the sky and spirituality", "when you're feeling well you connect with the world and have lots of energy", "connects to your soul and open your heart"
<b>Balance</b>	"need to be balanced", "it's about finding the balance"
<b>Wellbeing, healing</b>	"CAM therapies assists in the process of physical and emotional healing.", "Promise of healing", "It[CAM] supports me", "power of self-healing", "I feel very healthy...strong in my body and strong in my heart and my mind"
<b>Natural</b>	"plants that are growing there are supportive of healing", "plants are in tune with what we need...basically they support our system.", "interrelated"
<b>Leisure, play</b>	"motivates me to play and if I have health then I'm also willing to exercise", "deep relaxation"

**Figure 17: Anne's summary collage**



The image elicitation interview in particular provided great depth and insight that was not apparent during the first interview. Interestingly the main theme that arose in the second interview was of a 'spiritual' nature. This was not so evident in the first interview. Even Anne commented that "last time I said its [spirituality] not got much to do with it (laughs) but today that's all I'm talking about. That's what I noticed when I was choosing the pictures". Her summary collage highlights the key aspects that Anne values from CAM, such as it assists and supports physical, emotional and spiritual healing, holds the "promise of healing" and facilitates a process of transformation, gaining balance in life and feeling connected to earth, nature, sky, and spirit.

#### **4.12 Case 11 - Fiona**

Fiona first started using CAM health services 20 years ago when she went to see a chiropractor for on-going back pain and now continues to see a chiropractor on a regular basis for "maintenance" as well as other various CAM practitioners. However, more significantly, nine years ago, Fiona went to an acupuncturist for "polycystic ovaries" which she had suffered from most of her life experiencing "irregular periods". Fiona described it as "an incredible story" where she got "amazing results", not only did acupuncture help her resume regular periods but enabled her to conceive a child.

For the first time in my life after I had been seeing him for 6 months my periods became regular for the first time ever and I had been told I would have difficulty conceiving and my husband and I had conceived within 9 months of trying and I was 40, so pretty incredible to conceive and then have a perfectly normal healthy baby boy and the scans showed of my ovaries that I don't have polycystic ovaries anymore so pretty incredible stuff.

This experience of CAM cemented Fiona's resolve that CAM was going to be her and her family's primary form of health care. Even when mainstream medical intervention is required Fiona still seeks the guidance of a CAM practitioner. In Fiona's second interview, 5 out of 13 images were of "cold and clinical" images of mainstream medicine which depicted Fiona's view of "Western medicine" saying "I would have tried everything else first" before "relying on this". When asked if she had ever experienced this she told a story of when her son was seriously ill with chicken pox when he was 4 ½ years old and was in hospital for two weeks on drips and "it was really horrible because he didn't seem to be

progressing”. Fiona had her acupuncturist come into the hospital who “did some acupuncture on him and [gave him] some herbs to take as well” unbeknown to the medical staff at the hospital who she thought would not “have been happy at all.” Although she didn’t know what “fixed him in the end” she said it was “interesting to have both” and she “felt it was the right thing to do, even just to strengthen his body because of the huge doses of antibiotics he had been given I thought the acupuncture would be a good thing.” These two stories epitomise the key dimension that Fiona values from CAM health care, which is treatment results.

Having received many “amazing results” Fiona was keen to share her experiences “hoping that this study will wake them [mainstream medicine and health insurance companies] up to [CAM], [because] it would be much better to be funding [CAM] and then people will need to go to the doctor less.” Contributing to her successful results was the quality of care she received from CAM practitioners who are “professional”, “open-minded” and have “a holistic way of treating things”. Eleven key consumer value components emerged for Fiona (Table 17).

During the first interview, held in a local library, Fiona appeared to have a determined and pragmatic approach to her health care that was mostly about treatment results, however, during the second interview a very different view emerged. The key value components that emerged in the second interview were more about self-responsibility and being in control of her and her family’s health, depicted by the images in her summary collage of a “family dinner”, “fruit and vegetables” and a “family out biking”, all aspects Fiona deems important for good health. The yoga image and massage image represented for Fiona “looking after yourself so you can look after everybody else”. CAM health care has facilitated Fiona’s ability to “feel in control” and live a “healthy lifestyle.”

**Table 17: Fiona's perceived consumer value components with illustrative quotes**

<b>Perceived consumer value components</b>	<b>Illustrative quotes</b>
<b>Practitioner – service, manner, knowledge</b>	“it was important that he was professional”, “communication was important and he asked me my history”, “feel comfortable them”, “I like her open mindedness”, “my husband goes to see her as well so she gets to know the family dynamic”, “She’s an incredible advertisement for naturopathy”, “I take her advice”, “I definitely trust her because she’s a really good example of health”, “health practitioners I see are really healthy...they look after themselves”, “role models”. “It’s just a feeling of trust that they know what they’re doing and that they have my best interests at heart”, “respect my values regarding health”
<b>Knowledge, learning</b>	“I like to understand the reasons why I’m doing something and what the impacts are going to be”, “I like to talk to various practitioners about things and just get their viewpoints”, “I’ve certainly refined what I know about food because of doing CAM”, “I learned from the healthy food guide...I bought books”
<b>Integration</b>	“quite interesting having both”, “here’s a doctor that knows a lot about Western medicine but he can see the good things in the other forms too”, “I think wow that’s great they [Chinese] train acupuncturists to go and work in the hospital”
<b>Treatment results</b>	“got rid of back pain”, “periods became regular...and I conceived within 9 months of trying”, “I have a son and that’s amazing”, “amazing results”, “successfully treated”, “within an hour of [acupuncture] his temperature was normal...it was amazing”, “The acupuncturist was able to fix that [arm injury]”, “The acupuncturist could treat me for stress”, “free from constant lower back pain”, “his [husband] digestive system works really well now”, “I don’t have polycystic ovaries anymore, I don’t carry an extra 5 kgs of weight and I don’t have irritable bowel syndrome”
<b>Value for money</b>	“would be much better to be funding that [acupuncture] and Naturopathy and then people will need to go the doctors less”, “I really wish it [CAM] was funded”, “I look at it as an essential thing to do to stay healthy and well for the rest of life so I’m quite happy to pay that”,
<b>Physical environment</b>	“professional...I wouldn’t have felt comfortable if it had been in a dodgy room somewhere”, “clean and tidy and up to date and that there is a receptionist, that it’s just like going to the doctor”, “naturopath is in a beautiful space...with lovely wooden floors”
<b>Holistic</b>	“holistic way of treating things”, “connection between what you put inside your body and how well you are”, “[life] balance”
<b>Natural</b>	“they don’t have side effects”, “gentle”, “not foreign to the body”, “made sense to help the body heal itself”. “It’s a healing machine, we’re built to heal”, “less traumatic”, “its natural”
<b>Self-responsibility, self-awareness, social self</b>	“I tend to trust myself more than anything”, “living a healthy life and feel in control”, “I’m choosing to treat things in the way that I feel is right for me”, “I’m regimented”, “it made me aware”, “I like to know what’s going on and try and understand”, “you feel like you’re taking control when you’re using natural medicine”, “looking after yourself so you can look after everybody else”, “I’ve learnt sadly not to share my experiences...because of their reactions”
<b>Leisure participation</b>	“getting into the outdoors”, “it’s about the family playing together and having down time in nature as well and no play station”, “you have to schedule in that type of activity...it’s important...[to enable] your body recover from the stress of everyday life”
<b>Wellness, wellbeing</b>	“to optimise health because we’re living in this environment with a whole lot of stress and pollution”, “preventative”, “to stay healthy and fit and disease free for the rest of my life”, “healthy lifestyle”

**Figure 18: Fiona's summary collage**



### **4.13 Case 12 - Jane**

At the time of the first interview Jane was in “remission” from “mesothelioma which is a cancer, an asbestos related cancer”. Jane’s oncologist believes this was “triggered” due to the stress of losing her partner who had drowned at sea a year earlier, which had also contributed to her having a heart attack 3 to 4 months prior to the diagnosis. Jane was only 49 years old at the time. Jane’s oncologist who she describes as “outstanding” told her “time is not on your side” and gave her a prognosis of 16 to 18 months. After Jane was given the diagnosis she “freaked out” but decided to search the internet for alternative therapies because she “believed strongly that there may be an alternative” for her. After feeling overwhelmed with all the information she called her sister in-law who found her a CAM practitioner to see. Three days later she walked into the practitioner’s office in “an absolute state” and one of the first things he said to her was

Jane there is hope...so from the moment I met Ian he gave me hope and from there I’ve had quite an intense relationship which has developed into a really nice friendship and he has guided me stepped me through the holistic way

The supportive and positive practitioner relationship was integral to Jane’s CAM health care as highlighted in 18, however, it was also Jane’s commitment and perseverance to the treatment plan, which required her to make radical changes to her diet, take multiple supplements and vitamins and take on a positive mental attitude. Jane expressed “it was quite overwhelming but again if you know that’s it’s going to help you you’re prepared to put the effort in”. Her practitioner even commented that she was his “star patient” and that

he “enjoyed working” with her because she gave it her all. Along with seeing a naturopathic practitioner Jane also pursued other forms of CAM health care including Reiki, spiritual healing, and seeing a nutritionist to refine her diet. She believes “100%” that CAM health care contributed to her becoming well not only because it supported her body while having chemotherapy but it also supported her mentally, emotionally and spiritually enabling her to have a positive outlook and cope.

Of great importance to Jane was the naturopathic practitioner and oncologist’s preparedness to work together in that both respected each other’s course of treatment. An integrated approach to her health care was paramount and she felt “fortunate” to have the “best of both worlds”. CT scans throughout the chemotherapy treatment “showed that the tumours were shrinking” and after her treatment “they were gone altogether” and a year later there were still no signs. Unfortunately, four months after our first interview Jane needed to have a second course of chemotherapy and emailed to say she could not continue with the study at that point. It was felt that Jane had such an incredible story that was worthy of being included in this section despite only participating in the first phase of the research. Jane’s interview, held in a meeting room at the University, was animated, rich and inspiring. A testimonial interview video recorded with her CAM practitioner was also used as a form of data for Jane’s case analysis. Jane recommended this video clip found on the practitioner’s website.

Much of Jane’s interview detailed the many treatments she received during the time of her cancer treatment, both CAM and the chemotherapy sessions. She spoke of using Dove House, a registered charitable trust offering a range of service for people with life threatening illnesses. This is where Jane saw a Reiki practitioner which was primarily a relaxation tool for her and she described Reiki and Dove House as her “absolute lifeline for about 6-8 months”. Dove House also offered her the opportunity to talk to other people with cancer in a cancer support group. This highlights how essential an integrative approach was for Jane, not just between the naturopath and oncologist but all the practitioners and support organisations that were involved in her health care. The clinic that her naturopath worked from also used an integrated approach where Jane was referred to other practitioners who helped her specifically with asbestos toxicity and emotional distress. Jane talked about it “being a huge learning curve” where she was often inundated

with information; however, this information empowered her and gave her the belief that she could get well.

**Table 18: Jane's perceived consumer value components with illustrative quotes**

<b>Perceived consumer value components</b>	<b>Illustrative quotes</b>
<b>Practitioner - relationship, manner</b>	“he explains every single thing so clearly”, “he explains why”, “he’s incredibly thorough, he’s just so supportive...he’s very encouraging”, “from the moment I met Ian he gave me hope and from there I’ve had quiet an intense relationship”, “guided me”, “enthusiasm and his positivity”, “he’s totally there for you”
<b>Knowledge/learning</b>	“I’ve just spent a year reading cancer books, cancer, cancer, cancer, alternative stuff and nutrition but with Ian he covered, he’s like this massive umbrella”, “my mind was completely overloaded with information”, “I’ve had a massive learning curve”, “It’s just about being educated”, “they’ve got amazing knowledge”
<b>Treatment, treatment results</b>	“the first session I had with him was 2 hours, it’s pretty intense”, “when I had the scan after the chemo had finished the oncologist said to me Jane you’re a well woman”, “I’m supposed to be dead now and I’m not and I feel better than I’ve felt in a long time”, “when I started the Reiki I was going once a week it was my absolute life line”, “Started to build up my immunity...I started on smoothies, supplements, vitamin C, lots of different vitamins but also a big part of it was the psychology”
<b>Value for money</b>	“yeah it is an expense but if you can afford it, it gives you a longer life and a better quality and that’s worth everything”
<b>Quality product</b>	“I get all my stuff [supplements] through [the clinic] because it’s the best quality”
<b>Self-awareness</b>	“I’m open to it...I’m just open to anything that can help me”, “I’ve been reading a bit of Buddhist stuff and they teach you about the now, and it’s about living in the now and being grateful”, “it’s about positive psychology, positive thinking”, “I think it helped me put the loss of my mum [and Fred] in a more peaceful kind of accepting”, “meditation really helps”
<b>Self-responsibility</b>	“I’ve chucked, I’ve put everything into this”, “I’m discovering more and more [ideas]”, “if you know that it’s going to help you, you’re prepared to put the effort in”, “I just thought this thing is not going to get the better of me”, “when you’re faced with death you’re prepared to take anything on board really”, “it does take a bit of effort”, “I was super strict, absolutely strict to the bone [about diet]”
<b>Integrated</b>	“I’ve got to have chemo I’ve got to do both”, “Ian said [naturopath] tell him [oncologist] that you’re seeing me and I will be guided...and open to him...so when I saw the oncologist he said Jane that’s fine...do what you do with [the naturopath]”, “we will build you up to hopefully make the chemo less traumatic, to support your system though the chemo”, “I’m fortunate with those two [naturopath and oncologist] that they know each other...[there’s] a huge respect [for each other]”, “I’m just so fortunate that I’ve got the best of both worlds and I think that the medical profession seriously need to open up to the natural therapies”
<b>Meaning and purpose</b>	“I just had so much to live for”
<b>Spiritual – connected, holistic</b>	“she’s talking to your spirit”, “she calls up your spirit“, “I would see colours...yellow round my feet...white heaps of white, all I could feel was the white light”, “I just felt a lightness afterwards”, “holistic way”
<b>Wellness, wellbeing</b>	”I just felt like superwoman, I just had so much energy just phenomenal energy”

#### 4.14 Case 13 - Peter

Peter's CAM health care story started in 2000 when he met his wife who had an interest in natural therapies and had completed a number of courses on massage therapy and alternative medicine. Prior to this he had not considered CAM. Peter commented that he "trusted" his wife and was "none the wiser" so went along with what she suggested and began "to accept it as the norm and I think from there I've been more open to alternative medicine". In 2003 they moved to Sydney where she worked as a receptionist for a chiropractor. Within the same premises there was an acupuncturist which they used "while we were trying to get pregnant". In 2007 they moved back to New Zealand and continued to use a chiropractor and acupuncturist primarily. Peter was interviewed in a meeting room at his workplace, where he works as a contract consultant in a busy corporate environment. Although the work environment was relatively formal the interviews flowed well and Peter seemed happy to talk about his health and CAM experiences. The majority of Peter's story in both interviews revolved around his current experiences of his chiropractor/kinesiologist and acupuncturist for haemorrhoids and shingles as well as stress related issues after being made redundant a year prior. Peter's summary collage represented and highlighted the importance of receiving treatment and treatment results for these health issues at the time of this research. Although Peter seemed mostly concerned about the treatment and treatment results, underlying this Peter had a genuine respect for the natural, holistic and personal approach of CAM health care as is evident in this quote.

It [CAM] feels like it's in harmony with my body. It's prescriptive for my body so they mix up something for the bug that I might have or they, it's chiropractic treatment for the area that I need, and it's somebody that I can, it just feels like it's more of a personal relationship than a standard practitioner for some reason...doctors...they're doing it for you...the acupuncturist and chiropractor are asking your body to co-operate...I'm fully co-operative.

Seven consumer value components emerged for Peter (Table 19).

**Table 19: Peter's perceived consumer value components with illustrative quotes**

Perceived consumer value components	Illustrative quotes
<b>Practitioner – relationship manner, knowledge</b>	“trying to give your cooperation”, “I owe it as my part of the contract to follow that [advice] through”, “professional advice and their tools”, “she is very open...I feel at ease with her”, “provided feedback to me on how my body was progressing...it provides a third party to bounce back their professional view”, “I see the acupuncturist and the chiropractor as experts”, “I trust her”
<b>Treatment, treatment results</b>	“acupuncturist...within about 10 days...came through with the results and I still see him”; “Instant relief of back pain”; “the acupuncturist he would focus on those areas so for shingles providing relief and speedy recovery”, “for colds and bugs and things we go to the chiropractor, for anything more serious we still have a GP”, “It’s prescriptive for my body”, “these guys [CAM practitioners] have a programme”
<b>Value for money</b>	“feel comfortable spending the money and getting the value”, “acupuncturist is pretty good value”
<b>Holistic</b>	“It’s all holistic”, “mental part of it”
<b>Natural</b>	“It’s in harmony with my body”
<b>Self-responsibility</b>	“I felt like I had a degree of control”; “I use alternative medicine as a means of keeping me guided within a pathway rather than just going to the doctor when I’m sick...stay within the realms of control”
<b>Self-awareness</b>	“what value can I get from it and how might it enrich my life...that’s the approach that I take with this whole alternative medicine thing”

The practitioner relationship, self-responsibility and commitment were also important aspects that Peter valued with Peter often commenting that he was ‘trying’ to ‘give’ and ‘co-operate’ as much as he could with the practitioner. “If I had to eat liver twice a week, I’m not hot on liver, I would”. Having “a degree of control” over his health was imperative too, but at the same time he gave himself over to the treatment process. Peter saw having a relationship with a CAM practitioner as someone you could continually get feedback from on how your body was progressing in terms of general health and wellness. Unlike mainstream medicine where he “never get[s] any follow up...never get[s] any full closure from my GP, it’s here take these drugs, here’s a prescription, good luck”. Although “cynical” towards mainstream medicine and the pharmaceutical companies Peter and his family will see doctors for “serious” issues, however he did state “I have to be dying in a ditch before I will go and see the doctor”. Within 15 years Peter has gone from little experience with CAM to embracing and trusting CAM health care for himself and his family.

**Figure 19: Peter's summary collage**



#### **4.15 Case 14 - Bill**

Bill's CAM experiences, unlike the other participants, have revolved around learning and gathering tools such as self-hypnosis and Reiki to help himself deal with the “physical, mind, emotional and spiritual” aspects of his life. The consumer value components that were important to Bill are outlined in Table 20.

At 77 years old Bill, a retired businessman, continues to use Reiki and self-hypnosis believing strongly that “life is in your hands” and that using these self-help tools has enabled him to “keep balance” and look after himself “in a busy stressful world”. Bill was introduced to Reiki in the late 80's when his wife at the time decided to become a Reiki practitioner. He witnessed the great results she and his children were getting and decided to learn Reiki, through her, for himself. “I saw the results Pam was getting with our children...she had me doing this [Reiki] for 25 years”. Although Bill has been using Reiki primarily as a self-healing tool for his own physical, emotional and mental wellbeing he often uses it to help others. “The beauty of Reiki is that you can learn it to help other people”. The altruistic nature of Reiki seemed important to Bill who came across in his interviews as caring and sensitive. Bill described using Reiki “innumerable times” on himself and others over the years. During the first interview, held in a public library meeting room, Bill told many stories of when he'd used Reiki, for example, when he cut his finger, banged his head, to feel re-refreshed after business travel, helping a family

friend with a migraine, and a colleague with stomach pain. Reiki has been an important tool for Bill that he has learnt to use instinctively and is often his first port of call. However he does use Reiki in conjunction with mainstream medicine and other therapies and health related services such as Pilates, personal trainer, Body Harmony and self-hypnosis.

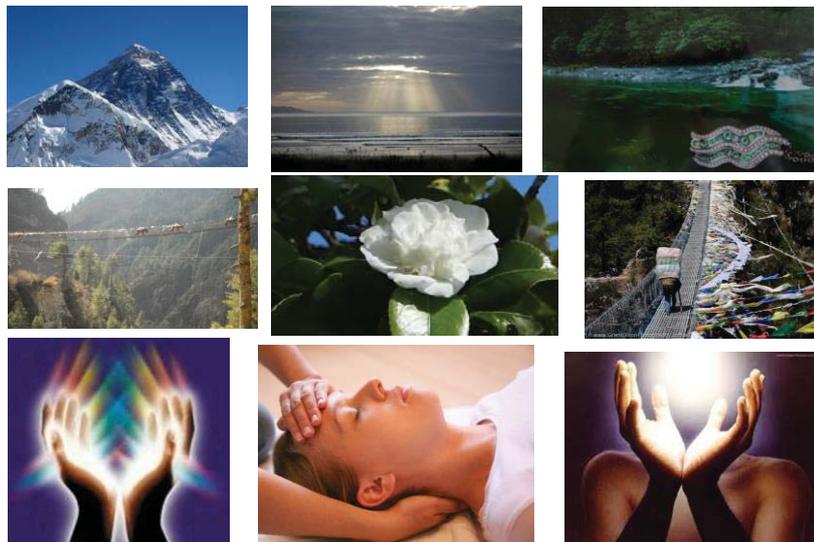
**Table 20: Bill's perceived consumer value components with illustrative quotes**

Perceived consumer value components	Illustrative quotes
<b>Practitioner</b>	"They never question you, they just accept you as you are"
<b>Knowledge, learning</b>	"The beauty of Reiki is that you can learn it to help other people but you can learn it also... to help yourself... I decided it was useful for me", "I learnt self-hypnosis", "It's [Reiki] a practical tool that I learnt"
<b>Self-responsibility, self-awareness</b>	"Give myself Reiki" "I personally use it [Reiki] regularly... give myself lots of self-treatment", "Life is in your hands",
<b>Treatment results</b>	"I saw the results Pam was getting with our children", "from my own experience, it worked for me, it definitely worked for me from a physical point of view and it kept me calm", "provides instant relief", "helps me go to sleep", "faster wound healing", "migraine had gone", "gentle, simple and relaxing"
<b>Natural</b>	"Reiki, it's so beautiful and gentle, it's non-intrusive", "constantly reminded of how wonderful your body is and it can heal itself", "natural, vibrational, hand-on healing practice that supports the body's self-healing ability"
<b>Spiritual - energy</b>	"she attunes you to the energy that is around so you're not using your own energy but you are using energy, universal energy which manifests itself by coming through you as a practitioner or as a person.", "energy goes in and it heals", "It's the power of the energy...connecting... it can be really powerful", "soul filling energy", "power of healing energy"
<b>Holistic</b>	"purity of everything... mind, soul, physical and emotional"
<b>Balance</b>	"Keeping balance and looing after yourself in a busy stressful world"
<b>Peacefulness &amp; tranquillity</b>	"Enables an appreciation of beauty, provides hope and peacefulness" "it's a lovely calming peacefulness"
<b>Altruism</b>	"Help other people"
<b>Wellbeing</b>	"I was terrified of heights ... so I learnt self-hypnosis to be able to cope with that sort of thing"
<b>Leisure</b>	"I learnt self-hypnosis to be able to cope with [crossing swing bridges in Nepal], "I will use self-hypnosis when my voice gets stuck...I sing in a choir"

Self-hypnosis is another self-help tool that Bill took upon himself to learn in the early 90's, primarily to help him overcome a fear of heights as he was planning to travel to Nepal and Tibet to trek in the Himalayas. The trek involved a number of high suspension bridges and he was "absolutely terrified of heights". Self-hypnosis enabled him to manage this fear and he continues to uses self-hypnosis in his everyday life to help with issues or situations that come along. One example Bill told was when his voice gets stuck when he sings he will

often use self-hypnosis. Bill belongs to a Choir and singing is an important aspect in his life. Bill described how singing too was very powerful and uplifting. The importance of self-hypnosis was evident in the second interview where Bill had provided images of the Himalayas, Tibet and suspension bridges which can be seen in his summary collage (Figure 20). Not only did these images represent him “conquering” his fear of heights but it enabled him to travel to a place where much healing took place. The picture of Mt Everest represented “freshness, soul filling, energy, healing power, and strength...a place to refresh and heal”. Bill’s experience of Mt Everest was life changing as it was a time when he was having some personal life challenges. This experience revived him and gave him a new perspective on life.

**Figure 20: Bill's summary collage**



Primarily the consumer value components that are important to Bill are the sense of self-responsibility and having your health (physical, emotional, mental and spiritual) in your own hands. Bill also perceives Reiki in particular to be a natural, gentle hands-on healing practice that uses “powerful” universal energy to support the body’s self-healing ability. These components are also highlighted in the three hand images along the bottom of Bill’s summary collage. Worthy of note are the flower and sunset images. These were photos that Bill had taken himself both representing how his use of CAM has enabled him to appreciate beauty and feel “tranquillity, peacefulness...and hope”.

## 4.16 Case 15 - David

David was attracted to CAM out of “interest” and “curiosity”. He and his wife were introduced to various forms of CAM by his sister and ex-brother-in-law, Americans, who taught massage and other ‘alternative’ types of therapies. David and his wife “took an interest in these things” so “did a course in TM (Transcendental meditation) and a course in Reiki”. They felt that CAM was an area that was “vast”, contained “more emotional content” and considered “spirituality”, and they “wanted to search beyond normal medicine”. Interestingly David’s father was a chiropractor in the United States back in the 70’s, and although he attributes some of his initial interest to his family background he was relatively scathing of the American chiropractor “business” and “marketing” practices. “They were trained how to market their business and they made no bones about it...they were really trying to con people into staying and sustaining a long term relationship telling them they had to have a maintenance check-up every week”. Hence David is attracted to more alternative forms of CAM, often found via word of mouth and operating out of quirky rooms, such as energy healing, Bowen Therapy, and Chinese medicine. “There are certain people like me or my family that are attracted to this form of medicine simply because it’s a bit weird and so if you went out for example and you had a big family ad in the newspaper I probably wouldn’t go and see you, but because you’re kind of hidden say in a corner somewhere and you have a strange room in your house with some crystals, that’s what attracts me.”

David, like Peter, was also interviewed at his workplace; the first interview was in his classroom during lunch break and the second in a meeting room. Although slightly disruptive with the occasional student wandering in and out, the interviews flowed well and David was willing to express his thoughts and feelings about his CAM experiences. David, like Rachel, was also a photographer who provided four (out of 9) images from his own photographic collection. David also formatted his summary collage and sent it through via email, to make sure it was exactly as he wanted it. The black and white central image in his summary collage was one of his own photos. The image represented that “CAM works in different ways, there’s this radiance from the inside out...divine light radiates within and without...so there’s energy, light and then suddenly there’s an element of spirituality in this whole holistic picture as well.” David was very proud of this picture

and it summed up his overall experience of CAM stating “it’s a transformational process which is the healing part but it’s also representative of the idea of body, mind, soul somehow combined.” Nine key consumer value components emerged for David (Table 21).

**Table 21: David's perceived consumer value components with illustrative quotes**

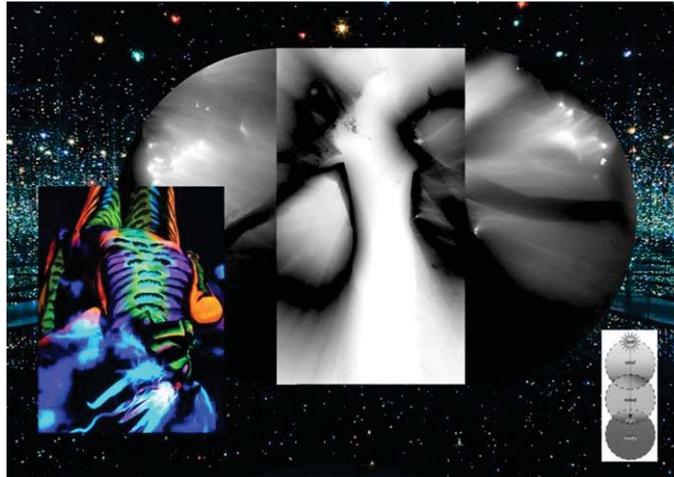
Perceived consumer value components	Illustrative quotes
<b>Practitioner</b>	“They’re more open-minded to their approach to spirituality”, “involved in the process”, “To be honest I found most of the practitioners rather strange...I’ve kept an open mind and thought well if the therapy works...that’s fine”, “in awe”
<b>Treatment</b>	“I’m always looking for a physical outcomes”, “treated me...for depression”, “immediate sense of relief...finally now relax a bit after a treatment”
<b>Value for money</b>	“reasonably expensive”, “I think spending the money has got little to do with choosing whether to go alternative or not”
<b>Holistic</b>	“holistic approach...looking at physical, psychological, spiritual”, “the soul, the mind, body”, “many layers...when you go for a treatment you might look at a certain layer bur there’s still more”, “beyond the body”
<b>Self-responsibility , self-awareness</b>	“involved in the process...emotionally or involved with your soul and your entire being”, “Helped me discover a few things which really enlightened me”, “realise that things [treatment] has transformed you and you can now just carry on being a lighter person”, “help me discover more about myself as I get older”, “will make me a better person moving forward”
<b>Social self</b>	“”My wife heard him speak and she said make an appointment, you’ve got to go. So behind every man that goes to see an alternative practitioner there has to be a powerful woman right? That’s my theory”, “my sister very early on was very involved in all of this stuff and in order to maintain a stable relationship with your sister I’ve had to be interested”
<b>Spiritual - connection</b>	“I’m trying to discover more about this spiritual connection”, “feeling of actually being in touch with other things rather than just the body”, “sense of multiple universes”, “divine light radiates within and without”
<b>Energy</b>	“regularly see an energy healer”, “feeling of lightness and relief...being able to sense a certain flow an brightness”, “emanation or radiation”, “there’s energy”, “feeling energised”, certain aura about it”, “raw energy”.
<b>Meaning and purpose</b>	“[CAM] enables, it certainly assists me on this [spiritual] path”, “Through CAM I have experienced, or get the feeling that there is so much more and it’s massive...so much we don’t know, you know in the sense of multiple universes”, “more treatments I do, the more I can see things are, I can kind of see a bigger picture”

The holistic approach was one of the main components that was important with David saying “we’re talking beyond the body which is why in the first place we’re all interested in CAM.” CAM for David is now more about personal development and self-discovery.

I think the bigger issue is really that it will allow me to discover more about myself as I get older and help myself maintain. So it’s not that I’m going to a practitioner saying can you fix this and I don’t need to deal with it because with alternative medicine is I need to deal with it, so if I

can, if I can discover things that actually I've been carrying around with me for the you know biggest part of my life and I can actually deal with that and then get rid of them hopefully that will make me a better person moving forward. Not just a healthier person but actually an all-round more yeah much improved.

**Figure 21: David's summary collage**



Spirituality also plays a big part of life for David and he contributes his experiences with CAM as having assisted him along his spiritual journey. Not only is this about being connected to a universal entity or divine spirit but it is also about being in “wonder and in awe” of the universe and practitioners that can tap into that universal energy, “when I go and experience someone who is a CAM practitioner then I’m often in awe. I just think it’s something new to me, it’s perhaps surprising and exciting whereas I don’t really get that with Western medicine”.

#### **4.17 Case 16 - Steven**

Twenty three years ago at the age of 26 Steven hurt his back and since, once or twice a year; he ends up with severe back pain. After a few years of seeking advice from his doctor and being sent to physiotherapists, he thought “there must be a way that I could solve the problem quickly”, instead of taking up to 5 weeks to resolve with physiotherapy treatment. At this stage he was married and his wife’s mother recommended he see an alternative practitioner she had been seeing. After seeing this practitioner and having ‘miraculous’ results started Steven on a journey of seeking CAM health care. Steven started to “explore”

other CAM options and on the recommendation of a business colleague Steven started seeing a manipulative therapist/acupuncturist for 3 years where he gained “significant results” which enabled him to resume normal functioning within 24 hours of experiencing back pain.

At the time of the research Steven had been suffering from severe headaches which he consulted his doctor about and who did all the “standard tests”. They both came to the conclusion that the headaches were probably stress related as Steven had a lot going on in his life at the time and the doctor prescribed medication to help with the pain. Meanwhile his wife, who suffers from chronic fatigue, was “really going down the alternative health path” and was seeing a “medical doctor who learnt osteopathy...and oxygen therapy.” She said “go see him. What are you going to lose apart from some money?” Much of the first interview, which was held in Steven’s office at work, he described in reasonable detail the various treatments he had received which he often found “fascinating”, for example,

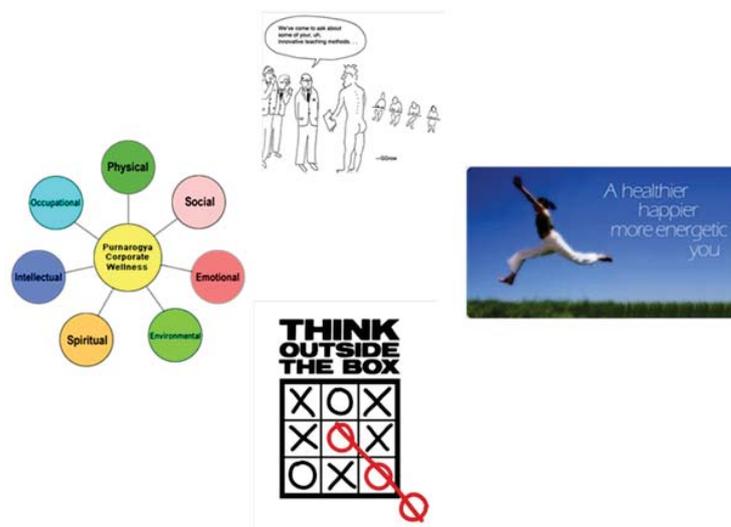
with this headache I went and saw [CAM practitioner] a number of times and one of the things he obviously first of all focused on my lower back because that’s where all the problems have always been and then I noticed that this left arm was sore and he said oh that’s probably a rotor cuff injury that you’ve got in here somewhere and so he focused on my shoulder area and a little bit of my back, uh back of my neck cos he said that was getting really tense up there...he injected oxygen in various parts of me and things like that, in one particular he said oh if it’s up here then that’s probably your C2, that’s the second one down, you’ve got a problem with that that’s linked so he, what I find fascinating with him is because he’s a medical doctor that’s done his osteo and he’s looked at some of these other things, so he’s got the cranial osteo, so he spent a lot of time with me on my, me lying on my back him with his hands round my neck and just pushing with his thumbs into those pressure points.

During the first interview it appeared that Steven was primarily interested in the treatment and treatment results, however, during the image elicitation interview with Steven other consumer value components emerged, such as self-awareness and personal growth, holistic approach, finding an underlying cause and the practitioner’s creative “outside the box” thinking as outlined below in Table 22 and Figure 22.

**Table 22: Steven's perceived consumer value components with illustrative quotes**

Perceived consumer value components	Illustrative quotes
<b>Practitioner – relationship manner, knowledge</b>	“there’s got to be some sort of defined expertise...certificate on the wall”, “warm and friendly”, “think outside the box”, “he was quite thorough”, “spent ¾ hour just him asking about my story...comprehensive”, “innovative way”, “person’s manner got to be good”, “he had a picture of a spine”, they’re looking at all [aspects of your life]”
<b>Practice - service</b>	“receptionist is smiley she sees you coming”, “offer you a glass of water”, “remembers you”, “customer service, I like that side”
<b>Knowledge, learning</b>	“I like to explore how things work so it’s learning a bit about my own body”, “they had taught me all about posture”, “teach me how to use the tools”
<b>Treatment, treatment results, treatment planning</b>	“take less than 10 minutes to do this technique and then within 24 hours your back was fine, so it was pretty miraculous”, “for about 3 years all I needed was one session”, “significant results that I’d go back to being normal, feeling manageable, managing the pain”. “this is my third day with no headache wow”, “twice a week for the next four weeks”, “he gave me a plan”
<b>Value for money</b>	“he was \$20 cash no eftpos machine”, “he was someone who charges \$80 for the first visit and then \$66 for the second”, “fees are reasonable”, “I had the money to do it”, “\$80 a pop for 4 or 5 sessions”
<b>Physical environment</b>	“you’re left there in a very nice peaceful room”
<b>Holistic, Root cause</b>	“he’s taken that truly holistic look at the whole body”, “what caused it”, “you’ve got to find what’s causing the pain”, “it makes sense”, “looking at the underlying emotional things”, “getting this holistic picture”, “looking at the whole person”
<b>Self-awareness, personal growth</b>	“It’s a gradual growing”, “they’re offering potential for new growth within me”, “all the alternatives is trying to get an understanding of who is Steven”, “try to find a healthier me that embodies everything, the purpose of all this [CAM]”

**Figure 22: Steven's summary collage**



At the time of second interview Steven had been to see a chiropractor that he had met at a Health Expo, determined to find a long-term solution for his back issues. Steven appreciated the holistic approach of this practitioner who considered all parts of his life including his “hobbies”, “occupation”, “emotional wellbeing”, “spiritual thoughts” as represented by the circle diagram image in his summary collage. What also emerged from the second interview was the value Steven placed on most CAM practitioners ability to “think outside of the box” as highlighted by the image in his collage above. This was one of five images that represented the idea of the practitioner having “new ideas”, being “innovative”, and being prepared to go in a “different direction”. Having been exposed to CAM for a couple of decades Steven talked of it being a “journey” and a “gradual growing” where CAM practitioners have offered not only solutions but “potential for new growth” within him. It is important to note that Steven is wary of some alternative medicine because of his Christian beliefs. “I’m a Christian so I’m wary of some of the stuff that probably works no problem at all it’s just that they from my understanding they’re invoking energies that could potentially cure but I don’t want to have those energies around me.” Steven also has genuine “respect for GPs” and prefers CAM practitioners to have some sort of “medical background”.

#### **4.18 Summary of In-case Analysis**

The 16 participants who were involved in the research have been presented as individual case studies primarily to show how individual consumers assessed and processed value for themselves, and demonstrated how the consumer value themes emerged. Therefore each case was written up to provide an overview of the participant’s experiences of CAM health services providing insights into the CAM phenomenon. Importantly, each case highlights the key consumer value themes that arose from their consumption of CAM health services and provides evidence of these themes with quotes from the participant. Subsequently the themes that arose from the in-case analyses were then used and informed the cross-case analyses. This chapter also presents each participant’s summary collage, the fifth step used in the visual metaphor elicitation interview, as visual data to support the findings and demonstrate the power of using photo-elicitation techniques in qualitative research.

# Chapter 5 Cross-Case Analysis

## 5.1 Overview

This chapter presents the findings from cross-case analyses on consumer value and value co-creation. Data from all three phase interviews were used in this analysis. Data from the third phase interview was primarily used to explore value co-creation and refine the findings on consumer value. The chapter is organised to address the research questions ‘What do CAM consumers value from their CAM health service consumption experiences?’ and ‘How do CAM consumers co-create value through their consumption experiences of CAM health services?’ Firstly, the consumer value components and sub-components that emerged from the data are identified and detailed. Secondly, the three aspects that determined how the participants co-create value that emerged from the data are reported and presented in table format with illustrative quotes.

## 5.2 Consumer Value Components

Eight broad consumer value components, which the participants experienced during their consumption of CAM health services, surfaced during the data analysis of phase 1 and 2 interview transcripts. These consumer value components were then refined in the data analysis of phase 3 and include: 1) quality of care, 2) treatment efficiency, 3) physical environment (aesthetics), 4) esteem value, 5) social value 6) spiritual value, 7) ethics (natural aspects), and 8) play. As previously mentioned in 3.6.2 the initial data analysis of phase 1 was deductive, whereby phase 1 interview transcripts were coded using seven key consumer value themes from the literature and included quality, efficiency, aesthetics, social value, play, spiritual value and ethics (Holbrook, 1999; Sanchez-Fernandez et al., 2009). However, after a code-recode procedure of the phase 1 and 2 data, the consumer value components were labelled to reflect the CAM consumer’s perceptions of value in a CAM health service, for example, quality of care and treatment efficiency. Importantly the final eight consumer value components identified in this research were only finalised after

the analysis of phase 3. During the phase 3 interview the participants were asked to comment on seven of these consumer value components which were presented as an initial model of consumer value. As a result of the phase 3 analyses an eighth component was established and the consumer value model presented to the participants was refined. Please note that the consumer value model developed through the findings of this research is presented and discussed in detail in 6.3.9, the discussion chapter.

Within each broad consumer value component sub-themes (sub-components) also emerged from the data, for example, under quality of care there were six sub-components 1) client-centred cooperative relationship 2) Empowering approach 3) Practitioner knowledge and expertise 4) Educational and co-learning 5) Supportive, empathetic and caring manner, and 6) Authenticity, as outlined below. Overall the emergence of the sub-components was primarily inductive and driven by the data; however, some sub-themes emerged in light of the literature, for example ‘co-learning’ a term coined by McColl-Kennedy et al. (2012).

Each consumer value component along with the sub components are presented and outlined in turn. Illustrative quotes to support the findings on each of the eight consumer value components that emerged from the data are presented in table format. Please note, to enable easy referencing to the tables, the consumer value components that have more than three sub-components are profiled in separate tables, whereas those that do not are collated in one table.

### **5.2.1 Quality of care**

The first and most prominent consumer value component that arose from the findings was ‘quality of care’. The consumer value ‘quality of care’ was primarily around the practitioner-client relationship. Six key ‘quality of care’ sub-components surfaced and include: 1) Client centred co-operative relationship 2) Empowering approach 3) Practitioner knowledge and expertise 4) Educational and co-learning 5) Supportive, Empathetic and Caring Manner, and 6) Authenticity, integrity and trust. Each component is outlined below and includes a table with illustrative quotes as evidence.

### 5.2.1.1 Client Centred Cooperative Relationship

A “co-operative”, “collaborative” and “partnership” relationship with the practitioner was found to be an integral component for many of the participant’s health care (Table 23).

**Table 23: Quality of care component 'client centred cooperative relationship' with illustrative quotes**

Quality of care component	Illustrative Quotes
<i>Client centred cooperative relationship between CAM consumer and CAM practitioner</i>	<p>“There is a partnership between the client and the practitioner, you both need to put in as much effort and you both learn from each other.” (Olivia, 24)</p> <p>“He’s [acupuncturist] always asking for feedback ... so it was this cooperation... It’s a collaboration between the practitioner and the patient.”(Anne, 60)</p> <p>“I’ve chucked, I’ve put everything into this, as I’ve said I’ve had amazing support.... you know he’s totally there for you... he has guided me.” (Jane, 51)</p> <p>“It really is strongly about connecting, it’s very much about collaboration with the person I’m being treated by, it’s not an isolated thing, its partnership and they really connect.” (Rachel, 45)</p> <p>“Mutual respect or mutual regard” (Jules, 31)</p> <p>“You need someone...[to] be able to bounce off and help you shape it.” (Vivian, 52)</p> <p>“I think their whole philosophy is about team, like working as a team.” (Steven, 49)</p> <p>“It just feels like it’s more of a personal relationship than a standard practitioner...The alternative offer preventative avenues are more about partnership and building something” (Peter, 40)</p> <p>“Involved in the process... the practitioner wants to work with you not at you, it makes sense” (David, 50)</p>

The relationship between the participant and their practitioner/s was valued in terms of the level of involvement each participant wanted which ranged from being considered “a partnership”, to being “collaborative”, to gaining the practitioner’s “advice”. For example, Olivia, Rachel and Peter spoke of valuing a “partnership” with their practitioners. Anne, Fiona, Rachel and Peter appreciated the “collaborative” and “cooperative” nature of their relationships. Jules valued a relationship that had “mutual regard” and Vivian a relationship where she could “bounce” ideas around. Others like Lilian, Margaret, Jenny and Steven appreciated the “good communication”, “advice”, “guidance” and “team” approach. Essentially the participants valued a client-centred, cooperative relationship that involved them in the health care process. Other important relationship aspects that were valued such as the empowering approach, ability of the practitioner to educate, impart knowledge and provide tools, supportive and empathetic manner, and integrity and trust are discussed in more detail below in the other sub-components.

### 5.2.1.2 Empowering approach

An empowering approach primarily involved the practitioner and participant working together, with the practitioner empowering the participant with choice and control over his or her health and well-being (Table 24).

**Table 24: Quality of care component 'empowering approach' with illustrative quotes**

Quality of care component	Illustrative Quotes
<i>Empowering approach</i>	<p>"I really appreciate them giving me empowering information... it puts it in my hands and I appreciate that...the most important thing is that I'm in control." (Mandy, 26)</p> <p>"It's helping me to help myself." (Olivia, 24)</p> <p>"The absolute core of the whole thing...I feel it's my body, my health, I do feel empowered" (Lilian, 46)</p> <p>"Having it in your own hands." (Vivian, 52)</p> <p>"The practices involve me more and allows me more choices so I do have a greater sense of success and empowerment which I also thinks contributes to my emotional wellbeing and also my confidence that I can continue staying well instead of having that dependency to a GP where they say this or not take this I feel more like it's my responsibility to stay well."(Anne, 60)</p> <p>"Part of an empowering relationship is the both people are holding." (Jules, 31)</p> <p>"Being able to live a healthy life and feel in control of it as well...I'm choosing to treat things in the way that I feel is right for me." (Fiona, 40's)</p> <p>"I give myself lots of self-treatment." (Bill, 77)</p> <p>"I'm not comfortable just going to the Doctor and being told take this. I like to understand the reasons why I'm doing something and what are the impacts going to be, what are the side effects." (Fiona, 40s)</p> <p>"I'm empowered with the tools, I've been given the knowledge, I understand the reasoning why" (Steven, 49)</p>

Olivia, Anne and Jules all spoke of having “empowering relationships” with their practitioners. Mandy, Jane and Vivian alluded to being empowered by saying they appreciated having their health ‘in [their] own hands.’ Peter commented that he felt in control of his health by choosing CAM. Margaret, Lilian, Steven and Jenny all appreciated gaining knowledge from their practitioners. Many of the participants gained empowering knowledge and information from their practitioner enabling empowerment and learning to take place. The practitioners imparting their knowledge giving participants a deeper understanding of his/her health issues (uncovering and subsequently treating the cause) or “educating”, enabling participants to have some choice and/or control of his or her health and well-being was important for everyone.

### 5.2.1.3 Practitioner knowledge, expertise and tools

Practitioner knowledge was important on some level to all the participants. For some, “expertise” and a high level of “competence” was essential. Lilian, Jenny and Steven, for example, all spoke of valuing a practitioner being the “expert”, “having expertise” and in some cases having a medical background with “certificates on the wall” (Table 25).

**Table 25: Quality of care component 'practitioner knowledge, expertise and tools' with illustrative quotes**

Quality of care component	Illustrative Quotes
<i>Practitioner knowledge, expertise and tools</i>	<p>“What makes her good, her knowledge, herself, her abilities... being really knowledgeable at the technical things.” (Margo, 39)</p> <p>“She [Naturopath] has so much knowledge which she passes on.” (Vivian, 52)</p> <p>“They have information and expertise and also tuning into you I think that’s really important.” (Anne, 60)</p> <p>“I find her very competent, very thorough...she had a pharmaceutical background.” (Lilian, 46)</p> <p>“There’s got to be some sort of defined expertise yeah it would need to be some sort of certificate on the wall... [also] you need ‘out of the box’ thinking...they have many different tools that they could use or directions they could take it.” (Steven, 49)</p> <p>“I see the acupuncturist and the chiropractor as experts...there’s professional advice and their tools...you’re left with their tools...which could be a spray, it could be advice.” (Peter, 40)</p> <p>“The journey has been one of gathering tools such as self-hypnosis and Reiki.” (Bill, 77)</p>

Steven also appreciated the CAM practitioner’s ability to be “innovative”, “think outside the box” and provide “tools” to help solve the underlying cause of the health problem. Steven, Vivian, Jules, Lilian, Peter, Bill and David all spoke of the CAM practitioners having “tools” that they impart. Peter commented that “there’s professional advice and their tools and then you’re left with their tools...[CAM is about] taking on board the tools and the advice.” Jules spoke of the importance of the CAM practitioner providing tools through education, “that’s where the education comes in; it’s like having the different tools I can use to maintain myself that way.” Steven said “they’ve [CAM practitioners] have got a whole lot of tools... [and] they teach me how to use the tools.” Tools in this context can vary from practical advice such as specific dietary recommendations, breathing and muscular exercises, meditation, yoga, positive thinking to prescribed remedies and supplements, to specialised instruments and equipment used during treatment.

### 5.2.1.4 Educational and co-learning

Importantly it was not just the practitioner’s knowledge that was crucial but their ability and willingness to impart that knowledge to their clients. The participant’s experiences of CAM were frequently described as being “educational”, gaining “knowledge” and “learning”. This ‘educational’ aspect was in part facilitated by the empowering approach of the CAM practitioner which enabled and motivated the participants to manage their health. The majority of the participants appreciated being informed and valued gaining knowledge about CAM, CAM treatments, their health issues as well as general knowledge about nutrition and how the body works (Table 26).

**Table 26: Quality of care component ‘educational and co-learning’ with illustrative quotes**

Quality of care component	Illustrative Quotes
<i>Educational and co-learning</i>	<p>“I find with her what’s really good is a lot of education... they are learning something and the same time you’re learning something... so just going forward together.” (Olivia, 24)</p> <p>“I do learn a lot of things from her too because she’s really knowledgeable... it’s kind of like having this tutoring during the consultation.” (Margo, 39)</p> <p>“I just gradually educated myself which I think is actually part of the aim of natural therapies to educate people so that they can take better care of themselves and have more of an integrated lifestyle and I feel really positive about that.” (Jules, 31)</p> <p>“I am open to him and describe everything that is happening to me and he listens to me and gives me the time.” (Jenny, 28)</p> <p>“CAM works really well for me in that practitioners are keen to share the information.” (Mandy, 26)</p> <p>“The beauty of Reiki is that you can learn it to help others but you can learn it also to help yourself...to me it’s a practical useful tool that I learnt” (Bill, 77)</p> <p>“I like to explore how things work so it’s learning a bit about my body...so yeah it’s a journey of learning” (Steven, 49)</p>

Many of the participants involved themselves in personal knowledge building. Some participants would often share this information with their practitioner or bring a problem to the practitioner whereby both the practitioner and participant learn. Hence, a form of co-learning existed between the participant and the practitioner. For example, Olivia, commented that the practitioner learns too when “you have a problem they haven’t come across before and they have to do a bit of research into it.” Co-learning also consisted of the participants being open and willing to learn from the practitioner, taking information and personalising it and providing the practitioner with detailed information about themselves. Equally it was important to the participants that the practitioners share their knowledge with, listen to and learn about the participant.

### 5.2.1.5 Supportive, empathetic and caring manner

Most of the participants valued an empathetic practitioner who was supportive and caring (Table 27). Some participants had negative experiences and were not prepared to continue with practitioners who were perceived to lack empathy or not ‘care’. Practitioners that had a supportive, empathetic and caring manner seemed to encouraged continuity and treatment compliance. Some participants, such as Mandy, Jane, Vivian, Olivia, Anne, Jules and Peter, valued “empathy” and the “emotional support” offered by practitioners. The others just appreciated a “warm”, “friendly”, “kind” and “caring” manner.

**Table 27: Quality of care component 'supportive, empathetic and caring manner' with illustrative quotes**

Quality of care component	Illustrative Quotes
<i>Supportive, empathetic and caring manner</i>	<p>“He’s incredibly thorough, he’s just so supportive.” (Jane, 51)</p> <p>“They must have empathy... they need to show that care... If I feel like a lump of meat I won’t go back.” (Vivian, 50)</p> <p>“We will talk about the journey you know so it’s kind of like being together on this journey and being supported through this process.” (Anne, 60)</p> <p>“I think a huge component of it [CAM health care] is emotional support... it’s a caring thing to do.” (Mandy, 26)</p> <p>“He put me at ease straight away so his manner is very friendly.” (Margaret, 46)</p> <p>“Without the support of that practitioner I don’t know if I’d still be alive to be honest. She wouldn’t have known the extent her support meant to me.” (Jules, 31)</p> <p>“I went to the chiropractor because I was all locked up and tense, I was generally feeling unwell, I knew I was going to burst into tears...I just sobbed face down on the table...we talked a bit about it as to why... I’m not sure that would have come out if I’d been to see my GP.” (Peter, 40)</p> <p>“I’ve got to be relaxed for it to be effective um so I guess that’s where that manner comes in that the person’s manner has got to be good”. (Steven, 49)</p>

### 5.2.1.6 Authenticity, Integrity and Trust

It was important for some participants that CAM practitioners were perceived as having “integrity”, and were considered “authentic” and “genuine” (Table 28). Integral to this was the participants’ perceptions and feelings of “trust” with their practitioner. Many participants talked of the importance of trusting the CAM practitioner and this came from a belief in the practitioner’s “integrity” and “authenticity.” Integral to this was transparency in that the practitioner was perceived to be practicing “from the heart” or “have my best interests at heart”, and being “respectful”. Those participants who had a strong preference for more ‘partnership’ and ‘collaborative’ relationships tended to value practitioners who practiced “from the heart”, and had genuine respect for the individual’s physical, mental,

emotional and spiritual wellbeing. Congruence was also important to some participants and practitioners were evaluated in terms of whether they emanated health and well-being themselves. It was expected that the CAM practitioner be a role model in terms of health and wellbeing and this contributed to the perceived authenticity and integrity of the practitioner.

**Table 28: Quality of care component 'authenticity, integrity and trust' with illustrative quotes**

Quality of care component	Illustrative Quotes
<i>Perceived as having congruence (trust, (integrity and authenticity)</i>	<p>"I'm looking for authenticity and authenticity is does this person have integrity...and the integrity is you feel they're talking from the heart and they're looking to do the best they can for you." (Vivian, 52)</p> <p>"I've got to really trust them and that's about both their integrity and their experience." (Lilian, 46)</p> <p>"There's a huge amount of trust in them." (Rachel, 45)</p> <p>"It's just a feeling of trust that they know what they're doing and that they have my best interests at heart and that also they respect my values regarding health and care." (Fiona, 49)</p> <p>"That they [practitioner] never question you, they just accept you as you are...I think that's important... that they're not judging you." (Bill, 77)</p> <p>"I probably trust her more than I trust the GP" (Peter, 40)</p> <p>"Congruence is really important, it's clear to me now who is practicing from an integrated place for themselves." (Jules, 31)</p> <p>"All of the health practitioners I see are really healthy...they are role models these people as well." (Fiona, 49)</p>

## 5.2.2 Treatment efficiency

The second consumer value component that emerged was 'treatment efficiency'. CAM participants evaluated their CAM health care via six main 'efficiency' subcomponents 1) Treatment results 2) Treating the cause 3) Treatment ease of use & customisation 4) Access & waiting times 5) Consultation & treatment time 6) Value for money. Each of these subcomponents is discussed below including a table with illustrative quotes.

### 5.2.2.1 Treatment results and timeframes

Treatment results were essential to the participants and varied from pain relief (back, shoulder, headaches), sinus relief, increased energy, digestive relief, speedy recovery from shingles, relief from menopausal and premenstrual syndrome symptoms, stress relief, sense of wellbeing, supporting chemotherapy treatment, to dissolved cysts and kidney stones, to conceiving a child (after natural fertility treatment). The timeframes varied from immediate (results experienced in the first session) to two years (chronic condition resolved to a

manageable level). Those with chronic conditions were prepared to give treatments time, knowing they were not a quick fix. Some experienced immediate results (usually pain relief) and for others the results were gradual.

**Table 29: Treatment efficiency component ‘treatment results and timeframes’ with illustrative quotes**

<b>Treatment efficiency component</b>	<b>Illustrative Quotes</b>
<i>Treatment results and timeframes</i>	<p>“There’s instant relief. I know I can go in with a headache and come out without a headache... the chiropractor put a plan in place, basically it was twice a week for 6 weeks and then once a fortnight and now I’m down to once a month.” (Margaret, 46)</p> <p>“Hay fever went away and was away for several years.” (Lilian, 46)</p> <p>“Kidney stones just disappeared.” (Jenny, 28)</p> <p>“I went to see a naturopath for two years which completely resolved my [period] pain to a manageable level...no more bed rest and all my acne cleared up, all my stressed reduced, my digestion got much better so it was just so immediately apparent how effective that was and since then I rarely go to a GP.” (Jules, 31)</p> <p>“The treatment overall was about 3 months and then we went for an ultra sound and everything was gone.” (Anne, 60)</p> <p>“Within about 10 days things had come right...he came through with the results and I still see him...I’ve seen him for 10 sessions and I’m doing another 10...[then] I will come in and see him for 1 month in, 1 month off, 1 month on.” (Peter, 40)</p> <p>“Within 24 hours your back was fine, so it was pretty miraculous in many ways.” (Steven, 49)</p> <p>“So he gave me like a plan and said that this is the first bit we’ll do for four weeks, we’re going to do this and then at the end of that we’ll reassess and see whether we should be looking at some preventative thing. That’s the first people that have said that to me.” (Steven, 49)</p> <p>“Reiki in particular you almost get an instantaneous result, it’s very quick, it’s very rapid.” (Bill, 77)</p>

Time efficiency was important in terms of managing the participants’ expectations of when to expect results. CAM practitioners who provided a timeframe and plan within which the participant might expect to experience health benefits encouraged ongoing use of CAM. For example, Margaret was given a timeframe of 6 weeks to expect the full benefits of her chiropractic treatment. Peter was given a plan for his acupuncture. Anne’s acupuncture treatment for cysts was 3 months, by then the cysts had gone. Steven was given a plan that involved a 4 week treatment programme and reassessment. Vivian on the other hand described an experience when she had sought help from a holistic doctor for depression and anxiety. This practitioner had given little indication of when to expect results and after months of treatment and no results she “gave up”, highlighting the importance of providing a time frame.

### 5.2.2.2 *Treating the cause*

Treating the cause of the health problem was an important factor to the overall treatment for some participants with many commenting that CAM health care treats and looks into the “cause” of the issue. Rachel for example valued that her osteopath considered and treated the cause of her headaches. Steven appreciated that the practitioners he had seen looked into the cause of his back pain and headaches, including “underlying emotional things.” Olivia also commented that CAM practitioners, such as energy healers, go to the cause by helping “clear emotional baggage.” Others just simply commented that CAM health care goes to the “root” of the problem and does not just treat the symptoms.

**Table 30: Treatment efficiency component ‘treating the cause’ with illustrative quotes**

<b>Treatment efficiency component</b>	<b>Illustrative Quotes</b>
<i>Treating the cause</i>	<p>“Treating the cause, it shows that we’ve got so many layers going on.” (David, 50)</p> <p>“Goes to the root [cause].” (Jenny, 28)</p> <p>“When he did certain things it would cure the thing at the other part of my body that was hurting and he was talking about preventative health long term as opposed to quick fixes.” (Vivian, 52)</p> <p>“They look into the root cause.” (Olivia, 24)</p> <p>“Looking at...what’s causing the headache.” (Rachel, 45)</p> <p>“Treating the root cause rather than the symptom.” (Fiona, 49)</p> <p>“Seeing a root of things.” (Jules, 31)</p> <p>“They’re looking for an underlying cause...looking at the underlying emotional things.” (Steven, 49)</p>

### 5.2.2.3 *Treatment ease of use and customisation*

Ease of use of prescribed remedies (herbal, homeopathic, nutritional supplements), treatments and implementation of dietary changes and exercise rehabilitation prescription were considered important to some of the participants. Ease of use appears to facilitate compliance, whereas difficult to administer treatments, advice and prescribed remedies reduced compliance. For example, prescribed remedies such as homeopathy were considered easy to take due to being “sweet” and “easy to digest”. Whereas some found taking herbal remedies difficult because they were “strong” or because they had to be taken two or three times a day and participants often “forgot”. Dietary changes and exercise prescriptions were generally taken on board because most were happy to “co-operate”. Peter sums this up by saying “usually they give me bits of homework, take these pills or do these exercises so if I didn’t do them I’m letting down my end of the partnership.”

However, complicated or long treatment prescriptions were sometimes not carried out, for example, Margo was prescribed exercises by her osteopath that took 20 minutes, which she did not have time to do.

One of the key factors that appeared to have facilitated compliance was the perception that the CAM practitioner “customised” or “individualised” the treatment, treatment plan and/or prescriptions to the individual. In some cases having a written copy outlining what to take/do and when was appreciated. A negative experience by Vivian demonstrates the importance of customising treatment plans to ensure compliance. Vivian commented that she wouldn’t comply with treatment advice if it was not customised to her specific health issues.

**Table 31: Treatment efficiency component ‘treatment ease of uses and customisation’ with illustrative quotes**

<b>Treatment efficiency component</b>	<b>Illustrative Quotes</b>
<i>Treatment ease of use and customisation</i>	<p>“Homeopathy is quite easy to take.” (Jenny, 28)</p> <p>“Reiki, it’s so easy, beautiful and um gentle, it’s non-intrusive.” (Bill, 77)</p> <p>“Had to give 4 drops twice a day...it would be easy to forget.” (Lilian, 46)</p> <p>“If it’s just kind of things I’m taking for daily nutrition kind of thing its easy, but if I’ve got...to remember taking all the things 3 times a day...it’s hard.” (Margo, 38)</p> <p>“She [Naturopath] would type a prescription and it would say what it was, how much to give and what it was meant to do and some other comments and it was really good because it was all there. Hugely important thing as you could forget very quickly.” (Lilian, 46)</p> <p>“She [naturopath] handed me a sheet of paper and it didn’t feel very customised and it felt like she’s just given me a sheet of paper with this is what you do and I didn’t go back and I didn’t follow the sheet of paper ... I equated that with this won’t work.” (Vivian, 52)</p> <p>“It’s prescriptive for my body.” (Peter, 40)</p> <p>“Tailored to you.” (Steven, 49)</p> <p>“You come out and he’s written it all up [treatment plan].” (Jane, 51)</p>

#### **5.2.2.4 Access and waiting times**

CAM health services were perceived to be relatively efficient in terms of appointment waiting times and access. A number of participants described experiences where the CAM practitioner went out of their way to fit them in if there was an urgent need or have a phone consult if no appointments were available. However, some experienced long waiting times for popular practitioners and these participants were prepared to wait.

**Table 32: Treatment efficiency component ‘access and waiting times’ with illustrative quotes**

Treatment efficiency component	Illustrative Quotes
<i>Access and waiting times</i>	<p>“The osteopath was very lovely, really caring, he dropped everything to treat me.” (Mandy, 26)</p> <p>“If I rang up today and said I really need to see him [chiropractor] they’d fit me in, there is no waiting lists and that kind of gives you that safety net.” (Margaret, 46)</p> <p>“Sometimes I just call my family practitioner [homeopath] and he recommends medicines.” (Jenny, 28)</p> <p>“A couple of times I would talk to her [Naturopath] on the phone which was great.” (Lilian, 46)</p> <p>“Unfortunately for me my acupuncturist is fully booked until Christmas so I keep to my time...on the waiting times component I find in New Zealand if you’re good that’s just the way it goes.” (Peter, 40)</p>

### 5.2.2.5 Longer consultation and quick follow up treatment

Most participants talked of valuing time with their practitioners. What appeared to be valued the most was the long initial consultation which ranged from 45 minutes to 2 hours. Participants’ perceived these consultations to be “comprehensive” and “thorough”. Interestingly, for some participants, quick treatment times were also important, particularly those having regular on-going chiropractic and osteopathic treatments. Follow-up treatments for this type of CAM health care were 10 to 15 minutes. Time efficiency appeared to play an important role for participants who needed regular on-going treatment. However, others still appreciated longer treatment times and follow-up appointments for CAM health services such as acupuncture and naturopathy etc.

**Table 33: Treatment efficiency component ‘longer consultation and quick follow up treatments’ with illustrative quotes**

Treatment efficiency component	Illustrative Quotes
<i>Longer consultation and quick follow-up treatment</i>	<p>“The CAM practitioner they actually spend time with you. There was the [initial] consultation that was about an hour and then he [acupuncturist] spends time treating you.” (Anne, 60)</p> <p>“The first session I had with him was 2 hours... it was intense.” (Jane, 51)</p> <p>“He was quite thorough in that we spent nearly ¾ of an hour just him asking about what was my story, where I was coming from, what were things that were niggling me um... so he was trying to get this whole comprehensive [picture].” (Steven, 49)</p> <p>“The initial consultation was forty five minutes and they take x-rays and they do a proper check of your spine... and now its 10 minutes once a month.” (Margaret, 46)</p> <p>“The chiropractor works for me because it’s actually quite quick, so it’s only about 15 minutes for a regular check-up.” (Vivian, 52)</p> <p>“It would literally take less than 10 minutes to do this technique.” (Steven, 49)</p>

### 5.2.2.6 Value for money

Many participants commented that although CAM health care was expensive they were prepared to pay for it as long as they were gaining positive results from the treatment. Fiona viewed it as “essential” to keep healthy and would love to see CAM health care subsidised. Rachel thinks the money she’s spent “is worth it”, in terms of gaining health and wellbeing. Margaret said she was prepared to pay to be “pain free”. Others like David, Steven and Peter find the money because they are getting results. Margo is relatively cynical about practitioners who charge high rates for consultations and likes practitioners who “offer a good deal”. Margo also prefers practitioners who are perceived to be “not just doing it for the money”, but are genuinely interested in helping people. Lilian and Vivian are happy to pay because they can afford it, but don’t like practitioners who sell the products they prescribe, seeing this as a conflict of interest. Others however like the convenience of the practitioner having available the prescribed products.

**Table 34: Treatment efficiency component ‘value for money’ with illustrative quotes**

Treatment efficiency component	Illustrative Quotes
<i>Value for money</i>	<p>“I’d hate to think how much money I’ve spent but it’s just all worth it...people don’t value spending time and money on their health.” (Rachel, 45)</p> <p>“I look at it as an essential thing to do to stay healthy and well for the rest of my life so I’m quite happy to pay that. It would be nice if they were cheaper.” (Fiona, 40’s)</p> <p>“If it [chiropractic treatment] wasn’t working then it would be expensive but it is working so I just look at the fact that I’ve got to pay that if I want to be pain free.” (Margaret, 46)</p> <p>“Our energy healer he’s \$80 a pop every time and you know of course it pains me to be spending a lot of money, I wouldn’t go see him fortnightly but we we’ve had the results and any other medical practitioner would cost that much too so it’s what it is. I think spending the money has got little to do with choosing whether to go alternative or not.” (David, 50)</p> <p>“I’m not the kind of guy who’s got heaps of money to splash around; the acupuncture is about \$20 a session I think um so I find money for that.” (Peter, 40)</p> <p>“I always like people who offer a good deal.” (Margo, 38)</p> <p>“It is an expense but if you can afford it, it gives you a longer life and a better quality and that’s worth everything.” (Jane, 51)</p>

### 5.2.3 Physical environment

The physical environment was an important indicator of quality and professionalism for some participants. Lilian, Fiona, Olivia and Margaret in particular required a certain “level of professionalism” with the physical environment. This is highlighted by illustrative quotes in Table 35. However, others were more concerned about the quality of treatment and care. Jules and David particularly enjoyed quirky environments which gave “a certain

aura about it.” Some participants like Rachel whose preference was for a professional environment said “it wouldn’t matter” as long as they got “the right treatment.”

**Table 35: Physical environment consumer value components with illustrative quotes**

Physical environment components	Illustrative quotes
<i>Indicator of quality and professionalism</i>	<p>“Smart offices...not clinical but a little bit and very warm...it was in this cool old building with wooden floors and rugs.” (Lilian, 46)</p> <p>“The osteopath is now in a very style [sic], very designed space for its function, what it was designed for and I like that. I personally require a level of professionalism.” (Rachel, 45)</p> <p>“Clean and tidy and up to date and that there is a receptionist, that it’s just like going to the doctor...the naturopath is in a beautiful space with lovely wooden floors.” (Fiona, 40’s)</p> <p>“Clean, tidy, spacious...normal looking” (Olivia, 24)</p> <p>“You’re left there in a very nice peaceful room.” (Steven, 49)</p> <p>“It looked professional because it’s on its own, it’s not upstairs it’s not umm behind anything it’s kind of out in the open, it’s got a good carpark so everything about it is easy...waiting rooms are nice and bright and airy and very calming.” (Margaret, 46)</p>
<i>Quirky environment</i>	<p>“Chinese doctor...has a tiny clinic in the back of his shop, in a rather grotty street front shop, but I know he’s an excellent practitioner...I feel very comfortable there.” (Jules, 31)</p> <p>“Hidden away in a corner somewhere... [in] a strange room in your house with some crystals there, that’s what attracts me.” (David, 50)</p> <p>“The environment was not really upmarket or anything like that whereas a medical doctor’s place tends to be quite swish and you’re thinking well that’s where part of my money’s going.” (Steven, 49)</p> <p>“I would do anything to get the right treatment, so at the end of the day it wouldn’t matter. I mean I’ve been to some fantastic Chinese masseuses who have very quirky environments.” (Rachel, 45)</p> <p>“Less concerned about the physical environment...my acupuncturist works out of a tin shed in front of his house...as long as it’s clean and safe...I’m buying them.” (Peter, 40)</p>

## 5.2.4 Esteem value

Esteem value in this context was experienced as inner self-oriented esteem, as opposed to status and other-oriented esteem. Esteem value was inherently facilitated by participants’ experiences of CAM health care and through gaining better health and enhanced well-being. Four esteem value components emerged from the data and include: 1) self-responsibility, 2) sense of self and self-worth, 3) self-discovery, and 4) self-awareness. These four components are outlined below.

### 5.2.4.1 Self-responsibility

An important component was the participants’ perceptions of “taking responsibility” and being responsible for his/her own health.

**Table 36: Esteem value component ‘self-responsibility’ with illustrative quotes**

<b>Esteem value component</b>	<b>Illustrative quotes</b>
<i>Self-responsibility</i>	<p>“I’m in a place where I know enough to maintain my own health.” (Mandy, 26)</p> <p>“I need to make choices about what really suits me, what style of treatment.” (Anne, 60)</p> <p>“I’m choosing to treat things in the way that I feel is right for me.” (Fiona, 48)</p> <p>“The beauty of Reiki is that you can learn it to help yourself.” (Bill, 77)</p> <p>I am constantly looking after myself...it’s a commitment to honouring what you need.” (Rachel, 45)</p> <p>“I completely take responsibility for my own health.” (Lilian, 46)</p> <p>“I’m able to maintain a level of health myself.” (Jules, 31)</p> <p>“I’m always prepared for things.” (Jenny, 28)</p> <p>“I’m taking responsibility for my health, for my wellbeing.” (Margaret, 46)</p> <p>“Realisation of self-responsibility.” (Vivian, 52)</p> <p>“I treated it myself.” (Margo, 38)</p> <p>“It’s helping me help myself.” (Olivia, 24)</p> <p>“I felt like I had a degree of control.” (Peter, 40)</p>

Self-responsibility was experienced three ways. Firstly, many participants felt empowered to take more control over their health and well-being for themselves. This was often obtained through gaining “knowledge” and “empowering information” via their practitioner. CAM practitioners, as discussed earlier, enabled and facilitated this sense of “control” and “self-responsibility” by imparting knowledge and encouraging self-care. The second way self-responsibility was experienced was via the participants making choices about their health care and taking action by considering CAM health care and choosing treatments that “suit” and “feel right” for them. The participants perceived by making choices about their health care and the treatment/s they were “taking responsibility” for their “health” and “wellbeing”. Thirdly, self-responsibility for some was about “honouring what you need” and giving themselves a “level of care” that enabled them to continue to be well. For many this was committing to regular on-going treatment. What came out in the third interviews was that often this sense of self-responsibility, taking control and making choices about health care had a positive impact on the participant’s sense of self. Peter sums this up by saying “the reason I do it [CAM] is for my well-being, so I’ve done it so I feel good about myself.”

**5.2.4.2 Sense of self and self-worth**

Many of the participants gained a ‘sense of self’ from their experiences with CAM health care and this was linked to feelings of well-being. A ‘sense of self’ relates to participants

gaining self-worth via an increased sense of well-being which took on many forms including physical, emotional, mental and spiritual.

Physical well-being was demonstrated by Margaret who found her chiropractic treatment gave her “physical freedom to do things and participate in activities” that gave her a new sense of self. Anne, Jules, and Rachel’s experience of well-being was more emotional and was about being vital, happy and confident enabling them to “stand tall”, “claim strongly what is mine” and “feel like me again’. Through CAM Bill overcame his fear of heights, Peter, David and Steven managed their stress, and Jane and Oliva were able to let go of “emotional baggage”. This enabled them all to gain an increased sense of self. As David highlights “when you go and see a practitioner something shifts whether it’s physical, emotional or spiritual...that transforms my attitude, my approach and my thinking.”

**Table 37: Esteem value component ‘sense of self and self-worth’ with illustrative quotes**

Esteem value component	Illustrative quotes
<i>Sense of self and self-worth</i>	<p>“When my health isn’t at its best it’s clouding who I am...I’m a better person for having all this treatment...I feel like I’m me again” (Rachel, 45)</p> <p>“I come out [of the chiropractor] feeling like a new woman... it’s like freedom, being able to run and jump and do just want I want to do.” (Margaret, 46)</p> <p>“I guess for me when I’m looking at health care that’s the kind of practitioner I’m looking at that can support my natural unfolding, my next step, my knowing for myself, my rightness in myself.” (Jules, 31)</p> <p>“If I’m in my ideal self I’m fit, I’m vital I’m able to travel the world and I’m able to say no to rest of society or to anything that’s not right for me and I’m really able to claim strongly what is mine, it’s that kind of empowerment to health that is the keystone to the rest of my empowerment I feel.” (Jules, 31)</p> <p>“Are you still feeling stressed, as stressed out as when you walked through the door? Nah actually so that’s the value that I’m getting.” (Peter, 40)</p> <p>“I was terrified of heights, absolutely terrified of heights...so I learnt self-hypnosis to be able to cope with that sort of thing...conquering fear mentally and emotionally.” (Bill, 77)</p> <p>“I just had so much energy just phenomenal energy...I just felt like superwoman.” (Jane, 51)</p> <p>“What value can I get from it [CAM] and how might it enrich my life...that’s the approach I take with all this alternative medicine thing.” (Peter, 40)</p> <p>“I feel very healthy...it’s like feeling strong in my body and strong in my heart and my mind... I feel so much more energy and you know capacity to do things...If I have all these aspects in balance then my heart is happy and then I can stand tall in the world.” (Anne, 6)</p>

### **5.2.4.3 Self-discovery**

Self-discovery was about gaining an understanding of the self and self-identity. Jules, Olivia, Rachel, Anne, David, Steven and Bill’s experience of CAM initiated a “process” or “journey” of “self-discovery” and/or “transformation” that has given them insight into who

they are and what they want from life. Jules’s, for example, attributes CAM health care to enabling her to come back to her “own natural rhythm”, “own selfhood as an identity thing” and her “own orientation around what is healthy” for her to live her life. Jules “reclaimed” her self-identity by gaining physical, emotional, mental and spiritual strength through CAM health care. Olivia said her journey with CAM health care has enabled her to work out “who I am and what’s sort of holding me back...I am sort of on my path which I haven’t strongly felt before.”

**Table 38: Esteem value component ‘self-discovery’ with illustrative quotes**

<b>Esteem value component</b>	<b>Illustrative quotes</b>
<i>Self-discovery</i>	<p>“They’re offering potential for new growth within me...it’s a gradual growing...try and find a healthier me...all the alternatives are trying to get an understanding of who is Steven.” (Steven, 49)</p> <p>“I think when you see health professional it brings up that big what do want in life, how do I want to be.” (Olivia, 24)</p> <p>“[CAM] health care is about me coming back to my own natural rhythm and my own self hood as an identity thing.” (Jules, 31)</p> <p>“Assists me in the process of transformation.” (Anne, 60)</p> <p>“Journey of self-discovery... It makes you realise or confirms that you can do anything; it’s up here in the brain. You can do anything and this is an additional aspect of that.” (Bill, 77)</p> <p>“I think the bigger issue is really that it will allow me to discover more about myself as I get older... So it’s not that I’m going to a practitioner saying can you fix this and I don’t need to deal with it because with alternative medicine is I need to deal with it, so if I can, if I can discover things that actually I’ve been carrying around with me for the you know biggest part of my life and I can actually deal with that and then get rid of them hopefully that will make me a better person moving forward. Not just a healthier person but actually an all-round more much improved [person]...it’s a transformational process which is the healing part.” (David, 50)</p>

#### **5.2.4.4 Self-awareness**

Many participants spoke of having “awareness” and being “aware” of the possibilities CAM health care provided them. This often stemmed from the participants being “open-minded”, “curious” and “inquisitive”, with many describing themselves this way. This self-confessed open-minded personality trait enabled the participants, through their experiences of CAM health care, to gain awareness about themselves (body, mind, and emotions) learn to be “in tune” with and aware of their body’s needs, and be engaged in the health care process. For some participants like Jules and Rachel, self-awareness, was also about determining the level of care they needed from CAM providers.

**Table 39: Esteem value component ‘self-awareness’ with illustrative quotes**

<b>Esteem value component</b>	<b>Illustrative quotes</b>
<i>Self-awareness</i>	<p>“My personality is into curiosity, to explore, to look for [other ways].” (Vivian, 52)</p> <p>“I’m a person that likes to try things and I’ve always been like that.” (Olivia, 24)</p> <p>“I think self-awareness is hugely important...you’ve just got to be in tune...I can be a bit self-focused about my health...I’ve always been very open minded to things.” (Rachel, 45)</p> <p>“I was already in the mind-set...as well as having an open mind.” (Fiona, 48)</p> <p>“I’ve always been open.” (Jane, 51)</p> <p>“I think it comes down to your personality...I’m open to anything and everything...there’s a natural curiosity.” (Peter, 40)</p> <p>“I’m very inquisitive...I try and be more than open-minded, I give myself over to the process.” (David, 50)</p> <p>“I think I’ve got a bit of an open mind.” (Lilian, 46)</p> <p>“I became a lot more aware of my body.” (Mandy, 26)</p> <p>“If you engage in the practice regularly it just deepens your awareness.” (Anne, 60)</p> <p>“I’m really into self-development.” (Olivia, 24)</p> <p>“When I look at healthcare I’m very aware....all the support I’ve given myself has actually created a far better outcome for myself if I hadn’t had those health support processes.” (Jules, 31)</p>

### **5.2.5 Social value**

Social value was both gained and lost in this context and was experienced both positively and negatively in two ways. Firstly, via the ideal social self and secondly via social influences, these are discussed below and highlighted with illustrative quotes in Table 40.

#### **5.2.5.1 Ideal social self**

The ideal social self in this context was about being able to engage positively in social activities and relationships with others such as family members, friends and work colleagues and being seen as healthy, energetic and happy. A number of participants talked about being “a better person” for using CAM and becoming well, which had a positive impact on their relationships. Rachel was a prime example of this when she said “I’m better for having all this treatment...I’m less grumpy...people would rather that you were energetic and interesting and pleasant to be around.” Margaret too felt she could be more “family orientated” and participate in activities with her family. Those with children felt CAM health care provided more in terms of keeping children well.

#### **5.2.5.2 Social influences**

Social influences on participants’ CAM health care experiences were both positive and negative. The negative aspects were mostly around the participants dealing with people’s



The positive aspects included being influenced by others to use CAM and being drawn to others who are conscious of their health and wellbeing. Of particular interest and the only key difference detected between the men and women participants was that all the men were influenced by their wives to consume CAM health care. This is summed up by David who said “behind every man that goes to see an alternative practitioner there has got to be a powerful woman.” This was considered a positive influence with all the men initially being influenced and/or encouraged to look after their health by their wives. Bill and Peter had wives that were CAM practitioners. Bill’s ex-wife was a Reiki Master who encouraged Bill to learn Reiki when they were together. Peter’s wife is a massage therapist and he was introduced to CAM when they met. Peter’s wife continues to quietly encourage him to keep maintaining his health as is outlined in this quote.

I’ve been pushed into that gratefully by my wife whose probably heading more down towards the integrative. She’ll do the shopping and that’s organic and she’s off to a meditation class tonight...we do massage, acupuncture, she lined up the chiropractor, she’s pushing all of that stuff and I’m slip streaming in behind that.

Steven and David both have wives who use CAM health care and have often suggested they see particular practitioners. Despite this influence, the four men in this study all value their CAM health care and attribute it to them maintaining good health.

## **5.2.6 Spiritual value**

Five key spiritual value components emerged from the data and are outlined. The five components include being considered holistically, gaining meaning and purpose in life, connection with nature, connection with an energy or spiritual force, and feelings of peace and balance. Each component is discussed in turn below.

### **5.2.6.1 Considered holistically**

One of the most important spiritual aspects was being considered holistically. All of the participants spoke of valuing a holistic approach. The majority of participants referred to holistic as mind, body and spirit (or soul), whereas others thought of holistic as treating and looking at interrelated parts of the body or looking for an underlying cause. Nevertheless in all cases the interrelationship between the different components of a person

(mind, body, emotions and/or spirit) was imperative throughout their consumption experience of CAM health care.

**Table 41: Spiritual value component ‘considered holistically’ with illustrative quotes**

Spiritual value component	Illustrative quotes
<i>Considered Holistically</i>	<p>“It’s [CAM] about holistic healing, healing energy, healing mind, body and soul.” (Margo, 39)</p> <p>“They respect all the different components of who we are... all the different levels physical, mental, emotional and spiritual.” (Anne, 60)</p> <p>“I also like to have a holistic way of treating things.” (Fiona, 40’s)</p> <p>“It’s something around trust and I guess fundamental to that is those deep spiritual values like respect and dignity and wholeness... in terms of who I would go and see regularly I would expect that higher spiritual nature to be there.” (Jules, 31)</p> <p>“What value can I get from it and how might it enrich my life and I think that’s the approach that I take with this whole alternative medicine thing, where it’s all holistic.” (Peter, 40)</p> <p>We’re talking beyond the body which is why in the first place we’re all interested in CAM...yeah the holistic approach...the soul, the mind and body.” (David, 50)</p> <p>“He’s [chiropractor] taken that you know truly holistic look at the whole body.” (Steven, 49)</p>

### 5.2.6.2 Gaining meaning and purpose in life

The second component that surfaced was around participants gaining meaning and a sense of purpose in life (Table 42).

**Table 42: Spiritual value component ‘gaining meaning and purpose in life’ with illustrative quotes**

Spiritual value component	Illustrative quotes
<i>Gaining meaning and purpose in life</i>	<p>“I think when you see [CAM] health professionals it brings up that big what do I want in life, how do I want to be.” (Olivia, 24)</p> <p>“On the spiritual side, for me, it’s looking for more meaning.” (Vivian, 52)</p> <p>“I want to be living my true purpose in life.” (Mandy, 26)</p> <p>“I guess for me when I’m looking at health care that’s the kind of practitioner I’m looking at that can support my natural unfolding, my next step, my knowing for myself” (Jules, 31)</p> <p>“It represented for me a new beginning...freedom...to do things I’ve always wanted to do.” (Margaret, 47)</p> <p>“Yoga really helps me on with my spiritual path or life path.” (Anne, 60)</p> <p>“I think the bigger issue is really that it [CAM] will allow me to discover more about myself...it’s a transformational process” (David, 50)</p> <p>“They’re offering potential for new growth within me.” (Steven, 49)</p>

The consumption of CAM health care, as discussed in 5.2.4.3, became for many a journey of self-discovery and personal growth which enabled some participants to find meaning and purpose in life. This ranged from having a sense of freedom to participate in activities after long-term shoulder and neck issues were resolved, to building wellness and good health to reach personal potential, to gaining a deeper spiritual awareness. This was

somewhat facilitated by the holistic, educational and empowering approach of the CAM health care practitioner who encouraged growth and self-discovery.

### 5.2.6.3 Connection with nature

The third component that arose was the idea of being connected with nature. The essence of the ‘connection with nature’ component was the underlying belief that given support with natural products and treatments, the body (a natural organism) has the ability to heal itself. An interconnected theme also emerged whereby some participants, such as Jules and Anne considered themselves connected with the natural world and “being in harmony with nature” and being “connected to mother earth.” Another aspect important to some was about the appreciation of nature providing ‘natural’ products, such as herbs, that enabled healing to take place.

**Table 43: Spiritual value component ‘connection with nature’ with illustrative quotes**

Spiritual value component	Illustrative quotes
<i>Connection with nature</i>	<p>“It gives me a world view or paradigm that fits for me spiritually in terms of what I want to align myself with and I do think that health comes from being in harmony with nature and natural rhythms. I feel part of....human’s relationship with nature and earth, and that feels really beautiful for me like really meaningful somehow being part of that sense of connectedness to humanity and to the earth.” (Jules, 31)</p> <p>“Natural things are more in line with what we need because we’re natural and made out of natural materials, rather than synthetic...they’ve got that life force.” (Margo, 39)</p> <p>“We are an organism...there are better ways of doing it that are more natural to the body.” (Vivian, 52)</p> <p>“Plants are in tune with what we need and how we’re interrelated and basically they support our system...when you’re feeling well you connect with the world...connected to the mother earth and the sky and spirituality.” (Anne, 60)</p> <p>“It just made sense to help the body heal itself.” (Fiona, 40’s)</p> <p>“How Reiki works it is a natural, vibrational, hand-on healing practice that supports the body’s self-healing ability” (Bill, 77)</p>

### 5.2.6.4 Connection with an energy or spiritual force

The third component was around the participants’ experiencing a connection with spiritual or energy forces which enabled healing to take place. Healing energy was often experienced during the consumption of CAM treatment, particularly with hands-on treatments such as osteopathy, acupuncture and energy healing therapies such as Reiki. Consistently the word ‘energy’ was used to describe this connection, however, the source of that energy varied. The energy described by the participants ranged from an exchange of

personal energy from the practitioner to the consumer, to tapping into universal energy to channelling divine energy. In the majority of cases the experience typically involved the practitioner either transferring their ‘healing’ energy or tapping into and channelling a universal or divine source. It is important to note that this spiritual component was not just confined to the treatment experience. More often than not the participants continued to experience this transfer of energy and in some cases learnt to channel that energy themselves.

**Table 44: Spiritual value component ‘connection with energy or spiritual force’ with illustrative quotes**

<b>Spiritual value component</b>	<b>Illustrative quotes</b>
<i>Connection with god, energy or spiritual force</i>	<p>“God has given these things [plants] for curing.” (Jenny, 28)</p> <p>“She [Spiritual Healer] would connect with spirit if you like and connect with the earth and then she will have her guides working with you and she would be directed to help me heal.” (Vivian, 52)</p> <p>“I certainly feel there is a spiritual component to it [CAM]” (Anne, 60)</p> <p>I went to an energy healer...she cleared my energy channels and I could actually feel a line of energy running up and down my body.” (Olivia, 24)</p> <p>There is that sense of freedom for me...when I’m feeling healthy and balanced I feel like I have space and energy for more grace and more connection.” (Jules, 31)</p> <p>“I had quite interesting things happen when I was having Reiki...I could feel this white light...heaps of white light...the white’s a healing colour.” (Jane, 52)</p> <p>“I saw a spiritualist...it’s quite weird she goes back to your spirit...she went back to like 7 lives ago...she’s talking to your spirit...out of the blue something would flash, it was bizarre.” (Jane, 51)</p> <p>My therapist has their own energy that they feed in to me which helps me get my own energy back.” (Rachel, 45)</p> <p>There’s an energetic level to healing...energy healing...energy work kind of helps your soul.” (Margo, 39)</p> <p>“She [practitioner] attunes you to the energy that is around so you’re not using your own energy but you are using energy, universal energy which manifests itself by coming through you as a practitioner or as a person.” (Bill, 77)</p> <p>“You could say CAM works in different ways, there’s this radiance from the inside out... thinking about how divine light radiates within and without, in some way trying to show that so this is probably more the spiritual side of things you could say so there’s energy, light and then suddenly there’s an element of spirituality in this whole holistic picture as well.” (David, 50)</p>

#### **5.2.6.5 Feelings of peace and balance**

The last component was about gaining a sense of balance and feelings of peace and calm. Balance for some participants was an inner balance where the mind, body, emotions and spiritual aspects of their lives were perceived to be in harmony. For others it was simply about gaining the ability to achieve life balance. CAM health care helped these CAM consumers to experience and achieve a sense of balance enabling them to cope better with the stresses of life.

**Table 45: Spiritual value component ‘feelings of peace and balance’ with illustrative quotes**

Spiritual value component	Illustrative quotes
<i>Feelings of peace and balance</i>	<p>“A huge part of the [healing] process for me is learning to de-stress, be a lot calmer, be a lot more balanced.” (Rachel, 45)</p> <p>“I came out of those sessions and I would feel really rebalanced.” (Vivian, 52)</p> <p>It [CAM] helped me kind of put the loss of my mum you know in a more peaceful kind of accepting.” (Jane, 52)</p> <p>“It’s [CAM] has made me strive for balance.” (Mandy, 26)</p> <p>“From my experience with natural therapies I really feel it’s like a balance...about keeping balance and staying centred...if you’re all out of balance they help you get back into balance.” (Olivia, 24)</p> <p>“If I’m off balance myself and am around a practitioner who is strong and clear... I can come back to collecting myself which is really what I see health care being about.” (Jules, 31)</p> <p>“It is about finding the balance.” (Anne, 60)</p> <p>“It’s a lovely calming peacefulness...Reiki enables me to keep balance in life.” (Bill, 77)</p> <p>“Peace and harmony comes nothing like looking back to a problem and despite where you are now, even if you realise it was depression and you’re out of depression or you’re out of pain or whatever it is you’ve now got peace and harmony.” (Steven, 40)</p>

### 5.2.7 Natural

Many of the participants were attracted to CAM initially because it was seen as being ‘natural’ and in some cases non-invasive as outlined in Table 46. The key aspect was about the participant’s valuing that the CAM therapies, treatments and prescribed remedies were nature based and non-invasive. Often this was in comparison to pharmaceutical drugs that were considered synthetic or in some cases toxic and harmful to the body, and surgery which was considered invasive. Interestingly the statements “it makes sense” and “it must be a better way” were frequently used to explain the natural aspect of CAM health care. The perception that natural must be better, because we as humans are natural, was very strong. The natural aspect of CAM was also related to hands-on treatments such as chiropractic manipulations, massage therapy, acupuncture, osteopathy and Reiki which were perceived as non-invasive.

**Table 46: Natural consumer value components and illustrative quotes**

<b>Ethics value components</b>	<b>Illustrative quotes</b>
<i>Based from nature and non-invasive</i>	<p>“It’s really nature based...their main medicines are made out of specific plants, it’s really nature based...herbal medicine and homeopathy doesn’t have any side effects of bad reactions.” (Jenny, 28)</p> <p>“Realised and found out that conventional medicine is actually harmful for your health rather than good for you and that natural things are more in line with what we need... Modern society makes you toxic and unhealthy and conventional medicine can make your body toxic and unhealthy and so it (natural products) helps get rid of the bad effects of the other stuff...they are form nature, closest to nature.” (Margo, 39)</p> <p>“It [CAM] uses natural remedies.” (Anne, 60)</p> <p>“My fundamental belief is we are organisms and we’re surrounded by chemicals...being entirely organic and chemically free that probably is best for you...acknowledging you need extra and it should be of good quality.” (Vivian, 52)</p> <p>“I’ve always had this sense like isn’t natural medicine better...it makes more sense to use something that was already put here than to use something that’s synthetic...we’ve got everything in nature that we need to heal ourselves...nature already has it all.” (Olivia, 24)</p> <p>“I liked the sound of what he [acupuncturist] was doing because I didn’t like taking drugs on going...I would just rather not do that because they had just had so many side effects...It just made sense to help the body heal itself, it’s a healing machine, we’re built to heal...they don’t have side effects...they are very gentle on the system so that’s what appeals to me.” (Fiona, 49)</p> <p>“I don’t really like knocking around the body with antibiotics and I don’t even take disprin unless it’s major so it feels like it’s in harmony with my body.” (Peter, 40)</p> <p>“I’m not into modern medicine as being the be all end all. I will go to the doctor if I think I need to go but I’m not keen on the doctor prescribing medication or in this case surgery...I thought it [Chiropractic manipulations] was the most non-invasive natural way of doing it.” (Margaret, 46)</p> <p>“It’s non-invasive... how Reiki works it is a natural, vibrational, hand-on healing practice that supports the body’s self-healing ability.” (Bill, 77)</p>

### **5.2.8 Play**

Play in the CAM context was experienced three ways, as a form of relaxation, through leisure prescription and by enabling leisure participation. These are discussed below and outlined in Table 47.

#### **5.2.8.1 Relaxation**

CAM health care was often experienced as ‘relaxation’, especially during hands-on treatments such as massage therapy, acupuncture, osteopathy and chiropractic care. A number of participants described these treatments as “relaxing”. Although most did not see the treatment itself as a ‘treat’ they did often enjoy the time to ‘relax’. Not only was the treatment itself relaxing but some treatments also enabled the participant to be relaxed, after the treatment.

**Table 47: Play consumer value components with illustrative quotes**

<b>Play consumer value components</b>	<b>Illustrative quotes</b>
<i>Relaxing</i>	<p>"I've had practitioner experiences where it's just gentle and it's focused on you and its nice and relaxing...hands-on sort of work like the chiropractor and massage." (Olivia, 24)</p> <p>"I usually come away feeling really relaxed." (Rachel, 45)</p> <p>"Sometimes I want relaxation." (Jenny, 28)</p> <p>"The whole thing for me is relaxing, even though I might be walking in there in pain...I know when I walk out I'm not going to have any pain." (Margaret, 46)</p> <p>"Feeling a bit relaxed and blissed out." (Margo, 39)</p> <p>I guess relaxation stands out for me...it is important to me and then if I do, then things can be released." (Anne, 60)</p> <p>"It's an odd feeling [acupuncture] but you can actually, surprisingly enough you can relax with it and you're left there in a very nice peaceful room to just lie there." (Steven, 49)</p>
<i>Leisure prescription</i>	<p>"I've had practitioners say to me go for a walk on the beach and it makes sense in a way, it's like it's easy, it's cheap and it makes you feel good." (Olivia, 24)</p> <p>"I do yoga and dancing and cycling.... these help me slow down, have life balance and keep fit." (Rachel, 45)</p> <p>This guy [practitioner] is talking about yoga, this person is talking about aerobic exercise and actually the answer is um both...so I went to Pilates" (Peter, 40)</p> <p>"I have a personal trainer and he says look Bill you're never going to go in the Olympics but we're going to keep you supple and able to move yourself." (Bill, 77)</p>
<i>Enabling leisure participation</i>	<p>"Kayaking is something that I love. I'd never been able to because I just haven't got the strength in my arms and shoulders to do it whereas now I do, so that just kind of gives me freedom." (Margaret, 46)</p> <p>I sing in a choir...self-hypnosis helps when my voice gets stuck...I use Reiki after if I've been in contact with someone at the choir with bugs... It enhances your ability to be able to play, in my case its bowls, it enhances my ability to be able to breathe and concentrate, it really enhances." (Bill, 77)</p> <p>All of those things combined keep me relatively fit and supple and mobile...self-hypnosis enabled me to conquer my fear for heights and I was able to walk the swing bridges in Nepal." (Bill, 77)</p> <p>"[CAM is] giving me that sense of empowerment being strong enough to travel that are not healthy...in my ideal self I'm fit, I'm vital, I'm able to travel the world." (Jules, 31)</p> <p>"I don't have the ability to do lots of stuff, I can't dance the salsa if I haven't got any energy...if I don't keep well." (Rachel, 45)</p> <p>"I was doing a lot of sewing, a lot of creative work but my back was too sore to sit at the sewing machine for too long and I was also making shoes, so don't feel I can achieve my creative goals when my body isn't in good order, so it's kind of a base line for anything else I want to achieve." (Mandy, 26)</p> <p>"With a stuffed back you can't do anything...it enables me to participate." (Steven, 49)</p>

### **5.2.8.2 Leisure prescription**

Play was also experienced by some participants via prescription from CAM practitioners as part of the treatment, for example, walking or yoga. Leisure activities were also taken up by the participants to 'complement' their treatment, provide life balance and contribute to their health and wellbeing. Steven and Peter, for example, took up Pilates to help with their back problems. Bill had a personal trainer and went to the gym regularly. Rachel, Anne, and Lilian participated regularly in yoga.

### **5.2.8.3 Enabling leisure participation**

For some their CAM treatment enabled them to participate in leisure activities that they would normally find difficult to do. The value was in the physical freedom the CAM treatment enabled. Margaret after her chiropractic treatment was able to play sports with her boys and go kayaking. Rachel could keep up her salsa dancing, biking and yoga through on-going osteopathy. Jules wants to gain physical strength and immunity via CAM to enable her to travel. Bill used self-hypnosis to enable him to travel and trek in Nepal. Bill also uses Reiki to help his voice when he sings in a choir. Mandy wanted to gain physical strength through CAM to pursue her interest in sewing and fashion design.

## **5.3 Consumer Value Co-creation in CAM Health Care**

Analyses on how the participants co-create value were carried out using data from all three phases. However, phase 3 was where key value co-creation themes were refined and in some instances expanded upon and/or identified. From the analyses three significant areas that contribute to how CAM consumers co-create value with CAM health services were identified and include: 1) consumer's approach to health care, 2) consumer value co-creation relationship styles and 3) consumer value co-creation activities. This section presents the findings of each area separately, however, it is important to note that the three areas interrelate and these interrelationships are discussed in-depth in chapter 6. The findings from each of these consumer value co-creation areas are outlined in turn. Tables with illustrative quotes are presented for each area to support the findings.

Firstly, three consumer approaches to health care were identified and include reactive, proactive and integrative approaches. These approaches to health care impacted on the type of relationship styles participants preferred to have with CAM services and the co-creation activities they engaged and/or participated in, therefore the findings of this area are presented first. Secondly, three consumer value co-creation relationship styles emerged from the data, namely advisory, consultative and partnership styles, which influenced how the participants co-created value. Thirdly, twelve consumer value co-creation activities that participants engage in were identified.

### **5.3.1 Approach to health and health care**

How the participants approached their healthcare and health in general arose as a broad value co-creation theme during the analyses of phase 1 and 2 data. It became evident during the analyses that the participants approached their healthcare in three different ways. The researcher labelled these three approaches 1) Reactive approach, 2) Proactive approach, and 3) Integrative approach. During the phase 3 interview the participants were presented with these approaches on a power point slide (Appendix K) and given a brief description and asked to give their feedback. All the participants presented with these approaches agreed with the descriptions and indicated which approach they had adopted at the time of the research, which was in line with the approach the researcher had thought the participant had adopted.

Each approach is described below and summarised in Table 48 with illustrative quotes to support. It is important to highlight at this point that although the participants, at the time of the research, predominantly adopted one of the three approaches there is evidence of movement between the approaches and this finding is described in each approach below and discussed further in chapter 6. Interestingly, it became evident during the phase 3 interview that there was movement from one approach to another over a period of time for some participants. Primarily, the movement appears to be down the table from reactive to proactive and proactive to integrative. Each approach is now presented and described.

#### **5.3.1.1 *Reactive approach***

Participants who predominantly adopt a reactive approach tend to only seek CAM health care when health issues arise and are focused primarily on treatment outcomes. Lilian, Jenny and Margaret are potentially typical ‘reactive’ CAM health consumers. Lilian will go to an osteopath when she experiences back pain and usually only goes for 1 or 2 treatments. Lilian has the same approach to the Naturopaths she has seen also. Generally, Lilian has sought out a Naturopath when her allergy/cold prone child gets sick and her Doctors have only offered antibiotics as a solution. As Lilian describes she has “dabbled in and out” of CAM health care for a number of years and uses it when “standard medicine isn’t meeting my needs.” Lilian tends to approach CAM health care as she would mainstream medical care, seeking both when an issue arises and looking for a result.

**Table 48: Participant's approach to health and health care**

<b>Health care approach</b>	<b>Summary of the approach</b>	<b>Illustrative quotes</b>
<i>Reactive</i>	Seeks CAM health services when required, primarily when health issues arise	<p>"I have come in at the reactive stage, that's how I got introduced to it out of frustration with other solutions or short-term results." (Steven, 49)</p> <p>"I've been to osteopaths for years...you go in, sore shoulders fixed, leave, no exercises to do, beautiful." (Lilian, 46)</p> <p>"When I get a bit stiff, a bit sore then I know well ok I can go back [to the chiropractor]." (Margaret, 46)</p> <p>"I'm interested in outcomes, results...for example if there is an infection...one of my kids has a sore throat...I will use homeopathy to fix the throat." (Jenny, 26)</p>
<i>Proactive</i>	Regularly seeks CAM health services. Uses CAM for maintenance and prevention	<p>"I'm here probably, proactive...[I] do massage, acupuncture [and] chiropractor." (Peter, 40)</p> <p>"I see an osteopath every 10 days...I've learnt you have to invest in your health all the time...to feel good." (Rachel, 45)</p> <p>"What are the things I need to do that I've learnt along my journey...having collected lots of things, knowledge, best practice and saying...what do I need to do...Would I be proactive yes." (Vivian, 52)</p> <p>"I'm choosing to treat things in the way that I feel is right for me." (Fiona, 49)</p> <p>"The most important thing is that I'm in control and that I know the stuff that I'm doing to get healthy." (Mandy, 26)</p>
<i>Integrative</i>	CAM has been integrated into lifestyle. Uses CAM for wellness. Often self-treats.	<p>"[I'm] Integrative I'd say...it's the whole lifestyle, ensuring I have great balance, life balance." (David, 50)</p> <p>"I'm a combination of the bottom two proactive and integrative...I just do it (Reiki), it is part of my life, an integral part of my life. (Bill, 77)</p> <p>"There's some sense of ownership that starts to be produced, people start to self-regulate...there are actions and becoming actively involved is the first step in engaging in self-healing and taking responsibility...I'm probably here [integrative]" (Anne, 60)</p> <p>"To keep yourself healthy and vibrant and well...[It's] about maintaining health and wellness." (Margo, 39)</p> <p>"I've been using natural remedies for 17 years I guess I know, I feel I can identify more clearly what I need at what time so yes I just make a choice around that...I'm looking for that next level of empowerment where I'm able to maintain a level of health myself." (Jules, 31)</p>

Jenny on the other hand has a long-term relationship with her homeopathic practitioner but only uses him for more complex health issues when they arise. Although Jenny self-administers simple homeopathic remedies to herself and her family it is 'reactive' and is only used occasionally for minor ailments when she or her family gets sick. Jenny too generally approaches CAM health care as she would mainstream medical care when health issues arise. Jenny's describes her use of mainstream medicine and homeopathy for emergencies and issues that arise in the following quote.

Actually if it's really serious...I would probably go for allopathic first, because my elder daughter she has asthma so I preferred that for her, but if she has something else I have gone, because once she had a urine infection so I used homeopath and it really worked, but if she has something like an emergency that I feel it has to be cured very rapid way then I usually go to allopathic...If there is an infection sometimes I have used homeopathic as well.

Margaret although 'reactive' had the potential to move towards being more proactive. Margaret went through an initial 6 week programme with a Chiropractor which resolved most of her shoulder and back issues. After the 6 week programme she went to the Chiropractor approximately once a month for 6 months but mostly when an issue arose like shoulder pain or headaches. By the third interview Margaret had stopped seeing the Chiropractor. This was primarily due to miscommunication from the clinic receptionists who booked her in with another practitioner without consulting her. Margaret's case also demonstrates the importance of the practitioner-client relationship from the consumer's perspective. Margaret had built up a relationship with her chiropractor and she felt "disappointed" and "disregarded" when she wasn't asked whether she was comfortable seeing another practitioner because her practitioner was away. If Margaret had continued to see her Chiropractor on a regular basis for maintenance she would have moved to being more 'proactive'. Margaret said she should look for another Chiropractor but hasn't got round to it and will probably do so when her "shoulder and neck issues get bad again".

Steven however was in the process of moving from being 'reactive' to 'proactive'. Over a period of years Steven just went to a CAM practitioner once a year when he experienced a sore back. Prior to this he also did the same with mainstream medical care, e.g., physiotherapist and his doctor, looking for "a quick fix". However, after recently experiencing debilitating headaches and wanting to find a permanent solution for his back issues Steven came to the realisation that he needed to be more 'proactive' with his health. Steven commented in the third interview that he started CAM health care "at the reactive stage" and feels he is now moving into the "proactive area" because he is "starting to realise that maintenance is important," as he ages. At the time of the third interview Steven had found a Chiropractor that he resonated with who offered a preventative view of health, demonstrated in this quote.

One of the things the chiropractor said, do you want to just come here for the 4 weeks which will just solve the pain problem or do you want to then look at it further as a preventative thing and there's other things we can look at so I thought that was quite interesting...being older I'm starting to realise that maintenance is important.

The key characteristics of a 'reactive' CAM health care consumer are seeking CAM health care only when health issues arise and using CAM health care primarily to 'fix' a problem. Essentially the participants in the 'reactive' group were looking for professional advice and seeking treatment to solve their 'physical' health, for example, back problems, neck and shoulder pain, coughs and colds.

### **5.3.1.2 Proactive approach**

Proactive participants tend to use CAM health care on a regular basis for on-going maintenance of their health and wellbeing. The proactive approach is characterised by participants who have made a commitment to their health and are prepared to invest time and money to keeping well. Six participants, Peter, Mandy, Jane, Vivian, Rachel and Fiona have adopted this approach. These participants have all moved from being 'reactive' to taking a more 'proactive' approach to their health and health care viewing a proactive approach as necessary for good health. Rachel for example goes to her osteopath approximately every 10 days for maintenance. This quote from Rachel sums up the proactive type CAM consumer.

I see an osteopath probably every 10 days because I find its just such a responsive treatment, it suits my personality, I have the sort of physique that if I'm out of alignment or out of whack you feel it and its just brilliant...its seems to me that people don't value spending time and money on their health, that they kind of feel they have to do it when things are really bad but I've learnt if you invest in time and money on your health all the time you're more likely to feel good most of the time, so it's worth it.

Peter and Fiona are similar to Rachel, with both seeing an acupuncturist and a chiropractor on a regular basis for maintenance. Mandy gets regular massage and sees other practitioners such as Naturopaths to guide her along with her health and wellbeing. Vivian too uses a chiropractor regularly and has used Naturopaths to "bounce ideas off" and gain knowledge to help her keep well. Vivian however commented in her third interview that

although ‘proactive’ she can sometimes be ‘reactive’. For example, at the time of the third interview Vivian had started seeing a spiritual healer because of a personal circumstance she needed help with. Jane although initially ‘reactive’ after her lung cancer diagnosis, continued to see her Naturopath regularly for on-going maintenance after her chemotherapy treatment. The key characteristics of a proactive approach are using CAM health care on a regular and on-going basis for maintenance and wellbeing on all levels, physical, mental, emotional and spiritual.

### **5.3.1.3 Integrative approach**

An integrative CAM health care approach is characterised by the participants having incorporated CAM health care into their lifestyle and having strong beliefs about CAM philosophies on healing, for example, the body has the ability to heal itself given support and a holistic approach that considers mind, body and soul. Six participants Olivia, Anne, Margo, Jules, Bill and David fall into this category. Olivia, Anne, Margo and Jules all regularly see CAM health care practitioners for health issues, on-going maintenance and wellness, and have integrated CAM and healthy living into their daily life. Margo, for example, sees a cranial osteopath regularly for maintenance and a Holistic Doctor for any complex issues; otherwise she treats herself and her family, sources her own nutritional supplements and herbs, eats primarily organic foods and strives to live a “healthy lifestyle”. An integrative approach to health care is summed up by Margo when she said:

It’s all the different things we discussed the healthy eating and natural traditional medicine, herbal medicine and holistic mind, body and soul approach and body work and healing energy work and all the things that work together to create that.

Olivia, Anne and Jules are similar in that they too have all embraced CAM as their primary form of health care, take a wellness approach and have a healthy lifestyle including eating organic. Anne and Jules are vegetarians and Olivia is conscious of eating well and is now studying nutrition. Bill has an integrated approach due to his regular practice of Reiki and self-hypnosis which has become a part of his overall health care and is often his first port of call. He often uses Reiki as a preventative, for example, to prevent jet lag on business travel. David is an example of a CAM consumer who has recently moved to being integrative as he continues on his CAM health care journey. In the third interview when

asked if he started reactive and ended up integrative he replied “I sure did”. For David being integrative was about:

The whole lifestyle, ensuring I have great balance, life balance, being able to define myself in different facets, thinking hard about this journey that I’m going on. All of those things kind of feed into that, it’s integrative.

All the participants in this group except Anne started out their CAM health care as reactive and over the years have gone from reactive to proactive to integrative. Jules says

when I was younger and I had some severe symptoms I was definitely looking for relief of those symptoms and so I think I would always want relief of symptoms but I realise there is actually something more for me now as I get older it is actually about my vitality itself rather than necessarily certain outcomes.

Anne is somewhat different in that she felt she always had an integrative approach. Her journey began many years ago when she started moving in “alternative circles”.

### **5.3.2 Consumer value relationship styles**

Client-practitioner relationships surfaced as a strong theme under ‘quality of care’ during the analysis on consumer value as discussed in 5.2.1. In the initial analysis of phase 1 and 2 interviews the sub-theme ‘partnership’ arose under the consumer value component ‘quality of care’. In light of the literature the ‘partnership’ relationship style uncovered in this research was at that stage of the analysis compared to McColl-Kennedy et al’s. (2012) ‘partnering’ consumer value co-creation practice style. However, during the analysis of the third phase interview, when the ‘quality of care’ consumer value sub-component on ‘partnership’ client-practitioner relationships was discussed, it became apparent that there were distinct preferences for different relationship styles by the participants. Accordingly, further analysis of the client-practitioner relationship using data from all three phases was carried out. From this analysis three relationship styles that the participants’ preferred emerged from the data and were labelled by the researcher as: 1) Advisory Relationship Style 2) Consultative Relationship Style and 3) Partnership Relationship Style. Each relationship style is described below and outlined in Table 49 with illustrative quotes.

**Table 49: Preferred consumer value co-creation relationship styles**

<b>Health care approach</b>	<b>Summary of health care approach</b>	<b>Illustrative quotes</b>
<i>Advisory</i>	Practitioner is perceived as the expert. Participant is primarily seeking advice.	“I was guided by what he said.” (Margaret, 46) “I go to the practitioner for advice... I think he is more knowledgeable... and I am dependant on him for information.” (Jenny, 28) “Professional...preparedness to answer questions with lots of facts...I liked the fact she’d done a pharmacy degree.” (Lilian, 46)
<i>Consultative</i>	Practitioner-client relationship is perceived as collaborative. Participant is seeking guidance in a co-operative way.	“I built up that relationship and trust with her...able to bounce off and help you shape it.” (Vivian, 52) “It’s really strongly about connecting...It’s very much about collaboration with the person I’m being treated by.” (Rachel, 46) “I appreciate them giving me empowering information...it puts it in my hands and I appreciate that.” (Mandy, 26) “Communication is important...It’s a collaboration between the practitioner and the patient.” (Fiona, 49)
<i>Partnership</i>	Practitioner-client relationship is perceived as relatively equal with mutual respect. Participant is seeking a partner with genuine joint interests and values on health.	“I’m involved...I ask her about what she’s detecting and what she thinks is going on and she talks about her findings as she goes along.” (Margo, 39) “It’s kind of like being together on this journey...It’s a different engagement, a different relationship than a GP.” (Anne, 60) “Partnership between the practitioner and the client just like the joining of one, one can’t work without the other, you’ve both got to be in it.” (Margo, 24) “Part of an empowering relationship is that both people are holding...it’s like mutuality...mutual respect (Jules, 31)

### **5.3.2.1 Advisory relationship style**

An ‘advisory’ relationship was primarily around the participants seeking and taking on advice from the practitioner. The main difference with this relationship style compared to the other styles was that the participants generally perceived the practitioner to be the “expert”. Four participants preferred this style including Margaret, Lilian, Steven, Jenny. Lilian and Steven for example valued their CAM practitioner’s being qualified, such as, having “a pharmaceutical background” or “some sort of medical background”. Margaret and Jenny valued getting “professional advice”. Generally the participant’s level of personal knowledge about CAM was medium to low. Jenny had a reasonable knowledge of homeopathy, enough to treat herself and her family for minor ailments and relied on her practitioner for more complex health issues. The others, Margaret, Lilian and Steven relied

on their practitioner/s to have the knowledge and expertise. Philosophical views were mostly around CAM being “natural” and/or “holistic”. Holistic for this group was around the body being considered holistically, i.e., looking for underlying causes and considering the body as interrelated parts. Interestingly those who are more ‘reactive’ tend to have a preference for an ‘advisory’ type practitioner relationship.

### **5.3.2.2 Consultative relationship style**

A ‘consultative’ relationship is based around the participant ‘consulting’ with the practitioner about their health and health issues, but in a “collaborative” and “co-operative” way. Hence the preference was for a “co-operative” relationship but with some advisory aspects. Seven participants, Peter, Mandy, Jane, Vivian, Rachel, Fiona and David had a preference for this style. The participant’s levels of knowledge on CAM varied from high to medium, with the majority having a reasonable amount of personal knowledge of CAM. This level of knowledge on CAM enabled the participants to contribute to the relationship collaboratively; however, the majority of these participants were also still seeking guidance. Vivian sums up the ‘consultative relationship style’ when she said “you need someone who will listen to your story and be able to bounce off and help you shape it.” Fiona and Rachel talked of the relationship being “a collaboration between the practitioner and the patient.” Peter expressed the importance of “building” a “long-term” relationship and committing to the treatment. Philosophical views of CAM for this group were mainly around it being “natural”, i.e., in line with what the body needs and “holistic”. Holistic for this group was mostly about being considered as a whole being – mind, body and soul. Participants who preferred a consultative relationship style also tended to have adopted a ‘proactive approach’ to their health care. Primarily, this was due to the knowledge gained using CAM health care.

### **5.3.2.3 Partnership relationship style**

A ‘partnership’ relationship is based on the premise that the participant is seeking a relationship whereby they are “working together” in “partnership” almost on an equal level with “mutual regard” with their practitioner. The key difference between the ‘consultative’ style and the ‘partnership’ style is that the participants had high levels of knowledge about CAM and therefore wanted a practitioner relationship where there were genuine joint

interests and values on health. Five participants, Bill, Olivia, Anne, Margo and Jules have a preference for this style of relationship. These participants had a high level of personal knowledge of CAM due to gathering their own knowledge via books, internet and attending CAM related courses, as well as gaining knowledge from practitioners over the years. These participants had been using CAM regularly as their main form of health care for many years. Importantly these participants had strong philosophical views on CAM and CAM health care in terms of health and healing. Jules for example had strong feminist political views about CAM. Margo, Anne and Olivia had embraced and integrated CAM health care and philosophies about health and healing into their daily lives. Bill learnt Reiki and self-hypnosis for himself and when he uses CAM practitioners the relationship is mostly on an equal level with similar views and outlooks on health

#### **5.3.2.4 Summary of consumer value relationship styles**

What is important to understand in the analysis of client-practitioner relationships was that the three relationship styles were the dominant styles that each participant preferred. Data from the third feedback interview helped refine these styles. However, it also revealed that some participants, particularly those in the ‘partnership’ and ‘consultative’ groups, would sometimes seek a different style depending on the health issues they were seeking treatment for. For example, Margo whose preference style is ‘partnership’ would sometimes seek more of an ‘advisory’ relationship with her Holistic Doctor for ailments that arose that she was unsure of. Vivian preferred a ‘consultative’ style with the Naturopath where they worked together to form a treatment plan, whereas she preferred an ‘advisory’ style with her chiropractor, who she relied primarily on for treatment when back issues arose (i.e. reactive approach). Significantly, as outlined at the start, there is evidence of an interrelationship between the participant’s approach to health care and the consumer value relationship style they prefer. It appears that when a participant adopts a different approach, for example, moves from being reactive to proactive, the preferred relationship style also changes from advisory to consultative. Even a temporary movement from integrative to reactive seems to impact on the relationship style preferred.

### 5.3.3 Consumer value co-creation activities

When considering how to analyse the research question on how CAM consumers co-create value through the CAM health care consumption experience, the literature was referred to. It was evident in the literature on value co-creation in health care, in particular McColl-Kennedy et al. (2012) and Sweeney et al. (2015), that consumer value co-creation activities would be an important consideration in how CAM consumers co-create value. Therefore the consumer value co-creation activities identified in the above scholars' research were used as a starting point for the analysis of co-creation activities in this research. The analysis revealed that participants in this research engaged in a number of activities that enabled them to co-create value both within and outside of the clinic environment. Twelve consumer value co-creation activities emerged from the data, five which were experienced within the clinic and seven outside the clinic environment. Interestingly, many of these activities had actually been identified during the analysis of the consumer value components as highlighted in 5.2, prior to consulting the literature. Therefore, McColl-Kennedy et al's. (2012) and Sweeney et al's. (2015) research was also used to help categorise and name the co-creation activities identified in this study. Firstly, the five within clinic activities are described and summarised in Table 50 with illustrative quotes. Following this the seven outside clinic activities are described and presented in Table 51.

**Table 50: Within clinic consumer value co-creation activities with illustrative quotes**

<b>Consumer value co-creation activities</b>	<b>Illustrative quotes</b>
<p><b>Cooperation</b></p> <ul style="list-style-type: none"> <li>• <i>Active participant in the treatment sessions</i></li> <li>• <i>accepting information and advice</i></li> <li>• <i>being open to the practitioner and treatment</i></li> </ul>	<p>"You're trying to give your energy, you're trying to give your cooperation, you're trying to follow their instructions to the letter because it is very much they're having to tap into your body to some degree, so if you're not going to give them access then that's going to make the job a lot more difficult." (Peter, 40)</p> <p>"He lies you on your back and he gets you to take a breath in and lift you one leg up." (Steven, 49)</p> <p>"I go in there and connect myself to the treatment and tune in, knowing this will help." (Anne, 60)</p> <p>"Try to look at how the practitioner is looking." (Steven, 49)</p> <p>"You should be open to him [practitioner]." (Jenny, 26)</p> <p>"He was engaged with the idea [hypnotherapy] the way the hypnotherapist spoke to him." (Rachel, 45)</p> <p>"I look at his [chiropractor's] chart of the spine on his wall during the treatment and I can see and understand how if those bits are out then it's going to effect this." (Margaret, 46)</p> <p>"Everything she [nutritionist] was just so valuable, it was just so important and I was just captivated listening to her... Understanding the philosophy around it [energy healing] and working with it." (Olivia, 24)</p> <p>"I'm open... I give myself over to the process...I just do what feels right for me...If you didn't</p>

	bring that with you, an openness towards the holistic sense, you wouldn't have a good treatment." (David, 50)
<b>Colearning</b> <ul style="list-style-type: none"> <li>actively sharing personal information with the practitioner</li> <li>seeking and sharing knowledge</li> </ul>	<p>"You have to describe your problem very well because a single symptom can change the medicine...describe everything that is happening to you." (Jenny, 26)</p> <p>"Asking about what my story was and where I was coming from." (Steven, 49)</p> <p>"You need to give as much information as you can, if you go and see the chiropractor or the osteopath you tell them all the injuries, they need to know that." (Olivia, 24)</p> <p>"I found a research paper on the internet about his condition." (Rachel, 45)</p> <p>"I can inform myself...so I feel I can make a greater informed choice...[about] the treatment." (Anne, 60)</p> <p>"They're learning something and the same time you're learning something, because you're helping them, say like you have a problem they haven't come across before and they have to do a bit of research in to it." (Olivia, 24)</p>
<b>Coproducing</b> <ul style="list-style-type: none"> <li>actively being involved in treatment planning</li> <li>shared decision-making</li> </ul>	<p>"He discusses the plan with you...[you get to discuss] is that what you want...once you agree that's fine...at the end of 6 weeks...you discuss whether things are working and what he sees and what you see." (Margaret, 46)</p> <p>"[It's about] the coming together with the practitioner and working together...going forward together." (Olivia, 24)</p> <p>"What you need is to have someone...to be able bounce off and help you shape it." (Vivian, 52)</p> <p>"Provides feedback...provides a third party to bounce back their professional view." (Peter, 40)</p> <p>"I build a relationship with the practitioner over time, I can see the progress and can re-decide where to take it or when to stop it." (Anne, 60)</p>
<b>Communicating</b> <ul style="list-style-type: none"> <li>actively communicating with the practitioner</li> </ul>	<p>"I do it with all practitioners, including doctors...quiz them...keep asking...I need to understand." (Lilian, 46)</p> <p>"I went to an acupuncturist and he started treating me generally and I said listen actually buddy, this was on the 2<sup>nd</sup> or 3<sup>rd</sup> session, what I'd really like you to focus on is this" (Peter, 40)</p> <p>"I'm quite frank with him [Homeopath]." (Jenny, 28)</p> <p>"There was consultation." (Anne, 60)</p> <p>"I was so comfortable with him it was ok I've talked to you, you've listened." (Margaret, 46)</p> <p>"I like to talk to the various practitioners about things and get their viewpoints." (Fiona, 49)</p> <p>"I'd spend my whole appointment just chatting and just asking questions for things I wanted answers for." (Olivia, 24)</p>
<b>Commitment</b> <ul style="list-style-type: none"> <li>investing time to attend visits</li> <li>investing money</li> </ul>	<p>"Initially it was twice a week for 6 weeks...now the only commitment I have to give is 10 minutes once a month and if it brings relief then I'm quite prepared to give that 10 minutes...I'm going to pay the money...I just look at the fact that I've got pay that if I want to be pain free." (Margaret, 46)</p> <p>"You need to be prepared to invest a large amount of time...you can't expect a quick fix...I've learnt if you invest in time and money on your health all the time you're more likely to feel good most of the time, so it's worth it." (Rachel, 45)</p> <p>"The level of health care I've given myself...for the last 4 to 5 years [is seeing my practitioner] every week...I spend a lot of money on health care...it's actually really appropriate for me to give myself that kind of support...doing that gives me better health outcomes." (Jules, 31)</p> <p>"Initially I went [to acupuncture sessions] 2 to 3 times a week." (Anne, 60)</p> <p>"I had been seeing him [acupuncturist] for 6 months." (Fiona, 49)</p> <p>"I've seen him for 10 sessions and I'm doing another 10..." "I find money for that [acupuncture treatment]." (Peter, 40)</p> <p>"It was about \$1000 a month, which I could afford." (Vivian, 51)</p> <p>"I look at it as an essential thing to do to stay healthy and well for the rest of my life so I'm quite happy to pay that." (Fiona, 49)</p> <p>"The natural therapy way is a really expensive way to go in a whole picture sense...it's really expensive to get yourself on to that track." (Olivia, 24)</p> <p>"It is an expense... [but] worth everything." (Jane, 51)</p>

### **5.3.3.1 Within clinic consumer value co-creation activities**

The consumer value co-creation activities that were experienced within the clinic included:

1) Cooperation – with the practitioner by being an active participant in the treatment, accepting information and advice, and by being open to the treatment process. 2) Colearning – by actively sharing personal information about themselves with the practitioner, and sharing personal knowledge gained about health in general and their health condition. 3) Coproducing – by being actively involved in the treatment planning and willingly participating in shared decision-making. 4) Communicating – with their practitioner honestly, openly and confidently. 5) Commitment – by investing time and money into CAM health care.

### **5.3.3.2 Outside clinic consumer value co-creation activities**

The consumer value co-creation activities experienced outside the clinic included: 1)

Cognitive processing – having an open mind to CAM health care and the treatments, and by being able to overcome any negative influences and opinions of others. 2) Compliance – complying with treatment advice, prescriptions and adopting the practitioner's recommendations such as dietary and lifestyle changes. 3) Connections – making personal connections with people who support the use of CAM health care and establishing personal connections with nature, and energy and/or spiritual practices. 4) Control – gaining and maintaining control over personal health and wellbeing by engaging in personal knowledge building. 5) Coordinating other activities – by seeking and participating in other health related activities such as yoga, Pilates, gym, meditation, and visualisation. 6) Changing lifestyle factors – of own accord changing lifestyle factors such as diet, exercise and stress reduction. For some it was about converting to organic foods and/or vegan/vegetarian diets. 7) Co-integration – by actively integrating other forms of CAM health care and in some cases mainstream medicine.

**Table 51: Outside clinic consumer value co-creation activities and illustrative quotes**

<b>Consumer value co-creation activities</b>	<b>Illustrative quotes</b>
<p><b>Cognitive Processing</b></p> <ul style="list-style-type: none"> <li>• <i>having an open mind</i></li> <li>• <i>overcoming negative influences and opinions of others</i></li> </ul>	<p>“Helped having an open mind.” (Fiona, 49)</p> <p>“My personality is into curiosity, to explore, to look for [other ways].” (Vivian, 52)</p> <p>“I’m a person that likes to try things and I’ve always been like that.” (Olivia, 24)</p> <p>“I’ve always been very open minded to things.” (Rachel, 45)</p> <p>“I was already in the mind-set...as well as having an open mind.” (Fiona, 48)</p> <p>“I’ve always been open.” (Jane, 51)</p> <p>“I think it comes down to your personality...I’m open to anything and everything...there’s a natural curiosity.” (Peter, 40)</p> <p>“I’m very inquisitive...I try and be more than open-minded.” (David, 50)</p> <p>“I think I’ve got a bit of an open mind.” (Lilian, 46)</p> <p>“I thought there must be a way I could solve the problem.” (Steven, 49)</p> <p>“I don’t eat wheat...people used to be and some still are snarky about it...and I think really!...I’m really clear that’s what happens when I eat wheat.” (Fiona, 49)</p> <p>“I don’t want people thinking oh god, Pauline’s coming what are we going to cook...I can tolerate little bits...I call it the social eating.” (Jane, 51)</p>
<p><b>Compliance</b></p> <ul style="list-style-type: none"> <li>• <i>Complying with treatment advice, prescriptions, recommendations, exercises</i></li> </ul>	<p>“There were three exercises I had to do...several times a day...I thought no I’ve got to do them.” (Margaret, 46)</p> <p>“I’m quite determined...I don’t find them hard [osteopath exercises] to do.” (Olivia, 24)</p> <p>“Requires discipline, you’ve got to take it each day that was the only problem I think and with any exercise as well, yes it’s me being complaint with the programme and remembering to do it.” (Steven, 49)</p> <p>“Put me on a severely restricted diet and huge range of supplements...I went off my diet...lived on fish and rice...within a week I felt fantastic” (Rachel, 45)</p> <p>“The acupuncturist told me I was lactose intolerant and on his advice and it was very hard to do because I loved my milky coffees, cheese and whipped cream but I gave up dairy and instantly that phlegmy throat went.” (Fiona, 49)</p> <p>“I went to see a naturopath...I took on her advice...I’m taking a bunch of herbs.” (Mandy, 26)</p> <p>“I started on smoothies, supplements, vitamin C, lots of different vitamins but also a big part of it was the psychology...went on a really clean diet...it was quite overwhelming but if you know it’s going to help you you’re prepared to put the effort into it...I’ve chucked, I’ve put everything into this.” (Jane, 51)</p> <p>“The acupuncturist said you will eat these foods and take these tablets and I followed that through... I’m hopeless at remembering...so I got a permanent marker pen and I write twice a day with food or whatever it was and I just had them in a big plastic container... I take exactly what they say and I do it religiously.” (Peter, 40)</p> <p>“I would have a little Tupperware container [for the supplements].” (Lilian, 46)</p>
<p><b>Connections</b></p> <ul style="list-style-type: none"> <li>• <i>Making personal connections with people who support CAM</i></li> <li>• <i>Connecting personally with nature, energy, spiritual aspects</i></li> </ul>	<p>“I met people who were into natural therapies and medicine.” (Margo, 39)</p> <p>“I knew these people who were into natural healthcare...so I started talking to [them]...I started to get some answers and understand it more.” (Olivia, 24)</p> <p>“I wouldn’t live with anyone else who wasn’t a vegetarian and I probably wouldn’t date someone who wasn’t...I like to be around people who have consciousness around what they eat and how they treat their bodies.” (Jules, 31)</p> <p>“I talked to other people about it [health and CAM].” (Anne, 60)</p> <p>“If I put my hand on you you’d feel the energy straight away.” (Bill, 77)</p> <p>“Sometimes I go to the pharmacy and ask the pharmacist...I also consult my friend or my mother.” (Jenny, 26)</p> <p>“I feel like when I empower myself with what I can with my health and with living a natural healthy lifestyle I can appreciate the bounty and abundance of the earth and I can put myself in alignment with that...health comes from being in harmony with nature and natural rhythms.” (Jules, 31)</p> <p>“Being out in nature.” (Margo, 39)</p> <p>“It’s connecting different aspects of myself...when I look at the sky I think yep I am connected. Same with the flowers as well, they bring me out of my inner world into contact with the world.” (Anne, 60)</p>

	<p>"I believe we are all energy...what we put into our body and what we do around it and who we hang around with would all be impacting us at some level...If you're more conscious of spreading from your energy the right things or actually getting rid of things then that's going to be more healthy." (Vivian, 52)</p> <p>"It's the power of the energy relaxing, connecting with that making you go to sleep...it can be really powerful." (Bill, 77)</p> <p>"I'm slowly discovering now...there is a divine light or divine source of some sense that lifts us to a different awareness...I'm trying to discover more about this spiritual connection so that to me is an integral part." (David, 50)</p>
<p><b>Control via knowledge and learning</b></p> <ul style="list-style-type: none"> <li>• <i>Gaining and maintaining control over health through personal knowledge building</i></li> <li>• <i>Applying knowledge and learning, e.g. self-treatment</i></li> </ul>	<p>"I have quite a sense myself now...I have a lot of books on it [homeopathy]...I have quite a bit of knowledge now...I can apply my knowledge to minor things." (Jenny, 26)</p> <p>"Then I go and read up, for example, not being aware of our adrenals so I go and read up, and on aging and other issues women have." (Vivian, 52)</p> <p>"I learnt about it and realised...natural things are more in line with what we need...I came across different information from books and people that I met, from the internet...the more I learnt about it the more strongly I felt. (Margo, 39)</p> <p>"I see Naturopaths and get the information from them and make up my own mind." (Mandy, 26)</p> <p>"I gradually educated myself...which is the aim of natural therapies...to take better care...and have more of an integrated lifestyle...I do have broad knowledge that I can apply to myself that generally works for me." (Jules, 31)</p> <p>"I do feel I can read up about it, that I can inform myself...so I feel I can make a greater informed choice of my health and wellbeing." (Anne, 60)</p> <p>"I've spent a year just reading cancer books, cancer, cancer, cancer, alternative stuff and nutrition...recently I found a new guru...she's written a book Crazy Sexy Cancer...this woman has been such an inspiration to me." (Jane, 51)</p> <p>"Beauty of Reiki is that you can learn it to help yourself." (Bill, 77)</p> <p>"At the moment I'm feeling strong and healthy partly because I am self-treating with aromatherapy oil...because I've been using natural remedies for 17 years I guess I know, I feel I can identify more clearly what I need at what times so yes I just make a choice around that." (Jules, 31)</p> <p>"I'm reading a lot more, doing like my own personal stuff." (Olivia, 24)</p>
<p><b>Coordinating other activities</b></p> <ul style="list-style-type: none"> <li>• <i>Seeking and participating in other health related activities such as yoga, Pilates, gym, walking, meditation, visualisation</i></li> </ul>	<p>"The other thing I also did was Yoga Nidra...it's a very deep yoga where you visualise yourself becoming well...I did that twice a day... "Deep relaxation and visualisation I think they're really important components of healing as well." (Anne, 60)</p> <p>"I do yoga and dancing and cycling are the three regular things I do every week and when I stop doing things like that I always pay for it." (Rachel, 45)</p> <p>"I've done a lot of yoga...I've tried different types of meditation...[they're] really good for you." (Olivia, 24)</p> <p>"I'm 77 now so health is pretty darn important and I believe that by going to the gym and keeping myself mobile helps...I go to Pilates." (Bill, 77)</p> <p>"Go there once a week (Dove House) and they do facials, massages, aromatherapy, counselling, Reiki and there's groups you can join." (Jane, 51)</p> <p>"I bought my own aurosoma products which I use a lot." (Vivian, 52)</p> <p>"I went to Pilates." (Peter, 40)</p> <p>"Started Pilates...definitely feel my core getting stronger." (Steven, 49)</p> <p>"I practice meditation and there are methods in that that are common...like breath work and visualisation work...I've done a lot of dance practices, yoga practices, chi practices." (Jules, 31)</p>
<p><b>Changing lifestyle factors &amp; habits</b></p> <ul style="list-style-type: none"> <li>• <i>Changing diet to include more healthy foods, often organic</i></li> <li>• <i>Changing habits</i></li> </ul>	<p>"Biggest realisation for me in life was that slowing down of everything, of getting balance, staying fit, eating well...The single most important lesson I've learned is that health it isn't at one point that's its solved it's your whole life that you're dealing with it." (Rachel, 45)</p> <p>"I was off alcohol, off coffee, off tea...I didn't eat any refined sugars, ice cream or lollies or chocolate or any crap was gone." (Peter, 40)</p> <p>"I've experimented...I've tried many different diets...I was part of an organic coop...I have a raw diet." (Anne, 60)</p> <p>"I have a wonderful diet...I've been on the whole organic bandwagon." (Jane, 51)</p> <p>"Ideals around eating organic, eating quality food, it's not eating excessively." (Jules, 31)</p>

	<p>"Its ways I change my life to influence these new, like better habits to get myself better...for example I'll start using organic make-up... when I'm sitting...I take more notice about my posture" (Olivia, 24)</p> <p>"Eating very healthy, trying to eliminate stress." (Margo, 39)</p> <p>"Eating healthily, eating as natural as possible, fresh unadulterated, not genetically modified, grown slowly, and organically and grown at home if possible." (Fiona, 49)</p>
<p><b>Co-integration</b></p> <ul style="list-style-type: none"> <li>• <i>Integrating other forms of CAM health care and/or mainstream medicine</i></li> </ul>	<p>"I'm just so fortunate that I've got the best of both worlds [CAM and mainstream medicine]." (Jane, 51)</p> <p>"I checked it all [CAM treatment] with the GP and her opinion was look it's not going to do him any harm...merits of both, I don't see it as exclusive but as complementary." (Lilian, 46)</p> <p>"My normal medical practitioner could be complementary to the other means [CAM] and its down to me entirely to make that happen." (Peter, 40)</p> <p>"There are two or three things together [homeopathy, massage, allopathic medicine], I can't just rely on one thing." (Jenny, 28)</p> <p>"It's the bringing together of all practitioners...you're getting massages...you're seeing the osteopath...one works with bones the other works with muscles...see a herbal medicine specialist and a nutritionist...one is working on nutrition and the other on herbal medicine." (Olivia, 24)</p> <p>"If I had something where I needed an antibiotic...I don't think Reiki's necessarily going to be a quick fix...that's when I would go to a doctor." (Bill, 77)</p> <p>"I did her spiritual course." (Vivian, 52)</p> <p>"Sometimes I'll go to the chiropractor, she will have limited success. I'll have a massage, go back to the chiropractor again, better success." (Peter, 40)</p> <p>"We tried a gastroenterologist...he didn't have any solutions...we set about researching... [and found] it was worth looking into hypnotherapy...I booked a hypnotherapist and then changed my mind and swapped it to a naturopath...went for 7 to 9 months...we took him to the hypnotherapist." (Rachel, 45)</p> <p>"Alongside that I've had lots of body work mostly from osteopaths; I've had a little bit of physio work and again acupuncture for several injuries and a Chinese massage practice...Alexander Technique." (Jules, 31)</p> <p>"About just keeping balance...even with the practitioners, like going to too many practitioners could be a problem too...it's all about integration...both [mainstream and CAM] go hand in hand." (Olivia, 24)</p>

## **5.4 Summary of Cross-Case Analysis**

Comprehensive cross-case analyses of the 16 participant's interview data have uncovered some interesting and significant results. Firstly, eight consumer value components - quality of care, treatment efficiency, physical environment, esteem value, social value, spiritual value, ethics and play - emerged from the data providing much insight into what CAM consumers' value from their CAM health service experiences. Essentially the participants valued client-centred cooperative relationships that were empowering, holistic, and educational which fostered colearning and self-responsibility. Participants also gained a sense of self-worth, had the opportunity to gain meaning and purpose, connected with nature and spiritual/forces and had the ability to play because of enhanced physical, emotional, mental and/or spiritual wellbeing, which were facilitated through their CAM health service experiences. Secondly, this research found that value co-creation for the participants is determined by 1) the participant's approach to their health and CAM health care, 2) their preferred consumer value co-creation relationship style and 3) the value co-creation activities they engage in. Significantly, the findings show that there are important interrelationships between what the participant's valued and how they co-created value during their consumption experience of CAM health services. There is an indication of a process whereby the participants' experienced value and value co-creation prior, during and after the service interaction with their CAM health service and practitioner. This consumption process and the interrelationships between consumer value and value co-creation are discussed in chapter 6.



# Chapter 6 Discussion

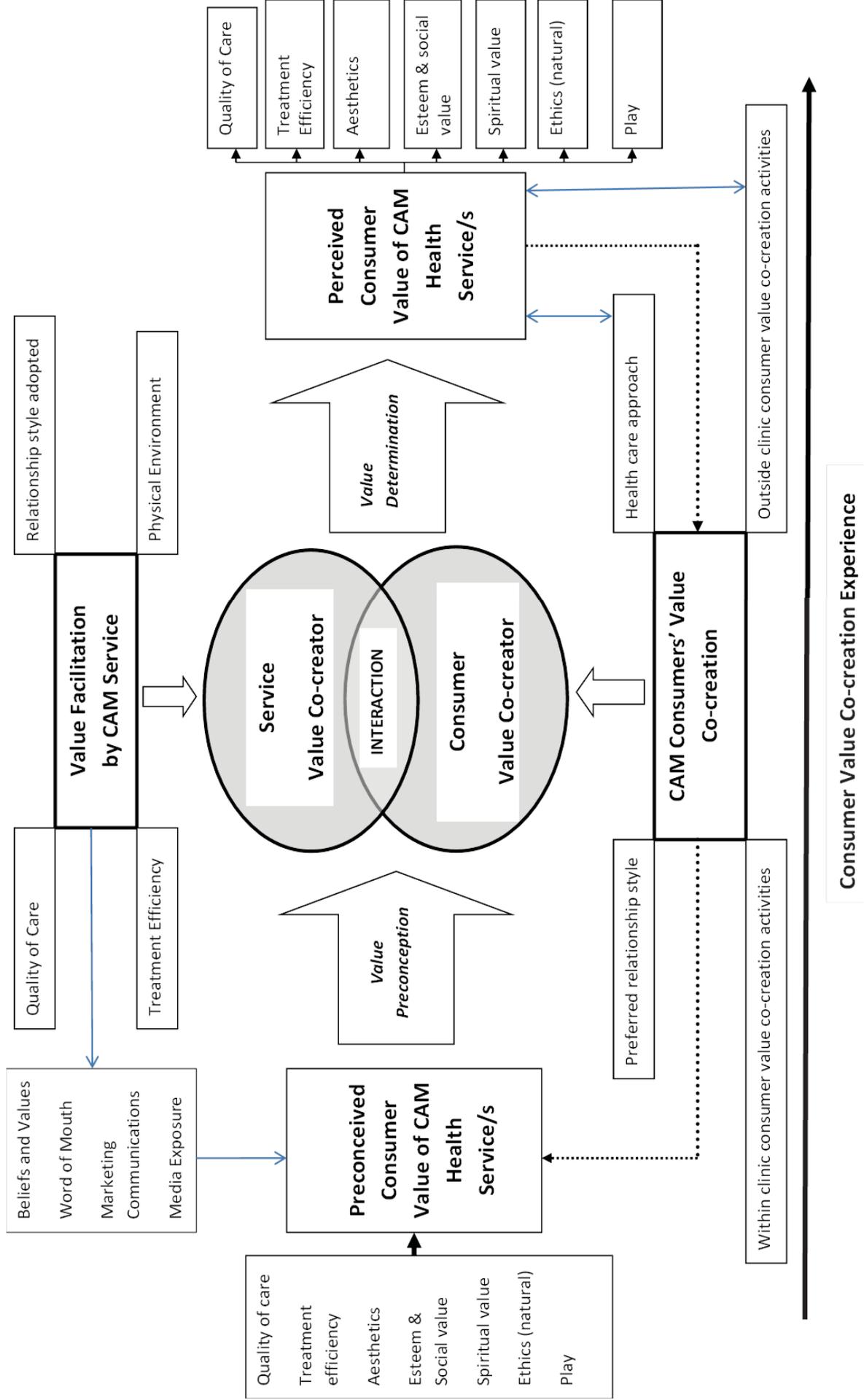
## 6.1 Overview

One of the major revelations of this research is the linking of the concepts ‘consumer value’ and ‘value co-creation’ and the development of a consumer value co-creation framework. The specific findings of this research on consumer value and value co-creation provide important foundations for this framework. Specifically, this research determined what CAM consumers’ value and how they co-create value through their health care consumption experiences, advancing knowledge in service experience consumer value and value co-creation in several important ways. Firstly, this research identifies eight key consumer value components and proposes a modified consumer value model that builds on existing models of consumer value to incorporate findings from within a CAM health services context. Potentially this proposed consumer value model provides a useful frame of reference for all health care services. Secondly, the study provides valuable insights into how consumers co-create value within CAM health services, confirming and building on previous research on value co-creation in mainstream health care. This chapter is organised in the following manner. Firstly the consumer value co-creation framework in CAM health services is presented and discussed. Thereafter each section provides an elaboration of each dimension of the framework. Lastly, methodological considerations that were significant to the findings are highlighted.

## 6.2 Consumer Value Co-creation Framework

A significant contribution of this research is the development of a consumer value co-creation framework (Figure 23), based on evidence from the findings. Grönroos (2011a) argues little is known about “the process of value creation, when it starts, what

**Figure 23: Consumer value co-creation framework in CAM health services**



it includes and when it ends” (p. 282). This research goes some way to explaining the value co-creation process in a health care service context and illustrates the complexities of this process in terms of what is involved and the measurement of start and end timeframes. This research found, in a CAM health context, that the co-creation process has no absolute defined beginning or end, supporting the idea of Vargo and Lusch (2012, p. 4) that “co-creation of value thus recognizes that value creation is an ongoing, iterative, and continuous process extending well beyond individual transactions.”

The proposed consumer value co-creation framework has the following dimensions:

- (a) Preconception and determination of consumer value components in CAM health services (horizontal dimension)
- (b) CAM service facilitation and consumer value co-creation in CAM health services (vertical dimension)

The horizontal dimension of the framework suggests that CAM consumers experience value prior, during and beyond the service interaction. Prior to a service interaction CAM consumers have ‘preconceived’ consumer value perceptions which have been formed primarily by previous experiences of CAM health services (demonstrated by the feedback arrow from ‘CAM consumers value co-creation’ to ‘preconceived consumer value of CAM health services’) and the consumer’s philosophical beliefs and values about health. A CAM consumer’s philosophical beliefs and values on health and healing was highlighted in the CAM literature as a key reason why people use CAM (see Astin, 1998; Bishop et al., 2008; Furnham & Lovett, 2001; Lindeman, 2011; Vincent & Furnham, 1996) and hence its inclusion in the framework. Prior to the service interaction some or all of the eight consumer value components - quality of care, treatment efficiency, aesthetics (physical environment of the service), ethics, esteem value, social value, play and spiritual value - identified in the findings are often preconceived by the CAM consumer prior to the service interaction. Thus the consumer value components can be antecedents in the consumption experience. The author argues that consumer value preconception would also be influenced by CAM health services’ marketing communications such as advertisements and websites. Media exposure via news stories of CAM and CAM health care, both positive and negative, would also have an impact. News media coverage of health issues and solutions

to health issues, including CAM, has increased substantially in recent years influencing consumer's choice of health care (Bonevski, Wilson, & Henry, 2008). Although marketing communications and media are not explicitly explored in this research there is some evidence that exposure to media and marketing communications influences how the CAM consumer perceives CAM services. Future research could explore this aspect further.

During the service interaction the CAM consumer evaluates the value of their health care experience primarily on 'quality of care' and 'treatment efficiency', with the 'physical environment' playing a small role. It is through valuing these consumer value components during the service interaction that the CAM consumer begins to value the other components such as 'social value', 'esteem value', 'spiritual value' and 'play' during, but most often beyond the service interaction (demonstrated by the feedback arrow from 'consumer value of CAM health services' to 'CAM consumers' value co-creation'). Beyond the service interaction the consumer value components - quality of care, treatment efficiency, aesthetics, esteem value, social value, spiritual value, ethics and play - continue to be determined by the CAM consumer.

The vertical dimension of the framework indicates that the CAM health service provider facilitates the co-creation of value primarily via 'quality of care', 'treatment efficiency', 'physical environment' and the relationship style adopted by the practitioner. Whereas the CAM consumer co-creates value primarily through the 'within clinic consumer value co-creation activities' they engage in which are influenced by their health care approach and preferred relationship style. Engagement in 'outside clinic consumer value co-creation activities' also has implications on how CAM consumers' co-create value during the service interaction. For example, compliance (or non-compliance) with treatment outside the clinic will have implications for value co-creation during the service interaction. The CAM consumer's experience of the consumer value components will often determine the CAM consumer's engagement with outside clinic consumer value co-creation activities and has an influence on their health care approach. The CAM consumer's engagement in outside clinic CVCA and their health care approach will also often determine their experience and perceived value of the CAM health service. In a CAM health service context consumer value and value co-creation potentially never ends.

Importantly this research contributes to the development of S-D logic (Vargo & Lusch, 2004, 2008) by providing further evidence and understanding of the consumer value and value co-creation concepts. This research supports S-D logic's foundational premises that value is always determined by the consumer during the consumption experience and the customer is always a co-creator of value. An important finding in this research is that the consumer value components - quality of care, treatment efficiency, aesthetics, ethics, esteem, social, play and spiritual - are experienced and determined by the CAM consumer during the process of consumption of CAM health services. This research also found that CAM consumers co-create value by engaging in various co-creation activities which are determined by their approach to health care and preferred relationship styles. The consumer value and value co-creation foundations of the consumer value co-creation framework are now discussed in detail to provide context.

### **6.3 Consumer Value Components (Horizontal dimension)**

Understanding what consumers' value is critical to understanding how they co-create value and is integral to the process of value co-creation. The eight consumer value components identified in the findings provides the underlying foundation for the consumer value co-creation framework. Fundamentally the broad consumer value components – quality of care, treatment efficiency, physical environment (aesthetics), ethics, esteem value, social value, spiritual value and play – identified in this research builds on the consumer value components outlined in Holbrook's (1994, 1999) consumer value typology and Sánchez-Fernández et al's. (2009) proposed model of consumer value. Although this research confirms the relevance of these scholar's consumer value models it also offers a unique perspective on consumer value within a health services setting where all of the consumer value components play a role. Thus a modified model of consumer value is presented and discussed later in section 6.3.9. Firstly, each consumer value component is discussed.

#### **6.3.1 Quality of care**

The consumer value 'quality' in CAM health care revolves primarily around positive person-centred practitioner-client relationships. The importance of the practitioner and client relationship in CAM health care was linked to positive health outcomes, supporting previous research (Bann et al., 2010; Bishop et al., 2011; D'Crus & Wilkinson, 2005).

Likewise, in mainstream medical practice, reported quality of care from a patient's perspective has also been associated with patient-centred interaction styles (Adams, et al., 2012; Huygen et al., 1992; Flocke et al., 2002; Theofilou, 2011). The results of this study supports the position that CAM consumers value positive therapeutic relationships that are empowering, empathetic, client-centred, encourage self-responsibility, participatory, holistic and supportive (Adler et al., 2009; Bann et al., 2010; D'Crus & Wilkinson, 2005; Gale, 2008; Long, 2009; Thompson & Mark, 2007).

The importance of relationships in a health care context is not new. Practitioner-client and doctor-patient relationships have received reasonable attention in the CAM and mainstream medical literature (Bann et al., 2010; Bishop et al., 2011; Flocke et al., 2002; Theofilou, 2011). In CAM health care the client centred, 'mutualistic' therapeutic relationships are integral to perceived quality of care (Bann et al., 2010; Bishop et al., 2011). The doctor-patient relationship too has long been described "as the keystone of care" which leads to "optimum health outcomes" (Adams et al., 2012, p 127). Flocke et al. (2002) found that doctors with a person focused interaction style were linked to higher reported quality of care by patients. The findings in this study support the observation that CAM consumers and indeed many health care consumers value person-centred relationships and good communication. This study found that some CAM consumers valued a 'partnership' type relationship with their practitioners that are collaborative and cooperative. Likewise Adams et al. (2012) in their study on doctor-patient relationships found there is a cluster of people who value positive long-term relationships with their doctor and this is linked to a "positive partnership" based on factors such as cooperation, good communication, choice and shared decision-making. Importantly, this research contributes to the concept of quality of care in client/patient-centred relationships, in the CAM context, to include the following key aspects: the empowering approach of the practitioner; the practitioner's empathetic, supportive and caring manner; the ability of the practitioner to educate, impart knowledge and be involved in colearning; and the perceived authenticity, integrity and congruence of the practitioner. Each of these aspects will now be discussed in turn.

Interestingly, it is the empowering approach of the CAM practitioner that was integral to the CAM practitioner-client relationship, which contributes to the CAM consumer's sense

of self responsibility and wellbeing. Bann et al. (2010) found evidence that aspects of the CAM therapeutic relationship were associated with empowerment, and this was responsible for shaping the healing experience as well as being linked to beneficial health outcomes. CAM consumers who have a preference for ‘consultative’ and ‘partnership’ relationship styles (relationship styles are discussed further in 6.4.2), acknowledged the empowering approach of their CAM practitioner and being empowered as important. Empowerment, in this context, was about having “control” over his/her health and wellbeing. Essentially, an empowering approach primarily involves the practitioner imparting their knowledge and educating, providing a deeper understanding of the health issues, and enabling the consumer to have some choice and/or control of his/her health.

Along with an empowering approach and gaining self-responsibility CAM consumers also value being supported and cared for. Practitioners that have a supportive, empathetic and caring manner tend to encourage continuity and treatment compliance. Some CAM consumers are not prepared to continue with practitioners who are perceived to lack empathy or not ‘care’ (refer to 5.2.1.5). This finding is consistent with mainstream medical literature that a doctor’s affective connection with patients is associated with greater patient satisfaction (Flocke et al., 2002). CAM’s encouragement of self-responsibility in health care has been accused of absolving the practitioner from offering patient care (Miskelly, 2006), however, the findings in this study found the opposite to be true. The empowering and collaborative approach of the CAM practitioner which often leads to self-responsibility is considered an act of support. Mainstream medical literature too has found a link between shared decision making and patient satisfaction (Adams et al., 2012; Flocke, 2002).

Similar to mainstream medicine where practitioner competence in terms of skill, knowledge, and expertise are valued (Liu et al., 2006), CAM consumers also value this level of competence. Although this component is particularly important for those that prefer an ‘advisory relationship style’, everyone appreciates a high level of knowledge and expertise that enables learning to take place. Importantly it was not just the practitioner’s knowledge that is crucial but their ability and willingness to impart that knowledge to their clients. The experiences of CAM health care are frequently described as being ‘educational’. This ‘educational’ aspect is in part facilitated by the empowering approach

of the CAM practitioner which enables and motivates the CAM consumers to manage their health. This finding is supported by Bann, et al. (2010) who posit that “in the context of CAM treatment, empowerment reflects a type of support that enables and motivates people to take the necessary steps to manage and improve their health in a self-directed manner” (Bann et al., 2010, p. 746). What is not so evident in medical and CAM literature is the importance of the ‘educational’ component of the client-practitioner relationship, the ability of the health care practitioner to impart empowering knowledge and how this gives people a sense of control over their health and ultimately contributes to positive health outcomes. What surfaced strongly in this study is that CAM health care consumers feel they have ‘tools’ for life via knowledge and the educational practices of their practitioners, enabling them to maintain their health and wellbeing. This knowledge and learning also enables them to be active participants in their health care both within clinic and outside of the clinic. The more knowledge a CAM consumer has of CAM philosophies and treatments, their health condition/s and about themselves the more actively involved they become.

Recent marketing literature in health care services has alluded to this ‘educational’ and ‘learning’ aspect of health care (McColl-Kennedy et al., 2012; Sweeney et al., 2015), in particular the activities that health care consumers involve themselves in to co-create value for themselves (consumer value co-creation activities are discussed further in 6.4.3). Co-learning, a term coined by McColl-Kennedy et al. (2012) is a central theme for the participants in this study. McColl-Kennedy et al. (2012, p. 378) define co-learning as “actively seeking and sharing information from other sources”. Many of the CAM consumers involve themselves in personal knowledge building and will often share this information with their practitioner. Co-learning in the CAM context also consists of the participant being open and willing to learn from the practitioner, taking information and personalising it and providing the practitioner with detailed information about themselves. Equally it is important to the participant that the practitioners share their knowledge with, listen to and learn about the participant.

Lastly, in terms of quality of care, this research found that CAM consumers value practitioners who are perceived as having integrity, and are considered authentic and trustworthy. The importance of trusting the CAM practitioner is essential and this came

from a belief in the practitioner's integrity and authenticity. A practitioner's integrity and authenticity is also about transparency in that the practitioner is perceived to be practicing "from the heart" or have the client's "best interests at heart". This practice is often referred to as 'congruence' and stems from and is integral to "person-centred" counselling and psychotherapy literature (Grafanaki & McLeod, 2002). Coined by Carl Rogers 'congruence' is about the counsellor being authentic, engaging sincerely and having a genuine interest in their client (Grafanaki, 2013). Congruence in the CAM setting or any health care setting is potentially an essential health care practice.

### **6.3.2 Treatment efficiency**

Along with quality of care, treatment efficiencies are an important component of CAM consumer's value through their direct experiences and interaction with CAM health services. Within this component six sub-components emerged including treatment results and timeframes, treating the cause, treatment ease of use and customisation, access and waiting times, longer consultation and quick follow-up treatment and value for money.

Results from CAM health care treatments, treatment plans, prescriptions and advice which occur both within the clinic and outside the clinic are critical to CAM consumers. Not only did CAM consumers value being relieved of symptoms and ailments but more significantly they value the CAM practitioner treating the causes of the problem and not just the symptoms. Sharma (2001) argues that one reason people turn to CAM is because of mainstream medicine's failure to get to the 'root cause' of chronic illness. This study found that the initial reason for most people seeking CAM health care is to treat a 'chronic' health issue that either has not been resolved via mainstream medicine or is perceived to require a 'complementary' or 'alternative' approach. This supports previous research that found people are predominantly 'pushed' towards CAM health care because they are dissatisfied with mainstream medicine (Shmueli & Shuval, 2006). Other studies however found that CAM users are 'pulled' towards CAM because of their beliefs and values about health and healing (Astin, 1998; Lovgren, 2011). This is true for some in this study who were initially attracted to CAM because they are open to alternative experiences and curious to try alternative methods.

What this study found that does not appear evident in the literature on the ‘push’ vs ‘pull’ debate is that once people experience CAM health care the ‘pull’ factor becomes predominant. Once people have experienced positive results and quality of care components of CAM this compels and often convinces them to continue using CAM health care, including trying other forms of CAM therapies. A multiplying value effect can then occur whereby CAM consumers gain value from using different CAM health care services for various health issues. Essential to the ‘pull’ factor was the learning and knowledge gained by the consumer about health and healing as well as experiencing a person-centred empowering and holistic approach to health care. The more knowledge and learning the consumer receives the more predominant the ‘pull’ factor towards CAM health care use becomes. The underlying philosophical beliefs about health and healing are often learned during the CAM consumption experience. The educational and empowering component of CAM health care can also perhaps explain the puzzling phenomenon of ‘therapy hopping’ that has been negatively associated with CAM health care (Miskelly, 2006). CAM consumers are often committed to the philosophy of CAM health care. Therefore, if results are not experienced then consumers will discontinue with that particular practitioner and often search for another practitioner or form of CAM believing there must be a way to solve the health issue.

In CAM health care the timeframe in which CAM consumers experience results is an important subcomponent. The timeframes in which people experience results varied from immediate (results experienced in the first session) to two years (chronic condition resolved to a manageable level). Those with chronic conditions are prepared to give treatments time, knowing they are not a quick fix. Some experienced immediate results (usually pain relief) and for others the results were gradual. CAM practitioners who provided a timeframe within which the consumer might expect to experience health benefits encourage ongoing use of CAM supporting previous research (Bishop et al., 2010). Therefore providing a treatment timeframe and outlining when people should expect to experience results is a critical practice in CAM health care services.

Ease of use of prescribed remedies or supplements, recommended dietary changes and/or exercise rehabilitation prescription are potential areas where value is lost or gained in terms of treatment efficiency. For example, value is lost if a prescribed herbal remedy that

has to be taken three times a day is inconvenient. If a consumer only manages to take it once or twice the value of the product is not realised. Another example might involve a consumer who is given an exercise prescription to complete daily by an osteopath. Research has demonstrated that compliance to exercise rehabilitation prescription contributes to successful recovery of various musculoskeletal conditions (Howard & Gosling, 2008). Value is gained through treatment compliance. In line with the value-in-use idea the value of CAM consumers' health care can only be realised during its use and this includes treatment compliance and ease of use outside of the CAM clinic. Therefore it is the consumer that co-creates value by complying and co-operating with the prescribed treatment and/or treatment plan as discussed later in 6.4.3. One of the key factors that appears to have facilitated compliance is the perception that the CAM practitioner "customises" the treatment/treatment plan to the individual. The practitioner too has an opportunity to co-create value by ensuring the treatment prescription and/or plan is individualised and achievable. This supports Bishop et al. (2011) who found private sector acupuncture patients "valued the individualised" care and treatments that were "tailored to the individual patient" (p. 7).

Treatment customisation is in part enabled by the longer consultations with CAM practitioners. The CAM consumer values the longer consultations with their practitioners, supporting previous research (Berger et al., 2012; Emmerton et al., 2012). The key aspect that CAM consumers value about the longer consultation time is that it is perceived as comprehensive and thorough but more importantly they are engaged and involved in the consultation process. Often the initial consultation takes an hour and involves extensive history taking and an understanding of the 'whole' person (i.e. they are considered holistically – mind, body and soul). Longer follow-up consultations, which averaged 30 to 45 minutes, are also valued. This is because they allow sufficient time for the practitioner and consumer to discuss the treatment programme and make appropriate changes to suit the individual's needs. Time efficiency; however, appears to play an important role for people who need regular treatment. Quick treatment times of 10 to 15 minutes are particularly valuable for those having regular on-going chiropractic and osteopathic treatments. The CAM consumer's requirement for varying consultation times did not appear evident in the CAM literature and yet the implications for practice are important.

CAM health care services, in particular, chiropractors and osteopaths, need to carefully manage the consumer's expectations in terms of consultation time.

Similar to mainstream medicine, CAM health care services are also evaluated in terms of short waiting times, prompt access and dealing with emergencies and problems efficiently (Liu et al., 2006). This study found that CAM consumers value CAM practitioners and/or CAM health care practices that are perceived to be efficient in terms of appointment waiting times and access to appointments. CAM consumers who have regular treatments value being able to schedule an appointment quickly when health issues arise. Paradoxically, CAM practitioners that are difficult to get appointments with due to their popularity are also valued. In this instance consumers book ahead and keep to their appointment time which contributes to on-going treatment compliance and better health outcomes.

Lastly, value for money, with respect to paying for private health care such as CAM, is an important consumer value component. Although CAM health care is considered expensive most are prepared to pay for it as long as they are gaining positive results from the treatment. This is supported by Bishop et al. (2011) who claim that consumers seeking private acupuncture were willing to pay for an effective treatment and judged their experiences on results. This research also found that some CAM consumers perceive CAM health care as a personal investment. When CAM consumers become aware of the preventative aspects of CAM health care it is viewed as essential for keeping well and is considered an investment in one's health and wellbeing.

### **6.3.3 Physical environment (Aesthetics)**

In consumer research there are linkages between the concept of aesthetic value and consumer decision-making where service setting atmospherics such as décor, style and design are considered in the consumption and purchasing process (Sánchez-Fernández et al., 2009; Wagner, 1999). In this research the physical environment of the practice in terms of style and design, for some, is an important indicator of quality and professionalism. For others the physical environment is not essential as long as they get the right treatment and quality of care, which supports Bishop et al's. (2011) finding that CAM consumers are more concerned about the treatment than the physical environment. Interestingly some

CAM consumers are attracted to back street ‘alternative’ and ‘quirky’ environments which they perceive to be more authentic. However, a level of professionalism in terms of the physical environment is an important aspect in terms of CAM being recognised as a legitimate form of health care. From a services marketing perspective tangible evidence of health care facilities have been found to have a relatively strong effect on satisfaction (Andaleeb, Siddiqui, & Khandakar, 2007). Ambient aspects within health care clinics, such as decor, colour, signs, symbols and artefacts, provide excellent healing environments and are valued by health consumers (Fottler et al., 2000; Liu et al., 2006).

#### **6.3.4 Esteem value**

Esteem value emerges in this research as a meaningful outcome of CAM consumers’ experiences of CAM health care. Esteem value in this context is inner-oriented and primarily about gaining a sense of self-worth and enhanced self-esteem via the empowering approach of the CAM practitioner and an increased sense of well-being through the treatment (Sointu, 2006). The experience of esteem value in a health care context is somewhat different to Holbrook (1994, 1999) and Sánchez-Fernández et al. (2009) view of esteem value. Esteem value from their perspective is other-orientated and sits alongside status under the banner of social value. In CAM health care esteem value and social value emerges as very different concepts. Hence, esteem value is separated from social value (this is discussed further in 6.3.5 and 6.3.9). Esteem value was pivotal and linked strongly to the CAM consumer’s feelings of well-being. In this research esteem value consisted of four sub-components including self-responsibility, sense of self-worth, self-discovery and self-awareness. These findings provide new insight into the importance of esteem value in a health care context.

Self-responsibility is the most significant of the esteem value sub-components whereby gaining control over and making informed choices about health contributes to a consumer’s sense of self-worth and ultimately their well-being. Integral to this is the person-centred and empowering approach of the CAM practitioner. This is in-line with previous research that has found that CAM health care encourages self-responsibility through its empowering nature which leads to positive health outcomes and increased well-being (Andrews, 2002; Bann et al., 2010; Gale, 2008; Sointu, 2006).

Self-worth is gained via having responsibility and control, feeling physically, mentally and/or emotionally well due to treatment, being recognised by the practitioner as a ‘whole’ person with mind, body, emotions and spirit, and in some cases being encouraged to explore the self in terms of personal attitudes and ways of thinking about health. Regardless of the way self-worth is gained this generally leads to increased well-being supporting Sointu’s (2006, 2006a) findings. Sointu (2006, 2006a) argues that CAM health care practices foster self-worth by recognising personal and emotional concerns and seeing the client as “an active, empowered and knowledgeable agent” who has choices (p. 346). In this research CAM health care, for some, facilitates self-awareness and self-discovery that gave a greater understanding of themselves (physically, mentally, emotionally and spiritually), insights into what they want from life, and in some cases a sense of rediscovered identity.

### **6.3.5 Social value**

In line with Holbrook (1994, 1999) and Sánchez-Fernández et al. (2009) social value in this context is other-orientated and relates to the consumer’s perceptions of how others see them. Social value is both gained and lost in this context and is experienced both positively and negatively. Firstly, social value is experienced through gaining good health and a sense of well-being which contributes to a person’s social self. The concept of social self has a long history in consumer behaviour (in relation to self-concept) and is defined as “how consumers feel others see them” (Schiffman et al., 2012, p. 105). It is not in the scope of this research to delve into literature on the social self and self-concept, however, it is important to acknowledge that this is a potential area for further research in the health care sector (this is highlighted in 7.7). In this context social value is about being able to engage positively in social activities and relationships with others such as family members, friends and work colleagues and being seen as healthy, energetic and happy. Social value, however, is also lost for those that experience or perceive negative reactions from others about their use of CAM or changes they make to their lifestyle as a consequence of their CAM treatment such as dietary changes. The social self is impacted on by his/her perception that people think they are fussy, alternative or going against mainstream practices. Generally this does not deter the use of CAM health care but in some cases dictates social groups and people’s willingness to share information about CAM.

Secondly, social value is experienced via the influence of others such as family to use CAM health care which ultimately results in positive health outcomes. One interesting finding is how men appear to be influenced to take care of their health and try CAM health care by significant women in their lives, primarily in this study a wife or partner. Prior research indicates that men are less likely than women to seek help from a health professional regarding their health and this is attributed to ‘traditional masculine behaviour’ (Galdas, Cheater & Marshall, 2005). This masculine behaviour is primarily related to men seeking to be independent and self-reliant which is linked to both quality of life and their self-concept (Smith, Braunack-Myer, Wittert, and Warin, 2008). This study found that once men are encouraged to seek CAM health care, a positive attitude and preventative mind-set towards their health care is often gained due to: the empowering approach of the practitioner, a sense of control over their health, and perceived self-responsibility, via gaining knowledge and ‘tools’ to enable them to be involved. The active involvement in their health is pivotal to this because it enables them to remain independent and self-reliant. Research in mainstream medical literature identifies core qualities that men value when communicating with a doctor that relate to a person-centred approach (Smith et al., 2008). This research extends this concept further by including an empowering approach, advocating self-responsibility and providing relevant tools and knowledge enabling control.

### **6.3.6 Spiritual value**

Spiritual value is a complex concept to study due to its varying meanings and conations. This research goes some way to teasing apart and understanding spiritual value further. Specifically, this research confirms that spirituality and spiritual value is an important aspect in a health care context, and should be viewed as an essential component to health and healing (Goldstein et al., 1988; Hill, 2003). Therefore, acknowledging and providing for health care customers’ spiritual needs is a major consideration for all health-care providers (Greasley et al., 2001; Liu et al. 2006), particularly in CAM health services where spirituality and spiritual beliefs are thought to be one of the key reasons why people use CAM (Astin, 1998; Bishop et al., 2007; Ellison, Bradshaw, & Roberts, 2012; Petry & Finkel, 2004; Vincent & Furnham, 1996).

Five spiritual value subcomponents are identified in the study including being considered holistically, connection with nature, gaining meaning and purpose in life, connection with energy or spiritual force and feelings of peace and balance. One of the most important subcomponents is being considered holistically. Many CAM consumers are attracted to CAM due its holistic nature which considers and treats the mind, body and spirit (Astin, 1998; Barrett et al., 2000; Coulter, 2004). Particularly important is how the physical, mental and spiritual wellbeing of a person is interrelated and difficult to separate (Andrews, 2002). CAM health care also enables people to connect with a ‘power’ and/or life-supporting cosmic forces, referred to as vital energy or ‘vitalism’ (Kaptchuk & Eisenberg, 1998). Not only do some CAM consumers experience this ‘vital energy’, their search for health can take on “sacred proportions” enabling a person “to discern ultimate meaning and make profound connections with the universe” (Kaptchuk & Eisenberg, 1998, p. 1063).

This study concludes that spirituality and spiritual value in the CAM setting is a multifaceted concept that covers a wide range of experiences from: a sense of connection with themselves, nature, a god or a spiritual/energy force as described by Holbrook (1994, 1999), Dossey (2003) and Hungelmann, et al. (1996); to gaining ‘meaning and purpose in life’ (Eisler and Montuori 2003; Post et al., 2000); to simply being respected and considered holistically; to experiencing feelings of peace, inner harmony and balance (Skousgaard 2006). For some it is an integral part of their health care because of their beliefs (Bishop et al., 2007; Petry & Finkel, 2004). Although the words ‘spiritual’ or ‘spirituality’ were not always used by participants in this study, their inclusion under ‘spiritual value’ is justified based on the definition of spirituality by Skousgaard (2006) in a consumption context as having feelings of peace, inner harmony and joy.

### **6.3.7 Natural (Ethical value)**

CAM health care is perceived by CAM consumers to be natural and this aspect is valued, supporting previous research (Siahpush, 1999a). Specifically, consumer value is perceived if the CAM health care provider uses natural remedies (such as herbal formulas, homeopathic remedies and nutritional supplements) and/or non-invasive treatments, such as chiropractic manipulations, osteopathic treatments, acupuncture and gentle hands-on treatments such as massage therapy and Reiki. Interestingly, this natural component of

CAM health care is often compared to the use of pharmaceutical drugs and surgery in mainstream medicine, which are perceived as unnatural or in some cases toxic and invasive.

The CAM consumer's perception of value is based on the belief that "natural is better for the body" or "in line with what we need". This supports the notion of consumers perceiving CAM to be 'natural' and supporting the body to heal itself (Hill-Sakurai, 2008; Nichter & Thompson, 2006). Generally the natural aspect of CAM is a self-oriented goal, in that the use of natural remedies and natural therapies is to benefit the body and support the body's ability to heal itself (Coulter, 2004). However, this researcher argues that the underlying beliefs, values and philosophy of the CAM consumer (Astin, 1998), assumes a more altruistic 'ethical' goal in CAM consumption. CAM consumers are making choices that have positive impacts on others, for example, using herbal remedies knowing they are better for the environment (Nichter & Thompson, 2006). Kaptchuk and Eisenberg (1998) argue that a consumer's use of 'natural' treatments or adhering to 'nature's' healing philosophy is an opportunity to save both the self and the world. Hence, valuing the natural aspect of CAM health care could arguably be considered ethical and therefore experienced as ethical value. However, further research is required to explore this consumer value component further.

### **6.3.8 Play**

Play in the CAM context is experienced in three ways, via relaxation, leisure prescriptions and enabling leisure participation. Relaxation is valued during hands-on treatments such as massage therapy, osteopathy and chiropractic care. Some CAM consumers use therapies such as massage, aromatherapy and reflexology as 'treats'; describing these therapies as "pleasant experiences used for personal enjoyment rather than any specific problem" (Bishop et al., 2008, p. 1701). The enjoyment of such therapies can be considered 'value-in-play', an experience enjoyed for its own sake (Holbrook, 1999). Play is also experienced by CAM consumers via prescription from CAM practitioners to partake in leisure activities, such as walking, meditation and yoga, as part of the treatment. Leisure activities are also taken up by CAM consumers during their treatment to provide life balance and contribute to their health and wellbeing supporting Trenberth's (2005) claim that leisure can contribute to health. The value of the CAM treatment in this instance may only be

realised while participating in these prescribed ‘leisure’ activities supporting the value-in-use idea.

For some their CAM treatment enables them to participate in leisure activities that they would normally find difficult to do. The value is in the freedom to ‘play’ and enjoy leisure activities. Leisure and health have long been connected (Payne, Ainsworth, & Godbey, 2010; Trenberth, 2005). The positive impacts of engaging in leisure on a person’s health, wellbeing and quality of life are well documented (Trenberth, 2005) and include increased optimism, heightened sense of self-expression and autonomous control, and a sense of well-being (Dowd, 1984). However, what is not well documented in the literature is how health care services can facilitate, through quality of care and positive treatment outcomes, the value of ‘play’. This research provides some insights into this aspect.

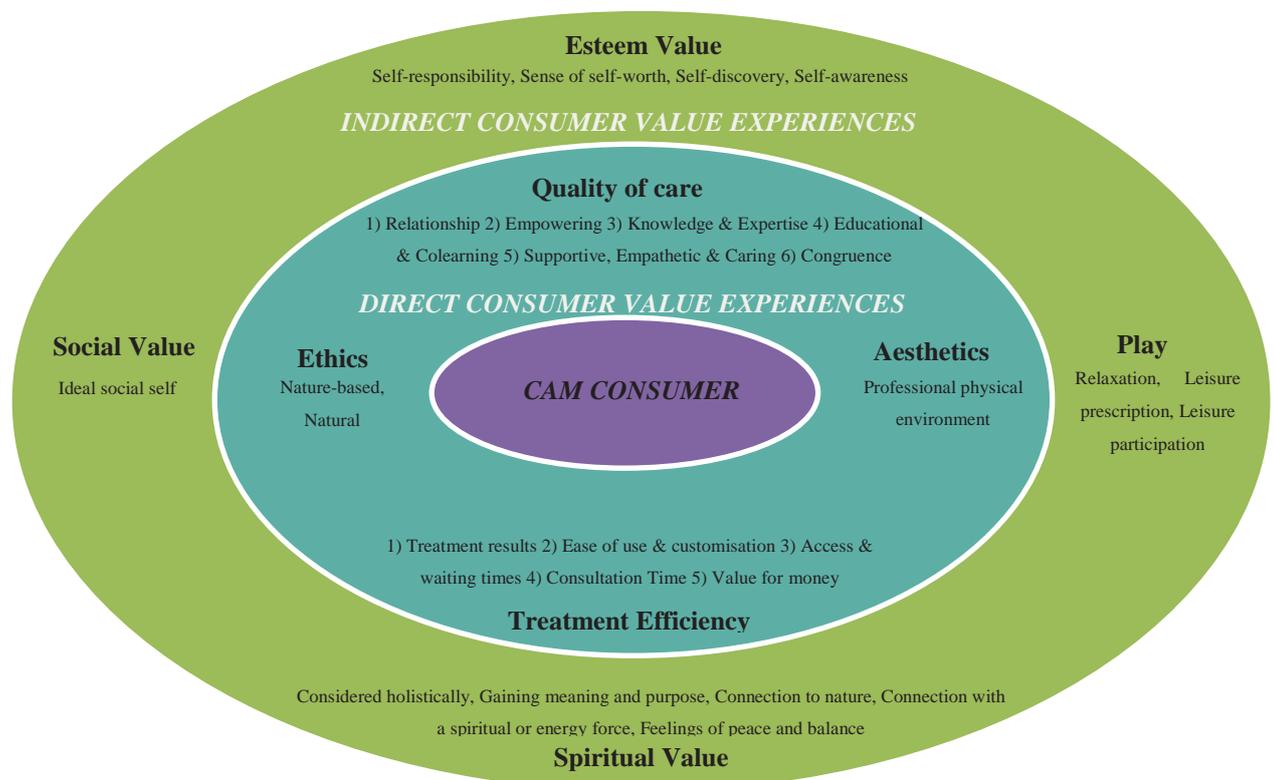
### **6.3.9 Proposed consumer value model for CAM health services**

Studying consumer value within a CAM health services context provides a worthwhile and meaningful foundation for exploring consumer value due to CAM’s multi-faceted and holistic components. Based on the findings of this study and relevant literature the author argues that in a health care service setting consumer value should be represented ‘holistically’ (i.e. not as separate components but as interconnected parts). Hence a consumer value model relevant to CAM health services and potentially all health care services is proposed (Figure 24). In the health service context it is deemed appropriate to represent consumer value using a three layered concentric circle model as opposed to a typology (Holbrook, 1999) or a basic radial model (Sánchez-Fernández et al., 2009). The construction of a concentric circle model conveys the interconnectedness of the consumer value components from the consumer’s perspective, particularly within a health service setting. Furthermore the model is designed to show that CAM consumers experience consumer value on two levels, direct consumer value experiences (DCVE) and indirect consumer value experiences (ICVE), from CAM health services.

At the heart of the model is the CAM consumer, representing the importance of a consumer/customer/client/patient centred approach to health care as critical. The second layer represents the consumer value components that the CAM consumer experiences during the interaction with CAM health services (direct consumer value experiences). In

this layer the CAM consumer evaluates the value of their health service experience primarily on quality of care and treatment efficiency with the physical environment playing a small role. Integral to the CAM experience is that it is perceived to be ‘natural’ (ethics). The third and outer layer (ICVE) represents consumer value components - esteem value, social value, spiritual value and play – which are generally experienced via experiencing and valuing the second layer consumer value components (DCVE), in particular the quality of the practitioner-client relationship and efficiencies such as the treatment results. There appears to be strong interrelationships between the layers whereby experiencing value in one component can facilitate experiencing value in another, for example, through quality of care via co-learning and empowerment a CAM consumer can gain esteem value (through gaining a sense of self responsibility and self-worth). This is a significant finding with potentially important managerial implications for all health care providers as outlined in 7.5.

**Figure 24: Proposed model of consumer value in CAM health services**



Other important considerations of this proposed model include the demarcation of social and esteem value, and spiritual value and ethics. Specifically this model splits social value

and esteem value (as per 6.3.4 & 6.3.5). Sánchez-Fernández et al. (2009) consumer value model proposes social value to include esteem and status, deeming that these aspects were primarily about others perception. Holbrook (1994, 1999, 2006) also considers esteem value as other-orientated and combines esteem and status as social value in his conflated typology. However, within a health care context esteem value is primarily about the self, whereas social value is primarily about the perception of others.

Likewise, this model also separates spiritual value and ethics (as per 6.3.6 & 6.3.7), whereas Holbrook (2006) and Sánchez-Fernández et al. (2009) combine these consumer value components under the banner of altruistic value. Understanding the spiritual value CAM consumers' gain is particularly important because acknowledging and providing for health care customer's spiritual needs has become a major issue for health-care providers (Greasley et al., 2001; Liu et al., 2006). Spiritual value does not always fit under the banner of altruistic value. Particularly in a health care setting, experiencing spiritual value can often be self-orientated and not always other-orientated as deemed by Holbrook (1994, 1999). Being considered holistically and gaining meaning and purpose are two spiritual value components that more often than not are self-orientated. The same is true for the ethics component where the natural aspect is not just about altruism but is mostly about how 'nature' can help heal the self.

### **6.3.10 Summary of research question 1**

The objective of research question 1 is to determine what CAM consumers' value from their CAM health service experiences. CAM consumers experience eight key broad consumer value components: 1) Quality of care, 2) Treatment efficiency, 3) Aesthetics (physical environment), 4) Esteem value, 5) Social value, 6) Spiritual value, 7) Natural (ethics), 8) Play. This research also reveals many consumer value sub-components (within each broad consumer value component) that are experienced by CAM consumers during the consumption process that influence and impact on how the CAM consumer co-creates value. Importantly this research shows that CAM health consumers value a person-centred, empowering, holistic, educational and collaborative approach to their health care that is congruent and fosters co-learning and self-responsibility. The biggest insight and the most important finding is that consumer value in this context is experienced throughout the

consumption process prior, during and beyond the service interaction. Ultimately CAM consumers value an increased sense of well-being which is experienced on many levels including physical, emotional, mental and spiritual. Wellbeing is achieved through ‘quality of care’ and ‘treatment efficiency’ which assists in experiencing (hence valuing) the other consumer value components such as a sense of self-worth, self-discovery, connection with nature and energy forces, gaining meaning and purpose, peace and balance, and participating in leisure activities.

#### **6.4 Consumer Value Co-creation in CAM Health Services (Vertical Dimension)**

The vertical dimension of the consumer value co-creation framework demonstrates how CAM consumers co-create value with their health care providers. This research found three key aspects that contribute to how a CAM consumer co-creates value with CAM health services and include: 1) consumer approaches to health and health care, 2) consumer value co-creation relationship styles, and 3) consumer value co-creation activities. The last two aspects, consumer value co-creation relationship styles and consumer value co-creation activities, builds on previous research by McColl-Kennedy et al. (2012) and Sweeney et al. (2015) by incorporating findings from CAM health services. However, the first aspect, approaches to health and health care, provides a new perspective on value co-creation in a health service setting. Furthermore, this research offers a Typology of Consumer Value Co-creation in CAM Health Services (see 6.4.4) which incorporates the three value co-creation aspects plus key consumer value components, highlighting the interrelationship between consumer value and value co-creation.

This section begins by discussing the findings on approaches to health and CAM health care. Following this consumer value co-creation relationship styles and consumer value co-creation activities are discussed in light of previous research. Next, the Typology of Consumer Value Co-creation in CAM Health Services is presented and discussed. Lastly, a summary of the findings addressing the second research question is given.

### 6.4.1 Consumer approaches to health and CAM health care

This is, to the researcher’s knowledge, the first study to consider how a health consumer’s approach to health and health care impacts on how they co-create value. How CAM consumers approach health and health care have implications on how CAM consumers co-create value. The three consumer approaches to health and health care are: 1) Reactive, 2) Proactive, and 3) Integrative. These approaches are outlined and summarised in Table 52. A reactive approach is where the CAM consumer primarily has a treatment results outlook and tends to only seek CAM health care when required. A proactive approach on the other hand is where the CAM consumer has a preventative outlook and regularly seeks CAM health care for maintenance and prevention. CAM consumers with an integrative approach have a wellness outlook and have integrated CAM and CAM health care into their lifestyles which includes self-prescribing and implementing health aspects beyond the CAM provider and their services.

**Table 52: CAM consumers' approach to health and CAM health care**

	<b>Reactive</b>	<b>Proactive</b>	<b>Integrative</b>
<i>Experience of CAM health care</i>	Seeks CAM health care when required, primarily when health issues arise	Regularly seeks CAM health care. Uses CAM health care for maintenance.	CAM health care has been integrated into lifestyle. Uses CAM health care for wellness. Often self-treats.
<i>Health care outlook</i>	Treatment results orientation	Preventative orientation	Wellness orientation
<i>Level of knowledge on CAM/CAM health care</i>	Medium/low	High/medium	High
<i>Philosophical views about CAM</i>	Holistic (considers the body as integrated parts)	Holistic (mind, body & soul)	Holistic, way of living

In the findings there is evidence of a progression, where CAM consumers generally begin their experiences of CAM health services as ‘reactive’ but can move to ‘proactive’ and ‘integrative’ respectively as they become more involved. CAM consumers can transition

from one approach to the other and this is contingent on the CAM consumer integrating resources both within the clinic and outside the clinic environment epitomising the “customer is always a co-creator of value” idea (Vargo & Lusch, 2008). Resources in this context may include the level of knowledge about health and CAM health care, involvement with CAM health care and the various consumer value co-creation activities. Those with a ‘proactive’ and ‘integrative’ approach are generally more satisfied with their CAM health care and experience enhanced wellbeing on all levels: physically, emotionally, mentally and spiritually. It also appears evident that those who have moved towards an ‘integrated’ approach have adopted CAM as a way of living.

Importantly, from a services perspective, it appears that the transition from one approach to another can be facilitated by the empowering, educational, preventative and holistic approach of CAM health care service and practitioners. This supports the view that “the customer creates value, and the firm facilitates value creation” (Grönroos, 2011, p. 289). In-line with S-D logic the CAM health care service can only offer value propositions and collaboratively co-create value only when the consumer (customer) accepts or takes on the value propositions (Vargo & Lusch, 2008).

Although there is evidence of a progression it is not assumed that all CAM consumers will necessarily transition; some may continue to remain ‘reactive’ and ‘proactive’. Others may revert back to being ‘reactive’ depending on the circumstances, for example, in the case of a new health issue. Further research is required to understand the transition from one approach to another and the factors that enable and assist a transition. Understanding this could have significant implications for all health care providers in terms of assisting health customers/consumers to become proactive with their health.

#### **6.4.2 Consumer value co-creation relationship styles (CVCRS)**

The consumer value co-creation relationship styles (CVCRS) developed in this research builds on McColl-Kennedy et al’s. (2012) customer value co-creation practice styles (CVCPS), in particular, the ‘partnering’ practice style where patients/clients work together “collaborating and cooperating” with their health care professional. Significantly, this research on CAM consumers is arguably the first study to establish consumer value co-creation relationship styles (CVCRS) in a CAM health service setting. Although McColl-

Kennedy et al. (2012) and some medical researchers (Flocke et al., 2002) use the terminology ‘practice styles’, in the CAM context ‘relationship styles’ is deemed more appropriate because it reflects the importance of the client-practitioner relationship from the consumer’s perspective in terms of co-creating value. Three relationship styles emerge from the findings in this research and are labelled: 1) Advisory, 2) Consultative and 3) Partnership. All three relationship styles have a cooperative client-centred orientation but differ in terms of the consumers’ perceived relationship equality, knowledge of CAM, experience with CAM health care, philosophical views of CAM, and approach to health and health care as outlined in Table 53.

**Table 53: Summary of consumer value co-creation relationship styles**

	<b>Advisory</b>	<b>Consultative</b>	<b>Partnership</b>
<i>Perceived relationship equality</i>	Practitioner perceived as the expert	Practitioner-client relationship is perceived as collaborative	Practitioner-client relationship is perceived as relatively equal with mutual respect
<i>Level of knowledge on CAM</i>	Medium/low	High/medium	High
<i>Experience of CAM health care</i>	Medium/low	High/medium	High
<i>Philosophical views about CAM</i>	Holistic (considers the body as integrated parts)	Holistic (mind, body & soul) and natural	Holistic, way of living, political statement
<i>Approach to health and health care</i>	Reactive	Proactive	Integrative

An advisory style in the CAM context is similar to what Flocke et al. (2002) describe as a “person-focused interaction style” in community-based medical practices. Flocke et al. (2002) found that doctors classified as having a person-focused approach are perceived to be open to the patient’s agenda, willing to negotiate options, have higher levels of interpersonal communication, and more accumulated knowledge about the patient. Likewise the ‘advisory relationship style’ preferred by CAM consumers valued a ‘cooperative’ approach with their practitioner. An ‘advisory relationship style’ in

comparison to the ‘consultative’ and ‘partnership’ style however differs in that the CAM consumers are primarily seeking advice from the health practitioner. Practitioner “expertise” and a high level of “competence” are essential to those who prefer an ‘advisory practice style’. Value for these CAM consumers is gained when they perceive the practitioner to have ‘expertise’ and sound ‘knowledge’, but still involve them in shared decision-making. This supports Emmerton et al. (2012) who explores consumers’ experiences and values in both conventional medicine and CAM and found consumers value involvement in treatment decisions (shared decision making). Preference for the ‘advisory relationship style’ is mostly explained by the CAM consumer’s ‘reactive’ approach to health care. CAM consumers that have a preference for an ‘advisory relationship style’ tend to only seek CAM health care when a health issue arises. These CAM consumers also have lower levels of personal knowledge and experience of CAM and CAM health care practices.

The ‘consultative’ and ‘partnership’ relationship styles are similar in that both have a preference for client-centred relationships that are cooperative and empowering. Although CAM consumers with a preference for these practice styles do not necessarily see the practitioner as “the expert” they appreciate a high level of knowledge enabling empowerment and learning to take place. CAM consumers who prefer these relationship styles also value practitioners that respect an individual’s physical, mental, emotional and spiritual wellbeing (i.e., have a more highly developed holistic approach to health care). The primary difference between the ‘consultative’ and ‘partnership’ style is the CAM consumer’s approach to health care. Those who prefer a ‘consultative relationship style’ tend to be proactive about their health and often use CAM health care for maintenance, prevention and general wellbeing. Whereas those who prefer a ‘partnership relationship style’ have integrated CAM and CAM healthcare into their lifestyle, have a high level of knowledge about CAM and are generally highly involved in their health care. CAM consumers that prefer the ‘partnership practice style’ want “mutual respect” and tend towards practitioner-client relationships that are more transparent in terms of congruence.

Subtle differences towards the empowering approach of the practitioner are also detected between the two relationship styles. Empowerment is integral to the client-practitioner relationship for those that have a preference for a ‘partnership relationship style’

relationship. On the other hand for those who have a preference for a ‘consultative relationship style’ it is primarily about gaining empowering knowledge and information from their practitioner. As Gale (2008) points out CAM consumers are generally seeking more equitable practitioner-client relationships and client empowerment is an integral part of that. Personal empowerment is considered important for health and CAM practitioners tend to focus on empowering more than their conventional counterparts (Barrett et al., 2000).

There is evidence that CAM consumers can also transition from one preferred relationship style to another. This transition from one relationship style to another seems to be influenced by the CAM consumer’s approach to health care (i.e. it appears evident that when a CAM consumer’s approach to health care changes his/her preference for a particular relationship style changes too). For example, when a CAM consumer’s approach to health care transitions from ‘reactive’ to ‘proactive’, the relationship style preferred tends to change from ‘advisory’ to ‘consultative’. Hence there is some indication of a relationship between a CAM consumer’s approach and the preferred relationship style. Interestingly the transition between relationship styles can also be temporary. For example a temporary movement between styles might involve a CAM consumer who normally has a preference for an ‘integrated’ approach and ‘partnership’ style may revert back and have a preference for an ‘advisory’ style if a health issues arises that they need to ‘react’ too. The relationships between the consumer’s approach to health care and their preferred relationship style are discussed further in 6.4.4 where a typology of consumer value co-creation is proposed.

### **6.4.3 CAM consumer value co-creation activities (CVCA)**

The role of the consumer in co-creating value is central to S-D logic (Vargo and Lusch, 2004, 2006, 2008). This research provides empirical evidence, in the CAM health care context at least, that consumers do in fact co-create value and confirms the importance of the actions and role that consumers play in the value co-creation process. In particular, this research identifies twelve consumer value co-creation activities that CAM consumers participate in which confirms and builds on the research by McColl-Kennedy et al. (2012) and Sweeney et al. (2015) on customer value co-creation activities (CVCA) and effort in

value co-creation activities (EVCA) in health care. McColl-Kennedy et al. (2012) identify eight CVCA that cancer patients involve themselves in, including: cooperating, collating information, combining complementary therapies, colearning, changing ways of doing things, connecting with family and friends, doctors and other health professionals, and support groups, coproduction and cerebral activities. Whereas, this research on CAM health care consumers identifies five CVCA that occurred within the clinic environment and seven that occur outside the clinic environment, reinforcing Sweeney et al's. (2015) finding that CVCA occur in both environments.

#### **6.4.3.1 Within clinic consumer value co-creation activities**

The CVCA that are experienced within the CAM clinic include: 1) cooperation, 2) colearning, 3) coproducing, 4) communicating and 5) commitment. Cooperation, colearning and coproducing are similar to the CVCA McColl-Kennedy et al. (2012) identify ('cooperating', 'colearning' and 'coproduction') but also differ within a CAM health care setting. Firstly, cooperation in a CAM health care context is experienced within the clinic environment where CAM consumers accept information and comply with the treatment. In some CAM health clinics, in particular, chiropractor, osteopathy, kinesiology, acupuncture, Reiki and other energy type therapies consumers are required to co-operate by being actively involved in the treatment itself. For example, often chiropractic and osteopathic treatment relies on the consumer lying a specific way, lifting a leg or completing an exercise within the clinic. CAM consumers can also cooperate by "being open" (i.e. open to new experiences or open-minded) to alternative treatment and treatment processes. Secondly, colearning as discussed in 6.3.1 is where CAM consumers actively seek and share information from other sources. Within a CAM health care clinic colearning also involves the CAM consumer sharing in-depth personal information about their health and health history. This is particularly important in this context because many remedies, for example homeopathic and herbal prescriptions, are individualised according to specific reported symptoms. However, this aspect can also be relevant to mainstream medicine, where drug prescription and treatment planning can be customised to the individual.

Thirdly, coproducing again is similar to McColl-Kennedy et al. (2012) with CAM consumers being involved in the treatment planning and redesigning of the treatments.

However, in this context co-production is extended to include the concept of shared decision-making. Shared decision-making in a health care context has gained a lot of interest in mainstream medical literature which shows evidence that some patients want to be involved in the clinical encounter and “negotiate options” for their health care (Adams, 2012; Flocke, 2002). Those patients that are involved in shared decision-making are generally more satisfied and report greater quality of care (Flocke, 2002). However, there are still suggestions that some patients do not want shared decision-making or do not have the capacity to do so (Miskelly, 2006; Siegel, Barnwell & Sisti, 2014). Sweeney et al. (2015) found that being proactively involved in decision-making is a value co-creation activity that many patients with chronic illness do not undertake. However, those patients that did involve themselves in joint decision-making report greater satisfaction with the health care service and experience higher levels of quality of life. In the CAM context it appears evident that coproducing (including shared decision-making) is an important co-creation activity that contributes to a CAM consumer’s sense of self-responsibility and empowerment leading to greater cooperation and compliance, and thus enhanced wellbeing.

Two within-clinic CVCA that this study found to be important in a CAM context that McColl-Kennedy et al. (2012) and Sweeney et al. (2015) have not identified per se are ‘communicating’ and ‘commitment’. Communicating is somewhat implicit in other CVCA such as coproducing and colearning. However, in the CAM context ‘communicating’ is deemed important enough to warrant recognition and discussion in its own right. Due to the longer consultation times in CAM health care, more time is devoted to communicating. Even with mainstream medicine, patient-doctor communication is considered important and has been linked to higher compliance and better health outcomes (Roter & Hall, 2013; Theofilou, 2011). However, most studies have focused on the doctor’s ability to communicate with their patient and not the other way around (Cegala, Chisolm, & Nwomeh, 2012). Previous research has indicated that patient communication in the patient-doctor relationship is important (Cahill, 1998; Cegala, Street Jr, & Clinch, 2007; Kaplan, Greenfield, Gandek, Rogers, & Ware Jr, 1996). This study found that the CAM consumer’s ability to communicate with their practitioner honestly, openly and confidently is an important CVCA which often results in the consumer gaining more information from the

CAM practitioner. This supports Cegala, Chisol & Nwomeh's (2012) study that found patients who actively communicate with their doctors obtain more detailed information about their condition.

CAM health care requires a reasonable amount of commitment from the CAM consumer in terms of time and money to attend and pay for treatment sessions. This research found that CAM consumers understand that many CAM therapies are not a "quick fix" and are often prepared to commit time and money to "invest" in their health and wellbeing. This supports Bishop et al. (2011) who found that people who access private sector acupuncture are "willing to pay for it because they valued their health" (p. 5).

#### **6.4.3.2 Outside clinic consumer value co-creation activities**

The seven consumer value co-creation activities experienced outside the CAM clinic include: 1) cognitive processing, 2) compliance, 3) connections, 4) control, 5) coordinating other activities, 6) changing lifestyle factors and 7) co-integration. Cognitive processing is similar to McColl-Kennedy et al's. (2012) 'cerebral activities' where people take on a "positive attitude" about their health situation and treatment. However, in a CAM health care setting it also includes the CAM consumer having "an open mind" to consider CAM health care and take on treatment advice. It is also about the CAM consumer cognitively processing negative reactions from others towards CAM and overcoming these.

Compliance with treatment advice, prescriptions and adopting the practitioner's recommendations such as dietary and lifestyle changes is imperative to co-creating value in health care. In-line with S-D logic and the value-in-use idea consumers may not experience health benefits if they do not comply. McColl-Kennedy et al. (2012) include "compliance with basic requirements" as part of their 'cooperating' CVCA. Sweeney et al. (2015) place "compliance with basic requirements" as a within-clinic activity. However, in this research 'cooperation' is more about cooperating within the clinic environment with the practitioner whereas 'compliance' is about complying with the treatment plan outside of the clinic environment. In the CAM health care context and possibly other health care contexts such as General Practitioners, Physiotherapists, Occupational Therapists, complying with treatment advice (diet, exercise), prescriptions (herbal medicines, drugs, therapeutic exercises), outside the clinic is essential to co-creating value.

Similar to McColl-Kennedy et al. (2012) and Sweeney et al. (2015) this research found that making connections, coordinating other activities and changing lifestyle factors were important co-creation activities that CAM consumers engage in outside the clinic. What perhaps differs in this context is the type of connections, activities and lifestyle changes that are made. For example, CAM consumers not only connect with other people but often connect with nature and pursue spiritual practices where they connect with energy/spiritual forces as highlighted in 6.3.6.

Control in the CAM health care context is an important activity outside the CAM clinic. Primarily control consists of actively engaging in personal knowledge building. For example, many CAM consumers went on courses, read books or used relevant internet sites to learn about health and different CAM therapies that they could implement themselves. Control is different to ‘colearning’, where information is sought to share with the practitioner, but is similar to Sweeney et al’s. (2015) finding where “seeking information” was an activity done outside the clinic. In the CAM context the activity control is about gaining personal knowledge to enable self-responsibility and control over one’s health outside the clinic environment.

Co-integration is an activity that involves integrating other forms of CAM health care and in some cases mainstream medicine. Whereas McColl-Kennedy et al. (2012) found that cancer patients involve themselves in “combining complementary therapies”, this study found that CAM consumers coordinate other CAM health care therapies and mainstream medicine. Many CAM consumers are often using two or more CAM health services simultaneously for different conditions, for example, a chiropractor for back pain and a naturopath for female related health issues such as menopause. Most CAM consumers have a General Practitioner that they see for health issues that they believe requires medical intervention, such as, antibiotics for infections, or for aspects such as blood tests, smears, breast examinations and other medical tests.

#### **6.4.4 Typology of consumer value co-creation**

A typology is proposed which demonstrates the interrelationships between the CAM consumers’ approach to health care, preferred relationship styles, key consumer value components and consumer value co-creation activities (Table 54).

**Table 54: Typology of consumer value co-creation in CAM health services**

Typical approach to CAM health care	Typical preferred relationship style	Key consumer value dimensions	Consumer value co-creation activities	Consumer value co-creation activities
<b>Reactive</b>	Advisory	<ul style="list-style-type: none"> <li>• Knowledge and expertise of practitioner</li> <li>• Professional advice</li> <li>• Treatment results</li> <li>• Learning from the practitioner</li> <li>• Considered holistically - see and treat the body as integrated parts</li> </ul>	<p><i>Within clinic</i></p> <ul style="list-style-type: none"> <li>• Co-operating with the practitioner - accepting information and advice</li> <li>• Co-learning - giving personal information, Coproducing - some involvement in treatment planning</li> <li>• Communicating</li> <li>• Commitment - time and money</li> </ul>	<p><i>Outside clinic</i></p> <ul style="list-style-type: none"> <li>• Cognitive processing - open mind, overcoming negative influences</li> <li>• Compliance with treatment advice, prescriptions, exercises</li> <li>• Coordinating other activities</li> <li>• Co-integration of mainstream and CAM</li> </ul>
<b>Proactive</b>	Consultative	<ul style="list-style-type: none"> <li>• Knowledge of practitioner</li> <li>• Empowering approach of practitioner</li> <li>• Learning and gaining tools</li> <li>• Preventative</li> <li>• Gaining self-responsibility</li> <li>• Sense of self &amp; self-discovery</li> <li>• Considered holistically - mind, body and soul</li> <li>• Feelings of peace and balance</li> <li>• Connection with an energy force</li> </ul>	<ul style="list-style-type: none"> <li>• Collaboration with the practitioner - working together with the practitioner</li> <li>• Co-learning - sharing personal information and some knowledge</li> <li>• Coproducing - involvement in treatment planning and shared decision making</li> <li>• Communicating</li> <li>• Commitment - time and money</li> </ul>	<ul style="list-style-type: none"> <li>• Cognitive processing - open mind, overcoming negative influences</li> <li>• Compliance with treatment advice, prescriptions, recommendations</li> <li>• Connections with nature and energy forces</li> <li>• Control - personal knowledge building</li> <li>• Coordinating other activities</li> <li>• Changing lifestyle factors - diet, habits</li> <li>• Co-integration of mostly other CAM health care providers and mainstream providers</li> </ul>
<b>Integrative</b>	Partnership	<ul style="list-style-type: none"> <li>• Knowledge of practitioner</li> <li>• Empowering approach of practitioner</li> <li>• Learning and gaining tools</li> <li>• Preventative and focus on wellness</li> <li>• Being self-responsible</li> <li>• Sense of self and self-discovery</li> <li>• Considered holistically - mind, body &amp; soul</li> <li>• Spiritual connection</li> <li>• Gaining meaning and purpose in life</li> </ul>	<ul style="list-style-type: none"> <li>• Collaboration with the practitioner - working together with mutual regard</li> <li>• Co-learning - sharing personal information and knowledge</li> <li>• Coproducing - shared decision making</li> <li>• Communicating</li> <li>• Commitment - time and money</li> </ul>	<ul style="list-style-type: none"> <li>• Cognitive processing - open mind, overcoming negative influences</li> <li>• Compliance with treatment advice, prescriptions, recommendations</li> <li>• Connections with other people, nature, energy and spiritual forces</li> <li>• Control - personal knowledge building and applying knowledge to self, e.g. self-treatment</li> <li>• Coordinating other activities</li> <li>• Changing lifestyle factors have often already been implemented</li> <li>• Co-integration of CAM health care providers</li> </ul>

This research contends that a CAM consumers approach to health and CAM health care dictates the preferred relationship style, and thus the consumer value components experienced and valued, and the consumer co-creation activities engaged in. However, paradoxically it is often the client-practitioner relationship that has helped shape the CAM consumer's health care approach in the first place. On the one hand the preferred relationship style appears to be influenced by the consumer's approach to health care and on the other hand the relationship style adopted by the practitioner can often influence the CAM consumer's approach to health and health care.

CAM consumers who have a reactive approach to their health and CAM health care tend to prefer an 'advisory relationship style' and mostly value aspects such as the practitioner's knowledge and expertise, professional advice and treatment results. These consumers tend to have low to medium levels of personal knowledge about CAM and rely on the advice and knowledge of the CAM practitioner. Professionalism of the CAM practitioner and CAM health care service is important. The level of professionalism and perceived expertise facilitates the level of co-operation with the practitioner. For example, these consumers were then prepared to give personal information about themselves and their health, take on the advice of the practitioner and comply with treatment plans and prescriptions recommended by the practitioner. Value begins for the 'advisory style' 'reactive' participants with the anticipation of potential treatment results and for some the pre-conceived notion that it is natural, non-invasive and holistic (i.e. considered the whole body).

CAM consumers who have a proactive approach to health care tend to prefer a 'consultative relationship style'. These consumers mostly have established relationships with their CAM practitioner/s. At this stage most have firm beliefs about CAM and CAM health care being natural, holistic (considers mind, body and soul), advocates prevention and encourages self-responsibility. Key consumer value components that are important include the knowledge and empowering approach of the practitioner that facilitates learning and the ability to gain tools that provide a sense of self-responsibility. These consumers are also beginning to value a sense of self and self-worth through increased wellbeing and some are on a path of self-discovery. CAM consumers who have a proactive approach involve themselves in more co-creation activities than the advisory group, such

as colearning, coproducing, connections, control and changing lifestyle factors. Cooperation with the practitioner is more collaborative and involves the sharing of knowledge and shared decision-making. Outside of the clinic these participants engage in more personal knowledge building and changing lifestyle factors of their own accord than the advisory group. All the proactive consumers have taken some ‘control’ of their health and wellbeing through gaining knowledge and tools, and implementing them with the aim of keeping themselves well.

Those that had an integrated approach have a preference for a ‘partnership style relationship’, which in some cases has almost gone beyond the practitioner to relying heavily on their own knowledge and engaging in lots of self-treatment. Co-creation activities outside the clinic such as connections, control, coordinating other activities, changing lifestyle factors are integral to the health and wellness of these participants. A ‘wellness’ outlook as opposed to a “‘treatment’ and ‘preventative’ outlook which the ‘reactive’ and ‘proactive’ consumers have was the main focus. Despite being in control of their own health all have long-term relationships with CAM practitioners that they work in ‘partnership’, with ‘mutual regard’. The key consumer value components that are important to this group include the empowering approach and congruence of the practitioner, being self-responsible, gaining a sense of self and having connections with nature, energy and/or spiritual forces. All have gained a wealth of knowledge about health and CAM health care through their own personal knowledge building. The expectations they have of CAM practitioners is high in terms of shared decision making and authenticity.

#### **6.4.5 Summary of research question 2**

The objective of research question 2 is to determine how CAM consumers co-create value through their consumption experiences of CAM health services. CAM consumers co-create value three key ways, firstly, through their ‘consumer value co-creation practice style’ preferences, secondly, via their approach to health and CAM health care, and lastly, by actively engaging and participating in consumer value co-creation activities. Grönroos (2011, p. 290) argues that “co-creation of value can take place only if interactions between the firm and the customer occur” and if no direct interaction takes place then no value co-creation is possible. This research supports this notion as one of the key ways CAM

consumers co-create value is via their interaction (relationship) with CAM health care services and practitioners. However, it is not just the interaction that is important but the quality and approach of the interaction, preferred practice style and the consumer value co-creation activities involved and engaged in that determines how much value is co-created or not. As Sweeney et al. (2015) found the more effort the health customer puts into value co-creation activities the greater the satisfaction which leads to higher level of quality of life. Like Sweeney et al. (2015) this research found that health consumers not only co-create value via direct interaction within the clinic environment but also indirectly outside the clinic by integrating other resources and participating in activities “beyond firm-customer service interactions” (p. 11).

## **6.5 Methodological Considerations**

The literature suggests that the concept of value within marketing and consumer research remains abstract and nebulous, has multiple meanings and is potentially one of the most misused concepts (Gallarza & Gil-Saura, 2006; Khalifa, 2004; Sánchez-Fernández & Iniesta-Bonillo, 2007). In designing this study, the expectation was that it would be difficult for the participants to express and articulate what they value and how they co-create value in a standard interview setting. This proved to be the case, as evidenced by the tendency for participants in the first phase interview to underreport and/or provide only surface ‘conscious’ behaviours and experiences. However, the chosen method which moved beyond simple interviewing techniques allowed an exploration and elicitation of in-depth, rich and ‘unconscious’ responses that advanced the understanding of consumer value and value co-creation. The three phase semi-longitudinal method, incorporating a storytelling interview, the visual elicitation technique and interview, and final confirmatory interview, was very successful at eliciting underlying meanings and processes about value and value co-creation. In particular, the use of visual metaphor elicitation techniques (ZMET) and the semi-longitudinal nature of the study were two critical aspects that significantly contributed to the findings of this research. A discussion on each follows.

According to literature combining visual elicitation methods with in-depth interviews can create new ideas and knowledge through the meanings that people ascribe when they combine images and words (Pink, 2007). Visual images enable research participants to

explore deeper meaning and insights into the phenomenon being studied that cannot be elicited by interviews alone (Harper, 2002; Rose, 2012). Visual images can often change the emotional tone of an interview enabling participants to express and articulate more easily (Reavey, 2011). During the second image elicitation phase of this research, consumer value components that were underreported in the first phase came to the fore, in particular sensitive aspects, such as esteem and spiritual value. This is attributed to four key reasons. Firstly, and most importantly, the participant's involvement in the research process by producing and/or gathering images, pictures and/or photos enabled the participant to become personally invested and engaged in the research and therefore more willing to express their thoughts and feelings. This supports literature that found participants who produce or gather his/her own images enables them to become involved in the generation of research data, which empowers the participant and leads to rich sources of information (Belk, 2013; Brace-Govan, 2007; Pink, 2007; Rose, 2012). Secondly, the process of searching and selecting pictures and images produced emotional and unconscious thoughts and feelings not previously considered or articulated in the first phase interview. Thirdly, the participant had time to process ideas and thoughts about the phenomenon being studied, and fourthly, the participant-produced images provided a tool for the researcher to probe further.

The following examples demonstrate the power of the image elicitation technique to generate new ideas and open up sensitive topics not previously given much attention in the first phase interview. As previously mentioned consumer value components such as spiritual value and esteem value became evident in the second phase interview. Two sub-components of spiritual value that strongly emerged from the second phase was the idea of being 'connected with energy, spiritual and/or universal force' and 'inner-balance' (as outlined in 6.3.6). Figures 25 and 26 provides examples of images that different participants brought to the second interview to express these components. It is interesting to note that participants often had similar images that represented the same aspect, for example, the hand images in Figure 25, and the stone images in Figure 26, highlighting the importance and strength of visual metaphors in driving participants' thinking and behaving (Coulter & Zaltman, 1994). Figure 27 provides examples of images that participants brought to the second interview that enabled them to express their thoughts and feelings

about CAM health care facilitating a sense of self and self-discovery (as outlined in 6.3.4). Again similar images emerged but sometimes the images were specific to the participant but essentially represented the same component.

**Figure 25: Examples of participant's images that expressed 'connection with energy, spiritual and/or universal force'**



**Figure 26: Examples of participant's images that expressed 'inner-balance'**



**Figure 27: Examples of participant's images that expressed 'sense of self' and 'self-discovery'**



The image elicitation phase also provided a means for the researcher to triangulate and check on the researcher's preliminary findings (Brace-Govan, 2007). When the researcher analysed the transcripts for sub consumer value components she would cross-check with the imagery. Cross-checking with the imagery often reinforced the importance of the consumer value component/s emerging, particularly with sensitive topics such as spiritual value. Even with well-established consumer value themes that emerged in the first interview, such as 'nature-based' and 'cooperative and collaborative relationships', the image elicitation phase confirmed and gave the researcher confidence that these components were important.

The benefit of the semi-longitudinal nature of the research method was two-fold. Firstly it gave the opportunity for the researcher to develop rapport with the participants over time, enabling the participant to feel more comfortable which provided more in-depth data. Secondly, it enabled the participants to reflect on their CAM experiences between each phase enabling deeper insight. Thirdly, it allowed the researcher to explore the concept of value co-creation over time. It was assumed that value co-creation is a process that occurs throughout the consumption experience (Grönroos, 2011a; Vargo & Lusch, 2008, 2012). As previously discussed there is evidence of a consumer value co-creation process and consumer progressions from one approach and relationship style to another. The semi-longitudinal method assisted in determining this supporting McColl-Kennedy et al's.

(2012) call for longitudinal research to determine whether preference for consumer value practice styles changed over time.

## **6.6 Summary of Discussion**

This study makes an essential contribution to understanding consumer value and value co-creation within health care services and offers a framework for the process of consumer value co-creation that can potentially be applied to all health care service contexts. Specifically, this research determines what CAM consumers' value and how they co-create value through their CAM health service consumption experiences. Answering these questions contributes to understanding and advancing service experience consumer value and value co-creation in several important ways. Firstly, this research identifies eight key consumer value components that not only provides a useful framework for all health care services but builds on existing models of consumer value to incorporate findings within a health care context. Secondly, the study provides valuable insights into how consumers co-create value within CAM health services and proposes a framework of consumer value co-creation that can be considered in in other health care contexts and potentially in broader consumption experiences. Finally, important methodological considerations are discussed highlighting the power of visual elicitation techniques and semi-longitudinal research in health care research.

# Chapter 7 Conclusion

## 7.1 Overview

The overall purpose of this research is to explore the ‘lived experience’ of CAM health service consumers. Specifically, the study aims to find out what value individual CAM consumers determine and co-create from their consumption experiences of CAM health care in order to understand the CAM phenomenon and extend the concepts of consumer value and value co-creation. This final chapter provides conclusions, an overview and discussion of the theoretical and methodological contributions of this doctoral research and implications for practitioners, confirming that the research aims were achieved. The chapter also addresses limitations of this study, considers broader applications of the proposed consumer value and value co-creation models and proposes areas for future research.

## 7.2 Conclusions

The conclusions of this research are now considered in relation to the overall aim and the specific research questions:

1. What do CAM consumers value from their CAM health service consumption experiences?
2. How do CAM consumers co-create value through their consumption experiences of CAM health services?

Within CAM health services understanding what consumers’ value and how they co-create value are critical to understanding the CAM phenomenon and its place in modern health care (Adams, 2014). This thesis addresses and answers the above research questions, tying together consumer value, value co-creation and health care management and service marketing theories and concepts. Significantly this thesis presents a framework for

understanding the process of value co-creation in a CAM health care context and potentially all health care contexts. Although formulating a value co-creation framework was not initially in the scope of this research, it is a surprising and worthy outcome of this study with major implications for theory development and practice (as discussed below in 7.3 and 7.5 respectively).

Specifically, this research addresses the first research question by identifying a gap in the literature with regards to the value CAM consumers determine. It was evident in medical and CAM health care literature why CAM consumers are motivated to ‘use’ CAM health care, with motivators such as their philosophical orientation and postmodern health values, disenchantment with mainstream medicine, empowerment and self-responsibility, holistic approach, natural underpinnings, and spiritual, intuitive and paranormal beliefs driving consumption of CAM. Essentially the literature suggests that CAM consumers are ‘pulled’ towards CAM because of their underlying values, beliefs and philosophical orientation towards health and life. However, what was not evident in the extant literature is once CAM consumers ‘use’ CAM services, what do they value from the experience?

This thesis concludes that consumer value is multi-dimensional and CAM consumers can potentially value eight key components of their CAM health services: 1) Quality of care; 2) Treatment efficiencies; 3) Physical environment; 4) Ethics (natural); 5) Esteem value; 6) Social value; 7) Spiritual value; and 8) Play. This finding of multi-dimensional consumer value that consists of many interrelated components is consistent with other scholars (Holbrook, 1994, 1999; Sheth et al., 1999; Sánchez-Fernández & Iniesta-Bonillo, 2007). Within each consumer value component are sub-components pertinent to CAM health services that have managerial implications for both CAM and mainstream health care (as will be discussed further in 7.5 managerial implications). This thesis proposes a consumer value model that is relevant to CAM health care and potentially all health care services. This thesis argues that in a health care service setting consumer value should be represented as a holistic model. It is proposed that CAM consumers evaluate the value of their health care experience primarily on quality of care and treatment efficiency, with the physical environment playing a small role. It is through valuing these experiences, in particular, the quality of the practitioner-client relationship and efficiencies such as the treatment results that the CAM consumer begins to value the other components such as

social value, esteem value, spiritual value and play. Essentially, CAM consumers' value a person-centred, empowering, holistic, educational and collaborative approach to their health care that is authentic and fosters co-learning and self-responsibility. This client-centred and cooperative relationship along with treatment results assisted in experiencing (hence valuing) other consumer value sub-components such as a sense of self-worth, self-discovery, connection with nature and energy forces, gaining meaning and purpose, peace and balance, and participating in leisure activities.

This research addresses the second research question by determining how CAM consumers co-create value and supports the idea that consumer value is ultimately determined and 'co-created' by the 'user' during the consumption experience (Vargo & Lusch, 2006, 2008; Grönroos, 2008, 2011). In line with the value-in-use concept, consumer value is experienced during the 'use' of CAM health care. 'Use' in this context is experienced both within the clinic and outside the clinic environment where CAM consumers ultimately co-create value. How consumers co-create value with their health care providers and services has important implications for health care practices and is essential to their overall health outcomes and quality of life (McColl-Kennedy et al., 2012; Sweeney et al., 2015). This research found three key aspects that contribute to how a CAM consumer co-creates value with CAM health services and include: 1) consumer approaches to health and health care, 2) consumer value co-creation relationship styles (CVCRS), and 3) consumer value co-creation activities (CVCA). The last two aspects, CVCRS and CVCA, builds on previous research by McColl-Kennedy et al. (2012) and Sweeney et al. (2015) by incorporating findings from CAM health services. However, the first aspect, approaches to health and health care, provides a new perspective on value co-creation in a health service setting.

The CAM consumer's approach to health care and health was a key determinant in how value was co-created because it often dictated the relationship style preferred and thus the consumer value co-creation activities engaged in. However, paradoxically it was primarily the client-practitioner relationship that has helped shape the CAM consumer's health care approach. A typology of consumer value co-creation (Table 54) shows the interrelationships between the three value co-creation aspects. Therefore a major conclusion the thesis draws from the proposed typology is that the three aspects - approach, preferred relationship style and consumer value co-creation activities - are

interrelated but primarily determined by the approach. CAM consumers with a ‘reactive’ approach to health care had a preference for an ‘advisory’ style relationship that involved cooperation on the level of accepting advice with some involvement in treatment planning. The ‘reactive’ CAM consumer also tends to have less engagement in outside clinic co-creation activities such as connections and changing lifestyle factors. CAM consumers with a ‘proactive’ approach have a preference for a ‘consultative’ style relationship that involves collaboration, sharing knowledge and being involved in treatment planning and shared decision-making. Proactive CAM consumers have a tendency to engage more in outside consumer value co-creation activities. CAM consumers with an ‘integrative’ approach have a preference for a ‘partnership’ style relationship where there is mutual regard and complete shared-decision making. Integrative CAM consumers engage heavily in outside consumer value co-creation activities, such as control, connections and integrating lifestyle factors.

Lastly, this research demonstrates the significance and relevance of using qualitative and case study research methodology for theory building (Gillham, 2000). The theoretical contributions are now presented.

### **7.3 Theoretical Contributions**

This study makes a number of theoretical contributions to consumer value theory, value co-creation concepts, S-D logic and health care services marketing. The contributions are listed below under the relevant area and discussed accordingly.

Theoretical contributions to consumer value theory include:

1. Development of a model of consumer value for CAM health services that potentially can be used as a consumer value framework for all health care services and ultimately all consumption experiences (refer Figure 24, p. 225)
2. Elaboration of individual consumer value components in a CAM health care context as follows:
  - a. Consumer value component ‘quality’ elaborated to include six key sub-components that determined ‘quality of care’.

- b. Consumer value component ‘efficiency’ elaborated to include six key sub-components that determined ‘treatment efficiency’.
  - c. Consumer value component ‘aesthetics’ elaborated to include aspects of the physical environment.
  - d. Consumer value component ‘esteem’ elaborated to include four key sub-components.
  - e. Consumer value component ‘social value’ elaborated to include two key sub-components.
  - f. Consumer value component ‘spiritual value’ elaborated to include five key sub-components.
  - g. Consumer value component ‘ethics’ elaborated in a CAM health care setting to include ‘natural’.
  - h. Consumer value component ‘play’ elaborated to include three key sub-components.
3. Reconceptualization of Holbrook’s (1994, 1999) typology of consumer value and Sánchez-Fernández, Iniesta-Bonillo and Holbrook’s (2009) model of consumer value. Specifically demarcating ‘spiritual value’ and ‘ethics’, and ‘social value’ and ‘esteem value’ as distinct consumer value categories.

Theoretical contributions to the concept of value co-creation include:

- 4. Proposed a framework for the process of value co-creation that is relevant to CAM health care services and potentially all service contexts (Refer to Figure 23, p. 208).
- 5. Identified three consumer value relationship styles (CVCRS) within a CAM health care services context which builds on McColl-Kennedy et al’s. (2012) customer value co-creation practice styles (CVCPS). Specifically the thesis elaborates on the ‘partnership’ practice style.

6. Identified twelve consumer value co-creation activities (CVCA) occurring both within and outside a clinic environment which builds on McColl-Kennedy et al's. (2012) and Sweeney et al's. (2015) concept of CVCA in a health care service setting.
7. Determined that a consumers' approach to health care and health is an important consideration in how consumers co-create value.
8. Developed a typology of consumer value co-creation relevant to CAM health care services (refer to Table 54, p. 237).

Theoretical contributions to Vargo and Lusch's (2004, 2006, 2008) S-D logic by providing empirical evidence:

9. Evidence that consumers co-create value in a health care context. Confirming that "the customer is always a co-creator of value" (Vargo & Lusch, 2008, p. 7).
10. Evidence that value in a health care context is experiential and contextual. Confirming "value is always uniquely and phenomenologically determined by the beneficiary" (Vargo & Lusch, 2008, p. 7).
11. Evidence from a health care consumers' perspective that firms can only offer value propositions. Confirming "the enterprise cannot deliver value, but only offer value propositions" (Vargo & Lusch, 2008, p. 7).
12. Evidence and confirmation that value co-creation is an ongoing, iterative, and continuous process extending well beyond individual transactions.

Theoretically this research contributes to our understanding of consumer value within CAM health services and provides not only a foundation to study consumer value in other health care settings but potentially all service contexts and ultimately all consumption experiences. As discussed in 6.3.9 this study highlights the interconnected nature of consumer value, particularly within a health care setting. One of the major contributions of this thesis is the reconceptualization of Holbrook (1994, 1999) and Sanchez-Fernandez et al. (2009) models of consumer value. This thesis contends that in a health care context that

consumer (customer) value is experienced holistically and as interrelated components. This thesis proposes a consumer value model that represents this holistic and interrelated approach. It was found that consumer value is initially experienced via the consumer value components ‘quality of care’, ‘treatment efficiency’, ‘ethics (natural)’ and ‘aesthetics’ (physical environment). Experience of these consumer value components, in particular ‘quality of care’ and ‘treatment efficiency’, determines the experience of the other consumer value components ‘spiritual value’, ‘social value’, ‘esteem value’ and ‘play’.

The elaboration of the individual consumer value components to incorporate findings from a CAM health care consumer’s perspective has also contributed to our understanding of these consumer value aspects. Of particular note is the reconceptualising of spiritual value as distinct from ‘ethics’ and esteem value as distinct from social value. Spiritual value was deemed difficult to demarcate from ethics and was combined to make a single consumer value component ‘altruistic value’ (Sánchez-Fernández et al., 2009). However, this research found that ‘spiritual value’ was significant in its own right and was not necessarily always altruistic. Not only is understanding a health care customer’s spiritual needs and spiritual value in health care context important (Liu et al., 2006); spirituality and spiritual value has been acknowledged as an important consideration in the consumption experience of potentially all consumers (Brown 1999; Elliot & DeBerry-Spence 2010; Holbrook 2001; Kotler et al., 2010; McKee 2003; Skousgaard, 2006). As recommended in 7.7 ‘spiritual value’ needs to be put back on the consumer research agenda. ‘Esteem value’ too was found to be distinct from ‘social value’. ‘Esteem value’ in a CAM health service context was primarily about gaining self-responsibility and a sense of self-worth and therefore about self-esteem and feeling good about one’s self, as opposed to social value which was primarily about the social self and opinions of others.

The concept of value co-creation, although coined approximately 10 years ago, is still in its infancy in terms of theoretical grounding and empirical evidence. However, many scholars are now devoting time to researching this concept in various industries and contexts. In health care scholars such as McColl-Kennedy et al. (2012) and Sweeney et al. (2015) have made major contributions to understanding value co-creation from a health care customer’s perspective in this service context. This thesis builds on these scholars’ work to include findings from another health care setting. Studying how CAM consumers co-create value

has given further insight into the activities that consumers potentially engage in, not only to co-create value with CAM health care but ultimately to co-create health. This research found that the more CVCA consumers engage in, particularly outside the clinic environment, the better health outcomes, in terms of enhanced wellbeing, are experienced. This finding has implications for all health care providers in terms of the potential role they have in facilitating and encouraging health care customers to engage in health promoting CVCA as will be further discussed in 7.5.

Within health care services, practitioner practice styles and patient/client-practitioner relationships are central to how health care consumers co-create value (McColl-Kennedy et al., 2012). This research found that CAM consumers' preferred CVCRS are often determined by their approach to health care. Movement of the consumer's approach from 'reactive' to 'proactive' to 'integrative' appears to be facilitated by the quality of care consumer value component such as the practitioner having a client-centred, cooperative and empowering approach. What seems to be happening is that the more empowered a CAM consumer becomes, the more likely they are to take on a more 'proactive' or 'integrative' approach to their health care. With this change in approach often comes a change in preferred CVCRS as well as an increased engagement in CVCA. There appears to be an interrelationship between a CAM consumer's approach, CVCRS and engagement in CVCA as outlined in the typology in 6.4.4. However, further research is required to understand these interrelationships further (as is outlined in 7.7).

The new contribution this thesis makes is the proposal of a framework for the process of value co-creation in CAM health care and potentially all service contexts. According to Grönroos (2011a) little is known about the process of value co-creation. Vargo and Lusch (2012) contend that value co-creation is an ongoing and continuous process, but with little empirical evidence to support their idea. This research provides evidence, in a CAM health care context at least, that the process of value co-creation is indeed an ongoing, continuous and iterative process. Not only does this research contribute to the process of value co-creation it also provides evidence that key foundational principles of S-D logic hold true.

## 7.4 Methodological Contributions

This research implemented a unique semi-longitudinal case study methodology using a three phase process that incorporated an elicitation method, the Zaltman Metaphor Elicitation Technique (ZMET). This methodological process, it is believed, is the first of its kind to be implemented in a health care services context. The specific methodological contributions of this research include:

1. Development of a three-phase semi-longitudinal procedure
2. Use of a shortened version of ZMET
3. Use of ZMET and participant produced images to uncover deeper meanings of consumer value and value co-creation

The development of a three-phase semi-longitudinal procedure enabled three key things to occur; rapport with the participants, ability to study value co-creation over a time period and triangulation. Firstly, building rapport with participants was essential to gaining depth on their experiences of CAM services and instilling confidence to discuss a sensitive personal issue such as health. By the third phase interview participants were comfortable and engaged in the research process. Secondly, studying value co-creation over a time period enabled the researcher to investigate the process of value co-creation. Although the timeframe was relatively short in terms of the majority of the participant's involvement and history with CAM health services, the semi-longitudinal nature of the research did provide some insight into the process and changes that occur. The semi-longitudinal approach also enabled the participants to reflect on their experiences between each phase. This thesis concludes that semi-longitudinal iterative research, particularly within a health care context, is beneficial in terms of understanding people's experiences of health care services. Thirdly, the three-phase process enabled triangulation of the data contributing to the robustness of the research. The researcher is confident that not only do the findings reflect the participant's experiences but has provided a solid foundation for theory building.

The use of a shortened version of ZMET to auto-drive the second phase interview proved to be an efficient and easy technique to implement. The five step procedure that used storytelling, missed images, sorting task, most representative image and summary image, was sufficient enough to uncover deeper unconscious thoughts and feelings and yet simple enough to administer. Although a number of participants commented that finding the images was time consuming, they enjoyed the use of the images during the interview process and were able to articulate their thoughts more freely. The novelty of the participant-produced/gathered visual method and ZMET process also kept the participants engaged and invested in the research process.

Finally using visual elicitation methods proved to be an invaluable technique in terms of uncovering deeper unconscious thoughts, feelings and meaning of the CAM health service experience and hence ideas about consumer value and value co-creation. As previously outlined in 6.5 consumer value components such as ‘spiritual’ and ‘esteem value’ came to the fore during this phase of the research. What was particularly interesting is the different way each participant approached and interpreted the task – “I would like you to take and /or gather up to 20 photos and/or pictures (minimum 12) of images that represent what you think and how you feel about your experiences of complementary and alternative medicine.” Some provided a very linear approach and provided images in a logical sequence, others took a more random approach and found images based on key words they searched for in google images, and some provided their own images. It is important to note that even when participants used word searches in google images, they chose images that they liked and believed represented their thoughts and feelings the most. In some cases the images were focused on particular aspects and others gave a broader overview of their experiences. What was apparent is that the images tended to represent the most important aspects of their CAM health care experiences.

## **7.5 Managerial Implications**

### **7.5.1 CAM health service practice**

CAM consumers are seeking holistic, empowering and more equitable practitioner-client relationships in their health care (Bann et al., 2010; Gale, 2008). This study’s findings

concur with this and suggests that by understanding the value CAM consumers gain from their experiences of CAM services, could help CAM practitioners improve the level of their service and health care to their customers. Based on the consumer value findings it is advocated that CAM health services focus on quality of care. Quality of care in the CAM context is defined as the practitioner having a high level of expertise, knowledge and congruence, and uses this to foster a client-centred, cooperative, empowering, supportive and educational relationship that facilitates colearning and self-responsibility. Quality of care coupled with treatment efficiency such as treatment results, treatment ease of use and providing timeframes for treatment results could enhance CAM consumer's perceived value of the CAM service. Adhering to these aspects could potentially lead to increased health outcomes for the CAM consumer. Along with these aspects understanding how CAM consumers co-create value can also aid in better health outcomes, in particular, having an understanding of the CAM health care consumer's approach to health care and preferred CVCRS.

Drawing from the findings there are a number of specific areas CAM health services could focus on to improve the perceived quality and efficiency of their practice. These are outlined below under the relevant area.

#### Quality of care

1. Fostering client-centred, cooperative and collaborative relationships with the client throughout the treatment programme by listening, continually asking the client for feedback, and involving the client in and customising treatment plans to each client's needs, avoiding standardised hand-outs where possible.
2. Ensuring the consultations are educational and empowering by providing appropriate information that empowers the client to manage their health.
3. Ensuring a holistic approach is implemented and the client's physical, emotional, mental and spiritual needs are considered and met.
4. Involving the client in a process of colearning, whereby the practitioner actively encourages the client to seek and share information about their health.

5. Practicing ‘congruence’ by engaging sincerely, showing genuine interest and respecting their client’s values and beliefs on health; plus providing support and showing empathy and care.
6. Continuing to update knowledge by attending professional development seminars and keeping abreast of the latest health research.

#### Treatment efficiency and physical environment

7. Specifying timeframes in which the client could expect to see results and outlining the number of treatments and/or follow-up consultations required.
8. Developing administrative processes that ensure quick and easy access to appointment times, particularly for acute cases.
9. Offering long initial consultations (45 minutes to 1 hour) with shorter follow-up consultations or treatment sessions (15 minutes to 30 minutes).
10. Establishing a warm, friendly and professional environment

As previously discussed the client-practitioner relationship is an important aspect to CAM consumers co-creating value. The following two practices could be implemented by CAM practitioners to enable the CAM consumer to co-create value and thus contribute to their health and wellbeing. Firstly, CAM practitioners could consider their client’s current approach to health care and adopt the appropriate CVCRS to match while gradually encouraging their client to move towards being more proactive and integrative. Secondly, CAM practitioners could identify the CVCAs that the client is currently engaged in both within and outside the clinic and facilitate those CVCAs not actively involved in. These practices could be included as part of the initial consultation, whereby the CAM practitioner asks relevant questions to elicit this information and makes notes accordingly.

#### **7.5.2 Health care practice and policy**

Adams (2014, p. 1) argues that research addressing “critical questions such as why, when, and how alternative therapies are currently consumed and practiced” is essential to understanding the place CAM has in “contemporary health care”. This research goes some

way to answering these questions. It is considered in the best interests of patients/health care customers, mainstream health care providers, CAM health providers and policy makers to understand what value CAM consumers get from using CAM health care. The key finding from this study, for all health care providers both mainstream and CAM, is that CAM consumers value the empowering, holistic (i.e. considered as an integrated whole – mind, body spirit) and cooperative approach to their health care. Three main recommendations for health care practitioners, providers, and educational institutions are proposed.

The first recommendation is for all health practitioners who have clients/patients who use both CAM practitioner/s and medical practitioner/s (GP, Medical specialist etc.) to be sensitive towards their patients/clients health care choices. According to Clarke et al. (2015) most people using CAM “do so to complement conventional care” (p. 1), therefore Medical practitioners with patients’ who are involved in CAM health care, should be aware of what CAM therapies their patients are using and inform themselves on these practices, without necessarily agreeing with the CAM therapy itself. Often CAM consumers are reluctant to tell their medical practitioners that they are also seeking advice and getting treatment from CAM practitioners because they believe their medical practitioner won’t understand or value their choice. Likewise, CAM practitioners need to be open and supportive of their clients using medical practitioners. CAM practitioners must also be aware of their ‘scope of practice’ and refer clients to medical practitioners when required. The overall health outcome for the individual is paramount. CAM consumers using CAM and medical practitioners would prefer both types of practitioners to be open and accepting of the consumer’s choice of health care. Therefore, the second recommendation is for mainstream medical practices and practitioners and CAM health practitioners and clinics to actively connect and develop relationships with each other. An integrated approach (i.e. mainstream medical providers building relationships with and working alongside CAM health care providers) to an individual’s health care will potentially benefit all involved.

To increase awareness of CAM in mainstream medicine the third recommendation is for medical and nursing schools to introduce nursing and medical students to CAM. Despite reservations towards CAM there is a growing interest among the medical community with many “primary care physicians [wanting] to increase their knowledge about CAM

modalities” (Sewitch et al., 2008, p. 150). In particular, an understanding of the health and healing philosophies behind the different CAM therapies may provide mainstream medical practices greater insight into CAM health care. Kelner and Wellman (1997b) in their study on health care and consumer choice concluded that many consumers feel free to choose from a range of health care options from mainstream medical care to CAM therapies in the search for better health and personal growth. In this consumer driven era the author reasons that a collaborative effort is required to ensure not only CAM consumers but all health care consumers achieve better health outcomes.

The findings of this research also have broader implications for mainstream medical practice with many of the above quality of care recommendations for CAM health care practices being transferable. The author argues that some health care customers are looking for a level of health care that puts them at the centre. Therefore, treating these health care customers as active, informed and seeking client-centred relationships that empower and have a holistic approach is a consideration for all health care providers. The researcher acknowledges that there are many issues and challenges, not addressed in this research, that impact on mainstream medicine, such as marginalised people, cultural sensitivities and low patient education. She acknowledges that CAM health care, in New Zealand anyway, is consumed mostly by fee paying, educated consumers. Regardless, she believes this research can provide a foundation for mainstream medical practices with regard to understanding consumer value and value co-creation in a health care setting.

## **7.6 Limitations**

All research has limitations and this study is no exception. Although this research provides a platform for understanding what CAM consumers’ value and how they co-create value from their experiences, it was exploratory and more empirical research is required to generalise these findings. The main limitations of this study are around the small sample size and limited cultural diversity. Other specific limitations included recruitment methods, time commitments and potential researcher bias. The data collecting issues that arose in this research included gaining access to participants, time commitment required by participants, and researcher bias. The main limitations of this study are now discussed in turn.

### **7.6.1 Small sample size**

This research was exploratory and used a case study approach to understand the service experience of the CAM consumer, therefore, the sample size of 16 was considered satisfactory. Case study research using a small number of participants is widely accepted in consumer research to study consumers' consumption experiences (Elms & Tinson, 2012; Woodside et al., 2008). More importantly theoretical saturation was reached with this sample size in that no more new themes were arising. The data gathered from the 16 participants (and from 43 interviews) has not only enabled theory building but has also provided relevant and worthwhile managerial implications for both CAM and mainstream medical practice about the value CAM consumers gain and how they co-create value.

### **7.6.2 Cultural diversity**

Cultural differences amongst consumers in terms of CAM consumption was not in the scope of this research, therefore, selecting individuals from different cultural background was not a recruitment criterion. However, the researcher acknowledges the potential importance of understanding cultural diversity in health care and makes future research recommendations (refer 7.7) in this area. Of particular importance in the New Zealand context is Maori and Pacifica health care issues and concerns.

### **7.6.3 Gaining access to participants**

Gaining access to the research participants was critical to the success of this study. The recruitment of research participants relied on self-selection, which posed a risk if potential participants (CAM consumers) did not volunteer themselves. In an attempt to mitigate this risk an attempt to make the initial information about the research project compelling was made. As discussed previously CAM clinics within the Auckland region were approached to gain permission to advertise on their clinic noticeboard for volunteers. This proved to be an effective way of recruiting women. The men proved difficult to recruit via CAM clinics; hence a second-hand contact sampling technique was used.

The self-selection process also posed a potential problem in that participants with strong views about CAM health care may have been interested in participating. The research results therefore could be skewed towards participants who had either strong positive or

negative experiences. However, it was found that most of the participants had both positive and negative experiences of CAM health care. This proved useful in terms of understanding consumer value and how consumer co-create-value.

#### **7.6.4 Time commitment required of participants**

Participants were asked to commit to the research study for a period of up to 12 weeks, including three interviews and an image gathering exercise. This equated to approximately 12 hours over a 12 week timeframe. The large time commitment resulted in three key issues and included 1) discouraging potential participants who would have otherwise participated in a single interview, 2) participants pulling out part way through due to unforeseen circumstances or time constraints, and 3) participants taking longer to complete the phases. Four potential participants that made contact about the research after receiving the information sheet about the time commitment declined to participate. The 16 participants that agreed to participate were aware of the time commitments and were asked to only consider participating if they were able to commit to both the timeframe and time involved. As previously discussed three participants did not complete all three phases. Two participants participated in just the first phase and one participant in phase 1 and 2. The participant attrition rate was considered relatively low considering the time commitment involved. Fortunately the data collected from these participants could be used and therefore they each made a contribution to this research. Finally, participants generally found the image collection exercise time consuming and this phase took longer than anticipated.

#### **7.6.5 Researcher bias**

The issue of 'bias' has already been discussed with respect to the role as the researcher. In qualitative research, personal opinion and orientation of the researcher is inevitably bound up with not only data collection but analysis and interpretation. It is important to note at this point that the researcher is a qualified non-practicing Naturopath with experience and knowledge of CAM that may create bias. The researcher was mindful of this during the interviews and analysis process. This experience was considered more of an advantage in that she was able to relate to the participant by understanding the nature of CAM, health issues discussed and the CAM therapies participants are undergoing.

## 7.7 Future Research

This section outlines a future research agenda for various areas relating to health care services, consumer value and value co-creation. Firstly, replications of this study could be carried out in other health care settings, in particular, other clinic-based environments such as General Practitioner medical centres, physiotherapy clinics, podiatry, counselling services etc. Consumer value is important to understand in all health care settings (Zainuddin, et al., 2011). Not only would research focusing on consumer value and value co-creation within these settings provide an interesting contrast to the CAM health care context, it would also determine whether the proposed consumer value model and the value co-creation framework fits a variety of health care service settings. McColl-Kennedy et al. (2012) have studied value co-creation in an out-patient hospital setting, however, further research looking at consumer value and value co-creation within in-patient health care in both public and private hospitals could be carried out. This is particularly relevant for hospital settings in countries such as New Zealand and Australia and the like where the public health system operates differently to private sector health care.

This CAM research was exploratory and involved a small sample of participants that were predominantly female and culturally homogenous (i.e. primarily European). Therefore future research could consider focusing on male health care consumers, diverse cultures, and larger quantifiable samples. These research areas are now outlined in turn. Although an attempt was made to study men in this research only four men volunteered to participate. However, men's health care is important and further research that focuses on men, in both CAM and mainstream medical care, is critical to understanding what men value from their health care experiences. Prior research has indicated that men are less likely than women to seek help from health professional regarding their health (Galdas et al., 2005). Further research could help determine what men value and how they co-create value providing a framework which health providers can use to actively promote and encourage men to seek health care. Likewise a similar study could focus on how different cultures perceive value and co-create value within health care services. Many health care providers are faced with catering for and meeting the health care needs of various cultures. Understanding how different cultures perceive value and co-create value could guide health care service practices in terms of enabling access to health care and meeting the

cultural needs of their patients/clients. Ultimately, future research could involve the development of a scale of health care consumer value components and consumer value co-creation aspects identified in this research and others that can be used to measure consumer value and value co-creation in all health care services.

Although this research undertook a semi-longitudinal approach the researcher agrees with McColl-Kennedy et al. (2012) that more longitudinal research is required in various health settings including CAM to determine how value is experienced and created over time. It is postulated, based on the findings in this research, that the value CAM consumers gain changes according to their length of experience with CAM health care. As Grönroos (2011a) argues little is known about “the process of value creation, when it starts, what it includes and when it ends” (p. 282). This research provides some insight into the process of value co-creation, however, more longitudinal research in various health care and service settings could contribute to understanding the process of value co-creation further. Further research is also required to understand the factors that enable and assist the transitions that health care consumers make with their approach to health care. Understanding this could have significant implications for all health care providers in terms of assisting health customers/consumers become proactive with their health. Likewise, further research is required to understand the factors that contribute to the consumer transitioning from one preferred relationship style to another and the interrelationships between a person’s overall approach to health and health care and relationship styles.

Further research is also required into individual consumer value components, in particular, spiritual value, social value, esteem value and ethics, within other health care settings but also in broader consumer consumption contexts. The findings from this research with respect to these consumer value components cannot be generalised to other health care services or other consumption contexts where these consumer value components may be of importance. Spiritual value, for example, is becoming increasingly relevant as consumers are demanding to be considered as whole human beings that want functional, emotional and spiritual fulfilment in the products and services they consume (Kotler et al., 2010). Understanding and meeting peoples’ spiritual needs in health care has also been deemed a critical area to study (Liu et al., 2006). Since Holbrook (1994, 1999) proposed spiritual

value in his typology, little research on this specific area has been undertaken and spiritual value has gone under consumer researchers' radar. Therefore spiritual value needs to be put back on the consumer behaviour and consumption experience research agenda. Spiritual value could potentially be experienced in a variety of consumption contexts, for example, travel and tourism, leisure and recreation, and retail.

Likewise exploring social value and esteem value to demarcate these components is also required. This research found that social value in a health care context is primarily about the social self and how better health and enhanced well-being can contribute, in a positive way, to peoples' social self. On the other hand esteem value was about gaining self-worth and increased self-esteem via good health. Importantly, both social value and esteem value were facilitated by the use of CAM health care. Therefore, health care services potentially have the ability to contribute positively to peoples' self-concept. The impact of health care on the self-concept is an area requiring further exploration.

The consumer value of ethics in health care also requires further exploration. This research touches on ethical value in terms of the CAM consumer perceiving CAM health care to be natural and therefore consuming this service is potentially perceived as an 'ethical' act. However, it is not clear whether the perception of 'being natural' constitutes ethical value for the consumer or not and whether this act is inner-orientated, outer-orientated or both. Holbrook (1994, 1999) views the consumer value ethics as the consumers' perceived value from an ethical action that favours others (i.e. other-orientated), for example, giving to a charity. Further research into ethical consumption and the perceptions of ethical value in CAM health care services could shed light on this value component. Another interesting area for future research would be exploring the perceptions of CAM health care in contrast to mainstream medical care in terms of ethical value. The perception of CAM being natural was often made in contrast to mainstream medicine being unnatural.

This research focused on consumer value and value co-creation in CAM health services. However, the product side (vitamins, dietary supplements, herbal/traditional remedies) of the CAM sector is a large and growing industry, with industry revenues estimated at \$3.5 billion in Australia alone (Complementary Medicines Australia, 2014). The CAM product market also warrants study from a retail marketing and consumer behaviour perspective. In

particular, how consumers co-create value through the consumption of natural health medicines and products bought over the counter in pharmacies, natural health retail stores and online.

Lastly, the use of image elicitation techniques such as ZMET, requires further development in services marketing research. These techniques are well established in advertising and product/brand research, but have not been used extensively in services marketing and consumption experiences. Future research could focus on establishing visual methods in these areas.

## **7.8 Final Conclusions and Closing Reflections**

In conclusion this research makes important contributions to consumer value and value co-creation theory, CAM and mainstream medical practice and research methodology. Theoretically, the research uncovers what CAM consumers' value from their CAM health care services and how they co-create value. Essentially CAM consumers value an empowering, holistic, educational and collaborative approach to their health care which fosters co-learning, self-responsibility and for some a sense of self. Importantly, this research not only determines the value gained by CAM consumers in terms of quality of care, treatment efficiency, physical environment, social value, esteem value spiritual value, ethics and play but it proposes a consumer value model that is relevant within a CAM health care setting. The model can also be used to assess consumer value in other health care service contexts. How CAM consumers co-create value to obtain better health outcomes is also determined by this research. This study provides valuable insights into the consumer value co-creation activities (CVCA) that CAM consumers involve themselves in both within and outside the clinic environment. The research also establishes that CAM consumers have three approaches to health care, reactive, proactive and integrative, and demonstrates the interrelationships between the approach adopted with the preferred consumer value co-creation relationship style (CVCRS) and the CVCA's engaged in. Importantly, this research provides evidence of a progression from one approach to another, where CAM consumers start as 'reactive' but can move to 'proactive' and 'integrative' respectively. This progression is contingent on the CAM consumer integrating resources both within the clinic and outside the clinic environment and is often facilitated

by the empowering, educational, preventative and holistic approach of CAM health care service and practitioners. Most significantly this research provides a framework for the process of value co-creation in CAM health care services that can potentially be applied to all service contexts. Managerial implications of this research highlight the importance of all health care providers considering and treating the CAM consumer as active, informed and seeking a level of care that put them at the centre. It also provides specific recommendations for CAM and mainstream medical health care practice, policy makers and educational providers. Finally, this research makes important contributions to methodology by developing and implementing a semi-longitudinal three phase process that used a visual elicitation technique. This unique methodology proved to be valuable in terms of uncovering deeper meaning of consumer value and value co-creation enhancing our understanding of these concepts.

As the story began, the story now ends with some final personal reflections.

Part of the aim of natural therapies [is] to educate people so that they can take better care of themselves and have more of an integrated lifestyle... I feel respected as a whole person instead of just surface symptoms that might not actually deal with the depth of what's going on so I felt like there's time, there's an understanding of historical events that have contributed to the stress factors that may have contributed to an injury or the background that may have contributed to a health condition, rather than just skimming around on the surface and trying to find a solution to a symptom. I've really enjoyed an ongoing relationship with the practitioners, that means I have supervision for my life (Jules, 31).

The above quote from one of the participant's Jules, sums up for me both the essence of this research and why I began this journey in the first place. I wanted to understand what people really value from their experiences with CAM health services and how CAM consumers and CAM practitioners work together successfully? I now have the answers. I feel blessed and grateful for the opportunity to have spent nearly four years (I started on the 28<sup>th</sup> of February 2012) exploring these questions and gaining insights into human behaviour, human relationships and the quest for good health. I believe without our health our quality of life is diminished. I acknowledge all the scholars ancient and new, from all disciplines, that have and are devoted to research that enables people to gain quality of life

not only via medical breakthroughs but more importantly through quality health care practices. It is my wish that this research contributes, from a marketing and consumer behaviour perspective, to the body of knowledge on health care and health care services.

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# Appendices

## Appendix A – Cochrane list of therapies

Acupressure  
Acupuncture (e.g., needle acupuncture, electroacupuncture)  
Alexander technique  
Aromatherapy  
Arts therapy (e.g., dance therapy, drama therapy, music therapy)  
Ayurvedic traditional medicine (Ayurveda)  
Balneotherapy  
Bee products (eg, honey, pollen, propolis, royal jelly, venom)  
Biofeedback  
Chelation therapy†  
Chinese traditional medicine  
Chiropractic (i.e., spinal manipulation)  
Color therapy (i.e., chromotherapy)  
Craniosacral manipulation  
Dietary supplements (non-herbal)† (e.g., vitamins, hormones, amino acids)  
Diet therapy† (e.g. low fat diets, vegan diets)  
Distant healing  
Electric stimulation therapy† (eg, transcutaneous electrical nerve stimulation)  
Electromagnetic therapy†  
Eye Movement Desensitization and Reprocessing (EMDR)  
Feldenkrais method  
Herbal supplements (eg, echinacea, garlic)  
Homeopathy  
Hydrotherapy  
Hyperbaric oxygenation†  
Hypnosis  
Imagery (i.e., visualization techniques)  
Light therapy† (phototherapy)  
Magnetic field therapy† (eg, transcranial magnetic stimulation)  
Massage  
Meditation  
Morita therapy  
Moxibustion  
Naturopathy  
Osteopathic manipulation  
Ozone therapy†  
Play therapy  
Prolotherapy  
Qi gong  
Reflexology  
Reiki therapy  
Relaxation techniques  
Snoezelen  
Speleotherapy  
Spiritual healing (eg, prayer)  
Tai chi  
Therapeutic touch  
Traditional healers and healing practices (other than Chinese) (eg, Kampo, Shamanism)  
Tui na  
Ultrasonic therapy†  
Yoga

## Appendix B – Cochrane CAM categories

Complementary and Alternative Medicine-related reviews in *The Cochrane Library*, Issue 4, 2009 organized by subtopics\*† (Wieland et al., 2011, p.16-17)

<p><b>Alternative Medical Systems (107)</b></p> <ul style="list-style-type: none"> <li>• Ayurvedic Medicine (4)</li> <li>• Chinese Traditional Medicine (87)               <ul style="list-style-type: none"> <li>➤ Chinese herbal drugs (87)</li> </ul> </li> <li>• Homeopathy (12)</li> <li>• Japanese traditional medicine (1)</li> <li>• Naturopathy (1)</li> <li>• Tibetan traditional medicine (2)</li> </ul>	<p><b>Natural Product Based Therapies (354)</b></p> <ul style="list-style-type: none"> <li>• Chelation therapy (1)</li> <li>• Hydrotherapy (3)</li> <li>• Nutrition therapy               <ul style="list-style-type: none"> <li>➤ Diet therapy (22)                   <ul style="list-style-type: none"> <li>▪ Calorie control or calorie restriction (2)</li> <li>▪ Carbohydrate-restricted (1)</li> <li>▪ Casein-free diets (1)</li> <li>▪ Fat-restricted diet (2)</li> <li>▪ Gluten-free diet (1)</li> <li>▪ High-fibre diet (2)</li> <li>▪ Low glycemic-index diet (4)</li> <li>▪ Protein-restricted diet (3)</li> <li>▪ Sodium-restricted diet (3)</li> <li>▪ Vegetarian or vegan diet (1)</li> <li>▪ Other diet therapies (2)</li> </ul> </li> <li>➤ Dietary supplements (258)                   <ul style="list-style-type: none"> <li>▪ Amino acids (20)</li> <li>▪ Enzymes &amp; co-enzymes (7)</li> <li>▪ Fats (26)</li> <li>▪ Hormones (10)</li> <li>▪ Minerals (56)</li> <li>▪ Probiotics (23)</li> <li>▪ Vitamins (76)</li> <li>▪ Other supplements (39)</li> </ul> </li> </ul> </li> <li>• Oxygen therapy (5)</li> <li>• Ozone therapy (1)</li> <li>• Herbal medicine (56)               <ul style="list-style-type: none"> <li>➤ African prune (1)</li> <li>➤ Artichoke leaf (1)</li> <li>➤ Cayenne (1)</li> <li>➤ Cranberry (2)</li> </ul> </li> </ul>
<p><b>Energy Therapies (154)</b></p> <ul style="list-style-type: none"> <li>• Acupuncture therapy (154)               <ul style="list-style-type: none"> <li>➤ Acupressure (87)</li> <li>➤ Acupuncture (5)</li> <li>➤ Electroacupuncture (6)</li> <li>➤ Laser acupuncture (6)</li> <li>➤ Moxibustion (1)</li> </ul> </li> <li>• Breathing exercises (0)               <ul style="list-style-type: none"> <li>➤ Qi gong (0)</li> </ul> </li> <li>• Distant healing (1)</li> <li>• Electric stimulation therapy (32)</li> <li>• Magnetic therapy (11)</li> <li>• Phototherapy (7)</li> <li>• Reiki therapy (2)</li> <li>• Therapeutic touch (3)</li> <li>• Ultrasonic therapy (11)</li> </ul>	
<p><b>Manipulative and Body-Based Methods (21)</b></p> <ul style="list-style-type: none"> <li>• Alexander Technique (1)</li> <li>• Chiropractic Manipulation/Spinal Manipulation (8)               <ul style="list-style-type: none"> <li>➤ Cranial Massage (0)</li> <li>➤ Feldenkrais Method (0)</li> </ul> </li> <li>• Massage (10)</li> <li>• Osteopathic Manipulation (0)</li> </ul>	

<ul style="list-style-type: none"> <li>● Reflexology (2)</li> </ul>	
<p><b>Mind-Body Interventions (54)</b></p> <ul style="list-style-type: none"> <li>● Biofeedback (3)</li> <li>● Hypnosis (7) <ul style="list-style-type: none"> <li>➤ Imagery (0)</li> </ul> </li> <li>● Meditation (2)</li> <li>● Play therapy (1)</li> <li>● Relaxation techniques (7)</li> <li>● Sensory art therapies (24) <ul style="list-style-type: none"> <li>➤ Aromatherapy (5)</li> <li>➤ Art therapy (1) <ul style="list-style-type: none"> <li>▪ Colour therapy (0)</li> </ul> </li> <li>➤ Dance therapy (1)</li> <li>➤ Music therapy (14)</li> <li>➤ Other sensory therapy (1)</li> </ul> </li> <li>● Tai chi (5)</li> <li>● Unconventional psychotherapies (1) <ul style="list-style-type: none"> <li>➤ Morita therapy (1)</li> </ul> </li> <li>● Yoga (4)</li> </ul>	<ul style="list-style-type: none"> <li>➤ Devil's claw (1)</li> <li>➤ Echinacea (1)</li> <li>➤ Feverfew (1)</li> <li>➤ Garlic (5)</li> <li>➤ Ginkgo biloba (6)</li> <li>➤ Horse chestnut (1)</li> <li>➤ Kava (1)</li> <li>➤ Milk thistle (1)</li> <li>➤ Passiflora (1)</li> <li>➤ Saw palmetto (1)</li> <li>➤ St. John's wort (1)</li> <li>➤ Valerian (1)</li> <li>➤ White willow (1)</li> <li>➤ Other plants or plant extracts (29)</li> <li>● Prolotherapy (1)</li> <li>● Speleotherapy (1)</li> <li>● Topical therapies (5)</li> <li>● Unconventional synthetic drugs (1) <ul style="list-style-type: none"> <li>➤ Laetrile</li> <li>➤ Procaine (1)</li> </ul> </li> </ul>

\*Totals include reviews in progress (protocols) and withdrawn reviews, as well as current reviews.

†Systematic reviews that encompass multiple CAM therapies (e.g. 'Complementary and alternative therapies for pain management in labour') are classified under the subtopic of each therapy reviewed. The total number of reviews in this table is therefore greater than the total number of CAM-related Cochrane reviews.

## Appendix C – Clinic information sheet



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### ***Consumer Experiences of Complementary and Alternative Medicine***

#### CLINIC INFORMATION SHEET

##### What is the research project about?

Complementary and Alternative Medicine (CAM) is a popular and growing form of healthcare both in New Zealand and worldwide. Although research has begun to explore CAM's popularity, more research is required on the CAM consumer to understand CAM's growth and its place in modern healthcare. The purpose of this PhD research is to understand some of the factors driving growth of consumption in this healthcare market and more specifically to explore the consumption experiences of CAM consumers with CAM healthcare providers and CAM treatments. This is an exploratory in-depth study that hopes to provide further insights into the CAM consumer's experience. The implications of these insights can be used to guide CAM healthcare business practices.

##### Who is the researcher looking for to participate?

I am looking for people aged 20 years and over who are either:

- 1) seeing a CAM practitioner or therapist on a regular basis (once a month), for example, getting a regular massage, regular visits to an osteopath, chiropractor, acupuncturist, aromatherapist etc for health management; OR who are
- 2) currently seeing a CAM practitioner, for example, naturopath, herbalist, homeopath, acupuncturist etc, who has given a treatment programme requiring follow-up visits.

##### What's the commitment for the participant?

This is an in-depth study of consumer behavior. The commitment includes meeting up to three times with the participant at a mutually agreed place and at their convenience to discuss their CAM experiences. It will also require them to take photographs and/or gather images (for example, from Google Images) that represent their experiences of CAM (please note the participant is not expected to take photos of their treatment session). This visual research method has proven to be very effective at gaining more in-depth information than just interviewing alone. It is anticipated that the time involved over a three month period will be approximately 6-8 hours depending on the length of the interviews and time it takes to gather images or take photographs.



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**What is the Clinic's involvement?**

There is no commitment required from the clinic other than providing an opportunity to advertise the research. Clinic and practitioner names will **NOT** be used in the research. The research is only interested in consumers' experiences. If you are interested in the results then I am happy to provide you a summary at the completion of my PhD.

**Who to contact with regards to the research?**

If you are happy for me to advertise the research then please either txt me on 027 2883558 OR e-mail me [s.dodds@massey.ac.nz](mailto:s.dodds@massey.ac.nz).

Thank you very much for your time and help in making this study possible.

Sarah Dodds  
School of Communication, Journalism and Marketing  
Massey University  
Private Bag 102 904  
North Shore City 0745  
Auckland

If you have any queries or concerns about this project then please feel free to contact my supervisors:

Dr Sandy Bulmer  
School of Communication, Journalism and Marketing  
Massey University  
Private Bag 102 904  
North Shore City 0745  
Auckland  
Telephone: 4140800 Ext 43315  
Email [s.l.bulmer@massey.ac.nz](mailto:s.l.bulmer@massey.ac.nz)

Dr Andrew Murphy  
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This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 12/094. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43279, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).

## Appendix D – Example advert



# Are you a CAM consumer?

I'M LOOKING FOR WOMEN 20 YEARS & OVER TO PARTICIPATE IN MY PHD RESEARCH ON COMPLEMENTARY & ALTERNATIVE MEDICINE.



Complementary & Alternative Medicine (CAM) is a fast growing healthcare market. Understanding this growth is important if CAM is to become a widely supported form of healthcare. Research on CAM consumers is critical to this.

*“Your help could contribute to the understanding of what people value about Complementary & Alternative Medicine”*

If you are currently using any form of CAM therapy like the ones listed above and would like to talk about your experiences then I would love to hear from you. As a thank you each participant will be given a **\$50 voucher** of their choice.

Do you use any of the following CAM therapies?

- Naturopathy
- Homeopathy
- Acupuncture
- Osteopathy
- Chiropractors
- Herbal Medicine
- Massage Therapy
- Aromatherapy
- Reiki
- Energy Healing
- Ayurveda Medicine



Sarah Dodds  
School of Communication, Journalism & Marketing

Mobile: 027 2883558  
Email: s.dodds@massey.ac.nz

Please contact if you are interested in participating ▶▶▶

Appendix E – Example flier



## Are you a CAM consumer?

I'M SEEKING WOMEN AGED 20 YEARS & OVER TO PARTICIPATE IN MY PHD RESEARCH ON COMPLEMENTARY & ALTERNATIVE MEDICINE.



Complementary & Alternative Medicine (CAM) is a fast growing healthcare market. Understanding this growth is important if CAM is to become a widely supported form of healthcare. Research on CAM consumers is critical to this.

if you are currently using any form of CAM therapy, e.g. naturopathy, homeopathy, osteopathy, chiropractor, herbal medicine, massage, acupuncture, reiki, energy healing etc, and would be happy to talk about your experiences then I would love to hear from you.

*As a thank you for the time commitment involved each participant will be given a \$50 voucher of their choice.*

For further information please contact



Sarah Dodds  
School of Communication,  
Journalism & Marketing  
Mobile: 027 2883558  
Email: s.dodds@massey.ac.nz

## Appendix F - Participant information sheet



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### ***Consumer Experiences of Complementary and Alternative Medicine***

#### **PARTICIPANT INFORMATION SHEET**

##### **Who is the researcher?**

My name is Sarah Dodds. I am a PhD (Doctor of Philosophy) student at Massey University with the School of Communication, Journalism and Marketing who is undertaking a research project on Complementary and Alternative Medicine (CAM) consumers. The focus of my research is exploring and studying the experiences of people who choose complementary and alternative medicine as a form of healthcare. By CAM, I am referring to the use of various therapies such as Chiropractors, Osteopathy, Naturopathy, Homeopathy, Herbal Medicine, Nutrition therapy, Acupuncture, Traditional Chinese Medicine, Aromatherapy, Massage therapy, Reiki, Energy Healing, Reflexology, Bowen, Kinesiology, Ayurveda etc.

Thank you for showing an interest in my research. You are invited to participate and I appreciate any assistance you can offer me. Below are further details of the research.

##### **What is the research project about?**

Complementary and Alternative Medicine (CAM) is a popular and growing form of healthcare both in New Zealand and worldwide. Although research has begun to explore CAM's popularity, more research is required into the CAM consumer to understand CAM's growth and its place in modern healthcare. The purpose of this PhD research is to understand some of the factors driving growth of consumption in this healthcare market and more specifically to explore the consumption experiences of CAM consumers with CAM healthcare providers and CAM treatments. Ultimately the research hopes to provide healthcare services, both CAM and mainstream, a greater understanding of the CAM consumer and some insight into how they can support their clients achieve their health goals.

##### **Who is the researcher looking for to participate?**

I am looking for participants aged 20 years and over who are either:

- 1) seeing a CAM practitioner or therapist on a regular basis (once a month), for example, getting a regular massage, regular visits to an osteopath, chiropractor, aromatherapist etc for health management; or who are
- 2) currently seeing a CAM practitioner, for example, naturopath, herbalist, homeopath, acupuncturist etc, who has given a treatment programme requiring follow-up visits.



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**What's the commitment for the participant?**

The commitment includes us meeting up to **three times over a 3 month period** at a mutually agreed place and at your convenience to discuss your CAM experiences. It will also require you to gather pictures (for example, from Google Images, magazines) and/or take photographs that represent (or symbolize) your experiences of CAM (please note you are **not** expected to take photos of your treatment sessions). This visual research method has proven to be very effective at gaining more in-depth information than just interviewing alone.

**What's involved as a participant?**

Our first meeting will involve us discussing the reasons you chose CAM and the CAM therapies you have used, your general experiences of CAM, the specific CAM therapy you are currently using and your experiences so far, including your health goals, health status and why you are seeing a CAM practitioner. After the first meeting I will ask you to gather pictures from magazines or the internet and/or take photographs of images that represent or symbolize how you feel about your experiences of CAM. Our second meeting will take place approximately three-four weeks after the first meeting. In this session we will discuss the photographs and pictures. The third meeting will take place approximately four-six weeks after the second. The purpose of this meeting is to essentially get an update on how the CAM therapy and treatment is going, and a chance to discuss the results of the previous two sessions. It is anticipated that the meetings will take approximately 60 minutes each.

**What are your rights as a participant?**

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

Please note that this is a study of personal experience and opinions. There are no right or wrong answers. I would prefer to audiotape the discussion sessions but this would only be done with your consent. You may ask for the recorder to be turned off at any time during the interview. If you wish to have a digital audio copy of your interviews I will provide this for you. I intend transcribing the audio-tapes into written documents myself. However in the event that a professional transcription service is required, the transcriber(s) will be required to sign an agreement to protect the confidentiality of the research data and the participants.



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**What happens to the information collected?**

All discussions and material gathered from you will be kept strictly confidential. Audio-tapes, transcriptions, photos will NOT contain any personal details (name, phone numbers, address) that can identify you. Individual's names will NOT be identified in the research report. You will be given a pseudonym. The information you provide will be analyzed and then written up as a case study in my thesis. If the information you provide is reported/published, this will be done in a way that does not identify you as its source. The responses from this study may be used in other consumer behavior studies and may be used for publication purposes.

All transcripts, audio-tapes, photos and journals will be stored for up to 10 years from the date of the interview they refer to, in a secured cabinet in the School of Communication, Journalism and Marketing at Massey University, Albany, after which they will be destroyed.

**What's in it for the participant?**

The research hopes to contribute to a growing body of research about CAM. Your participation will provide an insight and greater understanding of the experiences of CAM consumers.

In recognition of the time commitment required for this research I will give each participant a \$50 voucher of their choice. You will receive this voucher at the second interview. It remains your absolute right to withdraw yourself or your information from the research, irrespective of whether or not you have received the voucher or not.

**Who to contact with regards to the research?**

If you are interested in finding out more and participating in this study please either txt or phone me on 027 2883558 OR e-mail me [s.dodds@massey.ac.nz](mailto:s.dodds@massey.ac.nz) with your contact details and a convenient time to call.

Thank you very much for your time and help in making this study possible.

Sarah Dodds  
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Massey University  
Private Bag 102 904  
North Shore City 0745  
Auckland



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If you have any queries or concerns about this project then please feel free to contact my supervisors:

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This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 12/094. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43279, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).

## Appendix G – Phase 1 interview guide

# Consumer Experiences of Complementary and Alternative Medicine

### Interview Questions/Guide – Session 1

Thank you for agreeing to help out with my research. Have you read the information sheet outlining the project and your involvement? (*Go through information sheet highlighting participants rights and what is required of them*). Are there any questions you'd like to ask before we start (*Ask them to sign the consent form. I will then give a brief background of myself and my interest in CAM*)

I will begin by asking a few broad questions about your use of CAM, what you are seeing the practitioner for, how you are finding the experience so far. As we go along I will ask specific questions according to your responses. It will be more of a discussion, a bit like a conversation. Please remember you are free to stop at any time or decline to answer any questions.

Main Questions/Points of Discussion	Possible follow-up questions
1. Tell me your story of what has led you to use CAM and the things that attract you about CAM	Describe <point of interest> Tell me more about <experience> Why did <aspect> attract you?
2. Tell me about your experiences of using CAM	Tell me more about <experience> What aspects do like? What aspects do you dislike?
3. Tell me about the CAM practitioner you are currently seeing?	What aspects do you like/dislike about the practitioner? Explain <aspect> How would you describe your relationship?
4. Tell me about the treatment you are getting?	Describe further <treatment> Explain how difficult/easy the treatment is Describe how the treatment makes you feel
5. What benefits have you experienced so far ? Any issues?	Explain <benefit> Tell me more about <benefit>
6. What do you value about your experience/s with CAM and the practitioner you are seeing so far?	Describe <experience> Tell me more about <value>
7. What do you hope to achieve through CAM?	What are your health goals?
8. Do you have any further comments? Or is there anything else you would like add?	
9. Finally, may I record your age and occupation (If not already been volunteered during the course of interview)	

Thank you very much for sharing your experiences with me and giving up your time today. I am very grateful to you for assisting me in my research.

## Appendix H – Photo/image gathering guidelines



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### ***Consumer Experiences of Complementary and Alternative Medicine***

#### **Participant Photography/Picture Project**

##### **Purpose of the project**

This research is interested in your experiences of Complementary and Alternative Medicine (CAM). In our first session we began to talk about the CAM therapies you have experienced and are currently experiencing. For our second session together I would like you to take and/or gather photographs and pictures that represent what you think and how you feel about your CAM experiences to guide our discussion. Pictures, photographs and images can help to uncover feelings and thoughts about your experiences that are often difficult to articulate by just talking alone. Below are guidelines for gathering photographs and pictures.

##### **Photography and image gathering guidelines**

Over the next two weeks, prior to our second session, I would like you to take and/or gather up to 20 photos and/or pictures (minimum 12) of images that *represent what you think and how you feel about your experiences of complementary and alternative medicine*. It is entirely up to you whether you just gather pictures; take your own photographs, or a combination of both. Pictures can be gathered from a variety of sources, for example, magazines, internet (google images), newspapers etc. If you decide to take your own photographs you can do this using your own camera or I can provide you with a disposable camera.

##### **Photograph and image collection**

Once you have taken and gathered the photographs and pictures I will arrange to collect these prior to our next session. I will organise and supply any material required for the return of the images, e.g. USB stick for photographs taken on a digital camera or images downloaded from the internet, courier package for the return of disposable camera, USB stick, cut out images gathered from magazines etc.

Once I have received the photographs and images I will arrange a suitable time to meet with you to talk about the photographs and images you collected. This will be approximately 3-4 weeks from our first meeting.

Thank you very much for your time and help in making this study possible.



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**Contact Details**

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If you have any queries or concerns about this project then please feel free to contact my supervisors:

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Appendix I – Phase 2 interview guidelines

## **Consumer Experiences of Complementary and Alternative Medicine**

### **Photo-elicitation Interview – Session 2**

Firstly I'd like to start by asking if you have any questions about our last session and the transcripts I sent you to read. *Go over the transcripts.*

Thank you for taking the time to complete the photo/picture exercise. This session will focus on the photographs and pictures you have taken (found).

<b>Main Questions/Points of Discussion</b>	<b>Possible follow-up questions</b>
<p><b>Step 1: Story Telling</b> - Go through each photograph/picture</p> <ul style="list-style-type: none"> <li>• Tell me about this picture</li> </ul>	<p>Tell me more about &lt;picture&gt; Describe what's going on in &lt;picture&gt; Why did you take this &lt;picture&gt;?</p>
<p><b>Step 2: Missed Images</b> – I am interested too in pictures that you would have liked to have taken but couldn't for some reason.</p> <ul style="list-style-type: none"> <li>• Are there any pictures you would have liked to have taken but couldn't?</li> <li>• Describe the pictures you would have liked to have taken?</li> <li>• Why couldn't you take the picture?</li> </ul>	<p>Tell me more about &lt;untaken picture&gt; Why are these pictures important to you?</p>
<p><b>Step 3: Sorting Task</b> – I would like you now to sort the pictures into meaningful piles (groups) and provide a label or description for each pile</p> <ul style="list-style-type: none"> <li>• Tell me about each pile</li> </ul>	<p>Why did you group the photos this way? Why did you give the pile that label/description?</p>
<p><b>Step 4: Most Representative</b> – Now I would like you to choose one picture that MOST represents your experience of CAM</p>	<p>Tell me about this &lt;picture&gt;? Why this &lt;picture&gt;?</p>
<p><b>Step 5: Summary Image</b> – Lastly I would like you to pick up to 6 pictures that are most important to you in terms of your experience and create a summary picture or collage. You are free to complete this however you wish, there are no guidelines it is more or a creative exercise.</p>	<p>Tell me about your summary picture?</p>

Thank you very much for sharing your experiences with me and giving up your time today. I am very grateful to you for assisting me in my research.

## Appendix J – Phase 3 interview guidelines

# ***Consumer Experiences of Complementary and Alternative Medicine***

## **Interview Questions/Guide – Session 3**

### **Introduction**

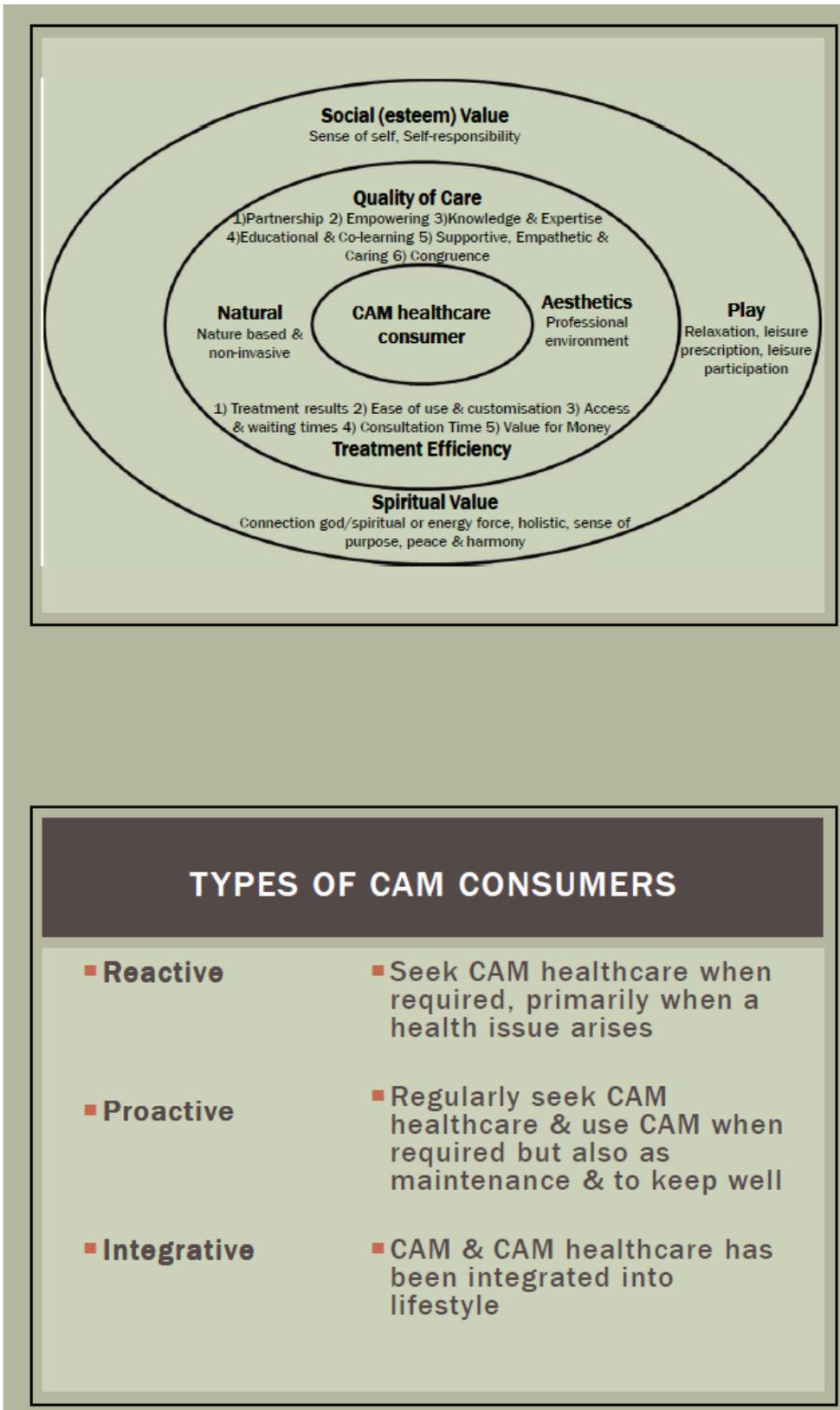
Firstly I'd like to start by asking if you have any questions about the transcripts I sent you to read. *Go over the transcripts.*

This session is a final follow up to see how you are going and to discuss further your CAM experiences. In this session I would also like to get your feedback my initial findings from the first two sessions and will be showing you a short presentation. Please remember you are free to stop at any time or decline to answer any questions.

<b>Main Questions/Points of Discussion</b>	<b>Possible follow-up questions</b>
1. Since we last met tell me about your experiences with the CAM practitioner and the treatment.	Tell me more about <experience> Describe <experience>
2. Describe the aspects of your CAM experience that you are getting the most from?	Tell me about <experience> Why that <aspect>?
3. Describe the aspects of your CAM experience that you getting the least from?	Tell me about <experience> Why that <aspect>?
4. Tell me what you value most out of your experience of CAM	Tell me about <value> Why that <value>?
5. Run through the power point presentation on the findings and ask for feedback	Probe
6. Do you have any further comments? Or is there anything else you would like to add?	

Thank you very much for sharing your experiences with me and giving up your time to participate in this research. I am very grateful for your help.

**Appendix K – Power point slides used in phase 3 interview**



**TYPES OF CAM CONSUMERS**

- **Reactive**
  - Seek CAM healthcare when required, primarily when a health issue arises
- **Proactive**
  - Regularly seek CAM healthcare & use CAM when required but also as maintenance & to keep well
- **Integrative**
  - CAM & CAM healthcare has been integrated into lifestyle

## Appendix L – Participant consent form



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### *Consumer Experiences of Complementary and Alternative Medicine*

#### PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name - printed \_\_\_\_\_

Appendix M – Transcriber’s confidentiality form



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***Consumer Experiences of Complementary and  
Alternative Medicine***

**TRANSCRIBER’S CONFIDENTIALITY AGREEMENT**

I ..... (Full Name - printed) agree to  
transcribe the recordings provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those  
required for the project.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Appendix N – List of codes used in analysis

<b>Miscellaneous Codes – Background information</b>		
	CT	CAM therapies used by the participant
	H	History – health history, background, CAM health care background
	W	Why uses CAM
	Q	Questioning CAM/uncertain
	Ref	Referral
<b>Consumer Value Codes</b>		
<b>Broad code</b>	<b>Sub codes</b>	<b>Meaning</b>
Quality	P	Practitioner – any aspects not covered by other codes
	Pk	Practitioner knowledge and expertise
	Pm	Practitioner manner – empathy, care, friendliness
	Ps	Practitioner service
	Pr	Practitioner relationship – partnership, involvement, collaboration, cooperation
	Pt	Practitioner trust, integrity, authenticity
	E	Empowering
	K	Gaining knowledge, learning, being educated, colearning
	Qp	Quality products
Em	Emotional support	
Efficiency	M	Money, cost of CAM
	R	Root cause - Looks at the root underlying cause of illness
	T	Treatment – any aspects of treatment not covered in other codes
	Tc	Consultation time
	Te	Treatment efficiency – ease of use, convenience
	Tr	Treatment results
	Tp	Treatment planning, customisation
Aesthetics	A	Physical clinic environment
Ethics (natural)	MHW	Modern health worries, combat toxic environment, helps cope in toxic world
	N	Natural, makes sense, no reactions, in line with body, back to basics
	Pre	Preventative
Social and esteem value	Soc	Social self, social acceptability
	SR	Self-responsibility, control
	SA	Self-aware, sense of self, self-discovery, transformation
	We	Wellness, Feel well, wellbeing, maintenance, healing, promise of healing
	J	Personal journey/path
Spiritual	S	Spiritual – connection with energy force, god, spirit
	Sh	Spiritual – holistic considers mind, body, soul, balance

value	Sp	Spiritual – meaning, sense of purpose, sense of hope
	Rec	Reconnecting – nature, people
	En	Energy, energy healing, body is energy
	In	Intuitive
Play	L	Enables leisure participation
	Lr	Leisure - relaxation
	Lp	Leisure prescription
<b>Value co-creation codes</b>		
Value co-creation activities	Co	Cooperation, collaboration
	Cl	Colearning
	Cp	Coproducing
	Com	Communication
	Ct	Commitment
	Con	Connections
	Ctrl	Control
	Ca	Coordinating other activities such as yoga, Pilates etc
	Ch	Changing lifestyle factors and habits
	Ci	Integration of other forms of health care
	CP	Cognitive processing
C	Compliance	
Relationship styles	Ad	Advisory type relationship
	Con	Consultative relationship
	Pship	Partnership
Approach	Re	Reactive type of health care
	Pro	Proactive, preventative
	Int	Integrative approach to health care